Health & Social Care Bulletin

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Health

Publication of the final report of the Mid Staffordshire NHS Foundation Trust Public Inquiry

Robert Francis QC, Chairman of the Inquiry has published his final report following consideration of over 250 witnesses and over one million pages of documentary evidence.

The Inquiry has been examining the commissioning, supervisory and regulatory bodies in the monitoring of Mid Staffordshire hospital between January 2005 and March 2009. It has been considering why the serious problems at the Trust were not identified and acted on sooner, and identifying important lessons to be learnt for the future of patient care. It builds on Mr Francis’s earlier report, published in 2010 after the earlier independent inquiry on the failings in the Mid Staffordshire NHS Foundation Trust between 2005 and 2009.

The Inquiry identifies a story of terrible and unnecessary suffering of hundreds of people who were failed by a system which ignored the warning signs of poor care and put corporate self interest and cost control ahead of patients and their safety.

The Chairman makes 290 recommendations designed to change this culture and make sure patients come first by creating a common patient centred culture across the NHS.

The Chairman’s recommendations include:

A structure of fundamental standards and measures of compliance:

- a list of clear fundamental standards, which any patient is entitled to expect which identify the basic standards of care which should be in place to permit any hospital service to continue

- these standards should be defined in genuine partnership with patients, the public and healthcare professionals and enshrined as duties, which healthcare providers must comply with

- non compliance should not be tolerated and any organisation not able to consistently comply should be prevented from continuing a service which exposes a patient to risk

- to cause death or serious harm to a patient by non compliance without reasonable excuse of the fundamental standards, should be a criminal offence

- standard procedures and guidance to enable organisation and individuals to comply with these fundamental standards should be produced by the National Institute for Health and Clinical Excellence (NICE) with the help of professional and patient organisation

- these fundamental standards should be policed by the Care Quality Commission (CQC).
Openness, transparency and candour throughout the system underpinned by statute. Without this a common culture of being open and honest with patients and regulators will not spread. Including:

- a statutory duty to be truthful to patients where harm has or may have been caused
- staff to be obliged by statute to make their employers aware of incidents in which harm has been or may have been caused to a patient
- trusts have to be open and honest in their quality accounts describing their faults as well as their successes
- the deliberate obstruction of the performance of these duties and the deliberate deception of patients and the public should be a criminal offence
- it should be a criminal offence for the directors of trusts to give deliberately misleading information to the public and the regulators
- the CQC should be responsible for policing these obligations.

Improved support for compassionate, caring and committed nursing:

- entrants to the nursing profession should be assessed for their aptitude to deliver and lead proper care, and their ability to commit themselves to the welfare of patients
- training standards need to be created to ensure that qualified nurses are competent to deliver compassionate care to a consistent standard
- nurses need a stronger voice, including representation in organisational leadership and the encouragement of nursing leadership at ward level
- healthcare workers should be regulated by a registration scheme, preventing those who should not be entrusted with the care of patients from being employed to do so.

Stronger healthcare leadership:

- the establishment of an NHS leadership college, offering all potential and current leaders the chance to share in a common form of training to exemplify and implement a common culture, code of ethics and conduct
- it should be possible to disqualify those guilty of serious breaches of the code of conduct or otherwise found unfit from eligibility for leadership posts
- a registration scheme and a requirement need to be established that only fit and proper persons are eligible to be directors of NHS organisations.

Mr Robert Francis QC said:

"We need to ensure fundamental standards are enforceable by law – and the criminal law in the most serious of cases. Senior managers should be made accountable, patients need to be protected from poor nursing standards and all staff should be empowered to be open and transparent when it comes to the wellbeing of the people in the care.

The NHS can provide great care and the system and the people in it should make sure that happens everywhere. The recommendations I am making today represent not the end but the beginning of a journey towards a healthier culture in the NHS where patients are the first and foremost consideration of the system and all those who work in it. It is the individual duty of every organisation and individual within the service to read this report and begin working on its recommendations today."
Robert Francis QC chairs the Public Inquiry, which has been set-up under the Inquiries Act 2005 and Inquiry Rules 2006. It examined the commissioning, supervisory and regulatory bodies in the monitoring of Mid Staffordshire hospital between January 2005 and March 2009. It considered why the serious problems at the trust were not identified and acted on sooner, and identifying important lessons to be learnt for the future of patient care.

The then Secretary of State for Health, Andrew Lansley, announced the establishment of the Public Inquiry to Parliament on 9 June 2010.

**Background on the Inquiry:**
- the Procedural Hearing was held on 20 July 2010
- oral hearings – began on 8 November 2010 in Stafford and concluded on 1 December 2011
- the Inquiry itself sat for a total of 139 days
- in total, the Inquiry heard from 164 witnesses in person. In addition, 87 witness statements and 39 provisional statements were 'read' into the Inquiry's record. The Inquiry took 352 separate witness statements in total
- over a million pages of material was disclosed to the Inquiry (the Inquiry Database contains 64,319 documents and 1,190,648 pages)
- during the course of the Inquiry hearings 55,265 pages were used by Trial Director
- costs of the Inquiry up to November 2013 are approximately £13 million.

**Since 9 June 2010, the Inquiry has been through several stages:**
- July to August 2010 – four assessors were appointed and the Inquiry began requesting evidence
- 8 November 2010 to 1 December 2011 – public hearings were held to explore the evidence of important witnesses and examine key documents
- October to November 2011 – a series of seven public seminars were held to explore the ‘forward-looking’ part of the Inquiry’s terms of reference
- December 2011 to February 2012 – a series of seven fact-finding visits were undertaken to a variety of healthcare organisations
- December 2012 – the appointment of four independent health expert assessors were announced to assist the Chairman in reviewing his final recommendations
- 23 January 2013 – the Chairman announced that, following agreement from the Secretary of Health, he would hand over the final report on 5 February 2013 and publish it on 6 February 2013.

The final report of the Mid Staffordshire NHS Foundation Trust Public Inquiry can be found at [www.midstaffspublicinquiry.com/report](http://www.midstaffspublicinquiry.com/report)

**Source:** [www.midstaffspublicinquiry.com](http://www.midstaffspublicinquiry.com) 6 February 2013

**Managing NHS hospital consultants**
A new contract for hospital consultants, introduced in October 2003, delivered many of the expected benefits. This was in exchange for a significant increase in consultants' pay.
According to a new report entitled, ‘Managing NHS hospital consultants’ by the National Audit Office (NAO), there is still significant room for improvement in how trusts manage their consultants.

By 2011/12, there were around 40,000 hospital consultants employed at a cost to the NHS of £5.6 billion, 97 per cent of whom were on the 2003 contract. Of the expected benefits that could be measured, all have been either fully or partly achieved. Consultants' private practice work has not increased, pay progression has slowed and 97 per cent now have a job plan setting out their objectives, although 16 per cent of these have not been reviewed in the last 12 months. While indicators show that consultant productivity has continued to fall, the rate of decline has slowed significantly. The consultant participation rate (the ratio of full-time equivalent consultants to headcount) has also increased although it remains unclear to what extent this has resulted in consultants doing more actual work for the NHS.

More could be done to achieve better value for money, by fully realising the benefits set out in the Department of Health’s business case. Despite, for example, the contract providing a clear structure for paying for additional work at contractual rates, most trusts still use locally agreed rates of pay for additional work outside job plans, which ranges from £48 to £200 per hour. Pay progression is also the norm and not linked to consultant performance.

The contract significantly increased the cost of employing consultants. Between 2002/03 and 2003/04, total earnings per full time consultant increased by 12 per cent in real terms with a 24 per cent increase in the bottom of the consultants' pay band and a 28 per cent increase in the top. The NHS was investing up front for the expected benefits it hoped to achieve in the future.

Realizing the contract's benefits depends on how well individual NHS trusts manage consultants: for example, through effective job planning to improve the management of their time. There are examples of trusts adopting good management practice; however, more improvement can be made. According to an NAO survey, only 41 per cent of consultants thought that their trust motivated them to achieve the trust's objectives. While most trusts monitor consultant performance, only 43 per cent of trusts (27 per cent of consultants) thought that information was good enough to assess individual consultant performance. Trusts also reported that nearly a fifth of consultants have not had an appraisal in the last 12 months. Many trusts are not implementing the good practice job planning guidance published jointly by NHS Employers and the British Medical Association in 2011.

Source: www.nao.org.uk 6 February 2013

**Professor Sir Bruce Keogh to investigate hospital outliers**

As announced in the Prime Ministerial statement on the Francis Report, Professor Sir Bruce Keogh is to lead an investigation into hospitals that are persistent outliers in hospital performance and provide practical support.

The NHS Commissioning Board has announced that the first five hospital trusts confirmed are:

- Colchester Hospital University NHS Foundation Trust
- Tameside Hospital NHS Foundation Trust
- Blackpool Teaching Hospitals NHS Foundation Trust
- Basildon and Thurrock University Hospitals NHS Foundation Trust
• East Lancashire Hospitals NHS Trust.

Each of these has had outlying poor results for a key mortality measure (Summary Hospital-level Mortality Indicator) for a period of two years.

Professor Sir Bruce will undertake this investigation in his joint role as NHS Medical Director at the Department of Health and Medical Director of the NHS Commissioning Board. The Care Quality Commission, Monitor, NHS Trust Development Authority and Clinical Commissioning Groups will all be invited to be involved in the process.

Professor Sir Bruce Keogh said:

“Each of the hospitals we identify today is already under scrutiny by regulators. This clinically-led and practical investigation will allow me to assure myself, Parliament and patients that these hospitals have everything they need to improve.”

Source: www.commissioningboard.nhs.uk 6 February 2013

Most suspected cancers 'referred after first GP visit'

More than 80 per cent of patients with suspected cancer in England are referred by their GP after just one or two consultations, a study suggests.

Data from more than 13,000 cancer patients shows more than half were referred to a specialist after the first trip to the doctor.

Harder-to-spot cancers, such as lung cancer, took longer to identify.

Cancer Research UK welcomed the figures, but said there was more work to be done on early diagnosis.

Much work has been done on improving early diagnosis in the past decade, including awareness campaigns, National Institute for Health and Clinical Excellence (NICE) guidelines on the symptoms for suspected cancer, and targets to fast-track referrals.

Late diagnosis and treatment of cancers has been highlighted as one reason behind poor cancer survival rates in the UK compared with other countries.

The study showed that work was still needed on some cancers that are harder to spot. About a third of lung and stomach cancer patients needed three or more consultations before they were referred to a specialist.

Study author Dr Georgios Lyratzopoulos, from the Cambridge Centre for Health Services Research, said the results suggested progress was being made.

“We now understand the typical symptoms of some cancers, like breast and melanoma, very well and that helps doctors to spot them quickly.

“Other cancers have less typical symptoms, making them more difficult to recognise straight away.

“Not suspecting cancer early enough can be stressful for patients and their relatives so understanding the symptoms of these cancers better is where we need to be making greater research efforts to help spot the disease earlier.”

Prof Greg Rubin, the clinical lead for cancer at the Royal College of GPs and co-author of the study, said the results showed most patients were referred quickly but there was a significant minority who had a few trips to the GP before suspicion was raised.
“NICE referral guidelines have helped people with classic symptoms to be seen more quickly but, for patients with less typical symptoms, the decision to refer isn't always as simple,” he said.

Prof Rubin said the results, in the British Journal of Cancer, showed GPs now needed to think about smarter ways of picking up hard-to-spot cancers sooner.

Easier access to diagnostic tests was one way, but the Department of Health was also trialling decision-making tools to help GPs spot cancer when patients presented with multiple symptoms, he said.

"Not all cancers should be treated the same, we need to get more selective about where we direct our efforts", he added.

Sara Hiom, early diagnosis director at Cancer Research UK, said the findings were encouraging but there was still room for improvement.

"Progress is clearly being made but one in five people have to make more than two visits to their GP, although it's not surprising that this is usually for those cancers that are harder to spot," she said.

She added that it was important patients acted on any persistent health changes that concerned them and had the confidence to go back to their GP if problems did not clear up.

Source: www.bbc.co.uk/news 8 February 2013

A quarter of cancer patients face isolation each year

One in four (23 per cent) of the 325,000 newly diagnosed cancer patients in the UK - an estimated 70,000 patients each year - lack support from family and friends during their treatment and recovery, according to new research published by Macmillan Cancer Support. And a third of those (seven per cent) – an estimated 20,000 people each year - will receive no help whatsoever, facing cancer completely alone.

The ‘Facing the fight alone’ report – which looks at the number, profile and experiences of isolated people living with cancer - found more than half (53 per cent) of health professionals have had patients opt not to have treatment at all due to a lack of support at home from family and friends. Nine in ten (89 per cent) health professionals felt that a lack of support at home leads to a poorer quality of life for patients, whilst over half felt that it can lead to poorer treatment decisions (54 per cent) and a shorter life expectancy (56 per cent).

The detrimental effects of isolation on the lives of people living with cancer are far-reaching. More than half (53 per cent) of isolated patients have skipped meals or not eaten properly due to a lack of support at home. More than one in four (27 per cent) have not been able to wash themselves properly, while three in five (60 per cent) have been unable to do household chores.

Isolation also makes it harder for cancer patients to self-manage their medical care. Over one in ten (11 per cent) of isolated patients have missed appointments to hospital or their GP, while one in six (18 per cent) have been unable to pick up prescriptions for their medication.

Family members and friends living too far away, having other commitments or patients just having no-one to turn to are the most common reasons patients lack support. Other than a visit from a health professional, one in eight (12 per cent) of people living with cancer surveyed haven’t had a single visit from friends or family in over six months.
For some, isolation seems to be a direct result of their cancer diagnosis. Over one in six (18 per cent) have lost touch with family or friends because of their diagnosis, while four in five (80 per cent) say the financial impact of cancer means they can’t afford to see their family or friends as much.

Lis Blyth, 66, Surrey, was diagnosed with breast cancer in 2008, says:

“Living alone, I didn’t have the energy to do anything during my radiotherapy, so I just lived on ready-made meals. There were days when I went to bed having had nothing more than a glass of milk and a biscuit because I was too exhausted to cook. That was four years ago, but even now, due to the long term side effects of the treatment, I’m often still too exhausted to get on a bus and shop for food.

“With the exception of the doctor who diagnosed me, none of the hospital staff ever asked how I was or if I could support myself at home.”

Ciarán Devane, Chief Executive of Macmillan Cancer Support, said:

“This research shows that isolation can have a truly shattering impact on people living with cancer. Patients are going hungry, missing medical appointments and even deciding to reject treatment altogether which could be putting their lives at risk — all because of a lack of support.

“But these figures are just the tip of the iceberg. As the number of people living with cancer is set to double from two to four million by 2030, isolation will become an increasing problem and we need to address this now. That’s why we are launching a new campaign to help tackle this crisis and to ensure that in future, no-one faces cancer alone.”

Macmillan Cancer Support is calling on health professionals to adopt the recommendations in the Facing the Fight Alone report.

To read the report, or to find out more about the Not Alone campaign, visit www.macmillan.org.uk/notalone

Source: www.macmillan.org.uk 11 February 2013

Sir Bruce Keogh announces final list of outliers

On 6 February 2013, in response to a request from the Prime Minister, Sir Bruce Keogh, the Medical Director of the NHS, announced an investigation into hospitals that are persistent outliers on mortality indicators. Sir Bruce identified an initial list of five organisations that had been outliers for two years on the Summary Hospital-level Mortality Indicator (SHMI), and said that he would announce further hospitals shortly.

Sir Bruce has now announced the final list of hospitals that will be looked at as part of his investigation. These are the following nine organisations that have been outliers for two years on the Hospital Standardised Mortality Ratio (HSMR):

- North Cumbria University Hospitals NHS Trust
- United Lincolnshire Hospitals NHS Trust
- George Eliot Hospital NHS Trust
- Buckinghamshire Healthcare NHS Trust
- Northern Lincolnshire and Goole Hospitals NHS Foundation Trust (FT)
- The Dudley Group NHS FT
Sir Bruce said:

“These hospitals are already working closely with a range of regulators. If there were concerns that services were unsafe the regulators should have intervened.”

“The purpose of my investigation is to assure patients, public and Parliament that these hospitals understand why they have a high mortality and have all the support they need to improve. This will be a thorough and rigorous process, involving patients, clinicians, regulators and local organisations.”

Source: www.commissioningboard.nhs.uk 11 February 2013

Outlook for NHS and social care pessimistic as financial squeeze bites

Pessimism is growing in the NHS and social care as local leaders respond to mounting financial pressures, according to the latest quarterly monitoring report on service performance published by The King's Fund.

For the first time, the report includes a survey of directors of adult social services in English local authorities alongside its usual survey of NHS finance directors. Both surveys suggest that the financial squeeze is beginning to have an impact on quality and access to services in some parts of the country. A third of NHS finance directors report that the quality of patient care has worsened during the last year and more than a third of social services directors expect to have to cut social care services over the next year.

While most NHS organisations are on track to meet financial targets, it is clear that pressures are growing towards the end of the second year of the so-called Nicholson Challenge to find £20 billion in productivity improvements by 2015. The main findings from the survey of NHS finance directors are:

- a third (16) report that the quality of patient care in their area has worsened during the past year; this compares with only about one in six who said the same thing in the last survey
- more than three quarters (39) expect to end the financial year in surplus, with only three anticipating a deficit. Thirty-four are confident of achieving their cost improvement programme targets for 2012/13, with nine expressing concern
- in contrast, when asked how they felt in general about the financial state of their local health economy – not just their own organisation – over the next 12 months, around two-thirds (32) were pessimistic.

With local authorities grappling with the second year of a budget squeeze that will see an overall cut of 27 per cent in central Government funding by 2015, directors of adult social services are pessimistic about the financial outlook:

- nearly a third (18) predict an overspend on their budgets, with a similar number (17) expecting an underspend and 23 expecting to break even
• the financial pressures are set to have a significant impact on access to services, with more than a third (21) of directors anticipating having to reduce services and nearly a fifth (12) expecting to increase charges over the next year

• nearly three-quarters (43) said that they are pessimistic about the overall state of the local health and care economy over the next 12 months, with only three reporting any optimism.

The report also includes a dashboard of key NHS performance indicators. While these are mostly stable, the proportion of patients waiting more than four hours in A&E is at its highest level for this quarter since 2003/04. This remains within the Government's target range, with the increase to some extent accounted for by the relaxation in the target and seasonal factors. However, with more than a quarter of trusts (65), reporting breaches of the target, it is clear that many hospitals are struggling to maintain performance in emergency care.

The main findings from the analysis of performance measures are:

• 4.3 per cent of patients spent longer than four hours in A&E in the third quarter of the current financial year

• waiting times for hospital treatment are stable, with the proportion of patients waiting longer than the operational standards having increased slightly for outpatients and reduced for all other waiting lists

• impressive reductions in healthcare-acquired infection rates continue, with a 13.5 per cent drop in C difficile and a drop of nearly 12 per cent in MRSA year-on-year counts to November 2012.

According to the official statistics, delays in transferring patients out of hospital remain stable, despite more than 60 per cent (30) of NHS finance directors reporting that delayed transfers of care have worsened over the last year. With other feedback also suggesting delayed transfers have got worse, the report calls for further investigation into this issue.

Professor John Appleby, Chief Economist at The King’s Fund said:

“The NHS faces unprecedented financial pressures, and there are growing worries that patient care will suffer. For social care, it will be increasingly difficult for councils to make further savings without directly cutting services or affecting quality. Health and care services have coped well until now, but it is clear that many organisations expect things to become much more difficult over the coming year.”

The report ‘How is the health and social care service performing’ can be found at: www.kingsfund.org.uk

Source: www.kingsfund.org.uk 14 February 2013

Independent review invites public to share their experiences of the Liverpool Care Pathway

Members of the public have been invited to share their experiences of the Liverpool Care Pathway for Dying Patients (LCP), both good and bad, as part of the review being chaired by Senior Rabbi and Crossbench Peer, Baroness Julia Neuberger.

Their views will feed into the independent review of the pathway, which was announced in November 2012 by Care and Support Minister Norman Lamb to investigate concerns about the
pathway, particularly accounts of the withdrawal of foods and fluids from dying patients and the use of financial incentives.

Baroness Neuberger said:

“I am honoured to have been asked to lead this review. It will tackle a really important area of concern and, I hope, be able to make recommendations that will improve how dying people are treated within our health and social care system.”

The review will examine various elements of the LCP, including:

- the experience and opinions of patients and families
- the experience and opinions of health professionals
- hospital complaints
- the role of financial incentives in respect of the LCP
- the literature about benefits and limitations of the Liverpool Care Pathway.

Care and Support Minister Norman Lamb said:

“Experts agree the Liverpool Care Pathway, if applied properly, can help patients die a dignified and pain free death, but, as we have seen, there have been too many unacceptable cases where patients or their families were ignored or not properly involved in decisions. There have also been reports of food and fluids being denied to people inappropriately.

“It is vital for relatives to have complete confidence in the care that their loved ones are receiving. This is why we want to hear from people with experience of the Liverpool Care Pathway, where it met the high standards expected and where things went wrong.

“I urge people to get in touch to share their experiences, so we can ensure that lessons are learned and things put right.”

As part of the review, Baroness Neuberger will be holding meetings with families who have had experience of the LCP.

Baroness Neuberger has also announced full details of the panel of independent experts she has appointed to run the review:

- Denise Charlesworth-Smith – has experience of the Liverpool Care Pathway when her father was placed on it
- Tony Bonser – fundraiser for Macmillan Cancer Support; North Western Champion for the Dying Matters Consortium
- The Rt Revd Richard Harries – former Bishop of Oxford
- Lord Charles Guthrie – Chancellor of Liverpool Hope University; Chairman of both the Hospital of St John and St Elizabeth and St Johns Hospice
- Professor Emily Jackson – Dean of Law at the London School of Economics
- Dr Dennis Cox – Royal College of General Practitioners
- David Aaronovitch – columnist for The Times
- Lord Khalid Hameed – Chairman of the Alpha Hospital Group; Chairman & CEO of the London International Hospital
• Sarah Waller – a former trust chief nurse and director of human resources: currently leads The King’s Fund’s Enhancing the Healing Environment Programme.

The review will report to ministers and to the NHS Commissioning Board in the Summer of 2013.

Source: www.gov.uk/dh 16 February 2013

Infection prevention and control in care homes: information resource published

An information resource and summary for care workers on the prevention and control of infection in care homes has been published by the Department of Health.

These aim to assist staff in taking all reasonable steps to protect residents and staff from acquiring infections and cross infection; and provide information and guidance on infection prevention and control that will assist managers undertaking risk assessments and in developing policies.

The steps taken in care homes to protect residents and staff from infection represent an important element in the quality of care. Therefore families and carers want to be assured that the care their relatives and dependants receive is provided in a clean and safe environment.

Infections acquired in care homes may be serious and, in some cases, life-threatening. These may worsen underlying medical conditions and adversely affect recovery. Infections may be caused by organisms resistant to antibiotics and the high media profile they generate may alarm residents, their relatives and carers.

‘Prevention and control of infection in care homes: an information resource’ and ‘Prevention and control of infection in care homes: summary for staff’ are available at www.gov.uk/dh

Source: www.gov.uk/dh 18 February 2013

Mortality rate three times as high among mental health service users than in general population

Mortality among mental health service users aged 19 and over in England was 3.6 times the rate of the general population in 2010/11, new Health and Social Care Information Centre (HSCIC) figures show.

People in contact with specialist mental health services had a higher death rate for most causes of death, especially mental and behavioural disorders and diseases of the nervous system such as Alzheimer’s disease, according to new analysis about cause of death released for the first time.

However, a much higher level of mortality (considering people between the ages of 19 and 74) also occurred for lifestyle related diseases, including:

• nearly four times the general population rate of deaths from diseases of the respiratory system (at 142.2 per 100,000 service users, compared with 37.3 per 100,000 in the general population)
- just over four times the general population rate of deaths from diseases of the digestive system (at 126.1 per 100,000, compared with 28.5 per 100,000 in the general population)

- 2.5 times the general population rate of deaths from diseases of the circulatory system (at 254.0 per 100,000 compared with 101.1 per 100,000 in the general population).

Within these disease areas specific conditions that accounted for a high proportion of deaths among service users (under the age of 75) were:

- diseases of the liver; at 7.6 per cent of deaths (1,430 in total)
- ischaemic heart diseases; at 9.9 per cent of all deaths (1,880 in total).

The findings are based on extended analysis of linked data from HSCIC's Mental Health Minimum Dataset (MHMDS) to Office of National Statistics (ONS) deaths data. They are released as part of a the annual Mental Health Bulletin, which provides information about specialist mental health services in England; including the number of people in contact with services and the number who spend time in hospital.

Key findings from the new mortality analysis show that in 2010/11:

- the mortality rate was 4,008 per 100,000 (83,390 deaths in total) for mental health services users, compared to the general population rate of 1,122 per 100,000

- by age, the difference in mortality rates was largest among people aged 30 to 39; at almost five times that of the general population, 300 per 100,000 service users (520 in total) compared to 63 per 100,000 in the general population

- by underlying cause of death, the proportionate difference in mortality rates was greatest for mental and behavioural disorders (where the main cause of death was unspecified dementia) at just over twelve times that of the general population at 556 per 100,000 service users (11,570 in total) compared to 46 per 100,000 in the general population.

Key findings from the annual mental health bulletin provide the most comprehensive picture to date of activity in England. Based on a new, updated version of the MHMDS that includes additional data processing, the 2011/12 information captures even brief contact with services and shows that in 2011/12:

- just over 1.5 million people were in contact with specialist mental health services, equating to approximately one person in 32 in England

- a third of service users (530,830) were aged 65 or over. The proportion of the general population who are this age is much lower at just over 16 per cent

- 99,100 service users spent time in an NHS hospital - continuing the downward trend since 2009/10.

HSCIC Chief Executive Tim Straughan said:

"Today marks the release of the most comprehensive analysis of our mental health data. Not only is the data the most comprehensive it has ever been, but we have also been able to link this information with other data to report about the subject in greater depth.

"We know therefore that the mortality rate among people who are in contact with specialist mental health services is nearly four times that for the general population."
"While it may be assumed that the mortality rate would be higher for diseases like dementia among mental health service users, it is perhaps unexpected that the mortality rate for more lifestyle related conditions is also much higher than for the general population.

"This data is a very valuable starting point for health professionals and the public alike to understand what is happening to people who access specialist mental health services. Its high level of completeness provides compelling evidence as to what is happening within our communities and hospitals."

Source: www.ic.nhs.uk 19 February 2013

**Major decision made on the future of healthcare in North West London**

The Joint Committee of Primary Care Trusts (JCPCT) has made a decision on the future of NHS services for approximately two million people living in North West London.

The Committee agreed with all the recommendations put forward by the ‘Shaping a healthier future’ programme following public consultation. This will mean:

- investing over £190 million more in out-of-hospital care to improve community facilities and the care provided by GPs and others. Most of these improvements will be put in place before any major changes to local hospitals are made
- the five major acute hospitals with a 24/7 A&E and Urgent Care Centre will be: Chelsea & Westminster; Hillingdon; Northwick Park; St Mary’s; and West Middlesex
- Central Middlesex Hospital will be developed in line with the proposed local and elective hospital models of care, and will also include a 24/7 Urgent Care Centre
- Hammersmith Hospital will be developed in line with the proposed local and specialist hospital models of care, and will include a 24/7 Urgent Care Centre
- both Ealing and Charing Cross Hospitals will be developed in line with the proposed local hospital model of care, and will each include a 24/7 Urgent Care Centre. The JCPCT also recommended that further proposals for these two hospitals are developed in future by the relevant clinical commissioning groups (CCGs).

The ‘Shaping a healthier future’ programme was established to address a number of challenges being faced by the NHS in North West London, including the demands of an increasing, ageing population. There are more people with long term conditions, and unacceptable variations in the quality of care, evidenced by higher mortality rates for patients treated in hospital at night or during the weekend.

Following extensive public consultation, the JCPCT was asked to approve the 11 recommendations made in the ‘Shaping a Healthier Future’ Decision Making Business Case, as well as two further recommendations which refer to additional proposals for Ealing and Charing Cross hospitals.

Taking into account all of the evidence, the JCPCT has accepted all of the recommendations. These proposals will now take three to five years to implement, ensuring that improvements in out of hospital care are in place before major changes to hospital services are then implemented.

Jeff Zitron, Chair of the JCPCT, said:
“This is an important decision for the NHS in NW London. I am delighted that, after thorough and careful examination, we are able to fully recommend what clinicians feel will deliver the best possible care for local people for years to come. We have not taken this decision lightly, and have been very careful to consider the many thousands of responses we received during our extensive consultation last Summer. I am confident that this is the best decision for the people of North West London and for the NHS.”

Dr Mark Spencer, Medical Director for Shaping a healthier future and Ealing GP, said:

“This decision will save lives and improve care dramatically for the two million people living across North West London. I am pleased that the JCPCT agreed that this was the best decision for a clinically safe, high quality and financially secure future for all the hospitals and NHS trusts in North West London. There are urgent and pressing needs to make these changes. If we do nothing people will continue to die unnecessarily and services will fail.”

Recommendations before the JCPCT (the Decision Making Business Case)

The recommendations are included in the recommendation paper which accompanies the Decision Making Business Case (DMBC). This paper outlines the decisions that need to be taken by the JCPCT about the future shape of services in North West London. The programme has followed a process to develop a shared vision of care, evaluate different options, consult the public and stakeholders, develop and analyse recommendations, create a benefits framework and plan implementation.

The DMBC has been reviewed by the Programme Board, Clinical Board, Finance and Business Planning Group and other committees and groups established by the JCPCT to provide it with advice and recommendations. The JCPCT’s decisions will be enacted through Clinical Commissioning Groups (CCGs) and the NHS Commissioning Board contracts and agreements over the medium term.

A full copy of the DMBC can be found at www.northwestlondon.nhs.uk/shapingahealthierfuture

The recommendations included in the DMBC are as follows:

- to agree and adopt the North West London acute and out of hospital standards, the North West London service models and clinical specialty interdependencies for major, local, elective and specialist hospitals as described in Chapter 7 of the Decision Making Business Case (DMBC)

- to agree and adopt the model of acute care based on five major hospitals delivering the London hospital standards and the range of services described in Chapters 7 and 9 of the DMBC should be implemented in North West London

- to agree that the five major hospitals should be as set out in Chapter 10 of the DMBC: Northwick Park Hospital, Hillingdon Hospital, West Middlesex Hospital, Chelsea & Westminster Hospital and St Mary’s Hospital

- to agree that Central Middlesex Hospital should be developed in line with the local and elective hospital models of care including an Urgent Care Centre operating 24 hours a day, seven days a week as detailed in Chapters 7,9 and 10 of the DMBC

- to agree that Hammersmith Hospital should be developed in line with the local and specialist hospital models of care including an Urgent Care Centre operating 24 hours a day, seven days a week as detailed in Chapters 7,9 and 10 of the DMBC
• to agree that Ealing Hospital be developed in line with the local hospital model of care including an Urgent Care Centre operating 24 hours a day, seven days a week as detailed in Chapters 7, 9 and 10 of the DMBC

• to agree that Charing Cross Hospital be developed in line with the local hospital model of care including an Urgent Care Centre operating 24 hours a day, seven days a week as detailed in Chapters 7, 9 and 10 of the DMBC

• to agree that the Hyper Acute Stroke Unit (HASU) currently provided at Charing Cross Hospital be moved to St Mary’s Hospital as part of the implementation of resolutions 1, 2 and 3 above and as described in Chapter 6 of the DMBC

• to agree that the Western Eye Hospital be moved from its current site at 153–173 Marylebone Road to St Mary’s Hospital as set out in Chapter 10 of the DMBC

• to recommend that implementation of resolutions 1 to 7 should be co-ordinated with the implementation of the CCG out of hospital strategies as set out in Chapters 8 and 17 of the DMBC

• to recommend to the NHS Commissioning Board and North West London CCGs that they adopt the implementation plan and governance model in Chapter 17 of the DMBC

• the JCPCT commends the further proposals that Ealing CCG has developed for the Ealing Hospital in response to feedback from consultation. The JCPCT recommends that Ealing CCG and all other relevant commissioners should work with local stakeholders, including Ealing Council and Healthwatch, to develop an Outline Business Case (OBC) for an enhanced range of services on the Ealing Hospital site consistent with decisions made by this JCPCT. This OBC is to be approved by the SaHF Implementation Board before final submission

• the JCPCT commends the further proposals that Hammersmith & Fulham CCG has developed for the Charing Cross Hospital in response to feedback from consultation. The JCPCT recommends that Hammersmith & Fulham CCG and all other relevant commissioners should work with local stakeholders, including Hammersmith & Fulham Council and Healthwatch, to develop an Outline Business Case (OBC) for an enhanced range of services on the Charing Cross Hospital site consistent with decisions made by this JCPCT. This OBC is to be approved by the SaHF Implementation Board before final submission.

The ‘Shaping a healthier future’ programme

The ‘Shaping a healthier future’ programme was launched in January 2012 with the publication of the Case for Change. It was taken forward by eight clinical commissioning groups (CCGs), made up of GPs representing North West London’s eight primary care trusts (PCTs).

They have worked with hospital doctors, nurse leaders, providers of community care such as mental health services, social services, patient and voluntary groups and charities to develop the proposals for change. These proposals and their vision for the future of healthcare in North West London are set out in the Consultation document and all of the evidence and work that has gone into developing these proposals is set out in the pre-consultation business case.

The programme has four medical directors:

• Dr Mark Spencer, medical director of NHS NW London and a GP in Ealing

• Dr Susan La Brooy, former medical director of Hillingdon Hospital and a consultant physician in acute medicine and care of the elderly
Dr Mike Anderson, medical director of Chelsea and Westminster Hospital and a consultant gastroenterologist

Dr Tim Spicer, chair of Hammersmith and Fulham Clinical Commissioning Group and a GP in Hammersmith

NHS North West London

The North West London (NWL) Cluster was formally established on 1 April 2011 and is the largest commissioning cluster in London, with an annual health budget of £3.4 billion and serving a population of around 1.9 million.

It operates across eight boroughs: Brent, Ealing, Hammersmith & Fulham, Harrow, Hillingdon, Hounslow, Kensington & Chelsea, and Westminster. There are eight Clinical Commissioning Groups (CCGs) with local GP leadership operating in shadow form across all eight boroughs.

For the purposes of the ‘Shaping a healthier future’ consultation, three neighbouring boroughs – Camden, Richmond and Wandsworth – were included in many of the activities and associated communications since health services there are also likely to be affected by the proposals.

The Joint Committee of Primary Care Trusts (JCPCT)

The programme is overseen by the JCPCT, made up of voting representatives from the eight PCTs in North West London (NHS Brent, NHS Ealing, NHS Hammersmith & Fulham, NHS Harrow, NHS Hillingdon, NHS Hounslow, NHS Kensington & Chelsea and NHS Westminster). It also includes voting representatives from the three neighbouring PCTs affected by the proposals (NHS Camden, NHS Richmond, and NHS Wandsworth). The Chair is Jeff Zitron who is also chair of the NHS North West London Cluster Board.

Source: [www.london.nhs.uk](http://www.london.nhs.uk) 20 February 2013

Patients to get better care from healthcare assistants

A new independent review will look at how the training and support of healthcare and care assistants can be strengthened so they give better care to patients, Health Secretary Jeremy Hunt has announced.

The review will be led by Times journalist Camilla Cavendish who will report back to Government at the end of May 2013. It will look at how healthcare assistants can have the training and support they need to provide essential services to the highest standards. Ms Cavendish will also look at how recruitment can be strengthened to place the right people, with the right values and behaviours, in the right settings.

Healthcare and care assistants provide some of the most personal and fundamental support that people get – eating, washing, dressing, help getting out of bed or going to the toilet. They also take basic measurements such as temperature, pulse and weight.

In his report into Mid Staffordshire NHS Foundation Trust, Robert Francis QC set out the importance of looking at how care is provided at every level. Camilla Cavendish has agreed to conduct an independent study of healthcare and care assistants to ensure that they have the training and support they need to provide these essential services to the highest standards.

Health Secretary Jeremy Hunt said:

“We want everyone receiving treatment and support across the health and care sector to get the most safe, effective and compassionate care.
“So we need to make sure that the staff tasked with carrying out some of the most personal and fundamental jobs have the skills, values and behaviours needed to provide this.

“Camilla Cavendish has a long-standing and strong interest in the quality of care and compassion in health and social care. She will provide a fresh perspective on the key issues of valuing and supporting the staff who provide that care.”

The review will also explore how to raise training standards. This includes making sure people get the right training, development and feedback to provide compassionate and competent care in busy working environments and providing consistent training and development to help the best healthcare assistants progress to their potential in more senior roles.

Camilla Cavendish said:

“I’m delighted to be leading this review into a vitally important part of the health workforce. Feeding an elderly sick person, turning them and avoiding pressure sores are skilled tasks. There are more care assistants than nurses in this country, many of us will rely on them in old age, and we need them to be as good as they can possibly be.”

Ms Cavendish will be drawing on the experience of a wide number of people and organisations, including those who use these services, the staff that provide this care, leaders and supervisors, as well as employers. The work will also consider and draw on the key lessons from the Francis Inquiry.

Source: [www.gov.uk/dh](http://www.gov.uk/dh) 20 February 2013

Quality of stroke – Quarterly local hospital results for patients admitted between October and December 2012

New quarterly figures showing the quality of stroke care in hospitals in England are now available. Hospitals taking part in SINAP, the continuous national stroke audit which looks in detail at the first 72 hours of care, have supplied information on aspects of patient care, including:

- how many patients had a brain scan within one hour (nationally, 40 per cent compared to 40 per cent in the previous quarter)
- how many patients had a brain scan within 24 hours (nationally, 93 per cent compared to 92 per cent in the previous quarter)
- how many patients saw a stroke consultant within 24 hours (nationally, 85 per cent compared to 85 per cent in the previous quarter)
- whether or not the patient is admitted directly to a stroke unit, and whether or not they reached the unit within four hours (nationally, 66 per cent compared to 68 per cent in the previous quarter)
- whether or not the patient received thrombolysis (clot busting drug) when they were potentially eligible for it (nationally, 70 per cent compared to 69 per cent in the previous quarter)
- whether or not the prognosis/diagnosis was discussed with a relative/carer within 72 hours where applicable (nationally, 93 per cent compared to 89 per cent in the previous quarter)
- whether or not the patient had a continence plan drawn up within 72 hours where applicable (nationally, 84 per cent compared to 81 per cent in the previous quarter)
whether the patient was seen by nurse and one therapist within 24 hours and all relevant therapists within 72 hours (nationally, 68 per cent compared to 65 per cent in the previous quarter)

and other standards, which are included in the full results spreadsheet.

The audit, commissioned by the Healthcare Quality Improvement Partnership (HQIP), is carried out on behalf of the Intercollegiate Stroke Working Party by the Royal College of Physicians’ Clinical Standards Department. It is a continuous audit with hospitals submitting data on patients as they are admitted and treated. Individual hospital results are available on the Royal College of Physicians (RCP) website and this includes details of hospitals which are eligible to participate in the audit but did not submit sufficient (or any) data.

Source: www.rcplondon.ac.uk 20 February 2013

London’s clinicians pledge to deliver improved care which could save hundreds of lives

Londoners should get consistent high quality emergency and maternity hospital services seven days a week, as leading doctors pledge to deliver standards of care to save lives.

The standards aim to ensure that patients will be assessed by senior clinical staff, no matter what day of the week. Where services have been set up to provide consistent, consultant-delivered care, seven days a week, such as with stroke, major trauma and heart attack services, the outcome for patients is much improved, and the difference in mortality rates between weekdays and weekends is reduced.

Data previously published in 2011 showed that that people in London were more likely to die if admitted to hospitals at weekends; this amounted to more than 500 deaths that could have been avoided.

Dr Andy Mitchell, Medical Director at NHS London, said:

“We know that too many patients die following admission at weekends, not only in London, but across the country. Moving to a consistent seven day service with access to senior clinical staff with supporting diagnostic facilities will save hundreds of lives.

“Under these standards, we will see frail elderly patients with complex care needs having assessment from all the necessary clinical teams within 12 hours of admission, and a clear management plan established for them to ensure a smooth transition from treatment to discharge.

“Patients with fractured hips will undergo their surgery within 24 hours. Patients with acute surgical emergencies, such as colic and inflammation from gall stones, will have their problem diagnosed and surgery arranged more promptly.”

The publication of the London quality standards marks another important milestone in the journey of improvement of hospital-based acute emergency and maternity care and echoes the recent Francis Report and its call for standards across hospital care.

The standards are based on existing national standards and best practice, as identified by professional bodies of all disciplines, but have been adapted for London’s services. Their development has been clinically-led and supported by representatives of patients and the public. They have been endorsed by the London Clinical Senate, and agreed by the London Clinical Commissioning Council. Clinical Commissioning Groups (CCGs) are now considering how to implement the standards.
In addition to the development of the London quality standards, every hospital in London has been assessed against their compliance with the standards for acute medicine and emergency general surgery commissioned from April 2012. The full quality and safety audit data shows that while all London hospitals meet some of the standards, that no hospital in London currently meets all the standards.

The full quality and safety audit data for hospitals in London is at: www.myhealth.london.nhs.uk

Individual Trust data is available at: www.londonhp.nhs.uk/services/quality-and-safety-programme/audit/

Over 90 clinical experts together with patient and service user panels have developed the London quality standards. Wider engagement to inform the development of the standards took place at large stakeholder engagement events with around 300 delegates and regular meetings with primary and secondary care clinicians, representatives from professional bodies, commissioners and patient and public group representatives.

The standards are being introduced to ensure that the public know what standard of care they might expect if they were:

- to seek help through an A&E or urgent care services
- to be admitted through emergency medical or surgical wards
- to require the highly specialised services of an intensive care unit
- a patient who has a fracture resulting from a fall
- to need a transfer to another hospital for care
- a pregnant mother seeking safe high quality labour, birth and immediate post-natal care
- a family with a sick child who needs attention.

The London quality standards are not new; they are based on existing evidence-based standards drawn from the College of Emergency Medicine, a range of Royal Colleges and multi-disciplinary professional bodies. They reflect how clinical teams within London’s hospitals should function to provide optimal care, consistently across all seven days of the week. They have been widely endorsed by professionals and by patients, service users and the public.

The following are examples of patient healthcare before the standards are introduced and the improved patient healthcare once they have been:

**Gallstones**

Before:

- traditional model: patient arrives with abdominal pain at the Urgent Care Centre on Friday afternoon. Patient admitted, provisional diagnosis is acute cholecystitis (inflammation of gall bladder or gall stones) and patient starts antibiotics. Consultant sees patient Saturday morning and requests ultrasound (USS). USS often not done before Monday because considered urgent, not emergency, and many imaging departments currently staffed only for emergencies at weekends. USS Monday confirms diagnosis, patient recovers by Tuesday/Wednesday and goes home with plan for elective lap cholecystectomy. At least one in three chance of readmission with further episode of acute cholecystitis before date of planned surgery.
After:

- new model: patient arrives with abdominal pain at the Urgent Care Centre on Friday afternoon. Patient admitted, provisional diagnosis acute cholecystitis, starts antibiotics, has USS same day. Consultant sees Friday evening and gives information. Saturday morning patient has lap cholecystectomy and Sunday (or even Saturday evening) goes home.

Fractured hip

Before:

- traditional model: Elderly patient falls on a Friday morning and is taken to A&E by ambulance. A fractured hip is suspected and an X-ray is taken two and a half hours later that confirms a fracture. Admitted to orthopaedic ward on Friday afternoon. Patient reviewed by consultant surgeon the following morning who confirms that the patient needs surgery but the patient has co-morbidities including diabetes and heart failure and is on several multiple medications and a review by an ortho-geriatrician is requested to stabilise the condition under control before surgery can be undertaken. There is no ortho-geriatrician consultant ward round until Monday. The patient remains in bed on the ward all weekend in pain and discomfort until the consultant ward round on Monday morning. Following the consultant physician review on Monday the patient is optimised for surgery but there is no available theatre space that day so the patient is scheduled for their operation on Tuesday morning. The patient has waited four days for their operation.

After:

- new model: Elderly patient falls on a Friday morning, attends A&E and a fractured hip is suspected, receives X-ray an hour later, fracture confirmed and patient is admitted to orthopaedic ward on Friday afternoon. Pain block is offered as soon as the diagnosis is made so that the patient can wait overnight pain free and not need morphine which could cause confusion and create a potential delay. Patient reviewed by consultant surgeon on Friday evening who confirms that the patient needs surgery, the consultant physician then sees the patient on their Friday evening ward round and the patient’s co-morbidities including heart failure and diabetes are reviewed as well as a medication review. Surgery is scheduled for the consultant’s planned operating list the following morning, Saturday. The patient waited less than 24 hours for their operation.

Impact of new models:

- faster smoother journeys
- reduces time off work for patients
- better patient experience
- saves bed-days
- more cost-effective the for NHS trust.

Source: www.london.nhs.uk 22 February 2013

Celebrity chefs 'have failed to improve NHS food'
The Government has wasted more than £54 million on "failed" schemes to improve hospital food, according to the food and farming pressure group Sustain.
Its report says compulsory nutritional standards are needed to ensure patient meals improve.

It warned there had been little change in the past two decades despite numerous initiatives, many fronted by celebrity chefs.

A Health Minister said patients were being asked to influence menus.

Broadcaster Loyd Grossman and celebrity chef Albert Roux are among those backing the call for legally binding hospital food standards.

Both have fronted high-profile campaigns to improve hospital food.

The report from the Campaign for Better Hospital Food - which is run by Sustain and backed by 89 organisations - found that since 1992 there had been 21 initiatives to improve patient meals.

But the schemes failed because they relied on hospitals to voluntarily adopt their recommendations, the report concluded.

At a cost of more than £54 million, the money wasted was equivalent to 34 new hospital kitchens, it said.

The group claimed the Government had ignored at least 14 warnings from Government advisers, MPs, commercial caterers, and health, environmental and animal welfare organisations that voluntary initiatives to improve hospital food were failing.

It wants to see food-based standards in line with those introduced in schools in England in 2006 in all UK hospitals in the next 18 months.

Alex Jackson, co-ordinator of the Campaign for Better Hospital Food, said:

"This report must serve as a lesson to Jeremy Hunt that simply publishing recommendations for the improvement of hospital food isn't good enough, as every one of his predecessors in the last 20 years has found out.

"It's time for the Government to take effective action by introducing mandatory standards for patient meals."

Loyd Grossman, who led the Better Hospital Food initiative between 2001 and 2006, said although his team had a number of successes, their efforts were hampered by a lack of political will.

"There has not yet been a noticeable change in the way hospital food is produced, prepared, cooked and served."

Albert Roux, who was asked in 1995 by the Department of Health to give his opinion about how to improve hospital food, added that "meetings, speeches and gimmicks" do not work.

"What we need now is change to the whole hospital food system, starting with the introduction of food standards for every patient meal."

Health Minister Dan Poulter admitted that schemes based on celebrity chefs had not worked in the past.

"Patients are the ones who consume hospital food and are best-placed to decide what is good and what is not.

"That is why an army of thousands of patient assessors will join a tough new inspection programme starting in April 2013 to drive up standards."
He added that there were many fantastic examples of very good food across the NHS and centrally imposed standards were not the answer.

Katherine Murphy, Chief Executive of The Patients Association, said patients regularly contacted their helpline about poor standards of food in hospital.

"High quality, nutritious food is an essential part of a patient's overall hospital experience. It plays a fundamental role in their recovery and helps them to return home sooner," she said.

Source: www.bbc.co.uk/news 22 February 2013

Slow treatment "leading to thousands of diabetes-related foot amputations"

Thousands of people a year endure a diabetes-related foot amputation because their foot ulcer is not treated quickly enough, according to a new report.

The Diabetes UK report, entitled, ‘Fast track for a foot attack: Reducing Amputations’ warns that too many areas do not have the systems in place to ensure foot ulcers and foot infections in people with diabetes are treated within 24 hours. This is despite the fact that ulcers can deteriorate extremely quickly and a matter of hours can make the difference between keeping a foot and losing it.

The report has highlighted the lack of these systems at a local level as one of the main reasons the number of foot amputations is increasing – there are already 6,000 diabetes-related amputations a year and this is projected rise to 7,000 by 2015. It is thought that up to 80 per cent of these amputations could be prevented.

The report, which Diabetes UK has produced with the Society for Chiropodists and Podiatrists and NHS Diabetes, makes recommendations that could dramatically reduce diabetes-related amputation rates and bring an end to the current situation where people with the condition are over 20 times more likely to have an amputation than the rest of the population.

The recommendations include:

- all hospitals should have a multi-disciplinary footcare team (MDT), which brings together different healthcare professionals to ensure good quality care for foot problems in people with diabetes. The National Institute for Health and Clinical Excellence (NICE) recommends that these teams should be in place, but the most recent figures suggested 40 per cent of hospitals do not have them
- every hospital should guarantee that people with urgent foot problems can be assessed by an MDT within 24 hours, as it is vital that foot problems are treated quickly
- every area should have a system for identifying and regularly reviewing people at high risk of foot ulcers and infections, including annual foot checks and foot protection teams in the community
- people with diabetes who are at high risk of foot problems should know what to look out for and where to go in the event of a foot attack.

Barbara Young, Chief Executive of Diabetes UK, said:

"It is unacceptable that every single week people with diabetes who have treatable foot problems are having feet or toes amputated because they are not being treated quickly enough."
"It is not as if this is a problem we don’t know how to solve. If every hospital had a multi-disciplinary footcare team and ensured access to that team within 24 hours, then that would make a huge difference to the amputation rates.

"We also need to make sure people with diabetes are getting a thorough annual foot check and that those at high risk of amputation are given the help they need to prevent them. All too often, we hear stories about foot checks that are so fleeting that the person is not even asked to take their shoes off.

"This is not something that requires more money. In fact, putting these kind of systems in place can actually save money because the amputations that they prevent are so expensive. But we need leaders across the NHS, the NHS Commissioning Board and local Clinical Commissioning Groups, to insist that this happens and hold those areas that do not have these systems in place to account.

"We need action now."

Source: www.diabetes.org.uk 23 February 2013

New powers to check language skills of doctors

New checks are being introduced to make sure all doctors who work for the NHS can speak English well enough to treat patients.

The checks are detailed in the Government response to the House of Commons Health Committee Report '2012 accountability hearing with the General Medical Council'.

The paper provides the Government’s response to the three recommendations that were directed to the Department of Health – two of them concerned language controls for doctors and the third focussed on a right of appeal for the General Medical Council (GMC) against Medical Practitioner Disciplinary Tribunal decisions.

The majority of the Committee’s recommendations are for the General Medical Council and the Department is supporting these.

From 1 April 2013, there will be a legal duty to make sure a doctor can speak the necessary level of English to perform their job in a safe and competent manner before they can treat patients in a hospital or GP practice.

There will also be single national list that every GP will have to be on before treating NHS patients. Previously, every primary care trust held a list of GPs. One centrally held list will protect patients by ensuring poor performers will no longer be able to slip through the gaps between different local lists. Every GP will have to demonstrate their ability to speak English to be accepted on to this list.

The Government is also proposing to give the GMC new powers to prevent all doctors from being granted a licence to practise medicine in the UK where concerns arise about their ability to speak English.

The new checks will mean that for the first time there will be a comprehensive system so that European doctors wanting to work for the NHS will be have to demonstrate their ability to speak English when applying for a job.

Doctors from outside of the EU are already subject to language checks, but current EU law requires the UK to automatically recognise the medical qualifications of doctors from countries in the European Economic Area and to register them to work in the UK.
Health Minister Dr Dan Poulter said:

“These new checks will ensure that all doctors who want to work in the NHS can speak proficient English and to prevent those who can’t from treating patients.

“There are lots of excellent doctors from around the world working in the NHS – this is simply about protecting patients and having proper checks on a doctor’s ability to speak English.

"By introducing these steps we will be able to put an end to doctors treating patients without proper checks on their language."

Source: [www.gov.uk/dh](http://www.gov.uk/dh) 25 February 2013

**Launch of direct payments for healthcare consultation**

One way of managing a personal health budget is a direct payment for healthcare, where money is given directly to an individual for the management of their NHS care. They are currently only lawful within pilot sites. The Government's intention is to roll out personal health budgets more widely, including extending the use of direct payments, by updating the regulations so that they can be offered across the country. A new public consultation is consulting on the details of the changes. This is an opportunity to have your say. For more information visit [www.dh.gov.uk/health/category/publications/consultations/consultations-open/](http://www.dh.gov.uk/health/category/publications/consultations/consultations-open/)

The consultation proposes some changes to the regulations based on learning from the recent pilot programme and discussions with personal health budget holders, healthcare professionals and other organisations. It discusses what will be excluded, for example, acute and planned care and access to GP services. It also asks for views on issues including eligibility, paying family members for carrying out administrative functions, allowing local authorities to make direct payments for healthcare and separate bank accounts.

An impact assessment and easy read version of the consultation will also be published online. The consultation is open for anyone to respond, from individuals to organisations. The closing date is 26 April 2013.

Source: [www.commissioningboard.nhs.uk](http://www.commissioningboard.nhs.uk) 1 March 2013

**Many nurses 'feel discouraged' from raising care concerns**

Many nurses believe the NHS has a culture that discourages staff from raising concerns about patient care, a survey suggests.

Almost 30 per cent of 800 nurses polled by Nursing Times magazine said being seen as a troublemaker was the biggest barrier to them speaking out.

Inaction by managers was cited as a barrier by 23 per cent.

The Government said it had taken measures to support whistleblowers and was considering further action.

The survey was sent out to the magazine's database of nurses and was conducted online.

Some 84 per cent of respondents to the poll said they had raised concerns about a colleague's practice or attitude.

A total of 23 per cent of the nurses said they had done so "several times" or "regularly", and 23 per cent "at least once".
But of those who had raised concerns, 52 per cent said there had been no appropriate outcome after they had spoken out and a similar percentage said they had faced negative consequences as a result of doing so.

The poll comes after the public inquiry into the failings at Stafford Hospital - run by Mid Staffordshire NHS Trust - highlighted a lack of support for nurses who tried to raise concerns.

The inquiry report by Robert Francis QC argued for “fundamental change” in the culture of the NHS to make sure patients were put first.

Nursing Times editor Jenni Middleton said:

"If we want to make sure Mid Staffs does not happen again, we must welcome the input of staff and ensure they are heard, without fear of reprisal."

She added:

"I have personally spoken to nurses who, having raised concerns, have been sidelined and ostracised by their employers, bullied and marginalised by their colleagues - and end up feeling ashamed and guilty, as well as concerned that their careers are over.

"Regulation plays its part, of course, but the ability of staff to spot what's going on is irreplaceable in ensuring that the NHS is a safe NHS."

Dr Peter Carter, Chief Executive of the Royal College of Nursing, said:

"It is extremely worrying that a large number of nurses still feel their concerns are going unheard, even worse that some have to live with the threat of reprisal."

Dean Royles, Chief Executive of the NHS Employers organisation, said that while there had been "enormous efforts" by employers to encourage staff to speak out "we need to do more to build their confidence that they can voice concerns in safety".

Health Minister Dan Poulter said:

"We are determined that staff who have the courage and integrity to speak out in the interests of patient safety are protected and listened to.

"We have already taken a range of measures to protect and support whistleblowers in the NHS, including funding a national helpline, embedding rights in their employment contracts and issuing new guidance in partnership with trades unions and employers."

He said a new "contractual duty of openness" would apply to the NHS organisations from April 2013 when dealing with patients.

He added that ministers were also considering whether they needed to "go further" in the wake of the Stafford Hospital report.

Source: www.news.bbc.co.uk 3 March 2013

**Number of people diagnosed with diabetes reaches three million**

The number of people in the UK who have been diagnosed with diabetes has reached three million for the first time, equivalent to 4.6 per cent of the UK’s population, according to new analysis carried out by Diabetes UK and Tesco.

The figure represents an increase of 132,000 people diagnosed with diabetes over the last year. A further 850,000 people are thought to have undiagnosed Type 2 diabetes.
Experts have warned that unless more is done to prevent Type 2 diabetes and more help is given to help those with the condition, the increase could see the NHS burdened with unsustainable costs, which has huge implications for public health.

Every year in England and Wales, 24,000 people with diabetes die earlier than expected, a situation that is expected to get even worse without urgent action.

Tesco and Diabetes UK have announced the new figures to mark the launch of a major new national partnership that will see Tesco, its customers, colleagues and suppliers aim to raise £10 million.

The partnership will also fund the biggest-ever public awareness campaign on Type 2 diabetes risk factors, aiming to reach the estimated seven million people at high risk.

Barbara Young, Chief Executive of Diabetes UK said:

"We are hugely concerned that the number of people diagnosed with diabetes has reached three million for the first time. There is no reason to think this will mark the end of what has been a rapid rise in the condition.

"Instead, all the projections suggest that the three million figure will be a grim staging post on the road towards a public health emergency. This unfolding tragedy is already putting huge pressure on the NHS and will have potentially devastating consequences for those people who develop the condition. But this is not inevitable.

"By identifying those at high risk of developing Type 2 diabetes, we can ensure they start getting support to make the kind of lifestyle changes that can help prevent it. And by making sure people who have Type 1 or Type 2 diabetes are already getting the care and support they need, we can help them avoid the devastating complications diabetes can cause.

"I'm delighted Tesco has made Diabetes UK its National Charity Partner, as this will make a real difference in curbing the rise in the condition. Not only will the partnership fund the biggest-ever public health campaign on risk factors and symptoms of Type 2 diabetes, but, crucially, it will be funding pioneering research into a vaccine for Type 1 diabetes."

Source: www.diabetes.org.uk 4 March 2013

Unmanageable workload for medical registrars poses future threat to patient care, says Royal College of Physicians

Medical registrars are the backbone of any hospital delivering patient care round the clock. However, the heavy workload for medical registrars, compounded by limited training opportunities and an unequal distribution of senior specialist doctors across the country is posing a major threat to high quality hospital care. These are the findings of the Royal College of Physicians (RCP) new report entitled, ‘Hospital workforce: Fit for the future?’ The RCP is calling for urgent action to resolve these issues to prevent patient care being threatened.

The report, based on the largest surveys of UK hospital doctors, has three key findings:

Heavy workload for medical registrars

The workload of the medical registrar is now at crisis point. Medical registrars are the backbone of the hospital medical services, particularly at night. The RCP’s report highlights 37 per cent of trainee physicians describe the workload of the medical registrar as ‘unmanageable’ and 59 per cent describe it as ‘heavy’. This is compared to less than five per cent of general practice registrars who believe their own workload is either heavy or
unmanageable, resulting in a risk the best medical trainees will not choose a career that involves acute medical care.

**Limited training opportunities**

Training of registrars in ‘general medicine’ is highly variable and is too often compromised by the heavy workload. The report highlights that only 38 per cent of registrars feel that their training in general medicine was good or excellent compared to 75 per cent in their main specialty.

**An unequal distribution of senior specialist doctors across the country**

Senior specialist skills are not evenly distributed across the country. Patients in London have almost double the number of consultants per head of population compared to the East Midlands. There are big differences in provision across the 30 medical specialties in availability to patients. The amount of patients requiring general skills is increasing with the ageing population and frail elderly patients’ needs are best met by geriatric specialties but in 2011 it was not possible to fill 50 per cent of consultant posts advertised in geriatric medicine. Teaching hospitals are often large enough to attract the best candidates for jobs and diversify training but these problems are compounded in district general hospitals (DGHs).

To meet the challenges highlighted in ‘Hospital workforce: Fit for the future?’ the RCP is calling for

- a greater proportion of doctors being trained in the skills of emergency, general, acute and geriatric medicine
- the hospital workforce must be reorganised to meet the need of frail elderly patients
- the role of the medical registrar must be reassessed with their skills used more efficiently to better meet patients’ needs
- the way in which DGHs work needs to be re-examined to address this, which is being looked at by the RCP’s Future Hospital Commission.

**Source:** [www.rcplondon.ac.uk](http://www.rcplondon.ac.uk) 4 March 2013

**UK 'fares badly in European health league table'**

The UK is lagging behind progress by similar countries on many indicators for ill-health, research suggests.

Health data over 20 years was compared with figures from 18 other countries in the research published in the Lancet.

Although average life expectancy has risen by four years since 1990, it says the UK needs to increase its strategies for tackling preventable problems such as heart disease and stroke.

Health Secretary Jeremy Hunt has said he has a plan to address the lag.

The team of experts from the UK and the University of Washington in Seattle said the UK had a high burden of smoking-related illnesses, and greater priority should be given to reducing lung disease.

There was also a large rise in the number of recorded deaths related to Alzheimer's disease.

Mr Hunt, who is responsible for health policy in England, acknowledged the findings. He says he will announce plans which aim to cut the death toll caused by the UK’s five avoidable big killers - cancer, heart, stroke respiratory and liver disease.
He wants the premature death rate in England to be slashed by 30,000 by 2020. He said:

"For too long we have been lagging behind and I want the reformed health system to take up this challenge and turn this shocking underperformance around."

Leading UK health risk factors:
- tobacco smoke (including second-hand smoke)
- high blood pressure
- obesity
- too little exercise
- alcohol use
- poor diet.

Source: Global Burden of Disease project

In the 20 years from 1990 to 2010 that The Lancet study examined, average life expectancy increased by 4.2 years in the UK to 79.9 years.

But the premature death rate had hardly changed in the UK for both men and women aged 20-54.

Among the leading causes were heart disease, cancers and chronic lung disease.

And these are linked to avoidable risk factors such as smoking, high blood pressure and obesity, which were still all too common in the UK, say Chris Murray, from the Institute for Health Metrics and Evaluation, University of Washington, USA, and colleagues who carried out the analysis of global data.

But progress is being made on conditions like diabetes, where the UK appears to be ahead of many of its European neighbours and other high-income countries like the US and Canada.

Prof Murray says the UK also faces fresh challenges, like its growing burden of disability from alcohol use.

He and his team also acknowledged that making firm conclusions based on data from different countries was inherently problematic - not all record the same information and each has its own unique issues and policies that made interpretation and comparison difficult.

Recent figures from the Office for National Statistics suggested people in the UK were living in good health for longer.

In an accompanying editorial in The Lancet, Edmund Jessop from the UK Faculty of Public Health in London said the UK had done very well in many areas of public health - it had stronger tobacco control than any other country in Europe, for example - but there was still "plenty of room for bold action by politicians".

Public Health England, a new division of the Department of Health that will come into being in April 2013 along with the NHS organisational reforms, called the report a wake-up call.

Prof John Newton, Chief Knowledge Officer of Public Health England, said:

"Despite some enviable recent success, for example on smoking, we in the UK need to take a hard look at what can be done to help people in the UK achieve the levels of health already
enjoyed by other some countries. Central and local Government, charities, employers and retail businesses all have a part to play."

John Appleby, Chief Economist at The King's Fund, said:

"Changes in health outcomes take place over many years, if not generations. The UK's health expenditure has increased significantly but has only recently caught up with the EU average so we may not yet be seeing the full effects of this additional spending."

Source: www.news.bbc.co.uk 5 March 2013

Improving cardiovascular disease outcomes: strategy

The Cardiovascular Disease Outcomes Strategy provides advice to local authority and NHS commissioners and providers about actions to improve cardiovascular disease outcomes. It sets out outcomes for people with or at risk of cardiovascular disease (CVD) in line with the NHS and public health outcomes frameworks. It identifies 10 main actions to improve outcomes.

The strategy recommends:

- reducing premature mortality rates for CVD by improving prevention, diagnosis and treatment, bringing all services up to the standards of the best
- managing CVD as a single family of diseases and develop a standardised template for community and hospital care
- supporting better identification of families or individuals at high risk of CVD and improve its management in primary care
- improving intelligence, monitoring and research into CVD and publish comparative data on the quality of care provided for patients with CVD.

Source: www.gov.uk/dh 5 March 2013

MPs publish report on 2012 accountability hearing with the Nursing and Midwifery Council

The Nursing and Midwifery Council (NMC) is a vital safeguard for care quality and patient safety, but "over a number of years the NMC has failed to understand its function and properly prioritise patient safety" according to MPs on the Health Select Committee.

Launching a report from the second accountability hearing held with the regulator for nurses and midwives, Committee Chair Stephen Dorrell MP said,

"The NMC's job is to protect patient safety by registering Nurses and Midwives and by enforcing acceptable standards of practice. The simple fact is that in recent years it has fallen down on that task.

"We welcome the fact that the new management team in the NMC is committed to address its failings, and that the latest evidence shows that its performance is improving.

"However there continues to be a serious gap between current performance and acceptable standards. The NMC has proposed that fitness to practise cases should be decided on average within 18 months of a complaint being received; the Committee proposes that the average time taken to decide a fitness practise case should be reduced to nine months, and the maximum time should be set at 12 months."
"In the words of the new Chair of the NMC, its ‘‘fitness to practise’ functions are the engine room of the organisation”, but the regulator still faces a huge backlog of cases, some of which should have been resolved years ago.

"Measures to work through this have been put in place by the NMC’s new management team and we are optimistic that these changes will eventually bear fruit. Nevertheless, we believe the NMC must set to this task with greater urgency.

"In addition to excessive timescales, the NMC also has had a poor track record of fitness to practise decisions being challenged and overturned. The quality of NMC decisions is just as important as the timescale and we were concerned to hear that the Council for Healthcare Regulatory Excellence (CHRE) needed to make almost routine use of its power to refer NMC decisions to the High Court.

"We were pleased to hear, however, that there have been no such referrals since September 2010, and urge the NMC to maintain this improvement."

Under-investment

The Health Committee notes that chronic under-investment has characterised the NMC’s past approach to fitness to practise cases. Stephen Dorrell said:

"It is unacceptable that the NMC underestimated the budget for its fitness to practise directorate by 30 per cent. The Committee will be seeking reassurance at the next accountability hearing that this management failure has been addressed.

"We accept the NMC requires greater resources in order to do its basic job and we welcome the Government’s intervention to limit the effect of the fee increase on registrants. However, nurses and midwives still face a 32 per cent fee increase at a time of public sector pay restraint.

"In the light of these pressures the Committee does not believe a further fee increase can be justified and we recommend that the NMC should consider introducing a phased payment system for registrants."

Language and communication

The Committee notes that the language and communication skills of nurses and midwives remains a concern.

"Some progress has been made within the EU, and we welcome the Government’s willingness to take administrative action in the UK to address this issue. This remains an issue of real concern for its impact on patient safety."

Revalidation

MPs also question why the NMC has made such slow progress on a system of revalidation.

Stephen Dorrell said:

"We continue to believe that the NMC should operate a proportionate but effective revalidation process and we are concerned that so little progress has been made on this subject since the 2011 accountability hearing. We hope that when we meet the NMC later this year they will have a more fully developed proposal to extend the assurance of revalidation to cover all registered nurses and midwives.

"Lastly, the Committee notes that many of the NMC’s problems (connected with fitness to practise, the projected cost of future workload and how to target high risk groups for
revalidation) stem from inadequate IT infrastructure where two key systems cannot communicate directly and deliver incomplete or inaccurate information.

"If the NMC’s IT systems are inadequate, then the NMC cannot fulfil its regulatory role. The NMC must take urgent action now to resolve this problem and will be expected to provide concrete evidence of properly functioning IT at its next annual accountability hearing."

Source: www.parliament.uk 6 March 2013

ONS survey: Smoking halves in 40 years
Smoking in Britain has more than halved and people are drinking on fewer nights of the week, according to a snapshot survey covering the past 40 years.

The General Lifestyle Survey (GLS) indicates 45 per cent of adults smoked in 1974 compared with 20 per cent in 2011.

The proportion of men who said they drank alcohol at least five days a week fell from 22 per cent in 2005 to 16 per cent in 2011.

The proportion of women drinking five days a week dropped from 13 per cent to nine per cent over the same period.

There have been repeated campaigns to reduce smoking, which can cause heart problems and lung cancer.

The role of smoking in society has changed significantly, with smoking bans in the workplace coming into force across the UK and bans on cigarette advertising.

Smoking now looks less of a male-dominated habit. Men are still more likely to be smokers – 21 per cent of men now smoke compared with 19 per cent of women. However, back in 1974 the gulf was much larger – 51 per cent of men and 41 per cent of women.

The statistics suggest married people are less likely to smoke than singles, and the unemployed are more likely to smoke than their neighbours in work.

Older people are more likely to have a regular drink, the data indicates. Men and women aged 45 and above are more likely to drink alcohol on five or more days each week than younger generations.

The most significant changes in the past decade were in 16 to 24-year-olds.

In young men, the proportion drinking more than four units on their biggest drinking session of the week fell from 46 per cent to 32 per cent between 2005 and 2011. There was a similar pattern in women.

However, the Office for National Statistics (ONS) figures do not look at the amount drinkers are consuming overall. This is thought to be 40 per cent higher now than it was 40 years ago, despite a drop since 2004.

Alan Maryon-Davis, honorary professor of public health at King's College London, said the figures for alcohol and smoking were very encouraging, but there was still a long way to go.

"There is more work to be done educating the public about the dangers of drink. We haven't got labelling of drinks right and there is work to be done in terms of drinks promotions and the use of social media to target young people.

“There are also issues over price and availability. We need to get rid of really cheap discounts on alcohol.”
While hospital admissions for alcohol-related diseases were still high, Prof Maryon-Davis said, there was no room for complacency.

"Of those that do drink, the harms are increasing - and they take time to show themselves."

Commenting on the survey's findings, Dr Penny Woods, Chief Executive of the British Lung Foundation, said the significant decline in the numbers of people smoking in Britain over the last 40 years was "a testament to the effectiveness of combined legislation and awareness raising in tackling what is Britain's leading cause of preventable illness and premature death". But she added:

"The uptake of smoking by young people and childhood exposure to second hand smoke both, however, remain areas of concern."

"It is encouraging to see measures such as banning smoking in cars when children are present and introduction of standardised packaging for cigarettes being seriously considered by this Government."

Source: [www.bbc.co.uk/news](http://www.bbc.co.uk/news) 7 March 2013

'Stark variation in NHS surgery due to rationing'
The number of patients undergoing common surgical procedures varies widely across England because of funding restrictions, figures show.

Local NHS rationing of hernia repair, hip and knee replacements, cataracts and varicose vein surgeries has led to a "postcode lottery", say researchers.

Writing in the Lancet, they warned such policies could be "storing up problems for the future".

The Department of Health said access to services should not be decided on cost.

Suitability for surgery should be judged by clinical experts on the basis of individual need, a spokesman added.

There has been much anecdotal evidence about rationing of some surgical procedures on the NHS, but this has tended to focus on the number of policies in place rather than details on how this has affected patients being operated on.

And while there had been much debate about the "clinical value" of some elective surgical procedures, there was poor consensus on which treatments should be restricted to save costs, the Imperial College London team said.

A comparison of hospital data with primary care trust (PCT) policies on rationing of surgery showed a significant difference in the number of operations being done depending on local rules.

For cataract surgery, PCTs with rationing in place were admitting about 48 per cent fewer patients than those with no such policy in the first year restrictions were introduced, the figures showed.

And for knee replacements there was at least a 20 per cent difference in the number of patients having the operation, depending on whether there were restrictions in place, they found.

When rationing for hernia surgery was introduced in some areas in 2006/07, there were 59 per cent fewer patients being operated on in some PCTs, compared with those with no policy.
The researchers said this gap had since narrowed but in 2010/11 there had still been a 15 per cent deficit, which equated to 64 fewer operations per 100,000 people per year in areas with restricted access.

Significant variations had been seen in access for almost every year looked at since rationing policies had been in place, they said.

The type and number of procedures rationed by PCTs varied considerably and only 17 of 119 respondents had no policy for all five of the procedures looked at.

Study author Steve Beales, a health informatics and policy analyst, said the study did not address whether rationing itself was "good or bad" and there were legitimate arguments on both sides.

"But variation is a bad thing and there does need to be national guidance on this.

"NICE [The National Institute for Health and Clinical Excellence] would be best placed to do that," he said.

Although evidence was not yet available on the wider consequences of local rationing of surgeries, it did raise the question of whether England was "storing up problems for the future", he added.

And he said with a greater number of Clinical Commissioning Groups taking over from existing PCTs in April, "it is entirely possible this will lead to greater variation".

A Department of Health representative said:

"We have already written to the NHS to clearly set out that access to services should not be restricted on the basis of cost - it is wrong and compromises patient care.

"Decisions on treatments, including suitability for surgery, should be made by clinical experts taking the needs of each patient into account."

**Source:** [www.bbc.co.uk/news](http://www.bbc.co.uk/news) 8 March 2013

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**Outdoor walks 'boost stroke survivors' recovery'**

Regular brisk walking can help recovery, fitness and quality of life after a stroke, say researchers in the journal Stroke.

A three-month study found outdoor walking three times a week boosted endurance and resting heart rate.

Those taking part were able to walk independently or with a cane but researchers said many stroke survivors lack energy and fear falling.

A stroke charity said other exercises could help those unable to walk.

It is not the first time researchers have looked at the impact of low-stress exercise on stroke recovery, but previous studies tested exercise equipment such as treadmills or stationery bikes.

A team from the University of the West Indies in Jamaica wanted to assess exercise that could be done by anyone anywhere.

They devised a walking programme in the community where participants initially walked supervised along a 15-minute route three times a week, building up over 12 weeks to 30 minutes.
Among 128 men and women who took part in the study, those who took up walking had a 16.7 per cent improved quality of life due to better physical health compared with patients who had usual care with therapeutic massage.

The walkers could also get 17.6 per cent further in a six-minute walking endurance test. Researchers found that those in the massage-only group had a 6.7 per cent higher resting heart rate after three months.

Study leader Dr Carron Gordon, a lecturer in physical therapy, said:

"Walking is a great way to get active after a stroke. "It's familiar, inexpensive, and it's something people could very easily get into."

She added that after a stroke, many people lack energy and are afraid of falling while walking and withdraw from meaningful activities like shopping and visiting friends and family.

The average age of those taking part was 64 and had a stroke between six and 24 months before starting the exercise programme.

Dr Gordon said the results were applicable to any population as long as their stroke had left them able to walk and, over time, family and friends could go for walks with them rather than relying on an instructor.

"Walking can help control blood pressure, reduce lipid or fat levels and help with weight control - all cardiovascular risk factors," she added.

"So doctors should encourage it for patients who have had a stroke."

Dr Clare Walton, research communications officer at the Stroke Association, said exercise after a stroke can help boost both physical and mental recovery.

"It encourages the brain to use pathways that may have been damaged by the stroke and enables the individual to relearn how to do certain movements.

"Although the results of this study are not surprising, it is good to see that walking alone can have such positive effects on quality of life."

She added that for stroke survivors who may not be able to walk, there are other seated exercises which can increase your heart rate and improve overall wellbeing.

Source: [www.bbc.co.uk/news](http://www.bbc.co.uk/news) 8 March 2013

**Antimicrobial resistance poses ‘catastrophic threat’, says Chief Medical Officer**

Global action is needed to tackle the catastrophic threat of antimicrobial resistance, which in 20 years could see any one of us dying following minor surgery, England’s Chief Medical Officer Professor Dame Sally Davies has said.

The warning comes as the second volume of the Chief Medical Officer’s annual report was published, providing a comprehensive overview of the threat of antimicrobial resistance and infectious diseases.

Calling for politicians to treat the threat as seriously as MRSA, the report highlights a “discovery void” with few new antibiotics developed in the past two decades. It highlights that, while a new infectious disease has been discovered nearly every year over the past 30 years,
there have been very few new antibiotics developed leaving our armoury nearly empty as diseases evolve and become resistant to existing drugs.

In addition to encouraging development of new drugs, the report highlights that looking after the current arsenal of antibiotics is equally important. This means using better hygiene measures to prevent infections, prescribing fewer antibiotics and making sure they are only prescribed when needed.

The Chief Medical Officer also states that more action is needed to tackle the next generation of healthcare associated infections, including new strains of pneumonia-causing klebsiella that will be harder to treat.

Some 17 recommendations are made as part of the report, including:

- a call for antimicrobial resistance to be put on the national risk register and taken seriously by politicians at an international level, including the G8 and World Health Organization
- better surveillance data across the NHS and world wide to monitor the developing situation
- more work carried out between the healthcare and pharmaceutical industries to preserve existing drugs and encourage the development of new antibiotics to fill the “discovery void” of the last 20 years
- building on the success of the NHS in cutting MRSA rates, which have fallen by 80 per cent since a peak in cases in 2003 through better hygiene measures, which should be used when treating the next generation of healthcare associated infections such as new strains of harder-to-treat klebsiella.

Professor Dame Sally Davies said:

“Antimicrobial resistance poses a catastrophic threat. If we don’t act now, any one of us could go into hospital in 20 years for minor surgery and die because of an ordinary infection that can’t be treated by antibiotics. And routine operations like hip replacements or organ transplants could be deadly because of the risk of infection.

“That’s why governments and organisations across the world, including the World Health Organization and G8, need to take this seriously.

“This is not just about Government action. We need to encourage more innovation in the development of antibiotics – over the past two decades there has been a discovery void around antibiotics, meaning diseases have evolved faster than the drugs to treat them.

“In some areas, like cutting rates of drug resistant MRSA, the NHS is already making good progress so it’s important that we use that knowledge across the system and I hope my recommendations will prompt people to do that.”

The Department of Health will soon publish the UK Antimicrobial Resistance Strategy setting out how it will meet the challenge that the Chief Medical Officer has outlined.

The five-year UK Antimicrobial Resistance Strategy and Action Plan will:

- champion the responsible use of antibiotics – by ensuring NHS staff have the skills, knowledge and training to prescribe and administer antibiotics appropriately. Part of this will include reviewing and updating the curricula for medical undergraduates
- strengthen surveillance – by improving the recording of data on the numbers of antibiotics prescribed and trends in antibiotic resistance, this information can used by
clinicians to change patterns of prescribing. This will help reduce the level of resistance and help ensure patients respond to treatments

- encourage the development of new diagnostics, therapeutics and antibiotics, for example by continuing to support the Innovative Medicines Initiative (IMI) and other initiatives that encourage scientific research.

The Chief Medical Officer’s wide-ranging report makes several further recommendations on tackling antimicrobial resistance, including:

- new infection control measures should go beyond hospitals and be applied to home and community care settings
- the national approach to tackling antimicrobial resistance should not just focus on humans and the risk of antimicrobial resistance in animals should be managed closely by the Department for Food, Environment and Rural Affairs
- Public Health England should work closely with the NHS Commissioning Board to make sure that advanced testing facilities are available to treat infections brought into the country from abroad
- further promotion of the benefits of vaccination and encouragement of vaccine uptake during pregnancy to prevent diseases such as flu and whooping cough should be undertaken
- Directors of Public Health should work with schools to ensure the school nursing system is well-placed to deliver new immunisation programmes.

Source: www.gov.uk/dh 11 March 2013

CQC Care Update
People with dementia are not receiving care that meets their needs because health and adult social care services are struggling to cope, according to the Care Quality Commission’s (CQC) latest Care Update. The Update also highlights continuing concerns about the quality of services for people with mental health issues and learning disabilities.

The Care Update says that people with dementia living in a care home are more likely to go to hospital with avoidable conditions such as urinary infections, than similar people without dementia. Once in hospital, they are more likely to stay longer, be readmitted, and die there than similar people who do not have dementia.

It concludes that those services involved in caring for people must do more to make sure people get safe, quality care that identifies and meets their needs.

The Care Update also says that services for people with mental health issues or learning disabilities provided by independent hospitals and community services still have some way to go to provide a good quality of care.

The disparity between the quality of healthcare in independent acute and community services which continues to be high, and the quality of mental health and learning disability services, is still wide and is not improving quickly enough, says CQC.

CQC’s latest Care Update is based on more than 20,000 inspections carried out between 1 April and 31 December 2012.

CQC Chief Executive David Behan said:
“The majority of services are delivering good quality care, however, care providers must do more to make sure that care is based on people’s individual needs. This Care Update draws attention to two areas where this is not happening.

“The people in charge of care homes and hospitals must work better, individually and together to ensure the right services are in place for people with dementia and their staff must be trained to identify dementia.

“It’s six months since recommendations were made following the abuse of people with learning disabilities at Winterbourne View. While there has been some improvement by those delivering services for people with mental health problems and learning disabilities, there is still some way to go and CQC expected improvements to be made more quickly. We are still seeing too many independent mental health and learning disability services not delivering care that puts people first.

“A patient-centred culture of care needs strong leadership, openness and transparency, and CQC will look closely at this in the coming year, particularly in those services caring for some of the most vulnerable people in our society.

“We will also be using and sharing the evidence of what works well to drive change in those providers and services that need to improve.”

Source: www.cqc.org.uk 12 March 2013

Keep patients out of 'dangerous' hospitals, say doctors

More patients should be treated in the community rather than in "dangerous" hospitals, according to the NHS Alliance.

The organisation, which represents doctors, nurses and managers on the frontline, said there was an "immediate imperative" to shift non-urgent care away from hospitals.

The call came in a letter to the Times newspaper.

It follows concerns in the wake of the scandal at Stafford Hospital.

In the letter, the President of the NHS Alliance, Dr Chris Drinkwater, and its Chairman, Dr Michael Dixon, wrote:

"Hospitals can be dangerous places.

"If we are to put people before numbers and achieve high quality of care, as well as keeping an NHS free at the point of need for future generations, we must, as an immediate imperative, shift all non-urgent care from hospital into the community."

Dr Dixon added:

"Unless we increase our investment in care in the community, the NHS will not remain sustainable and patients will continue to be cared for in the wrong place."

The organisation is submitting ideas to the NHS Commissioning Board, which will soon oversee the NHS as part of the changes to the health service in England.

It wants a high-profile GP to champion care in the community.

Rick Stern, NHS Alliance Chief Executive, said:

"If the NHS is to survive and thrive it needs to change."
"We're categorically not suggesting further reform, but rather that everyone working to support patient care considers the importance of breaking down boundaries at every level - between clinicians and managers, between clinicians working in different specialist areas, between specialists and generalists, between primary care providers and the communities they serve, between in-hours and care out-of-hours."

A Department of Health representative said:

"The vast majority of patients get excellent care, but if the NHS is to meet the needs of an ageing population, it needs to seriously look at how it can improve how care is being provided, particularly to older patients and those with long term conditions.

"The NHS is already doing more to give patients better treatment - more patients are being sent home on the same day than ever before and the average length of stay has steadily come down over the last decade.

"We want the NHS to provide more preventative and integrated care, which will mean fewer patients need to be admitted to hospital."

Source: www.bbc.co.uk/news 13 March 2013

Conflicts of interest 'rife' among new GP commissioners

More than a third of GPs on the boards of new NHS Clinical Commissioning Groups (CCGs) in England will have a potential conflict of interest, an investigation suggests.

The British Medical Journal (BMJ) analysed 83 per cent of the 211 boards, which will play a key role in from April, and says potential conflicts will be "rife".

A code of conduct says board members must remove themselves from decisions if they could benefit from the outcome.

The NHS Commissioning Board (NHSCB) says it will issue final guidance soon.

The BMJ says 426, or 36 per cent, of the 1,179 GPs it looked at - who are in executive positions on boards - have a financial interest in a for-profit health provider beyond their own practice.

Their interests range from senior directorships in firms set up to provide services such as out-of-hours GP care, to shareholdings in large private health firms, such as Harmoni and Circle Health.

The information - obtained from Freedom of Information requests and analysis of CCG websites - also shows 12 per cent of the GPs had declared links with not-for-profit organisations that could present a conflict of interest with their commissioning role.

And nine per cent of GPs declared a conflict of interest through a family member.

The GP-led CCGs will take responsibility for organising NHS care worth about £60 billion.

The BMJ's editor in chief, Dr Fiona Godlee, said:

"These conflicts will make the commissioning of some services difficult.

"Although board members can excuse themselves from meetings when conflicts arise, this could mean some decisions are made by a group of predominantly lay people."

A spokeswoman for the NHSCB said:

"CCGs are under clear duties to ensure that they manage any potential conflicts of interest in ways that preserve the integrity of their decision-making processes."
“This is why it is so vital that everyone working for a CCG or serving on its governing body declares any interests they have.”

Six of the eight GPs running Blackpool CCG have declared an interest in the local out-of-hours provider.

The group has chosen to have four lay members - instead of the minimum of two - on its governing body, to help resolve any conflicts of interest.

Dr Laurence Buckman, Chair of the BMA's GP committee, said:

"While the majority of GPs have no involvement in private companies, we have long called for stronger safeguards against possible conflicts of interest in the new commissioning process.

"In our view, GPs who are directors of, or who have significant financial interests in, companies who might be awarded contracts to provide services should seriously consider their membership of CCG governing bodies.

"Alternatively, they should consider their position within provider companies."

But some GP leaders have warned that focusing on possible conflicts could distract from the main tasks facing doctors under the new structures.

Dr Michael Dixon, Chairman of the NHS Alliance, which represents organisations and individual professionals in primary care, said:

"The priority is to move services out of hospital and into primary care.

"The reason this hasn't happened to date is because of blocks in the system.

"It's more important to remove those blocks than be preoccupied with conflicts of interest."

The Shadow Health Secretary, Andy Burnham MP, said:

"Patients and public want those entrusted with making decisions about the NHS to have its best interests at heart.

"They will be shocked to learn that so many have a potential conflict of interest."

Dr Clare Gerada, Chair of the Royal College of General Practitioners, said:

"This is what the College warned about as far back as September 2011 when we issued guidance around the ethics of commissioning.

"Clinically led commissioning on this scale is unchartered territory and GPs are being presented with a tremendous range of new challenges.

"If conflicts of interest in CCGs are not managed effectively, the consequences could badly undermine the confidence of regulators, providers and, most importantly, patients, in the system."

Source: www.bbc.co.uk/news 14 March 2013

The UK is unready for ageing - Urgent action needed by the Government

The House of Lords Committee on Public Service and Demographic Change has warned that the Government is woefully underprepared for ageing. The Committee says that our rapidly ageing population will have a huge impact on our society and public services and unless Government and all political parties address this, the gift of longer life could lead to a series of crises.
The report entitled, ‘Ready for ageing?’ identifies how England will see a 50 per cent rise in the number of those aged 65 plus and a 100 per cent increase in those aged 85 plus between 2010 and 2030.

The report said that a longer life offers benefits for many, but to help people sustain a good quality of life over more years will require big changes in employment practices, pensions, health and social care services. An ageing society will greatly increase the number of people with long term health conditions, and health and social care services will need a radically different model of care to support such people in their own homes and in the community, and so avoid needless admissions to hospital.

For a major social change affecting everyone in England the Committee was concerned that the Government had not properly addressed this. It calls on the Government to publish a White Paper before the next general election setting out how our society needs to prepare for a longer life and calls on all parties, in working on their manifestos for the next general election, to consider the wider implications of the ageing society.

The Committee recommends that whichever party is in Government after the election should, within six months, establish two cross-party commissions to respond to the ageing society. One would work with employers and financial services providers to improve pensions, savings and equity release; the other would analyse how the health and social care system and its funding should change to serve the needs of our ageing population. Both should report in 12 months.

Suitable health and social care for an ageing society

The Committee has concluded that our current model of health and social care provision is failing older people now and is inappropriate to care well for the many more older people there will be with chronic health conditions. This will require a fundamental change to healthcare provision and the integration of health and social care systems and their funding.

The National Health Service will have to transform to deal with the very large increases in demand for and costs of health and social care. England has an inappropriate model of health and social care to cope with the changed pattern of ill health from an ageing population.

The report explains how radical changes to health and social care are needed and the Committee calls on the Government to set out a vision and framework so health and social care services progressively change to become much better fitted to meet the needs of an ageing society.

Supporting ourselves through later life

For many people there is a risk that a longer life could worsen the existing problem of insufficient savings and pensions. To help address this, people should be able to work later, if they wish to, often in part time work. Also private sector employers, Government and the financial services industry must together tackle the serious defects in defined contribution pensions so people get a clearer idea of what they can expect to get from their pension savings.

The Committee suggests that people may need to use their housing assets to support their longer lives and urges Government to work with the financial sector to support the growth of a safe, easy-to-understand equity release market, with low fees and high quality standards.

Attitudes to ageing

The Committee argues that with increasing longevity, our view of old age will have to change, for example: Government and employers should work to end ‘cliff-edge’ retirement.
Chairman's Statement

Commenting, Lord Filkin, Chairman of the Committee, said:

“As a country we are not ready for the rapid ageing of our population. By 2030, England will have double the number of people aged 85 and over than it had in 2010, and the large increase in our older population will have profound effects. The amazing gift of longer life is to be welcomed, but our society and politicians need to address the implications, and the changes needed to attitudes, policies and services so people are best able to benefit from it.

“Health and social care need to be radically reformed; both are failing older people now. A big shift in services is essential so that the many more older people with long term conditions can be well cared for and supported in their own homes and in the community and not needlessly end up in hospital. All health services and social care must be integrated to help achieve this.

“We need Government to support the choices each of us makes for our longer lives: people must be better informed and enabled to get a better idea of the income they may get in retirement from their pension savings; they should be able to work later if they wish to do so.

“The Government must set out in a White Paper the implications of an ageing society with a vision for living well and independently. It should set out how our health and social care services, our pension arrangements and our practices must change to achieve this. All political parties should be expected to consider the wider implications of the ageing society in their manifestos for the 2015 election.

“This is not a distant issue; our population is older now and will get more so over the next decade. The public are entitled to an honest conversation about the implications.”

Source: www.parliament.uk 14 March 2013

Financial pressures risk undermining volunteering in NHS and social care

A new report entitled, ‘Volunteering in health and care’ published by The King's Fund has found that, unless a more strategic approach is taken, financial pressures risk undermining the use of volunteers in health and social care.

An estimated three million people in England volunteer in the NHS, health charities and social care organisations, adding significant value to the work of paid staff. The report highlights the vital role they play in delivering services, for example assisting with mealtimes in hospitals, providing support for bereaved families and befriending older people in care homes. It suggests that volunteers could become an increasingly important part of the care team, providing trusted support to paid professionals and an important source of help for patients and service users.

However, research undertaken for the report suggests that if the right steps are not taken, the funding squeeze in the NHS and cuts to local authority budgets could have a significant impact on volunteering. Financial pressures are prompting concerns about the motivation of public bodies in using volunteers and heightening sensitivities about them 'substituting' for paid staff in future. Budget cuts are also increasing pressure on voluntary organisations providing and co-ordinating volunteering opportunities, with some smaller grassroots organisations struggling to survive the economic downturn.

The King's Fund has called for a strategic approach to volunteering throughout the health and social care system. Commissioners and service providers need to focus on how volunteers will help improve quality and bring benefits to patients and communities. Boundaries between professional and volunteer roles also need to be clarified to allay concerns of job substitution.
Chris Naylor, Fellow at The King’s Fund said:

“There are huge opportunities for volunteering to help transform health and social care services and bring about real improvements for patients and the wider public. However, for this to be realised service providers and commissioners must take a much more strategic approach to volunteering, with clarity of roles and clearly articulated objectives. Volunteering should be used as a means of improving quality rather than reducing short term costs, and this vision needs to be communicated clearly.”

The report is based on qualitative research involving focus groups with volunteers and patients, in-depth interviews with commissioners and providers of health and social care services, and a scenario analysis conducted with a workshop of invited experts. It also draws on a review of published evidence and benefited from the insights of an external advisory group.

The research was commissioned and funded by the Department of Health and conducted independently by The King’s Fund. The remit was to explore the future of volunteering in the context of the Health and Social Care Act 2012 and wider system changes.

The report includes a number of recommendations.

- service providers and commissioners should take a much more strategic approach towards volunteering, with a clear vision of how volunteers will help meet organisational objectives and benefit patients and the local community
- the value of volunteering needs to be better measured and articulated at all levels in the system. There is a striking lack of information about the scale or impact of volunteering in health and social care. Addressing this should be a priority
- volunteering should be used as a means of improving quality rather than reducing short term costs. The management of volunteering and supporting infrastructure should be adequately resourced or there is a risk it will not achieve its potential
- there is a need for clarity regarding the boundaries between professional and volunteer roles. Sensitivities around job substitution, real or perceived, need to be handled carefully.

Source: www.kingsfund.org.uk 14 March 2013

Monitor report highlights pressure on foundation trust A&E services

Overall, the NHS foundation trust sector continues to perform well in the challenging healthcare climate in terms of delivering services for patients and sound finances, according to Monitor, the regulator of foundation trusts.

However, Monitor is concerned that there has been a significant increase in the number of trusts failing to meet patient accident and emergency waiting times in Q3. At Q3 more than twice as many trusts (32) have failed to meet this target compared with this time last year (14).

Outbreaks of the winter vomiting bug, discharge delays due to problems accessing community care services, and increased attendances among elderly people were reasons cited by the trusts. These were in addition to the expected seasonal demand.

Of the foundation trusts with an A&E department 36 per cent missed the A&E target, compared with eight per cent in the previous quarter and 16 per cent in the same period a year ago. Early indications are that pressure on A&E is likely to continue in Q4.
Monitor remains concerned that a small number of trusts continue to miss other waiting times targets, but these are not the same trusts each quarter, and overall the trend across the sector is improving.

Monitor works closely with the Care Quality Commission (CQC) and follow up any concerns it raises about clinical care in foundation trusts. The number of trusts with moderate CQC concerns rose in Q3 (from 15 to 20). Major concerns that might trigger Monitor’s enforcement action were reported at two trusts, compared with one in Q2.

Stephen Hay, Managing Director of Provider Regulation said:

“There is a greater demand for A&E service across the NHS, but it is not acceptable that patients have to wait longer.

“Trusts need to work with local healthcare partners to understand and address these issues.”

The regulator also remains concerned that only one in four foundation trusts are delivering the cost savings they said they would make this financial year. For the third quarter in a row, delivery of cost savings was substantially behind plan and the cumulative slippage amounts to 16 per cent (£173 million) of the total savings planned (£1.07 billion) for the year to date.

Stephen Hay commented:

"It is important for all trusts to make sure they deliver cost savings in this tight financial environment, while maintaining and improving the quality of care for patients. Monitor has regularly reminded trusts of the importance of making savings early in the year to prevent problems being stored up for later."

Despite this overall shortfall on planned cost savings, financial performance remains ahead of plan at quarter three with an overall surplus of £365 million. Revenue is two per cent more than expected because of increased demand for hospital services.

The number of trusts in deficit in Q3 fell to 19 (from 26 in Q2), although the total amount of their deficit rose from £90 million to £112 million – largely driven by the five most financially-challenged trusts (Peterborough, Morecombe Bay, Sherwood Forest, Mid Staffordshire and Bolton foundation trusts).

The sector is on track to be in surplus by the end of the year and will therefore have available funds to reinvest in improving the quality of services for patients.

Source: www.monitor-nhsft.gov.uk 14 March 2013

‘Making a Difference in Dementia’ nursing vision and strategy launched

A new nursing vision and strategy for dementia care has been launched by the Department of Health.

It makes clear that every nurse can make a difference to the care of people with dementia.

This new resource will support the Prime Minister’s Dementia Challenge by:

- raising the profile of the wider nursing contribution to dementia care
- describing what is expected of all nurses to meet the level and quality of care expected in all care settings.

The vision demonstrates the 6Cs for dementia care by including nursing values and behaviours. It builds on ‘Compassion in Practice’, the national vision for nurses, midwives and care staff.
The ‘Making a Difference to Dementia’ vision recognises the unique and specialist contribution of all nurses and their teams who are involved in the care of someone with dementia at different stages along their care pathway.

There is a need to ensure people with dementia have the best, compassionate care and support from all nurses and their teams. All nurses can make a contribution across the dementia pathway, irrespective of provider, whether it’s within the NHS, social, private, voluntary or prison sectors. This support starts right from keeping well, awareness raising and reducing social stigma, through to early identification, diagnosis, maintaining health and wellbeing and finally end of life care and bereavement support for carers and their families.

All nurses – public health nurses, midwives, mental health nurses, learning disability nurses, district nurses, community nurses/matrons, practice nurses, Admiral Nurses, specialist nurses including specialist dementia nurses, acute nurses, Macmillan nurses and palliative care nurses – are able to contribute to achieving, and sustaining, better outcomes for people with dementia, at all ages. This list is not exhaustive – the vision is intended for all nurses, regardless of what sector they work in.

Pauline Watts, Nursing Professional Officer, Clinical Advisor Public Health Nursing and Department of Health Nurse Lead for Dementia Care, said:

“Dementia is every nurse’s business – with a change in mindset, practice, commissioning and education, nurses can make a real difference to people living with dementia and their carers and families.”

The dementia nursing vision has been developed by stakeholders from a wide range of NHS and other organisations, and carers, bringing together partners and clinicians with expertise and interest in dementia. They shared and consulted on the document with experts from the health, social care and voluntary sectors and their wider networks.

‘Making a Difference to Dementia’ is available at: https://www.gov.uk/government/publications/making-a-difference-in-dementia-nursing-vision-and-strategy

Source: www.gov.uk/dh 15 March 2013

Review of NHS complaints system
A review aimed at ensuring that all hospitals listen to and act upon the concerns of patients has been launched.

It will be led by Ann Clwyd, MP for Cynon Valley, and Professor Tricia Hart, Chief Executive of South Tees Hospitals NHS Foundation Trust and advisor to Robert Francis during his two inquiries into the Mid Staffordshire NHS Trust.

The review of NHS complaints handling was first announced by the Prime Minister in his response to Robert Francis’s report into failings at Mid Staffordshire NHS Foundation Trust.

Proposed terms of reference
The review will engage with patients and their carers and representatives, staff and managers to hear and understand their experience of the way trusts manage and act on concerns and complaints.

The review will consider the handling of concerns and complaints in NHS hospital care in England and, in doing so, will:
• consider how to align more closely the handling of concerns and complaints about patient care
• identify where good practice exists, and how good practice for delivering to those standards is shared and what helps or hinders its adoption
• consider what standards might best be applied to the handling of complaints
• consider how intelligence from concerns and complaints can be used to improve service delivery, and how this information might best be made more widely available to service users and commissioners
• consider the role of the trust board and senior managers in developing a culture that takes the concerns of individuals seriously and acts on them
• identify the skills and behaviours that staff, including clinical staff, need to ensure that the concerns of individuals are at the heart of their work
• consider how complainants might more appropriately be supported during the complaints process through, for example, advice, mediation and advocacy
• include the handling of concerns raised by staff, including the support of whistleblowers.

It will be encouraged to make recommendations about:
• any aspect of the NHS complaints arrangements and other means by which patients make concerns known
• the way that organisations receive and act on concerns and complaints
• how boards and managers carry out their functions
• the process by which individual organisations are held to account for the way that they handle concerns and complaints.

The review team will report to the Secretary of State for Health by the Parliamentary Summer recess.

Contacting the review team
Anyone wishing to submit evidence to the review is welcome to do so.

Email: ComplaintsReview@dh.gsi.gov.uk
Write to:
Review of NHS Complaints Handling
Department of Health
Room 5E43, Quarry House
Quarry Hill
Leeds
LS2 7UE

Source: www.gov.uk/dh 15 March 2013
Hospital deaths warning 'ignored'
More than 20,000 hospital deaths could have been prevented if warnings about high mortality rates had been acted on quickly, a Government adviser has said.

Professor Sir Brian Jarman has accused ministers and officials of ignoring data on high death rates for a decade.

Sir Brian is working on the Government review of 14 hospital trusts with higher-than-average death rates in the wake of the Stafford Hospital Inquiry.

The Government said the Inquiry report showed "failings across the system".

Sir Brian, director of the Doctor Foster research unit at Imperial College in London, has developed systems for monitoring death rates - known as hospital standardised mortality ratios (HSMRs) - and other data on a monthly basis.

He has been publishing such data for 12 years and it helped expose high death rates at Mid Staffs and the 14 trusts now under investigation.

Sir Brian, a former GP and former president of the British Medical Association (BMA), said he fought to bring the issue of high mortality rates to the attention of senior NHS officials - but he was ignored.

"For the last 10 years there were about four [hospitals] who have had continuously very high adjusted death rates. And actually I sent to the Secretary of State in March 2010, Andy Burnham, a list of hospitals that had high [rates], and there are seven of the ones on the list that have just been mentioned," he told BBC Radio 4's Today programme.

He said Mr Burnham replied in a note dated 24 March 2010 saying he had asked the Care Quality Commission (CQC) to study the data.

"He said he sent it to the CQC and they did not find that there was anything to worry them," said Sir Brian.

He added:
"Well I think that it's a pity that he didn't because you have seen at Mid Staffs and we've seen at other hospitals that when they have actually gone in and looked they have been able to reduce the death rates.

"We are talking about people dying there."

Mr Burnham, who was Health Secretary between June 2009 and May 2010, said he acted "firmly and immediately" when Sir Brian contacted him.

"I acted immediately and passed the data to the independent regulator... and I also invited Brian Jarman on to a working party to look at this very issue. So I don't think it's possible to say we were complacent or that we ignored these warnings," said Mr Burnham, now Shadow Health Secretary.

Sir Brian said looking at data from the 14 hospital trusts listed as having high HSMRs, the "observed deaths exceeds the number they were expected to have by the national average".

He said the number of excess deaths at these trusts alone over the past 10 years amounted to "a bit over 20,000".

"That's only looking at 14 of the 140 trusts - there are likely to be other trusts where they have numbers that exceed the national value," he said.

He went on:
“Those hospitals which had persistently high death rates over all those years and have now been listed for investigation should have been investigated earlier, because it is quite possible we would have had fewer deaths in those hospitals.

"I think there must be at least tens of thousands of avoidable deaths in those hospitals alone, when we should have been going in and we should have been looking at them."

The CQC said:

"The mortality data from the Dr Foster Unit at Imperial College London was taken into account when these services were registered with the CQC in April 2010.

"The CQC currently analyses a wide range of indicators to inform its regulatory activities and mortality measures are an important part of this. CQC is changing the way it inspects hospitals this includes looking at how it uses data."

The report on Mid Staffs by Robert Francis QC said “fundamental change” was needed to prevent in the NHS. It came after data showed there were between 400 and 1,200 more deaths than would have been expected.

The Department of Health said the report showed failings across the system, including by the Department.

It pointed out that it had already apologised and was now leading the inquiry into other trusts with apparently abnormally high death rates.

Source: [www.bbc.co.uk/news](http://www.bbc.co.uk/news) 16 March 2013

**NHS told to do more to 'reduce health inequalities'**

Health Secretary Jeremy Hunt has backed a report calling on health professionals to tackle the social and economic causes of ill health - not just the medical.

The report, supported by the British Medical Association (BMA), says more needs to be done to reduce the health divide between rich and poor.

It contains a commitment to making "social referrals".

The Health Secretary said the NHS had a legal duty to reduce health inequality.

It has been calculated that addressing health inequalities in the way the report suggests could save the NHS £5.5 billion a year.

The report from the Institute of Health Equity points out that eight people a second are seen by the NHS, yet not enough attention is given to social and economic problems underlying poor health.

It highlights examples of best practice including social referral schemes to employment and housing advice, training on nutrition for childcare providers and helping older patients to build social networks after a stay in hospital.

The report is led by Professor Sir Michael Marmot who highlighted in 2010 that inequality costs the UK £31-33 billion per year in productivity and lost taxes, and £20-32 billion in welfare payments - in addition to the added costs to the NHS.

Its recommendations include:

- better education and training on social causes of ill-health and opening up healthcare careers to people from all backgrounds
• recording social history alongside medical information and offering referral to range of medical, social services and other agencies
• ensuring NHS staff are paid a minimum income for healthy living
• using joint commissioning, data sharing and shared schemes to tackle health inequalities
• encouraging health professionals, students and healthcare organisations to act as advocates for patients, their families and local communities to improve social and economic conditions.

Sir Michael said despite having the most equitable health service in the world, inequalities in social and living conditions are driving inequalities in health.

"Even among health professionals who have this insight, there has been a sense that it is for others to respond, there is not much we can do.

"But the response we have had from the many organisations and individuals that have helped us with this report is not only should we be taking action but there is ample evidence that we can."

The gap in life expectancy across England between the best and worst-off is seven years but in some areas such as London, this rises to 17 and in Glasgow there is a 28-year difference in life expectancy between rich and poor.

From April 2013, local authorities in England have taken over responsibility for the prevention of ill health but this report is solely aimed at those working in the health service.

Dr Vivienne Nathanson, from the British Medical Association said many of their members are already using their position as doctors not just to focus on disease but also the wider social issues that contribute to their patients' ill-health.

"We need to spread the word about good practice so that doctors can learn from their colleagues who are successfully providing an integrated approach to healthcare, for example, by referring patients to employment, debt or benefits advice centres when these factors go hand in hand with their health problems."

Health Secretary Jeremy Hunt said:

"Everyone should have the same opportunity to lead a healthy life; no matter where they live or who they are which is why we must continue to work to narrow the gap in health inequalities.

"We have set out the first ever specific legal duties on health inequalities for the NHS and I recently set out my challenge on reducing premature mortality.

"Local areas must work together to address the health needs of their population and make a real difference in tackling health inequalities."

Source: www.bbc.co.uk/news 18 March 2013

Thousands of patients with long term conditions and dementia could benefit as GP contract proposals are unveiled

Thousands more patients will soon feel the benefits of better care at their GP surgery as an ambitious vision to improve the lives of people with long term conditions and people with dementia becomes a reality, the Department of Health has announced.
From April 2013, changes to the GP contract will see millions of pounds redirected into better care for patients.

Money that was once given to doctors for performing routine office functions like record keeping will now be used to reward steps which directly support and benefit patients. This includes better control of blood pressure and cholesterol, to prevent heart attacks and stroke, and assessing patients at risk from dementia.

In total, £164 million will be pulled away from bureaucratic box ticking exercises and into better care, the Department added.

Jeremy Hunt, Secretary of State for Health said:

“Improving care for patients has always been my priority. The GP contract needs to change to make sure the excellent care enjoyed by some patients is more consistent across the country.

“Providing better treatment for people with long term conditions helps save lives and I know GPs will rise to the challenge to make sure standards of care in this country are world class and continue to improve.

“We have listened to GPs and stakeholders and made some changes to our proposals to reflect these views and now feel we are in the right place to go forward.

“I am committed to ensuring that we improve quality of life for people with long term conditions – and I want GPs to lead this change from within their own practices.”

Under the changes, GP practices will need to match the high quality care seen in the best performing practices by ensuring that more patients are offered the best standards of care in 20 key areas. These are areas that are known to have an impact on reducing avoidable deaths, for instance for people who have heart disease. This approach will be extended to other areas of care in 2014 so that even more patients benefit.

These changes could mean around 1.5 million more patients will get better care in 2013/14. This could reach as high as 3.5 million by 2014/15 and could help doctors go further in spotting early warning signs of illness. It should mean more patients get the right tests, treatments and medicines if they have diabetes, hypertension, lung disease, heart failure or arthritis. This care can not only improve the health of patients, it potentially saves more lives.

GP practices will be rewarded for taking more proactive steps to identify people who may have dementia so that they and their families can receive earlier support. Rewards are also available for identifying and improving care for those people most at risk of avoidable emergency admissions to hospital.

Embracing technology as a way of championing better care will also be rewarded as GP practices will be paid for enabling patients to book appointments and order repeat prescriptions online.

The contract also incorporates the latest expert advice on the areas which will have the greatest impact on patient health. This includes improved support for cancer patients and those with depression, arthritis and diabetes.

All practices will receive a 1.32 per cent increase in current funding, allowing for a one per cent pay increase for GPs and practice staff, in line with public sector pay policy, and additional resources to cover non-staff expenses. There will also be a new £10 million investment in two new immunisation programmes.

Main changes
• the Minimum Practice Income Guarantee will be phased out over seven years from April 2014 and the resulting savings will be used to increase capitation (‘global sum’) payments for GP practices. This will stop some GP practices receiving thousands of pounds more than others that care for a similar number of patients with similar patient needs – and distribute resources more equitably between practices

• most of the recommendations by the National Institute for Health and Clinical Excellence (NICE) for improvements to the Quality and Outcomes Framework (QOF) will be implemented in full. Implementation of two of NICE’s recommendations will be deferred until April 2014 to allow more time for GPs to work with clinical commissioning groups to ensure the necessary referral services are in place

• QOF reward thresholds will be increased so that more patients benefit from the best evidence-based care that can help to save lives

• organisational QOF payments will be discontinued, releasing £164 million which will be used to help fund improvements in patient care through implementing the improvements recommended by NICE and paying for extra services from GP practices.

The extra services to be commissioned from GP practices will cover:

• a more proactive approach to identifying people who may have dementia so that they and their families can get earlier support

• improving care management for seriously ill patients or patients at risk of unplanned hospital admission such as frail older people

• ensuring that patients can book appointments and order repeat prescriptions online

• establishing new arrangements to help monitor the health of people with long term conditions, for example using technology to help patients manage stable conditions without having to go to their GP surgery as often.

This means GP practices will need to provide better services for patients in these four areas to maintain the practice income that they have up until now received for demonstrating organisational best practice (e.g. good recordkeeping). The NHS Commissioning Board will shortly be publishing more detailed specifications for these new schemes.

The Department of Health is investing up to £10 million annually (depending on take up) to GP practices for two new vaccination programmes for rotavirus and shingles.

As a result of the decision that GP locums should be responsible for their own employer superannuation costs, the funding that PCTs have historically used to pay for these costs is being transferred to practices.

Five stakeholder organisations responded to the consultation and some changes have been made to the original proposals to reflect some of the issues raised.

What changes have been made to the proposals on which were consulted?

• the Department of Health has deferred implementation of the two NICE recommended indicators rewarding practices for referral to rehabilitation services (cardiac and pulmonary) until 2014/15. This will give time for clinical commissioning groups to ensure these services are available

• the Department is phasing in thresholds for two of the indicators (on physical activity) and giving a greater proportion of QOF funding to these and the new indicator on blood pressure control to recognise the initial impact on practice workload
• the NHS Commissioning Board has indicated that it intends to adapt some elements of the new enhanced services to ensure that they are implemented in a phased way

• for 2013/14, the scheme to promote earlier diagnosis of people with dementia will focus on patients who have a higher risk of dementia because of their clinical condition (e.g. vascular disease or a long term neurological condition). The scheme to promote greater use of online services will focus on booking appointments online and ordering repeat prescriptions online.

Source: www.gov.uk/dh 18 March 2013

Dignity and nutrition inspection programme published
The Care Quality Commission (CQC) has published its first dedicated review of privacy, dignity and nutrition in both care homes and hospitals.

The 2012 Dignity and Nutrition Inspection Programme (DANI) has found that while most older people are having their needs met, a number of hospitals and care homes need to make improvements. It highlights the fact that often small changes can make a big difference to people’s experience of care.

CQC inspected 500 care homes and found 84 per cent respected people’s privacy and dignity and 83 per cent met people’s nutritional needs. This means staff were aware of people’s likes and dislikes and made sure people with dementia were given support to choose and their food. However, there were times when inspectors witnessed people not being given help to eat and drink or given personal care in a way that respected their privacy.

The report also looked at the same issues in hospitals following on from 2011’s report on respect, dignity and nutrition in NHS hospitals. It found improvements in the way people’s nutritional needs were met, with 88 per cent of hospitals visited making sure people were helped to eat and drink compared to 83 per cent in 2011. Whilst this is good progress there are also pockets of poor care.

Disappointingly, fewer hospitals are respecting people’s privacy and dignity, with 82 per cent meeting people’s needs compared to 88 per cent in 2011. CQC inspectors saw call bells left unanswered, leaving people without help to get to the toilet and without support for other needs.

CQC Chief Executive David Behan said:
‘We found good care and care that had improved. However, it is disappointing people are still not being given enough privacy when receiving personal care and that they are left alone when they call for help.

‘This is basic care and getting it right can transform a stressful experience for an older person into a supportive and caring one.

‘Safe, good quality care is not complex or time-consuming. Effective leadership and staff who feel supported make this happen every day. We want the all services to learn from the best.’

CQC published its first DANI programme in October 2011, which checked two standards at 100 hospitals. The inspections have been widened to include five standards for this programme.

The inspections took place in the Summer of 2012.
Inspection teams included nurses, geriatricians, dieticians and people with experience of using services, called Experts by Experience.

Source: www.cqc.org.uk 19 March 2013

Public expenditure on health and care services report
The values of the NHS are precious to all of us, but in future those values will only be reflected in practice if NHS and social care services are “re-imagined” according to a cross-party group of MPs on the Health Committee.

The care provided by the health and social care system will break down if quicker progress is not made to develop more integrated health and social care services which focus on meeting the needs of individual patients, warns the Health Committee in a report entitled ‘Public expenditure on health and care services’.

Launching the report about public expenditure on health and social care services, the Chair of the Health Committee, Stephen Dorrell MP, said:

“It’s unlikely that public expenditure on health and social care services will increase significantly in the foreseeable future. This means that the only way to sustain or improve present service levels in the NHS will be to focus on a transformation of care through genuine and sustained service integration.

“Services should be designed to treat people rather than conditions. They need to respond to individuals rather than expecting individuals to find their way round a bewildering range of specialist departments.

“To make this ambition a reality, we need to develop a much more joined up approach to commissioning health and care services; we propose that responsibility for this process in a given area should be vested in the Health and Wellbeing Board.

“Joined up commissioning would ensure that resources are no longer treated as ‘belonging’ to a particular part of the system, but become shared resources to use more efficiently to develop and deliver a more flexible and responsive local health and care services.

“Moving to this approach must not, however, result in less overall funding for care services. We therefore propose that the Government’s commitment to protect real-terms funding for health care should be extended to cover local authority social care services and that these funds should be ring fenced at current levels in real terms.”

Commenting on a range of other issues, the Health Committee also concludes:

- measures currently being used to respond to the Nicholson Challenge too often represent short term fixes rather than the sustainable long term service transformations
- changes in tariff payments within the NHS do not constitute ‘efficiency savings’ – they are simply internal transfers that only result in efficiency gain for the NHS if the NHS provider changes the way care is delivered
- under-spending against budget of money allocated to the NHS has attracted adverse comment. The MPs call for a general review of the operation of Treasury rules; in particular, they recommend that the rules on the use of reserves by NHS providers should be abolished to encourage investment by providers in necessary service change.
The NHS will not be able to rely on the present rate of paybill savings once the present restraints on public sector pay are relaxed in April 2013. Furthermore, although pay restraint is undoubtedly key in the short term, the Committee does not accept this can be regarded as a sustainable form of 'efficiency gain'.

The Committee says that “It is neither prudent nor just to plan for sustainable efficiency on the basis that NHS pay will continue to fall relative to pay elsewhere in the economy”.

Source: www.parliament.uk 19 March 2013

Independent sector dominates top ten for improved quality of life following elective hip and knee replacement

Independent sector organisations which carry out elective hip and knee replacement surgery for the NHS dominate the top ten providers for improving patients' quality of life (“health gain”) following the procedure, according to an analysis of Patient Reported Outcome Measures (PROMS) data published by the NHS Partners Network (NHSPN).

Of the top ten providers for hip replacement surgery, seven are from the independent sector. In the top five, four are independent sector providers. In the bottom 25, only one provider is from the independent sector. For knee replacement surgery, eight of the top ten are independent sector providers, and in the top five, three are independent sector providers. No independent sector provider appears in the bottom 25.

PROMS assess the “health gain” for patients who undergo hip and knee replacement surgery as judged by the patient him/herself. Data is available for all providers who carry out the procedures for the NHS in England. It suggests that NHS patients who had surgery in an independent sector facility are more likely to enjoy greater improvement in quality of life following the procedures. The figures are adjusted to allow for differences in the relative health of patients attending each hospital.

The independent sector now carries out almost a fifth (19 per cent) of all elective hip and knee replacement surgery in the NHS and is increasingly treating more NHS patients across a range of elective procedures, both in independent sector treatment centres (ISTCs) and private hospitals. Although the sector is only permitted to undertake certain types of cases, usually excluding the most complex, the data is adjusted for key aspects of case mix. The data also suggests that the case mix differences are not as significant as is sometimes claimed.

David Worskett, Chief Executive of the NHS Partners Network, said:

“This data clearly shows that independent sector providers deliver some of the highest quality orthopaedic care for NHS patents.

“Hip and knee replacements are two of the most commonly performed orthopaedic procedures and they can significantly improve the quality of life for patients. It is important that this data is available so that patients and their GPs can make informed decisions about where to go for treatment.

“The quality of clinical care is crucial, and this data, drawn from the NHS PROMS database, clearly shows that the independent sector delivers very high standards NHS care, seen from the patients' perspective”.

NHSPN has also published a briefing note, compiled from various official sources, which in addition to the PROMS results, shows that:
• almost all independent providers - 98 per cent in hospitals and 96 per cent in community services - are meeting the required standard on dignity and respect

• independent sector readmission rates for hip and knee surgery are significantly lower than the NHS average and comparable with specialist orthopaedic hospitals.

Mr Worskett added:
"Taken together, all of this provides a full and well-rounded picture of the care NHS patients receive from the independent sector, and demonstrates the great contribution the sector can make to the modern NHS. It is clear from the newly published Civitas research that 83 per cent of British people are entirely happy to use independent sector NHS services as long as they come up to standard - as they clearly do - and are free at the point of need."

Source: www.nhsconfed.org 19 March 2013

'Most family doctors' have given a patient a placebo drug
Most family doctors have given a placebo to at least one of their patients, survey findings suggest.

In a poll, 97 per cent of 783 GPs admitted that they had recommended a sugar pill or a treatment with no established efficacy for the ailment their patient came in with.

The PLOS One study authors say this may not be a bad thing - doctors are doing it to help, not to deceive patients.

The Royal College of GPs says there is a place for placebos in medicine.
But they warn that some sham treatments may be inappropriate and could cause side effects or issues such as drug resistance.

For example, one of the placebo treatments identified in the study was antibiotics for suspected viral infections.

Antibiotics are powerless against viruses and doctors are told not to use them.

About one in 10 of the GPs in the study said they had given a patient a sugar pill or an injection of salty water rather than a real medicine at some time in their career.

One in 100 of them said they did this at least once a week.

Almost all of the GPs said they had provided patients with treatments, like supplements, probiotics and complementary medicines that were unproven for their medical condition.

Three-quarters said they offered unproven treatments on a daily or weekly basis.

Dr Jeremy Howick, co-author of the study that was carried out by the University of Oxford and the University of Southampton, said:

"This is not about doctors deceiving patients.
"The study shows that placebo use is widespread in the UK, and doctors clearly believe that placebos can help patients."

The GPs in the study said they used placebos either because patients requested treatment or to reassure patients.

Half said they told their patients that the therapy had helped other patients without specifically telling them that they were prescribing a placebo.
Dr Clare Gerada, Chairwoman of the Royal College of GPs, said it was perfectly acceptable to use a placebo as long as it did not cause harm and was not expensive.

"Lots of doctors use them and they can help people.

"If you think about it, a kiss on the cheek when you fall over is a placebo.

"But there are risks. Not all of the placebo treatments that the researchers looked at in this study are inert. If you take too many vitamins, for example, some can cause harm."

She said fobbing off patients with an ineffectual treatment was never acceptable.

"But admitting to your patient that you do not know exactly what is going on, but that a therapy might help is."

Source: www.bbc.co.uk/news 21 March 2013

NICE to assess value of medicines from 2014
The National Institute for Health and Clinical Excellence (NICE) will take responsibility for assessing the full value of medicines when new pricing arrangements are introduced in 2014 the Government has announced.

The Government confirmed the plans in its official response to the Health Select Committee’s report on the future role of NICE which has been published. The move will give NICE a crucial role in the future value-based pricing arrangements for branded medicines. It will allow the body to build on its current drug evaluation processes by giving it broader scope to assess a medicine’s benefits and costs. The aim is to make sure that the price the NHS pays for new medicines is more closely linked to their value to NHS patients and society.

The announcement comes as NICE was also preparing to take on other new responsibilities. From April, its remit has been extended to cover social care, as well as the NHS and public health. This will assist in the development of better integration of services between different health and care organisations, according to the Department of Health.

Lord Howe, Health Minister said:

“We are delighted to announce the central role NICE will take in assessing the value of new medicines. This will allow us to draw on NICE’s world-leading expertise as we develop the Value-Based Pricing scheme.

“The role of NICE is developing and growing as it takes on new responsibilities in social care. We are grateful to the Health Select Committee for their detailed report and helpful recommendations covering various aspects of NICE’s work.

“We know NICE is facing new challenges and have every confidence that its Chair-designate, Professor David Haslam, will lead it successfully into the future.”

NICE will now work with the Department and other stakeholders to plan how it will undertake its role in assessing the value of new medicines.

The Health Select Committee’s report was published in January 2013 and was the result of a number of fact finding sessions held by the Committee as NICE looked to appoint Professor David Haslam as its new Chairman. It contained a number of observations and recommendations for the future of NICE which the Department of Health has now responded to in full.

The Government’s response also welcomes the Health Select Committee’s support for NICE developing healthcare quality standards for people with long term conditions, co-morbidities
and complex needs. It has also echoed the Committee’s calls for the development of better integrated care and the need for more integrated commissioning.

The Government’s response also welcomes the committee’s call for better information about drug trials and a new code of practice.

Source: www.gov.uk/dh 21 March 2013

**NHS remote monitoring 'costs more'**

Remotely monitoring patients with long term conditions is less cost effective than usual care, a UK trial suggests.

The British Medical Journal (BMJ) study, involving almost 1,000 patients, indicated the total costs for those using "telehealth" were higher.

It follows a recent study suggesting the use of such technology fails to improve patients' quality of life.

But the Department of Health said it had already addressed problems raised by the research.

Telehealth uses technology in patients' homes to monitor their condition and send data back to medical staff. For example, tracking changes in blood pressure or blood sugar levels.

The principle is that it reduces the need for hospital visits while allowing clinicians to keep an eye on a patient's condition.

But the researchers said most of the previous studies into the technology's use came from the US, used very small numbers of patients or were funded by industry.

In the latest Department of Health funded trial, researchers looked at 965 patients with heart failure, chronic obstructive pulmonary disease or diabetes.

They were selected for the trial by their GP and received either usual care or were provided with telehealth equipment.

After a year, the researchers found that taking into account all costs, including those to both health and social care, the telehealth scheme was not cost effective.

The cost per quality-adjusted life year - a combined measure of quantity and quality of life - of telehealth was £92,000 when added to usual care.

This is way above the threshold of £30,000 that the National Institute for Health and Clinical Excellence (NICE) has set.

A best-case scenario taking into account that the price of equipment was likely to fall over time and that services were not running at full capacity during the trial, saw the probability that the service was cost-effective rise from 11 per cent to 61 per cent.

The Government has been keen to promote telehealth as a way for the NHS to cope with an ageing population with multiple long term conditions.

Initial results from the Whole System Demonstrator trial of the technology seemed very positive, with fewer admissions to hospital.

But recently, more work from the trial showed no measurable benefit to quality of life, and the latest work suggests that claims telehealth will produce dramatic savings for the NHS were premature.
Study author Prof Martin Knapp, from the London School of Economics and Political Science, said there was likely to be a place for telehealth, but there remained a question about how to target patients who would most benefit.

"We need to use the evidence to give us an indication of who does better. It is about how we use it and what it is we are using."

He added: "Some patients do not want to lose that face-to-face contact."

Dr Mike Knapton, associate medical director at the British Heart Foundation (BHF), said:

"Telehealth and telemonitoring could potentially improve the quality of life for patients living with long term conditions such as heart failure.

"However... in the current financial climate, it is difficult to see how healthcare commissioners could justify investment in telehealth on the basis of this research."

Cathy Moulton, Diabetes UK clinical adviser, said detailed research was needed on the impact of telehealth on diabetes as a stand-alone condition to see if any savings were possible.

"While telehealth may suit some people with diabetes, it is extremely important that everyone with diabetes has access to individualised care which is tailored to their specific needs."

The Department of Health said:

"This is only one part of a much wider study carried out between 2008 and 2010.

"The whole study showed that using telehealth reduces mortality by 45 per cent, A&E attendances by 15 per cent and emergency admissions by 20 per cent.

"This part of the study confirms that to introduce the technology in isolation, at high cost and in low numbers does not bring the cost reductions we believe are there to be made.

"That is why our approach, known as the three million lives initiative, is different. It is about bringing in telehealth at scale and will create improvements in services, care and costs."

Source: www.bbc.co.uk/news 21 March 2013

Local Healthwatch on schedule for April launch

All 152 unitary and county councils in England will give residents the opportunity to voice their views on health and adult social care from 1 April through a new consumer watchdog which promises the ‘teeth’ to bring about real change.

According to new research conducted by the Local Government Association (LGA), 100 per cent of upper tier councils have set up or are in the final stages of commissioning a local Healthwatch and will have a service in place by the April deadline, helping to put patients and users of care services at the core of the health and social care system.

Under the reforms brought in by the Health and Social Care Act, councils have a statutory responsibility for ensuring health and social care services are effectively commissioned, delivered and scrutinised. Local Healthwatch will play a central role in this, gathering high quality feedback from local people and using their views and experiences of the service they receive to drive up standards, according to the LGA.

Each local Healthwatch has been set up as an independent body with the majority being run by local voluntary and community organisations, and will act as a ‘critical friend’ of the local authority. As well as sitting on the health and wellbeing board (HWB) to influence services at a local level, each Healthwatch will exist as part of a wider network that will be able to raise
concerns at national level through Healthwatch England and the Care Quality Commission (CQC) to ensure its voice is heard.

Councillor David Rogers, Chair of the LGA's Community Wellbeing Board, said:

"Ensuring local people have a say is one of the major strengths of local government, and through local Healthwatch we will be able to put patients and users of care services at the very heart of the new system.

"Each Healthwatch has been commissioned to meet the specific needs of local residents, in many cases building on the experience and knowledge built up by the Local Involvement Networks (LINks) over the last five or six years, to develop the foundations of a powerful and influential consumer voice both at a local and a national level.

"The LGA has worked very closely with our members to help them get everything up and running in time, and we will continue to help councils ensure their local Healthwatch is given the right support at a political and managerial level as well as on the frontline working with local people to make their voice heard."

Healthwatch Readiness Report figures:

- one hundred per cent of local authorities have completed or are on track to complete by 1 April
- one hundred and forty six (95 per cent) reported that they had awarded a contract, approved grant funding or established a social enterprise at 19 March 2013
- one hundred and twenty four local authorities commissioned or worked with a single voluntary or community sector (VCS) organisation or a number of VCO's as part of a consortium
- eleven local Healthwatch organisations have been directly created out of the existing community LINk with many others working closely with the LINks to retain valuable skills and knowledge
- seven local authorities commissioned a private company to establish an independent social enterprise to run their local Healthwatch
- one hundred per cent of local authorities have also completed or are on track to complete the commissioning of local NHS complaints advocacy services.

Source: www.lga.gov.uk 21 March 2013

‘Primary care: Access denied’

As many as three quarters of people (79 per cent) wouldn’t feel safe relying on NHS out-of-hours services in a medical emergency according to new research by The Patients Association.

The report entitled, ‘Primary care: Access denied’ uncovers new evidence that; almost two thirds of people (61 per cent) have to wait longer than forty eight hours to book an appointment with their GP and more than half (57 per cent) said the process was either ‘very difficult’ or ‘could have been easier’.

These findings, compiled from a survey of patients and the public, also found more than a third of people (38 per cent) have had to take at least a day off from work to attend an appointment with their GP.
In the last year there has been a huge rise in the number of calls to The Patients Association Helpline about primary care, and in particular, GP services.

Patients are telling the charity’s Helpline that they face day to day challenges in accessing local community based healthcare, and a lack of confidence and understanding about when and where to seek help when their GP practice is closed.

The Patients Association ‘calls to action’ for primary care are:

- NHS Commissioning Board should review emergency care across sectors, not just at A&E departments but at primary care level, to reduce costly admissions and keep care local
- the Government, the NHS and GPs need to work together to expand choice and access to primary care services by addressing barriers to appointments both during and outside office hours. Individuals should have the right to choose any GP surgery based on their needs, not restrictive geographical boundaries
- CCG’s should lead in delivering better local awareness campaigns to help improve patients understanding of when to use the range of services available, such as: Urgent Care Clinics, walk-in centres, NHS 111 and NHS Direct.

Katherine Murphy, Chief Executive of The Patients Association, said

“As many as nine out of 10 public interactions with the health and social care system are through primary care, including GP services, so it is essential we make sure access is fair to all. What our survey shows is that public confidence in out-of-hours services is worryingly low and that is not always as easy as it should be to get an appointment with a GP. “

“The majority of people are forced to take time off work simply to have a check-up and almost two thirds have to wait longer than 48 hours for an appointment.

“We need an NHS in every community that operates effectively, safely and compassionately during and outside office hours. Keeping people out of hospital and living independent, healthier lifestyles means delivering more integrated and accessible community based care. “

“Our calls to action set out clear steps towards this vision.”

Source: www.patients-association.com 22 March 2013

Patients should not be left in the dark over care quality
A major independent Review into whether the Government should introduce ‘Ofsted-style’ performance ratings for hospitals, general practices, care homes and other social care providers has been published by the Nuffield Trust.

Commissioned by the Secretary of State for Health, the Rt. Hon Jeremy Hunt MP, the Nuffield Trust’s Review notes that there is no independent and comprehensive system attempting assessment of the quality of care across all hospitals, GP practices, care homes and other providers.

This has led, they conclude, to a clear gap in the provision of comprehensive and trusted information on the quality of care of providers which might inform the public, and which might be used to improve the accountability of care providers to the public.

Informed by a wide-ranging consultation exercise with the public, professionals, regulators and policy-makers, the Review suggests that, firstly, ratings for care homes and other providers of adult social care services, and potentially for GP practices could be useful for the public.
The benefits of rating hospital performance are less clear-cut. This is because hospitals are large, complex institutions delivering a large range of often high risk services.

A single summary score of a hospital’s performance risks masking examples of good and poor care across different departments and wards.

Therefore, the Review recommends that any attempts to rate quality in hospitals should focus most closely on individual departments and clinical services, such as oncology or orthopaedic departments, rather than indicators based on management performance, such as finances.

Where a rating system is unlikely to be useful on its own is in spotting lapses in the quality of care. This is particularly true for complex providers such as hospitals, which manage vastly larger risks than those handled in schools; the public sector analogy most frequently drawn.

Indeed, the report notes that the biggest risk to a rating system, however good, would be that it becomes discredited by a lapse in care in a provider rated as ‘good’ or ‘excellent’.

To fulfil such a function, ratings would have to be combined with other approaches, such as robust surveillance, inspection and special investigations.

Commenting on the publication of the report, Nuffield Trust Chief Executive Dr Jennifer Dixon, who led the review, said:

“There is a major gap in the information available to the public on the quality of care of their local hospitals, GP practices, care homes and other providers, people are left in the dark.

“The information that does exist is spread across a number of sources, which may reduce its impact and use by the public. One aggregate, comprehensive rating of providers may provide more clarity and simplicity for the public, especially if it came from one ‘official’ trusted source.

“However, this is not a simple task and it’s clear from the responses we received to our consultation that there is more appetite for introducing ratings in social care and possibly general practice, than in hospitals which tend to be more complex in the range of services they provide.

“It is important to be clear about the purpose of a ratings system. For example, a rating per se is unlikely on its own to be useful in spotting lapses in the quality of care, particularly for services within complex providers like hospitals.

“It is here where the analogy with Ofsted’s ratings of schools particularly breaks down: hospitals are large, with many departments and different activities, seeing large numbers of different people every day, carrying out complex activities many 24/7, and in which people are sick and can die.

“Put another way, the risks managed by hospitals vastly outweigh those managed in schools.

“Constructing a summary rating for hospitals is possible but would be a difficult and complex task. Ultimately, the goal should be to introduce ratings that drill down to the level of individual departments and clinical services so that patients can have a much truer understanding of the quality of care provided in those departments.

“There should not be undue reliance upon any one indicator – a rating should be made up of a range.

“A summary rating may be easier to construct for social care due to the range of possible assessments being more limited and the types of services having a tendency to resemble each other across the sector.
“Either way it will take time to develop information at this level – a stable roadmap is needed for the next five to ten years rather than the chop and change that has disrupted development in the past.”

The Review recommends a number of factors that should be considered by the Government if it decides to implement a new national ratings system:

- any extra burden that a rating might impose on providers (or commissioners of care) which might detract from patient care is assessed explicitly and minimised as a priority. To help, inspections by the rating organisation would need to be developed effectively to target providers by risk

- the organisation doing the rating (the Nuffield Trust recommends the Care Quality Commission) is given the resources and time to manage and develop a new strategic direction, political support and support from other stakeholders, as well as stability from disruption over a period of time

- the design and presentation of the rating is sector-led with groups representing the public and users of care meaningfully involved. This way the rating might reflect more what really matters to patients, and win the hearts and minds of staff attempting to improve care. There would need to be alignment with existing frameworks for assessing quality and a consensual process agreed to further development of the rating in future

- further market research is undertaken to better understand how to communicate ratings to the public, particularly those in areas with limited choice of provider

- there is clarity as to how the rating fits with wider activities to help support providers to improve, for example commissioning, and the work of other regulators

- the rating system links closely with systems designed to spot, investigate and manage lapses in quality and the rating signals appropriately and early where there are concerns being investigated

- an evaluation of the costs and benefits occurs from the very beginning

- there is support for the development of ratings over the medium term (subject to an evaluation of the results) by political and other key stakeholders and a roadmap for indicator development is established over the next five to ten years. The emphasis here should be to develop assessment of individual clinical services (particularly within hospitals) and for groups of patients most at risk.

On the question of which organisation should carry out the rating, the report singles out the Care Quality Commission which already carries out many tasks which would support a rating, for example, inspection and data analysis.

However, it admits that this would shift the organisation’s focus beyond its current role around compliance regulation, and would require additional resources, significant support over a period of time, and a forgiving timetable given the complexities and pitfalls inherent to the enterprise.

The review notes the instability in the organisations overseeing performance ratings in the NHS in the past. This should be avoided in future, the report warns, as such instability has in the past reduced the time for regulators to develop the system of ratings, and evaluate their impact.

Source: www.nuffieldtrust.org.uk 22 March 2013
Increase in alcohol-related cancers despite well-established link
A new report from the Alcohol Health Alliance UK (AHA) has found that hospital admissions for alcohol-related cancer in England have jumped 28 per cent in just eight years.

The report entitled, ‘Alcohol and cancer’ highlights figures showing that the number of admissions to hospital for alcohol-related cancer increased from 29,400 in 2002/03 to 37,600 in 2010/11.

The AHA, which represents more than thirty leading health organisations, says that, despite the link between alcohol and cancer having been well-established for many decades, four out of ten people are still not aware that alcohol is a risk factor in cancer.

Commenting on the report, Sir Ian Gilmore, Chair of the AHA, said:

“This report clearly demonstrates that alcohol is one of the most important preventable causes of cancer in the UK and provides yet more evidence of the need for strong Government action, including a minimum unit price for alcohol.

“The UK’s unhealthy relationship with alcohol is putting more and more strain on the NHS, police and families as the nation struggles to cope with the rising tide of harm caused by alcohol misuse.”

Each year 12,500 people are diagnosed with alcohol related cancers in the UK, and around 3,200 people die from these diseases. Alcohol can cause seven types of cancer; mouth, larynx, oesophagus, pharynx, bowel, breast and liver.

The report highlights that people in the UK are drinking much more than they were fifty years ago, with alcohol consumption per head in the UK increased by 91 per cent between 1960 and 2010. In 2010, 26 per cent of men and 17 per cent of women reported drinking above the amounts recommended in UK guidelines in an average week.

Commenting on the report, Sarah Woolnough, Cancer Research UK’s executive director of policy and information, said:

“There’s strong scientific evidence that alcohol increases the risk of a range of different cancers – but this still comes as a surprise to many drinkers. It’s not just heavier drinkers who are at risk - the more you can cut down on alcohol, the better. Cancer Research UK recommends that people try to stay within recommended Government guidelines to reduce their risk of alcohol-related cancer; this means no more three to four units a day for men or two to three units for women.

“Simple things like having more drink-free days, or swapping every other drink for something soft, could really help cut the risk of cancer. We are also calling on the Government to take steps to make alcohol less affordable and attractive which will help reduce the amount of alcohol people drink.”

The more alcohol a person drinks, the higher their risk of developing cancer, but there is no level of drinking that can be considered ‘safe’ from the risk of cancer. Research has found that people who consumed up to an average of about 1.5 units a day, equivalent to just over one bottle of wine a week, had increased risks of mouth and upper throat, food pipe and breast cancers.

Alcohol has a wide range of complex effects on the body, some of which are likely to explain how it can cause cancer. The following processes are supported by good-quality evidence:
• ethanol is converted into a chemical called acetaldehyde in the body, which causes cancer by damaging our cells’ DNA
• alcohol acts as a solvent that helps the body absorb other carcinogens, such as those found in tobacco
• alcohol increases oestrogen levels in women, which can in turn increase the risk of breast cancer.

The report authors call for both population-wide and individual level interventions to reduce the number of alcohol-related cancer cases and deaths in the UK.

At a population level, the report calls for the implementation of the three major policy recommendations from the National Institute for Health and Clinical Excellence (NICE):
• increase the real price of alcohol
• make alcohol less readily available for purchase
• restrict the marketing of alcohol products to children.

On an individual level, the report recommends that screening individuals to identify those who may require additional support, brief interventions, and referrals are fully implemented. Individuals who drink should be supported to:
• understand how their current level of drinking affects their risk of cancer
• drink within current weekly guidelines: this may include reducing both the amount they drink regularly and the number of days a week that they drink
• address other lifestyle factors that may be working with alcohol to increase their risk of cancer, such as smoking.

Source: www.rcplondon.ac.uk 22 March 2013

NHS 111 phone number sparks concern
Doctors are questioning the safety of a new non-emergency NHS telephone advice line launching in England.

The 111 service, replacing NHS Direct, is being piloted in some areas ahead of a nationwide launch in April but has proved problematic, with some callers left on hold for hours.

Dr Laurence Buckman, the British Medical Association's GP Committee Chair, says rollout should be stalled.

The Department of Health says it is giving some areas extra time.

It has already sanctioned an extension of up to six months of the original 1 April 2013 deadline for regions struggling to set up the new service.

The NHS Direct 0845 4647 service will continue to be available to callers in areas where the NHS 111 service is not yet available, Health Minister Lord Howe insists.

These include: North of Tyne and Tees, North Essex, Bedfordshire and Luton, Cambridgeshire and Peterborough, Leicestershire and Rutland, Berkshire, Cornwall and Devon.

But the British Medical Association (BMA) is concerned that many of the places that are already offering the new service or that are due to launch soon are ill-prepared, putting patients’ lives at risk.
The BMA says it has been receiving widespread reports of NHS 111 failures
Some of the pilot regions have been unable to cope with call volumes or have suffered catastrophic IT failures.
In Greater Manchester the entire system crashed, meaning calls went unanswered.
One elderly patient had to wait 90 minutes for a call back from NHS 111.
Problems led to a surge in ambulance callouts and casualty visits as callers have resorted to other measures to get seen by a healthcare professional.
Dr Buckman said:
"The BMA is seriously concerned that these failures are not only having impact on other, already overstretched NHS services, but potentially putting patient safety at risk. Patients need to have their calls answered immediately and correctly and not be faced with any form of delay."
"The Department of Health needs to reconsider immediately its launch of NHS 111 which clearly is not functioning properly. They must ensure that the system is safe for patients before it is rolled out any further."
Lord Howe said:
"NHS 111 will help patients access the whole of the NHS through just one simple number. "Over the coming months this new service will replace the existing NHS Direct telephone advice line. To ensure that patients get the best care and treatment, we are giving some areas more time to go live with NHS 111 while we carry out thorough testing to ensure that those services are reliable."
NHS 111:
- the free one-stop number is for patients with urgent, but not life-threatening symptoms
- this includes people needing fast medical help, but who are not a 999 emergency
- trained advisers who answer the phones offer basic health advice and direct the caller to the most appropriate service for their needs - A&E or GP out-of-hours services, for example.

Source: www.bbc.co.uk/news 25 March 2013

Monitor urges support for all NHS providers
The health regulator Monitor has set out a range of recommendations as part of its Fair Playing Field Review to ensure the best providers can offer their services to patients in the NHS.
The Review found that providers from all sectors face obstacles in offering NHS services and called for more support to be given to them and to commissioners to help improve patient care.
In the Health and Social Care Act 2012, Parliament required that the Government commission a review to examine how patient care could be improved by removing obstacles faced by NHS providers.
The Government asked Monitor to investigate and after a nine month independent inquiry the regulator is putting forward a set of proposals to create a fairer playing field for all types of providers.
Of the 30 recommendations to ministers in the final report, more than half will help the voluntary sector, while other recommendations are aimed at helping both the public and private sectors in equal measure.

Alongside a number of recommendations to help charitable and not-for-profit providers put in bids for NHS contracts, the review includes recommendations to help the public sector operate more flexibly and to help clinical commissioners make the most of their new powers so that local health services can meet changing needs in their area.

Monitor consulted over 200 providers NHS trusts, foundation trusts, charities, mutuals, social enterprises and private sector providers and weighed the evidence they submitted according to the impact on patient care. Overall, Monitor’s recommendations are intended to support all providers across the public, private and voluntary sectors in their work to help patients.

Dr David Bennett, Chief Executive of Monitor, said:

"As the health sector regulator, our fundamental duty is to protect and promote the interests of patients. Our concern in carrying out the Review has been simply to identify any barriers that might be preventing the best providers from meeting patients’ needs. Our recommendations have been made with the aim of helping all providers and commissioners work together to improve patient care.

"We found that providers in all sectors – public, private and charitable – experience a range of advantages and disadvantages from the NHS playing field. A key conclusion of our Review is that the extent to which patients get access to the best possible provider is often determined by how commissioners go about their job. As the role of commissioners changes, Monitor will support them to do the best job they can for the people who use the NHS."

The Review can be found at: www.monitor-nhsft.gov.uk

Source: www.monitor-nhsft.gov.uk 26 March 2013

**Government publishes initial response to the Mid Staffordshire NHS Public Inquiry Report**

In response to the Francis Report on the Mid Staffordshire NHS Public Inquiry, the Government has launched plans to ensure that patients are always put first and people are treated with respect.

The Government’s initial response entitled, ‘Patients first and foremost’, sets out a collective commitment and plan of action for the whole health and care system and everyone who works in it.

Actions 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
• 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.

The response is accompanied by a statement of common purpose signed by the chairs of key organisations across the health and care system. It renews and reaffirms the commitment to the values of the NHS, as set out in the NHS Constitution, and includes pledges to work together for patients, always treat patients and their families with compassion, dignity and respect, to listen to patients and to act on feedback.

Health Secretary, Jeremy Hunt said:

“The events at Stafford Hospital were a betrayal of the worst kind. A betrayal of the patients, of the families, and of the vast majority of NHS staff who do everything in their power to give their patients the high quality, compassionate care they deserve.

“The health and care system must change. We cannot merely tinker around the edges – we need a radical overhaul with high quality care and compassion at its heart. Today I am setting out an initial response to Robert Francis’ recommendations. But this is just the start of a fundamental change to the system.

“I can pledge that every patient will be treated in a hospital judged on the quality of its care and the experience of its patients. They will be cared for in a place with a culture of zero harm, by highly trained staff with the right values and skills. And if something should go wrong, then those mistakes will be admitted, the patient told about them and steps taken to rectify them with proper accountability.

“I and the chairs of key organisations involved in care have pledged to do this and make our health and care system the best and safest in the world.”

The Government has also published a revised NHS Constitution following a recent public consultation. It is likely there will be a further consultation later in the year on further changes to the constitution, with the aim of incorporating further recommendations made by Robert Francis QC in his report of the Mid Staffordshire NHS Foundation Trust Public Inquiry.

‘Patients first and foremost’ can be found at: https://www.gov.uk/government/publications/government-initial-response-to-the-mid-staffs-report

Source: www.gov.uk/dh

Role of local authorities in health issues

The Communities and Local Government Committee has welcomed the return to local government of the responsibility to improve the health and wellbeing of local people according to a new report.

The Committee urges councils to fully grasp this opportunity by using every lever at their disposal to adopt a holistic approach to public health.

The report also, however, raises concerns over the complex accountability mechanisms of the reformed system. In particular, it argues it is not clear who will be in charge in the event of a health emergency and urges the Government to set out clearly and unambiguously the lines of responsibility. Finally, the report notes a perverse incentive in the funding formula and calls for it to be reviewed.

Conclusions & recommendations
On concerns about health emergencies:

- it is still not clear who would be in charge in the event of a regional or national outbreak. The Government should set out clearly and unambiguously the lines of responsibility.
- the Committee heard serious concerns about the arrangements for screening and immunisation. The Committee urges the Government and the NHS Commissioning Board to review the arrangements with a view to devolving these services to public health staff within local government, who have the local knowledge to make the system work.

Commenting on the issue, Committee Chair Clive Betts MP said:

“Without clarity there is only confusion, and a health emergency is no time for muddle. The Government must set out unambiguously the lines of responsibility, and it must do so now as a matter of urgency. These arrangements need to be clear and in place on day one, 1 April. Anything else is unacceptable.”

On accountability mechanisms of the reformed system:

- how, and for what, Health and Wellbeing Boards are to be held accountable appears to be an area of real confusion. They draw up a strategy which local Clinical Commissioning Groups and others should take account of and implement. The Government has to clarify lines of responsibility.
- at the top of the pyramid is the NHS Commissioning Board but it lacks local accountability and its status in relation to Health and Wellbeing Boards is unclear.
- nor is it clear to whom Clinical Commissioning Groups, the bodies that commission local services, are to be held accountable and the Committee is not persuaded by the Ministers’ arguments for not allowing councillors to sit on them. Who should sit on a local Clinical Commissioning Group is a local matter that should be left to local resolution.
- the Government should set out in detail what a Health and Wellbeing Board can do if the NHS Commissioning Board or Clinical Commissioning Groups fails to commission services consistent with its strategies.

Clive Betts MP said:

“Under the reformed system, considerable power is to be invested in a range of new bodies. With such power must come accountability.

“The purpose of localism is not only to devolve decision making to a local level, but to make it accountable to local people. With these changes it is clear that there is a shift of power and money from the Whitehall to local government and I welcome that. But the new arrangements are complex and responsibilities are shared across several bodies. The result is that lines of local accountability are fragmented and blurred.”

On adopting a more holistic approach to public health:

- local authorities must look beyond services traditionally considered as public health and adopt a holistic approach to tackling the factors affecting complex health problems.
- to succeed, Health and Wellbeing Boards won’t have budgets or powers to direct and so will need to become proficient at building relationships and influence. They should not focus exclusively on the detail of health and social care commissioning, but should
look to be creative by including individuals with responsibility for the social determinants of health, including those working in education, planning and economic development

- strategies will only be as good as the information on which they are based, but the current information-sharing arrangements are inadequate and need to be improved. The Government must involve the Information Commissioner in clarifying what data local authorities and the NHS can share. This should be done by the end of the year

- the Government should consider devolving further responsibilities to local government, including elements of the Work Programme and the Healthy Child programme, to address at a more local level the determinants of poor health

- if public health is to become an overarching priority for local authorities, it requires an overarching budget. The Government should work to clarify the funding formula for 2015/16 with a view to removing ring-fencing and moving to community budgets.

Clive Betts MP said:

“The return of a responsibility to improve the health and wellbeing of local people represents an exciting opportunity for local authorities. They must grasp this with both hands, using all resources at their disposal to tackle not just the causes of poor health, but the causes of the causes.

“Initiatives targeting individual behaviours in isolation have been shown not to work. Councils must take a more holistic approach that addresses the multiple causes of complex health problems.

“Housing, employment, and early years education are all vital determinants of people’s later health and wellbeing. Policy in these areas should not be considered in isolation, but must underpin local authorities’ public health strategies. To aid this, the Government should consider devolving more responsibilities to local government, and must be prepared to use national levers to support local level initiatives.”

“An overarching strategy needs an overarching budget. Community budgets, which allow all providers of public services to share budgets, are being piloted and in the medium term they may provide this, ensuring that money is directed at people and places, rather than organisations.”

On the funding formula:

- it took 11 months to finalise the allocations for 2013/14 with the final allocation only announced on 10 January 2013. The process left local authorities with a great deal of work to do in a very short period

- the Government should put in place a timetable for publishing and consulting on the 2015/16 allocations and finalise them by October 2014. This will provide those commissioning services and providers with at least six months in which to plan

- the Committee notes the perverse incentive of basing funding on health outcomes, as councils that improve the health of local people will have their funding cut. The Government should ensure the Advisory Committee on Resource Allocation reviews the allocation formula.

Clive Betts MP said:

“Under the current funding formula, areas that perform well and improve the health of their residents will have their funding cut. This perverse incentive will become even more marked if
still in place when the Health Premium is introduced and areas are simultaneously financially rewarded and punished for good performance.

“The funding formula must be reviewed and the timetable for doing so should be set out now. Furthermore, a parallel system of reward should be delayed until this review has taken place. We have to get the new arrangements right.”

Source: www.parliament.uk 27 March 2013

Regional variation in hospital admission rates for long term conditions

Hospital admission rates for patients with long term conditions differ markedly across the country, new analysis from the Health and Social Care Information Centre (HSCIC) has shown.

Emergency admissions for chronic ambulatory care sensitive conditions (ACSCs) - which include conditions like asthma, diabetes and epilepsy - ranged from 215 per 100,000 patients in one area of England to 1,742 per 100,000 in another in 2011/12.

Some hospital admissions for these conditions are considered preventable if the patient receives effective care in the community.

The report entitled, ‘Clinical Commissioning Group Outcomes Indicator Set: Emergency admissions’ presents data for the first time by the 211 proposed clinical commissioning group (CCG) areas - and provides more information about indicators within the CCG Outcomes Indicator Set.

The report and data aims to provide comparative information for CCGs and Health and Wellbeing Boards on the quality of commissioned health services in primary and secondary care and, as far as possible, the associated health outcomes.

The ACSC indicator has been published using revised methodology, along with another indicator that provides data on emergency admissions for acute conditions not usually requiring hospital admission. They are two of 16 indicators from a range of information sources that cover data on:

- GP patient surveys
- GP registered populations
- hospital admissions (Hospital Episode Statistics)
- mortality.

One indicator - about liver disease mortality among people aged under 75 - has been published as part of the Indicator Set for the first time.

The report is available at: www.ic.nhs.uk/catalogue/PUB10584

Source: www.hscic.gov.uk 27 March 2013

More GP-led groups will begin healthcare commissioning with a clean bill of health
Half of all the new GP-led groups will begin commissioning healthcare on behalf of their local communities on 1 April with a clean bill of health and no requirement of on-going national support, according to NHS England.

Every community in England is now covered by one of 211 Clinical Commissioning Groups (CCGs), which will be led by GPs and will plan and commission hospital, community health and mental health services on behalf of their local areas. Together, CCGs will be responsible for £65 billion of the £95 billion NHS commissioning budget.

They were authorised by NHS England (formerly the NHS Commissioning Board) to take on their functions, following an assessment process, in four “waves”. Groups of CCGs were authorised in December 2012, January, February and March 2013.

NHS England’s Authorisation Sub-Committee has now reviewed the progress made by CCGs in the first three waves of authorisation. This has resulted in 63 CCGs formally discharging all conditions on their authorisation, bringing the total of fully authorised CCGs to 106

A further 47 CCGs have formally discharged some of their conditions, while two have had legal directions lifted from their authorisation. Of those CCGs with remaining conditions, the majority (55 out of 105) have fewer than five conditions.

Fourteen CCGs are authorised with legal directions, meaning their conditions are underpinned by legally-mandated support from NHS England or another CCG.

Dame Barbara Hakin, National Director for Commissioning Development at NHS England, said:

“I am delighted that more than three quarters of CCGs will begin work with either full authorisation, or with only a small number of conditions. Local clinicians are enthusiastic about the opportunity to shape healthcare on behalf of their local communities, and that enthusiasm has shone through during the authorisation process.

“As we have always anticipated, CCGs are at differing levels of maturity, so some do need intensive support, while others are already well advanced. NHS England is fully committed to providing collaborative help and support for all CCGs.”

CCG leaders have worked hard over the past year to establish their organisations and set out robust plans and strategies for healthcare in their areas. NHS England has an on-going responsibility to support CCGs, and will continue to review conditions regularly, ensuring robust support and oversight is provided to those CCGs that still have work to do but removing conditions once CCGs have demonstrated progress.

This oversight extends to provision of new and additional support: the conditions review process has also resulted in a legal direction being added to one CCG’s authorisation, and to some conditions being upgraded from level II to level III, meaning the CCG must receive additional sign-off from NHS England for some areas of its work.

Dame Barbara said:

“NHS England will work with CCGs to help them identify areas where improvement is needed, and to help them make those improvements. We will publish the CCG assurance framework shortly, and we are working with CCGs to finalise procedures to be followed if there are concerns about any CCG’s ability to ensure quality and delivery today or transform services for the future.

“Thanks to the dedication shown by the leaders of CCGs all over England, most have established themselves extremely well, and all will continue to develop and mature over the
coming months and years. It is vital that they are as robust and capable as possible, with appropriate support where improvement is needed, as they are set to take on great responsibilities, controlling the lion’s share of the NHS commissioning budget.

“These organisations are pioneers, and we have all learned much from their establishment. Though many CCGs have developed excellent commissioning plans and governance arrangements, and recruited highly-experienced governing body members, some continue to need support in these areas. The NHS CB is working closely with these CCGs, and further insight from the authorisation process will be used to inform local and national planning for future years.”

Source: www.commissioningboard.nhs.uk 27 March 2013

CQC finds Mental Capacity Act not well understood across all sectors and calls for more work by providers and commissioners to improve

The Care Quality Commission’s (CQC) report on its monitoring of the Deprivation of Liberty Safeguards reveals that there is still a widespread lack of understanding of the wider Mental Capacity Act. The Mental Capacity Act (MCA) is a very important mechanism for protecting the rights of people who do not have the ability (mental capacity) to make certain decisions for themselves.

CQC’s evidence shows that in some care homes and hospitals, people’s freedom to make decisions for themselves is restricted without proper consideration of their ability to consent or refuse.

Some examples showed little or no evidence of any attempt to maximise a person’s decision-making capacity before resorting to restriction or restraint. The use of the phrase ‘best interests’ does not always appear to signal that there has been a process of best interests decision-making in accordance with the MCA.

David Behan, Chief Executive of the Care Quality Commission said:

“If someone has dementia or has a severe learning disability they can still contribute to decisions about their care. If this is done properly then people will receive appropriate care; if it is not done then people can be deprived of their liberty. Understanding the Mental Capacity Act and the way it is applied is critical to good quality, safe care. Those providing services must ensure that their staff understand the Act and what it means for the care and treatment of people.”

The report found

There is confusion among care staff about the basic MCA requirements especially relating to the use of restraint. The use of restraint is not always recognised or recorded properly. Because of this it is not easy to monitor.

The report identified a lack of training. In some cases it was reported that managers and senior staff had received training, but other types of care staff had not. This variation suggests that while some form of training is being provided it is not consistent.

The use of restraint can become routine when there is a lack of understanding and proper governance. It can also be hard for staff to gauge whether restraint is proportionate and in someone’s best interests.

Another theme identified was poor practice in services where non-detained patients were on wards alongside patients detained under the MHA and their rights were being restricted alongside those of the detained patients. This seemed to be due to a lack of staff knowledge and awareness concerning the differences between the MCA and Mental Health Act.
There is very little evidence of the involvement of people who use services and their relatives/friends in the processes of the Safeguards themselves. This is a significant omission: such consultation with the ‘relevant person’ and with their relatives and/or close friends interested in their welfare is a mandatory part of the assessment process.

**Improvement**

During 2011/12 CQC took a number of steps to strengthen the relevant skills and knowledge of compliance inspectors in order to promote a wider and more consistent understanding of the MCA in general and the Safeguards in particular. CQC devised an e-learning package for inspectors, and related learning has been included as an important and integral part of both permanent and bank inspector induction courses. CQC has also taken steps to improve the awareness of the staff who assess applications for registration. CQC acknowledges that it still has work to do to ensure that all relevant inspectors have a sufficient level of understanding of the MCA to support a consistent and effective approach to monitoring the use of the Safeguards.

**Conclusions:**

- providers and commissioners of services for vulnerable adults must improve their understanding of the Mental Capacity Act and the Safeguards
- care providers must implement policies that minimise the use of restraint
- providers and commissioners of services must establish robust review processes and other mechanisms for understanding the experience of people subject to the Safeguards.

*Source:* [www.cqc.org.uk](http://www.cqc.org.uk) 28 March 2013

**Smoking neglected in people with mental health conditions, leading to premature death**

A major new report from the Royal College of Physicians (RCP) and Royal College of Psychiatrists (RCPsych) says that smoking in people with mental health conditions is neglected by the NHS. The report entitled, ‘Smoking and mental health’ says that much of the substantially lower life expectancy of people with mental disorders relates to smoking, which is often overlooked during the management and treatment of their mental health condition.

One in three of the UK’s 10 million current smokers has a mental disorder. Although 20 per cent of the general population smokes, the figure among people with mental health disorders is 40 per cent, and is even higher in those with more severe mental health problems. Those with mental disorders also smoke more cigarettes, are more addicted to nicotine, and find it harder to quit, than those without.

Although the prevalence of smoking in the UK has fallen substantially over the past two decades, among people with mental disorders it has barely changed. Three Royal College Presidents – Sir Richard Thompson (RCP), Sue Bailey (RCPsych) and Lindsey Davies (Faculty of Public Health) say in their Foreword to the report that this is an indictment of UK public health policy and clinical service provision, and an area where change is long overdue:

“As smoking becomes less prevalent in our society, so the need to identify and reverse failures of health policy and service provision for those who remain dependent on tobacco smoking.
becomes more urgent. This report calls for radical changes in the prioritisation, service provision and prevention of this major cause of premature death and disability in people with mental disorders.”

The report says it is likely that the high prevalence of smoking accounts for much of the substantially lower life expectancy, some 10 years or more, of people with mental disorders. Smoking also reduces quality of life, exacerbates poverty, increases drug requirements to control symptoms, and adds to social stigma in this group.

Smokers with mental disorders are just as likely to want to quit as those without, but they are more likely to be heavily addicted, to believe it will be difficult to quit, and much less likely to succeed in any quit attempt. Many are discouraged by mistaking the symptoms of nicotine withdrawal for those of underlying mental disorder. However, stopping smoking improves mental health in the longer term.

Doctors, nurses and other health professionals are missing opportunities to help smokers with mental health problems to quit. Smokers with mental health problems are now more likely than other smokers to receive support to quit from their GP, but this reflects the increased frequency of their consultations. Over the course of a year, only half of smokers with mental disorders are advised to quit and only one in ten receive prescriptions of medicines such as Nicotine Replacement Therapy (NRT), bupropion or varenicline that can help them to quit. This suggests that much more could be done to encourage uptake of cessation support, or the use of medicinal nicotine to reduce harm from smoking.

People treated in specialist mental health settings are the most disadvantaged when it comes to the provision of cessation services. While heavy smokers often reduce consumption due to the smoke-free setting, studies have shown that there is a ‘culture’ of smoking in many service settings, and some light or moderate smokers will actually smoke more due to boredom, stress or as a means of socialising in service settings. Healthcare staff are often complicit in maintaining this culture, for example by prioritising supervision of smoking breaks rather than promoting a smoke-free policy.

Although all NHS mental health trusts in England have now implemented smoke-free policies, lack of monitoring makes it difficult to evaluate their effectiveness. Resources allocated to enforcing smoke-free policies, including those that would ensure the provision of adequate behavioural and pharmacological support (such as staff training and provision of NRT), are often lacking, and there are complex barriers to the implementation of effective tobacco dependence treatment in mental healthcare settings. Resources that could be used to help smokers to quit are often channelled primarily into enabling smoking, through the provision of smoking shelters, and staff-supervised smoking breaks.

In addition to the human cost of premature death and disease, the total overall estimated cost to the NHS of diseases caused by smoking in people with mental disorders based on financial year 2009/10 was £719 million, from an annual estimated 2.6 million avoidable hospital admissions, 3.1 million GP consultations and 18.8 million prescriptions. Reductions in smoking prevalence could also save up to £40 million on psychotropic drugs, many of which are required in lower doses among non-smokers.

Key recommendations of the report:

- smoke-free policy is crucial to promoting smoking cessation in mental health settings
- all healthcare settings used by people with mental disorders should therefore be completely smoke free
smokers with mental disorders using primary and secondary care services, at all levels, should be identified and provided routinely and immediately with specialist smoking cessation behavioural support, and pharmacotherapy to relieve nicotine withdrawal, promote cessation and reduce harm

commissioners should require mental health service settings to be smoke free, and to provide support for cessation, temporary abstinence and harm reduction

service indicators, such as the primary care Quality Outcome Framework (QOF) and Commissioning for Quality and Innovation (CQUIN), should measure and incentivise cessation, not just delivery of advice to quit

all professionals working with or caring for people with mental disorders should be trained in awareness of smoking as an issue, to deliver brief cessation advice, to provide or arrange further support for those who want help to quit and to provide positive (i.e. non-smoking) role models. Such training should be mandatory

research funding agencies should consider encouraging and investing in research to address this major cause of ill-health, and health inequalities, in British society.

Source: www.rcplondon.ac.uk 28 March 2013

BMA writes to NHS boss over 111 'concerns'
The organisation representing British doctors has written to NHS bosses to call for a delay in the launch of a new non-emergency telephone advice line.
The 111 service, replacing NHS Direct, launched on 1 April.
The British Medical Association's (BMA) letter to Sir David Nicholson follows reported problems in trial areas.

Health Minister Lord Howe has said some areas will have more time to go live with 111 while "thorough testing" to ensure reliability is carried out.

Lord Howe has already admitted the new 111 telephone advice service - which the Government has said will ease pressure on emergency 999 phone lines - had run into "teething problems".

But the BMA said that in several areas it seemed to have been completely unable to cope with call volumes or suffered severe IT failures.

It said patient safety was being put at risk.

Dr Laurence Buckman, Chairman of the BMA's GP committee, said:

"There have been widespread reports of patients being unable to get through to an operator or waiting hours before getting a call back with the health information they have requested."

"In some areas, such as Greater Manchester, NHS 111 effectively crashed because it was unable to cope with the number of calls it was receiving. The quality of advice being given out has also been questionable in some instances."

He said the "chaotic mess" of 111 was "placing strain" on overstretched parts of the NHS, such as the ambulance service, and potentially placing patients at risk.

NHS 111:

the free one-stop number is for patients with urgent, but not life-threatening symptoms
• this includes people needing fast medical help, but who are not a 999 emergency
• trained advisers who answer the phones offer basic health advice and direct the caller to the most appropriate service for their needs - A&E or GP out-of-hours services, for example.

"The BMA has been warning the Government about the problems with NHS 111 for almost two years. They must finally act to ensure that patient safety is guaranteed," he added.

The BMA said it had written to NHS Chief Executive Sir David Nicholson to call for a delay to the launch of 111 until it was "fully safe for the public".

Dr Buckman said:
"We cannot sacrifice patient safety in order to meet a political deadline for the launch of a service that doesn't work properly."

The Department of Health has already sanctioned an extension of up to six months of the original 1 April 2013 deadline for regions struggling to set up the new service.

The NHS Direct 0845 4647 service will continue to be available to callers in areas where the NHS 111 service is not yet available, Lord Howe has said.

These include: North of Tyne and Tees, North Essex, Bedfordshire and Luton, Cambridgeshire and Peterborough, Leicestershire and Rutland, Berkshire, Cornwall and Devon.

Source: www.bbc.co.uk/news 28 March 2013

'Recovery package' plan for cancer survivors
All cancer patients should receive a ‘recovery package’ at the end of their treatment offering ongoing support, the Government has announced.

Currently as many as three in four patients do not receive any information on coping with the long term effects of their illness, figures suggest.

The care plans will identify patients’ financial, mental and physical needs.

Ministers called on the NHS to take "urgent action" to help cancer survivors in England.

Macmillan Cancer Support, who helped develop the proposals with the Department of Health, said at the moment many patients felt isolated once treatment had ended.

Very few cancer patients are given any written information on recurrence or side-effects of treatment, the charity said.

Nor are they told how to contact someone outside of routine follow-up if they have any problems.

The recovery package is essentially a checklist for doctors and nurses to assess what emotional, physical and practical needs a patient might have after their treatment has ended.

This may include referrals to mental health or social services as well as advice on financial support.

Care plans will also forward patients to physical activity services to help them regain their strength and fitness.

A national survey of cancer survivors has shown that around a quarter feel isolated after treatment and 30 per cent say they have numerous issues that are not being addressed, which include fears about their cancer spreading.
Macmillan estimate that currently around 200,000 people do not get a package of support after their treatment ends.

Public Health Minister Anna Soubry said there are currently around 1.8 million people who have or have been treated for cancer, a figure set to rise to 3.4 million by 2030.

"This joint document calls on NHS England and local NHS teams to take urgent action and consider our recommendations when they provide cancer services based on their local community's needs.

"Whether it's specialist help to get back to work or being recommended to do a physical activity group, local NHS teams need to consider providing a new range of care services for cancer survivors to tackle their needs and improve their quality of life."

Ciarán Devane, Chief Executive of Macmillan Cancer Support added that many cancer patients are crying out for this type of personalised support.

"If the NHS does one thing for cancer survivors it should be to commission this recovery package for its local population.

"We also need to keep on top of how cancer patients' quality of life is affected long term."

Source: www.bbc.co.uk/news 29 March 2013

Social Care
Department of Health seeks views on NICE standards to improve quality of social care

Care and Support Minister Norman Lamb has launched a 12 week consultation to establish a full set of National Institute for Health and Clinical Excellence (NICE) quality standards and guidance for social care.

The Department of Health is seeking ideas from care users, their families and carers, service commissioners, care providers and front line staff to help decide on future topics for NICE guidance and standards.

The aim is to establish a full set of NICE quality standards and guidance in order to improve the quality of social care.

Some of the potential NICE standards for discussion in the consultation include:

- falls
- deprivation of liberty safeguards
- medicines management in home-based settings.

Care and Support Minister, Norman Lamb said:

"Improving the standard and quality of care and support services is one of our top priorities. From April of next year, NICE will join us in this challenge and take on an important role in driving up the quality of care.

“That is why we have started a consultation in which everyone can have their say on which topics NICE should focus on for future work. So please do get involved.”

NICE provides evidence-based guidance to support healthcare professionals and others to make sure that the care they provide is of the best possible quality and offers the best value for
money. Care providers will be able to use these standards and guidance as tools to help improve their services.

The 12 week consultation ends on 26 April 2013.

Source: www.gov.uk/dh 1 February 2013

New funding reforms announced for care and support

The Government has announced new measures for funding care to ensure that older people and those with disabilities get the care they need without facing unlimited costs.

The new measures are based on the recommendations made in 2011 by the Dilnot Commission, an independent panel set up to look at the fairest and most sustainable way to fund care and support in England.

The new measures include, from April 2017:

A cap on care costs, which gives everyone the reassurance that they will have a level of protection, if they have the most serious needs and incur very high care costs.

- if someone is assessed by their local authority as having eligible care needs, they will be told how much it will cost the local authority to meet those needs with local services. These costs count towards their cap. So, however great a person’s costs become, once they have reached the cap the state will step in and provide financial support

- due to the economic circumstances, the Government is introducing a cap that is equivalent to around £61,000 in 2010/11 prices – slightly above the £25,000-£50,000 range originally recommended by Andrew Dilnot. This is equivalent to £75,000 in 2017/18 prices. The Government expects up to 16 per cent of older people to face costs of £75,000 or more

- people of working age who develop care needs before retirement age will benefit from a cap that’s lower than £75,000. People who have care needs before they turn 18 will effectively have their cap set at zero.

New financial protection for those with modest wealth. People with the least will get the most support.

- currently only those with assets of less than £23,250 get help with paying for their care costs. The changes will mean that those with property value and savings of £100,000 (in 2010/11 prices) or less will start to receive financial support, with the Government paying a proportion of their residential care costs on a sliding scale. £100,000 was the amount recommended by Andrew Dilnot, and is equivalent to around £123,000 in 2017/18 prices. The most financial support will go to those with the greatest care needs and the least in savings or home value, and the poorest people will continue to have the majority of their care costs paid.

And from April 2015:

- no-one will have to sell their home in their lifetime to pay for residential care. If people cannot afford their fees without selling their home, they will have the right to defer paying during their lifetime
people will have clearer entitlements. A national minimum eligibility will make access to care more consistent around the country, and carers will have a legal right to an assessment for care for the first time.

The Government will legislate for these proposals. Subject to the passage of legislation, the changes above will take effect from April 2017 and will provide people with a new legal right to financial protection from very high care costs, from the state, which has not existed previously. The 2017 timing will ensure that these changes are affordable and sustainable for the long term.

Health Secretary Jeremy Hunt said:

“This is a watershed moment for our country. For too long, the issue of social care has been ducked by successive Governments, leading to an unfair system that has seen people selling their homes and losing nearly everything they’ve worked for to pay for their care. With us, that unfairness is ending.

“These historic reforms will give everyone the protection they want in their old age and save the family home. And they prove once again that despite these tough economic times, this Government is determined to get behind everyone who has worked hard and done the right thing and aspires to a better life for themselves and their children."

[Please see the article below entitled ‘Budget 2103 - Social care funding reform’ (20 March 2013) for further reforms and revised date of implementation.]

Source: www.gov.uk/dh 11 February 2013

Alzheimer’s Society launches Dementia Friends information sessions

From 12 February 2013, people across England will be able to sign up for sessions to become a Dementia Friend. Just over 12,000 people have already registered their interest in becoming Dementia Friends. Now those people and many more will be able to attend information sessions to find out more about what it’s like to live with dementia and then turn that understanding into action in their local community.

Dementia Friends is an Alzheimer’s Society initiative that aims to give a million people a better understanding of dementia by 2015. People becoming Dementia Friends will attend free sessions, which are being rolled out across England.

As well as encouraging people to sign up as Dementia Friends, Alzheimer’s Society is also calling on people to volunteer to be a Dementia Friends Champion. These are volunteers who talk to people about being a Dementia Friend in their communities. They will attend a training course, receive ongoing support and be part of a growing network of people creating dementia friendly communities together.

There are already 60 Dementia Friends sessions and 30 Dementia Friends Champion sessions lined up across England over the next three months, with more due to be announced soon.

Dementia Friends is jointly funded by the Department of Health and the Office of Civil Society, and Alzheimer’s Society will be working with a number of partners to deliver the programme across England.

Source: www.gov.uk/dh 12 February 2013
CQC finds common issues undermining majority of good home care

The findings of a report into home care launched by the Care Quality Commission (CQC) show that people want to be listened to, respected and able to exercise choice. The report entitled, ‘Not just a number’ was launched at a Parliamentary breakfast hosted by Rosie Cooper MP, member of the House of Commons Health Select Committee.

Overall CQC found most providers were delivering a good service, but a minority of people are affected by late or missed calls, lack of continuity of care workers, unsupported staff; poor care planning, and failures of providers to listen to people using services and their families and carers.

The report captures the findings from a programme of themed inspections covering 250 domiciliary care (home care) agencies providing at-home support and care to around 26,500 people. The inspections checked the quality of home care provision for people aged 65 and over across England.

David Behan, Chief Executive of the CQC said:

“People have a right to expect to be treated as an individual, to be able to exercise choice, and to make sure their carers are aware of their specific care needs. We found plenty of evidence of this, however, we also found elements of poor care which happen too often.”

The report identifies levels of compliance against five of CQC’s national standards:

Respecting and involving people who use services.

The overwhelming majority of providers were respecting and involving people (97 per cent or 241 providers). Where providers were failing to meet an element of the standard, CQC found people did not feel valued because their visits were often delayed or sometimes cancelled. This was made worse if people were not kept informed if their care worker was going to be late. It sometimes appeared that people were resigned to accepting a level of unreliability within the service.

The care and welfare of people who use services.

The majority of providers were promoting the care and welfare of people using this service (85 per cent or 212 providers). Thirty-eight providers were not meeting this standard, with just under a third of these located in London. CQC found a number of occasions when risks associated with a person’s care or medical conditions, such as diabetes or catheter care, had not been assessed, and care plans had not been updated for several years.

Safeguarding people who use services from abuse.

The overwhelming majority of providers were safeguarding people from abuse (96 per cent or 240 providers). Many providers had processes that detailed the action that staff and managers had to take if they suspected any abuse and all agencies had a whistleblowing procedure. Of the ten who failed to meet this standard five were found to have a moderate impact and CQC took enforcement action against one provider.

How providers support their staff.

The majority of providers were supporting their staff (88 per cent or 221 providers). People who receive care in their own home, and their relatives, value care workers who are knowledgeable and understand their or their relative’s condition. Twenty-nine providers were failing to meet this CQC national standard, of these, three were judged to be of moderate impact on patients and one service was judged to be major.

How providers assess and monitor the quality of the services they deliver.
The majority of providers demonstrated an ability to monitor and assess their services (85 per cent or 212 providers). CQC inspectors saw a range of effective methods of monitoring quality including: agencies that made weekly phone calls to people using services to check that the care was meeting their needs; and annual quality audits. Of the 38 agencies who failed to meet this standard 15 agencies were judged to have a moderate impact and two had a major impact on people.

Overall, the inspections have revealed that many agencies are providing a service to people in their own homes which they value and are content with. But CQC has also seen that some areas need improvement and action from those who commission and provide home care.

Overall the report makes 15 recommendations aimed at driving improvement across the sector. Providers need to work more closely with local authority commissioners to improve care and find solutions to these common problems, and put systems in place to monitor the impact of missed or late visits on people receiving care. Where providers are failing to meet CQC national standards they must learn from the good practice that exists across the sector.

The report has identified a reluctance to complain, some people are worried about getting their regular care workers into trouble and others may be worried about reprisals if they complain. The CQC wants to use this report to inform people of what good home care and poor home care look like.

What does good care look like?

CQC inspectors found a lot of good practice that could be reflected in all home care. The following were many of the characteristics of good care people and carers should look out for:

- continuity of care workers was one of the most important aspects of personalised care – the best agencies maintained a familiar roster of care workers for each person, with any changes notified in advance where possible
- care workers showing kindness, friendliness and gentleness with respect for a person’s property and belongings
- detailed care plans at home are kept up to date, with care workers accurately completing the daily logs. Regular reviews and risk assessments to adjust care plans responding to changing needs and preferences
- care workers introduced to the person before they started regularly attending
- care workers routinely knocking and announcing their arrival before coming in. The best care workers wear staff ID badges to confirm their identity and are aware of any security requirements
- encouragement and support for people to express their views and detailed records noting people’s preferences and choice
- people’s views are gathered in a variety of ways and fed back to improve the services provided. Personal contact from the management team shows good practice
- face-to-face explanation of the choices available to the patient from their domiciliary care service as well as clearly written information the patient can refer to
- high levels of involvement of relatives and carers in decisions about a person’s care
- staff understand the illnesses that people have, so are better able to provide the right amount of support when needed. A good understanding of dementia is important where a patient is suffering from dementia
people using services are aware of who to contact at the agency if they have concerns. People are given information about the types and signs of abuse

all staff undergo a Criminal Records Bureau (CRB) check before the provider offers a position and asks for references. Care workers introduced to the person before they started regularly attending.

What does poor care look like?

Where poor care exists, CQC’s concerns relating to home care services included the lack of continuity of care workers, missed or late visits, failures to keep people informed about changes to their visits and other areas.

- lack of consistency of care workers. Many comments were received about the number of unfamiliar care workers. In one instance a person had received 13 different care workers over 35 visits
- missed or late visits. Some staff told us it wasn’t unusual for them to be asked to cover an additional visit in their schedule for the day, which could mean they had to cut short other visits. There were numerous examples of rotas that did not allow time for staff to travel between visits. Weekends are a particular cause for concern
- lack of co-ordination of visits requiring two care workers. The report found a negative impact on care when a person required two care workers but one was either late or did not turn up. This means the time allocated to specific two-person tasks can be significantly reduced, resulting in people not getting the care they should
- failures to keep people informed about changes to their visits. Being dependent and having to wait for a visit from their care workers leaves people feeling vulnerable and undervalued
- inadequate systems to report abuse. In one isolated instance staff had raised concerns about missed visits where people were left without meals, medicines, or assistance, but did not feel management had listened and taken action. As a result, CQC issued the provider with a warning notice, which included a timescale for improvement
- lack of detailed care plans, staff knowledge and skill, particularly with regard to dementia. There were isolated instances where the care recorded in a person’s daily log did not reflect the care they actually received. The report notes inspectors saw many staff files that were incomplete and did not include records of supervision or performance appraisal meetings. 79 per cent of the services questioned, where the information was available, care for people with dementia.

The number of home care services registered with the Care Quality Commission (CQC) increased by 16 per cent in 2011/12, and a further six per cent in the first six months of 2012/13. CQC inspects at location level rather than at provider level - there were 7,227 locations registered in 2013.

Although home care is not just for older people, older people over 65 form the majority of those who use home care, accounting for 77 per cent of all state-funded home care services.

The domiciliary care inspections took place between April and November 2012 measuring against five of CQC’s national standards of quality and safety. These were:

- respecting and involving people who use services (Regulation 17 - Respecting and Involving service users)
• the care and welfare of people who use services (Regulation 9 - Care and welfare of service users)
• safeguarding people who use services from abuse (Regulation 11 - Safeguarding service users from abuse)
• how providers support their staff (Regulation 23 - Supporting workers)
• how providers assess and monitor the quality of the services they deliver (Regulation 10 - Assessing and monitoring the quality of service provision).

Source: www.cqc.org.uk 13 February 2013

More than one in 10 providing unpaid care as numbers rise to 5.8 million
Unpaid carers for the sick, disabled and increasingly elderly in England and Wales have grown by 600,000 since 2001 to reach approximately 5.8 million.

This is highlighted in a new Office for National Statistics (ONS) study entitled, ’Provision of unpaid care in England and Wales, 2011’. The study stresses that the provision of unpaid care is an important social policy issue because it not only makes a vital contribution to the supply of care, but it can also affect the employment opportunities and social and leisure activities of those providing it.

The importance of unpaid care was reflected by its inclusion as an item in both censuses in 2001 and 2011 and made it possible to compare over time the dramatic rise in the number of unpaid carers over a national, regional and local level.

In England there was a clear North-South divide with the highest percentages of care provision being in the North West, North East, East Midlands and West Midlands. Across local authorities the number of carers increased in 320 authorities and fell only in six. In Birmingham, the number of unpaid carers increased by more than 9,000. The highest increase in the extent of unpaid care occurred in the 50 hours or more per week category, which clearly places an additional burden on the work-life balance of those relatives, friends and other informal carers providing it.

Levels in unpaid care were higher in Wales for all categories (number of hours care was given) with more than 12 per cent of the population providing some level of care in 2011.

Source: www.ons.gov.uk 15 February 2013

Patient views highlighted as Care Quality Commission joins forces with patients’ charity to help root out poor elderly care.
The Care Quality Commission (CQC) and the Patients Association have joined forces to make sure concerns raised by people about care being provided to older people, can be shared quickly with the regulator and acted on where necessary.

Information from members of the public about the care they receive is valuable intelligence to CQC, as it helps identify where standards of care may be falling below national standards of quality and safety.

People can already contact CQC directly to report their experiences of care, but the regulator wants to reach more people and particularly gather more direct experiences about the care elderly people have received.
Through their joint project, the Patients Association will pass on to CQC any concerns from people who contact them so the regulator can take appropriate action. The charity receives more than 8,000 calls to its Helpline every year and has a network of volunteer ambassadors who encourage people to share their experiences of care.

David Behan, Chief Executive of the Care Quality Commission said:

“We rely on information from the public to help us target our inspections. This important resource helps us to protect and promote the quality and safety of the care patients receive.

“Our valuable partnership with the Patients Association will focus on gathering the experiences of elderly people and their families. As a number of recent reports, including our own State of Care report, have highlighted, there is a clear need to drive improvements to the care older people receive.”

Katherine Murphy, Chief Executive of The Patients Association said:

“Health and care services must listen to the public when they complain about the quality of care they receive. Every day patients and relatives contact our Helpline to report poor care. Working with the CQC is important in driving improvements in the care experienced by patients, wherever it is identified.”

The Patients Association Helpline number is 0845 608 4455. The Care Quality Commission can be contacted on 03000 61 61 61.

Source: www.cqc.org.uk 19 February 2013

Record numbers of people with dementia in care homes

Eighty per cent of people living in care homes – more than ever thought before - have either dementia or severe memory problems according to a new Alzheimer’s Society report.

However, while excellent care exists, less than half of these 322,000 people are enjoying a good quality of life.

The report entitled, 'Low expectations' finds evidence of a deep-seated pessimism about life in care homes. Only 41 per cent of relatives surveyed by Alzheimer’s Society reported that their loved ones enjoyed good quality of life. Despite this, three quarters (74 per cent) of relatives would recommend their family member's care home.

The report also reveals the severe image crisis facing the care sector. According to a YouGov public poll commissioned by the charity, 70 per cent of UK adults say they would be fairly or very scared of going into a care home. In addition, two thirds (64 per cent) do not feel the sector is doing enough to tackle abuse in care homes. The charity argues that public attitudes and scepticism about whether people with dementia enjoy a good quality of life in a care home is leading to a failure to drive up standards of care. Alzheimer’s Society is calling on Government and care homes to work together to lift expectations and to strengthen existing minimum standards to boost quality of life.

Jeremy Hughes, Chief Executive at Alzheimer’s Society said:

'When you walk into an excellent care home it’s full of warmth, activities and interaction. But between these best examples and the worst, which often dominate headlines, there is a forgotten scandal of people with dementia who are failed and left living a life that can only be described as 'OK'.
“Society has such low expectations of care homes that people are settling for average. Throughout our lives we demand the best for ourselves and our children. Why do we expect less for our parents? We need the Government and care homes to work together to lift up expectations so people know they have the right to demand the best.’

In addition, ‘Low expectations’ finds that:

- less than a third (30 per cent) of the public believe people with dementia are treated well in care homes
- the main factor (48 per cent) the general public would look for in choosing a care home is training of staff.
- less than half (44 per cent) of relatives said opportunities for activities in their relatives’ care home were good.
- over 9.3 million UK adults (19 per cent) know someone with dementia in a care home.

Source: www.alzheimers.org.uk 26 February 2013

Greater focus on prevention and integration essential to improve Care and Support Bill, warn Peers and MPs

A cross party group of MPs and Peers has warned that the Government has not fully thought through the implications of its social care reforms and may leave local authorities open to a deluge of disputes and legal challenges. In a unanimous report, MPs and Peers also warn that without greater integration with health and housing, and a focus on prevention and early intervention, the care and support system will be unsustainable.

The Committee also calls for a nationwide campaign to educate people about the need to pay for their own care, saying that adult care and support are poorly understood.

Launching the report, Rt Hon Paul Burstow MP, Chair of the Joint Committee on the Draft Care and Support Bill, said:

"We need care and support to be more focused on prevention and more joined up with health and housing. There is much in the Government’s draft Bill to welcome; it cuts through a complex web of arcane legislation that people struggle with. But there is room for improvement.

“The Government must take stock of its funding for adult care and support and think seriously about whether the transformation we all want to see can truly be delivered without greater resources.

“There is a growing imperative to join up services so they fit around people’s lives and make the best use of resources. The whole system must shift its emphasis away from crises and towards prevention and early intervention. The draft Bill helps, but we believe it could do more.”

Among its key recommendations the Committee calls for:

- a national campaign to raises awareness of what the national care and support offer is, how people can plan and prepare for their own care needs, and what rights they have to care and support
- information and advice for all (including self-funders) about support, care planning and housing options
• provision of independent financial advice about the different options available to pay for care, including deferred payment arrangements
• a new power to mandate joint budgets and commissioning across health, care and housing, such as support for the frail elderly, making it simpler for NHS and local councils to pool budgets
• a greater emphasis on assisting people to prevent and postpone the need for care and support
• fast-tracking of care and support assessments for terminally ill people
• an end to ‘contracting by the minute’ whereby care workers sometimes spend just fifteen minutes with the person being cared for
• new legal rights for young carers to protect them from inappropriate caring responsibilities and ensure they get the support they need
• an obligation on the Secretary of State to take into account the draft Bill’s wellbeing principle when designing and setting a national eligibility threshold
• stronger measures on safeguarding, including explicit responsibilities for local authorities to prevent the abuse and neglect
• independent resolution of disputes over decisions about care and support - and costs that count towards the cap – through a Care and Support Tribunal.

In addition, the Committee makes a number of recommendations to improve health research and the education and training of NHS workers, including:
• strengthening the Health Research Authority responsibilities by ensuring full disclosure of research data
• supporting greater integration of health and social care by ensuring more common training of care staff who often switch between the two sectors
• strengthening the duties of Health Education England to give clinical experience to managers.

The Committee also warns that restricting support and care to those with the highest levels of need will become entirely self-defeating, because it shunts costs into acute NHS care and undermines interventions to prevent and postpone the need for formal care and support.

The Committee makes over 100 recommendations for improvements in the draft Bill, including calls for:
• greater clarity on the boundary between NHS continuing care which is free and means-tested social care, which is not. The Committee warns that the current wording of the Bill is likely to lead to the unintended consequence that more people in residential care will fall into the means-tested system
• a statutory duty of candour – echoing the duty recently called for by Robert Francis QC in his report into failings at Mid Staffordshire hospital – to provide stronger protection for recipients of care or support services
• organisations – not just employees – who are found to have contributed to abuse or neglect in a care setting, should be liable to criminal prosecution for breach of corporate responsibility.
The report also highlights that the timing of the announcement on establishing a capped-cost model – along the lines of that recommended by Andrew Dilnot in his report on the future funding of care in 2012 – came too late for the Committee to consider its implications on the draft Bill in detail. However, the Committee calls for changes to be made to strengthen Parliamentary accountability for the operation of the new funding model, including the workings of care accounts and arrangements for means testing.

Source: www.parliament.uk 19 March 2013

Budget 2013 - Social care funding reform
The Government has announced that it will introduce a cap on reasonable care costs [Please see the above article entitled ‘New funding reforms announced for care and support’ (11 February 2013) for details]. This will give a level of financial protection to those with the greatest care and support needs. In addition, the residential care means test will be extended to give more people access to financial support for their residential care costs.

The Government has said that these reforms should help an extra 100,000 people who would not receive any support under the current system. The reforms will help people who want to work hard and save for old age, by providing peace of mind that the savings they want to leave to their children will not be at risk of being wiped out by care costs.

The Government has made clear that it would not implement these reforms without finding a way to pay for them. The Government has set out that the higher employer National Insurance Contributions (NICs) revenue that arises from the end of contracting-out for members of defined benefit occupational pension schemes will help cover the costs of social care reform for the duration of the next Parliament. As the single-tier State Pension will begin in 2016/17, Budget 2013 announces that the Government will introduce a £72,000 cap on reasonable care costs and extend the means test from April 2016.

The new social care cap will protect the assets of those who face the highest social care costs, and will particularly benefit older people who have worked and saved all their lives to build up assets. As announced in February 2013, the Government will freeze the inheritance tax threshold for three years until April 2018, providing a simple and fair way of ensuring that those with the largest estates, who are more likely to benefit from social care reform, help to fund it. The Government has set out that the inheritance tax freeze will contribute to the costs of social care reform in the next Parliament.

Source: www.hm-treasury.gov.uk 20 March 2013

Social isolation 'increases death risk in older people'
Social isolation is associated with a higher risk of death in older people regardless of whether they consider themselves lonely, research suggests.

A study of 6,500 UK men and women aged over 52 found that being isolated from family and friends was linked with a 26 per cent higher death risk over seven years.

Whether or not participants felt lonely did not alter the impact of social isolation on health.

It is not the first time that loneliness and social isolation has been linked with poor health. But researchers wanted to find out if it was the emotional aspect of feeling lonely that was having an impact or the reality of having little social contact.
Those who were socially isolated - that is had little or no contact with friends or family - were more likely to be older and unmarried and have long-standing illnesses limiting their mobility, such as lung disease and arthritis.

People who described themselves as feeling lonely were more likely to be female and have a wider range of health conditions, including depression.

Both social isolation and feeling lonely were associated with a higher chance of death.

But after adjusting for factors such as underlying health conditions, only social isolation remained important.

That risk did not change when researchers added in whether or not someone felt lonely in their isolation.

Writing in the Proceedings of the National Academy of Sciences, the researchers said they were surprised by their findings.

Study leader Prof Andrew Steptoe, director of the Institute of Epidemiology and Health Care at University College London, said:

"Social connections can provide emotional support and warmth which is important but they also provide things like advice, making sure people take their medication and provide support in helping them to do things.

"It would suggest that those practical aspects are quite important for older people's survival.

"There's been such an increase in people living alone. In the last 15 years, the number of 55 to 64-year-olds living alone has increased by 50 per cent.

"And it might be that people in those circumstances aren't looking after themselves so well."

Source: [www.bbc.co.uk/news](http://www.bbc.co.uk/news) 26 March 2013