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<td>Chief Inspector of Hospitals publishes his findings on Barts Health NHS Trust</td>
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<td>England's Chief Inspector of Hospitals, Professor Sir Mike Richards has published his first reports on the quality of care provided by Barts Health NHS Trust across three acute hospitals, three specialist hospitals and two birthing centres in Central and East London. As a result of the inspection, 15 compliance actions were issued to the trust (divided across all the hospital sites with the exception of Mile End Hospital).</td>
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<td>Chief Inspector of Hospitals publishes his findings on University College London Hospitals NHS Trust</td>
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<td>England's Chief Inspector of Hospitals, Professor Sir Mike Richards has published his first report on the quality of care provided by University College London Hospitals NHS Foundation Trust at University College Hospital. Overall, the team of inspectors, including doctors, nurses and specialists, found that services run by University College London Hospitals NHS Foundation Trust were safe, effective, caring, responsive to patients' needs and well-led.</td>
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<td>CQC to do more checks on the use of Deprivation of Liberty Safeguards</td>
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<td>Checks on implementation of the Mental Capacity Act (MCA) will become a routine part of hospital and care home inspection, the Care Quality Commission (CQC) has announced. In its fourth annual report into the Deprivation of Liberty Safeguards (DoLS), CQC said that these checks will become an integral part of its new approach to regulation, as it implements its fresh strategy 'Raising standards, putting people first'.</td>
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<td>Making mental health matter more</td>
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<td>The Government has set out that more needs to be done to help the one in four people who will suffer from a mental health problem at some point in their life. The document entitled, 'Closing the gap: Priorities for essential change in mental health' outlines 25 areas for health and care services to take action which will make a difference to the lives of people with mental health conditions. These changes will mean that the system is fairer for people with mental health problems. The document aims to encourage the NHS to take mental health as seriously and treat it as importantly as physical health.</td>
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<td>Care Quality Commission finally heading in right direction according to the Health Committee</td>
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<td>The Care Quality Commission (CQC) is now better able to protect patients and the public, according to a senior Committee of MPs. Launching the report following the Health Committee’s annual accountability hearing with the CQC, Committee Chair Stephen Dorrell MP said: “The CQC has been a case study in how not to run a regulator, but essential reforms implemented by the new management are turning the CQC around. The CQC has a renewed sense of purpose and now understands that it exists to ensure that care providers meet basic standards and to intervene when they do not.”</td>
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<td>NICE support for local authorities on improving access to health and social care services</td>
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<tr>
<td>Support for local authorities to improve access to health and social care services for people who don't routinely use them is the focus of a new local government briefing published by the National Institute for Health and Clinical Excellence (NICE). The new briefing on improving service access covers a range of areas important in ensuring that services meet the sometimes complex needs of people in their local area.</td>
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NHS waiting times for elective care in England
The National Audit Office (NAO) has highlighted the increasing challenge to the NHS of sustaining the 18-week waiting time standard for elective care and the importance for trusts of having reliable performance information and shared good practice. The report to Parliament entitled ‘NHS waiting times for elective care in England’ concludes that value for money is being undermined by the problems with the completeness, consistency and accuracy of patient waiting time data; and by inconsistencies in the way that patient referrals to hospitals are managed.  

130,000 people diagnosed at 65 or over survive cancer for at least a decade
With the right treatment, over 65s can survive for many years after cancer – yet UK survival rates in older people are among worst in Europe. More than 130,000 people in the UK have survived for at least 10 years after being diagnosed with cancer at 65 or over, according to new research by Macmillan Cancer Support and the National Cancer Intelligence Network (NCIN). This figure shows that, with the right care and treatment, over-65s in the UK can live for many years after cancer. However, if UK survival rates in this age group were not so poor this number would be even higher. Macmillan believes too many older patients in the UK are being assessed on their age alone and not their overall fitness.  

Attendance rates at major A&E departments highest in London
New figures for 2012/13 show attendance rates per 1,000 population at major (Type 1) A&E departments were highest in the London region and lowest in the South Central region. This follows on from the ‘Focus on A&E’ report published by the Health and Social Care Information Centre (HSCIC) in December 2013, which gave a national picture of the patient journey through A&E. The new report shows further information as well as regional figures.  

Rise in the use of the Mental Health Act, regulator finds
The number of people detained or treated under the Mental Health Act (MHA) has risen by 12 per cent in the last five years, the Care Quality Commission (CQC) says in its fourth annual Mental Health Act Report. The Act was used 50,000 times to detain or treat people under compulsion in 2013, the report says, and there were 45,000 uses of the Act in 2008/09.  

Report shows hospital trusts with persistently high or low death ratios
Eighteen NHS trusts in England have been categorised as having a 'lower than expected' or a 'higher than expected' mortality ratio over two years, according to analysis from Health and Social Care Information Centre (HSCIC). Between July 2011 and June 2013, 12 trusts were categorised as having a 'lower than expected' ratio, based on Summary Hospital-level Mortality Indicator (SHMI) data and six as having a 'higher than expected' ratio.  

One in three breast cancers are in women over 70
One in three women diagnosed with breast cancer in England each year are aged 70 or over. This age group also accounts for more than half of all breast cancer deaths annually, latest figures show. This comes as Public Health England launched a new national Be Clear on Cancer campaign to remind older women ‘don’t assume you’re past it’, and to visit their doctor if they spot any changes in their breasts.  

Chief Inspector of Hospitals publishes his findings on Princess Royal University Hospital, Orpington
England’s Chief Inspector of Hospitals, Professor Sir Mike Richards, has published his first report on the quality of care provided at Princess Royal University Hospital, Orpington, Kent. Princess Royal University Hospital was recently taken over by King’s College Hospital NHS Foundation Trust following the dissolution of South London Healthcare NHS Trust in October 2013. Overall, the report concludes the scale, number and longstanding nature of many of the problems that King’s College Hospital NHS Foundation Trust inherited at the Princess Royal University Hospital should not be underestimated, but that while the Trust has already begun to tackle some of the challenges that it faces there is still more to do.  

Hospital leaders reveal impact of the Francis Report one year on
Financial pressures and a complex regulatory environment are making it difficult for hospitals to create the kind of patient-centred culture recommended by Robert Francis QC, according to new research by health think tank the Nuffield Trust. But senior NHS staff interviewed for the research said that the 2013 Francis Report had added impetus to their efforts to put quality of care as their top priority. The research is the first look at how hospitals have responded to the findings and recommendations contained in Robert Francis QC’s Report.

The NHS is not meeting the "Nicholson Challenge" says Health Committee
The health and care system needs fundamental change if it is to meet the needs of patients, according to the Health Select Committee. The report states that the successful integration of high quality health and care services represents a substantial and growing challenge. It also recommends that the current level of real terms funding for social care should be ring-fenced.
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<th>Change needed to realise the potential of community services, says new report by The King’s Fund</th>
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<td>Radical changes to community services are needed to realise the ambition of moving care out of hospital and closer to people’s homes, says a new report published by the King’s Fund. The report argues that previous policy has failed to achieve this longstanding ambition. To address this, it sets out a seven step plan for change, based on community services working much more closely with groups of general practices and building multidisciplinary teams to care for people with complex needs.</td>
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<th>Sir Stuart Rose to advise on NHS leadership</th>
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<td>Sir Stuart Rose, who turned around the fortunes of Marks &amp; Spencer, will advise the NHS on how it can attract and retain the very best leaders to help transform the culture in under-performing hospitals. It will run alongside a separate review into how the NHS can make better use of its best existing leaders, so-called “superheads”, who could spread the highest standards for patients across the system by taking on struggling organisations or establishing national networks of NHS hospitals and services.</td>
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<th>‘Special measures’ successfully turning troubled hospitals around</th>
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<td>A report published by Monitor and the NHS Trust Development Authority NHS TDA finds that significant progress has been made turning around some of England’s most challenged hospitals. Each trust in special measures is required to produce an action plan which is published on the NHS Choices website and frequently updated. Of the 244 special measures actions across all the trusts, 82 (34 per cent) have been delivered and a further 127 (52 per cent) are on track for completion within the expected timescale. Monitor and the NHS TDA are holding trusts to account where actions have been delayed.</td>
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<th>Securing a health service fit for the future</th>
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<td>Eleven financially challenged health economies in England are to receive expert help with strategic planning in order to secure sustainable quality services for their local patients. Monitor, NHS England and the NHS Trust Development Authority (NHS TDA) have agreed to fund a series of projects to help groups of commissioners and providers work together to develop integrated five-year plans that effectively address the particular local challenges they face.</td>
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<th>Better care for mental health crisis</th>
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<td>Emergency support for people in mental health crisis is set to see dramatic improvements across the country as part of a far-reaching new agreement between police, mental health trusts and paramedics. The agreement – called the Crisis Care Concordat – has been signed by more than 20 national organisations in a bid to drive up standards of care for people experiencing crisis such as suicidal thoughts or significant anxiety. The Concordat will help cut the numbers of people detained inappropriately in police cells and drive out the variation in standards across the country.</td>
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<th>NHS England acts in response to concerns about information sharing</th>
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<td>NHS England has announced that the start of a new NHS data sharing scheme in England, known as care.data and involving medical records is being delayed by six months. To ensure that the concerns of the British Medical Association (BMA), the Royal College of General Practitioners (RCGP), Healthwatch and other groups are met, NHS England will begin collecting data from GP surgeries in the Autumn of 2014, instead of April, to allow more time to build understanding of the benefits of using the information, what safeguards are in place, and how people can opt out if they choose to.</td>
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<th>Anxiety: hospital admissions highest in women in their late 60s</th>
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<td>Hospital admissions for anxiety increased with age and were highest among older women, new figures from the Health and Social Care Information Centre (HSCIC) show. In the 12 months to November 2013 almost three out of ten anxiety admissions were women aged 60 and over (2,440 out of 8,720, or 28 per cent), with 65 to 69 the most common age group of female patient admissions (437, or eight per cent of all female admissions). The most common age group for male patient admissions was 45 to 49 (279, or 8.5 per cent of all male admissions).</td>
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<th>‘Family care networks’ – the future of primary care</th>
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<td>In future, ‘family care networks’ with GP surgeries at their heart should provide a wider range of services for patients outside hospitals, says a report on the future of primary care, published by The King’s Fund. These networks would enable GPs to strengthen their role as providers and coordinators of care in collaboration with other staff working in the community and some hospital-based specialties.</td>
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### Foundation trusts holding up under pressure
NHS foundation trusts are performing well in providing quality services to patients in challenging economic times, according to Monitor. The health sector regulator’s latest quarterly report for October to December 2013 shows foundation trusts are coping with winter pressures, as fewer missed the four hour A&E waiting time target than at the same period last year (28 compared to 32).

### NHS death rates ‘should be ignored’
A key measure of hospital death rates should be ignored, according to the expert leading the review into them. Prof Nick Black has been asked by the NHS to see whether they are an accurate indicator of poor care. His review is not due to be published until December 2014, but he told the BBC the most established method of measuring mortality appeared to have no value.

### Public Health England must find a clear direction
Public Health England (PHE) has not yet shown that it is able to be an effective champion of the nation’s public health interests according to the Health Select Committee. The Health Committee’s inquiry examined how PHE has set about establishing its policy priorities and programme of work. The Committee’s inquiry also examined the relationship between the Department of Health and PHE. Concern was expressed in evidence received by the Committee that PHE has yet to demonstrate that it is sufficiently independent of Government.

### NICE support for local government to encourage people to attend NHS Health Checks and make changes for better health
Helping local authorities to encourage people to attend NHS Health Checks and support them in making changes needed to improve their health, is the focus of a new briefing from the National Institute for Health and Clinical Excellence (NICE). The new NICE Local Government Briefing sets out effective ways to help local authorities support those delivering risk assessment and advice on making lifestyle changes, to tackle serious long term conditions in their populations. With local authorities’ remit for public health in communities, the new briefing highlights the importance of taking steps to address diabetes, cardiovascular disease and stroke to improve the health of local people, and also tackle health inequalities.

### Baby-boomer drug and alcohol warning
There is a growing problem of drug and alcohol misuse among older people, as “baby-boomers” age, campaigners are warning. A report from the charity DrugScope says more are drinking too much, and alcohol-related hospital admissions and deaths are rising. Drug misuse was also an increasing problem in the age group, it said. DrugScope said policy too often centred on young people and “age-appropriate” help was needed.

### NHS to tackle long waits for dementia assessments
The Department of Health has announced a £90 million package to improve dementia diagnosis and care and the appointment of a World Dementia Envoy to raise funds for research towards a cure. Leading British businesses have also signed up to the cause with over 190,000 staff at M&S, Argos, Homebase, Lloyds Bank and Lloyds Pharmacy to learn to support customers who have dementia.

### No clear strategy for tackling lack of specialist A&E consultants
The Public Accounts Committee (PAC) has published its 46th Report on emergency admissions to hospital and chronic shortage of specialist A&E consultants. In response to this report, the PAC expects the Department of Health to: confirm that it is responsible for the overall performance of urgent and emergency care; and set out how it will challenge local performance, step in when this performance is substandard and enforce beneficial local changes to save money and provide a better service when local agreement cannot be reached.

### Person-centred commissioning needed to end the health and social care split, says Labour Party review
Health and social care services need to be changed to make them more focused on the needs of individuals and to reduce fragmentation, a Labour Party policy Commission has recommended. The Independent Commission on Whole-Person Care’s report said that changes in how services are commissioned could result in better co-ordinated care that is focused on the holistic needs of individuals.

### Nearly a fifth confess to knowingly using A&E for non-emergencies
Eighteen per cent of people admit to having knowingly used A&E for a non-emergency at some point in their lives, according to new survey by Healthwatch England. One in four respondents said it is likely they would resort to using A&E in the future if they were unable to get a GP appointment in a reasonable timeframe, with one in three stating that they would do so if the non-emergency situation occurred outside of GP opening hours.
### Ageing society demands a ‘fundamental shift’ in how health and care are delivered

A fundamental shift is urgently needed in the delivery of health and care to meet the challenges of a rapidly ageing society, say the authors of a new report from the King’s Fund. The report entitled, ‘Making our health and care systems fit for an ageing population’ argues that health and care services have failed to keep up with dramatic demographic changes, which will see one in five people in England over the age of 65 by 2030. It finds that transforming services for older people will require a fundamental shift towards care co-ordinated around individual needs rather than single diseases, and that prioritises prevention and support for maintaining independence.

### Emerging findings from radical new approach to hospital inspection – compassionate care is alive and well in the NHS

The Care Quality Commission (CQC) has published findings from its 18 pilot hospital inspections completed last year, the first step in a radical change to its approach. The Chief Inspector of Hospitals led teams of specialist inspectors and members of the public representing patients, to complete this work between July and December 2013. The report concludes that compassionate care is alive and well in the NHS. Inspectors found care and compassion among frontline staff in every hospital visited, as well as a strong commitment to the NHS.

### The Mental Capacity Act is failing, says Lords

Social workers, healthcare professionals and others involved in the care of vulnerable adults are not aware of the Mental Capacity Act, and are failing to implement it. That is the key finding of the House of Lords Committee established to scrutinise how the Act is working in practice, as outlined in a new report. The Committee is recommending that an independent body is given responsibility for oversight of the Act in order to drive forward vital changes in practice. The Committee also found that the controversial Deprivation of Liberty Safeguards (DoLS), inserted into the Mental Capacity Act in 2007 by the Mental Health Act, are not fit for purpose. The Committee is recommending that the DoLS be replaced with legislation that is in keeping with the language and ethos of the Mental Capacity Act as a whole.

### Lung cancer rates climb by three quarters in women while halving in men

Lung cancer rates in women have risen by three quarters (73 per cent) over the last forty years according to new Cancer Research UK figures. But while the rate for women has continued to climb, the figures show lung cancer rates have fallen by nearly half (47 per cent) in men over the same period and by a fifth (20 per cent) for people overall.

### Health and care complaints system is ‘utterly bewildering’ for people

The concerns of users and worried family members looking to complain about the service they have received from their local hospital, GP or care home, are going unheard because the current system is simply too complex, according to Healthwatch England. Its work to map the complaints landscape has shown that 75 types of organisations in England have a role in complaints handling and support, from councils and clinical commissioning groups locally to national regulators.

### Monitor highlights need for innovation as funding pressures grow

The message from the Health Committee's annual inquiry into the work of Monitor, the regulator for health services in England, is that, under current funding regime, the NHS will only be able to deliver the care required from it by significant innovation in the provision of healthcare, but that insufficient change has yet been made.

### Halving avoidable harm and saving up to 6,000 lives

A new ambition to reduce avoidable harm in the NHS by half over the next three years, cut costs and save up to 6,000 lives has been outlined by the Health Secretary, Jeremy Hunt. He announced details of how NHS organisations can work together to improve patient safety and save money. Each NHS organisation will be invited to ‘Sign up to Safety’ and set out publicly their ambitious plans for reducing avoidable harm, such as medication errors, blood clots and bed sores over the next three years. The Government will also introduce a Duty of Candour, making openness and honesty the norm across all health and social care organisations. It will mean providers must notify the patient about incidents where ‘significant harm’ has occurred and provide an apology.

### Chief Medical Officer publishes annual report on state of the public’s health

Being overweight is becoming normal as the majority of the adult population is overweight or obese, Chief Medical Officer (CMO) Professor Dame Sally Davies said as she published her latest annual report on the state of the public’s health. Key areas of concern for the CMO featuring in this year’s report are: obesity; deafness and blindness and dementia; alcohol; and walking and cycling.
NHS England publishes new data on the progress of hospitals in acute emergency and maternity care across London

NHS England London has published new data on the progress of hospitals in meeting standards for acute emergency and maternity services across London and it shows more are delivering high quality acute emergency care for patients across all seven days of the week. Acute hospitals across the capital have been working towards meeting the 26 standards for acute medicine and emergency general surgery since April 2012. Latest data from 29 acute hospitals across the capital shows they are making progress on meeting these standards compared to data published last year.

Professional are divided over best care for hip fracture patients, latest audit results show

The latest report from the Falls and Fragility Fracture Programme (FFAP) National Hip Fracture Database (NHFD) shows that just over half of patients are receiving pain relieving anaesthetic (known as a ‘nerve block’) as part of their care for hip fracture. The National Hip Fracture Database Anaesthesia Sprint Audit of Practice results show that 56 per cent of hip fracture patients receive a peri-operative nerve block for pain relief and 44 per cent of patients do not. The Audit recommends that this type of pain relieving anaesthetic should be offered to all hospital patients who suffer hip fracture.

Social Care

Care loans scheme could cost councils up to five times more than estimated

A care loans scheme to help people meet the cost of care in their old age could be almost five times more expensive to administer than the Government estimates, new analysis has revealed. Figures published by the Local Government Association (LGA), which represents councils in England and Wales, show the cost of the scheme could reach more than £1.1 billion by 2025 – in comparison to an estimate based on Government assumptions of £230 million.

Councils in England ‘pay too little for home care’

Most councils in England are paying less than the industry recommended minimum for personal home care, a BBC investigation suggests. The UK Homecare Association (UKHCA), which represents providers, want them to be paid a minimum of £15.19 an hour, to cover wages, training and travel. But data obtained under the Freedom of Information Act (FOI) found the minimum paid met that in just four out of 101 cases.

London facing £17 million Care Bill shortfall

Getting ready to deliver the Care Bill will leave London facing a £17 million funding shortfall. Figures from London Councils show boroughs need around £90 million to prepare for the new system, which comes into force in part from April 2015. But new estimates by London Councils reveal the capital is likely to receive £72.75 million in 2015/16, leaving each borough with a potential £500,000 shortfall as a minimum.

No proven benefit from home care for older people, finds research review

There is no consistent or robust evidence to show that home care visits benefit older people, a review of research conducted over the past 20 years has concluded. There is no evidence to demonstrate older people who receive home care live longer or lead more independent lives than those who do not with similar needs, found an Oxford University and University College London analysis of 64 randomised controlled trials, mainly in the UK, United States and Canada.

Adult social care in England: overview

The National Audit Office (NAO) has highlighted in a new report the main risks and challenges as the adult care system changes radically. The report points out that the Government does not know if the limits of the capacity of the care system to continue to absorb pressures are being approached. It warns that major changes to the system to improve outcomes and reduce costs will be challenging to achieve. The report details increasing pressures on the system: adults with long term and multiple health conditions and disabilities are living longer; demand for services is rising while public spending falls; and there is unmet need for care.

A good life with dementia?

A new independent report commissioned by Red & Yellow Care has been launched to show what a ‘good life’ with dementia could look like. The report outlines a six-part framework for enabling a ‘good life’ with dementia – one rooted in universal notions of identity, happiness and fulfillment. The report draws on the expertise and insights of those working in the field of dementia, happiness and wellbeing as well as primary research with people with dementia and their carers.
The NHS and Government are 'flying blind' in planning services for vulnerable older people because there is no comprehensive way to quantify the impact that social care cuts are having on their health and wellbeing. The warning comes in a new Nuffield Trust and Health Foundation study examining cuts to social services for older people in England. The new research, which is part of the Nuffield Trust and Health Foundation’s QualityWatch programme, reveals that most local authorities are tightly rationing social care for the over-65s in response to cuts, resulting in significant drops in the number of people receiving services like home delivered meals and day care.

For further info
For further information on anything in this issue of the Health & Social Care Bulletin please contact:

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Health

Chief Inspector of Hospitals publishes his findings on Barts Health NHS Trust

England's Chief Inspector of Hospitals, Professor Sir Mike Richards has published his first report on the quality of care provided by Barts Health NHS Trust across three acute hospitals, three specialist hospitals and two birthing centres in Central and East London.

The Care Quality Commission (CQC) inspected the Royal London Hospital, Whipps Cross University Hospital, Newham University Hospital, the London Chest Hospital, St Bartholomew's Hospital, Mile End Hospital, the Barkantine Birthing Centre and the Barking Birthing Centre in November 2013.

As a result of the inspection, 15 compliance actions were issued to the trust (divided across all the hospital sites with the exception of Mile End Hospital). Three warning notices issued to Whipps Cross Hospital in June 2013 have been lifted following this inspection.

Overall, the team of inspectors, including doctors, nurses and specialists, found that generally services run by Barts Health NHS Trust were safe, but that staffing levels were variable across services and that equipment wasn’t always readily available. This placed patients at risk of harm.

Reports on the whole Trust and on each of the eight locations have been published on www.cqc.org.uk

Across the Trust, a significant number of staff told the inspection team that they felt disconnected from the Trust’s executive team and felt undervalued and not supported. The culture was not sufficiently open and some staff felt inhibited in raising concerns. Morale was low across all staffing levels, and some staff told inspectors they felt bullied.

Learning from incidents took place on individual sites, but not always Trust-wide. There were problems with patient flow through the hospitals, bed occupancy and discharge planning at both the Royal London Hospital and Whipps Cross University Hospital.

While the majority of patients said that staff were caring and compassionate, and the team saw people treated with dignity and respect, some people complained that they did not feel listened to. Inspectors were contacted by a number of people who were dissatisfied with the Trust's response to their complaints.

Actions that the trust must take to improve included:

- ensuring sure that risks identified are acted upon
- ensuring that there are sufficient staff with the right skill mix on all wards to deliver safe and effective care
- ensuring that equipment is readily available when needed
- ensuring that all patients receive nutritious food in sufficient quantities
- engaging the Executive Board better with staff; listening to them, responding to their concerns and adopting a zero tolerance approach to bullying.

Areas of good practice identified included:

- the care, commitment and compassion of staff
- palliative care, which was compassionate and held in high regard by staff, patients and friends and family
- good practice in children’s services, particularly in relation to education and activities for children while in hospital
• patients who had had a heart attack received equal treatment, whether admitted during the day or at night
• good support for relatives when patients were in a life-threatening situation or when difficult decisions needed to be made about continuing care.

Barts Health NHS Trust was one of the first to be inspected under radical changes introduced by the Care Quality Commission which are designed to provide a much more detailed picture of care in hospitals than ever before. As part of the inspection, the team held focus groups with staff and four public listening events.

The inspection team included doctors, nurses, hospital managers, trained members of the public, CQC inspectors and analysts. They visited the Trust to examine the care provided in accident and emergency (A&E), medical care (including older people’s care), surgery, intensive/critical care, maternity, children’s care, end of life care and outpatients.

CQC’s Chief Inspector of Hospitals, Professor Sir Mike Richards, said:

"We found that Barts Health NHS Trust was, in the main, providing services that were safe. My team identified a number of areas of good practice and the majority of patients we met were complimentary about the way they had been treated by staff.

"On a more negative note, we found that staff morale was low. Too many members of staff of all levels and across all sites came to us to express their concerns about being bullied, and many only agreed to speak to us in confidence. The Trust needs to take action to make sure people feel confident to speak up.

"Locally, the leadership of services is good, but there is a disconnect between the board and the ward. While the leadership team is well-established and cohesive, we found that it needs to be far more visible across all parts of the Trust.

"Barts Health Trust is a very large, complex organisation, which plays a vital part in the life of many Londoners. I would encourage local people to read the individual reports on their local hospital or service as these give a detailed view of the care we saw being delivered."

The Care Quality Commission has already presented its findings to a local Quality Summit, including NHS commissioners, providers, regulators and other public bodies. The purpose of the Quality Summit was to develop a plan of action and recommendations based on the inspection team’s findings.

CQC will continue to monitor Barts Health NHS Trust and will return in due course to carry out further inspections of all trust services as part of its regulatory programme.

Source: www.cqc.org.uk 14 January 2014

Chief Inspector of Hospitals publishes his findings on University College London Hospitals NHS Trust

England’s Chief Inspector of Hospitals, Professor Sir Mike Richards has published his first report on the quality of care provided by University College London Hospitals NHS Foundation Trust at University College Hospital.

The Care Quality Commission (CQC) inspected the hospital, which primarily provides services to people living in Camden, Islington, Barnet, Haringey and Westminster, in November 2013. This inspection focused on services provided by the Trust in accident and emergency (A&E), medical care (including older people’s care), surgery, intensive/critical care, maternity, children’s care, end of life care and outpatients.
Overall, the team of inspectors, including doctors, nurses and specialists, found that services run by University College London Hospitals NHS Foundation Trust were safe, effective, caring, responsive to patients’ needs and well-led. The inspection team saw many examples of good care, and were impressed by the dedication shown by staff and the emphasis at all levels of the Trust on putting patients first.

The vast majority of patients were very positive about the care they received, and staff told inspectors that they were proud to work at the Trust and proud of the level of care they were able to deliver.

However, the inspection team also noted areas of the hospital where staff were delivering care under pressure and where the environment was not at an appropriate standard.

Following the inspection four compliance actions were issued to the Trust, relating to the lack of full completion of the World Health Organisation (WHO) checklist, the safety and suitability of premises in A&E, and recording of care assessments and records management on the acute medical wards.

The WHO checklist, designed to ensure safer surgery, was not always being fully completed. This led to a risk that surgery could be unsafe.

In Accident and Emergency (A&E) staff were delivering safe care in very difficult circumstances. The physical environment was inadequate due to shortage of space, facilities and equipment. Patients were routinely doubled up in cubicles designed for one patient only, which severely compromised their privacy and dignity, and meant that only one patient at a time had access to monitoring equipment. There was a big risk of cross infection due to this practice.

The management of the outpatient clinic was not adequate, resulting in overcrowding and patients being left without seating in busy periods. In addition, the Trust was failing to ensure that the paperwork for patients who had been assessed as not requiring resuscitation was always fully completed.

The full report is available at www.cqc.org.uk

Areas of good practice identified included:

- the commitment of staff in A&E to good care despite environmental challenges
- there was a strong consultant presence at all stages of patients’ surgical pathways ensuring decisions on care and treatment were made by the appropriate qualified healthcare professional
- the outpatients’ clinics for children and young people had procedures in place to check reasons for non-attendance. This safeguarded children who might have missed appointments due to abuse or neglect
- areas of good practice in intensive/critical care included good examples of caring, efficient staff showing good multi-disciplinary working; good patient mortality rates and clinical outcomes; daily ward input from microbiologist; psychological support for patients and staff
- excellent caring staff on the acute medical wards, including positive caring interactions with patients. Staff provided people with regular information and promoted their involvement in their care. They maintained people’s privacy and dignity and promoted their independence.

Actions that the trust must take to improve included:
ensuring full completion in all cases of the WHO surgical checklist to help ensure safe surgery
reviewing the current A&E and children’s A&E provision and assessing what planned improvements can be brought forward or interim measures can be employed to mitigate risks to patient safety
in surgery, improving patient flow by alleviating pressure on beds and increasing bed capacity in the operating theatre recovery area
improving the quality, completeness of people’s care assessments, care plans and care delivery records on the acute medical wards to ensure that people do not receive inappropriate or unsafe care, and improving the care and security storage of patient records on acute medical units
ensuring that the paperwork for patients who have been assessed as not requiring resuscitation is always fully completed.

CQC’s Chief Inspector of Hospitals, Professor Sir Mike Richards, said:
"We found that University College Hospital was generally providing services that were safe, effective, caring, responsive to patients’ needs and well-led. My team saw many examples of good care, and were impressed by the dedication shown by staff, the support provided to staff, and the clear emphasis the trust places on putting patients first."
"The vast majority of patients spoken to were very positive about the care they received, and staff were proud to work at the Trust and of the level of care they were able to deliver. The Trust has a strong board and clear governance structure which has led to high levels of care being maintained in most areas.
"Despite all the positive things my team found, we also found areas where the trust needed to make improvements.
"We found that the World Health Organisation checklist designed to ensure surgical safety wasn’t always being fully completed. This placed patients at risk of harm.
"We also found that the environment in A&E wasn’t really fit for purpose – despite the staff there working hard to deliver safe care in difficult circumstances – and that improvements were also needed to records management on acute medical wards, and in a number of other areas of care.
"Our judgement is that this is an excellent hospital in many ways – but the failings we identified are preventing it from achieving excellence across the board. The Trust has told us it is taking action – and we expect to return in due course to find that the problems have been fixed."
The Care Quality Commission has already presented its findings to a local Quality Summit, including NHS commissioners, providers, regulators and other public bodies. The purpose of the Quality Summit was to develop a plan of action and recommendations based on the inspection team’s findings.
CQC inspectors will continue to monitor University College London Hospitals NHS Foundation Trust and will return in due course to carry out further inspections of all trust services as part of its regulatory programme.
Source: www.cqc.org.uk 15 January 2014
CQC to do more checks on the use of Deprivation of Liberty Safeguards

Checks on implementation of the Mental Capacity Act (MCA) will become a routine part of hospital and care home inspection, the Care Quality Commission (CQC) has announced.

In its fourth annual report into the Deprivation of Liberty Safeguards (DoLS), CQC said that these checks will become an integral part of its new approach to regulation, as it implements its fresh strategy 'Raising standards, putting people first'.

The strategy underlines CQC's commitment to strengthening its focus on the Mental Capacity Act (MCA), which includes the DoLS.

The MCA sets out how people in vulnerable circumstances should be cared for and how to strike the balance between respect for rights to liberty and independence and the need to protect people when they lack the capacity to make decisions.

The report into how the Deprivation of Liberty Safeguards have been applied during 2012/13, cites concern that the MCA is still not understood and implemented consistently across health and social care services. Findings include:

- People in care homes and hospitals may continue to be subject to restraint and possible deprivation of liberty without legal protection
- People’s experiences of the DoLS are mixed – CQC’s case studies show how the system can work well for people
- There has been a significant increase in the number of applications for the use of DoLS to protect the rights of people aged over 85
- Application rates continue to vary by region – but the reasons for this are unknown
- Around two thirds of care homes and hospitals are failing to notify CQC of the outcome of DoLS applications as required by law.

The report also recommends that NHS England should include an expectation on the effective use of the DoLS into the standard contract for providers.

For the first time, CQC surveyed local authorities on their monitoring of the MCA. Of 118 of 152 local authorities:

- Knowledge of the Deprivation of Liberty Safeguards system generally appears to be good. Most had appropriate structures and processes in place to operate the system effectively
- Some did not actively encourage people’s representatives or their Independent Mental Capacity Advocates to enable people to challenge authorisations.

Source: [www.cqc.org.uk](http://www.cqc.org.uk) 16 January 2014

Making mental health matter more

The Government has set out that more needs to be done to help the one in four people who will suffer from a mental health problem at some point in their life.

The Department of Health said that although there have been improvements in recent years, there is still a long way to go to make mental health as important as physical health and drive out unacceptable practices that still exist, such as long waiting times, people being transferred long distances to get a bed, face-down restraint being used too often and children being cared for on adult wards and facing a cliff-edge of support when they turn 18. People with severe mental illness also face shorter life expectancy – this shows that more needs to be done to help those with mental health problems stay physically healthy as well.
The Deputy Prime Minister Nick Clegg addressed a conference which brought together mental health experts, charities and users of mental health services to talk about how mental health can be improved.

The document entitled, ‘Closing the gap: Priorities for essential change in mental health’ outlines 25 areas for health and care services to take action which will make a difference to the lives of people with mental health conditions. These changes will mean that the system is fairer for people with mental health problems. The document aims to encourage the NHS to take mental health as seriously and treat it as importantly as physical health.

A major step forward in this will be giving mental health patients more control over their care. From April 2014, for the first time, patients needing treatment for a mental health problem will be able to choose where they get their care in the same way that someone needing a hip or knee replacement has had a right to choose which hospital to have their operation at since 2008. And the choice will not be limited to an NHS provider – patients will also be able to choose a voluntary or independent organisation providing NHS services when they go to see their GP to seek help.

Key measures include:

- patients will have a choice about where they get their mental health care – just as someone needing an operation can already choose their hospital or the consultant-led team that will care for them
- from 2015, waiting time standards will begin to be introduced for mental health – giving mental health patients the same rights as someone who needs, for example, a hip replacement or treatment for cataracts
- the Friends and Family Test will be rolled out to mental health services for the first time so patients can give their own feedback on their care and mental health trusts will be able to take swift action if improvements are needed
- talking therapies are already helping 600,000 people - this will be expanded so that 300,000 more people will get help
- children with mental health problems will get more support – including an aim to roll talking therapies for children and young people out to the whole country by 2018 and better support for children moving from adolescent services into adult services
- £43 million will be invested in pilots on better housing for people with mental health problems or learning disabilities. Architects and builders will work with mental health experts and charities to bid for projects in 2015 with the aim of new homes beginning to be built by 2017.

Mental health problems are common and one in four people experience stress, anxiety and depression at some point in their lives. The cost of mental illness is not just counted in the NHS – it also costs the economy over £105 billion every year. Depression and anxiety alone cost £16.4 billion through NHS treatment and lost earnings.

Source: www.gov.uk 20 January 2014

Care Quality Commission finally heading in right direction according to the Health Committee

The Care Quality Commission (CQC) is now better able to protect patients and the public, according to a senior Committee of MPs.
Launching the report following the Health Committee’s annual accountability hearing with the CQC, Committee Chair Stephen Dorrell MP said:

"The CQC has been a case study in how not to run a regulator, but essential reforms implemented by the new management are turning the CQC around.

"The CQC has a renewed sense of purpose and now understands that it exists to ensure that care providers meet basic standards and to intervene when they do not.

"Putting in place systems to inspect hospitals and care homes proved too much for the CQC in previous years. Inspections were superficial and produced reports which bore little relation to reality, but the CQC now has a coherent plan to make sure providers are properly examined.

"Giving inspection teams the time and tools to understand what is really happening in hospitals, GP surgeries and care homes is fundamental. The CQC is now doing this by recruiting specialist inspectors who can understand and interpret what they observe during inspections."

The Health Committee’s inquiry also examined the CQC’s decision to introduce risk based regulation alongside a rating system which will issue providers with overall ratings ranging from ‘inadequate’ to ‘outstanding’. Stephen Dorrell MP said:

"Differentiated regulation is the right approach and will allow the CQC to target providers where failures would pose the greatest threat to patient care, without placing an excessive burden on routine services."

Mr Dorrell cautioned, however:

"There are some providers where services are inherently high risk and where regular inspection is a vital component in maintaining the highest possible standard of care.

"Achieving an ‘outstanding’ rating should never mean that high risk services are allowed to operate without oversight. Providers must not regard being awarded a positive rating from the CQC as a mechanism for escaping scrutiny."

The CQC is also introducing an new surveillance system which includes a large range of indicators related to quality of care. The CQC refer to the indicators as ‘smoke detectors’. When they suggest a provider is outside the expected range of performance then further examination and inspection will be triggered.

Stephen Dorrell said:

"Underpinning the new inspection regime with a detailed surveillance system is a necessary way of monitoring providers. It is particularly welcome that the CQC will include data on staffing levels within the indicators and the Committee is keen that this should include key information such as the ratio of registered nurses to patients on hospital wards."

"For the surveillance system to be successful the CQC must demonstrate that it can pick up on problems before they become known to the general public. If surveillance is perceived as slow, or reactive, it will not enjoy public confidence and credibility."

The Committee expressed concern regarding the CQC’s new responsibility to oversee the financial performance of adult social care providers. Mr Dorrell said:

"The CQC regulates care quality and not financial performance. We recommend that the Government should reconsider the proposal that the CQC should widen its remit in this way."

Finally Mr Dorrell added:
"The Department of Health has asked the CQC to oversee the introduction of the fit and proper persons test for the Directors of care providers, but perversely the test will not be applied to the Chairs of NHS Trusts or Foundation Trusts. We do not believe this exclusion will be understood by patients or the public."

Source: www.parliament.uk 22 January 2014

NICE support for local authorities on improving access to health and social care services
Support for local authorities to improve access to health and social care services for people who don't routinely use them is the focus of a new local government briefing published by the National Institute for Health and Clinical Excellence (NICE).

The new briefing on improving service access covers a range of areas important in ensuring that services meet the sometimes complex needs of people in their local area. There are many reasons why some people might not use health and social care services. These can include services having opening times or being in locations that aren't convenient, and people living in an isolated area, being an asylum seeker, not having English as a first language, and being a carer.

The cost of treating illness and disease arising from health inequalities has been estimated at £5.5 billion per year in England. In the working-age population, it leads to productivity losses of between £31 to £333 billion each year. Making it easier for people to use health and social care services can help to address issues before they become more serious and require more resources in the future. Local authorities have a unique insight into the demographics and needs of their local populations which gives them an advantage in planning for local people. The briefing draws on a wide range of existing NICE guidance to highlight ways in which local authorities can tailor what they and partner organisations offer - all based on the effective actions which also provide the best value for money.

Examples of effective recommendations highlighted in the new briefing include:
- considering the population characteristics of people who are not routinely accessing services and assess local need
- planning and delivering accessible local services
- partnership working and involving local communities
- targeting interventions for those with complex need.

NICE Local Government Public Health Briefings are available at http://www.nice.org.uk/localgovernment/

Source: www.nice.org.uk 22 January 2014

NHS waiting times for elective care in England
The National Audit Office (NAO) has highlighted the increasing challenge to the NHS of sustaining the 18-week waiting time standard for elective care and the importance for trusts of having reliable performance information and shared good practice.

The report to Parliament entitled, 'NHS waiting times for elective care in England' concludes that value for money is being undermined by the problems with the completeness, consistency and accuracy of patient waiting time data; and by inconsistencies in the way that patient referrals to hospitals are managed.
The introduction of the standards in 2008 was followed by more patients being treated within 18 weeks. The recent strengthening of the standards also appears to have had a rapid and significant effect on reducing the numbers of people waiting a long time for treatment. The number of people each month waiting longer than 18 weeks without treatment fell to 138,000 by the end of October 2012 (from 234,000 in October 2011) but by the end of October 2013 had increased to 169,000.

With few exceptions, the waiting time standards have been met nationally, although some trusts are breaching the standards. In 2012/13, for example, 58 trusts breached the standard, overall, in at least one month for patients admitted to hospital.

The report does suggest that published waiting time figures need to be treated with a degree of caution. The NAO has identified inconsistencies in the way trusts measure waiting time and errors in the waiting time recorded. Although the rules for applying the waiting times standards are set at a national level, the performances of individual trusts are not directly comparable owing to local variations in how and when each patient’s waiting time ‘clock’ is started, paused or stopped. The NAO’s review of a sample of cases also found that errors in trusts’ recording of patients’ time: in 167 cases, there was evidence of at least one error, leading to under- and over-recording of waiting time.

Mis-recording of referral to treatment waiting times data has also been identified at the North West London Hospitals NHS Trust and Barnet & Chase Farm Hospitals NHS Trust. In addition, Colchester Hospital University NHS Foundation Trust has misrecorded their cancer waiting times. The report also finds that NHS England does not have sufficient assurance about how trusts are performing. The system of checks that NHS England uses should spot some errors and inconsistencies, as well as discrepancies between trusts’ current and past reported performance. It will not, however, detect errors of the kind identified by the National Audit Office without independent validation of trusts’ data. The report recommends, therefore, that NHS England should seek additional assurance, possibly through a regime of test checking.

The NAO also spoke to patients who were unaware of their rights and responsibilities, for example, their right to be treated within 18 weeks of referral, or that they may be referred back to their GP and their waiting time starts again if they fail to attend an appointment. The NAO estimates that patients missing first outpatient appointments cost the NHS up to £225 million in 2012/13. The report recommends, therefore, that trusts should ensure their access policies are up-to-date, patient friendly and publicly available.

Source: www.nao.org.uk 23 January 2014

130,000 people diagnosed at 65 or over survive cancer for at least a decade

With the right treatment, over 65s can survive for many years after cancer – yet UK survival rates in older people are among worst in Europe. More than 130,000 people in the UK have survived for at least 10 years after being diagnosed with cancer at 65 or over, according to new research by Macmillan Cancer Support and the National Cancer Intelligence Network (NCIN).

This figure shows that, with the right care and treatment, over-65s in the UK can live for many years after cancer. However, if UK survival rates in this age group were not so poor this number would be even higher. Macmillan believes too many older patients in the UK are being assessed on their age alone and not their overall fitness.
The research, which is the first of its kind, also reveals that there are more than 8,000 people alive today who have survived for at least 10 years after being diagnosed at 80 or over.

There are almost twice as many long term (10 to 20 years) female survivors who were diagnosed at 80 or over as there are male (5,481 compared with 2,995).

A recent international study showed that for many common cancers (such as prostate, female breast, lung, stomach, ovary, kidney, non-Hodgkin lymphoma) the UK and Ireland have a lower five-year survival rate than the rest of Europe, and the gap is generally greatest for patients over 75. For example, the survival rate for lung cancer in the UK and Ireland is nine per cent worse than the European average for adults aged under 45, but 44 per cent worse for those aged 75 or over.

Macmillan Cancer Support is calling on all health providers in England to:

- adopt assessment methods that test a patient’s overall physical and mental wellbeing to ensure treatment decisions aren’t based on age alone
- give health professionals the time and resources to complete specialist training in elderly care to ensure services are accessible and provide the best quality care irrespective of age
- establish links with the voluntary sector, social services and teams specialising in dementia, falls and continence and address any medical, social, emotional or financial issues that may be preventing an older patient taking up treatment or that are impacting on their quality of life either during or after treatment.

Source: www.macmillan.org.uk 24 January 2014

Attendance rates at major A&E departments highest in London

New figures for 2012/13 show attendance rates per 1,000 population at major (Type 1) A&E departments were highest in the London region and lowest in the South Central region. This follows on from the ‘Focus on A&E’ report published by the Health and Social Care Information Centre (HSCIC) in December 2013, which gave a national picture of the patient journey through A&E. The new report shows further information as well as regional figures.

The regions with the highest rates of major unit A&E attendance per 1,000 of the population were London Strategic Health Authority (SHA) with 312 A&E attendances per 1,000 (2.6 million attendances overall) and North West SHA with 307 per 1,000 (2.2 million attendances). The lowest rates of attendance at major A&E departments were in South Central SHA (189 per 1,000 of the population or 790,200 attendances) and South West SHA (210 per 1,000 of the population or 1.1 million attendances).

The report also shows that GP referrals accounted for 5.8 per cent of attendances at major A&E departments overall (825,400). Regionally the highest percentage of GP referrals was for patients resident in the South West SHA (8.4 per cent or 94,000), while the lowest was for patients resident in the North West SHA (4.4 per cent or 96,400).

Finalised national information also shows shows that for A&E departments nationally in 2012/13:

- there were 18.3 million attendances at A&E departments recorded in Hospital Episode Statistics (HES) data between April 2012 and March 2013, a 4 per cent increase on attendances in 2011/12 (17.6 million)
- major A&E departments dealt with 14.3 million attendances, a rise of 340,500 attendances (2.4 per cent) on 14 million attendances in 2011/12
• almost three out of ten attendees at major departments arrived by ambulance (29.7 per cent). Elderly patients were much more likely to arrive by ambulance; this equated to six out of ten 65 and over year olds (63.1 per cent or 1.9 million) and eight out of ten 85 and over year olds (82.0 per cent or 664,900).

Source: www.hscic.gov.uk 28 January 2014

Rise in the use of the Mental Health Act, regulator finds
The number of people detained or treated under the Mental Health Act (MHA) has risen by 12 per cent in the last five years, the Care Quality Commission (CQC) says in its fourth annual Mental Health Act Report.

The Act was used 50,000 times to detain or treat people under compulsion in 2013, the report says, and there were 45,000 uses of the Act in 2008/09.

Examples of outstanding care were also found over the year, with inspectors seeing people with mental health problems benefiting from high quality and safe psychiatric care that respects their dignity.

However, access to crisis care remains inadequate and health-based places of safety for people experiencing a mental health crisis are often not staffed at all times, the report finds.

Some health-based places of safety have been found to be empty while patients are taken to police custody, and this contradicts the fundamental principles of the Act that urge the least restrictive care.

People with mental health problems in a crisis should have an emergency service that equals in speed and quality to that provided to people with a physical health emergency.

The MHA report does not include findings from inspections carried out under the Health and Social Care Act, although these two inspection programmes are merging.

Other findings in the MHA report include:

• one or more blanket rule was in place in more than three quarters of the wards the CQC visited – this is unacceptable. These rules most commonly apply to internet or mobile phone use, smoking, access to outdoor space or communal rooms, withholding post or phone calls
• some patients’ physical health needs were not met, of 550 records examined, the CQC found 14 per cent were on a ward with no access to a GP service
• staffing levels were linked to the quality of care in some places, with inadequate staffing preventing patients from taking leave and also exacerbating problem behaviour
• examples of patients in seclusion with inadequate regard for their privacy and dignity
• more than a quarter of care plans showed no evidence in patients being involved in creating them
• around a third of care plans do not show evidence of discharge planning – this means detention periods could be inappropriately long.

CQC inspections on the use of the MHA use teams of specialists as well as ‘experts by experience’, who are people who have experience of using mental health services.

Source: www.cqc.org.uk 28 January 2014
Report shows hospital trusts with persistently high or low death ratios
Eighteen NHS trusts in England have been categorised as having a 'lower than expected' or a 'higher than expected' mortality ratio over two years, according to analysis from Health and Social Care Information Centre (HSCIC).

Between July 2011 and June 2013, 12 trusts were categorised as having a 'lower than expected' ratio, based on Summary Hospital-level Mortality Indicator (SHMI) data and six as having a 'higher than expected' ratio.

This analysis features in an experimental report entitled, 'Summary Hospital-level Mortality Indicator (SHMI) - Deaths associated with hospitalisation, England, July 2011 - June 2013, Experimental Statistics, Supplementary Outlier Report'.

The SHMI compares the actual number of patients to die following hospitalisation at a particular trust with the number that would be expected to die, based upon average England figures, given the characteristics of the patients treated there. It considers deaths taking place during a stay at a trust and also within 30 days of discharge.

SHMI values for individual trusts are categorised 'as expected', 'lower than expected' or 'higher than expected'. The SHMI requires careful interpretation and needs to be viewed alongside other evidence, rather than as a stand-alone verdict on a hospital trust's performance.

The trusts categorised as lower or higher than expected in both the January 2013 publication covering (July 2011 - June 2012) and the January 2014 publication (covering July 2012 - June 2013) are:

'Higher than expected':
- Mid Cheshire Hospitals NHS Foundation Trust
- Colchester Hospital University NHS Foundation Trust
- Aintree University Hospital NHS Foundation Trust
- Wye Valley NHS Trust
- Blackpool Teaching Hospitals NHS Foundation Trust
- East Lancashire Hospitals NHS Trust.

'Lower than expected':
- Barts Health NHS Trust
- Royal Free London NHS Foundation Trust
- North Middlesex University Hospital NHS Trust
- Cambridge University Hospitals NHS Foundation Trust
- Guy's & St Thomas' NHS Foundation Trust
- St George's Healthcare NHS Trust
- The Whittington Hospital NHS Trust
- Chelsea & Westminster Hospital NHS Foundation Trust
- University College London Hospitals NHS Foundation Trust
- North West London Hospitals NHS Trust
- Barnet & Chase Farm Hospitals NHS Trust
- Imperial College Healthcare NHS Trust.

The report also provides additional, contextual, information on palliative care, method of admissions and deprivation:

Source: [www.hscic.org.uk](http://www.hscic.org.uk) 29 January 2014
One in three breast cancers are in women over 70

One in three women diagnosed with breast cancer in England each year are aged 70 or over. This age group also accounts for more than half of all breast cancer deaths annually, latest figures show.

This comes as Public Health England (PHE) launched a new national Be Clear on Cancer campaign to remind older women ‘don’t assume you’re past it’, and to visit their doctor if they spot any changes in their breasts.

Two thirds of women aged 70 and over (67 per cent) wrongly think women of all ages are equally likely to get breast cancer, when in fact a woman’s risk of breast cancer increases with age.

Around 13,500 women aged 70 and over are diagnosed with breast cancer in England each year, yet survival rates are lower in this age group compared to younger women. Lack of awareness of symptoms other than a lump, such as changes in the shape or size of the breast, is believed to be one of the reasons for this, which the campaign aims to change.

The earlier breast cancer is diagnosed, the higher the chance of survival – more than 90 per cent of all women diagnosed with the earliest stage survive for at least five years. This figure is around 15 per cent for women diagnosed at a late stage.

Source: [www.gov.uk](http://www.gov.uk) 3 February 2014

Chief Inspector of Hospitals publishes his findings on Princess Royal University Hospital, Orpington

England’s Chief Inspector of Hospitals, Professor Sir Mike Richards, has published his first report on the quality of care provided at Princess Royal University Hospital, Orpington, Kent. Princess Royal University Hospital was recently taken over by King’s College Hospital NHS Foundation Trust following the dissolution of South London Healthcare NHS Trust in October 2013.

Overall, the report concludes the scale, number and longstanding nature of many of the problems that King’s College Hospital NHS Foundation Trust inherited at the Princess Royal University Hospital should not be underestimated, but that while the Trust has already begun to tackle some of the challenges that it faces there is still more to do.

Significant failings were identified in a number of areas, especially management of patient records. The lack of availability of medical records in the outpatients department meant that at times patients were undergoing complex medical procedures without clinicians having access to a complete set of notes.

Waiting times in the Accident and Emergency (A&E) department were far too long, and poor patient flow led to patients having elective surgery cancelled and difficulty in transferring patients from the critical care unit.

The hospital was one of the first to be inspected under radical changes introduced by the Care Quality Commission (CQC) which are designed to provide a much more detailed picture of care in hospitals than ever before.

The CQC has told the Trust that it must take action to improve at Princess Royal University Hospital in a number of areas including:

- urgently addressing long waiting times in the A&E department
- urgently addressing problems with access to and availability of medical records
- engaging with and supporting all senior medical staff
- embedding ownership for improvement at every level in the hospital
- addressing discharge planning and patient flow problems
- ensuring all action is taken to minimise the risk of elective surgery being cancelled, and improving capacity
- ensuring that documentation, including fluid balance charts, are accurately completed
- regularly reviewing decisions related to patients’ resuscitation status and accurately recording and sharing these with staff
- developing and embedding systems for monitoring performance, quality and safety of care at all levels in the hospital
- ensuring staff adhere to infection control policies and procedures
- CQC found good practice in the Critical Care Unit (CCU), where patient diaries were being used.

An inspection team which included doctors, nurses, hospital managers, trained members of the public, CQC inspectors and analysts spent two days announced at the hospital during December 2013. They examined the care provided in A&E, medical care (including older people’s care), surgery, intensive/critical care, maternity, children’s care, end of life care and outpatients.

Inspectors also visited the hospital unannounced as part of the inspection, held focus groups with staff, and held a public listening event. The report is based on a combination of their findings, information from CQC’s Intelligent Monitoring system, and information provided by patients, the public and other organisations.

The Care Quality Commission has already presented its findings to a local Quality Summit, including NHS commissioners, providers, regulators and other public bodies. The purpose of the Quality Summit is to develop a plan of action and recommendations based on the inspection team’s findings.

CQC inspectors will return to Princess Royal University Hospital in due course to follow up on the findings of this inspection and to report on the trust’s progress in making required improvements.

Source: [www.cqc.org.uk](http://www.cqc.org.uk) 6 February 2014

**Hospital leaders reveal impact of the Francis Report one year on**

Financial pressures and a complex regulatory environment are making it difficult for hospitals to create the kind of patient-centred culture recommended by Robert Francis QC, according to new research by health think tank the Nuffield Trust. But senior NHS staff interviewed for the research said that the 2013 Francis Report had added impetus to their efforts to put quality of care as their top priority.

The research, published on the day of the first anniversary of the report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, is the first look at how hospitals have responded to the findings and recommendations contained in Robert Francis QC’s Report.

It draws on in-depth interviews with around 50 staff at five acute hospital trusts and an online survey of chairs and chief executives at more than a third (53) of acute and foundation trusts in England. Together these provide a snapshot of the impact of the Francis Report.

Robert Francis QC, who acted as an advisor to the research, has written a foreword to the study.
The research found that many of the themes from the Francis Report, including the importance of openness, adequate staffing levels and patient-centred culture, have resonated with leaders of the hospitals responding to the survey and interviews.

Four in five (82 per cent) of the hospitals responding to the online survey said they were taking new action in response to the report, and an even greater proportion (93 per cent) said they already had work underway on many of the relevant recommendations when the report was published.

In the interviews, senior NHS staff said that the 2013 Francis Report has added impetus to their efforts to put quality of care as their top priority, despite the straitened financial conditions facing the NHS, with one leader stating that, "I'd rather be hung for money than for quality and safety."

However, hospital leaders described how meeting financial goals and ensuring safe staffing levels in hospitals was very difficult and will only get harder in the future. As one hospital chair said:

"The one good thing Francis has done, the really good thing, is that it has ensured that safety and quality have become more prominent – that's really important. But I am left with a real concern about the do-ability of it all and the need for us to find a way forward."

The research also found that some hospital boards were finding it hard to meet increased demands for assurance and scrutiny from external regulators and commissioners that have arisen since the Francis Report.

Leaders often described a burdensome regulatory approach that seemed to be at odds with, and could distract from, their efforts to develop an open quality-focused culture in their own organisations. One leader told the Nuffield Trust that: "I've never, in my whole career, felt more regulated."

The study notes that while hospitals are being encouraged to use ‘cultural barometers’ to assess the health of their own organisations, there is no similar mechanism in place to assess the behaviour and functioning of the wider NHS system.

Source: www.nuffieldtrust.org.uk 6 February 2014

The NHS is not meeting the "Nicholson Challenge" says Health Committee

The health and care system needs fundamental change if it is to meet the needs of patients, according to a senior committee of MPs.

Launching a report entitled 'Public expenditure on health and social care', Health Committee Chair Stephen Dorrell MP said:

"The Nicholson Challenge requires the health and care system to deliver fundamental change so that services are joined up and focussed on the needs of patients. What we have heard during our inquiry indicates that while many of the straightforward savings have been made, we have not seen the transformation of care on the scale which is needed to meet demand and improve care quality.

"The NHS budget is static, and the social care budget is falling. In these circumstances, the successful integration of high quality health and care services represents a substantial and growing challenge.

"The situation is not helped by the current fragmented commissioning structures. The Committee’s view is that, as Health and Wellbeing Boards have been established to allow
commissioners to look across a whole local health and care economy, their role should be developed to allow them to become effective commissioners of joined-up health and care services.

"We also recommend, as we did a year ago, that the current level of real terms funding for social care should be ring-fenced. Alongside the Government's commitment to maintain health spending at current levels in real terms, this would give certainty about budgets for a whole health and care economy and provide a firm financial basis for Health and Wellbeing Boards to plan and implement transformative service change.

"Without stronger commissioners and ring-fenced health and care funding, we believe there is a serious risk to both the quality and availability of care services to vulnerable people in the years ahead."

Among other issues that the Committee considers in the report are:

- the Committee is concerned that in the case of the proposed merger the Royal Bournemouth & Christchurch Hospitals and Poole Foundation Trusts the competition authorities intervened to obstruct a proposed service reconfiguration on competition grounds without being able to substitute another proposal to deliver service change. It recommends that recommends that the Government should examine the background to the Bournemouth and Poole proposal in order to ensure that unnecessary impediments to necessary change are removed
- the Committee welcomes the Government’s recognition that the future of the health and care system cannot be built on an open-ended pay freeze: "If the health and care system is to be a good employer (which it needs to be if it is to deliver high quality care) it needs to undertake transformative change in order to ensure that its committed staff are better able to meet the needs of users of its services"
- the Committee notes that 48 per cent of trusts are forecasting a deficit in the current financial year, and that at the beginning of the financial year 19 foundation trusts were in breach of their terms of authorisation. It comments that in successive reports during this Parliament "We have drawn attention to the urgency of transformative change of the care model if the needs of patients are to be met. The fact that the number of NHS trusts and NHS foundation trusts reporting underlying deficits continues to grow represents evidence that the pace of change has not been sufficient to meet the challenge."

Source: [www.parliament.uk](http://www.parliament.uk) 12 February 2014

**Change needed to realise the potential of community services, says new report by The King’s Fund**

Radical changes to community services are needed to realise the ambition of moving care out of hospital and closer to people’s homes, says a new report published by the King’s Fund.

The report, which is based on the findings of a working group of community trusts convened by the Fund, argues that previous policy has failed to achieve this longstanding ambition. To address this, it sets out a seven step plan for change, based on community services working much more closely with groups of general practices and building multidisciplinary teams to care for people with complex needs. This would reduce hospital admission rates, releasing resources for patients to be cared for at home and stemming growing demand for hospital beds.
The report argues that the scale for community services is poorly understood and not well served by the way the debate on health services is often dominated by 'GPs and hospitals' and 'primary or secondary care'. However, it found a growing consensus about the important role of community services and the changes needed. The seven interrelated steps identified by the working group are:

- reduce unnecessary complexity of community services
- forge much closer relationships with groups of general practices
- building multidisciplinary teams for people with complex needs, including social care, mental health and other services
- support these teams with specialist medical input - particularly for older people and those with chronic conditions
- create services that offer an alternative to hospital stay
- build the information structure, workforce, and ways of working and commissioning that are required to support this
- reach out to the wider community to improve prevention, provide support for isolated people, and create healthier communities.

Source: [www.kingsfund.org.uk](http://www.kingsfund.org.uk) 13 February 2014

**Sir Stuart Rose to advise on NHS leadership**

Sir Stuart Rose, who turned around the fortunes of Marks & Spencer, will advise the NHS on how it can attract and retain the very best leaders to help transform the culture in under-performing hospitals, Health Secretary Jeremy Hunt has announced.

It will run alongside a separate review into how the NHS can make better use of its best existing leaders, so-called "superheads", who could spread the highest standards for patients across the system by taking on struggling organisations or establishing national networks of NHS hospitals and services.

Sir Stuart will advise the Health Secretary on how the NHS can build on existing work to recruit top talent from within and outside the NHS.

Drawing on his experience as a former Marks & Spencer chairman, he will also advise on how NHS trusts can improve organisational culture, through leaders being more visible and in touch with frontline patients, services and staff.

In a separate review, Salford Royal NHS Foundation Trust Chief Executive, Sir David Dalton, will look at how to end the isolation of failing hospitals from the best NHS management and practice – a key finding in the wake of the Mid-Staффs Inquiry.

Sir David will investigate how to enable the best-performing NHS organisations and most successful chief executives to establish national groups of hospitals or services as beacons of excellence. This could include non-geographical networks of hospitals under one leadership team where one NHS trust has hospitals around the country.

Sir Stuart will particularly look at the problems faced by the 14 trusts currently in “special measures”, the programme to turn around failing hospitals.

Through a series of hospital visits, Sir Stuart will mentor NHS leaders and examine the challenges facing doctors, nurses and management boards. He will provide advice in an unpaid capacity until the end 2014 when he will submit a short report to the Department of Health.
More than 1,300 people from outside the NHS have already applied for 50 places on the NHS fast-track leadership programme that involves study at Harvard, starting in June 2014. This 10-month programme by the NHS Leadership Academy will include executive education by Harvard Kennedy School, an industry placement, and six months delivering a transformational change programme in a top NHS trust under a chief executive mentor.

Sir David Dalton will look at:

- the extension of the buddyng and mentoring schemes in the special measures hospitals programme
- management contracts so that outstanding leadership teams can take on a more formal relationship
- improving incentives for the best NHS hospital trusts to take on turnaround projects and extended management responsibilities
- a new framework for NHS providers who are appropriately credentialed certified as the go-to people for turnaround projects and extended management responsibilities
- the arrangements which could enable local and non-geographical networks of hospitals or services under one leadership team.

Source: [www.gov.uk](http://www.gov.uk) 14 February 2014

‘Special measures’ successfully turning troubled hospitals around

A report published by Monitor and the NHS Trust Development Authority (NHS TDA) finds that significant progress has been made turning around some of England’s most challenged hospitals.

Special measures – a package of regulatory tools designed to provide intensive support to challenged trusts – was put in place in July 2013 after the Keogh Review into hospitals with higher than average mortality rates identified failings in the quality of care at 11 NHS trusts and foundation trusts. Since July 2013, a further three trusts have been placed into special measures.

Each trust in special measures is required to produce an action plan which is published on the NHS Choices website and frequently updated. Of the 244 special measures actions across all the trusts, 82 (34 per cent) have been delivered and a further 127 (52 per cent) are on track for completion within the expected timescale. Monitor and the NHS TDA are holding trusts to account where actions have been delayed.

At a number of trusts, the Keogh Review raised concerns around staff levels. In the first three months of the special measures programme alone, trusts appointed nearly 650 more nurses and nurse support staff and over 130 additional doctors.

Detailed summaries of progress at each trust in special measures can be found at [http://www.nhs.uk/nhsengland/specialmeasures/pages/about-special-measures.aspx](http://www.nhs.uk/nhsengland/specialmeasures/pages/about-special-measures.aspx)

The 14 Trusts in special measures are:

- North Cumbria University Hospitals NHS Trust
- United Lincolnshire Hospitals NHS Trust
- East Lancashire Hospitals NHS Trust
- George Eliot Hospital NHS Trust
- Buckinghamshire Healthcare NHS Trust
- Tameside Hospitals NHS Foundation Trust
Basildon & Thurrock University Hospitals NHS Foundation Trust
Burton Hospitals NHS Foundation Trust
Medway NHS Foundation Trust
Northern Lincolnshire & Goole Hospitals NHS Foundation Trust
Sherwood Forest Hospitals NHS Foundation Trust
Colchester NHS Foundation Trust
King’s Lynn NHS Foundation Trust
Barking, Havering & Redbridge University Hospitals NHS Trust.

Source: www.monitor-nhsft.gov.uk 14 February 2014

Securing a health service fit for the future

Eleven financially challenged health economies in England are to receive expert help with strategic planning in order to secure sustainable quality services for their local patients.

Monitor, NHS England and the NHS Trust Development Authority (NHS TDA) have agreed to fund a series of projects to help groups of commissioners and providers work together to develop integrated five-year plans that effectively address the particular local challenges they face.

As part of the annual planning round, all NHS organisations are being urged to plan over a five-year period in future as part of a concerted effort to tackle the long term financial and operational challenges facing the system.

The 11 areas have been chosen on the basis that they will most benefit from external support in the first few weeks of the new financial year, and potential suppliers are now being invited to tender for the work.

Responsibility for delivering strategic plans remains with the individual commissioners and providers. The appointed supplier will act as a critical friend, seeking to bring together all partners in the health economy and testing whether the organisations are undertaking their long term strategic planning in the most effective way.

Suppliers will be appointed at the end of March 2014 and will begin a programme of work lasting around 10 weeks across four workstreams:

- a diagnosis of supply and demand
- solutions development and options analysis
- plan development
- implementation.

The 11 health economies are:

- South West London
- North East London
- Cumbria
- Eastern Cheshire
- Staffordshire
- Mid Essex
- Cambridge & Peterborough
- Leicestershire
- Northamptonshire
- East Sussex
Better care for mental health crisis

Emergency support for people in mental health crisis is set to see dramatic improvements across the country as part of a far-reaching new agreement between police, mental health trusts and paramedics.

The agreement – called the Crisis Care Concordat – has been signed by more than 20 national organisations in a bid to drive up standards of care for people experiencing crisis such as suicidal thoughts or significant anxiety.

The Concordat, announced by the Care and Support Minister Norman Lamb, will help cut the numbers of people detained inappropriately in police cells and drive out the variation in standards across the country.

The Concordat, which has already been signed by 22 organisations including NHS England, the Association of Chief Police Officers and the Royal College of Psychiatrists, sets out the standards of care people should expect if they suffer a mental health crisis and details how the emergency services should respond.

It challenges local services to make sure beds are always available for people who need them urgently and also that police custody should never be used just because mental health services are not available. It also stipulates that police vehicles should not be used to transfer patients between hospitals and encourages services to get better at sharing essential need-to-know information about patients which could help keep them and the public safe.

Local areas will now sign their own regional and local agreements to commit to working together across services to improve care and potentially save lives.

The Crisis Care Concordat challenges local areas to make sure that:

- health-based places of safety and beds are available 24/7 in case someone experiences a mental health crisis
- police custody should not be used because mental health services are not available and police vehicles should also not be used to transfer patients. The Department of Health wants to see the number of occasions police cells are used as a place of safety for people in mental health crisis halved compared 2011/12
- timescales are put in place so police responding to mental health crisis know how long they have to wait for a response from health and social care workers. This will make sure patients get suitable care as soon as possible
- people in crisis should expect that services will share essential ‘need to know’ information about them so they can receive the best care possible. This may include any history of physical violence, self-harm or drink or drug history
- figures suggest some black and minority ethnic groups are detained more frequently under the Mental Health Act. Where this is the case, it must be addressed by local services working with local communities so that the standards set out in the Concordat are met
- a 24-hour helpline should be available for people with mental health problems and the crisis resolution team should be accessible 24 hours a day, seven days a week.

Source: www.gov.uk 18 February 2014
NHS England acts in response to concerns about information sharing

NHS England has announced that the start of a new NHS data sharing scheme in England, known as care.data and involving medical records is being delayed by six months.

According to NHS England, the care.data programme will benefit patients by

- ensuring the highest standards of care and clinical safety are consistently met throughout the NHS and alert NHS England to where standards drop, allowing it to take prompt action
- helping NHS England understand what happens to people, especially those with long term conditions, who are cared for away from hospital, and to ensure their needs are met
- providing NHS England with the vital information needed to assist and support research into new medicines, and the better treatment of disease.

To ensure that the concerns of the British Medical Association (BMA), the Royal College of General Practitioners (RCGP), Healthwatch and other groups are met, NHS England will:

- begin collecting data from GP surgeries in the Autumn of 2014, instead of April, to allow more time to build understanding of the benefits of using the information, what safeguards are in place, and how people can opt out if they choose to
- work with patients and professional groups – including the BMA, RCGP and Healthwatch – to develop additional practical steps to promote awareness with patients and the public, and ensure information is accessible and reaches all sections of the community, including people with disabilities
- look into further measures that could be taken to build public confidence, in particular steps relating to scrutiny of ways in which the information will be used to benefit NHS patients
- in the meantime, NHS England will work with a small number of GP practices to test the quality of the data. This will be voluntary.

Source: www.england.nhs.uk 19 February 2014

Anxiety: hospital admissions highest in women in their late 60s

Hospital admissions for anxiety increased with age and were highest among older women, new figures from the Health and Social Care Information Centre (HSCIC) show.

In the 12 months to November 2013 almost three out of ten anxiety admissions were women aged 60 and over (2,440 out of 8,720, or 28 per cent), with 65 to 69 the most common age group of female patient admissions (437, or eight per cent of all female admissions).

The most common age group for male patient admissions was 45 to 49 (279, or 8.5 per cent of all male admissions).

The report also looks at hospital admissions for stress which were highest in girls aged 15 to 19 years (295) and men aged 40 to 44 years (343) and three quarters of patients were under 50 years old (74 per cent or 3,580 out of 4,840).

The pattern of admissions for anxiety or stress by age and gender was similar to the previous 12 months. However, total admissions fell by over two per cent for anxiety (from 8,930 to 8,720) and almost 14 per cent for stress (from 5,610 to 4,840).

The overall trend in admissions by age showed that anxiety admissions increased with age and stress admissions amongst adults aged 45 years and above decreased with age.
The report focuses on a special topic which is part of a wider monthly publication of all NHS-commissioned provisional inpatient, outpatient and A&E activity in England. For all hospital admissions for anxiety or stress between December 2012 and November 2013:

- women accounted for three in five anxiety admissions (62 per cent or 5,440) whereas more than half of stress admissions were men (55 per cent or 2,660) and this was similar to the previous 12 months (63 per cent and 55 per cent respectively)
- almost nine out of ten anxiety cases (89 per cent or 7,750) and eight out of ten stress cases (78 per cent or 3,760) were emergency admissions
- one in five anxiety cases were diagnosed with high blood pressure (19 per cent or 1,660) and one in four stress admissions had a personal history of self-harm (25 per cent or 1,230)
- Merseyside Area Team had the highest rate of admissions for anxiety and stress (29.7 and 18.4 per 100,000 of the population) and Thames Valley Area Team had the lowest rate of admissions for both conditions (7.2 and 2.0 per 100,000 respectively).

Source: www.hscic.gov.uk 19 February 2014

'Family care networks' – the future of primary care

In future, ‘family care networks’ with GP surgeries at their heart should provide a wider range of services for patients outside hospitals, says a report on the future of primary care, published by The King’s Fund.

These networks would enable GPs to strengthen their role as providers and co-ordinators of care in collaboration with other staff working in the community and some hospital-based specialties.

NHS experts have long called for a shift in the way care is provided, with more services delivered closer to people’s homes, in order to meet the needs of an ageing population and the increasing numbers of people living with multiple long term conditions. The report argues that most GP practices are too small to do this on their own and need to work together in federations or networks to achieve the necessary scale.

The report includes case studies from four localities where practices are working in this way. These practices are providing additional services beyond those required under their core contract making use of the flexibilities that do exist, but are generally not taken advantage of by many other GP practices. This innovation is often dependent on local leaders taking the initiative to build on the core requirements of existing contracts. However, more radical options are needed if practices are to adapt to changing patient needs and provide integrated services in the community alongside other providers.

The report entitled, 'Commissioning and funding general practice: making the case for family care networks' proposes a new GP contract, to sit alongside existing arrangements, which would:

- fund a defined population (the registered list) which would be determined by a combination of population need and the range of responsibilities included in it - bringing together funding for general practice with funding for other services
- require practices to link up with others to work at scale and benefit from pooled expertise and resources
- be focused on the outcomes that providers would be expected to deliver under the contract not on how they deliver them, offering providers greater freedom to innovate and collaborate
facilitate a shift to proactively managing the health of their local population and responding quickly to patients in crisis.

This would encourage family care networks to provide a wider range of services than most general practices are currently delivering and to work with community nurses, health visitors, pharmacists and social workers to deliver all but the most specialised and complex care outside hospital. This should include out-of-hours care and ensuring that services are available 24/7 to meet urgent care needs.

The report highlights some further considerations:

- there would need to be effective governance measures in place to deal with any conflict of interests
- clinical and financial risk management would require networks to cover populations in the range of 25,000-100,000
- networks would need a range of capabilities to manage the contract successfully and well-developed clinical leadership
- providers would need to develop sophisticated means for contracting and incentivising within their networks.

The report concludes that sufficient time is required for the new contract to be implemented and evaluated so that there is time for modification and adaptation. It suggests that at least five years will be needed to assess whether the expected benefits are being delivered.

Source: www.kingsfund.org.uk 19 February 2014

Foundation trusts holding up under pressure

NHS foundation trusts are performing well in providing quality services to patients in challenging economic times, according to Monitor.

The health sector regulator’s latest quarterly report for October to December 2013 shows foundation trusts are coping with winter pressures, as fewer missed the four hour A&E waiting time target than at the same period last year (28 compared to 32).

Foundation trusts have also met performance standards for all three elective waiting time targets. However, more trusts breached the targets than both last quarter and the same period last year. There has also been an increase in the number of trusts breaching the target for cancer patients to start treatment within 62 days of referral by a GP.

Overall, the 147 foundation trusts (two-thirds of all NHS hospitals) are continuing to make a surplus (£135 million so far this year). However, this is less than was planned (£173 million) for this stage of the financial year.

The number of trusts in deficit (39) is also more than expected (24), and almost double the same period last year (21). The combined deficit of these trusts (£180 million) was higher than expected (£168 million) but 60 per cent is attributed to five organisations which are already subject to regulatory action by Monitor.

A further 17 trusts have very small deficits. Monitor’s analysis shows that the fall in value of the surpluses across all foundation trusts was more significant in eroding the sector’s overall financial performance than the growth in the size of the gross deficit.

The report also shows that foundation trusts have delivered efficiency savings of £867 million so far this year, although this is 18 per cent (£185 million) behind what they planned at this stage.
NHS death rates 'should be ignored'
A key measure of hospital death rates should be ignored, according to the expert leading the review into them.

Academic Prof Nick Black has been asked by the NHS to see whether they are an accurate indicator of poor care.

His review is not due to be published until December 2014, but he told the BBC the most established method of measuring mortality appeared to have no value.

But Dr Foster - the research group which has pioneered their use - rejected the criticism.

Prof Black's team are looking at two measures of mortality - the hospital standardised mortality ratio (HSMR), which compares the expected rate of death in a hospital with the actual rate of death, and the summary hospital-level mortality index (SHMI), which covers deaths after hospital treatment and up to 30 days after discharge.

Prof Black has already looked into HSMRs, but is now doing this in more detail as well as looking at SHMIs.

He told BBC Radio 4's File on 4 programme that based on what he already knew, HSMRs should be ignored.

He said they could not entirely take into account factors such as burden of illness and were skewed by other factors such as the availability of hospice care in the area - where there is less hospice care patients are more likely to be in hospital when they die.

"I don't think there's any value in the publication of HSMR and I'd go further, I think it's actually a distraction because it gives... a misleading idea of the quality of care of a hospital."

When asked what the public should make of media coverage of death rates, he added: "Personally, I would suggest that the public ignore them."

Prof Black was asked to look into mortality rates after the Keogh Review, published in July 2013, found failings in care at the 14 hospitals with the highest death rates.

Source: [www.bbc.co.uk/news](http://www.bbc.co.uk/news) 25 February 2014

Public Health England must find a clear direction
Public Health England (PHE) has not yet shown that it is able to be an effective champion of the nation's public health interests according to a senior committee of MPs.

Launching a report following the Health Committee’s first meeting with PHE, Committee Chair Stephen Dorrell MP said:

"In April 2013, PHE was created to put public health at the heart of policy making but we are concerned that PHE has not yet found its voice.

"Parliament created PHE as an independent voice within Government to champion the policies that will make the greatest difference to the nation’s health but the organization has not yet developed a clear set of priorities."

The Health Committee’s inquiry examined how PHE has set about establishing its policy priorities and programme of work.
Mr Dorrell said:
"Tackling alcohol misuse, smoking and the crisis of obesity are fundamental to improving the nation’s health, but PHE has yet to strike the right tone when addressing these issues. Its public comments have often been faltering and uncertain when they should have been clear and unequivocal."

The Committee’s inquiry examined the relationship between the Department of Health and PHE. Concern was expressed in evidence received by the Committee that PHE has yet to demonstrate that it is sufficiently independent of Government. Mr Dorrell said:

"Drawing a contrast between the Government’s commitment to create an independent voice for the Care Quality Commission (CQC), and qualified independence of PHE the Committee concluded: "We are concerned that there is insufficient separation between PHE and the Department of Health. The Committee believes that ……there is an urgent need for the relationship to be clarified and for PHE to demonstrate that it is genuinely able to ‘speak truth unto power.’"

"PHE should not look to the Department [of Health] or other parts of Government to prompt its research or, still less, to authorize its findings. PHE can only succeed if it is clear beyond doubt that its public statements and policy positions are not influenced by Government policy or political considerations."

The Committee noted, however, that the transition from the old public health arrangements and the creation of PHE was undertaken successfully. This included incorporating the functions of the Health Protection Agency into PHE. Mr Dorrell said:

"The Committee does not underestimate the challenge of transition and incorporating staff and functions from over 100 predecessor organisations.

"The successful transition meant that PHE was able to tackle last year’s measles outbreak and deliver the vaccination catch-up programme. We also recognise that PHE maintained continuity of the vital work undertaken by the Health Protection Agency and we found no evidence of any reduction in the quality or availability of services during this period."

Mr Dorrell warned, however, that further clarity is required to understand where responsibility lies in instances of local or national public health emergencies. Mr Dorrell said:

"Public Health England is central to health protection but the degree of authority they enjoy in dealing with health emergencies is unclear. The Government should put these important issues beyond doubt so that every organisation with a stake in health protection understands how emergencies will be responded to."

Source: [www.parliament.uk](http://www.parliament.uk) 26 February 2014

**NICE support for local government to encourage people to attend NHS Health Checks and make changes for better health**

Helping local authorities to encourage people to attend NHS Health Checks and support them in making changes needed to improve their health, is the focus of a new briefing from the National Institute for Health and Clinical Excellence (NICE).

The NHS Health Check is a national programme for people aged 40 - 74 years which assesses a person's risk of developing diabetes, heart disease, kidney disease and stroke. It then provides the person with tailored support to help prevent the condition, advising on lifestyle changes to reduce their risk. Nationally, there are over 15 million people in this age
group who should be offered an NHS Health Check once every five years, and local authorities are responsible for commissioning NHS Health Checks.

The new NICE Local Government Briefing sets out effective ways to help local authorities support those delivering risk assessment and advice on making lifestyle changes, to tackle serious long term conditions in their populations. With local authorities' remit for public health in communities, the new briefing highlights the importance of taking steps to address diabetes, cardiovascular disease and stroke to improve the health of local people, and also tackle health inequalities.

The briefing builds on related NICE guidance recommendations that can support NHS Health Checks through advice on identifying people at a high risk of developing serious conditions. Examples of effective recommendations highlighted in the new briefing include:

- promote NHS Health Checks and increase uptake: Use community engagement methods to identify networks of local people, champions and advocates who have the potential to promote health checks as part of an integrated health and wellbeing strategy
- help people reduce behavioural risk factors: Offering help and advice across a range of risk factors and lifestyle behaviours including smoking, alcohol, weight control, diet and physical activity, is effective. A wide-ranging programme of initiatives, covering all local authority departments, will help encourage and empower local communities to adopt more healthy lifestyles
- plan services: Services should be provided in a range of settings. The NHS Health Check programme is for people aged 40 to 74 years and so providing interventions in the workplace may increase uptake.

Source: www.nice.org.uk 26 February 2014

Baby-boomer drug and alcohol warning
There is a growing problem of drug and alcohol misuse among older people, as "baby-boomers" age, campaigners are warning.

A report from the charity DrugScope says more are drinking too much, and alcohol-related hospital admissions and deaths are rising.

Drug misuse was also an increasing problem in the age group, it said.

DrugScope said policy too often centred on young people and "age-appropriate" help was needed.

The oldest of the baby-boomer generation are now reaching old age, and the charity says their attitudes were formed when alcohol was becoming more widely available and socially acceptable.

In addition, they tend to have drunk more in middle age than previous generations, establishing worrying patterns for old age.

The European Monitoring Centre for Drugs and Drug Addiction has estimated that the number of people aged over 65 needing treatment for drug problems in Europe will double between 2001 and 2020.

The DrugScope report says about 1.4 million people aged over 65 exceed recommended drinking limits.
And between 2002 and 2010 alcohol-related hospital admissions for men aged 65 and over have risen by 136 per cent and for women by 132 per cent.

Office for National Statistics (ONS) figures show alcohol-related deaths among the over-75s are at their highest level since 1991, when records began.

Overall, the number of people in drug treatment is declining, as is the number of people starting treatment for heroin and crack cocaine.

But the number of people aged 40 and over in treatment is rising, as is the number of people in that age group who are "new starters".

Public Health England (PHE) has said this "ageing population", overwhelmingly made up of heroin users, is now becoming "one of the key features of drug treatment in England" and poses "a significant challenge for treatment services in the years ahead".

DrugScope said increased use of other illicit drugs, particularly cannabis, was also a growing problem among middle-aged and older age-groups.

The charity says services need to be specifically targeted for older people with drug and alcohol problems.

Source: www.bbc.co.uk/news 27 February 2014

**NHS to tackle long waits for dementia assessments**

The Department of Health has announced a £90 million package to improve dementia diagnosis and care and the appointment of a World Dementia Envoy to raise funds for research towards a cure. Leading British businesses have also signed up to the cause with over 190,000 staff at M&S, Argos, Homebase, Lloyds Bank and Lloyds Pharmacy to learn to support customers who have dementia.

Following the ambition set out as part of the Prime Minister’s Challenge on Dementia, NHS England will invest £90 million in diagnosing two thirds of people with dementia by March 2015. As part of this, NHS England will work with local areas where the Department knows that in some it takes up to 25 weeks to carry out diagnostic assessments whereas in others the wait is as little as six weeks on average.

As well as improving diagnosis, the GP Contract that the Health Secretary recently negotiated will mean that, from April 2014, every person over 75 will have a named accountable GP and the most vulnerable two per cent in each practice will receive an enhanced service including same day telephone consultations and proactive case management. People diagnosed with dementia and their carers will also be able to sign up to a new service on the NHS Choices website to get essential help and advice in the early stages of their condition.

From April 2015, councils and the NHS will get £3.8 billion in the Better Care Fund to work with each other and the voluntary sector and it is expected that local areas will use some of this to improve care for people with dementia, such as providing access to dementia advisors, reminiscence services and counselling. The best areas already do this and the Health Secretary is asking Health and Wellbeing Boards to make this a reality across the country. In some areas:

- Dementia Advisors are available to support those with dementia and their families – someone who they and their family can get to know, who knows the local services and who is there for them every step of the way to give them expert information and advice and help them to manage their condition
• ‘reminiscence care’, such as memory boxes filled with personal items from someone’s past or time spent listening or dancing to music they remember to help keep their memories alive, is already playing a key part in excellent care
• counselling is offered, not just to someone diagnosed with dementia, but also to their family or carers, to help them adjust to this life-changing news and prepare for the challenges that will lie ahead.

In addition, four major British businesses have all pledged staff to become 'Dementia Friends'. Sixty thousand staff at Marks & Spencer, 70,000 Lloyds Pharmacy employees, 50,000 staff at Home Retail Group – which owns Argos and Homebase – and 11,500 customer facing staff at Lloyds Bank will learn to understand what dementia is, how it can affect a person’s ability to do day to day things and how they can help make a difference. On top of the 60,000 people who have already signed up to the Alzheimer’s Society Dementia Friends programme, this will bring the total number of Dementia Friends to over 250,000.

Alongside this, the Health Secretary announced that, following the agreement between the G8 countries following a summit in London in December 2013, Dr Dennis Gillings, CBE, Ph.D., who has over 30 years of experience of drug development, applications and theory has been appointed by the Prime Minister as the World Dementia Envoy. He plans to create a World Dementia Council to stimulate innovation, development and commercialisation of life enhancing drugs, treatments and care for people with dementia, and in protection of those at risk of dementia, within a generation.

Source: www.gov.uk 28 February 2014

No clear strategy for tackling lack of specialist A&E consultants
The Public Accounts Committee (PAC) has published its 46th Report on emergency admissions to hospital and chronic shortage of specialist A&E consultants.

The Rt Hon Margaret Hodge MP, Chair of the Committee of Public Accounts, said:
"Any attempt to improve emergency admissions services in the NHS is being completely stymied by the chronic shortage of specialist A&E consultants.
"Nearly one fifth of consultant posts in emergency departments were either vacant or filled by locums in 2012.
"There are also major problems in training enough doctors in emergency medicine. In 2012, only 18.5 per cent of first year of higher training posts were filled.
"What we found amazing is that neither the Department nor NHS England has a clear strategy to tackle the shortage of A&E consultants.
"With many hospitals struggling to fill vacant posts for A&E consultants, there is too much reliance on temporary staff to fill gaps. This is expensive and just does not offer the same quality of service.
"Struggling hospitals, such as those placed in special measures, find it even harder to attract and retain consultants. There are currently no incentive payments to make working in these hospitals a more attractive prospect.
"So, we raised with the Department the possibility of paying consultants more to work at struggling hospitals.
"You could also make greater use in A&E of consultants from other departments, or mandate that all trainee consultants spend time in A&E, or make A&E positions more attractive through improved terms and conditions.

"The slow introduction of round-the-clock consultant cover in hospitals – which will not be in place before the end of 2016/17 – is also having a negative impact. More people die as a result of being admitted at the weekend when fewer consultants are in A&E.

"Changing this relies on the British Medical Association and NHS Employers negotiating a more flexible consultants’ contract, and neither the Department nor NHS England has direct control over the timescale or details of these negotiations.

"Emergency admissions to hospitals have increased by 47 per cent over the last 15 years at a time when budgets are under pressure. Bed occupancy rates across hospitals continue to rise year-on-year and the ambulance service is also under stress.

"Hospitals, GPs and community health services all have a role to play in reducing emergency admissions – but financial incentives to make this happen are not in place. Attempts to ensure patients are treated without coming to A&E are not working.

"While hospitals get no money if patients are readmitted within 30 days, there are no financial incentives for community and social care services to reduce emergency admissions.

"Both the Department of Health and NHS England struggled to explain to us who is ultimately accountable for the efficient delivery of local A&E services, and for intervening when there are problems.

"Without clear accountability and responsibility it is much more difficult to achieve the changes needed to improve the situation."

Margaret Hodge was speaking as the Committee published its 46th Report of this Session which, on the basis of evidence from the Department of Health (the Department) and NHS England, examined emergency admissions to hospitals in England.

In 2012/13, there were 5.3 million emergency admissions to hospitals, an increase of 47 per cent over the last 15 years. Two thirds of hospital beds are occupied by people admitted as emergencies and the cost is approximately £12.5 billion. NHS trusts and NHS foundation trusts, primary, community and social care and ambulance services work together to deliver urgent care services. Since April 2013, A&E services have been commissioned by clinical commissioning groups, which are overseen by NHS England. However, it is the Department of Health that is ultimately responsible for securing value for money for this spending.

It is not clear who is accountable for the performance of local urgent and emergency care systems, and for intervening when local provision is not working effectively. The Department accepts that it has overall responsibility for the urgent and emergency care system. But it discharges its duties through various arms-length bodies, and both the Department and NHS England struggled to explain to the PAC who is ultimately accountable for the efficient delivery of local A&E services and for intervening when there are problems. Delivery is fragmented, and the health sector does not consistently work together in a cohesive way to secure savings, better value and a better service for patients. Urgent care working groups, which have been established to create better integration, have no powers and are overly reliant on the good will of all those involved. A tripartite group, accountable to the Department and comprising NHS England, Monitor and the Trust Development Authority, is intended to oversee the performance of various aspects of the urgent and emergency care system, including urgent care working groups. However, it is unclear under what circumstances the tripartite group would intervene at a local level.
Recommendation

In response to this report, the PAC expects the Department to:

- confirm that it is responsible for the overall performance of urgent and emergency care
- set out how it will challenge local performance, step in when this performance is substandard and enforce beneficial local changes to save money and provide a better service when local agreement cannot be reached.

Financial incentives across the system are not aligned, which undermines the co-ordination of care across the system. All parts of the health system have a role to play in reducing emergency admissions, including providers of social, community, primary and secondary care. However, the financial incentives to limit A&E admissions are not working across the whole system. Hospitals get no money if patients are readmitted within 30 days and a reduced rate if they admit patients above an agreed limit, but there are no financial incentives for community and social care services to reduce emergency admissions. A new ‘year of care’ funding model is being piloted that aims to promote the integration of services for patients with long term conditions by providing funding per head of population for the totality of their care, both in and out of hospital. From April 2015, the £3.8 billion Better Care Fund is intended to ensure better integration between health and social care. However, £2 billion of this funding will have to come from additional NHS savings, mainly in the acute sector, on top of the four per cent savings the NHS already needs to make in 2015/16.

Recommendation

The Department, NHS England and Monitor should review the overall system for funding urgent and emergency care, including the impact of the ‘year of care’ funding, to ensure that incentives for all organisations are coherent and aligned.

Neither the Department nor NHS England has a clear strategy for tackling the chronic shortage of A&E consultants. Many hospitals, and especially those facing the greatest challenges, struggle to fill vacant posts for A&E consultants. There is too great a reliance on temporary staff to fill gaps, which is expensive and does not offer the same quality of service. The Department told the PAC that it was working with the College of Emergency Medicine and Health Education England to increase the supply of emergency medicine doctors. Solutions may include the greater use in A&E of consultants from other departments, mandating that all trainee consultants spend time in A&E, making A&E positions more attractive through improved terms and conditions, and providing financial incentives for consultants to work in more challenging hospitals. But the PAC is not convinced that the Department has a clear vision of how to address either the immediate or longer term shortage of A&E consultants.

Recommendation

The Department and NHS England should urgently develop and implement a strategy which considers all available options and addresses the immediate and longer term shortages of A&E consultants.

The PAC is not convinced that additional funding from the Department to support A&E services during the Winter has been used to best effect. Trusts receive additional funding from the Department to support the additional workload they face in Winter. The Department allocated £250 million to help 53 struggling urgent and emergency care systems prepare for Winter in September 2013, and further funding of £150 million was announced in November 2013. The Department acknowledged that the allocation of this funding so close to Winter was not ideal as it means that hospitals cannot plan ahead and instead resort to more expensive temporary solutions, such as engaging agency staff to meet demand. The Department plans to release the £250 million Winter fund for 2014/15 in the first quarter of that year. However, the
Department said it was difficult to assess where the money could best be allocated to address real need rather than rewarding failure.

Recommendation
The Department should evaluate promptly the impact of additional Winter pressure money allocated for 2013/14 and the timing of when the money became available, and use this analysis to inform the early and effective allocation of this fund in 2014/15.

The PAC welcomes the proposed shift to 24/7 consultant cover in hospitals, but are concerned about the slow pace of implementation and the lack of clarity over affordability. The introduction of round-the-clock consultancy care will start with A&E services, but will not be in place before the end of 2016/17. Round-the-clock hospital services are intended to reduce weekend mortality rates and make more efficient use of NHS assets and facilities. However, its implementation will rely on the British Medical Association and NHS Employers negotiating a more flexible consultants’ contract, and neither the Department nor NHS England has direct control over the timescale or details of these negotiations. The Department and NHS England are also uncertain about the likely costs of moving to 24/7 consultant cover, which early evidence suggests could increase hospital running costs by up to two per cent.

Recommendation
The Department should act with urgency to establish the costs and affordability of this measure and develop a clear implementation plan.

Commissioners and urgent care working groups lack the quality data needed to manage the emergency care system more effectively. Those who manage urgent and emergency care services need a clear understanding of demand, activity and capacity across the system. However, performance management is hampered by poor quality data. For example, the National Audit Office reported concerns that the current measure for delayed discharges from hospitals to social care does not accurately reflect the scale of the problem, and figures for the time spent by patients in ambulances upon arrival at hospital before being handed over to A&E departments are not reported consistently. In addition, information across local urgent and emergency care services is not available in one place so that the public can easily make comparisons and hold their local organisations to account.

Recommendation
NHS England should ensure that reliable information is available across the urgent and emergency care system and that local information is published collectively in one place.

Source: www.parliament.uk 4 March 2014

**Person-centred commissioning needed to end the health and social care split, says Labour Party review**

Health and social care services need to be changed to make them more focused on the needs of individuals and to reduce fragmentation, a Labour Party Policy Commission has recommended.

The Independent Commission on Whole-Person Care's report said that changes in how services are commissioned could result in better co-ordinated care that is focused on the holistic needs of individuals.

The Commission, chaired by John Oldham, was set up in 2013 to provide the Party with a blueprint for achieving Shadow Health Secretary Andy Burnham's vision of fully integrated health and social care.
The report states that health and social care budgets should be used collectively to achieve outcomes defined by individuals rather than institutions and central Government.

In particular, it proposed that alliances of multiple providers should be commissioned under a single contract where individual services only gain if the whole alliance delivers on the commissioned outcomes.

It also suggested appointing lead providers who are required to direct all care services for specific groups of people – including those within particular geographical areas or people with specific health conditions.

These approaches also need to be underpinned by local flexibility, added the Commission’s report, as "what makes sense in inner-city Birmingham is not likely to make sense in Cornwall."

The Commission also called for the development of websites and apps that help family and friends to support individuals even when far apart, and for workforce bodies such as the Health and Care Professions Council to increase their emphasis on multidisciplinary practice.

It also said health and care records should be shared between agencies by default, although individuals should retain the ability to opt out of this.

Other recommendations include:

- changing planning and building rules so that they do not prevent the adaptation of homes for the elderly or disabled
- allowing local health and social care services to create single shared budgets if they want to
- offering all older people preventative checks designed to identify their needs and risks they may face
- making improved assessments of carers a local priority.

The report said its recommendations would foster more person-centred health and care services without requiring "expensive and distracting" structural reorganisations of public services.

The Commission’s recommendations will inform Labour’s Health and Care Policy Commission, which is tasked with developing the party’s policies for the next general election.

Source: [www.communitycare.co.uk](http://www.communitycare.co.uk) 4 March 2014

**Nearly a fifth confess to knowingly using A&E for non-emergencies**

Eighteen per cent of people admit to having knowingly used A&E for a non-emergency at some point in their lives, according to new survey by Healthwatch England.

One in four respondents said it is likely they would resort to using A&E in the future if they were unable to get a GP appointment in a reasonable timeframe, with one in three stating that they would do so if the non-emergency situation occurred outside of GP opening hours.

Despite two thirds of respondents expressing concern about the NHS’s ability to cope with the pressure on urgent and emergency care, the research suggests that when it comes to our own health and that of our loved ones, many of us will continue to use services how we want, when we want, until real alternatives are provided.

The survey results also identified an issue with awareness of alternatives. Around a third of those who responded said that they didn't know where their nearest minor injuries unit or NHS walk-in centre was or the services it provides. While four out five people said they were aware
of NHS 111, just one in five report having used it or its predecessor NHS Direct when in need of non-urgent care.

Millions of pounds have been spent on poster campaigns, radio advertising and even apps to ‘educate’ us about how to make the most appropriate use of services. However, these results show there is still more to be done, said Healthwatch England.

Local Healthwatchs have spent the Winter talking to patients about what is really going on in hospitals around the country and why. In support of their work, Healthwatch England commissioned YouGov to survey 1,762 people to find out how and why patients end up in A&E and what can be done to ease the pressure on this vital frontline service.

Ultimately, the problem seems to be the lack of services provided elsewhere. GPs simply aren’t flexible enough to meet consumers’ needs, at the same time walk-in centres are being closed and social care is under significant pressure.

In order to stop people using A&E as a ‘catch-all’ service the health and care system will have to become more consumer focused and develop new products and services to entice us elsewhere within the system. There is some work ongoing in this area already – the Keogh Review of emergency care for example, which is welcome.

Source: www.healthwatch.co.uk 4 March 2014

Ageing society demands a 'fundamental shift' in how health and care are delivered

A fundamental shift is urgently needed in the delivery of health and care to meet the challenges of a rapidly ageing society, say the authors of a new report from the King's Fund.

The report entitled, 'Making our health and care systems fit for an ageing population' argues that health and care services have failed to keep up with dramatic demographic changes, which will see one in five people in England over the age of 65 by 2030. It finds that transforming services for older people will require a fundamental shift towards care co-ordinated around individual needs rather than single diseases, and that prioritises prevention and support for maintaining independence.

The authors identify nine individual components of care that need to improve with goals which include:

- enabling older people to live well with stable long term conditions, avoiding unnecessary complications and acute crises
- improving collaboration between the NHS and social care to ensure that patients can leave hospital promptly once their treatment is complete, with good support available in the community
- ensuring that in times of crisis, older people have rapid access to urgent care, including effective alternatives to hospital.

However, to make all this happen, the key component is integrated working across teams, to ensure that the right mix of services is available in the right place at the right time.

The report offers practical advice, evidence and guidance for service leaders to provide high quality care in each area. It also highlights examples of local innovation, including:

- the Gnosall GP surgery in Staffordshire provides patients over 75 with an annual health review, and uses experienced 'elder care facilitators' to support patients, help them
navigate the system and draw up care plans. This model has been positively received by patients, has reduced length of stay in hospitals and has released savings

- the University Hospitals Birmingham Dignity for Older Patients Project, where 506 ‘dignity champions’ from different teams work to promote dignity in care, with support from regular workshops and a series of annual events
- Newcastle West Clinical Commissioning Group, working with Newcastle City Council, has developed an ageing well strategy that includes targeted health checks aimed at identifying risk factors in those aged 40 to 74, and engages older people as volunteers and health champions.

Source: www.kingsfund.org.uk 6 March 2014

Emerging findings from radical new approach to hospital inspection - compassionate care is alive and well in the NHS

The Care Quality Commission (CQC) has published findings from its 18 pilot hospital inspections completed last year, the first step in a radical change to its approach.

The Chief Inspector of Hospitals, Professor Sir Mike Richards, led teams of specialist inspectors and members of the public representing patients, to complete this work between July and December 2013.

The report concludes that compassionate care is alive and well in the NHS. Inspectors found care and compassion among frontline staff in every hospital visited, as well as a strong commitment to the NHS.

The CQC said that it observed a lot of good practice. Inspectors found that critical care services were delivering high quality, compassionate care and were able to demonstrate how they monitored quality.

Maternity services were also generally providing good quality care, and were good at monitoring their effectiveness. Almost all units were using a performance dashboard that helped them understand their performance.

Many of the trusts were found to be making a determined effort to improve care for people with dementia, for example by creating dedicated wards.

However, inspectors found significant variations in quality between trusts and even between services within trusts.

Accident & Emergency Departments (A&E) were found to be under greater strain than other hospital services. Some haven’t adapted to increased volumes of patients, which is leading to overcrowding, long waiting times and staff shortages at times.

Outpatient services were poor – they were not responding well to patient needs across most of the hospitals inspected, with patients waiting unacceptably long times to be seen and some clinics being overcrowded as a result.

The report also found that apart from critical care and maternity, most services cannot demonstrate whether they are delivering effective care or not.

This inspection programme builds on elements of the review of trusts with high mortality ratios led by Professor Sir Bruce Keogh. The key new component of the process is the introduction of a ratings system, as trialled here with three trusts, which aims to help patients understand the quality of care as well as being a driver for improvement.
In all inspections, inspectors asked if services were safe, effective, caring, responsive to people’s needs and well-led and the CQC is consequently now finding out more about hospital quality than ever before, according to Sir Mike.

The new approach to inspection will see trusts receiving an official rating of outstanding, good, requires improvement or inadequate. Three of the 18 trusts inspected in the pilot programme agreed in advance to receive a trial rating.

The Royal Surrey County Hospital NHS Foundation Trust has a ‘good’ rating. The Heart of England NHS Foundation Trust has a ‘requires improvement’ rating; since rating the hospital the CQC has carried out another unannounced inspection and seen improvements made by the trust. Dartford & Gravesham NHS Trust also has a ‘requires improvement’ rating, and the CQC will be carrying out an unannounced inspection in the near future to review improvements.

Other findings in the report include:

- ‘critical care’ performed the best out of the eight core services, with ‘outpatients’ the least-well performing. This was unacceptably poor
- patients were not always moving through hospitals as they should have been, with delays from A&E to Acute Medical Units and then onwards to wards (this is referred to as ‘patient flow’). The CQC also found delays moving patients from critical care to surgical and medical wards and hospitals also had problems moving patients from wards back into the community
- there was a link between staff engagement and better patient outcomes
- a "them and us" culture between clinicians and managers was often in evidence within trusts that performed poorly
- trusts have made progress in moving towards the delivery of seven day a week services but this varied across trusts and needs to improve.

The CQC recommends that hospitals, commissioners and other national bodies such as the Trust Development Authority, Monitor and the Department of Health, act on these findings to make sure patients receive the services they deserve.

CQC has separately commissioned an independent review of its pilot programme by Professor Kieran Walshe to help it build on the learning already identified.

Source: www.cqc.org.uk 6 March 2014

The Mental Capacity Act is failing, says Lords

Social workers, healthcare professionals and others involved in the care of vulnerable adults are not aware of the Mental Capacity Act, and are failing to implement it. That is the key finding of the House of Lords Committee established to scrutinise how the Act is working in practice, as outlined in a new report.

The Committee is recommending that an independent body is given responsibility for oversight of the Act in order to drive forward vital changes in practice. The Committee also found that the controversial Deprivation of Liberty Safeguards (DoLS), inserted into the Mental Capacity Act in 2007 by the Mental Health Act, are not fit for purpose. The Committee is recommending that the DoLS be replaced with legislation that is in keeping with the language and ethos of the Mental Capacity Act as a whole.

Chairman of the Committee, Lord Hardie, said:
"The Committee believes that the Act is good and it needs to be implemented. What we want to see is a change in attitudes and practice across the health and social care sector which reflects the empowering ethos of Act. To achieve this we recommend that overall responsibility for the Act be given to an independent body whose task will be to oversee, monitor and drive forward implementation.

"Our other key finding concerns the Deprivation of Liberty Safeguards. The intention of the safeguards is to provide legal protection for people who are being deprived of their liberty for their own safety. The evidence suggests that tens of thousands of people are being deprived of their liberty without the protection of the law, and without the protection that Parliament intended. The Government needs to go back to the drawing board to draft replacement provisions that are easy to understand and implement, and in keeping with the style and ethos of the Mental Capacity Act."

The Committee further recommends that:

- Government works with regulators and professional bodies to ensure the Act is given a higher profile in training, standard setting and inspections
- Government increases the staff resources at the Court of Protection to speed up handling of non-controversial cases
- Government reconsiders the provision of non-means tested legal aid to those who lack capacity, especially in cases of deprivation of liberty
- local authorities use their discretionary powers to appoint Independent Mental Capacity Advocates more widely than is currently the case
- Government addresses the poor levels of awareness and understanding of Lasting Powers of Attorney and advance decisions to refuse treatment among professionals in the health and social care sectors
- Government review the criminal law provision for ill-treatment or neglect of a person lacking capacity to ensure that it is fit for purpose.

The Committee also recommends that the House of Lords seek an update from the Government twelve months from now to find out what they have done in response to their key recommendations.

*Source:* www.parliament.uk 13 March 2014

**Lung cancer rates climb by three quarters in women while halving in men**

Lung cancer rates in women have risen by three quarters (73 per cent) over the last forty years according to new Cancer Research UK figures.

But while the rate for women has continued to climb, the figures show lung cancer rates have fallen by nearly half (47 per cent) in men over the same period and by a fifth (20 per cent) for people overall.

The results come as Cancer Research UK called for a renewed effort to tackle the disease and change the way the public and researchers think about lung cancer.

Around 87 per cent of lung cancers are caused by tobacco, with the remaining 13 per cent of cases not related to tobacco. Lung cancer can take many years to develop, so these figures largely mirror changes in previous smoking rates.

Past smoking patterns vary between the sexes. Rates in men have been falling for many decades - since at least the 1950s - while for women this didn’t happen until the 1970s. In men the drop has been steady, while rates for women were stable for around three decades.
before the drop started. During the main period of decrease for both sexes (1970s-1990s) the drop was bigger for males than females.

The lung cancer rate in women is now 41 per 100,000, up from 23 in 1975. For men, it is now 59 per 100,000, down from 112 in 1975.

The latest figures show there was a total of around 43,500 cases of lung cancer in the UK in 2011 – around 23,800 men and 19,700 women.

There were also around 35,200 deaths from lung cancer, around 19,600 men and 15,600 women.

Lung cancer is the second most common cancer in the UK, but the biggest cancer killer. The fall in the men’s cancer rate is the result of reducing the number of smokers, but advances in treatment have been limited and public awareness of the disease has been low despite the high death toll.

Still relatively few people survive lung cancer. Over two-thirds of patients are diagnosed at a stage when it’s too late for them to be offered treatment that could cure them.

Fewer than 10 per cent of people diagnosed with lung cancer survive for at least five years after diagnosis.

Cancer Research UK believes there are several hurdles to overcome in improving the outlook for patients. Key to this is addressing the attitude that lung cancer is an unsolvable problem for research and society. This may often be excused with a suggestion that the disease is ‘self-inflicted’ due to the tobacco link - rather than acknowledging that many of those diagnosed with the disease are the subjects of a powerful addiction that has been promoted by the tobacco industry for over a century.

Other key priorities include raising awareness of the signs and symptoms of the disease, encouraging more people to go to their doctor earlier when symptoms are spotted, and creating a research environment that speeds up the understanding of the disease and leads to better, kinder treatments.

Efforts to continue reducing smoking rates remain vital. Plain, standardised packaging for all tobacco products must be introduced as soon as possible if the UK. Providing support – such as the NHS Quit Smoking Services – for smokers to successfully quit must also continue.

Source: www.cancerresearchuk.org 19 March 2014

Health and care complaints system is 'utterly bewildering' for people
The concerns of users and worried family members looking to complain about the service they have received from their local hospital, GP or care home, are going unheard because the current system is simply too complex, according to Healthwatch England.

Healthwatch England's work to map the complaints landscape has shown that 75 types of organisations in England have a role in complaints handling and support, from councils and clinical commissioning groups locally to national regulators.

Research conducted by Healthwatch England in October 2013 showed that one in three people report having experienced or knowing someone who has experienced poor care. Yet a YouGov survey Healthwatch England commissioned of 2,076 UK adults showed that less than half of those who had a bad experience between 2010 and 2013 actually did anything to report it.
The results showed that two in five (43 per cent) said this was because they didn’t know how to complain or provide feedback and half (49 per cent) said it was because they lacked confidence that their complaint would be dealt with effectively or thought that it wouldn’t make any real difference.

Of those who did pursue their complaint over one in 10 (13 per cent) entered a formal complaints process. This means the system is failing to take any formal learning from almost nine out 10 experiences of poor care.

Healthwatch England said that the failure of the complaints system is being compounded by the lack of consistent and easy to access complaints support services. Whilst NHS advocacy is fragmented, with the level of service varying across the country, advocacy for complaints in care is almost non-existent.

If the health and care system is to learn from its mistakes, then the complaints system needs to be simplified. It also needs to be more joined up to ensure there is ‘no wrong door’ for those looking to raise a complaint, and the right information and support needs to be made available for those who want to complain.

Source: www.healthwatch.co.uk 20 March 2014

Monitor highlights need for innovation as funding pressures grow

The message from the Health Committee’s annual inquiry into the work of Monitor, the regulator for health services in England, is that, under current funding regime, the NHS will only be able to deliver the care required from it by significant innovation in the provision of healthcare, but that insufficient change has yet been made.

The Committee concludes that:

- the model of care provided by the health and care system is not changing quickly enough with the result that pressures continue to build, threatening the financial stability of individual providers, and therefore the quality of care provided
- these pressures are likely to be particularly marked in the acute sector as plans are prepared and implemented to achieve the resource transfer required by the introduction of the Better Care Fund from April 2015.

Continuing this theme, the Committee argues that as the NHS financial situation tightens, the challenge for Monitor in supporting trusts in financial difficulty is likely to increase. The MPs emphasise the importance of addressing pressures within individual providers in the context of the local health economy. The requirement for major change in the care model can only be delivered if individual providers, and Monitor as their regulator, look beyond preserving existing structures and address the need to develop different structures to meet changing needs.

The Committee also welcomes the fact that, for a range of reasons, trusts are no longer being required to achieve foundation trust status by a particular date, saying it supports “this change of approach which focuses on the requirement to improve the underlying reality rather than meet an artificial timescale”.

The Committee expresses concern that Monitor has not done enough to reform the system of tariff payments for providers, arguing that the current tariff arrangements often create perverse incentives for providers and inhibit necessary service change. It recommends that Monitor and NHS England should initiate a formal joint process for a prioritised review of the NHS tariff arrangements with the objective of identifying and eliminating perverse incentives and introducing new tariff structures which incentivise necessary service change.
The Committee also says that:

- Monitor, not the Care Quality Commission (CQC), should be given responsibility for financial regulation of social care providers, given its focus on financial performance in the health sector [paragraph 45]
- Monitor needs to do more to explain the rules for competition and procurement [paragraphs 80-81]
- Monitor has not yet developed a sufficient understanding of providers in primary care and the third sector and needs to review its relationships in both these sectors [paragraph 86]
- it shares concerns about the decision of the Competition Commission in the case of the proposed merger between Bournemouth and Poole Trusts, and recommends that Monitor and the incoming Competition and Markets Authority should work together to develop joint guidance which should be consistent with Monitor’s statutory duty to enable service integration [paragraphs 98-100].

Source: [www.parliament.uk](http://www.parliament.uk) 26 March 2014

**Halving avoidable harm and saving up to 6,000 lives**

A new ambition to reduce avoidable harm in the NHS by half over the next three years, cut costs and save up to 6,000 lives has been outlined by the Health Secretary, Jeremy Hunt. In a speech at Virginia Mason Hospital in Seattle, USA, Mr Hunt announced details of how NHS organisations can work together to improve patient safety and save money.

Each NHS organisation will be invited to ‘Sign up to Safety’ and set out publicly their ambitious plans for reducing avoidable harm, such as medication errors, blood clots and bed sores over the next three years. The NHS Litigation Authority, which indemnifies trusts against law suits, has agreed to review the plans and, when approved, reduce the premiums paid by all hospitals successfully implementing them. Every year the NHS spends as much as £1.3 billion on litigation claims.

The Government will also introduce a Duty of Candour, making openness and honesty the norm across all health and social care organisations. It will mean providers must notify the patient about incidents where ‘significant harm’ has occurred and provide an apology.

Hospitals are now being approached to pledge their support to the movement and all trusts will receive an invitation to join over the next few months.

Other plans to improve patient safety as part of the package include:

- consulting on the threshold for duty of candour to include significant harm, as part of the Care Quality Commission’s (CQC) registration requirements
- recruiting 5,000 safety champions as local change agents, identifying where there is unsafe care and developing solutions to fix it
- creating a new Safety Action for England (SAFE) team that will consist of senior clinicians, managers and patients with a proven track record in tackling unsafe care. They will ensure that fast, flexible and intensive support is available where it is needed most
- launching a dedicated section of the NHS Choices website in June 2014 called ‘How Safe is my Hospital’. The online tool will give everyone the ability to compare hospitals in England across a range of patient safety indicators
- developing new reliable measures of avoidable hospital death rates and severe harm.
A strong reporting culture, where safety incidents are reported and monitored is essential to improving safety, according to the Department of Health. The measures announced are likely to lead to an increase in the numbers of reported harm in the NHS even though care will be getting safer. NHS England will lead a project to accurately assess whether a hospital is reporting fewer, more or an expected number of incidents.

Source: www.gov.uk 26 March 2014

Chief Medical Officer publishes annual report on state of the public’s health

Being overweight is becoming normal as the majority of the adult population is overweight or obese, Chief Medical Officer (CMO) Professor Dame Sally Davies said as she published her latest annual report on the state of the public's health.

Her concern is based on data showing that - taking into account average height and weight - the average man and woman in England is overweight. This brings with it an increased risk of diabetes, strokes and other health problems. The report highlights studies that show some people who are overweight believe they are 'about the right weight'.

The Chief Medical Officer’s Surveillance report is the first of two volumes of her annual report and is a compendium of data covering a number of public health areas. Key areas of concern for the CMO featuring in this year’s report are:

- obesity - According to estimates, almost two thirds of adults and one third of children under 18 are overweight or obese. She highlights that, in one study, 77 percent of parents of overweight children did not recognise that their child was overweight
- deafness and blindness and dementia - The GP patient survey shows a greater prevalence of dementia, including Alzheimer’s disease, in those with severe vision loss or severe hearing impairment. The CMO highlights the lack of robust data which hampers our understanding of this possible association. The CMO says that investigating this potential link could tell us more about the causes of dementia
- alcohol - In popular culture, drinking alcohol to excess is sometimes portrayed as normal behaviour. An analysis of six weeks of soap operas in the UK in 2010 found 162 instances of characters drinking to excess, with negative consequences rarely shown. In fact, 75 per cent of the population does not consume excessive quantities of alcohol, and the proportion of the population which abstains from alcohol is increasing
- walking and cycling - Safety for pedestrians and cyclists must be improved if we are to encourage people to walk and cycle more and reap the associated health benefits. The risk of serious injury for each kilometre travelled on a bike is 21 times higher than by car. The CMO says that the relative risks of walking and cycling are unacceptably high and must be reduced and that an integrated approach to improving safety for all road users must be taken.

The report also reaffirms the CMO’s previous views on added sugar in drinks and alcohol minimum pricing. The CMO calls on manufacturers to reformulate and resize products to use less sugar where possible. She also says that if voluntary efforts fail, then we may need to consider the benefits of regulation such as a

Source: www.gov.uk 27 March 2014
NHS England publishes new data on the progress of hospitals in acute emergency and maternity care across London

NHS England London has published new data on the progress of hospitals in meeting standards for acute emergency and maternity services across London and it shows more are delivering high quality acute emergency care for patients across all seven days of the week.

Acute hospitals across the capital have been working towards meeting the 26 standards for acute medicine and emergency general surgery since April 2012. Latest data from 29 acute hospitals across the capital shows they are making progress on meeting these standards compared to data published last year.

The latest self-assessments are being released by NHS England London, on behalf of London’s clinical commissioning groups (CCGs), to highlight areas of progress, show where further work is needed and demonstrate its commitment to ensuring all patients receive safe and high quality care, whenever they go to hospital.

Following the development of standards for acute medicine and emergency general surgery further standards were developed for the broader acute patient pathway – to include emergency departments, critical care and a common form of hip fracture known as fractured neck of femur – and paediatric emergency services along with maternity services, to ensure these services were also safe and high quality, seven days a week. For the first time, self-assessments are being published on this wider range of standards.

Analysis of the latest data for adult acute medicine shows patients are being seen and reviewed more quickly by consultants when admitted as an emergency and can access diagnostic tests more rapidly. Every standard for acute emergency services is being met by at least one hospital in London. However, there is still a significant way to go as no one hospital currently meets all the standards set.

The London Quality Standards were developed by clinicians and patients following concerns about how services are delivered over the weekend, with lack of access to senior medical staff and limited access to diagnostics cited as major factors in poor outcomes for patients.

Data showed that patients admitted for emergency treatment at the weekend have a 10 per cent higher risk of dying compared to those admitted on a weekday. If the mortality rate in London for patients admitted at the weekend was the same rate for patients admitted during weekdays, there could be a minimum of 500 fewer deaths a year.

The latest self-assessments show:

- fifty five per cent (16 out of 29 hospitals) of London hospitals now deliver consultant review for adult acute medicine within 12 hours compared to 35 per cent in 2012
- forty five per cent (13/29) of hospitals are meeting standards for timely access to diagnostic tests 24/7 for adult acute medicine compared to 21 per cent in 2012
- seventy two per cent (21/29) of hospitals now provide extended day working by consultants for adult acute medicine compared to 28 per cent in 2012
- twenty three per cent (6/26) of hospitals now provide multi-disciplinary team assessment within 12 hours for emergency surgery compared to zero per cent in 2012
- eighty one per cent (22/27) of the capital’s maternity services deliver one to one midwife care for all women in established labour
- ninety three per cent (27/29) have specialty trained doctors present in the emergency department 24/7
- ninety per cent (26/29) ensure that all ‘high risk’ patients are seen within an hour by a consultant when on an intensive care ward
• all paediatric inpatient wards have a minimum of two paediatric trained nurses on duty at all times.
• fifty two per cent (13/25) of hospitals undertake surgery for fractured neck of femur patients within 24 hours.

The London Quality Standards were all endorsed by the London Clinical Senate and the London Clinical Commissioning Council.

Source: www.england.nhs.uk/london 28 March 2014

Professionals are divided over best care for hip fracture patients, latest audit results show
The latest report from the Falls and Frailty Fracture Programme (FFFAP) National Hip Fracture Database (NHFD) shows that just over half of patients are receiving pain relieving anaesthetic (known as a 'nerve block') as part of their care for hip fracture.

The National Hip Fracture Database Anaesthesia Sprint Audit of Practice results show that 56 per cent of hip fracture patients receive a peri-operative nerve block for pain relief and 44 per cent of patients do not. The Audit recommends that this type of pain relieving anaesthetic should be offered to all hospital patients who suffer hip fracture.

Hip fracture is one of the most common reasons for frail, older people to require an operation under anaesthetic. The average age of a patient with a hip fracture is 83 years old. The number of people in the UK aged 85 and over is growing and the number of hip fracture cases continues to rise in line with this expanding group of people.

A nerve block is a form of anaesthetic which numbs the nerve area and is used to provide hip fracture patients with pain relief from the area of the fracture. Used in this way, nerve blocks can also help to minimise the need for, and side effects of, painkillers such as morphine.

With 56 per cent of patients receiving nerve blocks, it indicates a growing adoption of the technique, which the National Institute for Health and Clinical Excellence (NICE) recommended for use in 2011. The provision of this form of pain relief is varied across the UK because the preference for using them tends to come down to local standards and the individual clinician’s choice.

The audit was conducted between 1 May 2013 and 31 July 2013 and in the three months 16,904 patients were admitted with hip fracture to the 184 participating hospitals.

Source: www.rcplondon.ac.uk 31 March 2014

Social Care
Care loans scheme could cost councils up to five times more than estimated
A care loans scheme to help people meet the cost of care in their old age could be almost five times more expensive to administer than the Government estimates, new analysis has revealed.

Figures published by the Local Government Association (LGA), which represents councils in England and Wales, show the cost of the scheme could reach more than £1.1 billion by 2025 – in comparison to an estimate based on Government assumptions of £230 million.
Council leaders back the introduction of a deferred payment scheme which would work in a similar way to student loans, with people able to borrow to pay for care against their estate to help them manage the shift towards individual responsibility to meet care costs. The loans would be repaid from the sale of the individual's home.

But the potential costs associated with introducing deferred payments schemes across 152 different local authority areas could place additional strain on already over-stretched council budgets. The LGA has called for a new national body, underwritten by central Government, to oversee the scheme, and manage the financial costs associated with it.

The Government has pledged £110 million to help councils cover the new costs incurred for the first year, but whether this is sufficient will depend on how many people opt into the system to receive loans.

In subsequent years, the adequacy of funding will depend on the number of people requiring loans and the amount of time it takes for the debt to be recovered once a loan is complete. The LGA has estimated that the length of a loan will be 2.7 years, but demographic pressure and inflation will impact how much money councils will need to have tied-up in loan funds at one time.

A Government-backed system to run the deferred payment scheme nationally would not only lessen the financial risks to councils that will be holding this debt on their balance sheet, but it would also open up opportunities for economies of scale that could also considerably reduce the overall cost to the public purse.

Source: www.lga.gov.uk 28 January 2014

Councils in England 'pay too little for home care'

Most councils in England are paying less than the industry recommended minimum for personal home care, a BBC investigation suggests.

The UK Homecare Association (UKHCA), which represents providers, want them to be paid a minimum of £15.19 an hour, to cover wages, training and travel.

But data obtained under the Freedom of Information Act (FOI) found the minimum paid met that in just four out of 101 cases.

One provider said quality care was not possible at the levels being paid.

Trevor Brocklebank, Chief Executive of Home Instead Senior Care in Warrington, refuses to bid for council contracts.

The investigation, by BBC Radio 4's File on 4 programme, found the average minimum rate paid by councils was £12.26 an hour.

Home care services are paid for by councils - and often delivered by agencies - to older people and younger disabled adults in their own homes if they qualify through a means-tested assessment.

They include help with activities such as washing, dressing and eating.

How has the £15.19 figure been calculated?:

- it assumes a care worker is receiving the minimum wage - currently £6.31 for workers over the age of 21
- added to that is the cost of travel - that is the time and mileage the care worker racks up doing their job
• the cost of covering national insurance contributions, holiday pay, training and pensions is also taken into account.
• then there are the costs the agency accrues. These can add another 30 per cent to the cost, according to the UK Homecare Association.

Care and Support Minister Norman Lamb said:
"Local authorities must consider how they can do things differently to deliver better outcomes and quality care for people who need it.
"We know there are plenty of good examples of commissioning by councils, but we want this to be the reality everywhere."
Source: www.bbc.co.uk/news 4 February 2014

**London facing £17 million Care Bill shortfall**
Getting ready to deliver the Care Bill will leave London facing a £17 million funding shortfall, London Councils has warned.

Figures from London Councils, which represents all 32 London boroughs and the City of London, show boroughs need around £90 million to prepare for the new system, which comes into force in part from April 2015. Costs include delivering additional care user assessments, setting up and managing care accounts, providing information and advice and handling deferred payments.

But new estimates by London Councils reveal the capital is likely to receive £72.75 million in 2015/16, leaving each borough with a potential £500,000 shortfall as a minimum. This comes on top of an estimated 44 per cut in central Government funding for London boroughs by 2015/16.

Councillor Ravi Govindia, Executive Member for adult services at London Councils, said:
"These reforms represent the greatest change in the way adult social care is delivered for decades.
"In London, where care users are more likely to reach the contribution limit for their care earlier than in other parts of the country, the proposed changes will have a huge impact.
"Boroughs will need to have adequately trained staff and proper systems in place to meet the huge expected demand.
"Yet our figures indicate they are likely to get much less money than they need from central Government to cover the costs of preparing for these changes, which will put an even greater strain on existing budgets and potentially leave other services at risk."
Source: www.londoncouncils.gov.uk 12 February 2014

**No proven benefit from home care for older people, finds research review**
There is no consistent or robust evidence to show that home care visits benefit older people, a review of research conducted over the past 20 years has concluded.

There is no evidence to demonstrate older people who receive home care live longer or lead more independent lives than those who do not with similar needs, found an Oxford University and University College London analysis of 64 randomised controlled trials, mainly in the UK, United States and Canada.
The trials studied involved over 29,000 people aged over 65 who were living independently, and researchers analysed their findings about the impact of home care on mortality rates, falls, the risks of injury and illness, rates of hospitalisation or institutionalisation, and the overall quality of life.

The review examined trials that focused solely on home care visits and those where home care was part of a wider programme of services.

Researchers found that the quality of evidence from the trials was “variable” and many provided limited information on what might have worked and what did not work within services.

The review recommended that any future trials needed to provide more detailed information, such as why older people needed home care, how many home care visits they actually received, and the characteristics of older recipients of home care and the professionals delivering the care.

The study was published in the journal PLOS ONE.

*Source:* [www.communitycare.co.uk](http://www.communitycare.co.uk) 12 March 2014

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**Adult social care in England: overview**

In the first of a series of reports on the adult care system, the National Audit Office (NAO) has highlighted the main risks and challenges as the system changes radically. The report points out that the Government does not know if the limits of the capacity of the care system to continue to absorb pressures are being approached. It warns that major changes to the system to improve outcomes and reduce costs will be challenging to achieve.

The report details increasing pressures on the system: adults with long term and multiple health conditions and disabilities are living longer; demand for services is rising while public spending falls; and there is unmet need for care. The Government is engaging well with the adult care sector and aims to tackle the pressures in the adult care system through introducing the Care Bill.

While the need for care continues to rise, local authorities’ spending on adult social care fell by eight per cent in real terms between 2010/11 and 2012/13. The longer term trend of reducing the amount of care provided has continued, but NAO analysis shows that local authorities have also improved their ability to control their costs in delivering core services since 2010/11.

Local authorities are making efficiency savings by changing contractual agreements, paying lower fees and negotiating bulk purchasing discounts.

Paying lower fees to independent sector providers of care can put pressure on their financial sustainability, with some providers reporting problems meeting all but users’ basic needs and investing in training for their staff. Over the last ten years, many local authorities have raised the eligibility level they set for individual packages of care. Eighty seven per cent of adults now live in local authorities that arrange care services only for those with substantial or critical needs.

The report also highlights the increasing pressure on other parts of the care and health systems. Informal carers now provide more hours of care per week and on average they are getting older. In addition, poor quality social care can lead to unnecessary emergency hospital admissions. National and local government do not know the capacity of the care and health systems to continue to absorb these pressures and how long they can carry on doing so.

The adult care system is changing significantly and rapidly. The Department for Communities and Local Government is expecting local efficiency initiatives, service transformation and the
Better Care Fund to help local government manage financial pressures. However, there is weak evidence for which ways of commissioning and providing services are the most cost-effective. The Care Bill will introduce significant changes for local authorities which will be challenging to plan for because of a lack of information, lack of evidence on what works and short timescales.

The NAO warns that, while the Department of Health and the Department for Communities and local government are working together to understand the cumulative implications of changes to, and reduced spending on, health and social care, welfare and related local services, other departments are not. For example, changes to benefits for adults with disabilities and their carers will put further strain on care users’ ability to pay for their own care and for informal carers to provide support.

Source: [www.nao.org.uk](http://www.nao.org.uk) 13 March 2014

**A good life with dementia?**

A new independent report commissioned by Red & Yellow Care has been launched to show what a 'good life' with dementia could look like.

The report entitled, 'A good life with dementia' outlines a six-part framework for enabling a 'good life' with dementia – one rooted in universal notions of identity, happiness and fulfillment.

The report draws on the expertise and insights of those working in the field of dementia, happiness and wellbeing as well as primary research with people with dementia and their carers. As a result, the following six themes were identified as being key to a good life with dementia, which interestingly conflicts with the new research that shows 43 per cent of people in the UK don't think it's possible to live a good life with dementia:

1. How to better support people with dementia to maintain their sense of uniqueness and personal identity (Respecting identity: 'It's not one size fits all').
2. Achieving the right balance between memory-based activities and enjoying the here and now (Embracing now: 'It's a moment-living life').
3. Ensuring people with dementia are able to experience meaningful human connections (Sustaining relationships: 'You don't always need words').
4. Ensuring people with dementia are able to experience a full range of emotions (Valuing contrast: 'Good days and bad days').
5. Taking risks - what are we protecting people with dementia from? (Supporting agency: 'What's there to worry about?').
6. Promoting good overall health for those who are living with dementia including physical and emotional wellbeing (Maintaining health: 'My priority in life').

The report also examines the areas that people in the UK feel are important contributors to happiness such as independence (91 per cent), freedom to take risks (65 per cent), being supported and cared for (91 per cent), living in the moment (94 per cent) and not living in the past (72 per cent).

The Good life with dementia report was funded by Red & Yellow Care and published in association with the Alzheimer’s Society with a view of encouraging debate.

The report highlights three main barriers that still exist to help people live well with dementia:

- timely diagnosis without fear. Public fear of the condition is supported by research as almost two thirds (65 per cent) of people in the UK admit they are scared they or a member of their family will get dementia. However, experts interviewed in the report
agree that a timely diagnosis is key to enabling a good life with dementia, but also that there is a need for better post-diagnostic care and support

- increasing public awareness of dementia. A lack of understanding and acceptance is cited as potentially the single biggest barrier to living a good life with dementia. Placing the condition at the centre of society and accepting it as a new normal will go a long way to overcome the loneliness and alienation currently experienced by many people living with dementia

- improving the flexibility of care. Whilst the phrase ‘person centred care’ has been used for some time, in practice, it is rarely achieved. Investing in good health and delivering care packages that are truly individualised will give people with dementia and their families the best chance of living a good life with dementia.

The Good life with dementia report is available to download from www.redandyellowcare.com/goodlife

Source: www.alzheimers.org.uk 19 March 2014

NHS and Government ‘flying blind’ as deep cuts prevent hundreds of thousands of older people accessing social care

The NHS and Government are ‘flying blind’ in planning services for vulnerable older people because there is no comprehensive way to quantify the impact that social care cuts are having on their health and wellbeing.

The warning comes in a new Nuffield Trust and Health Foundation study examining cuts to social services for older people in England. The new research, which is part of the Nuffield Trust and Health Foundation’s QualityWatch programme, reveals that most local authorities are tightly rationing social care for the over-65s in response to cuts, resulting in significant drops in the number of people receiving services like home delivered meals and day care.

Other key findings include:

- almost a quarter of a million (245,855) fewer older people received publicly funded community services in the financial year 2012/13 compared to 2009/10, a 26 per cent drop

- home and day care spending by councils fell by 23 per cent (or £538 million) over the same period

- the number of older people receiving home delivered meals has more than halved since 2009/10, falling by 59 per cent (54,795 people). This is in response to a reduction in funding of 46 per cent for meals over the period

- while the number of people receiving 10 or more hours of care and overnight care remained constant between 2009/10 and 2012/13, around 42 per cent fewer people received lower-intensity care over the same period. This indicates that local authorities have responded to cuts by focusing on those most at need

- transfers of money from the NHS to adult social care have more than doubled since 2009/10, reaching £803 million in 2012/13. This suggests that cuts to social care services would have been even more drastic if not for these transfers.

As well as leaving hundreds of thousands of previously eligible older people without local authority support, the report says that these cuts mean those still receiving publicly funded services may be at risk of poor quality care. This is because the income paid to social care providers has been squeezed, which may have resulted in staff shortages, high staff turnover or reduced contact hours.
The study seeks to assess the impact of social care cuts on the health and wellbeing of older people and their carers, but finds that, due to a lack of available data, it is not possible to quantify this.

Despite increased numbers of older people attending A&E in recent years, for example, the NHS does not record whether someone is a user of publicly funded social care. Moreover, local councils themselves do not hold data on those who pay for their own care, only on those whose care is publicly funded.

Source: www.qualitywatch.org.uk 26 March 2014