Monday, 31st January 2011

Summary

The overall vision for healthcare set out by Government is one Age UK supports. Developing a much clearer focus on the outcomes the NHS achieves in terms of treatment and patient experience is a positive step. Increased emphasis on public health and prevention is equally welcome. For too long the NHS has delivered a 'national sickness service' without a coordinated strategy to deliver preventative care or tackle the wider determinants of poor health. Establishing a system that is orientated towards supporting people to achieve the best possible outcomes for their health and wellbeing, in the short and long term, will be essential to meet the twin challenges of an ageing population while improving productivity.

Older people already represent the largest cohort of patients in the NHS, accounting for over three quarters of NHS patients and 60% of hospital admissions. As our population ages, these trends will become more acute. The number of people aged 65 and over is expected to rise by 65% in the next 25 years to almost 16.4 million, while the number of people over the age of 85 is predicted to double. The combined effect of an ageing population and increasing life expectancy will bring with it a higher prevalence of people living with multiple long-term conditions, complex co-morbidities, mental health conditions, dementia and increased need through physical frailty. Overall, it is likely that a greater number of people will be living for longer with chronic illness towards the end of their life. Managing older people’s health effectively will be absolutely essential if the NHS is to meet this growth in demand without huge increases in funding. Yet the mainstream NHS is often poorly equipped to meet these needs.

The NHS does not deliver optimum treatment outcomes for older people, lagging behind other EU countries in successful treatment of cancer, stroke and heart disease for example. Nor does it deliver on experience of care for older patients. There are clear indications that ageist attitudes remain entrenched amongst health professionals and that substandard levels of care are tolerated in too many care settings. We need to see a real step-change in the way that the NHS views and treats older people.

Older people often struggle to access the basic care they need as the NHS continues to under-commission essential community and preventative services such as falls prevention, continence care and audiology. We are also aware that older people face discrimination in accessing mainstream services, for example mental health services. In addition, there are simply service gaps for many older people. The evidence is that nearly 400,000 older people living in a care homes face real difficulty accessing GP and primary care services. Commissioning is failing to reflect the reality of the NHS' largest patient group. There needs to be a complete review of how the NHS assesses, prioritises and commissions services to meet the needs of an ageing population.

The NHS also has a poor track record of providing joined-up care, personalised to meet patients’ needs or respect their preferences. Services and professionals operate in silos and fail to provide a coherent package of support across organisational boundaries, the most obvious example being between health and social care. However, problems also exist in the interaction between primary, community and acute services within the NHS. The failure to successfully integrate services and coordinate delivery has a huge
impact on older people, many of whom live with multiple long term conditions, co-morbidities and have cross-cutting health and social care needs. We need a fundamental change in the patient journey placing much greater emphasis on holistic care.

The case for change is clear and compelling, however it is not new. Although we have seen improvement in the NHS over recent years and pockets of good practice emerging, progress overall has been quite slow and patchy. Lack of effective, transparent levers within the NHS to address poor performance has long been a recognised problem, as has a lack of data analysis and commissioning expertise. As many of the challenges in improving healthcare for older people relate to service planning and commissioning, organisational culture and clinical practice, addressing these systemic weaknesses will be key. We are less convinced that the strategy articulated by Government and the provisions set out in the Bill will deliver improvements in health outcomes or succeed in eradicating the serious barriers older people face in accessing high-quality care. For reform to be successful it must embed the Government's overall vision into every level of the NHS. It must clearly articulate the roles and responsibilities each part of the systems holds for delivery, and it must provide the right tools and levers to drive improvement and hold the whole NHS to account for its performance.

The process of change is extraordinarily difficult for any organisation, let alone one as complex as the NHS. When set alongside the concurrent challenge the organisation faces in achieving the four per cent annual productivity gains necessary to effectively safeguard future provision, it is clear the immediate future is set to test the NHS to its limits. Given that many of the planned reforms are untested and the effectiveness of the system as a whole unknown, we urge caution in proceeding to undertake wholesale change on such a tight timetable. We are also concerned that current plans are moving quickly without demonstrating sufficient strategic planning or the support and engagement of NHS staff. Low staff morale and high turnover at such a crucial time can only impact adversely on patient care. Implementing reform on this scale brings a real risk of serious disruption to the day to day functioning of the NHS. For older people with complex health needs or living with long term conditions, any disruption to care or loss of services, even temporarily, could have very serious consequences. We want to see a robust process put in place for monitoring the impact of these changes on older patients and ensure that risk is well managed.

While the NHS reforms will impact on everyone to a greater or lesser extent, they are likely to be most keenly felt by older people. Getting it right for older people is fundamentally about getting it right for everyone. Poor communication by health professionals, lack of joined up care, service gaps and inappropriate care have a high impact on older people as frequent service users, but everyone suffers when poor practice is allowed to proliferate unchallenged.

Achieving better health outcomes in the Health and Social Care Bill

The Health and Social Care Bill has the potential to achieve better outcomes for people in later life but must be strengthened in order to ensure it fulfils its aims. We believe the following improvements could be made to the Bill:

1. Improving outcomes

The Bill establishes provisions for the Secretary of State to set out a mandate for the NHS Commissioning Board and commissioning consortia. In turn the NHS Commissioning Board and commissioning consortia must demonstrate how they have sought to meet the mandate in their plans and strategies, and report annually on their progress.

The draft NHS Outcomes Framework, which we presume forms the basis of the Secretary of State’s mandate with regard to health improvement, adopts a population wide approach to setting health improvement areas which we fully support. However, we know that older people’s needs are currently under-prioritised and under-recognised within the NHS. We also know that ageism in clinical practice persists, with older people lagging behind in terms of the outcomes. We are concerned that, unless there is a clear obligation to demonstrate improvement is being achieved across the whole population, the needs of older people will continue to be obscured.
In setting the mandate and outcomes for the NHS Commissioning Board the Secretary of State should have a duty to clearly demonstrate that she or he has taken into account the needs of the whole population, including those aged over 65. In order to demonstrate this, the Secretary of State should be able to justify how and why the improvement areas they have selected will contribute to improving the health of the whole population and should report annually on progress towards improvement. They should also be able to demonstrate that the improvement areas are balanced and fair in their focus.

The NHS Commissioning Board and commissioning consortia in turn should be under a duty to demonstrate how they plan to deliver continuous improvement in outcomes and the provisions set out in the Secretary of State’s mandate in relation to each section of the population, this should form part of their annual reports. For example, in cancer improvement they must disaggregate and demonstrate how plans and strategies will drive improvement across all age groups. They should also be able to demonstrate that activity across the population is balanced and fair in their focus. The risk otherwise is that the mandate incentivises commissioners to invest their efforts in driving improvement for those groups where they believe they can make the easiest and quickest gains.

GP commissioning consortia and local health and wellbeing boards should also be able to demonstrate how they have considered the needs of their whole population in setting their commissioning priorities.

The NHS Commissioning Board should have the power to conduct thematic reviews of commissioning performance and outcomes in relation to different areas of patient care (such as footcare services or falls prevention). The NHS Board should be under an obligation to do this if there is a persistent failure to deliver improvement in relation to an area of health care provision or a particular subsection of the population.

2. Health and social care integration

Services frequently operate in silos, failing to offer a coordinated package of support across health and social care. It is this lack of integrated delivery that causes difficulties for so many older people living with long term conditions and co-morbidities, and impedes better management of their care. Under the provisions laid out in the Bill, local health and wellbeing boards will take responsibility for producing the Joint Strategic Needs Assessment (JSNA) and a local health and wellbeing strategy. Consortia and local authorities are under an obligation to demonstrate that they have taken the strategy and JSNA into account in developing their commissioning plans. However, we are concerned that this does not give the local health and wellbeing board sufficient power to ensure that actual service delivery matches up or to challenge gaps in services. We believe that local health and wellbeing boards need to be given the power to undertake an inquiry into local service provision and publish independent public reports. Local authorities and commissioning consortia should be under an obligation to cooperate with any inquiry and have a duty to respond to any recommendations set out in a report.

3. Clear lines of accountability for delivery and powers to deal with failure in the system

Age UK believes that accountability for how well the NHS serves the needs of its users should lie with the Secretary of State for Health. Ultimately, it is the Secretary of State who should be responsible for transparent reporting of the activities of the health service and Parliament should have an opportunity to comment on how well the health service is meeting the needs of the population. So, Age UK believes that it is the Secretary of State who should lay before Parliament an annual report on the performance of the NHS not the NHS Commissioning Board. In light of the current financial challenges facing the NHS, the Secretary of State’s report should also include information on the financial and productivity performance of the NHS.

Under these proposals the NHS Commissioning Board will take responsibility for primary care contractors through direct commissioning of general practice, dentistry, pharmacy and optical services. This responsibility is currently held by PCTs. Where contract management currently works well, PCTs – working with professional representatives and expert advisors – take an active role in performance managing contractors. PCTs should develop a direct relationship with providers and have regular communication to make sure they are appropriately supported, and that any emerging problems are identified and managed before they impact adversely on patient care. This function is distinct from the role of CQC and Monitor as regulators who gather information about quality after the fact and are not well supported by professional or specialist expertise. Equally some PCTs have played an important role in developing and managing clinical
networks, for example, and spreading best practice. We are very concerned that this day-to-day provider management will be lost if overseen remotely by a single national board.

Although the Bill creates provisions for the NHS Commissioning Board to establish a regional presence, we believe that this will be essential if it is to adequately fulfil its obligations to properly performance manage primary care contractors.

4. Real power for patients and public to drive service user-led change

Patient advocacy in health care will be vital if all patients are to benefit from the opportunities to exercise greater choice and control. Whether choosing a care provider or making decisions about the management of their care, patients will require information and support. We know that information provision and patient involvement in decision making works best where patients are supported to interpret information and apply it to their specific circumstances. Many patients will be easily able to access online information and may feel confident to participate in decision-making with limited support. However, other patients with complex cross-cutting needs, or who may experience cognitive or sensory impairment, will need access to advocacy and advisory services able to provide them with additional support they need. The Bill currently limits mandatory advocacy services to complaints, we believe that this is a very narrow interpretation. Local authorities should have the responsibility to commission or provide a suitable advocacy service that delivers appropriate advice and support across health and social care to any person who needs it.

Currently provisions for patient and public engagement in the Health and Social Care Bill are weak. We want to see mandatory patient representation on all commissioning consortia and on the NHS’ Commissioning Board as part of their governance. If there is truly ‘no decision about me, without me’ this principle should extend to every level of the NHS.

In addition, we believe that there should be a public right to petition the NHS Commissioning Board to undertake a review into a particular health service at a national level or a thematic issue such as health inequalities.

The NHS Commissioning Board and commissioning consortia should be under an obligation to publish all information relating to their commissioning strategy and planning, results and outcomes including their rationale and justification for decisions. The minutes of meetings must be open to public scrutiny (with the same ability to restrict certain categories of business as would apply to a local authority). Meeting details should be published in an accessible format and made available in hard format on request, not just online.

If you would like to discuss any issue in this briefing or want further information, please contact Angela Kitching, Government and Stakeholder Relations Manager, angela.kitching@ageuk.org.uk or 020 8765 7299

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1 Based on Health Development Agency Annual Report 2005
2 “Acopia” and “social admission” are not diagnoses: why older people deserve better: D Oliver, J R Soc Med 2008: 101: 168-174
3 National population projections, 2008-based, Office for National Statistics (2009)
4 p67 Centre for Policy on Ageing, Ageism and age discrimination in primary and community healthcare in the UK (2009)
5 Royal College of Psychiatrists press release, 29 October 2009
6 p20, Ageism and Age Discrimination in Primary and Community Healthcare in the UK: A Clark, Centre for Policy on Ageing (2009)
7 Both issues were clearly articulated in the evidence and final report of House of Commons Health Select Committee enquiry into Commissioning, fourth report of session 2009-10 (January 2010).