Health & Social Care News

National Pensioners Convention Health & Social Care Working Party

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We hope you continue to enjoy our newsletter and that you will share your stories with us.

- Pensioners' Parliament, Blackpool, 12th – 14th June 2018. Tickets now available. £10 for all 3 days; £5 for one day.
- Housing & Older People: the NPC is embarking on a consultation on its policy document. We recognise only too well that poor housing and environment contribute to poor health.

www.npcuk.org

Delayed Transfers

The Local Government Chronicle has issued an analysis by Impower of NHS England on the performance of councils on delayed transfers due to social care need.

This analysis shows that 84 councils out of 151 (59%) missed the target for delayed bed days.

However, overall delayed transfer days dropped from 52,783 in November to 49,227 in December (2017). Compared to the previous 12 months, delayed transfers dropped from 36% to 33.9%

Councils were judged on 5 criteria:

- whether councils hit their targets in September 2017
- whether performance had improved since the corresponding month in the previous year
- whether performance had improved since February last year
- whether the council is in the bottom quartile for delayed transfer rates.

The analysis shows a total of 15 councils failed to meet the criteria. Of these 8 councils are operating at a level above the national target rate and therefore are most at risk of some form of intervention. These are:

- Bath & North East Somerset Council
- Bristol City Council
- Cambridgeshire CC
- Leeds City Council
- Norfolk CC
- Nottingham City Council
- Warrington MBC
- York City Council

Many councils are facing demands for home care that exceeds what is available. Home care providers are unable to cope with the increased referrals from hospitals.

Although the government has announced an extra £150 million will be available in the 2018/19 financial settlement, it is a sticking plaster over a gaping wound. Given that councils need more than £2 billion just to stand still, it is clear that little is being done to heal the wound.

Over 1million Pensioners Malnourished

Figures from the House of Commons Library show that the number of people aged over 60 whose primary diagnosis was malnutrition has more than trebled in the last decade.

The loss of meals on wheels' services, closures of local shops and community centres and loss of local transport are seen as the main causes of isolation and loneliness. Pressures on funding to local councils threaten services for older people.

There is limited data available on levels of hunger across the UK which means that there could be many more older people 'under the radar' suffering mal-nutrition.

The all-party Parliamentary Group for Hunger called for robust and reliable collection of data to identify, diagnose and treat the problem more quickly. Public Health England is seen as the body that should be tasked with this initiative.

Some form of 'screening' should be used at all levels of care to enable identification and treatment of older people in the community who are malnourished or at risk of being so.

It is estimated that malnutrition among the older population costs the health and social care services £11.9 billion – a cost forecast to rise further in years to come.

The social care system already needs an estimated £1.3 billion injection immediately – facing a £2.3 billion funding gap by 2020 according to the Local Govern-ment Association.

Under funding has led to shorter care visits with limited time for care workers to help prepare a hot, nutritious meal for older people.

Most patients diagnosed with malnutrition have other health problems.

Clearly early intervention/prevention is needed to ensure that older people are not left to suffer alone.

Do external consultants help the NHS? Not according to data collected from 120 hospital trusts in England. On average £1.2million a year per trust is being spent on consultants. However, efficiency improvements were the exception rather than the rule and in most cases making the situation worse.

Experts from the universities of Bristol, Seville and Warwick Business School said more research is needed, and questioned the continued use of external consultants at the current level.

Given the chronic underfunding and understaffing in the NHS, £1.2million would go a long way to helping those in need and those who deliver services.

ACOs – The Secret Paper!

James Leavy

Apparently Bedford, Luton and Milton Keynes is now an 'integrated' Accountable Care Organisation (ACO). Local people could not understand why the CCG foot-print was geographically inclusive of a Buckinghamshire hospital. Also, why Bedford, Luton & Dunstable hospital were administered by one management team.

Then, all became clear when we saw a secret document explaining the way in which it would work.

The ACO will be given money for each person in the 'catchment' area to provide or buy in under contractor provision, various health options, including social care.

As it stands, this is what the funding would appear to cover:

- Payment of staff.
- Contract provision responsibilities passed to ACO from CCG
- Allocation of funds to personal budgets for care in the home.
- Allocation of funds for provision of health care by contractors (either current NHS or out-siders).

IT and administration costs would be pooled and used jointly to cut costs. Records would be held by the ACO, provided to those on a need to know basis covered by data protection and access under the Freedom of Information Act.

Information on staffing is sketchy, nothing about training, pay, or standards. Nor is there mention of bed provision outside hospitals, by whom, how many, or where. There is the merest hint that a policy of discouragement will exist to keep numbers of people/patients out of hospital.

There seems to be a plan to instate a 'referral arbiter' somewhere between patients and A&E to ascertain whether we could be treated somewhere else rather than be a burden on hospital budgets.

So, for local people what does it mean? The 30,00 people in the Leighton buzzard and surrounding area are being referred (with few exceptions) to Milton Keynes hospital. Bedford is 2 hours away; Luton is one hour away located in Bedfordshire. Patients in Leighton Buzzard can reach Milton Keynes in 20 minutes approx. based on transport links utilised, although Milton Keynes hospital is out of county being located in Buckinghamshire while the remainder of Buckinghamshire is in the Oxford footprint!

This is just one example we have. If you have knowledge of your local footprint and ACOs, please let us know. There are two judicial reviews in place now on this issue and we await the outcomes with interest.

James Leavy is a member of the H&SC WP

~ still with the impact of STPS/ACOs ~

Another crowdfund is being launched to help people in South Yorkshire keep their own stroke services.

With the South Yorkshire and Bassetlaw STP, now rebranded 'Integrated Care Systems' emphasis on closing hospitals, Barnsley Hospital stroke services are being 'outsourced' to Pinderfields Hospital in Wakefield.

Pinderfields Wakefield, is a small PFI hospital with a growing neighbourhood because Dewsbury's District Hospital was fully downgraded in September 2017 and Huddersfield's Royal Infirmary is planned to be demolished soon, leaving Huddersfield the largest town in England without a class1 A&E. If Pinderfields is full, stroke patients will possibly end up in Leeds Teaching Hospital.

Out of the Bradford, Harrogate, Leeds, Airedale and Pinderfields hospitals one or possibly two, have also to lose their stroke services under the West Yorkshire and Harrogate Integrated Care System!

Further North Darlington hospital is under threat, as well as Stockton's North Tees Hospital A & E. A spokesman for the Darlington Hospital campaign said "We need all our A & E Departments here on Teesside. James Cook Hospital A & E too. All 3 of our A & E Departments are very busy since the closure of Hartlepool and Bishop Auckland A & E Departments."

In Dorset campaigners have just launched crowdfund appeals for Judicial Reviews for maternity services and the retention of a local A&E.

Hospitals and departments are being closed in most of the 'footprint' areas including, but not exclusively, The Wirral, Shropshire, Lincolnshire, Derbyshire, Greater Manchester, Cornwall, and Devon.

If you have not already signed this petition from 38 degrees, please do so and also encourage friends, family, neighbours – everyone – to do the same

https://you.38degrees.org.uk/petitions/stop-the-plans-to-dismantle-our-nhs

As this petition text says: Simon Stevens CEO of NHS England (formerly from United Health of America) has said 'that to make the NHS affordable we, the public, must get used to no longer having a major hospital within easy reach.'

But this is economic nonsense, driven by ideology and a preference for privatisation.

We need to stay vigilant and support those who are campaigning against the loss of vital services.

Profit-hungry firms are gambling on social care. Are the stakes too high?

The idea of care homes for older people being traded like financial instruments might be unpalatable, but it is a reality in today's adult social care sector. In what has been called the "financialisation" of care, private equity investors have pounced on a £16bn industry, attracted by a steady stream of income in the shape of fees from a growing population of older people.

Some 410,000 older people live in care homes in the UK, according to official figures, receiving everything from specialist dementia care to less complex nursing and bed and board. Those numbers are set to rise with lengthening life expectancy.

While these changing demographics are attractive to profit-hungry private equity firms, fears are mounting that some have racked up such huge debts to buy into the sector, they could trigger a financial crisis.

Investment in care homes has gone badly awry in the not-too-distant past. When care home provider Southern Cross imploded in 2011, residents of its 750 homes were plunged into a period of uncertainty. Much of the outrage focused on the firm's former owner, private equity group Blackstone, which walked away with estimated profits of 500m, leaving cash-strapped local authorities to pick up the pieces.

Today, 95% of the 11,300 care homes for older people are provided by the independent sector (both for-profit and charities). A total of 360 are owned by struggling private equity-backed Four Seasons Health Care. In January, the Clova House care home in Ripon, Yorkshire closed after Four Seasons said it was no longer financially sustainable. The shock news caused confusion and fear among residents, some already suffering the disorientating effects of dementia. Yet such closures are far from rare. A recent study by healthcare analysts Lang-Buisson found that 929 care homes, housing more than 30,000 older people, have closed in a decade, some for financial reasons, others due to serious failings in care.

Recent closures include 12 homes owned by Scottish provider Bield, Bupa's Hillview home in Eston, North Yorkshire and Valley View in Blaydon in the north-east, where residents were given a week to pack their things and leave. According to accountancy firm Moore Stephens, one in six UK care homes is at risk of failure.

While there is no reason to believe any are in danger of imminent failure, there are certainly signs of strain. Loss-making Four Seasons is owned by Terra Firma, the investment vehicle of Guernsey-based financier Guy Hands, who had hoped to extract £890m from the company via costly loans. Rising staff costs, stagnant fee income and crippling interest payments have since destroyed its profits and raised fears about the firm's survival.

With the business in difficulty, Terra Firma is now under pressure from US investment firm H/2 Capital Partners which bought Four Seasons' debt. Ongoing rescue talks

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aimed at securing a financial future for the company have been acrimonious and protracted, although the care homes appear safe for now.

HC-One, which was created from the ashes of Southern Cross and has more than 300 homes, is another major player with the finance hanging over it. Its debts are thought to have shot up to more than £600m last year after HC-One refinanced its debts and bought 122 care homes from Bupa in a £300m deal. The company says its debt is "modest" and that it is "very healthy financially".

The ownership and debt structure of care home chains would not give cause for concern were other structural issues not becoming more serious. Len Merton, chief executive of healthcare firm Advinia, which owns 38 residential and nursing care homes, says the industry is under strain due to a toxic combination of rising costs and stagnant income due to government austerity. "There's a desperate shortage of nurses, a situation that has worsened since Brexit was announced because nurses aren't coming over from Europe," he says. This has left employers turning to temporary agency staff, who cost more. Meanwhile, the "national living wage" – and the way it is being applied in care homes – has inflated payroll outgoings. "Costs have gone up and the fee contribution from local authorities has been behind where it needs to be for the past seven or eight years," says Merton.

The government announced an extra £2bn in funding for social care last year, but the Local Government Association says only a quarter of that is reaching care home companies because the government asked councils to spend most of the money on reducing delays in discharging patients from hospitals.

"Our estimate of the funding gap between what councils pay and what providers say they need right now is £1.3bn," says Linda Thomas, vice-chair of the LGA's community wellbeing board. Many councils are due to levy a 3% council tax "precept" from April to raise extra cash for the care of older people, but the £548m raised will be wiped out by increased staff costs.

The financial squeeze is most keenly felt in homes that have a high proportion of council-funded residents. On average, in 2016 "self-funders" paid £846 a week, while the council paid just £621 a week for those without the means to pay for themselves.

Nick Hood, a social care expert whose firm, Opus, has restructured the finances of many care homes, says debt-financed businesses have a particular problem. These firms, he says, typically need profit margins of up to 14% to be able to afford their massive debt interest payments. "It's completely inappropriate to have a financialised business model for a sector that isn't just low margin, it's no margin," says Hood. "The bottom line is that the sector makes no money and will make less and less as the minimum wage goes up. I'm deeply concerned that these heavily over-indebted care providers are underinvesting in homes, with serious implications for residents"

Research by consumer group Which?, ranking providers of homes for the over-65s by the percentage deemed inadequate or in need of improvement, shows that private equity-backed firms are rated among the worst. HC-One was placed 32nd of 54, with 29% of the 98 homes included in the study deemed not good enough. Four Seasons was 43rd with 35%. Orchard Healthcare, owned by private equity group Alchemy Partners, came in 49th, with nearly 45% of its 44 homes providing care that was not satisfactory.

The Care Quality Commission, which regulates the sector, keeps a close eye on the financial sustainability of care home companies that are so big that they would be difficult to replace. Hood fears that councils, who would have to pick up the pieces if a major provider failed, could not take the strain. "When Southern Cross happened, a lot of local authorities were still running homes and had the capacity and the expertise to bail these things out. That's not true anymore. The capacity has disappeared and expertise has been absorbed into the major private operators. I'm really not sure what the government thinks would happen if any of those businesses went bust."

Merton, while reluctant to criticise peers in the industry, also has concerns about large debt-fuelled care home companies.

"When you look at the top three or four providers with in excess of 200 homes, it depends on their financial model. If they're in large debt to buy those homes, they could be at risk." But if the sector is so unprofitable, why do private equity firms still find it so attractive? Hood says they are "dazzled by demographics ... they look at the market and say there will be another 25% who'll need care in the next 15 years. They think that sooner or later the government will have to make funding available and those prices will go up. But the numbers don't work right now because the government won't put the money in."

Barbara Keeley, shadow minister for mental health and social care, says: "The financial fragility of larger providers has been made worse by eight years of Tory cuts, raising serious doubts about how equipped councils are to step in in the event of provider failure. Labour would invest £8bn during this parliament with £1bn this year to ease the funding crisis. The social care system urgently needs a longer-term, sustainable funding solution to secure the future of services but questions must also be asked about the care system's reliance upon care home chains with continually high levels of debt. The piecemeal funding offered by the Tories is not enough to ease the crisis their cuts have caused."

In response, a Department of Health and Social Care spokesman says: "We know the social care system is under pressure due to our growing ageing population — that's why we've provided an extra £2bn and recently announced a further £150m for next year. We will shortly outline the government's plans to reform social care to ensure it is sustainable for the future."

This is exactly why the NPC policy is for social care to be funded in the same way as the NHS, free at the point of need. Publicly owned, publicly funded and publicly delivered.

A Guide to NHS Privatisation & What It Means for YOU

Jean Hardiman-Smith, Chair, Health & Social Care Working Party

Many of us are aware that the current big idea to push NHS privatisation is to sell off NHS assets; build a shiny new centre, which will not cater for the difficult or complex (who are not money makers), and then sell it off to private companies waiting to grab a profit. By this method, the public will quietly have been robbed via the government, of what rightly belongs to them. We, the public, then must provide whatever money is demanded to keep the privateers in island hideaways. We get nothing back, but the doubtful pleasure of paying through the nose. The expensive sick – the disabled, those with chronic health conditions, and the frail elderly do not figure in the master plan. Put bluntly, who in their right mind would fall for this?

It seems the public who are being cherry picked for "consultation" are falling all too often. Swimming in a sea of acronyms, and talking to people they feel they can trust, the idea is being slowly accepted in the public consciousness that the NHS must be modernised. Often the ideas are being sold by good people making the best of things and trying to do what they can for a population they may have served for decades. In that way the narrative is reinforced. There is no option, and defunding, deskilling and slashing services is supported by people with good intentions. This is hard to argue on a local level, where there is no obvious enemy. Hospitals and services are being culled – the easy targets first. Hard for activists to realise that the public may not be with them, when a nice shiny building is on offer against an old crumbling Victorian one, with an acute shortage of staff and a habit of cancelling surgery.

As we try to educate people who have no idea of what is going on - which we must do, I would caution against the use of acronyms. ACOs (look at the ideas behind them to work out if your local services are still enabling the pattern to be put in place) and Community care sound good, will work beautifully in the pilots, and have absolutely no future as a part of a working NHS system. I was told when attending a conference in East Asia, (a part of the world I didn't really associate with awareness and passionate support of our NHS), that we were a beacon of hope to the world, and so all the forces of privatisation and neo liberalism were being turned against us. They know that support for the NHS is high, and so we must be brought to turn against it very slowly. How are they doing this?

The attack is on many levels:

- Propaganda
- Making it unworkable
- Local blame, not the government
- International attacks
- Home grown legal attacks
- Human rights attacks
- Appeals to individualism
- Keeping it quiet
- Normalisation
- Useful idiots
- Smear campaigns

And probably more I haven't considered yet.

Propaganda can take many forms, and we are subjected to it daily via mainstream media, which no longer prides itself on telling the truth, but at best, regurgitating what the government says without questioning unless forced to if the issue becomes "news". It becomes a big problem if the governments values are not in the best interests of its population. Mid-Staffordshire was a simple misunderstanding of the data, which was turned into a national scandal. People had vested interests. Vases of flowers had been banned years before, but somehow frail patients were drinking from them? It was such a shame, because there was a genuine issue nationally, an issue which has been allowed to get so much worse. The propaganda rolls on, but no practical steps are taken to address the real issue of the neglect of our frail elderly and dying in our hospitals. In fact, we are accepting of the fact the old are the problem. It is bed blockers – rather than our dire record of beds per head amongst the developed world. Accountable Care Organisations push the problem into the community where the scandals will take place behind closed doors.

Which brings me to making the system unworkable: A lot of people, maybe most, want to die in their own beds. Of course, we all do, going painlessly in our sleep. The government is using this to justify cutting hospital beds to third world levels. I am told a lot of people when faced with the reality, change their minds. That is my whole point. Propaganda is dividing the generations. Propaganda is dripping away, and has been for 40 or more years, to put our own interests first – a better phone comes before collective provision like the NHS. People are not trained to question deeply now, and we are being trained to fear external influences like the EU. It is this same fear of loss of control that makes us opt for the scenario that most comforts us in death, and for Brexit without wanting to question if the alternatives might be even more unbearable, just because they are less overt, or even deliberately hidden from us.

We now have no way of simply recharging the NHS system. Propaganda to make medicine an unattractive proposition, and deliberate cuts in training mean that we cannot fix short term staffing

shortfalls. Deals are being talked about with India. I recently chaired a session on Indian healthcare in the House of Commons, and this does not fill me with confidence, since a major thread seemed to be how to get the poor to pay more for private healthcare. Systems along the lines of ACOs are common, and although their best people are good, I am less confident about the robustness of average training. Plus, for older people, there is a language, or pronunciation barrier. Good EU professionals with a good command of English will be rarer. Relying on our own people will take at least 5 years to begin to make a difference.

Behind the scenes staff are being down skilled, down banded, made redundant and their terms and conditions taken away. This is being driven by the need to stop investing in staff to support the public and start supporting private investors supporting themselves. Masses of money can be found to drive up pseudo competition – and domestic laws are in place to ensure this happens, thanks to the influence of one or two companies. According to all the top economists this is the opposite of what is needed to make a happy and fiscally healthy state. Those favouring the transfer of public money to private companies expect us to deliver ourselves to their control, via trade deals and acceptance of their courts. African countries have taken about 20 years for their populations to demand things change. Many of us will no longer be around to see the light slowly being switched back on again.

We need to be clear about what we are opposing in a way that someone who has never used the services can understand. A nice shiny building which suits their needs and has parking cannot be counteracted with warnings about American systems they see no sign of being implemented. We need in depth knowledge of local losses; e.g. you would need to travel 30 miles and pay a tenner to visit your mum; if your child is depressed there will be nowhere to turn to except in a crisis where they could be warehoused hundreds of miles away.

American ACOs started off benignly. They were for people like us. Slowly and gradually the good people leading were spun against. They were too old, not modern enough in their ideas, should give way for younger blood, and so on. They were a bit like our “penny in the pound” type of scheme, now acquiring professionalised CEOs and boards, with salaries instead of being volunteers. Very slowly they become successful, that is, they turn a profit for the shareholders, and oh so slowly we come to accept that, like insurances, they are not always being run for our interests.

In areas where this message that we no longer have an NHS and that services are being lost to us is not getting across, it may mean searching out the truth, attending health and wellbeing board meetings, and hospital and clinical commissioning group meetings to find out about the services being cut beneath the headlines, the real cost of that new building, the shortfalls in staffing and funding.

It is because people are persuaded of inevitability and lack of money in the country, or that anyone questioning is simply a bit odd in one way or another; people not engaging with issues the BBC hasn’t highlighted in its main news. They will engage with their chances of a hip operation; where they will have to go to when the local hospital closes – hard facts that affect them. These facts are getting more difficult to access, but if we can highlight the negatives and then show how our local losses and shortfalls fit in with the national and international pictures, maybe we can persuade a few more people not to queue at the kiosk for comforting lies.

The company developing a controversial ***“Airbnb for social care”*** model allowing homeowners to rent spare rooms to recuperating hospital patients is bidding to launch a new trial in Cambridge, according to reports in the Health Service Journal. The magazine says the plans have the backing of senior figures within the Department for Health and Social Care.

The man behind the idea, Paul Gaudin was a former "bagel mogul", who founded the New York Bagel Company 25 years ago, and started introducing the product into UK stores.

The company ***"CareRooms"*** would target those who are ready to leave hospital, but are unable to be discharged because the care they require either at home, or in a care home is not yet available. This approach would clearly focus on self-funders who could pay for their own room. Hosts could earn up to £1000 a month for letting out their rooms, but would not be regulated by the Care Quality Commission because there would be no element of care being delivered.

An earlier version of this scheme was abandoned by one of the Essex councils a few months ago, but now looks set to take off. Not only does it highlight the extent of the deep crisis in social care, but also the lengths to which the private sector will go in order to make money out of vulnerable older people and their families. The case for a National Care Service that delivers free at the point of need care, funded by society as a whole, is therefore becoming increasingly necessary.