Health & Social Care News

National Pensioners Convention Health & Social Care Working Party

Marchmont Street Community Centre, 62 Marchmont Street, Bloomsbury, London NW1N 1AB
020 7837 6622 info@npcuk.org www.ncpcuk.org

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Members of the Health & Social Care Working Party:

June Clark

Mary Cousins

Barry Finch

Jean Hardiman-Smith (Chair)

Marie Harrison

James Leavy

Terry Pearce

Pat Roche

Lena Sharp

Elaine Smith

Dot Gibson (Dep. Gen. Sec)

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

- Campaign for the retention of the free TV licence for over 75s. A petition can be signed at www.ageuk.org.uk/tvpetition. Please sign. Also watch out for further campaign materials in January.
- Dignity Day – 1 February 2019. Please support your local/regional events.

FAILING CARE HOMES MAKE £MILLIONS

An investigation by the Guardian has found that companies owning homes that have been rated 'inadequate', the lowest possible rating by the Care Quality Commission (CQC) are turning over a healthy profit. These homes care for elderly people with dementia, disabled people and those with learning difficulties.

Of the 220 homes rated 'inadequate' by recent inspection reports in England, at least 44 were owned by companies making millions in pre-tax profits. Many of the 220 homes receive government funding to care for residents. In 2017:

- Meadowbank Care Home in Battersea, South London is owned by BUPA Care Homes (ANS) and made £8.8m in pre-tax profits. Inspectors found too few staff to meet patient needs.
- Mulberry Manor, a care home for the elderly in Rotherham, Yorkshire is owned by Minster Care and made a pre-tax profit of £41.6m and paid out dividends worth £44.2m. Inspectors found that medicines were not safely managed; patients were at risk from dehydration and malnutrition; staff failed to uphold residents' dignity and treat them with respect.
- Chelmunds Court, Birmingham and Elizabeth House in Essex are owned by Runwood Homes. They made a pre-tax profit of £16.9m. Directors were paid £4.4m (the highest paid being £2.2m); dividends of £5.1m were paid. Inspectors found that at Chelmunds the provider failed to mitigate the risk of abuse by fellow residents. At Elizabeth House caring for elderly patients including those with dementia, inspectors found there were not enough staff on duty to keep people safe, and elderly patients were not treated with dignity and respect.
- Ashley Lodge Care Home, Hampshire is owned by BUPA Care Homes (CFhomes) which made a pre-tax profit of £7.5m. Inspectors found rooms dirty and unkempt; not enough staff to make the home safe; prescribed medicine issues with the risk of errors.

A small sample of what is going on behind the closed doors of establishments set up to care for the most vulnerable in society.

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Barbara Keeley, Shadow Minister for Social Care is reported as saying: *'This investigation has exposed the appalling standards of care being provided by some of the largest providers of outsourced residential care which has left large numbers of vulnerable people in need of care suffering terrible indignity and neglect.'*

The Shadow Minister is always too busy to meet with the NPC in order for us to say exactly that and provide a solution. Bring the whole area of care back into public ownership through a National Care Service, funded by the people for the people and accountable to the people.

You may remember that at the beginning of this year, we met with Lord George Foulkes who was concerned that those in care should be treated properly and if they weren't there would be a robust system in place for dealing with the impact. We will now contact him and ask his views on the outcome of this investigation and what progress he may have made towards a legal charter based on the NPC Dignity Code.

People Power!! Old People Take Over Home

The assertion of 'pensioner power' has transformed life at Bishop's Court (a block of 44 flats) in Bishop's Cleve, near Cheltenham on the edge of the Cotswolds.

It was not just the high fees they were forced to pay for the upkeep of their building, they were also fed up with a turnover of expensive workmen coming from all over the country.

They wanted local tradesmen they could get to know when they came to mow the lawn or wash the windows, so they formed their own company to take over the running of the block from the landlord, a national social housing group, Stonewater.

Five residents with the combined age of 428 years were appointed as directors who now employ the block's resident warden and will set the level of service charges (which had risen by 35% in three years).

They are now scrutinising their 'unbelievably high' utility bills; have retained a local company to take care of maintenance, and can now finally see where their money is going.

In the first week of their company operation, a saving of £1,000 was made as their local maintenance man came to mend the gutter and did another job for nothing.

So, you don't have to sit back and take what comes your way. If Bishop's Court can do it, so can you. With savings on outgoings, residents can have a little more money to do the things that keep them healthy and well.

£1,200 per year for a GP Appointment

NHS family doctors have begun offering 30 minute consultations and their mobile phone number to patients who will pay them an annual fee of £1,200.

More than 30 GPs in London and Hertfordshire have joined the Concierge Choice UK private scheme which allows patients to hand pick their doctor and request a same-day appointment.

The fee covers an annual health check. Some GPs will offer home visits. Patients have to choose a new Concierge GP from its list of doctors and cannot sign up with one at their existing surgery. Children go free if both parents sign up. Each GP is limited to 75 Concierge patients. In addition to the £1,200 a year fee, appointments will cost another £30.

The service takes advantage of the rules that allow GPs to generate a proportion of their income from non-NHS work, such as occupational health, sports medicine, acupuncture or private care.

It is said that GPs will spend 90% of their time on NHS work and Concierge patients will be a small part of the overall workload.

Given that there are already 10,000 less GPs in the UK than we need, perhaps those signed up to Concierge have time on their hands??

GP at Hand

'GP at Hand' is a practice in North West London operating under a GMS (a global mobile system) contract through the use of a mobile app provided by Babylon Health (a private health company).

It also provides 'in-person' services for patients requiring them at sites in and outside of Hammersmith & Fulham CCG area (who commissioned the service).

There are some worrying issues surrounding this service:

- Patients wanting to register with 'GP at Hand' must first de-register themselves from their current GP surgery list
- Patients must live within 30 minutes of one of the sites commissioned to provide the service
- Patients can also register if they work in London zones 1-3
- This is not one of NHS England's pilot schemes
- It maintains that patient records will be safe and the practice is subject to all governance, data protection and security rules applied to NHS practices

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However, there are some patients who may not be eligible to register and will be advised by the practice. The list includes:

- Women who are or maybe pregnant
- Adults with safeguarding need
- People living with complex mental health conditions
- People living with dementia
- Older people with conditions related to frailty
- People requiring end of life care
- Parents of children who are on the 'Child at Risk' register
- People with learning difficulties
- People with drug dependency

Apparently this type of digital model may not be clinically appropriate for these individuals and for those who do register and find further down the line they have something that 'GP at Hand' doesn't want to deal with, they have no other GP access.

'GP at Hand' operates from the following London clinics:

- 29 Upper Tachbrook St, Victoria, SW1V 1SN
- 21 Newby Place, E14 0EY
- 154 Drummond St, Kings Cross, NW1 3HP
- 139 Lillie Rd, SW6 7SX
- 292 Munster Rd. SW6 6BQ

Critics of the service believe this creates a two-tier service within the NHS; cherry-picking those patients who are cost effective. What do you think?

Changes to PIP, DLA and Attendance Allowance

The NPC has produced a briefing on the changes to Personal Independence Payments, Disability Living Allowance and Attendance Allowance and how they affect older people.

PIP is replacing DLA for disabled people aged 16 to 64, and all new claimants in this age group will be put onto PIP. Those 65 or over that make a new claim, or have had a previous PIP/DLA award that has ended and not been renewed, will have to apply for Attendance Allowance.

If a person is on PIP at 64 and there is no change to their status, they will stay on PIP post 65 and onwards.

For further information and the potential impact on older people of these changes please visit our website: www.npcuk.org and download the briefing paper. Not online – contact our head office on: 0207 837 6622 for a copy.

Please note the office is closed from 5.00 pm on Thursday 20 December 2018 and re-opens at 9.30 am on Wednesday 2nd January 2019

Integration .. what is it .. how does it work ..

Those of you who attended our Pensioner's Parliament in June this year may have completed the questionnaire from the Health & Social Care Working Party. Thank you for taking the time to do this.

Our questionnaire was intended to find out from our members how they wished to see NHS and Social Care services delivered and funded.

A 'joined-up' service was the overwhelming majority view, however, there was no consensus of opinion on who or how it should be delivered.

The Health & Social Care Working Party have spent most of this year in debate about what social care is; how it should be funded; what a National Care Service should deliver. A lot of progress has been made, but there are still some areas still under discussion. The main one is Integration.

There are various models of integration currently being implemented, most start off well, but then fall foul of cuts to funding and become an area of contention. For example, in Scotland, the Assembly froze council tax for three years; in 2018 it rose by 16%!! The reasons given were the need to raise money to pay nurses their wage increase and to 'prop up' social care services. It has severely impacted on local people and is still not enough to deliver the necessary care.

The long-awaited Green Paper on Care has not been released and it is more than likely we will not see it until early 2019 – if then.

So, let's talk about integration and what we mean in the NPC when we say 'joined-up' services. To us it says:

Joined-up services where patients and service users are able to access the services they need easily and seamlessly. Care that is tailored to individual needs is beneficial to the older person but choice must not be seen as the chance to create a marketplace in health care. The increased fragmentation of the services that may result is likely to lead to less co-operation between providers and instability.

Whilst there is widespread consensus that integration and joint working is the right way forward for the health and social care system to deliver the best and most effective outcomes for people and their families, it is a long way from being in place everywhere, with a range of longstanding legal, structural and cultural barriers hindering the pace and scale at which change can happen.

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Integration is the word (along with 'partnership') that is on everybody's lips. But what exactly does it mean? A report by the Nuffield Foundation found 175 definitions of the concept!

In theory there would seem to be four possible approaches:

- Merge NHS and local authorities
- Make local authorities responsible for health services
- Make the NHS responsible for social care
- Transfer relevant responsibilities of both to the NHS and the local authority social services into a new organisation created specifically for the purpose – an Integrated Care Organisation, as part of a new National Care Service

The feasibility of the first three of these options is not good. It is not just about differences in funding. The barriers are political and ideological. Local Authorities have, in the main, moved to commissioning roles and do not directly employ care staff. Staff would need to be re-trained back into the role of providing joint services with either the NHS or another partner.

Similarly, the NHS has become fragmented and open to rationing through CCGs decision-making and funding cuts from central government. The NHS taking responsibility for social care in its entirety requires a major change of mind-set.

The fourth option sounds better, but in reality to make it work requires sustained levels of funding never seen before and certainly not what the current government want to pay for.

The situation in England is confusing, not least because the terms used to describe what NHS England calls "new models of care" have changed several times, sometimes for a new organisation, sometimes for the same organisation with a new name, sometimes for a local initiative, and are usually referred to by acronyms. The Kings Fund paper called *'Making Sense of Integrated Systems, Integrated Care Partnerships and Accountable Care Organizations in the NHS'* published in February 2018, gives the following definitions:

- Integrated Care Systems (ICSs) have evolved from Sustainable Transformation Plans (STPs) and take the lead in planning and commissioning care for their populations and providing system leadership. They bring together NHS providers and commissioners and local authorities to work in partnership in improving health and care in their area.
- Integrated Care Partnerships (ICPs) are alliances of NHS providers that work together to deliver care by agreeing to collaborate rather than compete. These providers include hospitals, community services, mental health services and GPs. Social care and independent and third sector providers may also be involved.
- Accountable care organisations (ACOs) are established when commissioners award a long-term contract to a single organisation to provide a range of health and care services to a defined population following a competitive procurement. This organisation may subcontract with other providers to deliver the contract.

All of these have the potential for private provider delivery of services, although the Kings Fund believes that an increase in private companies obtaining contracts is negligible, we wait and see.

Notably, the English attempts at "integration" are mainly about integration within the NHS and do not usually include local authority social care services.

There are many models being explored and the Health and Social Care Working Party will continue to look at what we believe is the best way forward to achieving our policy of a National Care Service, free at the point of delivery.

The principles that Nye Bevan set are as good today as they were then, the need is greater and the battle needs to be won if we are to truly bring that vision to fruition.

The Health & Social Care Working Party thank

A backlog of 7,000 eye patients at University Hospital Southampton Foundation Trust prompted clinicians to send a formal letter of concern about these patients not given follow-up appointments. The Royal College of Ophthalmologists say these problems are a result of a significant and sustained pressure on eye services nationally and that backlogs are common across NHS Trusts.

The backlog includes 4,500 with glaucoma and 2,500 with diabetes-related eye problems. The Trust is reviewing affected patients and have written to NHS England calling for a 'national awareness message' to be given. There is clearly a mis-match between capacity and demand and ophthalmology is not prioritised as 'they mainly affect elderly patients' and are not seen as important as other specialities, such as emergency care. Ageism is alive and well!!

everyone for their support and assistance.

Motions Referred to Health & Social Care Working Party

Here is a list of those motions, what they asked for, and what we did about them.

Motion No.	Title	Content	Outcome
12	Sustainability & Transformation Plans	• Against imposition of STPs as there is no scrutiny by parliament; local health boards; local councillors and patient organisations	• We wrote to the Local Govt Assoc (LGA) • We met the Chair of LGA Community Well-Being Board • We found some common ground with LGA, although some solutions were not what we would want • We maintain contact with them
15	Carers	• Informal carers rights to assessments and follow up support • Appeal procedure does not include carers • Employed carers to be paid at least the National Living Wage • Older carers losing their carers allowance when reaching state pension age.	• We wrote to the Royal College of GPs (RCGP) asking if research had been done to identify gaps in the support carers receive. • We received a response which said the RCGP would circulate NPC regional contacts and inform GPs to contact them when local initiatives are coming up. • We wrote to the CQC. They replied that their regulatory role was not to monitor LA assessments, but that their local reviews may help in identifying any problems. • The DWP, as always, cites that an individual cannot receive 'overlapping' benefits. We keep going.
17	Rights of those in Care	• Couples being separated & put into different care homes • CCG responsible for the decision • Assurances needed that every effort will be made to keep couples together	• We wrote to NHS England asking them to ensure that a policy be in place in CCGs that enables older people the choice of where they are placed • We also asked that older people should not be placed apart from their partner and not die without that partner being present. • We have received no reply from NHS England, although a follow-up letter was sent.
19	Dementia	• Campaign for early diagnosis and more effective treatment of dementia. • Oppose diversion of funds away from dementia sufferers	• We wrote to Matt Hancock asking for a meeting. He replied he was too busy & suggested Caroline Dineage. • We wrote to her – also too busy due to pressure in the House! • Wrote and asked for a date

			early in 2019.

Technology – Plus or Minus?

The rise of the use of technological developments could revolutionise social care, but there are some concerns.

Last year, Southend-on-Sea became the first UK council to employ a humanoid robot to help older people with certain activities. Pepper (the robot) can play memory games, show videos and help with activities or exercise sessions.

Is this a glimpse of things to come? By 2050, one in four of us will be over 65 and the already over-stretched workforce in today's care environments is at crisis point.

Matt Hancock, Secretary of State for Health & Social Care recently committed to exploring new technologies that would revolutionise health and social care. But how will this technology influence future care jobs? There are particular concerns around the ethics of using automated technology for personal care or emotional support.

Donald Macaskill. CEO of Scottish Care (an independent sector association) recently launched a report '*Tech Rights'* on the ethical impact of the increased use of technology in care. His report calls for the Scottish government to fund and support a human-rights based ethical charter for technology.

Whilst recognising the potential of technology, he argues that there should be more discussion about the right to be supported by a person, rather than by a machine, as well as the implications of data gathering. There are concerns around a 'loss of control', to decisions being made by machines, to a loss of human contact and presence.

Three Sisters Care (London-based social enterprise homecare agency) say the organisation's 300 staff have already integrated new technology into their jobs. For example, care assessments are now done on tablets, not paper; staff arriving at, or leaving an appointment is done via an app and QR scanners rather than by phone.

Marches Care says technology should enhance a care workers' role, not replace it. A non-verbal stroke survivor in his 70s in one of their care homes recently Skyped his daughter in Italy with the support of his care workers.

There is no doubt that technology has a place in the caring environment – but to what extent seems to raise different views. It is one thing for individuals to accept technology in their homes as a way of keeping safe – it is a whole leap to be talking to a machine. Savings can be made by streamlining methods of working and supervision, but then the cost of new technology sold by companies has to be taken in account.

With cash-strapped councils, the cost of maintaining technology is difficult. We recently heard of a campaign in our West Midlands region against a council getting rid of their community alarm system because it cost £1.3 million a year. This was used by vulnerable people in the community who now have to sort out their own safety system.

Quite clearly, there needs to be a mix of both technology and human input for those who require daily care/end of life care. Appropriate levels of funding need to be made available by government to ensure that technology can not only be used but upgraded at nil cost to vulnerable users and training given to the workforce facing changes to their role.

Technology (when it works well) is a god-send, when it goes wrong life itself – if it sits on your phone or computer - can be very difficult with access to none of your information. For those without technology (the 67% of older people), they are excluded as all the things we would normally talk to someone about are only achievable online. And just because we are good with technology now, doesn't mean that as we get older, we continue to be able to use keyboards, phones and even grasp the plethora of new packages, apps and all the other bits and pieces of a technological lifestyle.

So, do we have the right to human care? Do we want a machine to hold our hand as we die? Does the machine have the ability to know our fears and soothe our anxiety? All questions worthy of wider

The Health & Social Care Working Party would like to wish you a Happy Holiday and a healthy 2019

Thank you for your support in 2018

debate.