Health & Social Care News

National Pensioners Convention Health & Social Care Working Party

Walkden House, 10 Melton Street, London, NW1 2EJ
020 7383 0388 info@npcuk.org www.ncpcuk.org

Issue : 10 August 2017

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.

- UN Older People's Day : 1st October. Let Head Office know what you are doing.
- Lobby of Parliament will take place on 25 October in the House of Commons.
- Report of 2017 Pensioners' Parliament available now.

Social Care
Not Tailored for Those Who Need It!

Occupational Therapists are calling for an end to a 'high volume, low cost' approach to social care, which they say leaves many older people missing out on vital services.

A new report from the Royal College of Occupational Therapists pointed to inequality in access to occupational therapy which helps people continue with everyday tasks like dressing, washing, or getting to the shops.

Evidence shows that doing the right thing for individuals can actually reduce their need for expensive long term care. Too often councils tell people what social care they will get based on what is most efficient to provide, instead of asking what they really need.

The gap between the service people get and the services they really want leads to costs arising elsewhere; for example, a costly hospital admission as a result of a fall by a gentleman who wanted to get up at 8 am when the council could only arrange a carer visit at 10 am.

Rather than seeing a person as whole, social care services often see a set of care needs which need to be addressed. Because of the unique set of skills, occupational therapists are perfectly placed to change this.

A spokesperson for *Which?* Said: *'People's individual needs must be central to decisions about what type of care they receive. Worryingly, this report indicates that care and assistance is not being tailored enough to best support those who need it.'*

The Chief Executive of the Red Cross stated: *'With an increasing elderly population and decreasing budgets for care, we must seek to do the best we can for everyone who needs care – not just the bare minimum. This research shows early intervention can help people stay in their own homes, continue with social activities and save money in the longer term.'*

The recommendations from the research is a call for more occupational therapists to be employed within primary care, such as GPs surgeries, to help older people adapt to ageing, increasing frailty and health problems

The full report (dated 13 July 2017) can be accessed at: https://www.rcot.co.uk

Positive Partnerships: How We Work Together

The Health & Social Care Working party has been in existence in partnership with the University and College Union (UCU) and members from across the National Pensioners Convention (NPC) for a number of years. Members who serve on this committee come from a range of employment and activist roles and many have links not only with their Trade Unions in areas such as Health, Education and the Public Services, but wider campaigning organisations. UCU, for example, represents a range of health professionals/educators who work in the higher education sector www.ucu.org.uk/healtheducators.

Further information regarding health and social care; general information and the latest Health and Social Care newsletter can be obtained from www.npcuk.org.

The work of the committee can be classified under three broad categories in terms of priorities.

The first is to support participation from all members of the NPC. To this end, concerns raised by members at conferences and meetings frame part of the working agenda. An example of this - an NPC discussion at a recent conference regarding the Health & Social Care crisis led to a subsequent motion from UCU for a National Health and Social Care to ensure services are free at the point of use.

The second priority is to work with others in order to ensure that health and social care is protected on behalf of those who are in work and those that are now retired. An example of this is a recent round table meeting in Parliament with regard to Health and Social Care convened by the NHS Support Federation and NPC. This meeting was attended by a number of stakeholders. The issue of ring fenced funding was discussed in the parliamentary meeting. The outcome of the meeting was initially that a question about the allocation of funding would be asked in Parliament. In addition, the NPC as a body has written to a number of MPs about the impact of austerity and the postcode lottery it causes. Other issues are end of life care and the increase in pauper funerals. Local NPC and UCU regions are encouraged to send information regarding their campaigns to the appropriate forum. Local news in a fragmented system is a very important tool in effective campaigning.

The third priority is to ensure that our information and campaigning is central to the workplace and the wider society. Given that the NHS was posited as a Cradle to a Grave solution, the work done by the Health & Social Care Working Party has a wider remit. It is for this reason it was decided that a more prescribed approach would be helpful. To this end, it was felt that it was important to write a toolkit linking information from the NPC and UCU, bringing together local and national issues. Upon completion, the full text will be made available to all branches, regions and local associations.

Editorial note: We have already featured our involvement with the Relatives and Residents Association and the National Council for Palliative Care. The policies of NPC are relevant to working people as pensioners of the future and the tool kit will be a mechanism for enabling regions and affiliated groups to widen their input and circulation of information.

NEED AN AMBULANCE? GOOD LUCK!!

Heart attack and stroke patients could have to wait longer for an ambulance to reach them as the current targets across England are scrapped amid a shortage of paramedics.

Targets will be relaxed for millions come September, with suspected heart attack moving from the life-threatening category to just 'emergency.' It means that patients will not be guaranteed an ambulance within 8 minutes – the health service current guidelines. From this autumn, the most serious calls (such as when a person is not breathing or their heart has stopped) will warrant a 7-minute response time.

A crisis in recruitment means that 1 in 10 paramedic roles are vacant. This impacts on ambulance response times and many severely ill patients have been left waiting more than an hour for an ambulance to reach them.

East of England Ambulance Service used cars for 42% of its most serious calls in April. Whilst a rapid response car allows the service to hit it targets, it can only carry patients well enough to sit in the back.

Find out what to expect in your area when you next need an ambulance.

The State of Care in Mental Health Services

The Care Quality Commission (CQC) have recently released their report of findings from a programme of inspections of all specialist mental health services in England. Care is provided by both mental health NHS trusts and independent mental health providers. The CQC has rated services provided by 54 NHS trusts and 221 independent mental health locations.

It is estimated that 1.8 million people were in contact with adult mental health and learning disability services at some point in 2015/16. The total number of detentions each year under the Mental Health Act rose by 26% from 2012/13 to 2015/16.

In many parts of the country, people with suspected dementia or with an eating disorder have to wait many weeks, and sometimes months, for specialist assessment. Children and young people with a mental health condition are facing longer waits for treatment. Meanwhile, the number of NHS mental health nurses has declined in recent years – a 12% fall between January 2010 and January 2017.

The report highlighted several areas of concern:

- **Safety of services:** for both NHS and independent mental health services, safe was the key question that was most often rated as requires improvement or inadequate. At May 2017, 36% of NHS and 34% of independent core services were rated as requiring improvement for safe. A further 4% of NHS core services and 5% of independent services were rated inadequate for safe. Contributory factors are the physical environment of many mental health wards located in older buildings that are not designed to meet the needs of today's acute patients; some services struggled to ensure wards were safely staffed at all times; and staff in both inpatient and community services not always managing medicines safely.
- **Persistence of restrictive practice:** 30 years after the introduction of legislation that enshrined the principle of least restriction, some patients still receive care that is overly restrictive. About 3,500 beds in locked mental health rehabilitation wards – with two-thirds managed in the independent sector. These wards are often a long way from the patient's home, meaning they are isolated from friends and family. The concern raised by inspectors is that some of these 'rehabilitation' hospitals are in fact long stay wards that risk institutionalising patients, rather than a step on the road to independent life. This model of care has no place in today's mental health care system.

  There were found to be great variations between wards in how frequently staff use restrictive practices and physical restraint to manage challenging behaviour. In those wards where the level of restraint is low or where it has reduced over time, staff have been trained in the specialised skills required to anticipate and d-escalate behaviours or situations that might lead to aggression or self-harm.
- **Access and waiting times:** A number of people have difficulty in accessing the service that is best equipped to meet their needs. Inspectors sometimes identify this unmet need directly on inspection; i.e. long waiting times in a community child and adolescent mental health service; a mental health crisis team that did not provide 24-hour cover, or patient's discharge being delayed because of the unavailability of a community care package. Other instances of unmet need are harder to gauge; e.g. how many people had been admitted to a distant independent hospital because a bed was not available locally. These difficulties with access to local services were sometimes due to decisions made by commissioners rather that providers.
- **Poor clinical information systems:** many clinical staff voiced frustration about the clinical record systems they have to work with. They are often unable to locate or retrieve information that others have recorded, have to enter essential clinical information into a number of different systems because these systems 'do not talk to each other', or have to work with a confusing combination of electronic systems and paper. It all consumes staff time that could be better spent in face-to-face contact with patients, increases the likelihood that essential information about risk is not communicated to staff who need to know, and can lead to care plans that do not reflect the contribution of all members of the multi-professional team – or sometimes the voice of the patient.

The mental health sector is at a crossroads and the staff, in NHS and independent sectors are genuinely the services' greatest asset. The aspirations of the *Five Year Forward View for Mental Health* can be achieved with more staff of the same calibre with leadership support to develop existing staff and retain them – and of course – funding! The outcomes of any report are only as good as the people who make decisions on commissioning and challenging the underfunding of much needed services to vulnerable people.

Full 'State of Care in Mental Health Services 2014-2017' at: www.cqc.org.uk

‘The Purple List’

…… a gay dementia venture

A 35 minute one-man performance exploring the highs and lows of Sam and Derek’s lives, as Derek’s dementia progresses.

The performance aims to raise awareness and to discuss a range of issues regarding dementia and diversity for those working in social care and for those caring for, or involved with people living with dementia.

Written by Libby Pearson and performed by Ian Baxter this is an emotional and hard-hitting view of living with dementia and how much harder it is made by prejudice and lack of understanding.

Primarily a tool for training and developing staff, the performance has a role in raising awareness in different audiences by enabling discussion of sensitive and thought provoking subject matter.

To organise a performance, please contact:

Libby Pearson libbypearsoncreatives@outlook.com
Tel: 07527640358

Ian Baxter ianbax@ntlworld.com Tel: 07906089395

Thank you to Leeds Older People’s Forum for sharing the information and experience.

Accountable Care Organisations (ACOs)

What You Need to Know!

Jean Hardiman-Smith

Accountable Care Organisations (ACOs) are surprisingly upfront about their aims, ambitions and raisons d’etre. The US frontrunner amongst ACO’s, Kaiser Permanente, emphasises the importance of bonuses, asserting that providers will make more money if they keep patients healthy. That might look reasonable until we think a bit more deeply about what it could mean; if a doctor gets more money if his patients are well, then the temptation is to maintain a list of healthy people as far as possible. In days of rising health inequality, we are talking about health organisations set up to cater to the middle classes – people who can evaluate health evidence, and have the means to follow a good diet, exercise, and be less burdened with severe income issues. The poor are likelier to adopt unhealthy lifestyles, including drink and drugs, as a means of coping, a way of shutting out the unfairness of society. They are not a source of profit. Healthcare then becomes biased to meeting the wants of the fit, young, healthy and monied, increasing the disadvantage of the poor, disabled, sick and elderly. This approach becomes normalised, and where it is questioned we have the narrative on deserving and undeserving patients to quiet our bad consciences.

Our medical professionals went into the NHS for good, caring reasons. Surely, they will not adopt this ethos? Even good people can run with the wrong ideas. The deaths of babies, especially at Morecambe bay hospital were partly attributed to a decades long campaign on natural childbirth. Somehow abandoning common sense and patient safety, midwives sincerely believed they were processing the dictated agenda – an agenda which took precedence over all other concerns and issues. Where it is so easy to prioritise agendas over people we cannot assume the Accountable Care agenda will not undermine and subsume free at the point of use cradle to grave care for all the idea on which Bevan founded the NHS.

America has been favouring, in law, the Accountable Care type organisation simply because it claims to save money. ACOs make providers jointly accountable, and save money by avoiding tests and procedures.

Of course, nobody wants unnecessary tests and procedures, but the money saved by ACO's they can keep. Again, the temptation to put money before patient's interests. In addition, if they take on more financial risks they get to pocket even more. It is so easy to see how the model will corrupt the co-operative ethos of the NHS, and lead inexorably to co-payments and insurance schemes, which are in nobody's interests but the very rich, as the US model, the worst in the developed world, shows.

ACOs can be set up by anyone. A foreign owned supermarket chain just needs to employ a GP. Even worse, health insurers can become ACO's, and have access to and oversee, patient data. That would seem a conflict of interests, since they could identify "expensive" or rather sick, patients on their lists. The US trend is to merge forming Super-ACO's. Where do you go when you are not able to get on a list due to being identified as "too sick" by the conjoined ACOs in your area? Remember we no longer have a Government with a duty to provide.

At the beginning, I mentioned co-ordinated care. That must be a plus as healthcare is becoming increasingly fragmented? Not so much when the underlying driver is to save, even at the expense of the patient. My GP currently coordinates my care and the idea would be even better in a co-ordinated and co-operating properly funded NHS.

Despite all this, ACOs are not the worst manifestation of the US healthcare system. They admit the American system is broken and know they are a flawed model. They hope their model will lead to a more efficient and sustainable system – not unlike our NHS before our government listened to American lobbyists and decided that their inferior model was the way for England to go. Interestingly their experts see it as one rung up on the way to a system like ours. ACO's, for us in England, are a downgrade from our current models, and a Trojan Horse to even greater degradation of our beloved system.

Yes, it will get worse. Many, though fewer now, repeat that they don't care if it is free. I think I have illustrated that ACO's are a model which will sooner or later lead to payments, insurances and rationing…disadvantaging the older and poorer sections of society. There are already people questioning just how dedicated the system is to keeping older people alive, and operations and procedures like hip and knee replacements are becoming a postcode lottery. Try to go private and you will see the real costs. Our NHS is no longer always free, even if you have the health need. Older people in general, and particularly the frail elderly are seen less as people, more as a drain of the system under this ideology. There is little profit to be made. The insurance industry is already eyeing up the gap, as anyone who uses a computer regularly can testify. Giant insurance corporations are major players in the ACO story. In years to come we may well be offered a "soft" version of insurance, and breathe a sigh of relief. Do not be fooled. In the USA the combination is toxic, with both the provider of healthcare and the provider of insurance joining to deny treatment for the sick, and even shockingly the dying. A colleague with Rheumatoid Arthritis, who then got breast cancer was made homeless by her healthcare requirements costs, and then denied lifesaving surgery. A compassionate academic, she was "deserving" in anyone's' book, but that is what this system boils down to. All of us will be depersonalised sources of profit. There will, in reality, be no deserving and undeserving categories.

To be fair another colleague didn't have such a bad experience with Kaiser, but she was a very well insured ex-public-sector worker. She likes the "joined up" system. She thought it the best of the best, and it does have a good point in ensuring all the specialists talk to each other, which we could easily emulate in the NHS, and sometimes do – though privatisation and commercial confidentiality is eroding this fast. We can look at any good bits, but we do not need or want the system as a whole.

In the UK, especially, but not only, in England, I see the ACO system as an enabler of "localism". By localism, I mean that power and funding is centralised, while localities bear the brunt of withholding of funds and poor decision making centrally, and are forced to take the blame. The public do not get to hear about the orders from above, but understand the consequences all too well. Disobey such orders? No funding, or much less funding, and the local people and patients are punished even more harshly. Well-funded ACO's may look good at first, as long as you are not living with a chronic condition, are disabled, or elderly, but at some point, the lack of funding and any private debts required for new builds, will hit. We need only look at the current care system to know just how bad an underfunded system driven by the private sector can get. There are, so we are told, going to be a lot fewer of them (ACOs) than our current hospital system. Imagine travelling past your local hospital, now a housing estate, then travelling on our congested roads for miles to get to your nearest ACO in an emergency. I cannot believe that in such cases our chances of survival would be enhanced. I can easily see the scenario would kill. Think those

mums encouraged into home births, needing a hospital procedure urgently for example.

Do the Americans get more bang for their bucks? I have worked with the system for more than a decade, and have a one word response. “no”. I know of people travelling a hundred miles to see a specialist, only to get there and find the appointment has been cancelled. Waits of months for a GP appointment.

Overworked and indifferent GPs – much worse than the NHS, except with an eye wateringly hefty bill. Demoralised doctors in a demoralising system, with a few benefitting greatly if they play the game.

STPs have gone quiet, and now it is all about ACO’s. Just how does everything fit in the new proposed system? More to come!!!

Bupa Care Homes ~ Fear Over Sale

The Company expected to buy Bupa’s 200 care homes could end up with debts of more than £600 million as a result of the deal.

Bupa homes bidder HC-One was born from the wreckage of Southern Cross Healthcare, whose collapse in 2011 caused a furore in parliament and the healthcare industry.

HC-One appears to have debts of £287million, but analysts have said the Bupa deal (worth up to £450 million) could take those debts beyond £600million, assuming it will be funded by leverage as HC-One’s recent take over of the Helen McArdle group of homes is thought to have been.

Controversial hedge fund Och-Ziff and US investment bank Citi recently refinanced HC-One’s loans. Accounts from before the Och-Ziff/Citi refinancing show HC-One spent £3.2million of £11.1million gross profit on interest payments last year.

HC-One’s corporate structure is complicated, adding vagueness to concerns about its finances.

Accounts state its ‘immediate parent’ is Jersey-based Libra Intermediate Holdco, while its ‘ultimate parent’ is a Cayman Islands-based entity called FC Skyfall LP. Another business, FC Skyfall Upper Midco Limited in the UK appears to be its main operating company.

Accounts for the latter show a number of debt transactions between the company and entities called FC Skyfall SPV, FC SkyfallTopCoLtd, FCSkyfallTA Ltd!!

It is thought the complicated structure is related to the business backing by two US private-equity funds.

Care home finances are worrying healthcare professionals amid deepening concerns that a lack of money is leaving patients poorly cared for.

The FC Skyfall Upper Midco accounts to September 2016 show that, of its 210 homes, 51 were ‘non-compliant’ with the regulator’s requirements. HC-One’s care staff fell by 800 to 10,979 in the same year. What is not clear is whether patient numbers fell during the same period, but it is known that companies have struggled to hire care home staff.

A senior adviser at Opus Business Services said: ‘Such a hike in debt at HC-One from the proposed Bupa acquisition would mean three of the four dominant players in the UK residential care sector each have debt of over half a billion pounds. HC-One’s offshore structure is simply not acceptable.’

HC-One say they are committed to investing into its business and claim to have the strongest record of quality in elderly care. The CQC inspections for April and May 2017 show that Daneside Mews, Callards Care Home, Chaseview Nursing Home, Priory Gardens and Cedar Court all require overall improvement. County homes requires overall improvement and is rated inadequate on being safe. Brindley Court is rated overall good.

Editorial note: We can see clearly why the sector is only creating half the extra beds needed for care of the elderly. Members may remember last year when we circulated the report ‘Where Does the Money Go? – well here is more researched proof of exactly where it goes – not to those who desperately need it.

Source: Evening Standard, 15 August 2017