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PSNC Briefing 104/13: Update on the Health and Care Landscape

This briefing is part of a series issued regularly by PSNC to inform pharmacy contractors and LPCs of developments in the wider health and care landscape beyond community pharmacy. It builds on the Health & Care Review articles which are published on the PSNC website every week.

7 day GP services?

In early October the Prime Minister announced a plan to pilot provision of GP access from 8am to 8pm, seven days a week. GP practices will be able to apply to a new £50m Challenge Fund to set up a pioneer programme. Pioneers will be established in every region of the country – nine in total – which together are expected to cover up to half a million patients. Ministers want to use the pilots as the first step to rolling the scheme out across the country and encouraging hundreds more GP practices to sign up.

The new pioneer GP groups will also test a variety of services to suit modern lifestyles, including greater use of Skype, email and phone consultations for those who would find it easier.

Differing views on GP funding

NHS England and the BMA have published their latest submissions to the Doctors and Dentists Review Body. The submissions present the organisations' evidence on GP funding for 2014/15 but unsurprisingly there is a divergence of view.

The BMA has called for at least an inflationary uplift for GPs practices, arguing that GPs have already delivered 'substantial efficiency savings' and have had their net pay cut over recent years. NHS England's response says it is not yet in a position to provide evidence on the level of gross uplift it deems appropriate for 2014/15, but any increase will need to be within the pay remit set by Ministers, of up to 1%.

Meanwhile, at the Royal College of GPs annual conference, the outgoing chair, Clare Gerada, said she thought the time was right for a re-evaluation of the independent contractor model for general practice. Dr Gerada said this could see the development of provider organisations led by GPs to reduce fragmentation of care, but this approach would mean a move to GPs being salaried.

New GP chief inspector unveils his plans

Professor Steve Field, the Care Quality Commission's new chief inspector of general practice has said in an interview with The Guardian that as many as 10% of GP practices in England need to make improvements. He said 'While we've got some of the best general practice in the world, it's let down by a small percentage of practices which aren't providing appropriate access or quality of care. I will not hesitate at all to order the closure of GP practices that we find to be unsafe, or providing poor access, or which do not care for patients properly or treat them with dignity.'

Professor Field also said he believed patients should have access to routine GP appointments 7 days a week, although this needn't be provided by a GP practice alone, as groups of practices could collaborate to cover the full week.

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In a later interview with Pulse he said the new inspection regime, which will start next April, will not be punitive and is likely to only identify a tiny proportion of practices that need to make major improvements. A sample of practices in each CCG will be inspected on a rolling programme by a team that includes a senior manager, a primary healthcare professional and a patient; where possible the inspection team will include a GP.

The inspections will include an examination of cross-cutting themes, such as out-of-hours care, access to the IAPT programme and medication in care homes; where necessary CCGs will be expected to raise standards following the inspection.

More detail on Labour's health plans

Speaking at the Labour party conference, Andy Burnham, shadow Secretary of State for Health, has set out more details on his plans for healthcare when the party next enters Government. The plans include repealing the majority of the Health Act 2012, making the NHS the "preferred provider" of NHS services and requiring CCGs to include a wider range of clinicians within their governance structure. In future CCGs would focus on designing services with clinician input, rather than commissioning them. In previous comments Andy Burnham has said he favoured local authorities taking control of CCG budgets; this is currently being considered by the party's Independent Commission on Whole Person Care, which will report in early 2014.

Mr Burnham also announced that 26 councils had signed up to become 'whole person care innovation councils' which would lead work on integration of health and social care services under a Labour-led programme.

More independence for CQC

The Secretary of State for Health announced in early October that the Care Quality Commission is to be given greater independence to ensure it can act 'fearlessly' as the nation's chief whistleblower on health. Under the proposals, the Health Secretary will relinquish a range of powers to intervene in the operational decisions of the CQC. This means that the CQC will no longer need to ask for Secretary of State approval to carry out an investigation into a hospital or care home. It will also remove the Secretary of State's power to direct CQC on the content of its annual report.

In addition, the newly created positions of Chief Inspector of Hospitals, General Practice and Adult Social Care, will be enshrined in law. This will place the positions on a permanent footing and ensure that individuals who are appointed to the roles are able to speak up for patients without fear of political interference.

Extension of Friends and Family Test

Francis Maude, Minister for the Cabinet Office, announced in early October that the Friends and Family Test will be extended beyond the NHS into other public services, including further education, Jobcentre Plus and the government's flagship youth scheme the National Citizen Service.

The simple test – answering the question "Would you recommend this service to your friends and family?" – will be extended to all NHS services in England, including mental health services, community nursing, and outpatient appointments by the end of March 2015.

Proposals to change the PbR tariff

Monitor and NHS England have published a consultation on new rules for the 2014/15 NHS Payment by Results system. They are proposing that new rules will come into force next year allowing local experiments in the way NHS-funded services (hospital and community services, not primary care) are paid for in order to develop innovative new models of care for patients.

The national tariff for 2014/15 will encourage providers and commissioners to develop local payment approaches that enable better integration of care so services are less fragmented and easier for patients to access.

The NHS payment system sets prices and rules which help CCGs work with providers like NHS trusts and foundation trusts to identify which health care services provide best value to their patients. Local price setting (excluding block contracts) currently accounts for about a quarter of the £67bn covered by the NHS payment system.

Responsibility for the national tariff has this year been passed from the Department of Health to joint arrangements in which Monitor, the sector regulator, sets the prices and rules for groups of health care services that are determined by NHS England.

The two organisations have agreed it is reasonable to expect providers to be able to make annual efficiency savings of 4%. The national tariff of prices and rules for 2014/15 also takes account of rising NHS costs of 2.1%, so on average the prices providers are paid for services next year should go down by 1.9 per cent.

Steve Field on primary care reform

In an interview with the Health Service Journal, Steve Field, Chief Inspector of General Practice at the Care Quality Commission has supported the greater use of pharmacy in the management of long term conditions:

"Patients also want continuity and that continuity can come by doing the urgent care in different ways with more self-care and better use of the pharmacist, [and] continuity through using nurses and pharmacists for [patients with] long term conditions."

No one-size-fits-all GP model

Sir Malcolm Grant, Chairman of NHS England, told the Commissioning in Healthcare conference held in early October that 'we need to think the unthinkable' for primary care provision.

Reflecting on the outcome of NHS England's ongoing consultation 'Improving general practice: a call to action', he said 'I am not a person for a single model of primary care. I think we at NHS England are very interested to see what funding arrangements can bring a greater rationalisation to the provision of primary care. I think that we will have a number of ways of approaching primary care.'

New Minister at DH

In the Government's recent re-shuffle, Jane Ellison, Conservative MP for Battersea, Balham and Wandsworth was selected to replace Anna Soubry as Parliamentary Under Secretary of State at the Department of Health.

She was elected as Member of Parliament for Battersea at the General Election of May 2010 and prior to becoming a Minister was a member of the Backbench Business Committee, a Parliamentary Committee inaugurated in 2010, which allocates time for debates to backbench Members. She is Co-Chairman of the All Party Parliamentary Retail Group and Vice Chairman of the All Party Parliamentary Australia and New Zealand Group and in December 2011, she set up the All-Party Parliamentary Group of Female Genital Mutilation.

Born in Bradford in 1964 Jane went to school there and then read Politics, Philosophy and Economics at Oxford. She previously worked for the John Lewis Partnership, joining the company from university. Prior to her election she managed the John Lewis customer magazine, after ten years of managing JLP's customer direct marketing.

Monitor report on the NHS funding gap

Monitor, the health sector's economic regulator, published Closing the NHS funding gap: how to get better value health care for patients in early October. The report says that to fulfil its constitution, the NHS must continue to provide a comprehensive, excellent service, available to all. But trends in funding and demand will create a sizeable funding gap. Recent projections from the Nuffield Trust and NHS England suggest this gap could grow to £30 billion a year by 2021. The gap could be smaller if the economy as a whole expands faster than expected. But commissioners and providers cannot rely on this happening. In short, the sector faces its greatest financial challenge of recent times over the next eight years or so.

To meet this challenge, health services must change fundamentally or the quality of care that patients receive will fall. The report identifies opportunities to close the gap including:

- Improving productivity within existing services;
- Delivering the right care in the right settings, including increasing care in the community;
- Developing new, innovative ways of delivering care;
- Making 'one-off' reductions in capital expenditure and staffing costs; and
- Changing the way health spending is allocated which is currently based on historic demand.

It says these opportunities won't be easily achieved, but have the potential to close the financial gap and improve the way services are delivered.

David Nicholson's messages to commissioners

In a letter to NHS commissioners and hospital trusts issued in mid-October, David Nicholson, Chief Executive of NHS England, has set out his assessment of the challenges facing commissioners. He highlights ten key points:

1. **Improving outcomes** - commissioners need to place improving outcomes for patients at the heart of their work, ensuring they prioritise an approach to planning that combines transparency with detailed patient and public participation.
2. **Strategic and operational plans** – CCGS and ATs need to develop ambitious plans that look forward for the next five years, with the first two years mapped out in the form of detailed operating plans.
3. **Allocations for CCGs** – CCGs will shortly be notified of their allocations for 2014/15 and 2015/16 to help them plan more effectively. NHS England is currently working with a subgroup of the Commissioning Assembly to finalise proposals for future allocation formulae for CCGs and direct commissioning, but stability is a key consideration and the pace of change is likely to be slow, given that the NHS is operating with very limited financial growth overall.
4. **The tariff** – NHS England and Monitor recognise the importance of stability in the payment by results tariff and the need for accuracy and responsiveness to the needs of patients.
5. **The integration transformation fund** – the £3.8bn ITF pooled budget will be created in 2015/16 and will be used at a local level with the agreement of Health and Wellbeing Boards. The ITF creates a substantial ring-fenced budget for investment in out-of-hospital care. However, it will also require the NHS to make savings of over £2bn in existing spending on acute care. This implies an extra productivity gain of 2-3% across the NHS as a whole in 2015/16. NHS England are currently exploring the feasibility of bringing forward an element of the 15/16 saving requirement into 14/15 to avoid a financial 'cliff edge' in 2015/16.
6. **Developing integration plans** – the NHS will only be sustainable in 2015/15 if the ITF is put to the best possible use and the demand for hospital services is significantly reduced. David Nicholson suggests that investment should be targeted at a range of initiatives to develop out of hospital care, including early interventions, hospital admission avoidance and early hospital discharge. This will require investment in social care and other local authority services, primary care and community health services.
7. **Working together** - a critical ingredient of success for the ITF will be the quality of partnership working at local level. Health and Wellbeing Boards will need to have strong governance arrangements for making transparent and evidence-based decisions about the use of the ITF.
8. **Competition** - the key requirement for commissioners is to determine how to improve services for patients including how to use integrated care, competition and choice. Commissioners should adopt transparent decision making processes which use competition as a tool for improving quality, rather than as an end in itself.
9. **Local innovation** - while NHS England will set a national framework for planning, they want to encourage local innovation and don't want to be overly prescriptive. Within the scope of the new payment by results tariff rules for 2014/15 agreed with Monitor, NHS England will welcome innovative local approaches that enable change to happen. For example, commissioners could add additional resources to the ITF or they could agree local variations to the national tariff, where they can demonstrate that it is in the interests of patients to do so. Commissioners could explore new contracting models, such as giving acute hospitals

responsibility for patients 30-100 days following discharge from hospital and introducing prime contractor arrangements for integrated care.

10. Immediate actions – Commissioners should focus on:
    a. Development of five year plans and engaging local people in this work;
    b. Strengthening local partnership arrangements so that they are well placed to make decisions about the ITF; and
    c. Identifying the things that will make the greatest difference to patients locally and maintain a relentless focus on putting them into action at pace.

NHS Confederation launches 2015 Challenge

In mid-October the NHS Confederation launched its 2015 Challenge, a two-part challenge to politicians to create the space for change essential for the NHS's future, and to the NHS to be ready to make the change, and do it well.

The NHS Confederations says that to make the sort of change necessary to bridge the NHS funding gap will require political courage and an NHS making a well-articulated and evidenced case for change. Undertaking such change is significantly easier in the two years after a general election, rather than the two years before.

It is vital that at the conclusion of the 2015 election, the NHS is in a position to get on with purposeful, planned change that addresses the real challenges the health service faces. If it does not achieve a post-election drive for change, it is very possible that the current basis of the NHS, free for all at the point of need, will become unsustainable in the future.

For this to happen it is vital that the political parties enter the general election with manifestos that recognise the need for change and which facilitate it at local level. The Confederations says no political party must be allowed to get away with understating the problems the health service faces.

The health service needs to play its part by recognising the challenges and looking at new ways of working to address them. Working with partners, it needs to work on solutions to the difficult issues. It also needs to engage with the public to help them understand that the health service they need now doesn't look like the health service in the 1960s.

For change to happen on the scale required, and in narrow timescales, there are four prerequisites, which form the objectives of the 2015 Challenge:

- **Objective 1** - At the 2015 general election, the three main parties share an analysis of the challenges facing health and social care, and that the analysis rings true with those in the health service;
- **Objective 2** - The main political parties are not overly prescriptive in their manifestos; their plans should focus on the 'what' and not the 'how';
- **Objective 3** - The 'deal' between the NHS and politicians over the necessary conditions for political consent to change is clearer and can be articulated in a way that the NHS locally can ask candidates to sign up to the principles; and
- **Objective 4** - As much of the NHS as possible should have developed plans for change in the run-up to the general election and be ready to go to consultation soon after. If the NHS starts planning change the day after the election it will not be ready to do implementation while it is still politically possible.

GPs must provide more support to care homes

Speaking at the Commissioning in Healthcare conference, David Behan, chief executive of the Care Quality Commission, has said that there is huge variation in how GPs see their responsibility to care home residents. He went on to say that he doesn't believe there is sufficient support provided to care homes by GPs and this is contributing to the number of residents being inappropriately admitted to hospital.

Burnham suggests free social care for all

Speaking at an event for local authority managers in mid-October, Andy Burnham, Labour's shadow health secretary, has suggested that a future policy might include aligning social care with the NHS approach to charging, so care is provided free at the point of use, funded via taxation.

Public campaign on care.data

In mid-October NHS England and the Health and Social Care Information Centre (HSCIC) set out the next steps to raise public awareness about care.data - a programme that will use information to improve the safety and care of patients.

In January 2014 all 22 million households in England will receive a leaflet explaining how the new system will work and the benefits it will bring. The leaflet drop is the next stage of NHS England's public awareness plan and follows wide consultation with a range of stakeholders including GPs and patient groups. The leaflet will clearly set out how peoples' information will be used and their right to object if they have concerns.

For the first time, the care.data programme will link information from different NHS providers to give healthcare commissioners a more complete picture of how safe local services are, and how well they treat and care for patients across community, GP and hospital settings.

The HSCIC, as the designated 'safe haven', will extract data routinely from all GP practices as well as hospitals. The data will be brought together in using automated systems in the secure environment of the HSCIC. After being linked together, the information is made available in a form that is stripped of information that could identify patients.

The information can also be used by NHS organisations to plan and design services better, using the best available evidence of which treatments and services have the greatest impact on improving patients' health.

NHS charges for migrants

Up to £500 million could be recovered from overseas visitors' and migrants' use of the NHS every year – making clear the need for changes to the current system, Health Secretary Jeremy Hunt revealed in mid-October.

The Department of Health published a comprehensive study of how widely migrants use the NHS. The study estimates that £388 million is spent each year on patients who find themselves in need of health care while in England and who should already be paying for their care, but who are often not processed and charged by the NHS. Only around 16 per cent is currently recovered by the NHS.

To tackle this issue and deter abuse of the system, the Government is:

- introducing a new health surcharge in the Immigration Bill – which will generate an estimated £200 million;
- appointing Sir Keith Pearson as an independent adviser on visitor and migrant cost recovery;
- identifying a more efficient system of claiming back costs by establishing a cost recovery unit, headed by a Director of Cost Recovery;
- looking at new incentives so that hospitals report that they have treated someone from the EEA to enable the Government to recover the costs of care from their home country; and
- introducing a simpler registration process to help identify earlier those patients who should be charged.

The study estimates the total cost of visitors and temporary migrants accessing NHS services to be between £1.9 billion and £2 billion. However, this includes some money that is already recovered, a number of vulnerable patient groups and services that it would be impractical or inappropriate to charge for in full, such as treatment for infectious diseases, and the full cost of international students' healthcare.

CQC and patient safety

At a Health Select Committee review of the work of the Care Quality Commission (CQC) in late October, the chairman of the CQC said that responsibility for patient safety should sit with his organisation rather than with NHS England. The role of the former National Patient Safety Agency was transferred to NHS England in the NHS reorganisation undertaken in early 2013.

National Clinical Director for Rural and Remote Care appointed

NHS England has appointed Lesley Boswell the new National Clinical Director for Rural and Remote Care within the Medical Directorate.

At the NHS Commissioning Board's Medical Leadership Conference in March this year, the National Medical Director, Professor Sir Bruce Keogh, announced the appointment of 26 National Clinical Directors (NCDs). Their roles are to work with NHS England to provide clinical leadership and support towards delivering improved health outcomes across the five domains of the NHS Outcomes Framework, set out in objectives within the Secretary of State's Mandate.

Lesley Boswell is a senior nurse and Chief Executive having held a number of senior positions in the NHS in the North West, South and South West and at regional level.

Simon Stevens new NHS England CEO

After much speculation over recent weeks in the healthcare press, NHS England announced in late October that Simon Stevens will replace Sir David Nicholson as CEO in April 2014.

Simon Stevens is currently the president of the global health division of UnitedHealth Group, the US-based healthcare organisation. Following studies at Balliol College, Oxford, he worked in health service management in the UK and abroad for nine years and was then appointed as policy adviser to Alan Milburn, co-authoring the 2000 NHS Plan. He held that position for four years and then moved to be Tony Blair's health adviser for three years, before joining UnitedHealth in 2004.

The salary for the post remains the same as that of the current postholder, £211,000. However in the light of NHS spending pressures, Simon has asked to take a voluntary 10% pay cut for the year ahead, so he will instead draw a salary of £189,900.

NHS Direct to shut down

NHS Direct announced earlier this year that it would seek to withdraw from its NHS 111 contracts, and Commissioners have now identified alternative providers. NHS Direct's 111 staff and call centres are due to transfer to five Ambulance Trusts by the end of November, details of which are currently being finalised. In the light of these transfers, the Board of NHS Direct has reviewed its future as a viable independent organisation and, in agreement with the NHS Trust Development Authority and NHS England, has arrived at a decision to cease operations at the end of this financial year.

They expect each of the services that NHS Direct is commissioned to provide beyond March 2014, will be transferred to other organisations, together with the staff who provide them.

If you have any queries on this PSNC Briefing or you require more information, please contact Alastair Buxton, Head of NHS Services.