NHS Report to PSNC Members

The following report was given to PSNC members in March 2013 by PSNC Head of NHS Services, Alastair Buxton. It may also be of interest to pharmacy contractors and LPCs.

The Francis Report

After nearly three years of work Robert Francis QC published his extensive report on the failings of Mid-Staffordshire Hospitals Trust in early February. With an executive summary of 125 pages, with 290 recommendations it is not hard to understand why Alastair McLellan, editor of HSJ, described it as ‘embarrassingly verbose’.

The views of a panel of experts at an HSJ roundtable event following publication of the report was summarised by the following statement, ‘The Francis report may be remembered as a symbol of a changing NHS rather than for its detailed recommendations, many of which are incoherent, over-complicated and even simply unnecessary.’ At the event, King’s Fund senior fellow, Nigel Edwards, quoted professor of health policy Kieran Walshe who had suggested that public inquiries had influence on policy in inverse proportion to the number of recommendations they contained.

Some of the recommendations are already being acted upon, as the NHS took pre-emptive action on matters such as the duty of candour. The Government will no doubt accept many of the proposals, but some already appear to have been dismissed, based on media reports or ministerial comments.

Key recommendations include:

- Modification of the NHS Constitution to enshrine the commitment to fundamental standards which need to be applied by all those who work in the healthcare system;
- NICE should develop standard procedures and practice designed to provide the practical means of compliance, and indicators by which both fundamental and enhanced standards can be measured;
- It should be considered the duty of all specialty professional bodies, ideally with NICE, to develop measures of outcome in relation to their work and to assist in the development of measures of standards compliance;
- GPs need to undertake a monitoring role on behalf of their patients who receive acute hospital and other specialist services; a GP’s duty to a patient does not end on referral to hospital, but is a continuing relationship;
- The need for a system which could hold the most senior health leaders to account. This recommendation has resulted in suggestions that Monitor could regulate individual managers;
- Registration of healthcare assistants providing direct physical care to patients;
- The creation of a single quality and finance regulator. The suggestion that CQC should absorb Monitor appears to have been rejected by Jeremy Hunt;
• The introduction of a legally binding duty of candour;
• Testing of prospective students entering training to be healthcare workers to make sure they have the right values and skills to provide good care;
• Decreasing the speed at which non-FT trusts are driven to become FTs in order to ensure trusts completing the process are safe; and
• NICE should develop evidence-based tools for establishing the staffing needs of NHS services, which would be policed by the CQC.

Review of bureaucracy
In the wake of the Francis Inquiry, Jeremy Hunt has asked Mike Farrar, CEO of the NHS Confederation to lead a review aimed at cutting bureaucracy in the NHS by a third. It is understood the review will look at what data is collected across the NHS, duplication of data capture across different organisations and the appropriateness of the methods used to collect the data.

NHS Commissioning Board (now NHS England)
Ian Dalton, the NHS CB’s deputy CEO and Chief Operating Officer is to leave the organisation to become President of BT’s Global Health division at the end of April. The Board has appointed Neil Churchill as the Director of Patient Experience (Domain 4); he is currently CEO of Asthma UK.

Meanwhile the NHS Confederation has appointed Dr Johnny Marshall, a Buckinghamshire GP and former chair of the National Association for Primary Care as its policy director. He has been heavily involved in the development of NHS Clinical Commissioners, a new national membership organisation for CCGs, formed by the NHS Confederation, NHS Alliance and the NAPC.

Labour’s health and care policy review
Andy Burnham launched a ‘root and branch’ review of Labour health policy on 24th January in a speech to the King’s Fund entitled ‘Whole-Person Care – A One Nation approach to health and care for the 21st century’. Two assumptions underpin the review – the need to get better health results in a tighter fiscal climate and the NHS has no capacity for further top-down reorganisation.

At the heart of the review is the question, is it time for the full integration of health and social care? Andy Burnham suggested use of one budget for health and social care, with one service co-ordinating all of one person’s needs: physical, mental and social.

In this vision local authorities would hold the majority of health and social care funding and Health and Wellbeing Boards would be at the centre of the management of health and care, with CCGs supporting them with technical advice. The existing organisations of the new NHS would be retained but the Health and Social Care Act 2012 and the rules of the market would be repealed.

In each area the NHS provider trust would be a “preferred provider” for hospital, community and social care services. They would be expected to move care from hospital settings to the community. The providers would not normally be subject to competition, but commissioners would have to satisfy the government they could call on “alternative” providers in the event of sustained poor performance.

It is understood that some services, including primary care, would be commissioned nationally, as now. The review is being be led by shadow Care and Older People’s Minister, Liz Kendall

Integration
Continuing the theme of integration, DH, the NHS CB and sector regulators are understood to be drawing up a joint statement of purpose to set how they will make integrated care a reality. The “common purpose framework” is
currently being drafted and is planned to be published by May this year. The document will set out a common vision which will set out how they will work together to support and promote integrated care, explain why integration is necessary, what the potential barriers are and what support is needed to help local services join up.

HSJ has also reported that the planned major policy announcement on integrated care experiments from health minister Norman Lamb, might be delayed beyond the original planned date for the announcement in the Spring. It is not believed the minister has encountered any resistance to his plans and it has been reported that he has also begun a series of fortnightly meetings on integrated care; Paul Bate, the Prime Minister’s senior policy advisor on health, is attending these meetings, signalling support from the top of Government for the plans.

PCT deficits
HSJ analysis of the latest published finance reports of nearly every PCT cluster in England has determined that at least 10 primary care trusts would face finishing 2012-13 in the red without loans or bailouts from their neighbouring commissioners.

DH financial rules state that no PCT can plan for a deficit in 2012-13 and debts incurred by PCTs in the current financial year will be passed to the clinical commissioning groups which succeed them. In the cases of Hillingdon and Bexley part of that support will come as loans, expected to be repaid by their successor CCGs after PCTs are abolished. In other cases, it will be straight transfers of funds from in-surplus PCTs.

CCG funding concerns
Some CCGs have raised concern about overspending in their first year of operation because large sums of money they were expecting to be within their budgets are now within the NHS Commissioning Board’s specialised services budget.

The extension of specialised services commissioned directly by the Board means their budget will increase from £8.5bn to £12bn. Leaders of several CCGs told HSJ their budget was between £10m and £30m smaller than expected.

CCG priorities
HSJ’s latest survey of CCG leaders asked their leaders about what impact they believed their CCG’s contracting would have compared to the past performance of PCTs. The impact that CCGs believed was most likely was that providers would be more “pressured to provide integrated services”.

CCG leaders also widely believe there will be more funding “moved to community services”, more “requirement to reconfigure services”, “bigger penalties for quality problems” and that providers’ income and activity will be reduced, or their growth slowed.

Meanwhile, the survey reveals CCGs’ priorities are focused on reforming the urgent and emergency care system and long-term conditions care.

NICE and ABPI
Negotiations on the introduction of the government’s flagship value-based pricing policy began last November but proposals for how it could work are still to emerge. The principle behind value-based pricing is that decisions on cost effectiveness will be based on a broader definition of value, taking into account wider benefits to society, such as whether a person can remain in work, and whether a drug is treating a previously unmet need.

HSJ has recently reported that DH is to hold parallel talks with the ABPI on issues that could have an impact on the policy, including the role of NICE. Stephen Whitehead, ABPI CEO, said in an interview with HSJ that the industry would like to see greater transparency from NICE about how it makes decisions, more patient involvement and power for the chief executive to overrule decisions made by its committees.
The current PPRS agreement expires in December.

Unions agree to reduce staff terms and conditions
Health unions and NHS Employers have agreed to reduce the pay, terms and conditions of NHS staff covered by Agenda for Change. The agreement will end automatic incremental pay rises, with staff instead having to meet local performance requirements.

Nursing workforce shortages
HSJ has reported that a DH-commissioned report by the Centre for Workforce Intelligence has suggested the NHS could be affected by a shortage of nurses in three years’ time. They report that in the worst case scenario, the gap between supply and demand will grow year-on-year, leading to an overall shortage of around 190,000 registered nurses by 2016.