

Social Care in Turmoil

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Social care is suffering through a lack of integration with the NHS – and the boss of NHS England’s latest plans will do little to help, writes John Lister

SOCIAL care is funded primarily through local government, although there are some funds from the NHS.

Year after year central government has also relentlessly cut local government funding, and as a result 400,000 fewer people who need social care are accessing services now than in 2010, and pressure on hospitals grows.

The cuts have led to fragmented and heavily privatised social care services, which are now largely restricted to those with the most severe needs (and therefore delivering little in the way of preventive support to those who, with the right services available, could possibly cope at home).

Domiciliary care is delivered by demoralised, underpaid staff working for grasping private employers. There is very little social care system for the NHS to “integrate” with. Add to this the complexity and political sensitivity of “integrating” two services, one of which (social care) has since 1948 been delivered by local government, subject to means tested charges and largely privatised, while the NHS is predominantly a public service delivered free at point of use and funded from taxation, and the whole project becomes even more questionable.

There are justified fears this could lead to some NHS services being subject to charges. This does not appear to have happened as yet. The biggest problem so far is that there is just too little of either service to deliver viable support outside hospital for tens of thousands who need it, and the quality of social care is so abysmally low.

In the current continuing austerity regime, there’s no prospect of what’s needed — for renationalisation of these services, and NHS funding and principles to be applied to deliver social care as a public service, free at point of use.

NHS England chief Simon Stevens’s pet idea of personal health budgets has already been trialled in social care, and in some mental health care and other limited sectors of the NHS.

But with a few, highly publicised exceptions these “budgets” include only pitifully small amounts of money, and in many cases there is no functioning market of providers seeking to offer the services required.

In the summer of 2014 Stevens made grandiose announcements of a vision, in which “north of five million patients” could be receiving budgets ranging upwards from as little as a few hundred pounds to more than £1,000, with a small number with complex needs receiving “much more” — paid for by “billions” of pounds from the NHS and local councils. This seems to have completely died away. It never made much sense. Even £1,000 per patient for five million patients would cost £5 billion — but just £1,000 per year (£20 per week) would not be enough to buy any significant services, or offer significant profits to private providers.

A glimpse of how it might affect services can be seen in the proposal for £3,000 birth budgets to be given to pregnant women to buy their own care, including private support from midwives — but midwives are trained by and largely work for the NHS, and it needs all the midwives it can get. So any new private midwifery service would undermine the provision of services in hospitals for some of the more complex and demanding cases.

Where they have been tried in some mental health care in England, establishing personal health budgets has led to loss of funding and closure of specialist NHS services. Budgets could only be an effective way to contain spending if patients could be persuaded to top up their budgets from their own pocket or with family support — but at this point it stops being a generous gesture by the NHS and starts to be the imposition of charges and self-funded treatment, with all the inequality that brings. How long could that go on before it started to hit news media headlines?

On top of this there is the problem that patients receiving budgets would still be able to access free care from hospitals and GPs. There is limited, questionable evidence of the effectiveness of personal health budgets in improving the health of patients, and they have led to problems in the Netherlands. And there is little proper evaluation of what has been bought with the money — or even what range of services may be available to patients. There are no statistical data on how many recipients of these budgets wind up having to receive additional care from social services or the NHS.

Another Stevens fixation is hightech solutions, through which money could be funnelled out of the NHS budget to private corporations, leaving patients to monitor their own health, avoiding the need for outpatient and GP appointments.

The Forward View looks forward to “an expanding set of NHS-accredited health apps that patients will be able to use to organise and manage their own health and care; and the development of partnerships with the voluntary sector and industry to support digital inclusion.”

Here too there is a failure to recognise some of the problems frail older patients in particular have in making use of such technology, or even remembering to do so. There is no real evidence on the cost-effectiveness of expensive ideas that may not deliver the expected results if rolled out beyond small and well-resourced tests and pilot schemes.

And while indeed some patients will happily and correctly renew prescriptions online, others may struggle to do this, make potentially serious or expensive mistakes, or seek to abuse the

system. Some may be happy to have a brief GP appointment by Skype, but others may quite reasonably want some examination to be done. Some GPs may also reasonably question whether such limited exchanges represent adequate quality and safe healthcare, when they could be held responsible for failing to detect serious problems.

A key proposal in the Forward View that can trigger knee-jerk reactions is for accountable care organisations, which Stevens admits is a US-style system: he would know, from his years in the US as a senior executive of the leading health insurer, UnitedHealth.

Some critics believe Stevens has never really left the company, and is still working to its agenda, however slowly. The circumstances, however are different. In the US the source of funding is through insurance companies rather than the public money of the NHS.

But accountable care organisations are providers which agree on capitation-based contracts setting a cost envelope to deliver care for a defined population. Money they don't spend they can keep — but if they get the sums wrong they could lose money. Here establishing an accountable care organisation in a locality would effectively outsource the commissioning role of the clinical commissioning group to a trust or private “lead provider.”

However, the new set-up would not escape the complexities of the tendering regime established in the Health & Social Care Act or abolish the purchaser-provider split. An accountable care organisation is unlikely to work without substantial investment in community-based healthcare, enhanced primary care and the establishment of social care to minimise demand for hospital care and support people living at home.

In the US, some of the bigger providers like Kaiser Permanente have always saved costs by delivering such care within their organisation. Of course the NHS could do so here too, more cheaply and fairly, if health and social care were integrated in one public service in place of the present split.

While the model is of questionable relevance to England, it's useful to remind fans of accountable care organisations of some of the problems they are causing in the US, where they effectively require providers to operate as insurers, causing all kinds of financial problems.

The Obama reforms removed the right of private insurers to exclude patients with pre-existing conditions, and as a result an increasing number of US accountable care organisations have found that they are not only taking on risks, but where they cover a less healthy and more risky population they are losing money — and many are walking away.

The NHS, unless it is substantially and very visibly reorganised, offers only limited options to exclude high risk and potentially costly patients. This makes capitation-based funding an unattractive gamble for private insurers, which would be lumbered with any deficit.

So at least in the medium term any accountable care organisation model here would need public funding, unless they were deregulated to allow them to escape responsibility for vulnerable patients, or provision of key services, leaving some patients without care if any scope is to be offered to make profits.

One facet of the Devo plans is indeed to reduce regulation, and open up more possibilities for patients to fall through existing safety nets.

But let's not forget that this too would be a very high-risk strategy for any party in government, not least the Tories, heavily dependent as they are on older voters, and with an ageing Tory Party membership, most of which, like the members and voters who back Ukip, support the NHS and oppose its privatisation.

Both of Stevens's main suggestions of new models of healthcare — multi-speciality community providers, to be led by GPs, and primary and acute care systems to be led by acute trusts — could potentially be delivered as accountable care organisations.

But attempts to launch accountable care organisations in England rather than simply merge or regroup existing services have been limited so far.

The lure of a share of the £1.8bn “transformation fund” no doubt means more will be tempted. Some local accountable care organisations are already happening, with the most high-profile one in Northumbria, where NHS England has stumped up £8.3 million over two years in development funds to kick-start an accountable care organisation covering 320,000 people and headed up by Northumbria Healthcare Trust, starting from April 2017.

The plan boasts that for the first time it will combine general practice and primary care with hospital, community, and adult social care, as well as mental health services. The principles of this sound reasonable: as long as the funding is adequate to allow all of the component services to operate properly, and the social care is in fact provided by an NHS organisation or on NHS principles.

The Northumbria plan was announced by then trust chief executive Jim Mackey. He is now leading the regulator NHS Improvement. Mackey recently spoke out against local sustainability and transformation plans being based on “trendy” ideas which are too complex and lacking in evidence: it's not clear whether his comments also apply to the accountable care organisation scheme being developed by his former trust.

In December 2015 it was announced that Barking and Dagenham, Havering and Redbridge will run a “devolution” pilot to develop an accountable care organisation, in which “primary and secondary care are more closely integrated.”

This in a part of London with the major hospital trust in chronic deficit, and social care in tatters after years of cuts. The chances of success are not that great: early figures suggest that the Barking, Havering and Redbridge health economy as a whole faces a substantial annual deficit adding up to around £440m by 2020.

The trust, one of nine that have not reported their waiting time data to NHS England, has also recently revealed a staggering total of 1,000-plus patients who have waited over a year for treatment. The scope to reduce hospital beds is also limited by the repeated black alerts at the acute trust with beds full at both its costly PFI-funded Queens Hospital in Romford and at King George's in Ilford, which the trust has been hoping to close.