



Sue Ryder Briefing in Advance of Opposition Day Debate on Health Wednesday 17th November 2010

1. About Sue Ryder

Sue Ryder is a charitable provider of health and social care services. We deliver care in a range of settings including people's own homes and communities, our hospices and our residential care centres. We are funded through voluntary donations and income from our network of 350 charity shops. We also have contracts with PCTs and local authorities.

We provide services across the continuum of care; from basic social care to specialist palliative end of life care. We therefore have a unique insight into the challenges faced by people with complex needs. Our services support people living with conditions including cancer, dementia, stroke, brain injury and multiple sclerosis.

Many of our service users have needs that span across the health and social care divide. The integration of the two services is therefore critical to their quality of life and outcomes.

We welcome this debate on NHS reorganisation and have outlined areas that are of primary concern to Sue Ryder below.

2. Health and social care integration

There are instances of integrated care working well (see appendix one) and improving quality of life and outcomes. However, many of those with complex needs suffer from 'cost shunting' between health and social care. This can blight funding and provision of services locking people out of receiving care until they reach a crisis point. Further good examples of integrated care must be encouraged to develop in the 2011-15 spending round.

By 2015 the public health system will be fully operational. While we welcome the recognition public health is being given, we are concerned that this reorganisation could produce another body to shunt costs towards. This would create an even more bureaucratic and challenging environment for service users to navigate.

These problems could be compounded by the harsh cuts social care will be experiencing and the rationing of funding within the NHS. There is no clarity about how service provision will be divided between the three bodies. This must be addressed to ensure targeted public health interventions addressing both health and social care needs are developed.



In our response to the government's white paper, we recommended the creation of a mechanism for local authorities to divert NHS funding to pay for healthcare public health interventions that prevent and postpone dependency.

We welcome the introduction of new funds specifically designated for health and social care integration (£1bn announced in the CSR). However, these funds are not ring-fenced and risk being diverted to other areas of local authority spending.

2.1 Sue Ryder believes that in order to ensure cost shunting does not spread and worsen:

- The government should create guidelines stating the dividing lines between the health, social care and public health systems. This should include designating how specific services should be funded.
- There should be local-based agreement about how services are funded and local authorities should be able to divert NHS funds to create truly integrated public health interventions.
- Information and advice on entitlements should be more readily available so that families do not have to reach breaking point before they are given the support they need.

3. The cost of NHS reorganisation

NHS reorganisation will undoubtedly place a strain on the NHS. Estimates for the reorganisation are between £1.7 and £3bn¹; the latter represents a burden that is too much for the system to cope with unless there are severe cuts to frontline services.

Over the next four years, the landscape Sue Ryder will be operating in will change significantly. Alongside the structural transformation outlined in the white paper, the funding systems for both palliative care (review chaired by Tom Hughes-Hallett) and social care (Commission chaired by Andrew Dilnot) are likely to change. We believe the pace of reform is worrying and risks compromising the quality of care as structural changes are focussed on.

Evaluation needs to be built into the timetable for reform. At the moment it is not clear how successes and failures will be learnt from as the process progresses. This is integral to undertaking a responsible change agenda.

¹ £3bn figure published in an editorial by Kieran Walshe in the BMJ. Extract can be found: <http://www.bmj.com/content/341/bmj.c3843.full?sid=7968b5ac-f61a-413d-8c8d-6f8bf26bf4db>



3.1 GP Consortia

We support the principle of handing choice and control down to patients, and we believe that GPs may be well placed in the future to commission care for their patients. However, we have established a number of provisos that must be addressed before we can offer whole hearted support to the proposals.

2008 research shows GPs are the least confident of all Doctors at deciding when a person needs palliative care.² If this is not addressed before GPs take over commissioning, many people will suffer unnecessarily without receiving the services they need. Sue Ryder is undertaking a significant education programme of GPs. In some areas we have spoken to two thirds of our GP practices about the services that we provide and the needs of people nearing the end of their life. This is not an England wide solution though and we would like to see the government taking action and outlining how much funding and time it will commit to education programmes.

There should be other solutions to this problem such as available expertise on the NHS Commissioning Board. This should be easily accessible and free of charge. As yet, we are unsure whether this will be the case.

Some of the services Sue Ryder provides such as residential neurological care and some end of life care are low-volume. In order to limit the administrative burden and ensure that innovative and choice-based solutions are available to service users, these services should be commissioned across Consortia boundaries. We would like the NHS Commissioning Board to encourage working across Consortia boundaries where it will improve delivery of care for service users. See appendix one for an example of a service that would benefit from being commissioned across Consortia boundaries.

3.2 Sue Ryder recommends:

- The government builds evaluation into their timeline for reform; this is currently lacking
- Information is released on the education programmes GPs will be required to undertake before they begin commissioning
- GPs are encouraged to work together across Consortia boundaries by sharing expertise and commissioning low-volume services together
- The government produces clear, transparent and detailed costing of how much NHS reorganisation is forecast to cost

4. Suggested questions

² National Audit Office: 'End of Life Care' (2008)

Sue Ryder

In this debate, we believe MPs should seek to determine how the NHS reorganisation is going to be funded and what effects the government thinks it will have on the quality and availability of frontline services.

- The localism agenda will make it difficult to assess the national effects of the spending cuts; how will the government monitor local areas to ensure that they are not compromising on quality when commissioning services?

We would also like clarity about how the responsibilities of GP Commissioners, local authority social care commissioners and local authority public health commissioners will be divided. It would be helpful to know whether there is going to be a local approach to the allocation of commissioning for specific services.

- Public health, social care and GP Commissioners must work together to commission integrated services, but to ensure cost-shunting does not continue, they also need to have discrete and clear roles and responsibilities; how will the government get this balance right?

Overall, the most important point for the coalition government and the opposition to consider is how models for integrated care will be encouraged and developed in these challenging economic times. Cooperation between the three systems (health, social care and public health) will benefit service users and yet there are existing barriers that need to be broken down between health and social care.

- What advice would the government provide to service users with complex health and social care needs about how they can ensure they get all of the care they need? How should they be navigating the system?

For further information about Sue Ryder or any elements of this briefing, please contact Blanche Jones, Public Affairs and Policy Manager on 020 7400 0445 or email blanche.jones@suerydercare.org



Appendix One

Sue Ryder – Bixley Road Supported Living (Ipswich)

Sue Ryder's Bixley Road is a supported living facility and an excellent example of integrated care improving outcomes and quality of life. Through the support of the PCT, local authority and a housing association, Sue Ryder was able to move 3 residents out of long term residential care, back into the community in a supported living facility. In the vast majority of cases those in residential care remain there until they die. This experiment has yielded such successful results we plan to replicate it across the country. The tenants in Bixley Road receive health and social care support; the social care is delivered in the home and the healthcare is delivered at Sue Ryder's nearby care centre. All residents are in control of their lives and what they do on a daily basis; they shape the care they are given. The new service has financial benefits; the PCT's bill has lowered since these individuals were placed in supported living, while the local authorities' has remained the same.

Describing Sue Ryder's supported living residence, Jane says, "It's like home. Me and my fellow housemates have our evening meal together and share the household chores such as cooking, gardening and cleaning. We have regular meetings each week in which we discuss house-rules and family and friends come and visit whenever they like."

Sue Ryder Nettlebed Hospice - Community Matron Service (Oxfordshire)

The Community Matron Service is a partnership project between Oxfordshire PCT and Sue Ryder. This is the sort of low-volume service that would benefit from being commissioned across GP Consortia boundaries. The role was developed in response to the Government vision of Community Matrons working in partnership with patients in their own homes to provide monitoring, case management and interventions as to help reduce the number of emergency attendances and admissions to hospital.

The aims and objectives of the role are to ensure every patient has access to palliative care services appropriate to their need, can exercise choice about their place of care at the end of life by ensuring patients receive adequate symptom management to promote a good death and by smoothing the patient pathway for palliative care by reducing unnecessary steps, duplication of effort and unnecessary admission.

The Community Matron Service also supports patients with long term conditions ensuring that all patients with end of life care needs are supported. These aims and objectives contribute to the delivery of the national End of Life Care Strategy.

Results: Evaluation has demonstrated a significant reduction in hospital stays and unplanned admissions representing a cost saving to the commissioning PCT. The Community Matron role has been recognised by the Department of Health as an example of 'making change happen'.

The approximate saving to the PCT in 2008 as a result of the scheme: £64,000