UNLOCKING VALUE

How can the NHS capitalise on a goldmine of unused land?

CARE QUALITY COMMISSION
We explore some of the new proposals from the CQC

GETTING IT RIGHT OFF THE GROUND
The GIRFT programme is now rolling out across different specialities

RECRUITMENT POST-BREXIT
How has the NHS begun to cater for post-Brexit staffing issues?
This year has seen increased emphasis on NHS estate management, with a focus on the untapped goldmine of unused land across these estates. And with a predicted value of £2.7 billion, there is now a clearer drive to incentivise trusts, and ensure it is released in the most effective way possible (page 8).

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Getting it right

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Emerging issues for the health sector

The research spans the full spectrum of data sources, from formal feedback channels to anecdotal input from patients and staff, and provides insight into the information senior leaders consider to be most valuable to them. Our research is designed to help boards across the sector to identify the most useful data channels, and understand best practice when it comes to implementing cultural change. Our findings suggest that culture is the most challenging aspect of improving patient safety.

A comprehensive report on the research will be launched at our Patient Safety Summit on 7 December 2017.

New guidance from NHS England

In August, NHS England published a draft contract for Accountable Care Organisations (ACOs), setting out conditions for managing the relationship between commissioners and providers. The contract is designed to be used by commissioners to commission baskets of services using a whole-population budget. These services include social care and public health services, alongside physical and mental health.

In addition, NHS England has updated its Integrated Support and Assurance Process guidance, which is designed to assure novel and complex contracts, which includes ACO contracts.

The publication of these two pieces of guidance is a very helpful step for commissioners and providers looking to develop new business models. They can be accessed at:

• http://bit.ly/2y2H1hY
• http://bit.ly/2v8BzR

DAC Beachcroft has extensive experience guiding commissioners and providers through the challenges of integrating healthcare and implementing new models of care.

Patient Safety Summit announced

Patient safety sits at the heart of delivering care in the NHS and independent sector. And data plays a pivotal role in delivering safe clinical services. The ability to collate and analyse the right data, and build a reliable picture of your organisation’s safety, is therefore essential to every health and social care provider; as is the culture that enables that ability.

But in an age of multiple layers of data, information comes from everywhere: clinical governance, incidents, contractual and commercial commitments, recruitment, estates and management, and so on. But which will paint the true picture?

As legal advisers to the health and care sector, DAC Beachcroft has been conducting detailed research into the data required by providers; how data is reported within organisations; and how it is used to improve patient safety.

Mental Health Consultancy Training

Mental health and capacity law is one of the most multifaceted and rapidly evolving legal areas in the health and care sector. And with complex and often contradictory legal frameworks to work within, it’s important for health professionals to remain up to date with any changes, and understand what is required of them.

DAC Beachcroft’s specialist Mental Health Consultancy Training is designed to allow mental health service commissioners or providers in health, local government and the independent sector to access bespoke training on these problem areas. The training includes courses for AMHPs, Best Interest Assessors, Mental Health Assessors & Signatories, s12/IAC professionals and Hospital Managers.

We also supplement these training services with a consultancy and advice service, which can be used in conjunction with the training, or accessed on a stand-alone basis and when issues arise.

Legal 500 2017 marks continued success for DAC Beachcroft

This year’s Legal 500 results have been published and we are delighted that, once again, we have maintained our tier 1 rankings for our Health sector expertise. Thank you to all of our clients who responded to requests for information from Legal 500 and the many positive comments our teams across the UK received.

The firm’s “Clinical Negligence: Defendant” offering maintained its tier 1 rankings across all of our UK offices, where we defend healthcare professionals and providers, including the NHS.

The Legal 500 “singly out” our Yorkshire team for its “approach to client support, wealth of expertise, and fair and balanced approach to managing claims”. Other teams across the UK also received high praise for their “excellent service delivering handsome, frank and well-informed advice”, and stating that we deliver “comprehensive and high-quality advice” to our clients.

These tier 1 rankings also extended to our broader health offering in London, the south-west, the north and north-west; and Yorkshire and the Humber, where our wider-range expertise includes partnership advice, handling procurement processes, defending judicial review proceedings and conducting compliance reviews, and where our experts are recognised as “excellent, responsive and knowledgeable… outstrips others in the field”.

For more on the Care Quality Commission, read our feature on page 16.

Platform

Patients need to know the information they share is secure and supports their treatment, says Professor Jane Dacre, president of the Royal College of Physicians.

Recently the government produced its response to the National Data Guardian for Health and Care’s Review of Data Security, Consent and Opt-Outs and the Care Quality Commission’s Review ‘Safe Data, Safe Care’. These documents set out recommendations for data sharing and security to support patient care, and the support that needs to be put in place to implement these recommendations.

The Royal College of Physicians welcomes the government’s adoption of these recommendations and, in addition, the focus on communicating the benefits of data sharing. Patients need to know that the information they share with health professionals about their care will be protected and used to support their treatment and the actions the government are taking will support stronger security standards and data protection. This will include strengthening leadership and accountability in data protection for health organisations, replacement of outdated systems, and a new focus on staff training.

The Care Quality Commission has recommended that staff be provided with the right information, tools, training and support to allow them to do their jobs effectively while still being able to meet their responsibilities for handling and sharing data safely. They have also committed to amending their assessment framework and inspection approach to include assurance that appropriate validation against the new data security standards have been carried out and make sure inspectors are appropriately trained. This extra monitoring may give patients and NHS staff more confidence in the data they share and the ambition to improve patient care.

To find out more about the research, or to book your place at the Patient Safety Summit, please contact Jemma Arscott at jarscott@dacbeachcroft.com, or call +44 (0)113 918 2703.

To find out more about this offering, visit www.dacbeachcroft.com/mentalhealthtraining.

For further information, please contact Charlotte Burnett, partner, on +44 (0)113 251 4785 or email ckburnett@dacbeachcroft.com.

www.dacbeachcroft.com/health

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NEW
As Briggs says, each speciality review is a fascinating exercise. And what makes GIRFT different is that it’s a peer-to-peer review. And it’s not by management or systems specialists. “Clinicians are going out to NHS trusts, showing what they need to do and what’s happening around the country. “When we appointed them, we did so with the membership colleges and societies, so we secured clinical leads with reputation and respect among their colleagues,” Briggs comments. However, the teams carrying out the reviews meet with the senior management team as well as clinicians. When their report comes back, it is the job of both the clinical and medical directors to drive the changes that need to happen to meet its recommendations.

The pilot
Led by Briggs, the pilot launched in 2013 after the publication of the GIRFT report in elective orthopaedics in 2012. It looked at Briggs’ own speciality of orthopaedic surgery. It reviewed the total pathway of adult elective orthopaedics and spinal activity in 120 trusts, and identified a surprising amount of variation in practice and outcomes. These included long-term deep infection rates for hip and knee replacements (which varied between 0.2 per cent and 1 per cent); returns to theatre due to complications (between 0 and 7 per cent); and a similar variation in the prices paid for hip and knee implants. Briggs admits he was surprised, but has some ideas as to why this variation may have come about, with some applying across the different specialties.

“I think that if you go back before 2010, the whole drive of the health service was about targets and getting waiting times down. Nobody had looked at the quality of what was being delivered. And a lot of these datasets we now use, like the National Joint Registry, were in their infancy.”

Other variations are specific to his own specialism. “Over 75 per cent of the surgeons doing complex knee replacements were carrying out ten or fewer procedures a year. The approach to surgical training used to be that a surgeon was trained to do all procedures. We now know that if you concentrate areas of expertise, with more specialisation of the complex work, your outcomes are better. It’s also the best use of bed days and resources.”

Making changes
Briggs says he “had no pushback” when presenting the findings to trusts. “I think it was the first time they’d been shown data in comparison with other hospitals, and I don’t think they’d realised what was happening around the country.”

What makes GIRFT different is that it’s a peer-to-peer review. And it has buy-in from clinicians, specialist bodies, arms-length organisations, the CQC and politicians. Once people settle down and discuss it, the solutions become obvious.”

He is now revisiting those trusts and, he says, finding distinct improvements. GIRFT estimates savings of around £50m in total since the first review. There’s also been a culture shift. “People have started to understand that we need to do things in a different way. We are now seeing networks develop, with surgeons talking to each other in different trusts, working in collaboration rather than competition,” says Briggs.

He also flags up the significant variations in litigation costs.

“Litigation cases were not discussed with the CQC and politicians. This also found considerable variations, and made 20 recommendations spanning surgical performance, choice, commissioning and care pathways, and data and performance measurement.

For example, it estimates that standardising consultant-led surgical triage and ambulatory emergency surgical systems would drastically reduce the number of unnecessary admissions, with a knock-on effect on costs.

Four more reports, covering vascular surgery, trauma surgery, urology, and neurosurgery, are expected by the end of this year.

With the appointment of the second tranche of clinical leads in February, the full range of specialties now extends to mental health and dentistry. (Interestingly, ‘medical negligence’ was in the first group so that report should be expected before too long.) Accordingly, each NHS trust now designates a GIRFT champion — typically a member of the directorate who sits at board level, and works with the clinical directors of each specialty to make sure the recommendations are taken up. “That champion is the person who makes sure things happen when we visit, and shows the GIRFT implementation team works with to ensure the changes are made,” says Briggs.

The GIRFT approach has also been adopted by other bodies. “I’ve been really pleased with the take up of the GIRFT methodology among clinicians — and also in specialist societies and colleges,” Briggs concludes. “My hope is that it helps to provide high-quality effective care that stands out unwanted variation; and that it makes a significant difference to improving patient care.”

To discuss the issues raised in this article, please contact Heather Durston-Hillyer on +44 (0)1962 705513 or hillyer@dacbeachcroft.com

www.dacbeachcroft.com/health
In these financially stretched times for the NHS, it may seem incredible that it is sitting on unused estates worth an estimated £2.7 billion. Currently, the NHS in England has an estimated 1,200 sites, 6,500 hectares of land, and buildings with a gross internal area of 26 million square metres.

Most people would view such a resource as an untapped goldmine, but the reality is that there has been little government guidance on how this land could and should be used, and trusts are not incentivised to do anything with it. However, this could be about to change, following a government commissioned report published in March from Sir Robert Naylor, the Government’s National Adviser on NHS Property And Estates.

The report builds on an earlier review this year by Lord Carter. It recommended the health service introduce efficient use of resources, including estates, to contribute to £5 billion savings over the next five years.

Naylor is former Chief Executive of University College London Hospitals NHS Foundation Trust. His review team investigated the opportunities presented by releasing inefficiently used or unused land for other purposes, including residential development.

Naylor says: “There is a very substantial amount of land and property that isn’t being used, or is being used badly and could be used better. “We found huge variability between different hospital trusts, and between different STP [sustainability and transformation partnership] areas in terms of the best utilised estate and the worst.”

He insists his ideas are not about selling off the NHS, arguing: “It’s about modernising the NHS, improving facilities for patients, and making better use of the huge number of buildings and facilities that the NHS has – not just in hospitals but also in primary care.”

Untapped money
Naylor calculated that the NHS could release estates no longer required to deliver health and care services worth a risk-adjusted value of £2.7 billion. Even better, the financial value could be much higher, as Naylor says: “If you acted in a more commercial way than the NHS normally does, then the actual value of disposing of the land could be as high as £6 billion.”

The report claims that for STPs to be able to deliver NHS England’s Five Year Forward View strategy, current capital investment in fund transformation and
maintain the current estate will need to increase by around £10 billion. This would need to be funded through NHS property disposals, private capital (for primary care) and the Treasury.

Anne Crofts, Partner and Head of Commercial Health at DAC Beachcroft, agrees that there is huge potential for improvement in how trusts use their assets. Crofts says: “Historically, trusts that own properties have treated them like the family silver. They see them as assets to be kept safe for a rainy day, but it’s not always entirely straightforward to dispose of the assets.”

The scale of opportunities varies across the country, as Anne Batanero, Partner and Head of Health Real Estate at DAC Beachcroft, explains: “There is a distinction to be drawn between properties in the south and south-east, where values are quite high, and surplus property in the north and more disadvantaged areas where values haven’t increased as much.

“What’s left is the stuff that is quite difficult – that’s why it hasn’t been sold – because it is complex. There are surrounding properties which may or may not be health properties and there will be issues, ransoms, neighbours with rights – all kinds of reasons why a site hasn’t been sold.”

Staff accommodation

One creative use of these resources outlined in the report is to prioritise the land for development of residential homes for NHS staff, in discussions with housing associations.

The idea has been championed by Niail Dickson, Chief Executive of the NHS Confederation. In an Observer newspaper interview in June, he urged the government to create a new £10 billion NHS Homes Fund, which would revive the tradition of the health service providing homes for staff to provide housing and tackle recruitment problems in some areas of the NHS.

Dickson said: “We believe there is a case for new style homes for NHS staff, particularly where the cost of housing is very high. This leads to staff not wanting to work in these places, because they can’t find proper accommodation, or have to travel long distances.”

A key barrier to trusts doing more with their estate is the lack of incentive, as a NHS Confederation briefing note explains: “The main barriers are the incentives in the system. These do not reward those organisations who are needed to put in the effort and resources to facilitate the unlocking of land for the purpose of building houses.”

To tackle this, Naylor has proposed a ‘two-for-one’ offer idea. He explains: “The question is how do you incentivise trusts to focus their attention on this?”

“Every trust in every STP is recommended to come up with a strategy for the utilisation of its estate. If it’s able to do that, then our recommendation is that the government will provide two-for one funding for any land and assets that they dispose of. So the trust will have twice as much money with which to redevelop its assets and make its services more efficient and effective.”

Guidance on using estates could come from a proposed NHS Property Board.

Government moves

Naylor believes that Chancellor Philip Hammond has effectively already backed this idea in his spring budget. He says the government is allocating £375 billion to fund capital investments in the most advanced STP footprints, and promised in his forthcoming autumn statement that he would find additional funds – providing trusts were able to identify disposable assets.

Better national guidance on using estates could come from another recommendation contained in the report – the creation of a new NHS Property Board to provide leadership, strategic direction and resource for STPs on these issues. The government has already moved towards creating just such a body.

Naylor says there is also interest in a further recommendation in his report – leasing accommodation to staff. “I am suggesting that we should build that accommodation and lease it to staff during the tenure of their employment. That will encourage staff to stay in employment at the hospital, and with a bit of innovation, you can see how staff could benefit from the increasing value of that property over time,” he explains.

There is enthusiasm for this kind of change from the larger trusts in the south and south-east, as Crofts says: “A lot of the big land-owning trusts are looking at this. There is also interest elsewhere in the country. Broadly, in areas where property values aren’t that great, the interest is more on collaboration around the way organisations can work more effectively together.”

“The big question for the system is to what extent should those benefits or the realisation of value be shared, and how should it be shared across a STP area.”

Private sector partnerships

One possible solution for the NHS is to form partnerships with private sector investors to use dormant NHS land and facilities. This is particularly relevant in primary care, where the majority of GPs are independent contractors who traditionally own their own premises – which can often be outdated.

In August, three property investors – Octopus Healthcare, Primary Health Properties (PHP plc) and Assura plc – offered to invest £2.3 billion to support the development of NHS primary care estates, and meet the Naylor report’s recommendations.

Octopus Healthcare are fund managers for the Medick Fund, which invests in primary care and modern purpose-built care homes.

Under the proposal, the money would fund around 750 state-of-the-art primary care centres through third-party development across England over the next few years. Servicing the investment would probably require around £200 million of rent per annum from the NHS.

Octopus Healthcare Director Tim Meggitt says: “This investment in the primary care estate could ensure that government priorities, like delivering efficiency savings and keeping people out of costly hospital wards, are met. We can deliver a one-stop solution for a primary care trust, care homes, retirement living and key worker accommodation.”

Anne Crofts says such proposals could be in line with the Five Year Forward View strategy.

“On the clinical side, there are new models being created for accountable care systems. These are designed to move as much activity as is reasonable and possible out of hospitals – out-patients for example – into facilities that are probably cheaper and more efficient.”

On this, he says: “In order to do that, we need fit-for-purpose, up-to-date, modernised buildings.”
On becoming Director of Workforce at University College London Hospitals in 2014, Ben Morrin discovered eight beds lying unused in one of the world’s most prestigious hospitals. “I remember going up to a ward in the National Hospital for Neurology and Neurosurgery as part of my induction, and walking past two bays with four beds each. They were clean and ready. I asked when they were going to be used, and was told there was no prospect of them being opened, as there were insufficient staff. “Seeing such shortages at ward level, and the consequences for a highly specialised unit providing complex surgery, was quite telling.”

Morrin, who has worked at the NHS, Department of Health and Downing Street Delivery Unit, says colleagues across the NHS are suffering in much the same way – trying to redesign services and drive integration against a backdrop of shortages. These are being caused not least by uncertainty over the continued supply of health workers from mainland Europe and beyond.

Mulling over the Neurology unit closures, Morrin assembled a group of nurses, HR professionals, communications specialists and unions to share thoughts about tackling vacancy rates of up to 17%.

“Authentic appeal”

Morrin says the trust decided not to use a private sector marketing partner, but to allow staff to think about how to portray and market their roles. Some months later, advertising material began appearing, promoting real life stories and images of trust employees. Hoardings at prominent trust sites like Tottenham Court Road, Euston Road, King’s Cross and Marylebone displayed the strapline: ‘At UCLH, our success starts with you.’

“The quotes about what it feels like to work at UCLH came directly from staff, they were not sanitised or spun. Staff chose the words themselves, and put podcasts on our website about their experiences. They front the way that we advertise, and potential candidates could speak to them for an authentic view of what it is like to work for the organisation.”

Vacancy rates fell to 6.5% over the following 18 months, according to Morrin, and have since levelled out at around seven or eight per cent – although they are “a little higher” in areas such as cancer, neonatal and neurology and neurosurgery.

“UCLH staff fronted the trust’s recruitment ads, and candidates could speak to employees for an authentic view of what it’s like to work for the organisation.”

He says staff appreciated being used as role models in the advertising. “We were delighted with how they responded to, and engaged with, the process.” Relations with unions and representative groups – such as the BMA, RCN, Royal College of Speech and Language Therapy, Unison and Unite – have also benefited. “Some people might have thought it risky to involve them in every senior management conversation about the issues we faced,” says Morrin. “But we were being deliberately open about challenges everything the
organisation has done and is doing. Having the representative groups around the table to help spark ideas meant they were more involved in the solutions, and have more ownership of them as a result.

At the other end of the employee journey, the trust also commissioned an independent company to carry out exit interviews, in order to examine what made staff leave.

Staff-led innovation
Nurses revealed that principal aides to staff-led innovation made staff leave.

"A lot of it came down to making the job affordable," Morrin explains. "However, government wants to react (in terms of the current pay cap), we’re committed to increasing reward wherever we can.

"There’s an obligation on employers to think practically about what they can do in terms of rewards, learning development, or meeting some of the costs of travel or housing.

Staff-led innovation has led to the creation of a careers clinic, where staff considering leaving can explore the possibilities of redeployment or retraining.

"The facility has been around for a year or so and, so far, some 165 staff have used it. A good proportion would very likely have not stayed if we didn’t have it," affirms Morrin.

Much is being made of trying to predict where technological advances will add to or reduce NHS workforce pressures. With this in mind, the trust set up the UCLH Future programme to assess where healthcare will be in the next ten to 15 years.

The trust worked with management consultants McKinsey to assess fundamental dimensions of future healthcare, such as how the trust will use digital technology to improve patient outcomes in the care delivery system. For example, a new coordination centre based in the central UCLH Tower on Euston Road gives clinicians and managers a clearer picture of available beds, facilities and hardware.

"It will allow us to track when a patient needs a bed, when they leave hospital, or where equipment is. Wheelchairs, testing equipment and kit will be tagged, so that they can be found very quickly in a large hospital. This technology is being tested in Wolverhampton, in Chester and UCLH, and we’re optimistic about how tracking our equipment better will speed up the flow of patients.

The trust has just signed a ten-year deal with a US electronic patient record company called Epic. The agreement will mean around a third to a half of training capacity investment will have to be refocused in 2018-2020 to prepare for its effective implementation.

Morrin says that organisations that have this system in the US and UK are significantly improving patient outcomes. "Professional experience has been really positive, because Epic allows you to ensure you are focusing on pathways and interventions that are premised on the latest clinical academic practice – encouraging research-intensive care."

And a common system could also mean better interactions with patients. "At a time of choice, patients will be able to pull down their record and communicate with a clinical colleague about their latest hospital experience," he says.

The trust is also pulling together a comprehensive picture of its workforce demographic: age, gender, home commitments and transport/commute needs. It has one of the youngest workforces in the NHS, and its average age is falling.

Morrin highlights the need to be flexible in this context.

"We need to be flexible. We need to recognise the responsibilities of staff who are parents and carers, or who might be in training in London, but likely to move away on qualification. And we need to be able to predict and respond to the factors that may prompt them to leave. We must be able to spot these before it’s too late."

He also points out that NHS staff are 50 times more likely to be affected by debilitating illness than the rest of the UK workforce. "That means that as employers, we need to invest in staff, and in how we support them when things go wrong – either with their health, or in times of challenge."

Finally, he pauses to consider what makes a good organisation: "It’s about demonstrating compassionate leadership, being mindful, being able to reflect and pause on the judgements we make as leaders that have a clear impact on our staff. Organisations that do that are demonstrating compassionate leadership and have the best patient outcomes."

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Ben Morrin has been Director of Workforce at University College London Hospitals NHS Foundation Trust since September 2014. He is an Executive Director responsible for 8,000 staff, including the trust’s HR and education strategy and services. He is currently leading work across London on retention and recruitment. UCLH won the national recruiter of the year award from the CIPD in 2016. Ben joined UCLH from government, having spent the preceding decade in the Prime Minister’s Delivery Unit and the Department of Health. He lives in Greenwich and with his two young sons, and is a season ticket holder at Ipswich Town Football Club. We"n

Morrin is keen to link the work of the trust and its colleagues at Ipswich Hospital into a shared system that might be adopted across the NHS housing system. Such an approach could reduce NHS workforce pressures. With this in mind, the trust set up the UCLH Future programme to assess where healthcare will be in the next ten to 15 years.
The Care Quality Commission (CQC) has been going through a wide range of consultations and announcements over the last 18 months, as it adjusts to a changing landscape of provision and accountability. A new assessment framework for NHS trusts is already underway, with adult social care and primary care providers expected to implement theirs from November 2017, and independent providers following this.

Overall, the CQC plans to retain its five Key Questions (see box), but is revising and fine-tuning the Key Lines of Enquiry and Prompts. Alongside this, the Commission is changing the frequency of some inspection regimes, and has singled out some areas for stand-alone inspection. It is also revising the number of bodies to be registered and inspected, and piloting new inspections which will operate across the sectors.

The CQC is trying to find ways to create new legislation, which allows it to track true accountability for quality and safety within the new corporate structures and models of care, says DAC Beachcroft partner Corinne Slingo.

"The CQC is trying to create new legislation, to track true accountability for quality and safety," says Slingo. "Good providers will simply add it in, but it will still mean more work preparing for an inspection. But providers who haven’t kept up with the cycle of reviewing may find it a lot harder."

However, she warns against making like-for-like comparisons when the new regime is extended to the independent sector. There could be tensions when, say, comparing the universal approach the regulator looks for in the NHS, with organisations set up to meet a particular need.

"The evidence base – especially for the independent sector – might be slightly different," she says. "How independent providers deliver services may not fit easily into a framework the CQC will recognise. That’s one of the biggest tensions providers will have to grapple with."

Trusts will know in advance when to expect an inspection, though the precise nature and focus of each inspection may vary from trust to trust. The first information requests are now being sent out, with the system expected to be fully embedded by spring 2018.

"It’s a big change, and for NHS bodies, it’s more regulatory scrutiny, and more compliance to get their heads round," Slingo points out. "Good providers will simply add it in, but it will still mean more work preparing for an inspection. But providers who haven’t kept up with the cycle of reviewing may find it a lot harder."

Well-led inspections

While some inspections will become more flexible, others will become more regular, depending on previous ratings. NHS trusts will be inspected on a service-by-service basis, with the frequency based on their previous rating for core services. For example, the maximum time before a revisit to a service rated as ‘inadequate’ will be a year, while one rated as ‘outstanding’ could see five years before the next inspection.

Each trust should also receive a stand-alone annual assessment for the ‘well-led’ key question, focusing on its leadership, governance and management. This will also examine how well the trust works with its partners, and integrates services across the sector. This is a new development for the CQC’s inspection regime, and fits in with an approach that believes that if the leadership is right, the overall quality should follow.

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From a CQC perspective, it’s a matter of robust risk management, but it does require greater understanding of diversity within leadership, staff and teams."
The five key questions for providers to answer
The CQC has five questions it asks of all care services:

- Are they safe? Patients are protected from abuse and avoidable harm.
- Are they effective? The care, treatment and support provided achieve good outcomes, help to maintain quality of life, and are based on the best available evidence.
- Are they caring? Staff involve patients and treat them with compassion, kindness, dignity and respect.
- Are they responsive to people’s needs? Services are organised to meet patients’ needs.
- Are they well-led? The leadership, management and governance of the organisation ensure that it provides high-quality care based on individuals’ needs, encourages learning and innovation, and promotes an open and fair culture.

New social care regulation
The CQC singles out adult social care services as a particular issue.

The commission recognises that the struggle to improve can be “a particular problem for some of the adult social care services that we have repeatedly rated as requires improvement.”

To tackle this, it proposes changes to how information is collected and providers are inspected.

While NHS trusts will move away from comprehensive inspections, adult social care services will continue to receive them. But the timing will vary. Services rated ‘good’ will be inspected after two and a half years; ‘outstanding’ services after three; while those rated ‘requires improvement’ will be inspected annually, and ‘inadequate’ after six months.

Slingo comments: “The difference is a slight divergence in frequency and content between NHS and social care providers. ‘Social care bodies will be scrutinised for everything, but ‘well led’ is built in. While for NHS trusts, inspections will be less comprehensive, there’s a stand alone inspection for ‘well led’. It’s changing for both sectors, and changing in slightly different ways.”

Senior scrutiny for independent providers
As part of its review of adult social care services, the CQC is also proposing a change in the line of accountability for provider groups. The change will require parent companies and group organisations considered to have a direct influence over quality and safety to be registered. This will include matters such as staffing, and to some extent, finances.

In theory, this should resolve the issues that arise when a provider must fall into line with a decision made by its parent organisation. In practice, however, Slingo highlights some potential caveats: “Organisations vary hugely in the level of autonomy they give to their subsidiaries, but this is not always reflected in the organisational structure.”

In addition, there are legal implications. Registering an additional legal entity makes it possible to act against both the parent company and the immediate provider.

“This could potentially pull back against the ‘robust’ structures of clinical governance that have been sought over the years, according to Slingo.

“The best practice currently in place is a really strong clinical governance structure, which enables everyone to learn from shared information. That suggests that it’s better to have a much closer relationship between the provider and its parent company. If the proposals go ahead, the CQC will need to take a slightly more analytical look at true control within an organisation. And as Slingo points out, the natural source for that is the clinical governance structure. “Ironically, this will mean organisations that have worked hard to establish a robust clinical governance structure being identified as having a close relationship. And this will necessitate registration for the parent governing body.”

Whole-system reviews
Slingo also points out that as health and social care systems work increasingly as integrated entities, separate inspection regimes may not always be appropriate.

“In some areas, there isn’t one single provider. So we’ll need alternative ways of monitoring and regulating service provision.”

To this end, from November the CQC will undertake a programme of local system reviews of health and social care in 20 local authority areas. These will also look at how commissioning is managed across the two areas – especially the way older people move from hospital to home or another care setting. It will also consider governance for managing resources.

Gardner believes that it’s the right approach to look at “quality of care in a place.”

“The NHS Five Year Forward View majors on coordinating care better across traditional organisational boundaries, and the regulatory regime needs to change to reflect that. Much of this is unknown territory, but it’s where the future of accountability lies.

“Ideally, the reviews would look at patient flow generally across local health systems, but the CQC has been asked to focus on how older people move between health and social care. No one wants to stay in hospital longer than necessary, but getting the right support outside of hospital is just as important as reducing delays.”

Margaret Wilcox, President of the Association of Directors of Adult Social Services (ADASS), takes this point further.

“These reviews will miss the point if they do not look at the whole system. That means primary, mental health and community NHS services which, alongside social care, keep people well in the community; and the interface between health and social care at the point of discharge from hospital.”

To discuss the issues raised in this article, please contact Corinne Slingo at cslingo@dacbeachcroft.com or on +44 (0)117 918 2152.
Recruiting for a post-Brexit world

The government has ambitious plans to expand the NHS workforce, with thousands more GPs and mental health workers promised. Faced with post-Brexit staff shortages, the NHS is looking to recruit via partnerships in India, and novel collaborations closer to home.

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The NHS in Numbers

132,000
of NHS England staff are foreign nationals

59,000
are EU nationals

73,000
are from non-EU countries

10,000
EU-national doctors work in NHS England

However, HEE stresses that this is not a long-term recruitment programme: “The nurses will not stay, but will learn and then return to an appropriate role in the Indian healthcare system.” All recruits will meet NMC registration requirements – which include English language skills to A-level standard – and will receive salaries equal to similarly qualified NHS staff. NHS trusts involved in the scheme will also pay any education costs. Apollo is optimistic about the scheme. On signing a memorandum of understanding with HEE, its Chief Executive Sangita Reddy said: “The collaboration will include clinical rotation of doctors, nurses, midwives, other health professionals and undergraduate healthcare students through mutual exchange. It will explore the possibility of establishing a global healthcare school, to ensure that opportunities for global learning are available to the healthcare workforces in both countries.”

A cautious welcome

DAC Beachcroft employment law specialist Udara Ranasinghe welcomes the initiative, while sounding a note of caution. “Any attempts to address NHS recruitment shortages are to be welcomed,” he says. “But it remains to be seen whether the HEE-Apollo arrangement will, for example, provide nurses in sufficient numbers to have a significant impact. Especially as applicants will still be required to comply with immigration requirements, which include passing the stringent Objective Structured Clinical Examination and International English Language Test. These have so far proven to be an obstacle to non-EU recruitments.”

“While it’s clear that however successful fixes of this kind are, they must run alongside longer-term strategies to bring more people into the healthcare profession.”

To discuss the issues raised in this article, please contact Udara Ranasinghe on +44 (0)20 7894 6727 or unransinghe@dacbeachcroft.com

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Don’t just look in the usual places

Facing relatively low UK unemployment (1.48 million in June 2017) and a competitive labour market, the NHS Confederation is encouraging employers to look to unconventional sources of home-grown recruits – such as the armed forces, ex-offenders and people with learning disabilities.

The organisation believes that recruiting from less well represented groups in the community is an under-used strategy. It is asking trusts to ensure communities are aware of their local NHS as a potential employer – one which can offer attractive pay, and flexible employment and learning packages.

The Confederation points to the example of South Tees Hospitals NHS Foundation Trust. The Trust is working with Jobcentre Pls to offer a 12-week pre-employment programme, offering opportunities to get back into the workplace through structured learning and vocational experience.

Public Health England’s Project SEARCH initiative supports young people with learning disabilities. It provides ten-month, rotating work-experience opportunities, combined with bespoke coaching and on-the-job training.

The Confederation also suggests contacting local organisations such as Nacro, which provides free advice to help employers considering recruiting someone with a criminal record. Or The School of Hard Knocks, a sporting charity that helps prepare disadvantaged groups for the workforce, and matches candidates to employers.

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Udara Ranasinghe

“However successful short-term fixes prove, they must run alongside longer-term strategies to bring more people into the healthcare profession.”
Patients are more interested than ever in how their data is used, and where it can be viewed. Trusts have an opportunity to harness this awareness by building rapport at the point of contact, creating opportunities for patients to get more involved with their health. 

The preparation
Organisations should be preparing themselves to ensure compliance with GDPR requirements, by taking steps to understand their current position. DAC Beachcroft can help by carrying out a readiness audit of your organisation. We will provide you with an overview of any compliance gaps, and rate the risk of any breach becoming a claim under the new regulations. We will also give you a list of recommendations to help mitigate the risk of non-compliance.

The benefits
Despite these risks, GDPR has its benefits. It should serve to ease the sharing of patient data across the health-social care divide, making the whole patient journey more efficient.

In addition, patients will be more interested than ever in how their data is used, and where it can be viewed. Trusts have an opportunity to harness this awareness by building rapport at the point of contact, creating opportunities for patients to get more involved with their health. For individuals responsible for information governance within trusts, now is the time to highlight GDPR – and its risks and opportunities – to their boards. Leveraging the extensive press coverage of the issue will help to secure full compliance and mitigate any risks.

Meet the experts
DAC Beachcroft is one of the largest health commercial law firms in the country, advising public and private healthcare providers and NHS commissioners. With one of the UK’s most experienced and forward-thinking health advice and clinical risk teams, we offer a comprehensive, integrated legal service from a business perspective to healthcare providers and commissioners.

The following are some of the Partners and Associates quoted in this issue. For details of our other health specialists, visit www.dacbeachcroft.com/health.

Anne Batanero
Partner, Commercial Property Specialist areas Real estate, retail, development, public sector
Anne advises NHS bodies on a range of property matters, bringing her experience of commercial property work, ranging from major development work to the acquisition and disposal of properties for national retail chains. Anne has been involved in the NHS surplus property PPP, and has spent time on secondment at NHS England managing the rationalisation of the NHS Learning Disability grant funding portfolio.

Giles Peel
Head of Governance Advisory Practice, Specialist areas Governance advisory, healthcare and clinical risk, public sector
Giles leads DAC Beachcroft’s Governance Advisory Practice. He is a Chartered Secretary with a broad background in a number of fields, ranging from FTSE financial services to the public sector. His particular interest is advice on governance and he has worked with numerous clients in the health and commercial sector.

Anne Crofts
Partner, Health Commercial Specialist areas Commercial law, NHS restructuring, governance, procurement, joint ventures and PPP, data protection and privacy
Anne advises public and private sector clients on commercial contracting, specialising in the health sector, particularly major procurements, joint ventures and partnering, shared services and restructuring. Anne also advises on R&D and is an expert in data protection of health informatics.

Udara Ranasinghe
Partner, Employment & Pensions Specialist areas Employee relations, international employment law, employee relations, equal pay, fit and proper person test.

Udara is an employment specialist who is recognised as a market leading employment lawyer and has a broad skills base covering contentious and non-contentious matters. He advises both the private and public (government/health) sector, including acting in business sales/acquisitions and outsourcing arrangements, advising on the usual due diligence exercise and negotiating appropriate contractual arrangements.

Corinne Slingo
Partner, Healthcare Regulatory and Public Law Specialist areas Healthcare and clinical risk, GIRFT, Personal injury and claims
Corinne advises on healthcare and regulatory law, from patient care (including statutory powers and regulatory relationships, particularly CQC). Her work includes advocacy in inquests, judicial review, risk assessment and governance. She also assists with capacity issues, consent and ethical dilemmas.

In Practice
It will also become far easier for organisations to meet the new General Data Protection Regulation (GDPR). However, the challenge will be especially acute for healthcare providers processing special categories of personal data. For them, the structure of care provision, patients’ data pathways, and the various links in the patient data chain present a number of issues.

The challenges
The new rights patients will have to access their own information have received considerable media attention. When the rules come into force, trusts can expect a surge of data access requests from patients – many of whom may be wrongly expecting to have full rights to their personal data.

Furthermore, the risk profile of data protection will change. Firstly, the financial penalties of non-compliance will be far more severe than the current maximum of £500,000. Under the new rules, fines could reach of up to £20 million or 4% of turnover (whichever is greatest). Under the new rules, fines could reach up to £20 million or 4% of turnover (whichever is greatest).

It will also become far easier for patients to claim in the event of a breach of the regulations – and organisations must inform people about any loss or misuse of their data. So with a long chain of information as part of the patient pathway, trusts must ensure diligence to mitigate the risks.

Trusts have an opportunity to harness this awareness by building rapport at the point of contact, creating opportunities for patients to get more involved with their health. For individuals responsible for information governance within trusts, now is the time to highlight GDPR – and its risks and opportunities – to their boards. Leveraging the extensive press coverage of the issue will help to secure full compliance and mitigate any risks.