UNISON Labour Link

Submission to Labour Party Partnership into Power 2012

Health

UNISON LABOUR LINK

UNISON Labour Link

Submission to Labour Party
Partnership into Power Consultation: Health

UNISON is the major trade union in the health service and the largest public sector union in the UK. We represent more than 450,000 healthcare staff employed in the NHS and local government, and by private contractors, the voluntary sector and general practitioners. There is also a wider interest among our 1.4 million members who use, or have family members who use, health services.

Summary

UNISON has answered a number of the questions laid out in the policy consultation document and these are covered below. The principles that the party has already laid out to protect the NHS are a good starting point. To build on this, UNISON would add the following priorities for a new vision for Labour on health:

- An emphasis on real clinical or lifestyle choices rather than consumerism and market-making.
- Promoting and defending Labour success stories, such as NHS Direct, Agenda for Change and NICE.
- Restating that the NHS should be the preferred provider of services.
- Investigating and promoting the benefits of "insourcing" (bringing outsourced services back in-house to boost patient care and save money).
- A commitment to halt the privatisation of hospital management through Hinchingbrooke-style franchising arrangements.
- Early engagement around reconfigurations – building up the clinical case for change, but involving staff, patients and the public far earlier in the process to build consensus.
- Personalisation that emphasises person-centred care rather than budget-dependent care (ie. personalisation without personal budgets).
- Where social enterprises are used, ensure they are genuinely "social" and bottom-up enterprises with staff support and engagement, rather than top-down initiatives.
- A strong commitment to safe staffing levels.
- Integrated care that focuses on a genuine desire to join-up health and social care services to benefit patients and service users, rather than the government's fig leaf for privatisation and the platitudes of much of the health commentariat.
- Related to this, go further by investigating the options for bringing the National Health Service together with a National Care Service.

How can we ensure a better experience of patient care?

First, the concept of patient choice and the expectations associated with it needs to be addressed.

UNISON supports patients and the public having as much engagement in and control over their healthcare as they can. The Derek Wanless "full-engaged scenario" envisaged this as the key for the NHS to remain sustainable in the longer-term.[1] Question marks persist, however, about how governments have attempted to facilitate patient choice. UNISON remains concerned that the choice agenda has been too narrowly focused and too easily equates patients with consumers. A King's Fund's publication on choice reports that patients are reluctant to exercise choice if it means moving away from local hospitals to which they continue to show great loyalty.[2] For most patients, knowing they have a good quality, locally provided health service is more important than having a list of providers to choose from.

There is therefore a crucial distinction to be made between real choice and the artificial creation of markets in the health service. When it comes to areas such as maternity or end of life, many patients do get a genuine choice between different clinical or lifestyle approaches. In other areas, the move to an Any Qualified Provider (AQP) system of service provision is more about creating a market with opportunities for new entrants from the private and voluntary sectors, with no evidence that this plurality increases the quality of care or patient experience, or that patients want it. For example, Age UK report that older people are sceptical about the role of choice and competition in improving the quality of health services which will "severely disadvantage those who are unable or unwilling to travel distances to access alternative providers... this was of particular concern in rural areas".[3] Academics such as Gwyn Bevan from the London School of Economics have pointed out how disadvantaged people have been less able to benefit from choice, thereby increasing health inequalities.[4]

Most patients place great faith in the health professionals treating them and will take their advice. It is also arguable as to whether patients currently even feel they get to express a genuine choice. It may be worth looking at the language around choice; for example, are we really talking about "expressing a preference"?

Secondly, some of the current consensus around how to personalise care needs to be challenged.

Across the sectors that UNISON organises in, the union supports many of the principles of more personalised care, such as early intervention, prevention, independent living and greater control for patients and service users in determining the services they need.

---

[1] HM Treasury, *Securing Good Health for the Whole Nation*, February 2004
[2] King's Fund, *Choosing A High-Quality Hospital*, November 2010
[3] Age UK, *Parliamentary Briefing on the Health Bill*, www.epolitix.com/fileadmin/epolitix/stakeholders/Age_UK_Health_Bill_briefing.pdf
[4] House of Commons Health Committee, Uncorrected Oral Evidence, 16 November 2010

UNISON believes that everyone should have as much independence and control over their own care and support arrangements as is right for them.

Such an approach is quite possible however without the ongoing over-dependence on the personal budget element of personalisation, which is unlikely to achieve the benefits sought and potentially threatens some of the founding principles of the NHS. The union expressed its dismay in responding to the government's *Liberating the NHS* white paper that plans for personal health budgets will be extended without considering whether the existing pilot process has demonstrated their success or not: the pilots will merely be used "to inform a wider, more general roll-out".[5] This is particularly worrying with reports suggesting that several pilots schemes have failed to get off the ground because PCTs are understandably preoccupied with planning for their own abolition.[6] It seems highly unlikely therefore that the testing will be sufficiently rigorous to justify a wider roll-out. Feedback from UNISON members indicates that there is little clarity on what makes an effective personal health budget assessment, and what agreed procedures, resources (especially extra time for assessments), training and workforce planning will be put in place to facilitate a system of personal health budgets in the longer term.

Personal health budgets could encourage pressure for patients to be able to top-up their care with their own money. Managers involved in the initial pilots voiced such concerns in the first report on the early experiences of the programme. And both the first and second reports have focused on concerns around equity. For example: "The need to provide more support for some groups of people raises the equity question again and whether some people will be intentionally ignored because of the cost implication of having to provide more support to certain people".[7]

There is also a very real issue of personal health budgets actually undermining the very choice they are designed to support. The experience from social care demonstrates that loss of critical mass in an existing service where users choose to spend their budgets elsewhere can lead to services such as home care centres closing, thereby depriving other users of this choice. (See Appendix WHAT IS HAPPENING TO DAY CENTRE SERVICES? UNISON report May 2012)

The Audit Commission backed up this concern with its recent report suggesting that allowing patients to purchase their own services may put existing services commissioned under block contracts under threat.[8]

How can we better extend services to hard to reach families and communities?

The Equality Human Rights Commission (EHRC) and the campaign Living in the Margins have set out examples and recommendations on how to reach venerable

[5] Department of Health, *Equity and Excellence: Liberating the NHS*, p18
[6] Pulse, "Patients shun personal budget pilots", 17 November 2010, www.pulsetoday.co.uk/story.asp?storycode=4127758
[7] Department of Health, *Experiences of implementing personal health budgets: 2nd interim report*, November 2010
[8] Audit Commission, *Financial management of personal budgets*, October 2010

communities and also the impact that cuts have had on hard to reach communities in accessing health and social care services. UNISON and other voluntary advocacy organisations have highlighted that the impact of cuts on care service support services and advocacy services (particularly in mental health) has meant that hard to reach groups will have less access and support in navigating health and social care services. The EHRC has already set out the lack of information, advice and guidance (IAG) available for elderly people to make informed choices over their care support needs. (http://www.equalityhumanrights.com/legal-and-policy/inquiries-and-assessments/inquiry-into-home-care-of-older-people/). UNISON played a key role on the Inquiry Board and full recommendations are set out at the end of the report in how to improve IAG for the elderly.

The results of the Living in the Margins FOI research on how BME communities have been affected by cuts in adult social care and mental health services will be out in Summer 2012 (http://livinginthemargins.org/category/keyfindings/). UNISON recommends that the report findings are addressed particularly as the use of mental health personal budgets will be increased and budget holders will need more support to navigate their budgets with local mental health services provision.

How should the health and social care service be funded in the future?

By direct taxation as now with the NHS – this is the fairest way to ensure quality services for everyone. The spectre of creeping charges, rationing and co-payments should be resisted at all costs.

In social care UNISON supported the Dilnot proposals as a step in the right direction but believed it did not go far enough and still left a large amount of care funding to be raised by general taxation. There is also little evidence that the insurance industry would be in a position to offer a sustainable long term funding model of care and regulations would be needed to be put in place to avoid any equity risk taking and debt swapping in the 'care market' that has befallen residential care at the detriment to care users.

UNISON supported the previous Labour government's plans to set up a National Care Service which would have universalised and made portable integrated care plans and services. An improved free national care system would need to include:

- plans to create efficiencies through integrated local health and social care services
- provision of a well paid and skilled care workforce
- modernisation programme of residential homes
- improved IAG for service users, regulation and monitoring of services
- improved governance structures of local health and social care services

UNISON estimates that the cost of a free National Care Service would likely to be £10 bn a year. If however the national Care Service became truly inclusive, integrated and comprehensive with health then efficiency savings would offset this amount and reduce the tax bill. Net funding of a free National Care Service would therefore likely be around

£7bn - an additional £0.75 per day. Relative to private health companies such as BUPA for example, who offer health insurance at £0.98 a day, this is a much better and inclusive system for all.

How should we best integrate physical, mental and public health services and social care?

At service recipient level: Seamless integration with service users having a local portable care plan and care co-ordinator to help navigate and access all services.

On the strategic planning and commissioning side: the use of Joint strategic needs assessments (JSNAs) and Joint health and wellbeing strategies (JHWS) are useful tools for joining up, planning, monitoring and commissioning of services in local structures such as Health and Wellbeing boards, CCGS or equivalent which have governance and accountability for planning, joining up and commissioning services.

At service delivery level: skilled staff, workforce terms and conditions and quality of service will need to be well funded. Sustainable commissioning needs to be based on awarding contracts for best quality and social value outcomes rather than a 'race to the bottom of lowest bidder'.

How can services be made more accountable to patients, public and staff?

UNISON welcomes Labour's pledges for councillors to use to protect the NHS. At the moment, however, the suggestion that Health and Wellbeing Boards can be the "last line of defence" for the NHS seems fanciful, given the lack of power the Boards have. HWBs should be strengthened by at least giving them a veto over local commissioning plans. In terms of integrating care, they should be able to do more than "encourage" local commissioners to work together.

There also needs to be a greater emphasis on proper democracy on the HWBs. Elected councillors should make up the majority of HWBs, rather than containing "at least one" as currently. This would give HWBs greater legitimacy and also ensure that larger numbers of councillors were forced to take an interest.

What would you list as the key principles for any health and social care service?

The current principles for the NHS are the right ones, as enshrined in the NHS Constitution: a service that is free at the point of need, comprehensive, universal, and funded by direct taxation. UNISON also believes that the vast majority of NHS services should be publicly provided, unless there are demonstrable gaps in capacity – this is the best way to ensure accountability and value for money.

Labour should restate its commitment to staff as well, particularly in terms of national pay and bargaining systems. In the NHS this should include defending Agenda for Change and actively speaking out to promote it as an equality-proofed system that

stands for fairness and was negotiated over time between government, employers and staff. It also provides for considerable flexibility and employers could do more to promote the Knowledge and Skills Framework.

Such principles need to be reinforced and extended wherever possible to social care:

UNISON believes that urgent issues need to be fundamentally reviewed to develop a proper and comprehensive social care system which addresses many of the problems of underfunding, monitoring and regulation. A new National Care Service would need to include the following elements to provide the quality of care and a workforce that would be fit for the twenty-first century:

- **A fairly funded care system** – A funded National Care Service should be provided free to all who need it on the same universal principles as the National Health Service (NHS) and not on the basis of ability to pay or location.
- **An integrated care service** – Individuals should be entitled to access a variety of health and social care services from a range of regulated providers. Patients, service users and carers should feel actively confident in managing their own personal care within an integrated care service, where their care experiences and needs are met at the highest standard. Integrated services need to operate to nationally agreed standards, regulations and enforcement framework and be flexibly designed locally to promote people, dignity, health and wellbeing.
- **A national portable assessment system** – Individuals should be able to access a single portable national assessment system which is transparent, easy to understand and use. Included in the national assessment process should be a mechanism for a self directed review and issues of access to work for disabled people to be considered. A national assessment system in an integrated care system must take into account the health and social care diagnostics requirements of different professional practices and values and have clear training and guidance on the boundaries of responsibility and accountability. There needs to be a transparent and consultative monitoring mechanism to measure both the quality and cost of health and social care services being delivered as part of a new assessment process.
- **A personalised care service** – Individuals in principle should have as much independence and control over their own care and support arrangements as is right for them and be able to access a range of personalised health and social care and support services made available that meet individual personal circumstances and needs. Personalisation is not just about choosing providers but is also about the choice of care and treatment, the way care is provided and the ability to choose types of budgets and how much to self-manage conditions of care. Within an integrated care system health and social care budgets would be merged and the responsibility for managing budgets should lie with the local authority or NHS.
- **A well-paid, skilled and registered workforce** – with excellent training, skills and career path opportunities for the care and health workforce regardless of sector or status. Provision for training budgets should be included in all Personal and Health budgets.

How do we best put patients back at the heart of the NHS and reintroduce cooperation rather than a market free for all?

As mentioned above, strengthening democratic legitimacy through stronger Health and Wellbeing Boards is one way.

The patient voice needs to be heard more strongly. The new Local HealthWatch are being set up to be very weak and should be strengthened. Their independence should also be guaranteed with a move away from HealthWatch nationally being situated within the CQC, and hosting arrangements for local HealthWatch should not be put out to tender as has been suggested during the debates on what is now the Health and Social Care Act.

A future Labour government needs to avoid another major top-down reorganisation, which would be unpopular with staff and public. But the responsibility of the Secretary of State for the NHS should be reasserted (rather than being pushed to arms length as in the Health and Social Care Act). A future Labour government could also look to take back powers from Monitor – ensuring it regulates quality rather than finance or competition, and with the Secretary of State taking back responsibility for pricing NHS services. Labour should investigate the legal options for extricating the NHS from the full force of EU competition law.

Just before the last general election, the cross-party House of Commons Health Committee described the purchaser-provider split in the NHS as "twenty years of costly failure", citing an "increase in transaction costs, notable management and administration costs" and reporting that these costs had risen to 14% of total NHS costs.[9] Labour should look at how the new model of clinical commissioning groups could be used to break down this divide.

The governance of CCGs should also be overhauled to ensure probity remains at the heart of the NHS. Conflicts of interest should be properly prohibited rather than merely documented.

Are there positive examples in your local NHS that others could learn from?

Freedom of Information requests by UNISON have shown that many of the best performing foundation trusts have now opted to bring their hospital cleaning services back in-house. There are many reasons for so doing, as demonstrated by numerous UNISON reports[10] that demonstrate the benefits in terms of cleanliness, team working and fair treatment of NHS staff. Labour should make a clear and unequivocal statement that a future NHS would issue guidance to hospitals on how to bring their cleaning services back in-house.

---

[9] http://www.parliament.uk/business/news/2010/03/20-years-of-costly-failure-mps-verdict-on-nhs-commissioning/

[10] See for example, *Making the Connections: Contracting Cleaning and Infection Control* , http://www.unison.org.uk/acrobat/14564.pdf

A more ambitious project has recently taken place in Colchester, where Colchester Hospital University FT brought all of its estates and facilities services back in-house to improve patient focus, to deliver greater flexibility in future, and to achieve better efficiency.[11] This project, that engaged staff throughout the process, should be looked at as model for other hospitals.

How can local and national governments build health into all policies, and what can we learn from health policy in Northern Ireland, Scotland and Wales?

There are many differences across the four NHS systems of the UK, for example in terms of funding, health problems, and population size and density. But both Scotland and Wales have demonstrated that it is possible to shun the market approach while continuing to improve the NHS. Northern Ireland has integrated health and social care and Scotland has set up boards to oversee joint working of health and social care. Labour should produce a proper analysis of the lessons from these elements of healthcare in the devolved nations.

How do you think the NHS can best work to reduce health inequalities?

Labour should reverse the current government's new approach to NHS funding allocation, in which age rather than poverty will be the basis. This is likely to skew funding away from the most needy, and could lead to an inadequate focus on the prevention agenda.

Which services need to work together to tackle health inequalities?

The simple answer is all of them. Inequalities cut across the board with various parts of the system reinforcing problems elsewhere. NHS, social care, education, housing, transport – all need to be taken into consideration. Also, it is too simplistic to base the inequalities focus purely on the north-south divide – pockets of deprivation in otherwise wealthy areas must also be targeted.

How can health and social care services be integrated locally to deliver the seamless quality in care service provision that patients have requested?

UNISON believes that the issues of fragmentation, regulation and poor quality, personalisation, a low status workforce, the tightening of eligibility criteria and the continued underfunding of care services need to be addressed as part of any future framework for integrating health and social care services.

The recommendations on how to integrate health and social care as set out by the King's Fund, Nuffield Trust (January 2012) and the NHS Future Forum are based on

[11] http://www.hsj.co.uk/resource-centre/best-practice/finance-and-efficiency-resources/why-one-trust-brought-all-its-facilities-services-back-home/5042742.article

accepting the premise of the Health and Social Care Bill that the Independent and private sector will have a larger role in the NHS and therefore will lead integration rather than the 'democratic' local Clinical Commissioning Groups or local authority governed public social care services.

UNISON does not support the proposals set out in the Health and Social Care Bill 2011 as it does not believe it will create a long-term sustainable and equitable NHS or a national integrated health and social care system fit for the future.

Instead it prioritises competition over collaboration and has the potential undermining of democratic legitimacy as decision-taking is taken away from local councils commissioning care. UNISON has already raised concerns that on Health and Well-Being boards councils need only have one member present.

The current social care market model (which the Health and Social Care Bill 2011 has modelled itself on) is not a basis for integrating health and care services. UNISON believes it is likely, based on the evidence in dentistry and social care, that the privatisation and competition model will create further fragmentation of service delivery, rising costs with the risk of fees in both health and social care services and post code lottery in both health and social care.

The King's Fund and Nuffield Trust integration proposals to remove NHS tariffs and encourage flexible financial incentives where Independent providers can take "financial risks" and introduce payment incentives with new "local currencies" shows a bias towards prioritising private competition rather than addressing the urgent need to provide extra public funds to improve service quality and workforce professional issues.

UNISON also notes that the government has officially agreed to the NHS Future forum recommendations on Integration, which are similar to the King's Fund and Nuffield Trust including:

- to test incentivised and integrated care provision outside hospital settings by using 'interoperability' agreements in provider contracts
- providing guidance for commissioners and providers to understand how competition, choice and integration can work together
- allowing Clinical Commissioning Groups the freedom and flexibility to develop local variations in tariffs and currencies within and for markets while new funding models are established

UNISON believes that developing local care currencies and tariffs will open up integrated health and social care services to greater involvement of private companies to deliver integrated services paid for by the tax payer. This will denationalise the NHS whilst creating an unsustainable and unstable care service where private companies will be allowed to charge fees for services (designated as outside the NHS) and cherry pick what care services they wish to deliver.

Shareholder profits rather than the patients or service users needs will become paramount if integrated care is based in a market model. Local tariffs and currencies will work against a national integrated care standard due to the introduction of local price variations. We have already witnessed this in social care provision.

The dismantling of PCTs is effectively removing established experienced commissioning networks and community care partnerships and replacing them with private contractors inexperienced in the commissioning process.

The importance of the commissioning role and process in delivering high quality care and ensuring the costs of care with sufficient resources for staff training and support was recently highlighted by the Equality and Human Rights Commission Inquiry into the dignity in elderly care. Commissioning guidelines need to include the recommendations made in the Inquiry report.

UNISON supports an integrated, or joined up, care service which is regulated nationally, free on demand, adequately funded through a national insurance NHS model and which provides clear statutory accountability in professional health and social care roles with clear, beneficial outcomes for service users.

What kind of service do we want to see for carers and families are there any examples of local services that are working well?

A mixed picture of what services are working well around the country depending on how local adult social care cuts have affected those services. However all recent UNISON research work confirms that the following services are seen as vital and preferred services by carers and families as they provide stress support and respite from care duties: Day care centres, meals on wheels, transport support services and counselling and advocacy support centres.

What can we learn from the Dilnot Commissions about to how we fund social care?

UNISON's research and evidence shows that you cannot get care on the cheap without adversely affecting the quality of service, placing service users at more risk, increasing the burden on family and reducing the majority of care workers to a precarious and unregulated low paid workforce.

UNISON has welcomed some of the proposals set out by the Dilnot Commission as a step in the right direction. However it warns that the Commission's recommendation of a partnership insurance (with a cap where people are responsible for the first £35,000 of their social care costs and the government picks up the bill after that) will not solve the problem of underfunding and in particular does not address the extra state funding needed for public social care support services – a minimum of £1.7bn a year estimated by Dilnot.

There are also risks that Dilnot proposals are more likely to create a two-tier system of care: high quality care paid by insurance (cap) and low quality care underfunded by the

state (non cap). Given the changes to health care provision and the introduction of marketisation and uncertainty around integration UNISON believes that Dilnots proposals need to be replaced by free social care provision as set out in UNISONs support for a National Care Service.

A National Social Care Service properly funded through national insurance to really tackle the growing crisis in elderly care. Without serious public funding there will be the disappearance of these services, an increase in private sector provision and a reliance on an 'unregulated personalised' care market. This is not the way to ensure a personalised quality care service or develop a quality well paid care workforce for the future.

There is now real concern that the proposals in the Summer 2012 White Paper on Social Care will not address a sustainable long term funding settlement which UNISON considers a missed opportunity.

What can we learn from the Scottish example of providing free personal care

In Scotland social care is free within its devolved operational functions of health and social care provision. Scotland is moving to more integration and recommendations for the Labour Party to produce a comparative devolved regional report on integration would be appropriate to inform future direction of travel of Personal care.

Personalisation of care in England and Scotland has shown that without proper funding it is a limited model and cannot offer the true choice that it has promised. Care cuts and the way that personal care has been funded, through the pushing of Direct Payments in particular, has meant that personal budgets have been seen as a means of making efficiency savings. As a result local authorities have been cutting local services stating that that these services are no longer financially viable on the basis that budget holders can choose what they wish to spend their budget on and so service requests are not guaranteed. Also there is evidence that mixed budgets are not being offered as a genuine choice which would safeguard local services requested as well as offer Direct Payments as part choice.

In Glasgow over the last 18 months service users campaigned against cuts in their Direct Payment budgets. What UNISON has learnt is that Personalised care must not be used a smoke screen to making care cuts. Also what is needed to protect funding rates is a commitment to have some universal programme of annual review so that the funding of Direct Payments goes up with inflation annually etc.