

Unite submission: Next Steps for the NHS Future Forum

This evidence is submitted by Unite the Union - the country's largest trade union. The union's members work in a range of industries including manufacturing, financial services, print, media, construction and not-for-profit sectors, local government, education and health services.

Unite is the third largest trade union in the National Health Service and represents approximately 100,000 health sector workers. This includes seven professional associations – the Community Practitioners and Health Visitors' Association (CPHVA), Guild of Healthcare Pharmacists (GHP), Medical Practitioners Union (MPU), Society of Sexual Health Advisors (SSHA), Hospital Physicians Association (HPA), College of Health Care Chaplains (CHCC) and the Mental Health Nurses Association (MNHA) – and members in occupations such as allied health professions, healthcare science, applied psychology, counselling and psychotherapy, dental professions, audiology, optometry, building trades, estates, craft and maintenance, administration, ICT, support services and ambulance services.

1. Executive summary

- **Unite continues to oppose the Health and Social Care Bill - it will lead to privatisation, fragmentation and increased costs. This process will damage public health outcomes.**
- **There is insufficient information and detail on the Government's proposals for Public Health England and the role of directors of public**

health. There needs to be clear systems of accountability and regulation fully integrated into this new system.

- There needs to be a contractual obligation upon all health and social care providers to collect, manage and donate any data, in the correct format, and in a timely manner, which the director of Public Health or the Clinical Commissioning Group thinks necessary.
- The Government has still not set out a national blueprint for skills or workforce planning in the NHS. Unite believes that there should be a specific duty on the Secretary of State to retain a national system of high-level education and training across all health professions.
- There is a lack of clarity as to who will have their responsibility for workforce planning at a national level over a long term scale. Under the new system this will also need to include local authority workers involved with public health.
- Unite is worried about the implications of commissioning on accountability and access to information, especially related to private providers.
- The Bill offers no explanation as to how joined up care records will be organised and stored.

2. Introduction

2.1 Unite continues to believe that the Health and Social Care Bill is not fit for purpose and should be withdrawn. The main thrust of Unite's previous evidence to the Future Forum¹ still holds. Despite massive spin from the Government, Unite is not convinced that the concerns raised by the Future Forum report have been properly integrated into the current Bill. Unite has submitted detailed evidence to the Health and Social Care Committee spelling out the continuing problems that exist in the draft Bill (see here:

http://www.epolitix.com/fileadmin/epolitix/stakeholders/Unite_evidence_to_the_Health_and_Social_Care_Bill_Committee_final.pdf).

¹<http://www.unitetheunion.org/pdf/Unite%20response%20to%20the%20Department%20of%20Health%20Listening%20Exercise.pdf>

2.2 Unite would strongly recommend that the Future Forum revisits the whole Bill, particularly in the areas that Unite has highlighted in this latter report. What follows should be considered supplementary and complementary to this previous evidence.

3. The NHS's role in the public's health

3.1 Unite believes that the Health and Social Care Bill will cause huge upheaval for public health. The Bill will result in the contracting out of health services to the private sector, which in turn will lead to further fragmentation of providers. Delivering health services is labour intensive. The drive to reduce costs to maximise profits will come at the expense of the number of staff employed. This will lead to excessive workloads for the remaining staff, which will damage their health and their morale. Unite has previously detailed why the Government's plans will result in a decrease in the quality and range of health services available to people, contribute to increasing health inequality, increase healthcare costs, and reduce accountability. Unite believes that this will lead to public health policy becoming more reactive, rather than long term and strategic. This will inevitably have a negative effect on public health.

3.2 The agenda of deep spending cuts that the current government is implementing - across public services, welfare and housing benefits - run contrary to any aims to improve public health. Unite fully supports actions that improve and prioritise preventative healthcare measures, but to be effective such measures must recognise the impact of the wider social and economic determinants on health and wellbeing. These wider determinants include – but are not exclusive to - employment, the quality of that employment, employers' duties to protect workers' health at work, housing, local environment, the strength of civil society, facilities for active recreation and both income level and income inequality. Poverty plays a crucial role in health inequalities and a person's health and wellbeing. In all of these areas current government actions and policies undermine progress in improving public health.

3.3 This is the bleak context in which any newly created public health agency, directors of public health or public health consultants will be operating. There is a danger that the role very quickly becomes about minimising the detrimental impacts of government actions on public health, rather than positively driving forward improvements in public health and local environments.

3.4 At the moment there is insufficient information and detail on the Government's proposals for Public Health England, the role of directors of public health and public health consultants. The roles, responsibilities and nature of Public Health England require substantial clarification. Unite believes Government's public health plans lack specific actions and measurable targets so that the success, or otherwise, of the implementation of the Government's public health agenda can be assessed. Unite is also worried about the level of funding being put into Public Health England given the large number of other institutions that are being rolled into it.

3.5 Directors of public health are to provide governance and professional guidance for public health staff, but these staff may be employed by independent organisations outside the NHS. Unless contracts are extremely carefully drawn up and monitored, this 'professional guidance' may be ignored where not considered commercially profitable. There is an urgent need for the Government to provide clarity about the reporting arrangements for these roles, how they will be regulated and how they are to be held accountable.

3.6 Unite believes that the role of director of public health must not be marginalised and should be given sufficient status to enable the post holder to operate strategically in promoting the public health of the local population. The role holder should therefore report directly to the local authority chief executive, have the duty to put their professional views on health matters into the public domain, and have a right of access to

elected members. The multi-agency public health challenge process must be recognised as part of the director of public health role, along side relations with communities, voluntary organisations and business. Unite public health members, who are from a multidisciplinary background, believe further that directors of public health should be statutorily regulated.

3.7 Unite is very concerned that, due to increasing pressures on NHS funding that some posts will be under resourced. We call on the Government to ring fence funds to protect services. For example, we know that Health Visiting will be protected until 2015; however after this there are no guarantees that this service will not receive cuts.

4. Integration

4.1 Unite is extremely worried about the outcome of the Health and Social Care Bill on service integration. As it stands the Bill will introduce privatisation, fragmentation and competition into services that need cooperation, coordination and integration if they are to deliver better services and reduce health inequalities. Unite is particularly concerned about the impact on established patient pathways, such as those for diabetes, asthma, stroke and end of life care.

4.2 There is an extreme lack of clarity within the Bill as to how commissioned services will deliver integration and coherence to the NHS. Unite sees these market mechanisms as having exactly the opposite effect on services. The insertion of bids from “Any Qualified Providers” (AQPs) will fragment services and undermine the ability of the NHS to make long term plans regarding service needs. Contracts will make services less accountable, as there are no accountability measures for private or voluntary sector providers. In fact independent providers will have exemptions from Freedom of Information and be able to hide the details and outcomes of their services through commercial confidentiality rules. This will mean a field day for contract lawyers and private sector

consultants but do little for integration, making savings or improving patient care.

4.3 The Bill will also mean that commissioned contracts could be subject to EU competition law, giving private sector organisations the “right to challenge” for contracts. This will increase legal costs and force open services for privatisation.

4.4 Unite is worried about the impact of all this on joint working. If there are numerous organisations providing each service, then there would be different restrictions placed on professionals and what they can do. For example Unite members report that a stroke patient could be seen simultaneously by several health professionals at the same time. This means that while the physiotherapist is working with the patient they can be seen by a speech and language therapist and then an occupational therapist. Under current proposals this joint working is thrown into doubt as each profession could be working under different contractual demands through different providers.

4.5 Contracting out of sections of the service will mean that patient support could become unnecessarily compartmentalised and there could be a break down in multidisciplinary working. Where there is no sharing of patient information, owing to different provider services being involved with the same patient, there will be no ‘key worker’ and the patient will find that they have to keep repeating their story to everyone they meet throughout their treatment. Currently health professionals refer patients within the system, for example a health visitor will refer a child to a speech and language therapist. Under the new proposals, the parent would need to go to the GP with an advisory letter from the health visitor and then it will be for the GP to decide whether to fund that referral. This, we believe, is a waste of everyone’s time and money and undermines professional expertise. Unite members highlight for example that if a patient needs repositioning up the bed - currently any professional could drop everything and help. This, however, could take some time if they needed personal

care as well. In the future they are likely to say that this is the job of a nurse, and therefore the patient would be poorly positioned in bed waiting for someone to become available.

4.6 Currently someone in the acute sector could tell someone in the community sector what they would want for a carry over of treatment and then the professional would assess this and use their judgement to determine the patient's treatment plan. In the future, the Clinical Commissioning Group (CCG) will determine the number of treatments the patient will get. Unite members report that if they knew that a patient on discharge would only get a few treatment sessions, they would keep them in acute care for longer to take their rehabilitation further, and only discharge when they knew they would get appropriate levels of community support. This would create bed blocking, as professionals will put patients' needs first, rather than have restricted treatments determined by CCGs.

5. Education and training

5.1 The Government has still not set out a national blueprint for skills or workforce planning. This key issue is absent from the current Bill and worse still the responsibilities conferred in previous legislation have been diluted (e.g. the duties on the Secretary of State). Once services begin to be commissioned, out Unite is concerned that training and skills will simply not be taken into account, leading to deficits in appropriate health professionals. Providers will either choose to fill these vacancies by employing already trained staff from the EU or by using lesser skilled and qualified staff in 'task' work, who do not have the skills to fulfil their role as part of the holistic care of patients. This is already happening in areas where pathology services are outsourced, and healthcare scientists are being replaced by under qualified staff who are not able to adequately interpret clinical results.

5.2 Unite is concerned about the impact of fragmentation on access to clinical training experience. It is not clear how new trainees will receive this experience and Unite suspects that this will become an additional cost in

any contract negotiations. It will be impossible for local providers who may have short term contracts to commit sufficient funds to adequately train the future health professional workforce. Equally, we consider that it will not be possible for providers who are in competition for contracts to engage in the necessary cooperation, pooled funding and long term planning to deliver the qualified person to the right job at the right time.

5.3 Unite therefore thinks that there should be a specific duty on the Secretary of State to retain a national system of high-level education and training across all health professions.

5.4 Unite continues to be concerned by the peaks and troughs in vacancy rates and poor workplace planning in many health professions. While the current system is not perfect, these variances are likely to be more marked in the future.

5.5 The fragmented commissioning arrangements in the Bill are expected to create barriers between different organisations and health staff, and will make it harder for there to be integration of training, particularly across services and providers. It will also make it more difficult to identify suitable and accredited training placements. Private providers, for example, may refuse to provide clinical placements for professionals in training making it harder to train students or newly qualified professionals. There is a lack of clarity as to who will have there responsibility for planning at a national level over a long term scale.

5.6 With AQP, a market will be created where providers will bid against one another to provide a particular service. This suggests that there would need to be over capacity in the system for a market to exist, and with the range of providers available, it will be hard to predict the number of commissions needed for any one post at a time in the future.

5.7 At the moment the health workforce is relatively mobile across the NHS due to defined job profiles under Agenda for Change. Unite is committed to ensuring that this system is maintained.

5.8 If there are no national structures in place for skills and training this will mean that skills and training will have to be commissioned at a local level. Unite is not convinced that local authorities will have the information or understanding to plan for long term public health skills needs in their area and this could lead to worsening workforce planning issues.

5.9 Public health failure, as defined by the World Health Organisation,² is very expensive for the NHS. Therefore we think that a much greater emphasis must be placed on prevention and early detection of problems. The Coalition Government and previous ones have policies and guidance on this, and in particular the policy to increase the number of health visitors to 4,200.

5.10 Unite is concerned that there is no additional commitment to increase school nurse numbers from the current extremely low number (1,104 whole time equivalent), with the obvious result that the investment in the health of under 5 year olds will not be continued as they grow older. The local guidance to the future Health and Well-Being Boards is not clear as to how they must prioritise prevention, and Unite is concerned that illness issues will dominate commissioning priorities. For example, where programmes (such as MEND) are commissioned to treat childhood obesity, or to measure childhood obesity (the National Child Measurement Programme), school nurses are still not trained and employed in sufficient numbers to prevent childhood obesity. We await the final NHS public health outcomes, but are not clear what sanctions are in place for local areas who by commission or omission fail to deliver them.

² For example substance misuse, poor nutrition leading to obesity, behaviour that results in injuries and violence and sexual behaviour which causes unintended pregnancy and disease.

5.11 As discussed earlier there is no suggestion yet that Public Health England will be well-equipped for workforce development roles. There appears to be a view that workforce development can be managed at local level but a national shortage of public health specialists and consultants will make that impossible.

5.12 Unite believes that AQP could lead to a break down in national bargaining, meaning health workers will be on different salaries in different areas. This will add considerable costs to employers and will open employers up to challenges through equality legislation.

6. Information

6.1 The provision of information is also a concern. Unite is worried about the implications of commissioning on accountability and access to information.

6.2 The Joint Strategic Needs Assessment (JSNA) relies upon accurate data in order to develop health services for the local population. Independent sector health providers will not be covered by Freedom of Information legislation and will be able to use issues of “commercial confidentiality” to avoid publishing information leading to inaccurate assessments, gaps in provision and health inequalities.

6.3 The choice and personalisation agenda also raises questions as to how patients will receive information to support them to allow them to choose between different health providers. Without regulation this will lead to patients being bombarded with advertising without proper information. Unite is particularly concerned about how this will effect vulnerable patients such as the elderly or people with mental health problems. Health professionals are regularly reported to their professional bodies because of lack of informed consent of patients for procedures. This can only become exaggerated, leading to more health staff being disciplined or struck off, where they do not have access to full information.

6.4 With a wide range of health providers there will be an issue about how patient records are kept. The Bill offers no explanation as to how joined up care records will be organised and stored. This poses many questions about joined up care and also data security. Unite suspects this will be another area where hidden costs and outsourcing will take place.

This evidence was submitted on behalf of Unite the Union by:

Rachael Maskell
Unite the Union,
National Officer for Health

Barrie Brown
Unite the Union,
National Officer for Health

For more information on clarifications please contact:

James Lazou
Unite the Union, Research Officer
James.Lazou@unitetheunion.org
020 7611 2504
Unite House,
128 Theobalds Road,
Holborn, London, WC1X 8TN

31/10/2011