

**Response to**

**‘Health and social care: reform and transformation**

**– Getting the structures right’**

**February 2016**

**1.0 Introduction and context**

UNISON represents a clear majority of healthcare workers, clinical and non-clinical, in the HSC framework. We have a duty to protect and promote their rights as workers and to act as advocate for their health, the health of their families, and public health in all dimensions of the population. All of our members are NHS users. Consequently we respond in our capacity of representatives of service users and representatives of the health workforce. This submission is made on their behalf.

This consultation takes place at a challenging time.

* Health inequalities, particularly those linked to social deprivation and poor mental health, are increasing from a base of existing crisis, and remain unaddressed.
* The health of the people demonstrably faces increasing damage from ongoing austerity.
* Ongoing cuts have reached crisis level and, despite commitment and professional standards from all health workers, the provision of many services is at the point of compromise to patient safety, a critical issue which UNISON has consistently raised at all levels.
* The financial envelope is unsustainable and under-resourced, while performance on key metrics is in a tail spin of decline and the failure to reduce inequalities places an unnecessary burden on HSC resources.
* The current commissioner-provider split structures are demonstrably not fit for purpose, and cannot deliver performance, standards of care, financial stability or address inequalities.

**UNISON is therefore calling for radical reform in which the voice of health workers is heard loud and clear.**

It is the formal position, not only of UNISON, but of all health unions affiliated to the Irish Congress of Trade Unions that the commissioner/provider split and the resultant local commissioning groups should be abolished. There is also no need in the system for the current Trust structures.

In place of the current system, which is clearly not fit for purpose, we need a single unified health and social care system which is resourced to be a public health system.

**Inadequacy of the Departments consultation**

We have already made submissions on the inadequacy of the Department’s consultation. This includes representations to the Minister, the Department and the Health and Social Care Board (HSCB). UNISON representations already made include:

* the fact that this is a “communication” rather than a consultation;
* the absence of trade unions as key stakeholders
* the absence of change protocols to protect the existing workforce including a commitment to;
  + no compulsory redundancy,
  + redeployment plans,
  + protocols for permanent protection, and
  + properly conducted screening and a full equality impact assessment in compliance with Section 75 of the NI Act and Equality Commission Guidance.

The Minister and the Department have demonstrated bad faith in respect of the two main vehicles for formal engagement between health service employers and health service trade unions.

The first concerns the formal health service negotiating machinery (the Joint Negotiating Forum) through which trade unions seek to protect and improve health workers terms and conditions. Recent statements made by the Minister that trade unions had refused to meet on the core issue of pay are factually incorrect and a disturbing indicator of the attitude of the leadership of the healthcare system to the rights of healthcare workers.

The second concerns the abolition, by the Permanent Secretary, of the Partnership Forum which was designed for genuine engagement of health policy between the leadership of the health service and the health unions. The ongoing failure of the Department to engage with trade unions in a genuine ‘Partnership’ model is a root cause of many current difficulties.

We await the urgent restoration of this Forum to progress trade union input and contribution into all key policy issues, including those addressed by Professor Donaldson.

**2.0 UNISON’s key principles for reform**

All workers within the health service contribute and add value to health and social care outcomes. The outcomes of this process must be tested against whether the institutional structures maximise this contribution. The following are UNISON’S key principles for reform.

|  |
| --- |
| 1. **The abolition of the internal market and the costly commissioner/provider split.** 2. **The replacement of commissioning and provider structures, including Trusts, with a public health model:**  * **that incorporates the creation of a single unified health and social care system and model for healthcare planning and delivery;** * **that is delivered on NHS founding principles within the public sector; and** * **that has eradicating health inequalities as a central goal.**  1. **Transparent funding and resource allocation not only in health but across Government Departments.** 2. **Workforce inclusion on the basis of respect for trade unions and their members.** 3. **The immediate restoration of the Partnership Forum, which enables trade union input and contribution into all key policy issues, including those addressed by the Donaldson Report.** 4. **Smart and strategic responses to the financial crisis imposed on the healthcare system by collaborative working with unions and staff to improve service delivery and terms and conditions of employment - both of which have seriously deteriorated. UNISON has demonstrated, over a period of 15 years that partnership working on the basis of equal partners can deliver both.[[1]](#footnote-1)** 5. **Recognising and acting upon the evidence that seemingly “neutral” administrative or systems decisions can cause hardship and compound inequality, with consequent health impact on the workforce, should be a normal way of working.** For example, recognising that moving low-paid women workers from weekly and fortnightly pay will have the above impact without paying any attention to the consequences of this on social and economic factors which exacerbate health inequalities, is unacceptable in a system which has the health and wellbeing of the people as its primary objective. 6. **The cessation of outsourcing of health and care services and the cessation of the privatisation of medicine.** 7. **Open, honest and transparent information to workers, patients and clients.** 8. **An end to the disgraceful practice of loosening and manipulating key targets, such as waiting times, in an attempt to gloss over the current crises.** 9. **The restoration of health as the number one priority in the Programme for Government.** |

**3.0 consultation and equality processes**

As outlined above, the current consultation and the equality processes undertaken thus far are inadequate and fail to meet legal requirements.

* The consultation document states that the Department will ‘communicate’ with staff, not ‘consult’. One of the greatest criticisms of the current decision-making process across the health and social care system is that decisions are taken in advance of consultation and negotiation and a sham consultation process is then initiated to make those decisions operational, irrespective of the views of the public, the patients, the clients, healthcare workers and their trade unions. The centralised Departmental civil service decision-making model cannot continue to dominate, with only retrospective consultation and scrutiny. There must be at least equivalent opportunities for the exercise of advance representation, speaking rights and collective voice from public, patients, clients, healthcare workers and their trade unions before decisions are made.
* The absence of real consultation, defined by Sir John Wood as the “ability to influence decisions before they are taken”, is underscored by the failure of the consultation documents to event mention trade unions.
* There must be significant improvement in the current low level model of Governance that those charged with decision-making are required to follow. Instead there should be a move to the generative governance approach which requires real outreach to affected constituencies and communities of need.
* The consultation document has no protocol for change, including redeployment, personal protection, and no compulsory redundancy. Such a protocol can only be achieved in consultation and negotiation with the recognised trade unions.
* The consultation period is for 8 weeks only despite the fact that the Department’s own Equality Scheme and Equality Commission NI guidance recommends 12 weeks. DHSSPS have not claimed any exceptional circumstances to justify any reduction in this case.
* There is nothing in the process to properly resource and enable input from some of the most disadvantaged groups in society who will be most affected by change.
* The screening document is a disgrace. It fails to draw on any of the data or submissions previously made on core matters such as equality of opportunity, impact on staff, and impact on health inequalities. There is a wealth of evidence and an extensive data base given the number of reviews conducted into most aspects of our health and social care system over the past decade alone. The blatant failure of this system to take cognisance of that data-base reduces the health services obligations on equality and human rights to a derisory tick-box exercise.
* The DHSSPS cannot ignore the of the Equality Commission’s Investigation Report into the Department for Social Development’s Housing Policy Proposals November 2015) which reconfirms:
  + that high level policies should be properly screened to identify policies likely to have an impact on equality of opportunity at the earliest possible stage[[2]](#footnote-2);
  + that the screening decisions, that is, whether or not to conduct equality impact assessments, must be “robust; provide an opportunity to improve decision making; support ‘evidence based’ policy making; and provide tangible evidence as to how the Department has given due regard to the promotion of equality of opportunity ... in the initial stage of policy development”.[[3]](#footnote-3)
* There is little detail about how financial flows will work in the new arrangements; how the savings on abolition of commissioning will be spent; and whether or not funds will be better targeted towards health inequalities (linked to deprivation and mental health particularly). Proper screening and a commitment to full EQIA are crucial prior to any final decisions.

1. **Response to issues raised in specific consultation questions**

In this submission we are responding to the key issues raised in the consultation questions posed. We point out, however, that UNISON has already submitted extensively on the full range of areas.

**4.1 System complexity**

The problems facing the system are not just simply a problem of complex administrative structures, although we have repeatedly raised the fact that the health service decision-making process has been made arcane and obscure - in our view deliberately so. However, the issues are wider than this and necessitate a change in organisational culture. This is one of the key areas which we had hoped to address through the now abolished Partnership Forum.

Key problem areas include:

* weak leadership due to the overly bureaucratic nature of the system and the adoption of “lateral” systems of management which disempower an entire strata of HSC managers from making real decisions;
* a lack of accountability, openness, transparency, and trust which permeates the system at all levels;
* an overly defensive culture that does not encourage true leadership;
* the continuous exclusion of front-line staff from decision-making on service improvement and development;
* the abject failure to restore local level industrial relations processes which in the past proved highly effective in resolving a wide range of workforce and service delivery problems;
* the replacement of direct engagement with service users and the public by gatekeeper systems which are neither representative nor effective.

Changing the culture requires that trusted and motivated managers, clinical staff and support staff are given the space, time, and resources to improve services rather than being diverted by the straightjacket of micro-management from the Department or other bodies.

**4.2 Innovation**

Innovation in terms of new technologies, new drugs and service delivery processes is of course necessary. However, improving health outcomes will only be sustainable if there is innovation with regards to the most valuable asset the NHS has – its staff. Increased investment in training and development is required – particularly for low paid staff such as cleaners, catering staff and porters whose role often goes unrecognised but who play a key role in the healthcare team.

Evidence demonstrates that the most significant innovation in the system comes from those with something to contribute, as opposed to the current model prevalent in the English NHS which appears to be based on those with something to sell.

In the rush to innovate, the system must ensure that principles at the heart of the NHS remain core:

* that it meet the needs of everyone and reduces health inequality;
* that it be free at the point of delivery;
* that it be based on clinical need, not ability to pay.

These three principles, in addition to supportive values of dignity, compassion and respect, have guided the development of the NHS over more than 60 years and remain at its core.

New employer/trade union partnerships which foster innovation and better ways of working should also be supported and mainstreamed. We again cite the series of unique UNISON/employer Partnerships[[4]](#footnote-4) that have produced real outcomes on improved care and satisfaction for patients, clients, health and social care workers alike.

The Collaborative model utilised within each Partnership has been described by the King’s Fund as ‘ground breaking’ and is based on true inclusion; real equality of decision-making, resources and support; as well as trust and respect for staff. These partnerships are underpinned by a number of common core priorities and objectives.

* Enhancing the delivery of health and social care services.
* Improving outcomes for patients, clients and other service users.
* Improving the working lives of staff through change interventions to improve their job satisfaction, health and well-being.

**4.3 Structures: Bureaucracy; commissioning; the role of Trusts; performance management**

Ending the commissioner provider split and the consequent restoration of ‘Trusts’ to a collaborative healthcare system is a core UNISON demand.

For the review to make a substantive difference, it has to consider the impact of the core principle of the commissioner-provider split in the context of sustained failure on performance, inequalities and financial management. Essentially, structures of complex and unaccountable decision making have led to bureaucratic confusion, proliferation and a lack of accountability.

At the Human Rights Commission evidence session on 1 December 2014, the Minister quoted from an historic Health Committee evaluation of a ‘4.1% on cost’. The evidential basis of this needs publication. It contrasts radically, for example, with the York University analysis[[5]](#footnote-5) of 14% transaction costs in split commissioner –provider systems such as that operating in the health and social care service in NI. Quoting this report the House of Commons Select Committee said in 2010 that:

*“… the purchaser/provider split… has led to an increase in transaction costs, notably management and administration costs. Research commissioned by the DH but not published by it estimated these to be as high as 14% of total NHS costs. We are dismayed that the Department has not provided us with clear and consistent data on transaction costs; the suspicion must remain that the DH does not want the full story to be revealed. We were appalled that four of the most senior civil servants in the Department of Health were unable to give us accurate figures for staffing levels and costs dedicated to commissioning and billing in PCTs and provider NHS trusts.”*[[6]](#footnote-6)

Since then there has been significant redefinition of such transaction costs in the English NHS in an attempt to present them as lower. However, even if we were to take the new definitions the Centre for Health and Public Interest state that:

*“… we may estimate that at least £5 billion of the NHS’s recurrent i.e. continuing, year-on-year running costs relate to the market. This is enough to pay for ten specialist hospitals or – perhaps more appositely - mount a major investment in community based services and advance dramatically the integration of health and social care[[7]](#footnote-7).*

Given that there has also been significantly increased commissioning activity in the channelling of work to the private sector, it is remarkable that the Department has produced a consultation document without the figures for Northern Ireland. These should be made immediately available.

However, ending commissioning alone is not sufficient to change the culture. The Ministerial decision to simply disband the HSCB does not change or address the problems and weaknesses throughout the system. What needs to change is **function**.

The key alternative to the current structure would imply:

* The reversal of a small element of HSCB function to the Department to strengthen Departmental policy and leadership roles.
* The creation of a single unified system that would replace commissioning and Trust functions with collaborative health care assessment, strategic planning and operational delivery under a single point leadership and accountability. Functions would include the setting of targets to reduce transaction costs, improve performance, and reduce health inequalities based on a proper assessment of need, objective need and eradicating health inequalities . The current Boards/Trust model has singularly failed to change key outcomes in these areas.

This unified structure must work with great openness and transparency. There must be rigorous disaggregated analyses of the efficiency, effectiveness and equality of outcome of its services.

Patient and clients should be able to draw on independent advocacy services. In respect of Professor Donaldson’s Recommendation 7 on patient safety, UNISON has already set out its view that there can be no in principle objection to the creation of an Institute for Patient Safety. However, there must be transparent revenue and capital funding for this using conventional public procurement, and location must be in one of the 10% most disadvantaged wards. There must be no diversion of funding from current budgets under pressure, and the additional cost must be an Executive collective contribution to our health.

Training in patient safety must be expanded and repeated to ensure consistent application and standards, and there therefore needs to be review and expansion of the diminished training budgets in the current system. This training must apply to all HSC/NHS staff who interact in any way with the patient and client environment. There must also be an expanded requirement for external providers in, for example, domiciliary care.

Instead of thinking in the traditional terms of redundancy and job loss an alternative approach should be undertaken to convert all roles to serve a public health system.

**Conclusion**

This Review will only be a fig leaf to the cuts created by the Executive and Departmental Budget strategy unless there is genuine consideration of the points made by UNISON in this submission and a clear commitment to engage with us and other relevant stakeholders.

We anticipate a detailed response to our comments which demonstrates that they have been given proper consideration. We believe that direct engagement with the Department is the most valuable form of engagement on this review.

**For further information contact**

**Thomas Mahaffy**

**Head of Organising & Development**

**UNISON NI, Galway House, 165 York Street, Belfast BT15 1AL**

**Email -** [**t.mahaffy@unison.co.uk**](mailto:t.mahaffy@unison.co.uk)**; Tel - 02890 27019**0

1. See the report ‘Time for Change: UNISON/Employer Partnerships. UNISON and employers working together to improve health and social care delivery and working lives’, October 2015 [↑](#footnote-ref-1)
2. Para 4.5 - ECNI Investigation Report under Schedule 9 of the Northern Ireland Act 1998 - Department for Social Development: Housing Policy Proposals, November 2015 [↑](#footnote-ref-2)
3. Ibid, Para 5.2 [↑](#footnote-ref-3)
4. See the report ‘Time for Change: UNISON/Employer Partnerships. UNISON and employers working together to improve health and social care delivery and working lives’, October 2015 [↑](#footnote-ref-4)
5. Bloor K et al (2005), NHS Management and Administration Staffing and Expenditure in a National and International Context, York University, unpublished (embargoed by the Department of Health) [↑](#footnote-ref-5)
6. House of Commons (2010), Commissioning, Fourth Report of the Health Select Committee, London: The Stationery Office [↑](#footnote-ref-6)
7. At what cost? Paying the price for the market in the English NHS, Centre for Health and Public Interest, 2014) [↑](#footnote-ref-7)