Submission on behalf of Leicestershire Unite Health Sector Branch (EM/LE32) to the Health and Wellbeing Scrutiny Committee discussion on the LLR STP - Leicester City Hall 29/3/17

This submission is informed by:

The LLR STP (Draft Nov 2016)
Presentation to LLR Union Reps (Dec 16)
Unite Health Sector Briefings
Member contributions at the Unite Health Sector Meeting (15/3/17)

We believe our members, wherever they work and in whatever capacity, do everything possible to deliver quality services to the public. We agree that the aims of the STP are admirable: to focus on illness prevention, to reduce gaps in care and quality, and to manage costs. However, we are deeply concerned that many of the proposals are not backed up by evidence, that the targets around cost savings will put patients and vulnerable members of our communities at risk and our members will be exposed to impossible workload pressures and potentially blamed when things go wrong.

Our Concerns are:

Funding

Financially, the STPs are set up to fail. It is clear and demonstrable that NHS funding is already at its lowest ever in terms of GDP and the local STP estimates a shortfall of £341.6million for healthcare and a further £57.7million for Social Care in the five years to 2021. This funding crisis has been created by central government. We know our concerns are shared by H&SC Managers and Leaders in LLR and are identified in the STP as a risk.

A recent Unite Press Release states that at least £17.6 million was spent on management consultancy advice in formulating the STPs from firms such as KPMG. McKinsey and PWC. This, when there is no money to support stretched A&E departments and when local CCGs and local authorities have had little input.
As Unions we have raised concerns about the money spent locally on these ‘consultancies’. We do not believe they deliver value for money.

We are sure councillors know, as do we, that as a result of financial constraints and legislative changes access to Social Care has been retracted. We believe this has already impacted on rising acute bed occupancy, and difficulties ensuring safe discharges (we object to patients being referred to as 'bed blockers'). Closing Acute and Community hospitals and beds will surely only add to the problem as the elderly population increases and health care becomes increasingly complex. The consequences will be an increasing wave of unmet need in our communities. We have seen the result of Mental Health 'Care in the Community' over the years as police stations, prisons, local authorities and emergency services struggle with a lack of provision for the mentally ill. We don't want to see the same happen to services for the physically ill and disabled.

In the presentation to Trade Union Reps in December 2016 the proposal that £288 million will need to come from 'operational efficiencies' was discussed. The workforce is Health and Social Care's greatest expense (and greatest asset). We are seriously concerned that the STP will be funded by large-scale pay cuts and down-banding. The impact of this will be a 'brain drain' as more experienced staff lose pay, status, job satisfaction and professional autonomy and opt for early retirement. Some of our members have already taken that decision. Commissioned services will have to be delivered to the letter, rather than to the spirit. Minimum contacts will achieve only the bare minimum of contract requirement, but not necessarily meet the needs of individuals.

Access to Services

Many of our staff are moving into 'agile' working to save money on premises and increase flexibility. There are both positive and negative views from members, depending on where they work and the local infrastructure to support them. Concerns were expressed that in some locations there is a shortage of available clinical spaces. Some members have raised IT connectivity problems and worries about confidentiality if forced to access IT in public spaces. Some members cited client difficulties accessing GP and other services, such as contraception services, due to accessibility and availability. Whilst bringing groups of GP's and Health Staff together to deliver services may manage some access issues we are concerned others may emerge. Patients in deprived inner city areas already report the impact of access difficulties, and some state they go to A&E and Urgent Care because they can't get GP appointments or an alternative surgery (run by the same group) is too far away to walk.
In some deprived inner city areas parking is an issue for practitioners. Parking Permits are restricted and, where they were available in the past, most community nurses and therapists do not have them. We pay our own fines if we get them. This is a transfer of cost to practitioners and does nothing for morale. It also contributes to the 'Inverse Care Law' where services are more accessible to those with more resources.

Agile working brings a risk of staff becoming isolated. There is concern that commitment to regular team meetings to maintain clinical supervision, shared knowledge, learning and emotional support will be lost in increasing work pressures.

It was suggested that there was something of a contradiction between integrating H&SC on one hand, and agile working on the other.

An overall reduction in the workforce of 5.7% with an increase of generic and 'associate' workers will increase the workload of all at a time when needs are known to be growing. Alongside other severe budget cuts, for example those in schools, there will be fewer opportunities for early intervention and prevention, and a greater likelihood of reactive rather than planned care, with the attendant anxiety and stress on all involved.

Quality and Patient Safety

New Models of Care, Service Reconfiguration and Redesigned Pathways of Care are the other areas targeted to deliver savings. We are concerned that there is no evidence that these can deliver the necessary savings. Service integration is complex, time consuming and requires investment in training. What works in one place does not necessarily work elsewhere. Where will the time and money come from to do this well given the lack of funds?

How do you integrate services that are means tested with those that are free at the point of delivery? How easily do you find appropriate services to meet clients needs when the constant commissioning cycle expends so much time and effort on making repeated bids and services are rarely around in one form for any significant time?

We are concerned at the increasing reliance on lower paid and lower skilled workers to reduce costs. Most patients and service users value continuity of care but breaking care down into tasks does not facilitate continuity and is not 'patient centred'.

A UHL member commented on an increase in jobs at the lowest pay bands, and increasing responsibilities in these pay bands. We are concerned this is unfair on both low paid workers and service users.
A community practitioner gave an example of a new (lower band) role which is so much more limited than the previous role it now requires two people to perform a task previously done by a lone worker. This is a false economy.
We would be happy to see apprenticeships in the NHS that allow young people to be paid whilst they learn, and that offer an opportunity to work through paid training to good professional qualifications and a rewarding career. We do not believe this opportunity exists as yet. We would like evidence of how this will be delivered and funded.

We are concerned that fully qualified staff are to be replaced by under-qualified staff. A recent BMJ article (Aiken et al in BMJ Quality and Safety 2016) concluded that '…caution should be taken in implementing policies that reduce hospital nursing skill-mix because the consequences can be life-threatening to patients'.
It is only a few short years since the Francis Report into the appalling standards at Mid Staffs Foundation Trust led to a call for a focus on quality above all other priorities. One of the concerns raised then was that of appropriate skill-mix.

Unlike Registered Nurses, Midwives and Therapists; Nursing Assistants and Associate Practitioners – a growing area - do not have a regulatory body to set and monitor standards and provide protection for the public.

A number of our members raised concerns about what 'Care in the Community' might mean for the most vulnerable and marginalised in our local communities. Has there been any kind of Equality Impact Assessment?
Is care at home a good thing if you have seriously sub-standard living conditions? If you have no transport and no money to access services? If you are homeless or socially isolated and friendless? If those around you lack resources and capacity? There was concern that the most vulnerable families will simply disappear from sight. What are the implications for children in poverty or at risk of abuse and neglect?

We have already seen 'service redesigns' that have removed or reduced a number of specialist roles in the wake of the transfer of budgets for Health Visitors and School Nurses to Local Authority Public Health Departments. The new '0-19' Services, alongside the reduction in Local Authority Children Services, will see an overall reduction in the services available to this vulnerable age group. Our members are concerned that specialist roles with Homeless Families, Asylum Seekers, SEND, DV and Teen Parents are all being reviewed and down- banded or reduced in numbers. We have seen the same happen in Therapies and, skilled as they may be, Associate Roles are new and developing and lack the autonomy and decision-making ability of fully qualified and experienced senior clinicians.

Concern was expressed for our colleagues in Community Nursing (District Nursing). When a hospital ward is full it cannot take any more patients but this is not the same for Community Practitioners. Their work is largely invisible. The RCN has recently commented on the concerns identified for this service by The Kings Fund (Understanding Financial Pressures Kings Fund March 2017). They quote that one in seven DN posts were lost between 2014 and 2016. They are essential to plans to move care into the community but the report identified premature hospital discharges and delegation of GP work to theses nurses as having a direct impact on the ability to provide end of life care at home, make full assessments of need or identify adult safeguarding concerns.

We concluded that not even staff working in Health and Social Care have heard of STP's let alone have a clear understanding of them. We feel the consultation is barely meaningful given how little people know.

Questions

- Who will be held to account if STPs fail?
- What will it mean for our communities?
- How can we work together to campaign for proper funding of Health and Social Care so that we can build capacity and the skills in both services?

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On Behalf of UNITE Leicester Health Sector Branch EM/LE32

21/3/17