The New Health and Social Care Economy

Sefton MBC, Liverpool and Greater Manchester City Regions and North West regional economy

Executive Summary

Dexter Whitfield

European Services Strategy Unit

NewDirections
A new concept in caring

New Directions
Head Office
3rd Floor, The Investment Centre
375 Stanley Road
Bootle L20 3EF
Tel: 0151 934 3726
www.ndirections.co.uk
A care provider owned by Sefton Council

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European Services Strategy Unit

(Continuing the work of the Centre for Public Services)

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Dexter Whitfield, Director

Adjunct Associate Professor, Australian Workplace Innovation and Social Research Centre, University of Adelaide

Web: www.european-services-strategy.org.uk

The **European Services Strategy Unit** is committed to social justice, through the provision of good quality public services by democratically accountable public bodies, implementing best practice management, employment, equal opportunity and sustainable development policies. The Unit continues the work of the Centre for Public Services, which began in 1973.

Research has included health and social care economy studies for the North West and East of England regions; two social and economic audits of health care in North Ireland; critical analysis of the case against the sale of residential care homes and/or outsourcing adult social care in over 15 local authorities, many in the North West; a successful alternative to the outsourcing and offshoring of prescription processing by NHS Business Services; the case for a Public Duty for Age Equality; the gender impact of outsourcing; and a analysis of the original Cashing in on Care proposals in 1984.

Executive Summary

New approach to the health and social care economy

A new ten-part model of the health and social care economy encompasses public health, wellbeing and tackling inequalities; the health and social care infrastructure; economic value, supply industries and services and the quality of jobs; improvement and reform, research and innovation, democratic governance, sustainable development and medical/health education and training.

A holistic approach is critical to maximise the local, regional and national benefits of health and social care system. It reinforces the need to fund the whole system, maximise the use of resources and to identify ways to improve the productivity and effectiveness of the health and social care system. The model helps to identify interdependencies in the healthcare system and to challenge how different parts are valued.

The new model is essential to understand the full impact and costs and consequences of reform policies that increase competition, marketisation and privatisation. An assessment of a sample of current local, regional and national NHS reports demonstrate a very limited understanding of the health and social care economy.

Importance in North West regional economy

The North West had the third largest total regional Gross Value Added outside of London and the South East in 2013. The health and social care economy accounted for 8.6% of the region's wealth in 2012. North West health expenditure was £15.1bn, the third highest in England after London and the South East.

Deep cuts in public expenditure

60% of the government's cuts in public services have yet to be implemented, so talk of 'after austerity' is illusory. Austerity policies have increased poverty, homelessness and ill-health, not least for disabled people. The 2015-16 Local Government Financial Settlement imposed an average cut of 1.8% on local authority revenue spending, but much larger reductions were imposed in Knowsley, Liverpool and Manchester of 6.0%, 5.9% and 5.1% respectively.

Chronic underfunding of social care in England has led to a 40% reduction in weeks-of-care for day care and home care by nearly 20% between 2008-2009 and 2013-2014. This could severely limit implementation of the Care Act 2014.

Major employer in the local and regional economy

The NHS, public bodies, private and voluntary sector organisations in the North West directly employ 551,802 people. The same organisations purchase goods and services that support a further 129,433 jobs in the North West. The household expenditure of the directly employed workforce plus those employed in providing goods and services in the regional economy support a further 159,403 jobs. Thus health and social care services in the North West generates 840,638 jobs (or 701,031 full time equivalents).

Four out of five of the North West NHS non-medical staff and the social care workforce are women in contrast to 43% of the medical staff and a similar percentage of dentists. Just over half of GPs and opticians are women. 26% of the NHS medical staff in the North West is Asian or Asian British and 54% white, which contrasts with the non-medical staff where only 3% are Asian or Asian British. Both the non-medical and adult social care workforce are predominately white.

In addition, there were 781,972 people providing unpaid care in the North West in 2011, of whom 113,003 carers provided between 20-49 hours per week and 199,476 carers provided over 50 hours per week.

Quality of care linked to quality of employment

There is conclusive evidence of a strong connection between the wellbeing of healthcare staff and the quality of care patients receive and their health outcomes. The health and social care economy approach encourages a more holistic perspective of patient/community needs, organisational and political boundaries to seek solutions to peoples needs, accelerate collaboration, and ultimately service coordination and integration between health and social care organisations.

Outsourcing continues

North West NHS Trusts and CCGs outsourced £41m of contracts to private and voluntary sector organisations between April 2013 and November 2014. In addition, NHS Trusts in the region outsourced £268.6m of facilities management services in 2013-2014. Evidence from several other regions reveals a growing trend of outsourcing core medical services. Local authorities now employ only 13.2% of social care staff in the region. A contract culture, financial crises, marketisation and privatisation have increased significantly since the original 2003 Health and Social Care in the North West economy analysis.

Increased role of private finance

The capital value of Private Finance Initiative hospital projects in the North West more than doubled from £765m in 2003 to £1,909m by 2014. The remaining unitary payments for PFI projects total £10,686.9m. The cost of services accounts for an average 40% of unitary payments, which would be incurred by the trusts irrespective of PFI projects, leaving a debt of about £6.4bn.

Twenty-three equity transactions took place in the North West PFI healthcare projects between 2005-2014, including the eight major PFI hospital projects. A majority involved the transfer of equity ownership to offshore infrastructure funds in Luxembourg, Jersey and Guernsey.

Social impact bonds are similar to PFI projects and are being promoted as a new way of financing health and social care, and they only serve to strengthen the privatisation of policy making, innovation, finance, contract management, service provision and the evaluation of performance.

Public cost of marketisation and privatisation

Significant public costs are incurred by public bodies in transferring services, private finance projects, wasted bids, contract terminations, public subsidies, reorganisation and consultancy costs. The national annual costs total nearly £7.5bn or £1.1bn per annum in the North West.

Corporate role in the health and social care economy

Increased outsourcing, private finance and use of the private hospitals by the NHS, is bolstering the private sector's role in the region. Approval of the Transatlantic Trade and Investment Partnership will lead to further deregulation and privatisation.

Impact on jobs and wages

Nearly 100,000 of the North West social care workforce could be earning less than the Living Wage. Zero hour contracts, 15-minute care visits, non-payment of travel costs, and high turnover rates are common in social care.

The North West share of the annual £1.2bn Working Tax Credit expenditure in the health and social care sector is approximately £147m per annum – in part a subsidy to private contactors low pay policies.

New care models and integration are unlikely to achieve genuine and effective care in the community, with the NHS continuing to absorb the high cost of this failure, until social care is equally valued and funding is available to end the exploitative, if not Victorian, employment policies.

Continuing health and economic inequality

A snapshot of health inequalities in the region is followed by an account of the Coalition governments attempt to reduce or eliminate adjustment for health inequalities in allocating resources. Income inequality is increasing in the UK and other industrialised countries. The gap between productivity and pay has markedly increased.

Regional industries and research

The North West is a major centre for biomedical research and has over 200 companies in biotechnology, pharmaceutical and healthcare industries. It is the largest cluster of advanced flexible materials manufacturers in Europe. The region has two Academic Health Science Networks funded to speed up innovation and collaboration.

Demographic change

The North West population is forecast to increase 3.6% between 2012-2022, half the rate for England. The region has eight of the ten local authorities with the lowest projected growth in England in the same period. The North West population aged 65 and over is forecast to increase by 56% in the 2010-2035 period

compared to a 4.8% increase in the 20-64 age group. Taking account of productivity improvements, between 77,000 and 63,000 new jobs will be required in health and social care services in the North West by 2035.

Reconfiguring health and social care

Continued marketisation and privatisation of the health and social care economy, in particular the commercialisation of NHS trusts and CCGs, is unsustainable. Assertions that the NHS will remain 'free at the point of use' are meaningless if health and social care is largely provided by private companies. This will fundamentally change the scope, range and quality of services and the principles and values on which health and social care is provided.

Integration initiatives can lead to better services, but there is very little evidence that it can achieve cost savings. Local and practical initiatives are likely to be more effective than further system-wide organisation.

Telehealth and telecare and new digital applications will have a significant impact on the delivery of health and social care. However, the geographic coverage, security, reliability, affordability and sustainability of high-speed broadband remain a key issue. Big data systems will be required, which the NHS and social care system will operate, although it is very likely they will not own or operate them directly, but through managed services contracts.

Planning and growth

Major infrastructure projects in the North West include the planned HS2 from Birmingham via two routes to Manchester and Leeds, the longer-term plan for the HS3 from Liverpool via Manchester and Leeds to Hull and several rail electrification projects. Up to 25,000 new homes are planned in the North West.

The growth areas provide an opportunity to provide state of the art facilities and public services through public investment. However, continued outsourcing of NHS and local government services will mean that private firms will be in a powerful position to win contracts in the new growth areas. This could have a significant knock-on effect on health and social care services in other parts of the North West as the private sector seeks economies of scale. It could raise a conflict of priorities between the allocation of resources in the new growth zones or investment to tackle inequalities in inner city areas.

Devolution, democratic accountability and participation

From April 2016 the £6bn NHS budget for Greater Manchester will be devolved to the Greater Manchester City Region (Combined Authority). This decision has significant potential benefits and negative consequences in equal measure until further details are revealed. Significant questions remain about democratic governance and participation.

NHS England often makes reference to staff wellbeing, but this does not include participation, involvement or engagement (NHS England 2014a and 2014c). It must be developed across the health and social economy. As ever, if the ideas, experience and innovation of staff are not harnessed in the reconfiguration of health and social services, it would be a lost opportunity and limit the effectiveness and benefits of reconfiguration.

Recommendations

The recommendations are divided into two parts. Firstly, health and social reconfiguration should urgently address the following priorities:

1. Secure long-term funding for the NHS with an immediate significant increase in local authority social care expenditure, together with a planned return to grant funding of community and voluntary organisations;
2. Begin an immediate roll-back of marketisation and privatisation by cancelling planned procurements; rigorous monitoring and review of outsourced contracts; the replacement of outsourcing with in-house service innovation and improvement plans prepared with staff, patient/user involvement,together with three-yearly service reviews;
3. Stop the transfer of NHS and local government services to social enterprises and trading companies, but increase their role in supply industries and research;
4. Public investment to replace Private Finance Initiative, social impact bonds and other private finance projects for health and social care infrastructure and services.
5. Immediately improve the terms and conditions for low paid workers, particularly in social care, with a living wage and an end to zero-hour contracts;

6. Achieve real and sustainable integration of health and social care services with collaboration and joint working between NHS Trusts, CCGs, local authorities and other public bodies;
7. Maximise regional benefits from closer cooperation between NHS trusts and local authority social care organisations, research institutes, innovation funds and the manufacturing and supply sectors;
8. Draw up local, city region and North West regional plans to develop the health and social care economy, to include housing and health adaption, emission reduction and renewable energy projects;
9. Prioritise local, city region and regional funding and action strategies to tackle health and economic inequalities;
10. Increase democratic accountability, scrutiny and transparency of NHS Trusts, health and social care organisations;
11. Launch a programme to involve staff and patient/user representatives in innovation and improvement, service integration and joint working initiatives;
12. Draw up a staff and management retraining programme to reinforce NHS principles and values, and public service management practice.

More detailed recommendations are grouped under reconfiguring health and social care; improvement and innovation; public ownership and investment; improving wages and benefits; assessing costs, benefits and impacts, tackling inequalities and democratising health and social care.

Reconfiguring health and social care

- The North West definition of the health and social care economy should be incorporated into policy-making, project proposals and business cases.
- Increase the awareness of the scope and importance of the health and social care economy and how its different dimensions can be incorporated into planning and decision-making.
- Local authorities and their care organisations should be proactive in responding to local hospital crises by offering to adjust service provision, such as reablement, to unlock blocked beds and to propose longer-term service redesign.

Improvement and innovation

- CCGs, NHS Trusts and local authorities should focus on in-house service delivery options, including a proactive role in developing NHS consortia or partnerships with procurement as a last resort.
- NHS organisations and local authorities should ensure that patient and community organisations are fully involved in health and social care planning and service improvement.
- Future health and social care infrastructure investment should be funded by direct public investment.
- CCGs, NHS Trusts and local authorities should strengthen their ability to monitor, review and scrutinise health and social care services.
- Health and social care organisations should operate with flatter management structures, devolve more responsibility to frontline staff.
- The NHS and local authorities should increase collaboration with research bodies in the region.
- Employer responsibilities linked to personal budget direct payments should be strenuously discouraged.

Public ownership and investment

- The government must substantially increase the resources for local government and specifically for care.
- The buy-out of PFI projects should only be considered if the government establishes a new Treasury debt-buy-out scheme.
- The outsourcing of NHS and local authority services to private and non-profit contractors should be drastically reduced and sanctioned only in circumstances of exceptional need.
- The purchaser/provider spilt should ultimately be abolished and replaced by policies that prioritise in-house provision supported by Service Reviews and three-year Service Innovation and Improvement Plans.
- The function of local CCGs and combined sub-regional CCGs and CSUs should be changed to develop a more integrated health and social care system by advising and supporting NHS Trusts and local authorities.
- CSUs must be retained in the public sector, otherwise they are likely to become a vehicle to drive further marketisation and privatisation in the NHS.
- Engage in the consultation of the NHS Reinstatement Bill that will reinstate the

government's legal duty to provide the NHS in England.
- Oppose the Transatlantic Trade and Investment Partnership (TTIP) and the Trade in Services Agreement (TISA) free trade agreement that are almost certain to increase the marketisation and privatisation of public services.

Improving wages and benefits

- The Living Wage should be paid to directly employed staff in health and social care public bodies and a requirement in outsourcing contracts.
- Increased regulation and enforcement of minimum wage legislation.
- Health and social care public bodies that transfer staff under the TUPE regulations should ensure that contractors meet their regulatory obligations.
- NHS organisations and local authorities should develop strategies for improving the health and wellbeing of their workforce, drawn up with staff and trade union representatives, and regularly monitored and reviewed.
- Contractor pay rates, pensions, and other terms and conditions, to be taken into account in the quality component in the evaluation of bids.
- The use of zero hour contracts should be abolished and 15-minute care time slots made permissible only in very limited circumstances.
- Statutory guidance should require NHS organisations and local authorities to include payment of travel time as a contract condition for home care providers.
- Care Quality Commission inspections of health and social care organisations should be extended to assess staff health and well-being standards and targets, which should include terms and conditions of employment.
- Public, private, non-profit and voluntary sector care providers should immediately implement UNISON's ethical care charter and regularly monitor and review progress.
- NHS employers, local authorities and Skills for Care should develop a career development framework for health and social care staff.

Assessing costs, benefits and impacts

It is vitally important that decisions on the provision of health and social care are preceded by rigorous cost benefit analysis and economic, social, environmental, equality and health impact assessment.

- Ensure a full public sector wide cost analysis is undertaken prior to any outsourcing and privatisation decisions.
- Economic, social and environmental impact assessments (including sustainability appraisals) should be carried out for the procurement of services, development and infrastructure projects.
- Equality impact assessments should include the direct impact on service users and staff and the wider community and local economy.
- NHS Trusts and other health and social care organisations should strive to maximise the local or regional sourcing of goods and services.

Tackling inequalities

- It is strongly recommended that a social justice approach should be adopted in further analysis of the health and social care economy in the North West.
- The provision of adequate and affordable social and key worker housing in close proximity to major health and social care facilities is essential.

Democratising health and social care

- The formation of new NHS and local authority owned/controlled health and social care organisations, joint ventures and partnerships in the region must be democratically accountable and transparent.
- NHS organisations and local authorities should take immediate steps to involve staff and trade unions in the reconfiguration process.
- NHS Trusts should be represented on Health and Wellbeing Boards, which should a duty to increase the democratisation and participation in the health and social care economy.

Transparency

- Freedom of Information requirements must be extended as a matter of urgency to private, non-profit and voluntary sector companies and organisations providing public services.
- Private health sector data collection must be re-instated together with regularly updated information on the private health and social care sector.
- CCGs should be required to fully cost and disclose every options appraisal, procurement and market making activity.

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