DRAFT

health & social care

This Policy Brief summarises the Co-operative Party's policies on Health and Social Care, drawn from the Party's national and local government manifestos and individual submissions to the first round of the 2014 policy process. More information is available on www.party.coop.

Note:
Healthcare policy is a devolved responsibility in Scotland, Wales and Northern Ireland. Some of the proposals in this paper are relevant for consideration across all jurisdictions however others, for example reforms to Foundation Trusts, are not. The primary focus of this paper is on health in England ahead of the Westminster General Election in 2015. Further information about the Co-operative Party's policy on health services in Wales and Scotland are available on www.party.coop .proposals will be developed by the Scottish and Welsh Co-operative Parties ahead of the 2016 elections to the Scottish Parliament and Welsh Assembly.

The NHS is undoubtedly Labour's greatest achievement. But its greatness stems not from its 60 year old management structure but because it delivers healthcare free at the point of need, irrespective of ability to pay.

Much of the public debate about our health service focuses on the NHS as a single monolith, publicly owned and publicly run. But this is misleading. There is considerable diversity in the provision of health care services including significant areas of activity which are provided by either profit making bodies or not-for-profit social enterprises and mutuals including GP practices, dentists, pharmacists, opticians, out of hours services. Many third sector organisations also provide specialist services in areas such as mental health, sexual health and palliative care. In England, more than half of all acute hospitals are now Foundation Trusts, public benefit corporations, regulated at arm's length from the Department of Health and accountable to their members.

Over the last 15 years, governments (both Labour and the current Coalition) in Westminster have seen the further diversification of health service provision as a key mechanism for driving reform, achieving a greater focus on outcomes and improving patient and public involvement. Up until four years ago, this was coupled with record spending on healthcare, during which time health outcomes on key indicators like deaths from cancer and heart disease improved.

Since 2010, NHS and social care have faced the greatest challenges in its history. Namely an aging population, entrenched health inequalities, the need to fully implement the recommendations of the Francis Report into the tragedy at Mid-Staffordshire hospital and the Care Act; all at a time when government cuts, cost inflation from new technologies and drugs is threatening the viability of the health and social care system.

The Co-operative Party believes we need to be brave and outline an alternative vision for health and social care; one that is built around the whole person - meeting their physical, mental and social care needs. This includes using positively all the determinants of health, including housing, education, the environment and employment.

We can only afford a system that truly integrates the different players in the system, delivering co-operation not competition and putting people before profit.

That one system must be grounded in democratic accountability, encourage self-help and self-responsibility while achieving equality. There is much talk amongst health and social care leaders about social capital and building more resilient communities. The co-operative movement has the most to contribute to these debates, and will advocate for a system built by co-production.

As the Welsh Co-operatives and Mutuals Commission put it in their report for the Wales Assembly Government[1]:

> *"We see the role of the state as being one of stewardship of services, goods and assets that promote the well-being of its citizens – this may not always mean being the provider of services itself. Indeed, mutualisation can be an effective way of involving citizens or service users, sometimes known as co-production, in service planning and delivery."*

Accountability – Who owns the NHS?

The first line of the NHS Constitution in England is 'The NHS belongs to the people'. The Co-operative Party believes that if the vision behind this statement is to be realised there needs to be a real debate about increasing the democratic accountability of the NHS to the individuals and communities it serves.

As the NHS Alliance[2] has argued,

There is a **practical imperative** – accountability has been shown to:

- Improve outcomes for patients
- Help create better services
- Facilitate the taking of necessary, but tough choices, through citizen involvement

1 (2014) Report of the Welsh Co-operatives and Mutuals Commission.

2 Who's NHS Is It Anyway? A national debate on an accountable NHS. http://www.nhsalliance.org/publication/whose-nhs-is-it-anyway-a-national-debate-on-an-accountable-nhs/

There is a **political imperative –** increasing the involvement of local populations can:

- Improve citizenship and encourage community involvement
- Improve health by increasing social networks

There is a **financial imperative** – evidence shows that harnessing patient views can lead to savings

This accountability needs to take two forms;

1) Individual accountability which includes the 'no decision about me without me' agenda and patient choice.

2) Collective accountability – which has been defined by the Kings Fund[3] as:

    a. 'taking into account' the views of local people

    b. 'giving an account' to local people

    c. allowing local people to 'hold to account' (with the power to amend or even reverse decisions if necessary).

There are currently a variety of accountability mechanisms in the NHS in England. These include; Healthwatch, the new mechanism for patient and public involvement at a local authority level; Health and Well-being Boards which bring together the local authority, social care and health partners to assess and improve local public health; regulatory oversight of health care providers by the CQC and Monitor; and Governor and Member engagement in Foundation Trusts.

However, the big question is the extent to which this creates real accountability – both to individuals and collectively - that is required and which fulfils the promise that the NHS belongs to the people. In particular, with the new Clinical Commissioning Groups now designing and commissioning billions of pounds of services on behalf of patients and communities there are concerns that governance arrangements and local accountability is not strong enough. CCG Boards are dominated by General Practitioners and other health professionals and are unelected.

The Co-operative Party believes that there is a case for a thorough and wide-ranging review of democratic accountability within the NHS. To provoke the debate, the Co-operative Party is interested in exploring the following ideas:

- Changing the constitution of clinical commissioning groups to allow local councillors to sit on their governing body.
- Holding elections to health and well-being boards from amongst the different staff groups to ensure the frontline is represented at the table. This would include at least one trades union representative.
- Extending the legislation around the duty to consult (in both the NHS and social care) to incorporate co-production as the method to engage the public in the options that are put

3 Dixon, Lewis and Thorlby (2008) Should Primary Care Trusts be made more locally accountable? Kings Fund.

out to consultation.

- Extending the provision in the Localism Act around assets of community value to all NHS assets.

Integrated commissioning of whole person care

The commissioning landscape contains more commissioners than ever before. The Health and Social Care Act introduced clinical commissioning groups and there are more of them than there were primary care trusts. Because of conflicts of interest, NHS England commissions primary care. Local authorities remain a commissioner. While the Labour Party is committed to no top-down re-organisation and Andy Burnham MP, Shadow Secretary of State for Health, is on record as saying that he will work with the structures that he inherits, the fragmented system of both commissioning and provision needs addressing.

The Co-operative Party endorses the proposals outlined in chapter five of Sir John Oldham's Independent Commission on Whole Person Care[4] commissioned by the Labour Party. This asserts that budgets need to be treated as a whole across health and social care. It also introduces the concept of 'community commissioning' where health and well-being boards become responsible for developing a collective commissioning plan for their local population.

More co-operative commissioning models are starting to emerge and The Co-operative Party supports the move towards prime or alliance contracts as long as 'Any Qualified Provider' is replaced with the NHS as preferred provider.

These two models are defined as follows[5]:

> *"The prime contractor model makes it possible for commissioners to access the expertise of a consortium of partners, each with a specific specialism, while only contracting with a 'prime' contractor for the organisation of a whole care pathway."*
>
> *"Alliance contracting operates on a similar basis, but are operated through a consortium or joint venture."*

Clearly, where any joint venture is set up, The Co-operative Party would expect it to be based on co-operative values and principles. ResPublica argues that "the democratic and inclusive characteristics" of friendly societies "would make them ideal as a prime contractor".[6]

The same report states "friendly societies could be promoted to play a much wider role in the provision of NHS services, as well as ... operating as facilitating organisations in a new NHS that would manage the transition from a siloed system to an integrated, patient-centred system of

4 Report of the Independent Commission on Whole Person Care (2014) One Person One Team One System

5 ResPublica (2014) Power to the People: The mutual future of our National Health Service. Pg 18

6 Ibid P. 19

care." [7]

The IPPR asserts that "moving towards whole person care and delivering transformational change across the country also requires more integrated providers or networks of providers... it is unlikely that single organisations could cover every aspect of care... To illustrate the complexity of service provision in England, just 13 per cent of adult social care jobs are in the public sector... Furthermore, the crucial role of housing, employment and other local facilities in health and wellbeing means that well-functioning networks that allow wider collaboration will be necessary even with more integrated organisations." [8]

This draws in a much wider part of the mutual sector, bringing with it many opportunities for new and existing social enterprises.

Community based healthcare

Whilst it is often hospital services that attract the majority of the headlines, community-based services including pharmacy, midwifery, dental care, health visiting, physiotherapy and of course GP services account for a substantial proportion of NHS activity and spending. Even in Wales and Scotland where the shift to a 'market' of provision has been less profound, a substantial proportion of community based provision is provided by profit making or not-for-profit but private or voluntary organisations.

NHS community services in England have undergone a huge change in the last fifteen years with the creation of Primary Care Trusts in 2000, the halving of their numbers in 2006.

In 2006 Labour Party Health Secretary Patricia Hewitt wrote "Unleashing the potential of new providers in the third sector and social enterprises can help us meet these extraordinary challenges and safeguard the founding values of the NHS for another generation[9]."

In 2008, Labour introduced the Right To Request Programme, which gave staff in Primary Care Trusts the opportunity to develop their own organisation's delivery of healthcare, including the setting up pf social enterprises. This created 38 'spin-outs' with around 22,000 NHS staff working with them.[10]

The 'right to provide' established by the Coalition Government increased the number of social enterprises that have established themselves. They range from single GP practices to large scale provider 'arms' providing and/or managing the provision of a wide range of community-based health and social care related services to local communities. The overarching intention has been to encourage staff to take on greater responsibility for decision making, based on evidence from other sectors that this will drive up productivity and better utilise expertise. In addition, the goal has been to increase local accountability.

Given these new organisations have only been formed in the last 2-3 years the evidence of their impact is still limited. However, research by the Kings Fund11 has shown many running the new social enterprises in health felt that the new way of working has led to a reduction in bureaucracy,

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7 Ibid P.5

8 Sarah Bickerstaff (2013) Towards Whole Person Care Pg. 13

9 Hewitt P (2006) Social enterprise in primary and community care. Social Enterprise Coalition.

10 ResPublica (2014) Ibid. P. 15

11 Addicott R (2011) Social Enterprise in health care: promoting organisational autonomy and staff engagement. The Kings Fund.

flatter decision making structures with a narrowed gap between Executives and the front-line, increased accountability for staff, and a reinvestment of surpluses back into services and staff development.

By the end of 2011, the value of public services delivered by dozens of NHS 'spin outs' was £866m, or 12% of the annual turnover of the social enterprise sector in the UK. [12] [13]

In 2010, publishing the White Paper ***Equity and Excellence: Liberating the NHS*** Andrew Lansley set out the Coalition's ambition that the NHS in England should become the ***'largest social enterprise sector in the world***."

In England in particular the legal form and organisational models which have been utilised in the process have varied from social enterprises, employee mutuals, Community Foundation Trusts and charities. As

Case Study – Ripplez Derby

Ripplez, Community Interest Company (CIC) is an award winning staff-led Social Enterprise that is an NHS provider of the Family Nurse Partnership (FNP) programme to vulnerable young parents in Derby City, Derbyshire and East Staffordshire.

Ripplez began life as a Social Enterprise in April 2011, emerging from the NHS under the "Right to Request" process. Ripplez has a small but growing team of 40 employees who provide family nursing, business support, company management, and support to our "community of interest", which is young parents.

Since their creation in April 2011, we have successfully grown our turnover from £500,000 to £1.8million, through gaining two more FNP contracts. We are currently supporting over 400 vulnerable teenage parents in Derby City, Derbyshire and East Staffordshire.

The Family Nurse Partnership is a preventive early intervention programme providing therapeutic support and parenting education through intensive home visiting to the most vulnerable first time teenage parents in localities from about 14 weeks of pregnancy until their child is two years old.

The aims of FNP are:

- To improve pregnancy outcomes;
- To improve child health and development and future school readiness and achievement;
- To improve parents' economic self-sufficiency.

Social Enterprises are businesses that operate on a commercial sector model yet they are distinctive because their primary aim is often to address social and environmental issues and not to create profits for shareholders. This is achieved by reinvesting the majority of the profits back into the local community to address the social aim or investing in the business to increase its capacity and effectiveness.

12 Ibid P. 16

13 The position in Wales is very different. The Welsh Co-operative and Mutuals Commission recently noted that co-operative provision of healthcare services in Wales is 'very limited'. Pg 43.

Cliff Mills and Chris Brophy[14] have noted this resulted from a preference for local determination over central proscription – in contrast to the move to Foundation Trust Hospitals.

The Co-operative Party believes that government needs to take steps to maintain momentum and ensure that firstly, the potential of the mutual and wider social enterprise sector in delivering community based healthcare services can be realised; and secondly that all necessary safeguards are put in place to ensure 'right to provide' spin-outs are strictly limited to those organisations that are legally committed to trading for a public or community purpose. While exact structures will continue to vary depending upon the nature of the differing services provided; it is vital that staff, patients, carers and the general public own and control the new organisations.

Key to building for the future will be provision of the necessary support for the creation of new mutuals and social enterprises and then the ongoing support and commissioning framework to promote long-term sustainability and success. Issues for consideration include:

- The procurement of financial, legal, technical and HR support necessary to successfully identify an appropriate model and then go through the process of 'spinning out' can be challenging and expensive. Collectively procured support and more mentoring by other organisations who have been through the process can help reduce these costs and burdens.
- The increasingly competitive market place in the healthcare sector offers opportunities but also risks for social enterprises competing against well funded private sector providers with longer track-records. They will need to meet patient and commissioner expectations, develop new products and services and innovate to stay 'competitive'.
- One of the early attractions of the 'right to request' programme for participants was the promise of a 5 year initial contract (compared to traditionally 3 years). Such contract lengths should be considered more widely for the not-for-profit sector in recognition of the challenges posed by more regular re-commissioning including the uncertainty it poses and the lack of investment lending that is often available to the sector.
- Where mutuals and social enterprises fit in 'alliance' and 'prime contractor' models.
- How to best demonstrate the added value of the mutual sector in relation to co-ordinating whole person care.

Prevention and good public health

It is vital that our public services, including the National Health Service, dramatically increase the amount of resources and focus on the prevention of ill-health and the support of healthy lifestyles. This will require radical and fundamental change but progress can also be made through relatively small and practical steps. Two areas in which co-operatives and mutual models could provide particular expertise are in supporting and developing local grassroots sports activities. The Wrexham and District Running Club, is an example of a sports club run by its members for the benefit of the members. It provides both the exercise and social element, which contribute significantly to health and well-being.

Such a model could be applied to any active hobby groups such as dance, bowls, tennis, ti chi, even yoga or karate for example. Secondly, getting the next generation into good eating habits

14 Brophy C and Mills C (2011) Community Health Services: Made Mutual. Mutuo.

could have a really positive long-term effect and breakfast and afterschool clubs where healthy food is available can play a key role. Where schools or local authorities are not providing these facilities groups of parents could be supported to come together to form clubs based on co-operative values.

Perhaps the strongest role for co-operatives in health is in improving public health via the formation of new local co-operatives - doing the kinds of things that promote health and well-being and reduce our chances of becoming ill in the first place - by creating new local organisations which involve people in carrying out socially and medically beneficial activities and also build up social capital.

Foundation Trust hospitals – ten years on

One of the most significant shifts in health delivery in England in the last ten years has been the creation of Foundation Trust Hospitals. The first Foundation Trust opened in April 2004 and since then more than 140 trusts have been established spanning acute, mental health and ambulance services. Ten years ago the vision was an ambitious one – a groundbreaking new legal structure modelled on traditional co-operative and mutual societies. They introduced for the first time in NHS-run services the concept of grass-roots membership with democratic governance. This offered a new model of healthcare that was controlled and run locally; giving staff, local communities and other stakeholders a far greater voice in how hospitals were run.

The last decade has produced much to be celebrated with some Trusts, particularly mental health trusts, seeking to make the most of this model. There are now more than two million members of Foundation Trusts and over 50% of Trusts say that members have influenced what they do. However, partly as a result of shortcomings in the original legislative framework and partly as a result of regulatory focus on finance and risk management to the exclusion of all else, the experience has largely been a focus on widening membership rather than deepening participation and democratic practise[15].

Co-ops UK have set out some of the key lessons to be learned:

"In practice the chain of accountability was always going to be complex. Trusts were deliberately made accountable to Parliament via the risk regulator Monitor. What's more, the development of membership tended to be less of a priority for many trusts than the development of the governor role.

There are some important differences from a traditional co-operative approach. In a co-operative organisation, the grass-roots members are the "owners" and its custodians. Their

15 Mayo, E (2013) Ten Years After: The democratic promise and potential of membership of NHS Foundation Trusts.

role is to provide the ultimate protection of the organisation, to make sure that it continues to deliver its corporate purpose. Like grass-roots members of most corporate bodies, their role is limited to: approve changes to the constitution; approve strategic mergers; decide whether to cease trading. It is recognised that public benefit corporations operate in a different context and that now these functions (the first two, at least) are the responsibility of the council of governors. However, the effect is to leave members with a more marginal role.

This is a cause for concern as it has a number of consequences, including making membership a relatively uninteresting proposition, with a knock-on effect in terms of recruitment and retention. This can also make governors more exposed as they lack the support or pressure of an active membership. It could also limit the range of individuals seeking election, thereby making it difficult for governors to represent the full community.

The hollowing out of membership has been exacerbated by the Health and Social Care Act 2012, which required certain decisions to be authorised by governors, rather than members.

While the act could have strengthened the position of members, in fact it did the opposite by requiring changes to the constitution to be approved by the governors (and directors). Previously trusts could choose for constitutional changes to be approved by their members. Public benefit corporations are now different in this respect from all other corporate bodies requiring governors to approve a range of other decisions including "significant transactions", mergers and acquisitions, and taking on or substantially increasing the amount of private work.

The Act introduces for the first time a requirement for an annual meeting of its members. Whilst in principle this is a good thing, it does not really enhance the position of members because:

- *The annual meeting has to be open to members of the public, so membership of the trust does not give anything additional.*
- *Members themselves have no rights in a Foundation Trust other than the right to vote in elections of governors. By comparison, members of a company (shareholders) who similarly have the right to attend the annual meeting, have a number of other substantial legal rights such as the power to remove directors. This makes their right to attend the AGM and ask questions rather more substantial than the equivalent for members of Foundation Trusts."*

The Co-operative Party believes that the values and vision behind the creation of Foundation Trust hospitals remain the right ones. In order to realize the potential of community owned health services the following reforms need to be considered.

- The rapid growth in the number of Foundation Trusts has seen a widening rather than a deepening of community engagement and in some areas the experience is that little commitment to the model is evident from hospital management. Whilst the aim that every hospital should be a Foundation Trust is right, in practice it risks allowing it to become a

'paper exercise' without the necessary commitment to making a real change in governance. Therefore, consideration should be given to removing the target that all hospital trusts should become Foundation Trusts and instead allow local communities (working with their local Healthwatch) to initiate the process of becoming a Foundation Trust.

- The Government should review the role of Monitor in regulating Foundation Trusts with amendments made to the regulatory framework to ensure Trusts are being judged on the extent to which they are engaging members in decision making and the vibrancy of governor elections. This would put governance higher up management's priority list and provide proper incentives for the best to demonstrate what is possible. [16]
- A strengthening of the role of members within Foundation Trusts should be considered and necessary legislation brought forward. This could include measures to increase the accountability of governors to members through a power to require updates, consultation and dialogue; reviewing whether there are powers currently held by governors that could be transferred to members; increasing the duties on Trusts to publish forward plans and up-coming decisions so that governors can consult and engage members ahead of key decisions.
- Healthwatch England should be asked to work with the Foundation Trust Network to consider emerging models of good practise in collaborative working between local healthwatch and Foundation Trusts. This good practise should be disseminated.

Transforming Social Care

The challenges facing the health and social care system are enormous. The solution has to be a co-production with its users and their carers. There is also a strong case for co-operative governance within individual institutions and with departments and smaller units, giving a voice to employees at every level – empowering them to think laterally - and encouraging management to listen and engage. This should involve the trades union from the start.

Case study – Mutual Support Sheffield

Mutual Support provides a new model of community-based homecare services for older and disabled people in South Yorkshire and North Derbyshire. Mutual Support is registered as a Cooperative and as an Industrial & Provident Society.

Mutual Support provides an innovative and ethical range of support to people; offering a new way forward for people and carers to take control of their lives.

Mutual Support cooperative is made up of three groups:

- People who need support to live in their community
- Paid care staff
- Unpaid carers/friends/family members

One of Mutual Support's aims is help its members find answers to often difficult and sometimes overwhelming questions about how to organize and maintain assistance that fits with their needs and puts them in control

Our goal is to give every care recipient and care giver the opportunity to utilise co-operative models of social care. The co-operative and mutual sector is already playing a growing role in the delivery of social care services and is showing what can be achieved both for the recipients of that care but also for the workforce. A nationally run co-operative training scheme for care staff would be welcomed.

The Co-operative Party notes that the Labour & Co-operative Government in Wales has introduced the Social Services and Well-being (Wales) Bill which aims to promote co-operative delivery models in the provision of care and provides a potential model for reform elsewhere in the UK.

The aspiration of many working age adults with a physical or learning disability is to find paid employment. The Co-operative Group has a strong track record in this area and their experience should be shared with the rest of the co-operative movement.

There needs to be significant change in the way social care is funded. The Co-operative Party supports the Independent Commission on Whole Person Care in their call for an 'Independent National Conversation' backed by all major political parties to define a consensus on the scope of services provided by, and the future funding of, health and social care as a single issue.[17]

The Co-operative Party fully supports the principle that users and carers should be given as much control as they want over the services that they require. We welcome the movement towards direct payments and individual budgets. However, to fully realise the potential of these changes there needs to be real diversity in the sort of provision available for people to choose from. We also believe there is a need to consider to regulation of Personal Assistants that have grown exponentially since the introduction of direct payments. There is currently no legislation in place to ensure the quality of these roles.

The Co-operative Party recognises the important work under the Department of Health's pilot programme of direct payments mutual – which was run by Co-operatives UK and Mutual Advantage[18]. The pilots brought together service users, informal carers and personal care assistants to ensure that both users and employees can benefit from a more formalised system of care and economies of scale. This means that recipients are able to remain in control of the day to day provision of how their care is provided, while personal care assistants of the co-operative are able to ensure that they are receive appropriate employment conditions.

The Co-operative Party would like all service users and carers to have access to a direct-payments mutual within their local community. In order to bring universal coverage, there will be a need to:

- Encourage local authorities to use their organisational capacity to help develop direct payments mutuals
- Develop a technical assistance fund for direct payments mutuals to cover start up capital costs

The Co-operative Party believers that service users and carers should have access to a direct-payments mutual within their local community. In order to bring universal coverage, there will be a need to:

- Encourage local authorities to use their organisational capacity to help develop direct

17 Report of the Independent Commission on Whole Person Care. Ibid. P. 65
18 Self-managed Care – a co-operative approach. Co-operatives UK and Department of Health.

payments mutuals

- Develop a technical assistance fund for direct payments mutuals to cover start up capital costs
- Ensure that local authorities do not use direct payments and individual budgets as a means of reducing overall budgets, and pay a rate that reflects the cost of being a responsible employer to high quality staff.
- Create micro co-ops, that build on the Fairtrade model, to ensure that all care, is relational, on a human scale, is co-produced and co-delivered ensuring 'dignity in care' for the carer and the cared for, based on the values and principles of co-operation.

One of the principal goals of social care is to support adults, both older people and those with physical and learning disabilities, to live independently in their own home for as long as possible. Co-operative housing solutions have a role to play in this and The Co-operative Party would be keen to hear from the sector about how they are responding to the increased focus on keeping people out of hospital and getting them home more quickly, once they have been admitted.

politics for people

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