co-operative party

POLICY PROCESS 2022

HEALTH

Our policy platform sets the agenda for our party and its representatives, and puts forward our to-do list for Parliament. In the tradition of co-operation, our policy process is member-led and this is your opportunity to shape the ideas we'll take to all levels of Government.

This year, the policy consultation will focus on two areas – health and international development. Members are invited to share their views and ideas through our consultation, running until 19th June 2022.

There are a number of ways to get involved – you could attend your local party meeting to discuss the topics and share your collective views, or send your individual answers to us. Resources and support are available to help you convene your meetings online, and you can also learn more at one of our regional conferences happening through the year – where expert speakers will debate these issues with our members.

Your contributions will be collected and considered by the NEC's policy sub-committee, who use your ideas and feedback to shape policy proposals. These will be brought to the Co-operative Party annual conference in the Autumn for delegates to debate and vote on.

This health consultation focuses on England as the majority of policy is devolved to the nations. There will be specific Wales and Scotland health policy consultations too to make sure our policy is relevant across the UK. The questions focus on a variety of topics, from better integration with social care and greater use of co-operative and community providers to ensuring patients' voices are heard and equality is promoted.

Health is a very broad policy area, so we appreciate that the consultation may seem daunting in its length and breadth at first. These questions are intended as a guide – members should share anything they feel is relevant to the debate and should not feel obliged to answer every single question either.

Patient voice

Accountability and control are important for improving outcomes, creating better services, involving service users in decisions, and ensuring financial sustainability.

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 realised there needs to be a real debate about increasing the accountability of the NHS to the individuals and communities it serves.

Questions

- If you give your views on health services in your area, do you feel it makes a difference? Which services you've interacted with are better or worse at ensuring your voice is heard?
- Please do let us know any thoughts on increasing patient voice, participation and accountability in health.
- Do you think that devolution like in Greater Manchester can offer more control over how health services are run? Why/ why not?

Health and care bill

There is a fear that the bill will increase private sector involvement due to increases in flexibility of procurement rules, the ability for private providers to hold seats on integrated care boards, and potential conflicts of interests in the awarding of contracts.

There are also concerns that the changes, especially where new services are being commissioned, would allow contracts to be awarded to new providers without sufficient scrutiny, or that it will result in more existing contracts being rolled over to the incumbent provider with little opportunity for co-operative, community or voluntary sector organisations to come forward.

Questions

- Where products or services, whether it's PPE manufacture, food and energy supply, or some specialist or local clinical services, cannot be provided by the public sector, what principles should underpin procurement rules in the NHS?
- How can a greater diversity of providers – especially co-operative, community and voluntary sector provision – be supported and encouraged through procurement processes to replace private sector providers?

- Where do you see opportunities for co-operative models? Do you have any local examples of best practice you can share?

The bill proposes significantly expanded powers for the Secretary of State to intervene earlier, be involved in many more decisions, and to direct NHS England. This means a much wider scope for political interference in everyday decision-making – potentially causing critical delays, decision-making logjams, and less independence for clinicians making choices that they have concluded will benefit patients.

Questions

- How can local decision-making by clinicians, communities, patients and providers be empowered rather than limited by political interference?

The bill should deliver opportunities to better integrate health and care – there is an opportunity to use this to improve people's outcomes and experiences of health and care services, but as explored in last year's social care consultation, budget cuts cannot be the primary objective of integration. It is clear that what is made of this opportunity depends on implementation.

Questions

- What are the potential benefits of better integration in health and social care services?
- Do you have experience of using health and care services – whether as a patient, a carer, or an employee – where the service has felt particularly joined up and/or particularly patchwork and disjointed? Please feel free to share anything from your experience that you think could help shape policy (for example, a best practice example, how a joined up or disjoined services made you feel, what the impact was on health outcomes)
- There is a fundamental link between mental and physical health – how can we improve access to, quality of and parity of esteem of mental health services, and ensure proper integration?

Staffing challenges

Diversity in NHS governance structures is poor. For example, a study by the University of Exeter in 2020 found that in 70 out of the 213 trusts all the board members were white. Overall BAME representation at board level was 8.9%. Medical directors of BAME ethnicity accounted for 19.4%, about the same as the overall percentage of BAME doctors. Statistics collected by the NHS show that women are underrepresented (43% board members, 77% workforce in 2017) and that disabled people are underrepresented (5.3% board members identify as having a disability compared with 17.6% of the population in 2017).

Questions

- What can be done to urgently improve diversity in NHS governance?

The NHS is the largest employer in England, with nearly 1.2 million full-time equivalent (FTE) staff working in hospital and community services. Throughout this pandemic, these workers have been on the frontline of the crisis, faced with especially challenging working conditions, pay freezes and long-term issues exacerbated - such as chronic excessive workload, burnout, stress, and inequalities experienced by many black and ethnic minority staff.

As well as these issues causing high levels of turnover and absenteeism, the NHS faces serious staffing shortages. There is a shortage of nearly 84,000 FTE staff, severely affecting key groups such as nurses, midwives and health visitors. There is a shortage of about 2,500 GPs which is forecast to increase to a gap of 7,000 within five years. 28% of nurses and health visitors leave the NHS within the first three years of service. These have been compounded by Brexit with many nurses and midwives from Europe, for example, leaving the country and a 90% drop in new nurses and midwives from Europe arriving.

Questions

- What needs to change to ensure the NHS is an inclusive, rewarding and supportive place to work?
- As co-operators, we know that organisations work best when people have a say and a stake in their workplace. How can our co-operative principles be applied in health services struggling to recruit and retain staff?
- Education is one of our co-operative principles – how can we ensure equal access to excellent ongoing education and training in the workplace in health services?
- How can we ensure that the culture within health services is one of co-operation which promotes parity between different roles and functions people have?

Health inequalities

The UK is home to shocking health inequalities. There is a systematic relationship between deprivation and life expectancy – in the least deprived areas of the country, men live 9.4 years longer and women live 7.4 years longer. People in the most deprived areas spend around a third of their lives in poor health, twice the proportion spent by those in the least deprived areas.

Many also experience barriers to accessing services – because of language, real or anticipated discrimination, or a lack of understanding of a complicated health system. This is often reported to be the case, for example, for asylum seekers and refugees, and Gypsy, Roma and Traveller communities. Studies show that this can especially be the case for disabled people who face barriers such as long waiting lists, long distances to access services, and difficulties accessing transport – which has only been exacerbated by the pandemic.

The availability of services is also unequal - more deprived areas tend to have fewer GPs per head for example – as is the experience of them. According to Stonewall, 13% of LGBT respondents reported experiencing unequal treatment because they were LGBT, with this number rising to 32% for people who are transgender and 19% for Black, Asian and minority ethnic LGBT people.

And outcomes are often, as a result, unequal. The data on maternity deaths in the UK, for example, show black women are four times more likely to die during pregnancy in the UK than white women. For Asian women, they are twice as likely to die. Another shocking example from a recent study shows that the UK has the largest female health gap among G20 countries and the 12th largest globally.

Questions

- Have you or someone you know experienced barriers to accessing services, or stigmas when they have? What were those barriers and how would you like to see them addressed?
- Equality is at the heart of the co-operative movement. How can our policy work on tackling health inequalities link better with our campaigning work as co-operators?

NHS and community wealth building

Given the strong correlation between socioeconomic factors and health, there is clearly a public health argument for tackling inequality and growing fairer more sustainable local economies.

Whether it is access to good quality, affordable food or decent workplace conditions, the co-operative movement has long been part of this work. Community Wealth Building, too, looks at health and local economic outcomes and their relationship. In Cleveland, Ohio, the original Community Wealth Building work was led by the Cleveland Clinic who used the power of their procurement to invest in employee ownership and reinvestment of local wealth. There are also examples like the Lambeth GP Food Co-op who use innovative community models to do social prescribing.

- Deprivation reduces life expectancy and worsens health outcomes and worsens health inequalities. What wider co-operative policy can help to tackle deprivation and socio-economic inequality – and how would you like to see this fit with new health policies?
- How can we harness the potential of health services and hospitals as anchor institutions to invest in a fairer local economy?
- How can we better embed health services in communities?

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