WRITTEN EVIDENCE SUBMITTED BY DOCTORS IN UNITE (HB138)

OUTLINE FOR EVIDENCE BY DOCTORS IN UNITE TO THE HOUSE OF COMMONS PUBLIC BILL COMMITTEE ON THE HEALTH BILL

1.Abolition of NHS England

Doctors in Unite were opposed to the creation of NHS England, believing that responsibility for the NHS should lie with the Secretary of State and not be outsourced to an arms-length body. Initially we welcomed its abolition until we realised that there were no plans to protect the important functions it fulfils, including healthcare public health, dental public health, NHS response to climate change, education and training, workforce planning, with loss of clinical expertise, severe short-term disruption and potential political interference in healthcare. There will be significant job losses without clear evidence of where these duties will be allocated and if the DHSC has enough capacity to absorb all these functions. Whilst there may be scope for savings in some areas, including some areas where duplication exists with DHSC, the large savings targets spread across the whole organisation will be very damaging.

Unite the Union strongly condemns the government's plans to abolish NHS England (NHSE), warning that the associated mass job cuts are unfunded and threaten patient safety. The union is demanding an immediate freeze on redundancies, adequate impact assessments, and genuine consultation with healthcare workers. Service standards and patient safety must be maintained.

Instead of abolishing NHS England **we suggest that all the clauses of the Bill which relate to the abolition of NHS England be abandoned and replaced by a single clause, repealing the entire contents of schedule A1 of the National Health Service Act 2006 and replacing them with a statement that the Secretary of State shall manage and direct NHS England, being accountable to Parliament for doing so. and making such arrangements as shall seem appropriate for the delegation of that function.**

This will bring the NHS back under the direct responsibility of the Secretary of State without a damaging and complex reorganisation.

2. Reorganisations Generally

Far too much strategic time and effort is wasted on NHS reorganisations. Whilst we believe that the NHS does need to be reshaped we think this can be done organically as particular needs are identified. Economies of scale can be achieved, where they exist, by organisations co-operating together. There is no reason, for example, why a number of small NHS bodies cannot share an HR department. And economies from decentralisation can be achieved by focusing appropriate functions at the appropriate level without requiring wholescale restructuring. **We suggest adding into the National Health Service Act, 2006, a clause requiring all reorganisations of NHS management to be carried out by such gradual organic methods and be evidence based, showing improvements in services and health outcomes and staff terms and conditions.**

3. Public Health

We are concerned there is no reference to public health in the Bill. Public health was clearly not a priority for the recently departed Secretary of State.

Public health is as important an element of health policy as health care since

- Life expectancy is declining and people are dying too early
- Inequalities in healthy life expectancy are not accounted for in current social care age-based funding formulae as poor people need care earlier
- Productivity is lost due to people being unable to work
- The NHS is collapsing under pressure of obesity, diabetes and heart disease
- The climate emergency threatens the health of us all

Public health was part of the NHS until 2013 (although only until 1974 in the case of environmental health) when the Lansley Act in England distinguished between "the NHS" and the "statutory health service" (the NHS plus public health) which George Osborne used as an excuse to cut public health funding. This redefinition should be reversed.

We need

- Good quality public health services, screening for ill health, and making it easier to choose healthier lifestyles. This requires
    - public health grant to increase in line with NHS funding growth from 2013 and further increase so all councils equal the best funded decile
    - a greater commitment to preventive spending within the NHS
    - better funding of other health-relevant local government services, especially including youth services, leisure and community facilities
- Community development to help communities improve health in their area
- Neighbourhood public health leads linked to primary care
- Effective regulation – Cuts in environmental health, the Environment Agency and HSE have seriously damaged the effectiveness of public health regulation
- Addressing commercial determinants of health, with a just transition
- Public health specialists must have a primary duty to populations, not organisations, and give advice in the public domain contributing freely to public debate, so the public trusts public health advice as independent.
- Health in all policies. Health needs to have the same cross-government status as the Treasury.
    - All public bodies should have duties towards health and climate change
    - All public agencies must receive advice from public health specialists
    - The Minister for Public Health in DHSC (and its devolved equivalents) must be a high-level appointment with a role across Government, supported by a team of public health lead Ministers in each Department
- A comprehensive publicly-provided occupational health service as part of the statutory health service
- A national health promotion agency and local health promotion teams

We support the comments by the BMA Public Health Medicine Committee (with which we have joint working arrangements) relating to the duties of the Secretary of State.

We have also drafted the following clause to protect the multiagency role of the DPH and suggest it be added to the Bill. Please note that the words enclosed in brackets {} and marled with an * are included only for compatibility with another clause we suggest on definition of the NHS and would not be needed otherwise.

There shall be inserted into s30 of the Health & Social Care Act 2012 after the material specified therein for insertion into the National Health Service Act 2006 the following addition to the insertion

73D The Director of Public Heath shall

(a) be an officer of the local authority and shall have responsibility for its public health functions

(b) be an NHS consultant in public health responsible for giving independent professional public health advice and for promoting public debate on health matters

(c) be a corporation sole and NHS body for working with others to initiate measures to improve the health of the people

(d) be an officer of the Crown responsible for such functions as the Secretary of State may specify

(e) as an officer of the Crown have power to draw the attention of the Chief Medical Officer and the Attorney General to events within the area of the local authority creating circumstances in which it might be appropriate to bring proceedings in the name of the Crown for public health purposes

(f) be an officer of the National Health Service responsible for promoting the provision of services which are outcome-focused, are provided following a proper needs assessment and pay attention to the promotion of health and the prevention of illness

(g) as an officer of the NHS, have power either personally (in the case of a body which primarily serves the population of the local authority which appointed the DPH) or through joint arrangements with other Directors of Public Health (in the case of a body which primarily serves the population of several local authorities) or through a collective arrangement established by the Chief Medical Officer (in the case of a body with a national remit) to appoint, or approve arrangements for the body to appoint, a consultant in public health to serve on the governing body of any NHS body {other than an NHS body which is a local authority}*, any NHS Foundation Trust, any of the bodies established under this Act or any of the bodies established under the Health & Social Care Act 2012 or any other legislation relating to the governance of the NHS.. For the avoidance of doubt the consultant so appointed may be, but need not be, the Director of Public Health personally

(h) as an officer of the NHS and of the local authority, have power either personally (in the case of a body which primarily serves all or part of the population of the local authority which appointed the DPH) or through joint arrangements with other Directors of Public Health (in the case of a body such as a joint board or combined authority which primarily serves the population of several local authorities) to appoint a consultant in public health to attend any local authority meeting and to advise the meeting whilst it is in session on

matters affecting the health of the people. For the avoidance of doubt the consultant so appointed may be, but need not be, the Director of Public Health personally and a different consultant may be appointed for different meetings

(i) be contractually required, subject to law, to carry out the functions in subsections b, c, e, f, g and h herewith as an independent health professional treating a population as a patient and pursuing the improvement of its health and to be contractually entitled not to be subject to any detriment by the local authority or by the Crown for so doing.

We have also drafted the following clause to eliminate the terminological distinction between the statutory comprehensive health service and the NHS and to return to the old nomenclature in which the statutory comprehensive health service was called "the NHS".

(1) In s1 of the National Health Service Act 2006 as amended by s1 of the Health & Social Care Act 2012 after the words "comprehensive health service" shall be inserted the words "to be called the National Health Service (which may be referred to as 'the NHS')"

(2) Throughout the Health & Social Care Act 2012 and the National Health Service Act 2006 all references to the health service shall be replaced by references to "the NHS", and all references to "the NHS" or "the National Health Service" (except those added by this clause) shall be replaced by "NHS Healthcare" (except that the term "NHS body" shall not be changed)

(3) A new paragraph shall be added to s66 of the Health & Social Care Act 2012 to supplement s66(4): "S66(4A) Those parts of the NHS which s66(4) excludes from the definition of NHS Healthcare shall be referred to as NHS Public Health"

(4) Local authorities insofar as they carry out the function of NHS Public Health, other bodies established to carry out the functions of NHS Public Health, and local authorities insofar as they carry out the function of environmental health authorities shall be added to the definition of "NHS body".

The Public Health Crisis and the Case for Parity of Esteem

KEY POINTS FOR DECISION MAKERS

The Public Health Crisis

Britain faces a public health crisis. Life expectancy is in decline. The NHS is buckling under the weight of preventable illnesses. The welfare system is struggling to cope with high levels of unfitness to work, including amongst young people. Poor health damages the economy.

In these circumstances it might be thought that a Labour government would prioritise public health. Instead spending on public health is falling in real terms, services for physical activity are being abandoned, there are wide disparities in the availability of services like smoking cessation services and health visiting. Proven beneficial measures like community development are brushed aside because they do not fit models of individualised care.

The public health specialist service (a medical specialty which also has a non-medical route of entry) is unable to address this problem because the breadth of its authority has been restricted and its establishment is often sacrificed to maintain spending on services. The reorganisation of public health national organisations is actually making health protection specialists redundant. The reorganisation of NHS England threatens to dismantle healthcare public health. Local authorities in England rarely feel able to fund an adequate public health specialist service and the freedom of public health specialists to offer advice across the whole range of the public services is often constrained by the belief that their responsibilities are limited to corporate responsibilities in their own authority.

Parity of Esteem

At a number of levels this reflects lack of parity of esteem. We are particularly concerned by

- Lack of parity of esteem between preventive and treatment services
- Lack of parity of esteem between preventive services and prevention by means of social policy
- Lack of parity of esteem between that part of the statutory comprehensive service which is defined as part of “the NHS” and those to which that nomenclature is denied
- Lack of parity of esteem between the specialty of public health and other medical specialties
- Lack of parity of esteem between health professionals employed in local government and health professionals employed in the NHS
- Lack of parity of esteem between public health specialists from the medical and non-medical routes of entry to the specialty.

Action Requested

To address these issues, we request

- Funding of the public health system must be viewed as being as high a priority as funding of front line NHS services
- Health in all policies must be institutionalised at national level in the machinery of government, with a commitment to a just transition for workers and communities affected by addressing commercial determinants of health) whilst at local level legislation should protect the broad multiagency role of Directors of Public Health. We can provide a draft for that legislation which could be a single clause added to the health service legislation proposed in this session of Parliament.
- The term “the NHS” should in future be used to refer to the whole of the statutory comprehensive health service (as it was from 1948-74) with the term “NHS Healthcare” being used for those services defined as “the NHS” by s66(4) of the Health & Social Care Act and the term “NHS Public Health” being used for the services provided for the health service by local government and the Secretary of State (we can provide a draft of the necessary legislation, which could be a single clause in the coming piece of health service legislation)
- Discrepancies of earnings and status between consultants in public health and other medical consultants should be addressed.
- A directive should be issued that all health professionals employed by local government or the civil service in the provision of the statutory comprehensive health service should be employed on NHS terms and conditions
- Public health specialists from the non-medical route of entry should be paid on medical and dental terms and conditions of service like their medical colleagues doing the same job.

FURTHER DETAILS

Parity Between Preventive and Treatment Services

Spending on the public health services transferred from the NHS to local government substantially increased in 2013 and notched up slightly more in 2014. But this was only a small part of total public health spending. With “public health” removed to local government the NHS faced even less pressure to prioritise prevention whilst, outside the ring fenced field of “public health”, local authorities were subject to severe spending cuts which were eroding environmental health services, youth services, community development and other services central to a public health strategy.
A significant part of the new money committed to public health services was used to ease the consequences of those wider local authority cuts.
The division introduced in 2013 between “the NHS” and the “statutory comprehensive health service” allowed the 2015 Cameron Government to cut funds for public health in England saying health visiting, school nursing, drug and alcohol services and NHS health checks were no longer part of the NHS! Andrew Lansley’s aim in introducing the division might have been to give public health a higher priority but it actually was used in the exact reverse way. The argument was that because “the NHS” had to have protected funding it was important that other areas of DH funding should be squeezed to help find that money. The 2013 and 2014 growth money were taken away and the cuts in public health spending then went further, biting even into the inadequate levels that Lansley had set out to improve.
Although this erosion has been partially halted by this Government, it has not been reversed. Indeed when spending on the national public health bodies is added in, spending on public health continues to decline in real terms.

Parity Between Preventive Services and Prevention by Means of Social Policy

Although the Government has developed some health strategies which go beyond mere provision of preventive services, especially in relation to tobacco and obesity, these still focus on modifying individual behaviour and, insofar as they seek to influence commercial determinants at all, they do so without addressing the issue of just transition for the workers and communities affected. At the start of the Government there were commitments to Health Missions in a number of departments of government, but most of these have withered away and the staff have been reallocated. There has been no equivalent to the Welsh legislation on well-being of future generations, and the Minister for Public Health in England focuses on preventive services not on cross-departmental coordination.

At local level public health specialists report that they are not free to comment on the health implications of broader measures, either within their authority or in outside agencies. They are perceived as speaking for their employer and attempting to doi their job of advising the population on health issues is perceived as corporate disloyalty. With most public health specialists at local level being subject to such restrictions and most public health specialists in national organisations operating under civil service restrictions, journalists tell us that they cannot rely on the professional integrity of any public health opinions. From 1875 to 2013 the people always had access to the professional opinions and advice of doctors whose job was

to analyse, comment on, advocate for, and work to improve the health of the people. They have this access no longer.

Parity Between the NHS and the Rest of the Statutory Comprehensive Health Service

The NHS is not just a way of paying for health care. It is also a mechanism whereby the health of the people is pursued as a social goal,

Nye Bevan's NHS had three wings – family health services (general practice. pharmacy, dentistry and opticians), the hospitals and the Health Depts of local authorities. Since a sharp bureaucratic divide now separates the NHS and local government we often forget that part of Bevan's NHS was run by local authorities and focused on prevention. In its first quarter of a century the NHS cleared the slums, cleaned the air, eradicated polio and diphtheria, and dramatically reduced the incidence of TB, enabling TB hospitals and TB wards to be closed or reused.

These achievements of the early NHS show that the NHS did once emphasise prevention. But since reorganisation in 1974 it has lacked the means to do so. Important elements of public health, such as environmental health, remained with local government but were no longer seen as part of the NHS, so that addressing the social and environmental determinants of health was no longer within the remit or the capacity of the NHS and no longer under the direction of public health specialists committed to analysing and improving the health of the people. Those specialists were now in the health authorities and were generally redirected away from addressing the determinants of health and towards health service planning. They were separated from public health nursing which moved to the new health districts and came to be seen merely as specialist community nurses.

From 1974 to 1997 spending on public health by the NHS and by local government depended entirely on the local priority given to it. Many environmental health departments were run down by their local authority and integrated into a regulatory function in which public health was only one element. Many NHS bodies did not perceive the importance of prevention and saw health visiting, school nursing and community clinics as sources for savings to fund their priorities in the hospital service. On the other hand, many local authorities and NHS bodies did see the importance of public health and where such prioritisation existed on both sides of the NHS/ local government divide vibrant public health programmes could be developed. There was a brief period under the leadership of Barbara Castle that public health had a national priority but she thought it too late to reverse the 1974 changes, perhaps not fully realising their baleful effect, and she survived only through the Wilson Government. There was no significant prioritisation of public health under the Callaghan Government, and the Thatcher Government had an ideological antipathy to public health.
The Major Government had a stance of regretting the decline of public health and expressing support for local initiatives but doing nothing to generalise them. Even this limited support changed in 1997. The Health Dept in the Major Government had not prioritised public health but it had permitted it to be prioritised locally. From 1997-

2010 prioritisation was centralised and it became more difficult for localities to pursue different priorities. Public health was not a priority of the Blair Government.
This changed briefly for the better in 2010. Andrew Lansley is not a hero of ours – he did much to damage the NHS by his unnecessary reorganisation, by his misplaced belief in commercial solutions and by his fundamentally damaging procurement laws. However, in one respect he is to be praised. He stands alongside Barbara Castle as one of only two Health Secretaries to have genuinely prioritised public health.
The adverse effects of 1974 could therefore have been reversed in England when public health returned to local government in 2013 but instead the coalition with the Liberal Democrats decided to introduce a distinction between "the statutory comprehensive health service" and the "NHS", with the latter being only a part of the former. Andrew Lansley's vision was that "the NHS" had become too firmly identified with health care and a new public health system needed to be built alongside it and to become the dominant element of the Dept of Health. However, like Barbara Castle, Andrew Lansley was quickly replaced by successors who did not share this vision.
Indeed, as we pointed out in our paper "Orwell and Environmental Health" in 2012 one consequence of redefining the NHS so as to consist only of healthcare is that it begins genuinely difficult to conceptualise an NHS which is the mechanism by which society pursues health as a social goal and genuinely difficult to understand its history and the debates that surrounded it in its first quarter century. Take away the word for something and you make it harder to imagine it.

Parity Between Public Health and Other Medical Specialties

There have been a number of issues, not only in relation to pay but also in relation to workforce planning where public health has been treated differently from other specialties.

In England the fact that public health doctors have a higher proportion of employment in local government, the civil service and the Universities than do other specialties has made this worse as those groups have been treated disadvantageously.

We deal with local government in the next paragraph, but the civil service is also problematical because of the failure to perceive public health (even health protection) as a service rather than as a managerial role, and because of the pressures that have been brought to abandon the clinical ring fence.

Parity Between Health Professionals in Local Government and in the NHS

There is a substantial pay differential in England between consultants employed in local government and those employed in the NHS. Although it was agreed in 2012 that local authorities needed to have the power to employ health professionals on NHS terms and conditions, only a minority did so and most of those have now stopped. In some cases, this has been because of fears that separate TCS would open the risk of equal pay claims – a fear that could best be allayed if, as in with the teachers' scheme, it was made compulsory.

The problem was aggravated by the refusal of LGE to recommend the Faculty guidance on job descriptions and job evaluations. Initially, where that guidance (which emphasised the cross-agency and public-facing role of consultants) was followed, job evaluation usually produced a grading within the range of NHS consultants salaries. However, many local authorities evaluated jobs without regard to that guidance and with inadequately expressed job roles.

As time has passed and NHS salaries have moved ahead of local government salaries this problem has deepened and some salaries which were initially acceptable have now slipped behind.

Similar problems have arisen for some other groups of health professionals when local authorities have taken services in house.

We ask for a directive to be issued that NHS TCS should be used for health professionals employed in local government public health. There is a power to do so in the 2012 Act.

Parity Between Routes of Entry to the Specialty of Public Health

The training that public health specialists undergo is the same whether they enter through the medical or non-medical route and their job descriptions are identical, yet a significant gap has emerged as medical and dental pay has moved ahead of AfC pay. The simplest way to ensure comparability would be to extend the medical and dental TCS to include public health specialists as they are members of a medical specialty who have undergone training approved by a medical Royal College.

This is not only UNITE policy but also BMA policy.

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