Health & Social Care News

National Pensioners Convention **Health & Social Care Working Party**

Walkden House, 10 Melton Street, London, NW1 2EJ
020 7383 0388 info@npcuk.org www.ncpcuk.org

Issue : 6 : December 2016

Members of the Health & Social Care Working Party:

Mary Cooke

Clive Evers

Jean Hardiman-Smith (Chair)

Claude James

Shirley Murgraff

Terry Pearce

Pat Prendergast

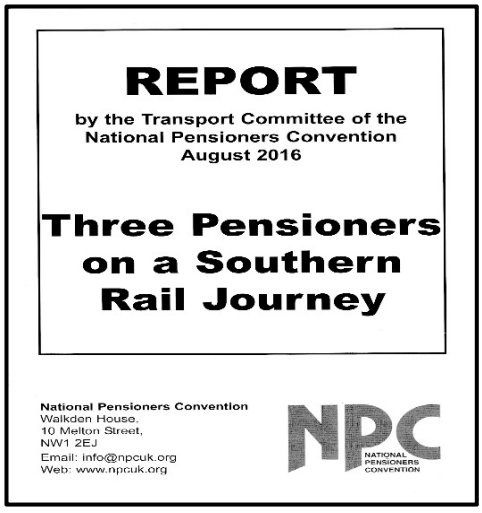
Pat Roche

Elaine Smith

Dot Gibson (Gen. Sec)

Jan Shortt (Vice President)

We hope you continue to enjoy our newsletter and that you will share your stories with us.



NPC SUPPORTS TRAIN GUARDS CAMPAIGN

On 1st November, Dot Gibson, General Secretary spoke at a rally held by RMT in the House of Commons in support of train guards against driver only operated trains.

The report drawn up by members of our transport committee: “Three Pensioners on a Southern Rail Journey.” was proudly presented and received with enthusiasm. Get your free copy now.

The conclusion of the report is that if driver-only-operation trains run into an unstaffed station with a passenger who is unable to exit the train unassisted, then an offence will have been committed under the 2010 Equality Act.

Southern Rail try to ridicule the railway workers by saying that they are simply arguing about who opens and closes the train doors. The media can always find disgruntled commuters to complain about striking rail workers but they fail to explain the dangers to safety on driver only operations.

The rail union is standing up for the safety of passengers faced with an incident, accident or emergency, and this particularly includes the rights of those with “protected characteristics,” those “at a disadvantage” or those “who have particular needs.” Those like our three pensioners on their journey.

Sustainable Transformation Plans

Slash ***Trash*** ***Privatise***

Each of the 44 footprints should now have published their plans for their communities. Not all have been published. Still awaited are those from Stafford, Hertfordshire & West Essex, and Bath, Swindon & Wiltshire. However, these may have since been released since this article went to print.

Of those already published, the feedback has been worrying. In a lot of areas, they are very vague, particularly on finance and in most areas they have been published without consultation with the public and GPs.

Councils are waking up to the reality of what STPs are about. They are about deliberately taking £22billion from NHS services over the next five years, leading to closures, loss of staff and/or moving services to locations not accessible to the local community.

So far, the following Councils have refused to sign off their plan or are challenging their footprint leads:

Ealing; Hammersmith & Fulham; Birmingham; Sutton; Wandsworth; Merton; Croydon; Kingston; Camden; Islington; Brent; Barnet; Enfield; Sefton and Cheshire & Merseyside.

Oxford City Council passed a motion on 5th December stating that the information in their STP was not adequate enough to show how decisions would be made; produced no evidence as to the plan achieving its financial aims by 2020/21 and was full of 'aspirational jargon'. The motion can be found on the Oxford City Council website should others wish to follow their lead.

There is no doubt that NHS England will push ahead with these plans despite the growing concerns of health professionals and the general public. Consultation will not take place until the plans have been accepted by NHS England, meaning that nothing in them can be changed. There is no mechanism for appeal.

The simple fact is that it is not possible to improve health and social care services when health professionals are fighting a losing battle to keep the show on the road due to six years of chronic underfunding.

There are some fundamental questions to be asked on each of plans:

- Some STP leads have admitted that "the financial component is a strong driver" to their STP so have made the financial aspects the first area of consideration. There is a concern that this is taking priority over clinical and patient need. We should be asking if the STP is able to demonstrate what actual savings will accrue from individual parts of the plan that aim to reconfigure, centralise, integrate or close services? We should ask does the plan increase fragmentation of services through reliance on other providers? Does the plan provide funding for both transformation of services and the delivery of financial sustainability and has funding for the capital requirements and programme management of the plan been identified and secured?
- If the STP can show a credible and deliverable financial plan, we then need to ask what that will mean for the patients. Does the plan improve access to GP and other NHS services for patients? Does the plan contribute to the delivery of Jeremy Hunt's vision for a 7 day NHS? What about prevention? What are the risks associated with anticipated reductions in bed numbers? This is one of the most difficult areas for STP's to satisfy given what we already know about closures and downgrades that seem to be financially rather than clinically driven.
- We should then be asking if the plans can tackle the crisis in social care and mental health. Does the plan improve integration between health and social care? Is parity of esteem achieved? Does access and entitlement to social care improve and will the plan reduce the number of days lost to delayed transfers of care? Where does the plan leave the health service at the end of five years? Does it put it in a good position to tackle the well-known demographic changes over the next 20 to 30 years?
- If the plans are to succeed they must have genuine local support across the various sectors which will be responsible for carrying out the plan. Have the local authorities been involved/signed off the STP? How does it align with other priorities and the strategic needs assessment? Have GPs, CCGs and social care commissioners been closely involved in developing, evaluating and financially analysing emerging proposals?
- We should be asking if there has been genuine involvement and engagement in the development of the plan. The voice of patients must be heard in these decisions. Past changes to services have only succeeded where patients have had buy-in to the proposals, so we would expect consultations

on these plans to include not only patient groups but also the voluntary sector, staff representatives, care providers, elected representatives, care professionals and of course the general public.

- Are there open and transparent accountability arrangements in place? Will the public and other key stakeholders have the opportunity to influence the plan at an early stage and is there sufficient information for engagement with stakeholders to consider a range of options?
- We also need to ask whether end of life care is part of their plan and if not, why not?

The Government have repeatedly said there are existing rules in place for changes to current services, but the Government have maintained that STP's as a whole have "no legal status" which means it may be difficult to challenge plans as a whole.

So, when the plans for your area are available (if you don't already have them), these questions are more than reasonable to put to the STP Leads, CCGs, Councillors and MPs. Only by sharing this accumulated knowledge can we all participate in what is certainly the most important challenge for us, the NHS and care.

What do Toyota, LEAN & NHS have in Common?

By Mary Cooke, NPC Eastern Region

LEAN Production was invented by (among others) the Japanese engineer Mr. Taiichi Ohno post the second world war. Toyota lean production is an assembly line methodology developed originally for Toyota and the manufacturing of cars. It is also known as the T production system or 'just in time' production. Lean production principles are also referred to as lean management or lean thinking.

Over the last twelve months NHS Improvement, have purchased the services of doctors, nurses and managers from the Virginia Mason Institute (VMI), Seattle USA, to enhance our understanding of lean methodology and safe practices. However, in fact, their American based hospital Centre was found to have some issues with safe practices after inspection by regulators in the USA a short time ago.

The VMI personnel are now entering five of our main hospitals to introduce their form of production system, using proven concepts adapted from the Toyota production system that effectively eliminates waste, in workplace processes.

Also Senior managers are to be sent on a £17,000 course to be taught the principles of "leanness" that transformed Japan's post war economy. That training continues throughout the public services and in Universities across the UK and there are now Master Degrees in the subject.

Ruthless focus on value for the 'customer' and eradicating unproductive activity waste is the main focus. Value is another main focus of the operational principles of lean and value is defined as the capability to deliver exactly the customised product or service a customer wants, with minimal time between the moment the customer requires the product or service and the actual delivery. By defining what customers want, process steps can be divided into value added and non-value added. Non-value added activities are called waste and those activities need to be removed or avoided. These systems need to be continually reinforced and thought out, needing collaboration with teams of workers who are constantly reassessing their practices with managers highly involved.

As we know Healthcare leaders are constantly searching for viable options to cut costs, increase efficiencies and improve the product that they offer 'customers'. Many are looking at different business models to adopt. By improving an 'operating system'; i.e. the configuration of assets, material resources, and staff - a lean approach can cut costs quite dramatically typically by 15% - 30%. Lean aims to optimise costs, quality, and customer services constantly. Therefore, Healthcare Executives have followed Toyota's lead and undergone a lean transformation.

Lean production provides a comprehensive set of tools and brings a rigorous evidence based approach to transformation (although some clinicians would question this as applied to health services). The need is to accept that people working in different areas of health care will naturally have conflicting styles of working, and goals, and many need to find that consensual agreement - as in lean – 'collaboration' is the way forward. Reports on these processes tell us that the true benefits of Lean lie in changing an organisations culture to ruthlessly eliminate waste, which is defined as a task or procedure that soaks up time, effort and money, without creating any value for your organisation. Lean thinking started as being used to resolve specific problems in hospitals but is now being applied

across boundaries of organisations to improve and re-design complex care pathways. Applying lean thinking is difficult in the private sector and more so in the public sector. Successful lean transformations must close the capability gap early in the process (so say Consultants McKinsey). So for managers and staff to make the transition to a new way of working, closing that gap typically involves hiring a few people with lean expertise and experience from outside the public sector to seed the transformation and build new internal capabilities. Lean requires more than just courage to uncover deep seated organisational problems; it may call for the ability to deal with job losses as well. The challenge of lean IS TO DO MORE WITH LESS (McKinsey).

Critics allege that Lean processes are a throwback to the group piecework systems of the 1920's where supervisors engage in full time monitoring and disciplining of under-performing workers relentlessly. STRESS is the single biggest criticism of the systems with the constant focus on improvement and elimination of waste which becomes an obsession and causing great stress in often an already stressed workforce. Stress levels can have a determinable effect on productivity and efficiency. There can be limitations on lean productivity. Lean tools such as 'just in time' inventory and six sigma systems (sometimes adopted in health care) allows for no safety stock or margin of error and vilifies any deviance from the codified optimal process, so that while striving for such perfection may lead to better performance, attaining such precision standards may not always be possible and at times unrealistic - perhaps owing to the vagaries of the requirements shall we say, of the natural idiosyncrasies of the human body for example when a nurse is dealing with some very busy periods on wards!

As part of the plans set out in the Five Year Forward View, and now being seen in the Transformation and Sustainability plans the CCG's have produced, there is a requirement for 'NHS Leaders'. Simon Steven's reforms and plans have moved on at a pace. The East of England NHS Education Committee recently brought about the education of the newly identified 'NHS Leaders', and their requirement for collaboration was given emphasis. All leaders in the clinical and management areas, be it in the CCG's, the LGA's, or the Community Trusts, Hospital Trusts, or council services across a number of the areas in the East of England were brought together with input from the American Health Educators Kaizer-Permanante, Virginia Mason Institute, The worldwide Hey Group, Humanitas , Educators from Romania, NHS Educators and the King's Fund. All of these people helped create a 'Next Steps Event' in the East of England. Throughout this education and instruction event the under-lying thread was the Toyota Lean Production methodology and the psychology of 'Collaboration'. A number of leaders will be attending NHS Universities for further education.

The cost of this event was not discussed, but the information proffered was that each new Leader was paid for by a sponsor. On checking each sponsor appeared to be the fund holders for the trusts or council etc. each leader came from. This event does not appear to have been offered to the general public.

I leave all NPC members with this information for them to be aware of this changing face of what was once OUR NHS!

For an explanation, those with computers might like to read through the report by NHS England. Google:- 'Transforming urgent and emergency care services in England Safer, faster, better: good practice in delivering urgent and emergency care: A guide for local health and social care communities'. You get the sense of what is expected to be delivered with these systems.

Editorial note: NPC understands the necessity to cut the cost of waste, but we are not certain that a method that focuses solely on getting more for less (or in some cases, for nothing) is beneficial to the NHS and healthcare in general. If you have any experience of the lean process, please let us know.

Health Campaigns Together

Health Campaigns Together (HCT) is a national network of over 30 NHS campaigning organisations and trade unions working together to co-ordinate action to defend the NHS. HCT believe the time has come to demonstrate the breadth and depth of support for the NHS.

A national demonstration will take place on 4th March 2017 in London. By March, the 'winter crisis' will not be over and the full reality of STPs will have become clearer to many more people.

If you wish to be involved, more information is available on their website, where you can join, donate or download their newsletter.

http://www.healthcampaignstogether.com

Fighting for Dignity and Quality of Life

When the elderly bus pass was introduced some regions of the country added extra concessions. South Yorkshire Passenger Transport Executive (SYPTE) brought in free train travel for elderly and disabled on trains in South and West Yorkshire. Greater Manchester, Liverpool, London and West Midlands also brought in free local train travel. In early 2014, the majority of councillors on the South Yorkshire PTE voted to remove this local concession.

Barnsley Retirees Action Group is affiliated to the NPC and decided to organise a protest meeting. We leafleted the train and bus stations in Barnsley to advertise the meeting. 300 turned up. People were angry at losing the concession especially when it was found out that the saving was only £330,000 – about £1.04 per pensioner in South Yorkshire. A further meeting decided that we would copy the idea from the American Civil Rights movement of starting Freedom Rides. The South Yorkshire Freedom Riders was set up and it was decided that on the day the concessions were due to be removed we would encourage people across South Yorkshire to turn up to their stations to travel to Meadowhall for a rally, refusing to pay the fare.

In Barnsley a very large number turned up not sure what would happen. Some thought we might all be arrested. A Northern Rail manager greeted us and said that fares were 'discretionary' on that day. We all got on the train and met fellow campaigners from across the county at Meadowhall. The rally voted to hold weekly Freedom Rides until our rail concession was returned. At the rally the value of rail travel as well as bus travel for mental and physical health was emphasised. *People spoke of taking the train from Barnsley to Meadowhall every day during the winter so that they would not have to spend money heating the house. Concessionary travel has much wider benefits than most people understand. If people can visit friends, do voluntary work, see their families at no cost, then they tend to remain fairly healthy.*

We continued our Freedom Rides to rallies. We also made links with the train drivers and got support from ASLEF, and we supported guards in the RMT campaigning to keep guards on the train.

Then Northern Rail announced they would not allow us to travel free any more. That day there was such an outcry that the manager backed down and let us go. The next week we found transport police blocking our entry to the platform. We went over the bridge to the north bound platform watched the surprised expressions on the police faces as we took off on another Freedom Ride while they stood on the wrong platform.

After that the transport police turned out in large numbers for each demonstration and stopped any access to either platform. But we held rallies outside Barnsley train station. We were told that we were wasting our time; we were silly old folk who should know better. Then, after 6 weeks, the SYPTE made a partial climb down and announced that free train travel in South and West Yorkshire would be brought back for all disabled pass holders and that elderly pass holders would be able to travel for half price but only in South Yorkshire

Another mass rally welcomed this but voted to carry on our protests until all elderly concessions were returned in full. On June 23rd Northern Rail and British Transport police kettled us on Sheffield station. We sang songs and let everyone know what we were protesting about. Then, without warning, two of the Freedom Riders were grabbed, one wrestled to the ground, and arrested. The case was dropped when it became clear that evidence given by the police was not supported by video evidence and the two Freedom Riders were able to walk free. The incident gave us a lot of publicity and encouraged us to carry on campaigning, but it also knocked our confidence for doing Freedom Rides.

We are still pressurising the SYPTE and Arriva, who have taken over the rail franchise, to look at bringing in more concessions. We have also worked with local bus companies to win better travel arrangements with them. It is important for the health and well-being of older people.

South Yorkshire Freedom riders have shown that taking action wins benefits. But it is more than that. We have a large group of people who meet fortnightly, have become used to supporting each other and those who need help like striking workers and, most importantly, have a positive opinion of ourselves because we stood up for what we believe is right.

George Arthur: garthu@gmail.com

Social Care Spending Falling Below Minimum

Local Authorities across the country are spending well below the £544 per week minimum amount recommended for the residential care of older people.

A number of councils, including Dartford, Wolverhampton, Leicester, Liverpool, Lancashire, Hampshire and North Lincolnshire, pay providers a local weekly rate well below £400.

Through a Freedom of Information request by a Birmingham councillor, it was revealed that Buckinghamshire paid £615 per week, whilst Birmingham had a rate of £436, with people being asked for 'top ups'.

The post-code lottery is still alive and kicking and soon to get worse.

As we go to press, Philip Hammond (having already failed to offer any additional funding to social care in the Autumn Statement), joins others in the government who think that the solution to the whole mess is to allow councils to bring forward increases in Council Tax from future years to help fill the gap.

With widening inequality in health and social care services (and many other public services), it would seem a ridiculous notion to accelerate this by applying extra charges from future years now. It remains the case that the poorest areas have the greatest need and the least potential to raise extra funds. One more sticking plaster applied in vain hope ..

Stephen Dorrell (former Conservative Health Secretary), now Chair of the NHS Confederation said: 'We are talking about a cash shortage that is threatening the stability not just of local government, but of the NHS. It comes when people find they can't have access to care homes, so they end up in A&E and GP surgeries. They can't be properly discharged from hospital when they are fit and ready to go.'

Lord David Lipsey said: 'There's a danger that poor people in poor areas will end up without care, living a squalid life. There could be areas left with no care.'

NPC believes that the government must be held to account for the consequences of leaving more and more people without the care they desperately need. We need a sustainable way of funding health and social care. Our policy of a National Health and Care Service, funded by everyone, accessed by everyone free when needed would end rationing of health and care services.

Hospital Discharges

Hospitals have been told to discharge thousands of patients to reduce pressure ahead of a potential winter crisis.

In a leaked memo to the Daily Telegraph, instructions were sent by NHS England and regulator NHS improvement that hospitals should pass on some scheduled surgery to private organisations and also banned managers from declaring 'black alerts' – the highest level when hospital services are unable to cope with demand.

The instruction was intended to reduce the levels of bed occupancy rates in hospitals, which are the most crowded they have ever been ahead of winter.

So, how do NHS England/NHS Improvement reconcile this with the proposal above?

SPOTLIGHT

BUPA Care Homes: October 2016: It costs on average £1,000 a week in some care homes. CQC have classed a third of BUPA's 238 UK care homes as either 'inadequate' (12) or 'requiring improvement' (78). Under-staffing meant that some care homes are guilty of multiple breaches of law as well as not attending to the needs of residents.

Salthouse Haven Residential & Nursing Home, Hull: November 2016 Divided into 5 separate lodges – Sutton (closed at present); Coniston, Bilton, Preston and Meaux. Coniston was the subject of concern which led to an 'inadequate' rating. Staffing, moving and handling incidents, medicines not given as prescribed and errors in administration.

Woodford Care Home, Hull: November 2016: rated 'inadequate'. Poor infection control practices; safety and welfare at risk; unsafe recruitment practices

Panorama undercover filming in Cornwall: November 2016: Clinton House, St. Austell is being closed. Raised issues of staffing, medication, proper attention to resident's needs.

Donwell House, Washington: November 2016: rated 'inadequate' for second time. Safety of premises – no gas or lifting equipment certificates. Risks not identified. Conflicting information in care records. Medicines not managed safely.

Burgess Park Care Home, Camberwell: November 2016: rated as 'inadequate' on safety. Call bells not answered (some waited 30 minutes for staff to attend). Rated 'good' on care.

Around 40% of people in care homes now pay for their care (some at a premium cost). For any resident, the establishment is their home and it is extremely upsetting for all concerned when a care home closes. There is a balance to be struck between a poor care home just closing and a strategy that might see the home remain open, improved, and taken back into public ownership