



(Amicus Section)

## **The Contribution of the NHS to Reducing Health Inequalities**

### **Written Evidence**

**This evidence to the House of Commons Health Select Committee is submitted by Unite (Amicus Section). Unite is the UK's largest trade union with 2 million members across the private and public sectors. The union's members work in a range of industries including manufacturing, financial services, print, media, construction, transport and local government, education, health and not for profit sectors.**

Unite (Amicus section) is the third largest trade union in the National Health Service and represents approximately 100,000 health sector workers. This includes seven professional associations - the Community Practitioners and Health Visitors' Association (CPHVA), Guild of Healthcare Pharmacists (GHP), Medical Practitioners Union (MPU), Society of Sexual Health Advisors (SSHA), Hospital Physicists Association (HPA), College of Health care Chaplains (CHCC) and the Mental Health Nurses Association (MNHA) – and members in occupations such as allied health professions, health care science, family of psychology, counsellors and psychotherapists, the family of dental professions, audiology, optometrists, opticians and building trades, estates, craft and maintenance.

### **Executive Summary**

- It is the view of this organisation that the NHS can make a significant contribution to reducing health inequalities, particularly thorough targeted support and early interventions for children and their families as delivered by health visitors in the home and school nurses in schools. However without a massive investment in these professions these effects cannot be felt.
- Unite-Amicus have highlighted below the contribution these professions could be making and outlines the further inputs required by government to ensure they are delivered.

### **Overview**

1. After a period of record NHS investment over the last 10 years, it is a tragedy that whilst this money has had great impacts on improving hospital waiting lists and patient satisfaction ratings, it has not had enough impact on reducing health inequalities (Wanless, 2007). Unite-Amicus support the view

of many that this is due to disinvestment in public health and particularly public health practice. Indeed over the past 15 or so years there has been a steady erosion of services which health visitors once offered. This has been compounded by:

- The loss of a specific training council in the early 90s,
- A removal of protection of this professional role in statute in 2001
- The introduction of grade mix into the delivery of a very complex role
- A subsequent reduction of skilled health visitors, which we know has contributed to a weakening of their contribution to reducing inequalities.

2. As the government has demonstrated (Cabinet Office, 2006) effective outcomes are related to the skills of the staff making the inputs when tackling inequalities. The Unite/CPHVA Annual Omnibus Survey (Durdle Davies, 2007), made clear that these changes had led to many health visitors often not having the resources to either identify or respond to the needs of many of their vulnerable clients (Craig & Adams, 2007 see Appendix 1). 32% of respondents reported they could no-longer respond to the needs of all their vulnerable clients. Further a survey by the Family and Parenting Institute showed that there is a postcode lottery of health visitor provision with the lowest caseload sizes not necessarily occurring in areas of greatest vulnerability (Gimson, 2007).

3. Currently we have the lowest number of health visitors employed for 13 years (The Information Centre, 2007) despite:

- A growing birth rate,
- Very high levels of immigrants, migrant workers and asylum seekers,
- An increasing number of children with complex needs,
- An increasing demand on their time from other agencies particularly social services.

Furthermore there have been:

- Reductions in health visitors trained by over 40% (Unite/CPHVA, 2007) for the past 2 years.
- Higher levels of stress amongst health visitors than most sections of the NHS workforce (NHS Employers, 2007). This was reinforced by Unite-Amicus' own survey where 75% of respondents (n=1,000) reported they were aware of colleagues off with work related stress and 77% indicated an increase in their own work places stress during this period (Durdle Davies, 2007).

4. Unite-Amicus believe that many of the health issues currently requiring increasing investment by the government relate to this reduction in the universal health visiting service. For example, obesity, and mental health. This is probably particularly important in relation to the increases in children requiring secondary input for emotional and mental health issues. These issues are most closely related to the family environment experienced by the child.

5. The health visitor can have a very profound working with families and particularly when children are vulnerable to social disadvantage or there are significant inequalities. Unpublished Unite-Amicus research has demonstrated that the health visiting service can impact in many ways to promote mental health in families (Adams, 2006). In so doing a child's self esteem and emotional resilience grows and that child is more likely to be successful in school, in the workplace and in developing relationships throughout his or her life. In this way children can leave a situation of emotional stress behind and be less likely to develop mental illness and become a victim of inequality.

6. Despite misunderstanding by some in government health visitors have traditionally and continue to focus many of their efforts on supporting their most vulnerable clients and many have very well developed specialist skills to do so. In particular they target those who are victims of significant health inequalities such as the homeless, gypsies and travellers, prisoner's families and young mothers. See Appendix 2 for details of how health visitors address the needs of some of these groups and in so doing address inequalities. (Unite/CPHVA, unpublished, 2008)

7. In 2007 the Department of Health published a review into the role of the health visitor (DH, 2007). Unite-Amicus completed a response to this document (Adams et al, 2007) and this has been included in Appendix 3 for the committee's information. Unite-Amicus are very concerned that unless the government moves very quickly to stem the loss of skilled health visitors the potential impact of their service on health inequalities will continue to diminish.

8. Unite-Amicus is equally concerned by the continuing low numbers of trained school nurses. Following specialist practice training school nurses are well equipped to support the most vulnerable school age children.

### **NHS contribution to reducing health inequalities**

9. As is demonstrated in Every Child Matters; Change for Children (DfES, 2006) health is a key aspect of any desire to reduce *health inequalities*, as is evident in the name itself. One of the advantages that the National Health Service has had previously is that of its acceptability of its services to those individuals and families that have historically had difficulty in accessing other services. In fact the advantage that every person in the country should be able to say they have a general practitioner, every ante-natal mother has a midwife and every new family has a health visitor should not be understated or underestimated. These professionals really understand communities and those who live in them. Through their universal access they are perfectly placed to assess need, identify vulnerability and activate other services to alleviate it by, for example, improving access to financial support or better housing. As Sure Start and family centres have found, accessing the most vulnerable children can be very difficult where there is not good support from health services and health led Sure Starts' have been found to produce the best outcomes for children (Barnes et al, 2005)

10. The ability of a child to embrace education is closely related to their degree of 'happiness' or emotional health. The education system is most challenged where the children are most challenging. Early intervention to better support families so children enter education with sound cognitive development and emotional resilience is therefore logical. There is also no doubt that children benefit from access to two parents who love them. Many have to be helped to be able to demonstrate love to their children and to understand their social health needs. Health visitors will provide this support where they are properly resourced. There are also well researched health visitor interventions to support the inter-parental relationship which is usually key to a happy home (Simons et al, 2003)

11. A reverse question could be set regarding every other public service, agency and department that deals with any issue. For example, how can local authorities contribute to health inequalities, given that many of the causes of inequalities relate to other policy areas?

### **Distribution and Quality of GP services**

12. One of the key issues raised by Unite-Amicus members concerning General Practice services are that unlike the rest of children and young people's services being more based around locality or geographically based, GP services are still provided via lists (where practices can decide whether to accept patients). This has the effect of creating confusion and difficulties regarding inter-agency and multi professional team working. Members report that as well as having to liaise with many agencies they also have to be linked to multiple GP practices; these often have many partners.

13. Care must be taken that GPs do not reject the most vulnerable as they are burdensome. Also, many very vulnerable people do not access GPs e.g. the homeless, travellers and asylum seekers. Systems need to be set up to improve access, we believe walk in centres have been helpful.

### **Effectiveness of public health services**

14. This raises two issues in so far as are smoking and obesity an example of causes of health inequality? You can look at the inequality being that some people smoke and if they smoke then they are more likely to be unwell, or that there is a section of society that has poorer access and ability to remain healthy and they are more likely to be a smoker/obese due to stress or lack of access to healthy foods. This maybe highlights some of the problem with some public health services, in that the service is designed around smoking cessation. This will by its nature be more appealing to those people who know they want to give up, and therefore, does this support those in 'higher' socio-economic groups. Those services that provide universal access will be able to uncover hidden vulnerability and ensure that inequalities are reduced by supporting client centred interventions. Someone who is unhappy and living in conditions of misery may smoke, drink or take drugs to help alleviate the stress. A holistic and client centred approach needs to be taken to help such individuals.

15. In general the most cost effective interventions for smoking and drinking are probably those which reduce access e.g. via taxation in general. However someone who is miserable may chose suicide as a way of coping if other 'props' are not available. They are less likely to respond positively to 'blanket' public health measures. Those with good emotional resilience are less likely to be substance abusers so early emotional support is worth investing in.

16. The question regarding public health interventions having the effect of increasing health inequalities may be in fact true, in that a proportion of the population will have greater health benefits than others. What should not be ignored, in that a greater positive impact is a good outcome, but also a more minimal improvement is still an improvement.

An example from a Unite-Amicus member would be:

*"When the new advice came out regarding delaying weaning babies onto solid foods until six months, people in higher socio-economic groups responded more quickly to the advice, but the lesser response from lower socio economic groups is still having a positive effect on their children's health".*

17. This also raises the question about social marketing in that to make something attractive to a group of people you can't just market it to the most socially excluded as they will see it as a stigmatised service.

18. An example of some of the problems experienced regarding the current 'targeting' in health inequalities could be shown by the following example:

Unite/CPHVA has consulted with its school nurse members to find out how the DoH's National Child Measurement Programme guidance is working in practice, and how it could be used better to prevent and treat overweight children in primary school. The department's target is that over 80% children will be measured, increasing year on year. The school nursing service varies tremendously with some areas employing health care assistants solely to do this work. In other areas school nurses are extremely hard pressed; we had examples where a school nurse and her colleague have a case load of 9,000 children. School nurses take their public health role seriously and are extremely frustrated that there are too few of them to carry out all the work which the various public health documents recommend in order to reduce health inequalities in children.

There is a general lack of belief that the data collected is an accurate reflection of the population. The nurses report that in every class, two or more children opt out from being weighed, and these are nearly always the overweight children. The nurses do not understand why a statistical sample of 11 years olds can't be used for national data collection. There are ethical concerns around the fact that as the data is collected anonymously, the school nurse has no mechanism to follow up overweight children. The health service will know that the child's BMI is

too high, but the parents will not. Therefore the child is not helped by this system, and nor are the health inequalities issues dealt with.

### **Impact of specific interventions**

19. One of the key issues raised by Unite-Amicus members regarding any initiative is the short term nature of any funding versus the desire to have long term outcomes and benefits. Members have contacted us with examples of issues raised with this approach. For example, a Unite-Amicus member reported that a regional area affected a massive reduction in the number of women smoking during the ante-natal period. This was achieved by a health visitor and midwife working together in a Sure Start centre in a team approach. When the Sure Start service was 'mainstreamed' into the Children Centre, the midwife was 'pulled' back into the acute service (returning to be hospital based) and the improvement in stop smoking was seen to reverse.

20. This experience of Unite-Amicus members appears to be supported in the document 'Our Future Health Secured' (Wanless et al, 2007) in that "this [conceptual public health] framework was not taken forward and, as a result, health policy has remained focused on short-term imperatives, public health practitioners feel undervalued and significant opportunities have been lost".

21. In some areas, Sure Start Local Programmes have attempted to ensure that black and minority ethnic populations are fully engaged. The report "Sure Start and Black and Minority Ethnic Populations, (Craig et al, 2007)" highlights the importance of health services being integrated into these services, "*acknowledging the key role health visitors play in delivering the programme and praised staff for their success in creating links with BME parents who felt that social services had little understanding of cultural and traditional parenting practices*" (Tweddell, 2007). However this cannot be a short term approach as to affect change in a population takes more time than 3-5 years.

22. An even more insidious outcome of the recent amalgamations of primary care trusts in England have been larger wholesale reductions in services where we have been provided with examples of services being cut. An example given by a Unite-Amicus member is the South East was that previously services had been developed to support women who have had a miscarriage. On the amalgamation of 2 trusts, the group leaders were asked to stop providing this well evaluated service as they couldn't provide it to all areas in this new trust, so it had to stop (Adams et al, 2007). Unite-Amicus believe this is a perverse outcome, especially when the Government is pushing an agenda where they support services being provided to those families that require them.

23. A major problem since the financial cutbacks in public health community practice has been the subsequent loss of leadership and innovation. Unite-Amicus experience suggests that in response to intolerable working conditions many public health practice leaders have voted with their feet by taking early retirement or leaving the NHS. Innovation has been

quashed by unrealistic caseloads and a lack of valuing of specialist services and professional expertise.

### **Success of NHS organisations co-ordinating activities**

24. One of the key problems with the attempts of the NHS organisations to co-ordinate their activity is the large variation that presents itself across England (Triggle, 2007). When it is considered that in one strategic health authority they may have upwards of five different organisational structures that are intended to provide the same services, it can be seen how this causes problems. There may have structures where health staff are employed by either a PCT, the acute service, a mental health trust, a local authority, a children's trust, a not for profit cooperative, a private limited company, a foundation trust etc (Amicus, 2005). This situation may become even more complex with future fragmentation of services being supported by policy. It is clear to Unite-Amicus that the losers are likely to be the most vulnerable.

### **Effectiveness of the Department of Health in co-ordinating policy**

25. With the devolvement of decision making from the 'national centre' to local decision makers, members have raised more frequent concerns regarding the decisions that are being made locally. An example would be with the decisions made around the number of staff employed. Which (2007) has highlighted several of the 'postcode lotteries' regarding provision of service. One, that of the number of health visitors, directly impacts on Unite-Amicus members. Nationally the government has recently provided support to the role of health visiting and a call for more health visitors. This message is being ignored by some local PCT's and their commissioners in favour of using less qualified staff, or by bringing in management consultants to reduce the service further (Harris, 2007 & Snow, 2007)

26. When challenged, PCT's are repeatedly arguing that as they are not being instructed to improve this situation, then they use their resources to tackle those targets which face tougher sanctions if not met. More recently, Unite-Amicus and its members have had to lobby MPs in London constituencies. In Enfield (Tarver, 2007) members have seen reductions in staff numbers (whilst having increasing numbers of families in the area) making the trust bottom in the 'league table' for the number of health visitors to children. This is combined with having the highest rate of infant mortality in London. Sadly this is not related to just one area, and just in London in 2007, similar situations were challenged in Redbridge, Waltham Forrest and Hounslow. In fact if you look at the league table produced by the Family and Parenting Institute (Gimson, 2007) and compare that with the index of multiple deprivation rank for the area covered by each trust, you find that there is no correlation between deprivation and numbers of key health promotion staff (Appendix 4).

27. Another example of local areas 'ignoring' national policy is that of school nurses. The Government, under the 2004 White Paper 'Choosing

Health' (Department of Health, 2004), allocated £42 million to PCT's, children's trusts and local authorities to provide at least one full-time, qualified school nurse to work with each cluster or group of primary schools. In 'Children's Health, Our Future' (Shribman, 2007) the number of school nurses was reported to have risen by 34%, but from Unite-Amicus figures, the target set will not be reached until 2023 at current training levels, with no school nurses leaving employment (Nursing Time, 2007). An example of this was Hounslow PCT who in September 2007 had none (Parish & Doult, 2007)

### **Public Service Agreements**

28. This seems unlikely unless a needs led, well trained health visiting service delivering interventions based on best evidence of effectiveness is supported much more robustly by government. To ensure public protection the role of the health visitor should once more be protected in statute as it was previously for almost 100 years. Furthermore the profession itself should be given more control to determine the shape of its training, health visiting leaders and specialists for vulnerable groups should be encouraged and supported and innovative practice valued. Over the past 15 years nursing had been very influential in the direction of health visiting, to its detriment as the role of the health visitor is a very different one based as it is on promoting health. To invest in health visiting and hence early intervention could produce massive savings to other areas of government expenditure related to inequalities in the longer term.

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**Appendix 1 (See attached)**

CRAIG, I & ADAMS, C (2007) Survey shows ongoing crisis in health visiting. Community Practitioner. Volume 80.11, November 2007, pp.50-53.

**Appendix 2 (See attached)**

UNITE/CPHVA (2008) The distinctive contribution of health visitors to public health practice. Unpublished.

**Appendix 3 (See attached)**

ADAMS, C et al (2007) Unite/CPHVA Response to Facing the Future; A Review of the Role of Health Visitors. Unite/CPHVA. London.  
<http://www.amicus-cphva.org/docs/CPHVA%20response%20-%20Facing%20the%20future3.doc>

**Appendix 4 – Index of Multiple Deprivation versus rank of Health Visitor numbers across England**

