Consultation Response

Labour Party National Policy Forum

Health and Social Care: Tackling health inequalities

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What measures should a future Labour government put in place to help reduce health inequalities across all parts of society?

All leaders of political parties should provide personal leadership to the prevention effort and lead the development of a plan to reduce preventable illness and mortality by at least 25 per cent by 2025. Public health programmes must be preserved given the potential positive medium and long-term impact on reducing health inequalities across society. Public health strategies of particular relevance to later life include malnutrition, late-onset drinking and loneliness. Other messages which can reduce health inequalities and improve healthy life expectancy include access to physical activity programmes, smoking cessation and efforts to reduce air pollution. It is important that public health campaigns reach out to marginalised groups so that they are truly focused on reducing health inequalities between sections of the population.

A greater focus on prevention to reduce health inequalities should include supporting treatment models such as intermediate care. These programmes can enable people, following an accident or injury, to regain their independence following a hospital admission. As well as improving outcomes for patients, rehabilitation care can address demand management and reduce pressures on health services.

A recognition of the impact that community and public transport to hospitals and routine medical appointments has on supporting people living independently and well at home and ultimately in reducing health inequalities. Ensuring people have access to the care and support they need can help reduce avoidable hospital admissions. Transport strategies should look for ways to enable hospitals to set up more voluntary driver schemes to take people to and from hospital.

Strategies to reduce health inequalities need to be integrated across central government, councils and the NHS. Recognition that levels of acuity and wealth vary greatly across different local authorities and Clinical Commissioning Groups (CCGs) and will significantly impact on the population's health outcomes. Older people living in the most deprived areas will live longer at the end of their lives with disability compared to people in the least deprived areas. It is reasonable to expect demand for services in areas with higher levels of disability will be greater. Strategies to reduce health inequalities need to address underlying causes such as the broader impact of poverty and the lower relative provision of primary care services in places where there is likely to be higher levels of overall morbidity.

There is also a strong economic argument for reducing health inequalities. In England, the cost of treating illness and disease arising from health inequalities has been estimated at £4.8 billion per year[i]. Ensuring that those eligible for certain benefits such as Attendance Allowance, the Disabled Facilities Grant and that the pension triple lock is maintained will maintain some level of financial security for some of the most vulnerable people in society.

• What plans could a future Labour government put in place to address health inequalities faced by particular groups in our society?

We live in an ageing society[ii] with increasing numbers of people living longer with complex, multiple long-term conditions. Whilst it is positive that the proportion of people living longer in good health is increasing, there are still wide gaps in healthy life expectancy across the UK[iii]. Specific strategies are needed to reduce variation in access to health and care services.

Hospitals are not sufficiently well designed and organised to deliver optimal care for older people living with frailty. This leads to inadequate assessment and poor planning throughout someone's stay and undermines their chance of a safe and effective discharge.

Pneumonia is the most common healthcare associated infection and age is a specific risk factor for both getting community-acquired pneumonia (CAP) and having complications as a result. Living with multiple long-term conditions, something more likely to affect older people, increases the risk of CAP and people aged 85-89 years have seven times more episodes of CAP than people aged 65-69 years[iv]. More than half of all pneumonia-related deaths occur in people over the age of 84[v]. Again there has been substantial growth in the number of admissions to hospital for pneumonia, increasing from 2,355 admissions per 100,000 people aged 75 and over in 2005/06 to 6,391 in 2014/15, a rise of 171.4 per cent[vi]. The rate of admissions grew by 19.3 per cent in one year alone between 2013/14 and 2014/15[vii]. Common to other ambulatory care sensitive conditions (ACSCs), these increases could be attributed to poorer access to alternative community-based services[viii]. A study published in 2016 examining the reasons behind growing admissions concluded that an ageing population alone was not a factor[ix]. Instead it pointed to the fact that some low-severity cases are now presenting to hospital when they would previously have been managed in primary care and the pressure on hospitals to discharge people more quickly following an admission; again suggesting that struggling primary and community care services are at least part of the problem.

Social care service users are subject to significant variation in the quality, provision and capacity of care services. Increasing demand for services coupled with chronic underfunding has reduced public access to services and contributed to 1.2m older people living with some form of unmet need[x]. The public have a right to choose high quality care and quality improvement must address the factors that create inequalities and inconsistencies across different care environments. Participants at Age UK listening events told us that quality and location are the most important factors when choosing care services[xi]. The Care Quality Commission reported on the falling capacity in the nursing home sector, 4000 fewer beds in two years, with wide regional variation in the distribution of these beds[xii]. This will impact on the experience of those for which residential nursing care is essential; forced to use services which are sub-standard or far away from their home and support network.

Public and community transport allows people the freedom to reach work, school, to socialise and to reach important appointments, medical or otherwise. Currently, around 25% of bus journeys taken by people aged 65+ are for medical appointments, yet many struggle with inaccessible or irregular bus services[xiii]. Whilst this is an issue that predominantly affects suburban and rural areas, it can also affect inner cities where public transport to hospitals and GP surgeries can also be patchy. There is an urgent need to support local authorities and service providers, who are often working within very tight budgets, to make travelling to hospital accessible and affordable for older and disabled people and their carers if they need to go with them. Bus stops at hospitals must be placed carefully to ensure disabled or older people could access the entrance easily from the stop. Older and disabled people who would struggle to get to their appointments without support, particularly those undergoing regular treatments such as dialysis and chemotherapy, should be able to travel with companions to routine medical appointments at no extra cost.

• What steps does the Labour Party need to take in order to create a sustainable health & social care workforce strategy that will truly assist in addressing health inequalities?

There appears to be little meaningful alignment between strategies aimed at the health sector and those aimed at the care sector. For example, last year's mental health workforce plan set out plans to grow the sector through offering new roles that could attract people working in social care.

Similarly, it has been noted that the creation of the Nurse Associate role in acute hospital trusts has contributed to a drain on care workers[xiv]. Not only do these policies risk shrinking the social care workforce at a time of acute shortage but further risks undermining the profile and esteem of social care if there is any impression that there is a "better" option in healthcare. Likewise, the recent Health Education England (HEE) workforce strategy made no meaningful mention of social care. Particularly in light of increasing the profile and esteem of the sector, HEE must be more joined up in planning its objectives, creating equal opportunities for cross-over between health and social care that recognises the needs and essential skills of all practitioners.

The Health Committee's inquiry into the nursing workforce reported on reductions in the availability of funding for continuing professional development (CPD) as a major factor contributing to nurses leaving the profession[xv]. Whilst those working in healthcare have to contend with falling CPD budgets[xvi] the enquiry acknowledged that 'for social care, the situation regarding access to continuing professional development is even worse'[xvii]. Under investment in training budgets undermines any meaningful attempts to retain the workforce and promises to invest in their development.

Participants in Age UK listening events on social care reform also highlighted the view that care workers are often not trained to a consistent standard[xviii]. Care workers should be expected to demonstrate knowledge, competency and capability across a range of relevant areas, including for example frailty, and this may include increasing the use and availability of relevant qualifications. For example, the number of people diagnosed with dementia is expected to rise to 1 million by 2025[xix] and it is important that staff are sufficiently knowledgeable to support and communicate with this growing cohort of older people. Recent surveys of home staff conducted by Unison found that more than two thirds (69%) of respondents have cared for people who live with dementia but more than a quarter (27%) had received no training in how to work with people with this illness[xx].

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[i] https://www.york.ac.uk/news-and-events/news/2016/research/nhs-inequality-costs/

[ii] https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/articles/overviewoftheukpopulation/july2017

[iii] https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/bulletins/healthstatelifeexpectanciesuk/2014to2016#healthy-life-expectancy-at-birth-differs-by-18-years-across-uk-local-areas
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[iv] https://www.ageuk.org.uk/documents/EN-GB/For-professionals/Research/The_Health_and_Care_of_Older_People_in_England_2016.pdf?dtrk=true

[v] https://www.ageuk.org.uk/documents/EN-GB/For-professionals/Research/The_Health_and_Care_of_Older_People_in_England_2016.pdf?dtrk=true

[vi] https://www.ageuk.org.uk/documents/EN-GB/For-professionals/Research/The_Health_and_Care_of_Older_People_in_England_2016.pdf?dtrk=true

[vii] https://www.ageuk.org.uk/documents/EN-GB/For-professionals/Research/The_Health_and_Care_of_Older_People_in_England_2016.pdf?dtrk=true

[viii] https://www.ageuk.org.uk/documents/EN-GB/For-professionals/Research/The_Health_and_Care_of_Older_People_in_England_2016.pdf?dtrk=true

[ix] https://www.ageuk.org.uk/documents/EN-GB/For-professionals/Research/The_Health_and_Care_of_Older_People_in_England_2016.pdf?dtrk=true

[x] https://www.ageuk.org.uk/latest-news/archive/12m-older-people-dont-get-the-social-care-they-need/

[xi] https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/care--support/RB_mar18_social_care_campaignreport.pdf

[xii] https://www.cqc.org.uk/sites/default/files/20171123_stateofcare1617_report.pdf
[xiii]https://www.ageuk.org.uk/contentassets/7354623c9df1491a84cc34ef46105647/painful_journeys_campaignreport.pdf
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[xv] https://publications.parliament.uk/pa/cm201719/cmselect/cmhealth/353/353.pdf
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