Protect Our NHS
Response to the NHS mandate consultation

Supported and signed, on November 18th 2015, by:

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Christopher O’Neill Patient who has worked with South West and Gloucester Cancer User Involvement Group
Peggy O’Riordon   Midwife, Bristol
<table>
<thead>
<tr>
<th>Name</th>
<th>Title and Details</th>
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<tbody>
<tr>
<td>Joelle Patient</td>
<td>Translator, artist and pensioner, Bristol</td>
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<td>Dr Charlotte Paterson</td>
<td>retired GP, Bristol</td>
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<td>John Slater</td>
<td>Musician. Self employed, Bristol.</td>
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<td>Barbara Smith</td>
<td>retired Health Professional, Bristol</td>
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<td>Jackie Stratford</td>
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<td>Dr Dominique Thompson</td>
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<td>Dr Julia Wallond</td>
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<td>Mavis Zutshi</td>
<td>former NHS Project Manager, former Social Worker, former Social Work educator, Bristol</td>
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[These were people who asked in just one day to add their names to the submission. Had there been more time, hundreds more signatures could have been added]

For further information on this submission contact protectournhs@gmail.com or ring 07891 432224

Mike Campbell, on behalf of Protect Our NHS
This response is being submitting by Protect Our NHS after receiving information about the NHS Mandate Consultation from HealthWatch Bristol

We will share this as widely as we can with the public, local politicians and the media, and via social media. Summary answers to the five consultation questions can be found at the end of the submission.

Our headline response is:

1. **The Government urgently needs to address underfunding of the NHS compared to other western countries.** We need a commitment from government to funding per head of population at least at average rates for comparable economies. We support the call for a **Royal Commission to be instigated** to review spending on the NHS.

Consultation process

2. It is deeply worrying that the consultation has been so inadequately publicised and so little discussed in the media. We will therefore send these comments to consultations.co-ordinator@dhi.gsi.gov.uk. Authors of this document only heard about it on Thursday 12th November via local HealthWatch. Indeed it reflects a lack of transparency in what the government has planned for the NHS and its lack of political will to set out the necessary ground rules and framework to protect it - including, but not limited to, real public and patient involvement and adequate funding.

3. The fact that the **consultation period was specifically shortened** because of the government’s imminent spending review may reveal its real intention. Inadequate consultation leads to fewer responses with fewer challenges to the consultation document, allowing more leeway to make spending decisions that are not in the interests of the NHS.

4. How can a new relationship between the NHS and the public (1.9) be forged when so little time has been given to the public just to respond to the mandate? The authors of this response have had just a few days to produce a document that needs to be much more comprehensive.

5. The government repeatedly stresses the need for transparency, accountability, participation and engagement but this particular consultation is, one feels, a rather transparent attempt to hide the mandate under the carpet.

6. **General statement of concern about the mandate:** it is concerning that the document mentions 'staff' only once (in relation to the flawed friends and family test) - and doesn’t mention doctors or nurses at all. This is a serious omission given the exodus of the skilled staff who are the backbone of the NHS.
Question 1 Do you agree with our aims for the mandate to NHS England?

Question 2 Is there anything else we should be considering in producing the mandate to NHS England

7. We do not agree with the mandate as it stands. Our comments, addressing the six priorities in turn, outline why we take this position and suggest areas for amendment.

8. Attempts to find the word 'comprehensive' in the mandate results in not one appearance of the word in the document. The question to be asked is why not, bearing in mind its aim is to set the direction of the NHS. It is a major omission given this document is supposed to summarise what our NHS will do in the future.

9. In the opening sentence in the Government’s priorities (page 5), the following amendments should be made to the mandate. Delete “most” in sentence “the changes needed to ensure that free healthcare is always there whenever people need it most." Is NHS England defining what ‘most’ means? It is clinicians, properly trained to assess and provide for need, who should decide need. It is not for the mandate to decide when people need free healthcare 'most'. This opens up the NHS to charges which we oppose.

10. It would reassure England’s patients and public to have the following priority inserted at the top of paragraph 1.10:

   Providing a comprehensive, fully integrated, cost-effective NHS by financing it through progressive taxation, in order that high quality services can be provided free at the point of delivery to patients whose welfare must always come first.

Preventing ill health and supporting people to live healthier lives

11. In order to prevent ill health and support people to live healthier lives (1.10, bullet point 1) government needs to invest in public health. Yet it is cutting public health funding.

12. Patients should not be discriminated against or be excluded from treatment on the basis of lifestyle. The NHS must be available for everyone, whatever their lifestyle choices. This does not preclude the NHS from promoting healthy lifestyles.

13. The NHS must promote healthy lifestyle choices in tandem with strong government action limiting the amount of fat, salt, sugar, and transfats in diets, discouraging smoking and alcohol use.
14. There should be a clear statement of intent that includes the priority to provide authorities with the necessary means to engage in public education on public health.

Creating the safest, highest quality health and care service

15. It is not possible to create the safest, highest quality health and care service without the goodwill of key staff, doctors and nurses. It is questionable that the Government has this.

16. Indeed, a general but key point that needs to be made is that in discussing the vision to create the safest, highest quality health care service apart from a passing reference to the highly flawed friends and family test the document mentions ‘staff’ only once. This is a serious omission given the exodus of the skilled staff who are the backbone of the NHS.

17. The two bullet points 3 and 5 fail to make any commitment to sufficient funding through the fairest and most efficient system which the evidence shows is public funding through progressive taxation. See paragraph 11 above.

18. There is a public credibility gap inherent in the 'mandate' system set out in the 2012 Act, with its greatly narrowed political accountability. Patients can be excused for feeling very unsatisfied to be 'consulted' on a document that is separated from the political and financial settlement, and which blithely states they have to wait for the Spending Review to see if any of the commitments are actually deliverable.

Maintaining and improving performance against core standards while achieving financial balance

19. The two linked objectives, 3.16 and 3.23, bear further scrutiny. Objectives to achieve ‘financial balance’ across the NHS (3.16) and expecting the NHS to live ‘within its means’ (3.23) are meaningless, unrealistic and just words. The mandate needs to reflect proper recognition of what it costs to run the NHS and its full administration costs.

20. In one fell swoop, scrapping the NHS market would release (depending on whose research evidence you take) between £5 billion and £30 billion per year.

Transforming out-of-hospital care, ensuring services outside hospital settings are more integrated and accessible

21. How can a mandate that guarantees routine patient access to a GP in the evenings and weekends be met when it is obvious to all commentators, both expert health and ordinary members of the public, that the NHS is haemorrhaging GPs and there are insufficient GPs being trained?
22. As patients and ordinary members of the public we can find no evidence that patients need routine access to a GP on a Sunday. There is no evidence that the new patient guarantee is achievable. Neither is Government able to fund it under its current fiscal policies.

23. Just before this response was drafted a report was published by the Organisation for Economic Cooperation and Development (OECD) claiming that the UK now has one of the worst health care systems in the developed world. While there is always room for improvement in any organisation, the government cannot fail to be aware that if you cut an organisation to the bone, leaving staff demoralised and heading for the exit door, it will start to fracture.

Driving improvements in efficiency and productivity

24. There is no mention of 'how’ this is to be achieved. NHS hospitals are already increasing their private patients, meaning fewer beds and longer waits for people without means to pay. The mandate should not be encouraging this practice – the supposed safeguards we were promised in 2012 are clearly insufficient.

25. Hospitals should be concerned with treating patients according to need, NOT on trying to maximise income. Hospitals should be funded to provide treatment as needed and not treated as if they are department stores promoting profit making activities.

26. 90% of hospitals are heading for deficit. The NHS is facing a financial black hole. Indeed, as hospitals' duties to provide mandatory services are whittled away, and again in the absence of an overarching duty to provide comprehensive health services across England, many hospitals are discussing how they can shed unprofitable procedures and patients.

General comments on specific aspects of the mandate

Person-centred care

27. We also feel particularly concerned about the way the heavy emphasis on so called 'person-centred' care is conflated with the notion of personal health care. These are two separate concepts. What does creating a “person-centred NHS, in which people are empowered to shape and manage their own health and care and make meaningful choices...” (3.12) actually mean in practice? [The mandate is, by the way full of fairly inaccessible and meaningless - at least to ordinary people - jargon and management-speak]

28. What do “meaningful choices" mean? None of us wish to have personal health budgets. We don’t want to shop around for our health care, and certainly don’t want to fragment an already over-stretched NHS budget with a voucher / top-up / health insurance system that would create financial anarchy in the NHS without any central planning
29. There is little evidence for the benefits of personal health budgets. There is some evidence that they will increase NHS costs, and will have a negative impact on health outcomes even when individuals patients are offered an up-front lump sum or 'sweetener' to take up a personal health budget.

Devolution issues

30. In paragraph 3.17 it appears that the proposed mandate reinforces the devolution of health, and joining it up with social care. We cannot support such a mandate of merging NHS and local authority spends. The impacts of expenditure through this route to date have not been sufficiently assessed, and the Public Accounts Committee found much money had been wasted. The Kings Fund has just raised serious concerns that the NHS cannot cope with devolution on top of its other challenges.

New technology

31. In paragraph 3.20 we note a vague commitment to 'harness digital and online technology'. NHS England is reportedly asking the DH to ask Treasury for extra billions in the spending review, not for health staff, but for profitable but dubious technology and 'systems' based on un-evidenced figures from McKinsey. Where is the evidence for the benefits of this? Who also profits from such 'innovation'? 

32. Once again, there is a paucity of evidence for the benefits of much of this ‘digital health’ and a surplus of magical thinking about its benefits. NHS England's recent submission to the Department of Health for the spending review (as reported in Digital Health) was full of words like “potential” and “may”. Again there is no evidence that such significant spending is going to benefit us, the patients.

Evidence-based health care

33. It is very worrying indeed that the word 'evidence' doesn't appear in this document about what should drive the NHS - not once.

34. The Kings Fund have raised similar concerns, particularly in relation to mental health, where they said recently week that 'trusts have embarked on large-scale transformation programmes aimed at shifting demand away from acute services towards recovery-based care and self-management. This has seen a move away from evidence-based services in favour of care pathways and models of care for which the evidence is often limited. There has also been little formal evaluation of the impact of these changes.' The Kings Fund characterized this as a 'leap in the dark' approach with highly deleterious consequences for the quality of patient care.

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SUMMARY ANSWERS TO CONSULTATION QUESTIONS

Questions 1 and 2
Do you agree with our aims for the mandate to NHS England?
Is there anything else we should be considering in producing the mandate to NHS England?

We hope that the first two questions have been answered by our comments above.

Question 3
What views do you have on our overarching objective of improving outcomes and reducing health inequalities, including by using new measures of comparative quality for local CCG populations to complement the national outcomes measures in the NHS Outcomes Framework?

Frankly this is a question that we have difficulty in understanding let alone to answer it meaningfully.

Question 4: What views do you have on our priorities for the health and care system?

1. There is STILL no duty for the Secretary of State for Health to provide comprehensive health care. **Comprehensive service must be central to the mandate.**

2. Given ongoing attempts inside and outside parliament to raise the issue of co-payments, the mandate should make an express **commitment to free healthcare for all, according to need.**

3. There is confusion in the mandate. ‘**Person-centred**’ does not equate to and should not mean ‘**personal health budgets**’. The latter are unproven and would be a disaster for the NHS and for most patients. The Netherlands abandoned personal health budgets after 12 years due to increased costs without improved health outcomes, fraud and complexity of management.
4. We welcome the notion of **seamless care between health and social care**. But this does not have to mean merging of NHS and local authority spending. The Public Accounts Committee found much of the money was wasted in the past. The Kings Fund has just raised serious concerns that the NHS cannot cope with devolution. There are also concerns that cash strapped local authorities, who have had up to 40% cuts to date and facing more over the next two years, will need to 'raid' the NHS budget to pay for social care. [We note the Prime Minister’s letter to his local council criticising the level of their cuts!] Combining health and social care budgets must not be included in the mandate.

**Question 5: What views do you have on how we set objectives for NHS England to reflect their contribution to achieving our priorities?**

1. The mandate needs to hear **what staff are saying**. There is only one mention of NHS staff. To provide an excellent service, the NHS must provide excellent conditions, training, supervision and opportunities for staff, clinical and others, at all levels. This must be included in the mandate.

2. This document does not talk about evidence-based practice. Nothing in the document states that changes should be based on strong evidence. The NHS mandate must require that all changes to clinical or organisational practices in the NHS have a **strong evidence base**.