Public Consultation on the NHS and 'The 10-Year Health Plan for England'

This response is from Keep Our NHS Public. We were founded in 2005 with the aim of preserving the National Health Service in England and campaigning against privatisation of the NHS estate and equipment and clinical and NHS support services.

Q1. What does your organisation want to see included in the 10-Year Health Plan and why?

HIGH LEVEL:

- **We would like to see a commitment to the founding principles of the NHS.**
  As Lord Darzi said in his September report: *'Nothing that I have found draws into question the principles of a health service that is taxpayer funded, free at the point of use, and based on need, not ability to pay.'* [i]
- *'Every advanced country has universal health coverage [except USA] but other health system models—those where user charges, social or private insurance play a bigger role—**are more expensive**.'* [Lord Darzi, emphasis added]
- **We would like to see more investment in our publicly provided NHS, not an increase in the use of the private sector.**
  The involvement of the private sector inevitably makes the cost of healthcare more expensive. Short term (or indeed longer term) diversion of funding to the private sector rather than investing in the capacity of the publicly provided NHS is costly and brings with it unintended consequences. These include a reduction of the availability of expertise within the NHS and a cream-skimming of 'easier' treatments by private sector organisations, leaving a weakened NHS with a higher proportion of complex cases to address.
- Competition for private sector contracts also makes it harder to achieve the high degree of collaboration on which the NHS depends.
- **The successful tackling of very long NHS waiting lists in the 2000s was through building NHS capacity**, and fundamentally not through 'independent sector treatment centres'. The House of Commons Health Select Committee reported in this vein in 2006.[ii] Their findings are striking and worth learning from and quoting:
  'We concluded that ISTCs had not made a major direct contribution to increasing capacity.'
- **International comparisons of health systems have consistently held the NHS at or near the top** amongst comparable economies, that is until 2015. The decade of austerity from 2009 impacted on the ability of the NHS to resource and maintain its comprehensive service to that high standard. [ref: Commonwealth Fund reports 2004-2021[iii] – the 2017 report, based on data up to 2015, maintained the NHS in number 1 position of 11 'Western style' economies.[iv]]

- The founding principles important to uphold in the NHS 10-year Plan include that the NHS will provide a service that is:
    - Universal, equitable, comprehensive, high quality, free at the point of delivery and available according to need, funded through general taxation including national insurance, publicly provided, and from the cradle to the grave…
    - … and so that, *'not only is it available to the whole population freely, but it is intended… to generalise the best health advice and treatment'* [Nye Bevan[v]].
- **Public funding must be used to invest in public services owned as public assets**
- Most people were disgusted at the actions during the pandemic that saw tens of £billions given to the private sector, only to see it fail to deliver adequate PPE or an effective test and trace system, or extra capacity in the private sector for NHS patients.
- We also know that the hospital building programme using PFI in the 2000s was paid for by PFI companies at an approximate cost of £12bn, for which repayments from the public purse will come to close to £80bn repaid over 30 years – *and in many of the early PFI contracts, the hospital property remains in the ownership of the PFI companies at the end of the contract.*
- **The scale of NHS estate needing to be repaired or rebuilt is demanding. But this must be seen as investment using public funding and to be retained as essential publicly owned assets.** The Government must avoid new forms of PFI or private ownership of new-build NHS estate. A return to this policy for short-term avoidance of national debt would be counterproductive and predictably inordinately expensive long term. PFI-built hospitals in the past, the later 'LIFT' schemes and privately owned health buildings, all result in crippling 'market rent' and service charges at great cost to the taxpayer. *PFI deals did not deliver the 'value for money'* that was promised. Relying on asset management companies to fund NHS infrastructure is not the way forward now.

MAIN POLICIES TO UNDERPIN SUCCESSFUL DELIVERY

- The vision of the NHS will be underpinned if supported by five pillars – five commitments which, if implemented and resourced, would restore the NHS and go beyond what it has been, to an even more impressive future.[vi] These commitments are to:
    1. **A recommitment to the publicly provided NHS and an end to outsourcing of NHS services** to private operatives; and a commitment to bring back in-house outsourced clinical, clinical support and non-clinical support (soft facilities) staff previously employed by the NHS
    2. **An NHS funded to succeed** – not defunded to fail; the NHS needs significantly more ongoing investment[vii]
    3. **Respect, recognition and decent pay and conditions for all NHS worker**s
    4. **An expansion of public health and illness prevention and a tackling of health inequalities**
    5. **Rebuild, restore *and expand* our NHS**

KEY AREAS OF DELIVERY [viii]

- **Rebuild primary care keeping the GP-led model**
  The Secretary of State for Health and Social Care has stated his intention to build back primary care around the model of the family doctor, with a primary care team:

'We will train thousands more GPs and cut the red tape that ties up their time so they can spend more time with patients. We will bring back the family doctor, so patients can see the same doctor at each appointment.' [ix]

- We hope that the Secretary of State will keep his commitment, because continuity of contact with a GP gives better care and outcomes and reduces costs. Longer consultation times than the average 9.2mins should be routinely available where needed.[x]
- **Pause and consult on the roles of physician, surgical and anaesthesia associates (MAPs) and nurse associates**
  Primary care and hospital teams should be well-staffed by trained clinicians including doctors, nurses and therapists. We share the growing and recent evidence-based concerns that staff in the 'medical associate professions' (MAPs) are being asked to perform duties that are beyond their training too often unsupervised and, quite mistakenly, are asked to perform first point of contact assessments of patients with undifferentiated health concerns. This must be stopped and there must be a return to the original purpose for physician and nurse associates – that they are trained to support their qualified colleagues, in specific skill areas within their training and competence, and always with access to advice and supervision.[xi]
- **End the situation where 1000s of trainees complete their training only to find no career posts are available in their speciality**
  2024 saw too many doctors unemployed or leaving the NHS disheartened by lack of opportunity to pursue their NHS career.[xii] [xiii]
- **We welcome Labour's commitment to 'bring about the biggest wave of insourcing of public services in a generation' and want this to apply to the NHS now**[xiv]
  Please act to end new attempts to outsource NHS clinical and support services by the East Suffolk & North Essex Foundation Trust (ESNEFT) and school vaccination staff in Greater Manchester and commit to bringing all outsourced staff and services back into the NHS when contracts expire or fail.
- **With respect to clinical services**, there are concerns that large-scale outsourcing eg in cataract and orthopaedic surgery is undermining training opportunities for NHS trainees and undermining those NHS teams by the haemorrhaging of funding to the private sector holding those contracts.
- **'Soft facilities' NHS workers (eg catering, cleaning, porters, security staff)** are the vital non-clinical part of the NHS serving patients without whom clinical care would fail. They are the lowest paid of NHS staff yet were widely praised and thanked for their dedication and sacrifices during the pandemic. They must not be 'rewarded' by being excluded from the NHS team.
- 'In-house' working under the direct control of NHS managers rather than inflexible terms of contract gives better support to patients and better morale for staff.
- **Rescue and rebuild NHS dentistry for everyone – an urgent crisis to address**
  Across the UK, there were 1,038 fewer dentists working in NHS primary care in 2020/21 than there were in 2019/20.[xv] Millions are struggling to find an NHS dentist and cannot afford charges. 9 in 10 NHS dental practices are closed to new adult patients.[xvi] Tooth extraction for dental decay is the commonest reason for 5-9-year-olds in England to be admitted to hospital.[xvii]
- **A mental health service well-resourced to meet need and deliver true parity of esteem**
  The commitment from a series of past political leaders to give parity of esteem to mental health has been no more than a sound bite. The level of mental health distress, anxiety and

depression is increasing. Public services are not resourced to meet such demand, and people are suffering from neglect. There is increasing inequality. Demand for care far outstrips current resources and, when community-based services are lacking staff and resources, the NHS has to rely increasingly on expensive, too often remotely located and critically unsafe private inpatient provision. We need mental health services built back in the NHS to deliver true parity of esteem, both community-based care and inpatient care. The evidence is there that excellent community care keeps young people with life-threatening eating disorders safely cared for out of hospital with their families in their communities.

- Information from Manchester mental health workers in the Early Intervention in Psychosis service (EIS) shows that while at least £10 million a year is spent on private hospital out of area beds for people with severe mental illness, the local service has been starved of resources. *Yet every £1 spent on Early Intervention would save £18 in costs to society, by reducing hospital in-patient stays and helping, and would save lives by keeping people well in the community.* The EIS staff are on strike calling for the funding for the service promised years ago.
- **Safe maternity services**
  Every child and every mother deserves safe maternity services and neonatal facilities. Damaging government policies have resulted in cuts, privatisation, staff shortages and disrespect for women and babies. Outcomes are getting worse for Black and Asian mothers.[xviii] Many women are not receiving the safe, high-quality care they deserve; there are multiple reports of avoidable baby deaths, notably the Ockenden Report in 2022.[xix] We must not emulate the US which has the highest infant and maternal mortality rates among high-income countries.[xx] Maternity care must be safe, universal, publicly provided and free for everyone at the point of need. Invest in safe levels of qualified midwives and other staff as recommended in official inquiries.[xxi]
- **An urgent move to a national care, support and independent living service**
  Significant moves to a national care service cannot wait any longer. This service must be free at the point of use and publicly funded, provided and accountable. This will end the exploitation of the care system by large private companies often funded through precarious private equity. The service must be nationally mandated but radically re-imagined and co-produced locally with service users, carers, workers and local communities, offering choice, control, dignity and independence providing support for carers and good pay and conditions for care workers. The problems of the NHS cannot be seriously addressed without reform of social care.
- **A restoration of universal access to the NHS must include an end to discriminatory NHS charges for adults and children living in this country who are migrant to the UK and not covered by a visa**
  The public health, clinical and moral arguments against the previous government's Hostile Environment are irrefutable. The policy is opposed by professional bodies including the Association of Medical Royal Colleges, the Royal College of Physicians[xxii], RCPCH[xxiii], RCM[xxiv], BMA[xxv]. The policy is dangerous clinically – with delayed access to diagnosis, treatment or immunisation.[xxvi] The policy scapegoats undocumented people blaming them for crumbling public services. This false narrative deflects blame from the deliberate policy-driven neglect of the NHS and fuels racism. Undocumented adults and children living in Britain are being charged for most NHS care. *This defines an end to the upholding of the principles of universal access to healthcare to all living in this country, free at the point of need.* Most NHS staff do not want to withhold care or witness its denial. We would like this regimen and

these charges for undocumented people, including over 200,000 children to end immediately. This would go a long way to reasserting the universal access to healthcare *for all people living in Britain* who need help.

- **Address inequalities and social determinants – with commitment from across all government departments**
  Professor Marmot estimates that health inequalities, driven by the social determinants of health, were responsible for over a million early deaths in England from 2011 to 2021.[xxvii] Cross-government commitment is needed to address social inequality, poverty, low pay and unsafe working conditions, poor housing, under-investment in children and young people, discrimination and racism, pollution, and climate change – the overarching causes of health inequality. There needs to be investment in the public realm, notably in public swimming pools, sports and health centres, and libraries which are important to people's physical and mental health.
- **Establish a cross-departmental committee on the health of the population**
  A health equalities impact assessment on the health of the public should be carried out whenever any new national policy is being considered, notably in the fields of housing, environment, food, employment conditions, transport etc. The establishment of a cross-departmental committee on the health of the population would strengthen delivery of cross-governmental commitment in these areas.
- **The national public health service should be restored, well-resourced and organically connected to local public health, local authorities and the NHS (primary and secondary).**
  It is an essential lesson from the Covid pandemic that, after years of national public health and local government cuts, fragmentation of policy strategy and privatisation of the procurement of supplies including PPE, the public health structures were unable to deliver and protect the country.
  The undermining of public health programmes such as health visiting, school nursing and help to stop smoking has had significant consequences for child safeguarding, early intervention and prevention of avoidable health conditions.
- **Restoration of sole ownership and control of NHS patient data by the NHS**
  There is widespread agreement that responsible use of NHS data could help improve health and enable NHS staff in their work. However, the confidence of the public and NHS staff must be restored through a rigorous safeguarding of confidentiality of patient data and a ban on the commercial exploitation of NHS patient data.
  It is highly inappropriate that a company like Palantir is in the driving seat controlling the national integration and use of NHS data. We call for an urgent review of this decision and the re-establishment of strong governance.

Q2. What does your organisation see as the biggest challenges and enablers to move more care from hospitals to communities?

- **Good and safe community-based care (CBC) is desirable and, where it has been resourced adequately, has been shown to be effective. It is not a cheap option[xxviii]**
  If CBC is to succeed and deliver safe clinical care and support, it needs the resources of skilled staff, excellent equipment, and IT that enhances patient care.
- **Research has not proven that CBC significantly reduces unplanned hospital admissions** and this should not be an assumption leading to reduction in hospital funding [xxix]
- **Learn from community mental health**

Note that the transfer of long-term hospitalised people with mental health conditions into the community in the 1970s only worked well and safely when significant resources were put into community mental health outreach teams to support people living in the community. Where this is inadequate – increasingly a nation-wide reality – dire consequences result.

- **Community-based care workforce requirements**
  Effective, safe CBC requires skilled teams of staff, who often work solo in home and community settings. It would not be safe care, and it would be unfair on the less qualified medical/nurse associates or health care assistants for them to effectively replace clinically qualified staff. Instead, these members of the multi-disciplinary teams should be there to support clinically qualified staff who have the responsibility and the time to always offer advice and supervision. Failure in this will result in unsafe practice which will undermine the confidence of the teams.
- **The best technology will be important to facilitate community and home-based healthcare, but IT is not more important than well-resourced and skilled staffing.**
  It would be wrong to have an overreliance on technology to deliver productivity with less staffing. At the heart of good primary and community care is personal contact with patients. Importantly, there are other pitfalls to be aware of: there are Wi-Fi dead spots, data security issues, personal safety of staff carrying equipment out in the community.
  Most important of all, there are large numbers of patients who may not have the ability to use technology and web-based interactive communications (those with physical disabilities, sensory impairments, learning difficulties, financial barriers, illiteracy etc).
- **Effective community teams will discover unmet need**
  Research over 30 years shows that well-resourced multi-disciplinary community-based teams can be effective. But this varies for a variety of health targets. Skilled teams uncover unmet need, hidden from view prior to staff going into homes and residential care. The counter-intuitive result can require more input from GPs, primary care and hospital departments too – timely diagnosis and intervention, early admission if needed, better care on discharge.
- **Hospital resources must not be reduced to fund community care**
  With 6.3m people waiting for 7.5m appointments, and 14,000 people dying avoidably in the last year caused by delayed access to emergency admission and treatment, the need to improve resources for hospital-based care remains high. The public expect waiting times to be quickly reduced. Secondary NHS care is in a state of deep stress at present. Reduction in hospital resources would be disastrous for patient care, staff morale and retention and would undermine safe community-based care.
- **Parallel funding is required at least for the first 5 years.** ***Do not reduce real terms funding to hospital sector.***
  Parallel funding would materially help hospital teams promptly treat and safely discharge patients. Investment in community health and care services to build new capacity and ways of working would improve community-based care and reduce some admissions. Without the maintenance of funding for hospitals, skilled hospital staff would be transferred into the community, undermining the already struggling hospital sector.
- **Multi-disciplinary and multi-agency teamwork across health and care** is essential, requiring community staff, GPs, hospital teams, social care and local authorities to work together and for children – Education too.
- **The community estate is frequently inadequate, crumbling or non-existent.**

Up-to-date equipment and properly designed premises make a huge difference to the efficiency of the service, improve the comfort of patients and enable teamworking, effectiveness and morale of staff working in it. *As Lord Darzi highlighted, 20% of primary care estate predates the founding of the NHS in 1948.* Capital investment is going to be needed to build the required estate and procure the required level of equipment. This will take a number of years, but it must start now.

- A repeat of the PFI mistake if new and refurbished NHS estate and equipment were put in the ownership of private companies would be a costly mistake and waste £billions of public money. Private ownership of NHS premises opens up the NHS, including primary care, to crippling market-rate rent and service charges in perpetuity. The results of capital investment should be retained as publicly owned assets.
- **Equitable access to community care**
  The essence of community care is to make care locally accessible. In the past most people in high density populations were within walking distance of their GP or pharmacy. Hundreds of GP surgeries have closed down over the last few years. The move to community 'hubs' must avoid the risk of fewer points of access further and further from many people who face barriers to accessing care. Otherwise, 'neighbourhood hubs' will increasingly not be in a patients' neighbourhoods.
- **Successful community care needs an effective social care support service**
  See 'An urgent move to a national care, support and independent living service' under Q1

Q3. What does your organisation see as the biggest challenges and enablers to making better use of technology in health and care?

ENABLERS

- **Appropriate technology, used within a strong ethical governance framework, will be an important facilitator of the work of NHS staff including:**
  - multi-disciplinary health teamworking across NHS organisational boundaries
  - inter-agency information sharing within agreed protocols
  - patient access to their own data and involvement in their own care
  - use of technology including AI to improve interpretation of health data provided there is human specialist tight overview
  - enhanced community and home-based healthcare
  - and when its priority is to enhance care not count it, and to assist well-resourced and skilled staff, not to replace them

CHALLENGES

BARRIERS TO USE OF TECHNOLOGY

- **It would be unwise to have an overreliance on technology to deliver productivity** with less staffing. At the heart of good primary and community care is personal contact with patients.
- AI and technology will only deliver major 'efficiencies' if there to support well-staffed teams with the reliable, easy to use up-to-date equipment they need
- **There are significant technical pitfalls:**
  - WIFI dead spots, security, patients' varying ability to use
  - Incompatibility of different software, staff frustration with the time taken to boot up old hardware and login to multiple software systems
  - data security issues

    - personal safety of staff carrying equipment out in the community.
- **Danger of discrimination and inequality**
  It is most important to support the large numbers of patients who may not have the ability to use technology and web-based interactive communications (eg those with physical disabilities, sensory impairments, learning difficulties, financial barriers, including a proportion of elderly people, those with very low literacy levels. The National Literacy Trust estimates that more than 7 million adults in England—16.4% of the adult population—are functionally illiterate).
- **Data protection and governance**
  There are issues to be addressed regarding confidentiality and safeguarding – where patients' confidential health data may be made available to other members of a household inadvertently or because online conversations are held in a home setting where the patient cannot have privacy.

Q4. What does your organisation see as the biggest challenges and enablers to spotting illnesses earlier and tackling the causes of ill health?

- **The social determinants of health are powerful causes of health inequality.**
  These are largely beyond the scope of the NHS to tackle directly. But cross-government commitment, led by the Health Department, is needed to address social inequality, poverty, low pay and unsafe working conditions, poor housing, under-investment in children and young people, discrimination and racism, pollution, and climate change – the overarching causes of health inequality.
- There must be recognition of, and a plan to tackle, **the financial and non-financial barriers to accessing health care** such as patients unable to take time off work without losing pay, travel impediments etc. Britain has one of the lowest levels of sick pay in Europe – a contributor to the very poor outcomes in the pandemic and the very high mortality and morbidity rates amongst low paid workers.
- **Restoration to health of the GP model**
  Improved access, longer appointments times where needed, and continuity of care when appropriate would make a great contribution to early recognition of health problems, early intervention, secondary prevention – and must be a priority.
- As outlined above, **very good care in the community** is an important contributor to a successful health care system but does not come cheaply or easily and must not be at the expense of other sectors in the NHS. If this is not understood well enough (see above) success will be quickly undermined.
- **Build back a national public health structure**
  There must be far better pandemic planning, emergency response, infection control, preventive health. And a strong public health service has been an essential part of the NHS since 1948, whether the service was located in the NHS or in local authorities.

Q5. Please use this box to share specific policy ideas for change. Please include how you would prioritise these and what timeframe you would expect to see this delivered in, for example:

1. **The NHS model is the best**[xxx]
   The evidence is clear that the publicly provided NHS when funded to succeed in service provision and delivery, has been amongst the very best, if not the best, health care system

serving the whole population in a major economy. (See Commonwealth Fund reports[xxxi] and 'The Rational Policy-Makers' Guide to NHS'[xxxii]

2. **The NHS needs more funding urgently**
   When funded to succeed, the NHS has been the most cost-effective and most democratically accessible service and must be retained and receive investment.
3. **Privatisation of the NHS, in its various forms, is not more efficient, it fragments the holistic care possible under the NHS, and by its nature takes funding out of the NHS for profit – the purpose of private business.**
   a. The NHS should be publicly provided and accountable, in addition to being publicly funded.
   b. Outsourcing of **NHS services** to private operatives is more expensive unless care is diminished or withdrawn and is usually poorer quality. There is a catalogue available documenting failed privatisation. (NHS Support Federation[xxxiii])
   c. A commitment is needed for the Government to apply to the NHS their Labour Party manifesto commitment to bring back in-house outsourced public services clinical, clinical support and non-clinical support (soft facilities) staff previously employed by the NHS.[xxxiv]
4. **Respect, recognition and decent pay and conditions for all health worker**s is essential and the dedication, commitment and sacrifice (including 2,000 health and care workers' lives) in the pandemic should be remembered.
5. **An expansion of public health and illness prevention and a tackling of health inequalities** are essential. The country was failed by the neglect of the previous government of public health, pandemic planning, the NHS and social care, the BAME communities, disabled people, children and the most economically vulnerable.
6. **Rebuild, restore *and expand* our NHS**
   These main pillars are expanded in the document 'Our vision for a People's NHS'[xxxv] part of Restore the People's NHS'[xxxvi]
7. **Start on the national care service capable of delivering support and independent living now – there are principles to agree now and decisions to be made (See under Q1)**
8. **Protect the NHS from future trade deals**
   We call on the Government to make a formal declaration that the NHS is a 'non-economic service of general interest' and 'a service supplied in the exercise of governmental authority' so asserting the full competence of Parliament and the devolved bodies to legislate for the NHS without being trumped by EU competition law and the World Trade Organization's General Agreement on Trade in Services.

Quick to do, that is in the next year or so

- Actions and words to rebuild the morale of the NHS and care workforce including addressing low pay.
- Statement of intent to build back publicly provided services.
- Fund public services and to end new outsourcing contracts.
- End currently outsourced contracts as soon as the contract ends or if the standard of provision is failing.
- If legislation is needed to do the above, then pass that quickly.
- Restore universal access to the NHS by ending the denial of free access to healthcare to undocumented adults and children – which is a public health risk and also discriminatory
- Consult on the creation of a National Care Service now.

- An early commitment to resolve the funding of social care is important here. Two important areas are the free provision of care as in Scotland and a return to the public ownership and accountability of residential care homes.
- There are gains to be made by moving away from the dominant model of hedge funds and private equity owning so much of social care homes and extracting as much as 40% profit,[xxxvii] whilst leaving the care homes they own short of staff, with low paid staff, a high turnover, and in some cases highly questionable care
- Statement of intent to build back primary care around the model of the family doctor, with a primary care team. Continuity of contact with a GP as much as possible, longer consultation times, routinely where needed

In the next 2 to 5 years

- Getting waiting times down to where they were in 2009 sustainably by investing in the NHS
- Legislation to end the commissioning/contracting model and replace with a public health-led needs assessment nationally and locally involved local authority, where services are funded to meet the national and local needs

Long term change, that will take more than 5 years

- Meet all the founding principles of the NHS
- Rebuilding the national interrelated set of health services based on cooperation rather than competition
- Match Scotland's free prescriptions – the charging system in England is a source of inequality and risk (with known deaths and morbidity from lack of affordability to those on low pay)

Dr John Puntis and Dr Tony O'Sullivan, co-chairs
On behalf of Keep Our NHS Public *2nd December 2024*
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