Setting the mandate to NHS England for 2016 to 2017

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Key points and recommendations

- Age UK support the mandate's aim of helping to make progress against the *Five Year Forward View*.
- There are significant funding pressures across government that risk undermining the aims of the mandate, in particular the continued squeeze on social care budgets and the cuts to public health funding for local authorities.
- We believe that any settlement for increased funding for NHS services should be front-loaded to support the embedding of new models of care while preserving existing access to services.
- Older people are the main users of health and care services and the overall levels of need in this population are growing. In the context of flat funding, all decision-making from NHS England should take into account the Equality Act and the public sector equality duty.
- We agree that addressing variation in access to and outcomes from care should be a priority. This should include making progress in reducing the gap in disability-free life expectancy, depending on where in the country you live.
- We do not believe that management of multiple medications by professionals or in settings such as hospitals has adjusted to increases in polypharmacy. Improving the provision and management of medication should be a specific priority for NHS England.
- The Department of Health should set all objectives in light of a human rights framework to ensure all decision-making supports people's ability to remain active and independent, regardless of where they live.

1. Introduction

Age UK welcomes the opportunity to respond to this consultation on setting the mandate to NHS England for 2016-17. This consultation comes in a time of flat funding for NHS services and during the growing crisis in social care funding with over a million older people having an unmet need for social care. Coming ahead of the spending review, we will not understand the full implications of spending decisions on health and care until after this consultation closes. In this challenging financial context, we believe that a priority for the mandate must be to maintain its commitments to the Equality Act and to operate within a framework that respects the essential human rights of all service users.

The establishment of the *Five Year Forward View* as the driving strategy document for NHS England, might appear to diminish the scope and importance of the mandate. However, we believe it can still have an important role in driving improvement in the NHS. As such, it is disappointing that the Department of Health has used a very short consultation window for this year's mandate and has made very little effort to publicise it. We believe there must be much more systematic engagement with the public and frequent users of the NHS in setting the department's objectives and they should be involved at every stage of the process for measuring achievement against these objectives.

2. Consultation questions

1) Do you agree with our aims for the mandate to NHS England?

Age UK supports the vision of the *Five Year Forward View* (FYFV), both as a means of establishing new models of care, but also for making progress in reducing the overall prevalence and impact of morbidity. We have also long called for a period of stability to allow NHS England to change how the NHS operates and address long-standing challenges in the way that older people are cared for. The proposal to budget for multiple years could be an important step in achieving this. As such we agree with the basic aims of the proposed mandate.

However, this is conditional on the following factors. In order to support the transformation of services while preserving the services that older people rely on now, we have called for the £8 billion of additional funding promised in this parliament to be front-loaded. Given the existing pressures on hospital services with a projected deficit of £2.2 billion this year and the long-standing under-investment in community services, making the bulk of the funding available in the next two years will be an essential step in achieving the aims of the mandate. Likewise, the crisis in social care funding must also be addressed. With over a million older people in England now having at least one unmet need for social care, which can lead to avoidable admissions to hospital and poorly managed health, the human and financial cost of failing to provide essential support will continue to grow.

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

There are a number of factors that must be recognized and acknowledged by the Department of Health and government in setting out their objectives for NHS England.

- Older people are disproportionately facing the impact of deep and substantial cuts to social care funding with more than a million older people in England now having at least one unmet need for social care (up from 800,000 in 2010).

- Between 2005/06 and 2014/15 the number of people aged 65 or over in England increased by almost a fifth and the number aged 85 and over rose by approaching a third. This is likely to accelerate in the coming years.

- There remains a significant amount of unmet need in access to essential care services. Cancer care and mental health, for example, are just two of the areas that see significantly poorer access and outcomes for older people.

With these factors in mind, we would expect the mandate to be considered in light of the Equality Act 2010 and in particular the public sector equality duty, i.e. to not only eliminate unlawful discrimination but also advance equality of opportunity and foster good relations between people who share a protected characteristic and those who do not. There is evidence that older people can be disadvantaged during periods of constrained spending (see for example the National Audit Office Report *Progress in making NHS efficiency savings*) and we have growing concerns that access to essential services such as hearing aid provision and cataract surgery have already reduced in recent years. See for example North Staffordshire CCG that has recently changed eligibility for hearing aids. Such decisions can have a severe impact on someone's quality of life and the chance to remain independent. We would expect the mandate to make explicit reference to the public sector equality duty and include a commitment to measure the performance of all NHS services in line with best practice.

Further evidence in our report *The health and care of older people in 2015* (2015) draws links between the under provision of social care and community services and increased admissions to hospitals and can be found at the following link: Briefing: The Health and Care of Older People in England 2015 (opens pdf).

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?

Further to our points in answer to question 2, we would strongly encourage all agencies to disaggregate comparative data by age. Our work with the Royal College of Surgeons has demonstrated huge variations in access to procedures such as breast excision and hip replacement for people over 65 and 75, depending on where you live. Such variation may not be captured in all-age data. There may also be large variations between age groups within a CCG. For example, access to IAPT services are poorer for older people, both in terms of starting the treatment and completing the course of treatment.

We agree with the overarching objective of improving outcomes and reducing health inequalities and share the belief that new measures of comparative quality can play a role. The mandate should consider services vital to older people when deciding on these measures. For example, intermediate care refers an important set of services that support people to return to independence after a period of poor health or spell in hospital. The latest audit published in November 2015 described significant variation in the provision of services. It cites the NHS Atlas of Variation as demonstrating the impact of this variation, including a nine-fold variation by CCG in being admitted to hospital with a stay of up to 24 hours and a staggering 604-fold variation in admission to care or nursing home, both for people over 75. Currently waiting times for intermediate care services are increasing.

Provision of specialist services for older people is also an important indicator. A recent NHS Benchmarking report on care in hospital showed that only 57% of NHS Trusts have a clearly defined strategy or operational policy for delivering acute medical care to older people. This is despite a very large proportion of emergency admissions to hospital being in this age group and the significant focus on reducing the pressure on hospitals through improved care of older people. The lack of a clear strategy may also account for the increased length of stay often experienced by older people. There is a further potential impact from nursing skill mix, with older people's wards having the lowest ratio of registered nurses to unregistered nurses when compared with other wards (a ratio of 44% to 56%).

An overarching objective must be to make progress in reducing the gap in disability-free life expectancy, i.e. the period you can reasonably expect to live in good health in later life. Currently there is a 9.3 year gap between women living in the lowest achieving areas and those in the highest achieving.

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

Age UK recently engaged with older people to explore what their priorities were for the NHS. Their feedback included:

- There was a clear view of what they think the healthcare system should be there to do for them:

    - To be there when they are ill and prevent serious problems developing
    - To keep an eye on their health and pick up problems before they develop

- 'Keeping them well/healthy' in terms of providing lifestyle support/advice is not spontaneously considered an aim for the healthcare system but older people are open to guidance on this. (There may be significant scope here to take advantage of "making every contact count" with regards to giving public health messages and guidance, yet the comments above suggests such opportunities are currently being missed).

- In general older people in this research felt able to access healthcare services in a timely manner and also felt that referral from GPs is working well. Although they did sometimes struggle to get a GP appointment, this was not, overall, a significant a concern.

- They find that appointments with GPs and care workers are not long enough to deliver real value and there was concern about not being able to see the same GP over a period of time.

- Many said they experienced confusion and anxiety about their medication (including those that were caring for someone else).

Many of the priorities outlined in this consultation do reflect some of the priorities of older people. However, we are very concerned about the negative impact of wider decisions across government on achieving these priorities. For example, the cut of £200 million to public health funding for local authorities, already struggling with the crisis in social care funding, is likely to significantly undermine attempts to improve general health and prevent the risk of many long-term conditions. We are also concerned by speculation in advance of the spending review that funding could be cut to Health Education England, which would reduce its capacity to address a long-standing skills gap in the wider health workforce with regards to care of older people and areas such as end of life care.

We are also not convinced about the push for seven day services as proposed in this consultation. We absolutely agree that people should be able to expect safe and high quality care, whatever day of the week they are being cared for. However, with flat funding growth, it is very difficult to see how capacity could be increased at weekends without impacting on services for the rest of the week. As the older people we spoke to suggested (see above), seeing the same doctor can be more important than immediate access, particularly where you have complex needs and benefit from continuity. It is unlikely that seven day services, without a substantial injection of additional funding, could be achieved without compromising such priorities.

Confusion and anxiety about medication is an issue that comes up frequently. Research we have completed with Exeter Medical School (2014/15) showed that the numbers of people on multiple medications has increased substantially in the last ten years. We do not believe that management of multiple medications by professionals or in settings such as hospitals has adjusted to these changes. We believe that improving the provision and management of medication should be a specific priority for NHS England. Prescribing medicines represents a significant percentage of the overall NHS budget and the impact of poor practice can have a significant impact on admissions to hospital and a person's overall ability to manage their health.

We also believe that engaging people on decisions around medication, with the right support, could underpin progress in spreading best practice on shared decision-making and self-management. Existing best practice such as the STOPP/START toolkit for medication management should be used more systematically in the care of older people. We do not support recent suggestions that the price of certain medications should be included on packaging. There is a risk this would lead to non-compliance with medication regimes and misses the opportunity to properly engage people with how they can best achieve their goals for treatment.

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

Age UK reiterates the need to consider equalities issues when setting objectives for NHS England, but also the value of a human rights framework in measuring impact. For measures such as patient experience, this can be extremely important, particularly where there have been long-standing issues with care of older people that does not respect and protect their dignity. We also believe that decisions around health care that do not have due regard for human rights could lead to some older people to having only very basic needs met , with little attention paid to maintaining resilience and engagement with communities. Older people living in care homes, for example, or with dementia are often provided with a poor level of healthcare since the expectation is simply that they are likely to have or need little daily activity. NHS England, particularly as the commissioner for primary care, could make a major contribution to addressing the support available to many isolated older people with complex needs.