



A Consultation on the NHS Constitution

**An analysis of the responses to the consultation –
report for the Constitutional Advisory Forum**

10 November 2008



Introduction

A national consultation on the draft NHS Constitution was held between 30th June and 17th October 2008. The consultation triggered significant response from a wide range of bodies. A total of 1000 responses to the consultation on the NHS Constitution were sent directly to the Department of Health. This is broken down as follows:

National organisations	Academic institutions	5
	Drug companies & industry representatives	8
	Independent providers	2
	Other organisations (eg arms length bodies, regulators, think tanks, research networks, research councils, NHS Confederation, etc)	40
	Professional bodies (eg Royal Colleges, Societies, General Medical Council etc)	41
	Third sector	67
	Unions	11
	TOTAL	174
Local organisations	Local Government	51
	Local third sector organisations	22
	TOTAL	73
Public/patients (assumed)	Letters	70
	Emails	324
	TOTAL	394
Staff	Letters	6
	Emails	172
	TOTAL	178
Questionnaire on NHS Choices	Staff	99
	Public	82
	TOTAL	181

Each SHA coordinated a regional consultation process and summarised the comments that they received from the PCTs and Trusts in their area. The scale of consultation in some regions was impressive – NHS East of England for example suggested that over 99,000 people had been engaged in discussions about the Constitution. [This first draft does not include full feedback from the SHAs- they will be submitting their reports on 14 November].

The vast majority of responses from across all interest groups expressed support for the concept of an NHS Constitution and its content. The responses were primarily comments about areas that were felt to be significant omissions, and suggestions about points that could be strengthened or clarified. Where concerns were expressed they focused on the risk that the Constitution may inadvertently encourage greater litigation or may raise expectations which would be difficult to meet in practice. Some concerns were also made about the Constitution being used for political purposes. However, apart from responses from Local Government, it was also significant that the area that provoked least interest was the accountability arrangements.



This report summarises the key themes from the consultation responses. It highlights those areas around which there is a significant consensus and topics that provoked significant differences in opinion. The report broadly follows the structure of the Constitution and the consultation questions.

General comments

There was broad support from all interest groups for an NHS Constitution.

Significant omissions. Later in this paper we cover the omissions that have been highlighted for both patient and staff rights, pledges and responsibilities. There were however, two general omissions highlighted by a number of interest groups which appear to apply to more than one section of the Constitution. The first omission was the lack of emphasis on the important role of the NHS in promoting health and well-being. This was highlighted, for example, by groups as diverse as the CQC, RCP, RCN and the Stroke Association. The second theme, raised by some NHS organisations and those representing environmental interest groups, was the duty of the NHS to consider the impact of decisions on sustainability. A further cluster of comments highlighted concerns that the Constitution made no specific mention of ageing and appeared to exclude age from references to discrimination. Several groups noted that dental and optometry services were not mentioned yet felt that there needed to be greater clarity about how some of the proposed principles might apply to these areas.

In addition to these issues there were some general concerns about the Constitution that may merit further consideration by the CAF.

The coverage of the Constitution. The title of the Constitution implies that it applies to the whole NHS both in England and in the devolved administrations/Governments. However, some of the points - for example on patient choice and the references to – would appear to more applicable to the policy context in England than to Scotland, Wales or Northern Ireland. One organisation suggested that the differences in provisions in the devolved administrations should be explained. One of the trade union respondents felt strongly that the Constitution should be for the whole of the UK. ...” *takes the view that when we refer to ‘nation’ or to the ‘NHS as a national system’ that we should be especially careful not to depart from the wider context. The nation – to which the NHS refers - is the United Kingdom. That’s why we further contend that the principles and values invoked should be sufficiently fundamental to command widespread agreement and application not only in England but across the devolved administrations as well.*”

Terminology. On balance, the majority of respondents acknowledged the need to differentiate between legal rights and patients’ preferences or expectations. There was also support for having rights brought together in one place by those respondents who explicitly mentioned this point. However, a large number of



organisations were unhappy with the terms ‘pledge’ and ‘strive’ which are used to refer to areas where the NHS will commit to making improvements either for patients or for staff – the sentiment was well put by one of the union respondents – *“to only say NHS bodies have to ‘take it into account’ will be seen as a way for Trusts to ignore their obligations... ‘Strive’ is not strong enough”*. Many suggested that the term “will” should be used. At one end of the spectrum, there are those who felt that the pledges should be rephrased as rights. In the centre there were comments such as that from the Parliamentary and Health Service Ombudsman that the term ‘strive’ works better for some pledges than others. At the other end of the spectrum, there are organisations (eg the MS Society) who are broadly happy with the term pledges but feel that they lack ambition. One practical suggestion, which they make, was that there should be a specific timescale for pledges to be delivered or to be turned into rights. The proposed review process for the Constitution would provide an opportunity to determine progress on the achievement of the pledges.

Perhaps a more fundamental question was that raised about the term ‘Constitution’ *‘There is a strong possibility that expectations will be raised in some quarters, only to be dashed later... In that sense the document is a misnomer and it would be better to have entitled the document the NHS Declaration rather than the Constitution’*

Political sustainability. A number of the staff representative bodies (eg Unison and the BMA) and some independent organisations such as the King’s Fund raised concerns about the political sustainability of the Constitution. The BMA expressed disappointment that while para 1.5 refers to the Constitution being part of a broader approach to improving governance in Britain that the Constitution had not included any proposals to change the way that the NHS is governed and which might reduce the risks of political interventions. NHS North East suggested that if the Constitution is to have lasting value *“It needs to have cross party support and wide buy-in to ensure it is meaningful”*¹.

The role of commissioning. The King’s Fund, the CQC and SHA responses highlight the point that (in England) the NHS is no longer a single organisation managed by the DH. PCTs are being encouraged to be impartial commissioners and make use of the independent and third sector where this can offer value for money and benefits for patients. The CQC suggests that the draft gives insufficient weight to commissioning, both in terms of involving people in the planning and decision making process. They recommend changes in the wording of pledges around the quality of healthcare and public engagement that mention commissioner as well as provider responsibilities.

¹ Throughout this document, comments quoted from SHAs are comments from views gathered by the SHA and not necessarily those of the SHA mentioned.



The source and status of the Constitution

In general, there was widespread support for the proposal that the Constitution should be short, enduring and flexible; that it should avoid fuelling litigation. Respondents cited a number of benefits that they felt a Constitution could offer. For example, it would encourage the NHS and other bodies to collaborate, *“The constitution will help people focus their minds on what the NHS is about”*. A further suggestion was that outlining a clear statement of purpose for the NHS would help in managing public expectations. NHS North East’s respondents felt that the Constitution was likely to be of value as a *“foundation for the resolution of conflict and disputes”*.

Responders to the NHS Choices questionnaire agreed that the Constitution would help improve people’s awareness of their rights and responsibilities (73% of staff and 62% of the non staff respondents agreed or strongly agreed with this statement). The figures for those who disagreed/strongly disagreed were 13% and 11% respectively.

Overall, there was support for all three of the consultation questions in this section.

Consultation question 1 (“Should all NHS bodies and NHS-funded organisations be obliged by law to take account of the NHS Constitution?”)

The majority of respondents from all groups agreed that both NHS bodies and NHS funded organisations should be obliged by law to take account of the Constitution. Over 80% of the questionnaire agreed or strongly agreed with the proposal. One NHS organisation recommended that from the perspective of the public the Constitution should spell out who it applies to and that this should *“include all those organisations that are commissioned by or purchased by the NHS to provide services to the NHS, including the less obvious ones such as Management Consultancy, the Regulatory bodies including the Healthcare Commission and Monitor and those many companies providing independent advice.”*

There were some differences however, within and across organisations about whether this proposal went far enough. For example, the BMA and some members of the RCN felt that the legal obligation should be stronger and more specific. The Royal College of Physicians by contrast suggested that the phrase ‘take account of’ was appropriate in that it did not bind organisations to any specific actions. Unison raised concerns about the use of the private sector in the NHS. They accept that there are already many private sector companies delivering NHS services and while these bodies should be obliged to take account of the Constitution, this would not be sufficient of itself to ‘preserve the values and ethos of the NHS. A slightly different point was made by National Concern for Health Care Infections. While they supported the proposal that there should be a legal obligation to take account of the Constitution they questioned what this meant in practice as organisations could not be legally accountable for pledges and there is not a proposal to enforce the Constitution. A significant number of organisations representing patients suggested that the term ‘take account of’ should be



better explained either in the Constitution or in the accompanying Handbook.

Consultation question 2 (“Should legislation require the Secretary of State for Health to renew the Constitution every 10 years?”)

The majority of respondents agreed that legislation should require the Secretary of State to renew the Constitution every 10 years but there were some differences in opinion about the frequency of the review process and how it should be carried out. The RCN for example, indicated that ten years should be a minimum as it would ‘demonstrate a commitment to the NHS that went beyond the usual political cycle of elections. A small number of patient organisations, including Health the Aged, felt that ten years is too long although the precise reason for their comments was not clear.

Several comments were made about the process for the review. A small number of respondents from NHS organisations, professional bodies and groups representing patients suggested that the review of the Constitution should be carried out by an independent body (the CQC or a Parliamentary Select Committee for example) and that patients and clinicians should be involved in the review – both methods were felt to be ways of depoliticising the revision of the Constitution.

Consultation question 3 (“Should the *Handbook to the NHS Constitution* be renewed every three years?”)

Sixty eight per cent of the respondents to the questionnaire and the vast majority of respondents from across the various consultation groups felt that revising the Handbook every three years makes sense. However, some differences in opinion were also expressed. A small number of organisations suggested more frequent revisions might be needed to ensure that the Handbook kept pace with the NHS Operating Framework or changes in professional practice and regulation. By contrast other professional bodies indicated that it might be preferable to *review* the Handbook every three years but only renew it if significant changes were needed. Two professional bodies suggested the Handbook should be revised in line with the renewal of the Constitution. Comments from NHS East of England and responses from Foundation Trusts suggested that it would be better to have flexibility about when the Handbook is renewed rather than a rigid date.

The purpose and principles of the NHS

Consultation question 4 (“Are the statement of purpose and the set of principles right? Are there any principles that should be added?”)

The majority of respondents were broadly supportive of the purpose and principles laid out in the Constitution. A wide range of comments were made on specific principles and some suggestions were made about additions to the purpose and principles that should be included in the final version. One group suggested that the statement of purpose



could be strengthened by a statement by the DH on how it wanted to see the Constitution used in practice by staff, patients and the public.

Proposed additions and deletions

The suggested additions to the statement of purpose included:

- The importance of putting the patient at the heart of the NHS
- The responsibility of the NHS in the training of health professionals
- An acknowledgement that the NHS is committed to working in partnership with other bodies, including housing, social services and the independent sector, so that it can meet people's needs effectively and comprehensively.

There was also explicit support from a small number of organisations for the NHS purpose to include a reference to helping people to have a 'good death'..

Additional principles suggested included the following:

- A principle relating to the NHS's duty to take account of sustainability. NHS East of England suggested that this could be worded as follows". [The NHS is committed to be a leading sustainable and low carbon organisation. – The NHS is working towards reducing its carbon emissions by 80% by 2050. It will encourage and enable its staff, users, suppliers and communities to be good corporate citizens.](#)"
- The principle of keeping within allocated budgets;
- A further principle could also be around the safe guarding of vulnerable members of the society by working in partnership with social care and the police?
- A reference to the NHS endeavouring to listen and hear patient's voices and understand what they have to say about their experiences and needs. Linked to this there were suggestions that the principles should refer to treating patients with dignity and respect.
- To develop and support health service provision in counties that provide the bulk of the country's newcomer populations and asylum seekers
- Service planning should be clinically led and involve patients;
- A reference to public health and health improvement – one group suggested that this could read ["the NHS seeks to promote and protect the health and wellbeing of communities and populations in addition to supporting the health and](#)



healthcare needs of individuals’.

- The commitment to reducing health inequalities and reference to the six statutory equality areas;
- The place of healthcare in providing education and training of health professionals;
- The aspiration that the NHS will equal or better the quality of health services available abroad;
- A reference to the role of research and the NHS commitment to collaborate with other organisations concerned with research. A large number of comments were made about the position of research in the Constitution, particularly the pledge contained in P24 of the Handbook (that “the NHS will do all it can to give patients...a right to know about research that is of particular relevance to them and, if they choose, to take part in approved medical research that is appropriate to them”). The main message here was that the focus on research in the Handbook should be mirrored by a reference to research in the Constitution itself. Further comments on research are covered in the analysis of comments on the Handbook later in this report.

Of these, the principles around public health and health promotion, inequalities and sustainability received specific support from several SHAs.

Specific comments on the principles

A number of bodies highlighted the risks of conflict between the different principles. Specific concerns were expressed about the conflicts between principles 4 and 6 by some of the professional representative bodies. One explanation for this potential conflict was suggested by NHS London “*the Constitution must provide a clearer differentiation between those aspects concerned with governance, the NHS’s responsibilities to populations and communities and the rights of individual patients.*”

Principle 1 - a comprehensive service available to all

Some organisations raised doubts about whether this principle could be fully achieved in practice. The word ‘comprehensive’ appears to be the one that caused greatest difficulty. The RCP for example, suggested that if this principles 1 and 2 were to be included then the Constitution should spell out what is or is not included as part of a free NHS. NHS London suggested that this principle’s passive wording could be replaced with the more active statement. ‘*The NHS provides a comprehensive health service physically and culturally accessible to all, irrespective of their sex, gender, race, disability or age*’. (CHECK)

Principle 2 – access to NHS services is based on clinical need, not an individual’s ability to pay



One group suggested that this principle potentially conflicts with the application of principle 6 as resources are finite and both commissioners and providers make decisions about clinical priorities. Several patient groups and SHA respondents noted that this principle may need to be clarified. For example, NHS North East suggested a comprehensive list of exceptions to free services should be made available to patients. The group representing patients involved in NICE took the opportunity in their response to refer to the debate about top-up payments and suggested that if these were allowed then this principle could be misleading unless qualified and explained. Other organisations including some of the SHA responses argued that this principle needed to be clearer and linked it to the points made about NICE approved drugs and local PCT discretion referred to in paras 4.19 and 4.20.

Many commented on the need to further define clearly “ except in limited circumstances sanctioned by Parliament.”

Principle 3 – the NHS aspires to high standards of excellence and professionalism

This principle was welcomed by the bodies representing health professionals. Several groups indicated that it would be preferable if the word ‘aspires’ were replaced with ‘is committed’, while NHS London suggested that the principle could be amended to give a sense of the changing nature of the NHS in order to deliver evolving standards of excellence and professionalism. A reference could also be added to minimum standards that are required for all healthcare providers. Two organisations echoed this by recommending that the principle should include a reference to safe, minimum staffing levels. A further comment was that this principle should refer to innovation as well as research. NHS East of England suggested that principle 3 should go beyond aspiring to high standards and refer to NHS organisations aspiring to improve their services and organisation on an ongoing basis.

Principle 4 – NHS services must reflect the needs and preferences of patients, their families and carers

While this principle was generally supported two specific amendments were proposed by organisations representing patients and carers and some of the professional bodies. The first was that patient and carer needs should be considered individually. The second suggestion was the need to include a reference to people who are unable to exercise their preferences and who would need the support of an advocate in order to express their views.

Principle 5 – the NHS works across organisational boundaries and in partnership with other organisations.

Concerns were raised about this principle by some of the unions and professional bodies who object to the use of the private sector in delivering NHS services. Others welcomed the focus on partnership and felt that the principles should apply to independent and third sector organisations that provide services funded by the NHS. Responses from Local Government welcomed this principle but felt partnership working needed to be reflected elsewhere in the Constitution.



Principle 6 – The NHS is committed to providing best value for taxpayer’s money and the most effective and fair use of finite resources

Few comments were received about this principle. The BMA noted that they believe a range of reforms eg PFI, the ISTC procurement, PbR and Connecting for Health have been poor value for taxpayers’ money and fallen short of this principle.

Principle 7 – The NHS is accountable to the public, communities and patients that it serves

A small number of third sector organisations doubted that the NHS is truly accountable in the way that this principle implies. Some of the professional bodies suggested that the reference to staff being involved in decisions should explicitly mention the NHS trade unions: the current wording does refer to ‘their representatives’.

Patients and the Public

This section of the Constitution attracted considerable comment. There was also broad support from across all groups for the list of public and patient rights although a small minority of third sector organisations felt that this was not giving patients anything new. A large number of new rights were proposed and some amendments to specific rights were recommended. In terms on the layout a small number of respondents felt it might be preferable to cluster the rights and pledges separately.

Additional rights that were proposed

These included the following:

- The right to expect the NHS to be held to account by a regulator with strong powers and a remit to act independently of the NHS and always in the public interest (CQC)
- The right to review your own care plans (RCofGPs)
- The right for patients and staff to be treated with integrity, respect and dignity (NHS North East).
- The right to high quality communication between NHS staff and patients so patients are given the right information at the right stages of their pathway
- The right to expect adequate nourishment in the care of the NHS
- The right to information on all treatment options available (FPA)
- The right to a second opinion (MS society)
- The right to accept or refuse treatment offered to you and not to be given a physical examination or treatment unless you have given valid consent (Scope)
- The right to have travel costs and travel costs for relatives for foreign treatment
- The right to spiritual support
- The right to know who is responsible for your secondary care and to know their status



- The right of female patients to choose a female doctor or consultant to examine them. The right to access appropriate dietary requirements and prayer facilities (Bangladeshi Welfare Association)
- The right to an interpreter if English is not their first language
- The right to be consulted on service changes and for an independent review where changes do not have local support and the right to independent arbitration where there is a disagreement about these changes.
- The right to make an advance refusal of treatment, to grant a lasting power of attorney on health and welfare to an independent mental capacity advocate or deputy if you are unable to speak for yourself.

One organisation noted that the pledge to share letters sent between clinicians with patients may already be a legal right.

Two national organisations felt that the Constitution should be more explicit about how the Human Rights Act 1998 underpins the NHS rights and that it might be helpful to use similar language to describe them.

Consultation question 5 (“Is the list of public and patients’ rights clearly explained and accessible to all sections of the population?”)

Several bodies felt that there was a need for a clearer explanation of the differences between rights and expectations. NHS London for example, noted that the focus solely on legal rights could be perceived by patients and the public as retrospective and out of date. They suggest that *“for the public ‘rights’ carries another meaning – what they would expect to be minimum standards. For example, most patients would expect that they should have a right to be treated in a clean and safe environment or to get vaccinations or screenings that are part of a nationally organised programme”*. The same point was made by NHS East of England who supported these pledges being rephrased as rights. Another respondent suggested that Section 3 of the Health and Safety at Work Act already requires NHS bodies to provide a safe environment.

Further explanation of how the pledges and rights apply to non-NHS bodies was also suggested.

Some organisations were worried that the Constitution and the Handbook was not equally accessible to all sections of the community and that there was a risk that it will further worsen health inequalities. To an extent this can be addressed by drafting the Constitution in plain English and ensuring it is available in different formats –such as easy read, audio, Braille, different languages etc. However there remain concerns about how the section on patient’s rights and responsibilities will be used in practice. Some comments illustrate the point well. *“There is a risk that empowered patients will benefit most from the Constitution at the expense of less empowered groups”* (professional body). *“This is fine for an articulate, well-educated person. But our population includes considerable numbers of people who are not articulate, cannot readily understand this cultural approach, so effectively cannot adopt these responsibilities/expectations. Does*



that mean the NHS then can say "you didn't keep your side of the bargain"? - hopefully not" (NHS North East).

Some rights were felt to be potentially misleading without further explanation. The NHS Confederation and other bodies for example, suggested that the right to seek treatment elsewhere in Europe needed some qualification. It is not clear whether this would include treatments available in Europe that are not available on the NHS, organ transplants, dentistry or procedures that are not legal in the UK but are in other countries eg euthanasia.

Organisations representing older people and some SHAs noted that the right not to be unlawfully discriminated against omits any mention of age and that this should be amended in the final version of the Constitution.

The right of access to local NHS services provoked several comments from patient organisations who felt that those with complex or rare conditions should have the right to access local *'and specialised NHS' services*

Consultation question 6 ("Is it useful to bring together all of the key public and patients' rights and pledges?")

There was strong support for bringing together all of the key public and patient rights and pledges. Over 75% of respondents to the NHS Choices questionnaire for example agreed or strongly agreed with this statement.

An interesting comment on this question was made by an NHS respondent *"setting out the rights and responsibilities of both public and staff is helpful, but The NHS Constitution as it stands suggests a kind of parallel universe for the two groups. The NHS will best flourish if those groups achieve a cooperative equilibrium and do not view their rights and responsibilities in a competitive light."*

However, there were also some respondents who felt that there was potential for confusion between rights, pledges and responsibilities and that this should be made clear when publishing the final constitution.

Consultation question 7 ("Do you agree with a new legal right to choice about your NHS care?")

The proposed new legal right to choice about NHS care provoked a mixed response. Many respondents wanted further clarification on what this right actually meant for patients. Eg right to a named consultant?

There was broad support from the groups representing patients but more qualified support from other organisations. Their main concerns were about the limitations to choice and the impact that this right may have on health inequalities. The proposal was opposed for example by Unison who felt that this was not an essential right and was



more a reflection of government policy. If it is to be introduced, however, they recommend that efforts must be made to protect the most vulnerable sections of society from being further disadvantaged. On a similar note the Royal College of GPs suggested that this right will need to be accompanied by support for GPs and NHS staff so that they can advise patients accordingly. Another professional body highlighted that patient choices will have implications for health service capacity. *“People should have the right to exercise choice ...about what type of care they wish to receive....We believe this form of choice can only be brought by investing in staff capacity and ensuring staff have sufficient resources.”*

Some mental health foundation trusts suggested that a legal right to choice in mental health might not be helpful.

Both the Patients Association and the RCN expressed support in principle but questioned the practical implications and what arrangement for redress would be made if patients were not able to have their choices met. A third sector organisation highlighted the risk that this right could clash with principle 6 (value for money). NHS South West made a similar point *‘The directions under Section 8 of the NHS Act 2006 will need to carefully specify the scope of this right and specify which services are covered by these arrangements. This is to enable NHS organisations to both meet this right and the commitment to provide best value for taxpayers’ money and the most effective and fair use of resources.’* NHS East of England noted that *“Having the legal right implies an option for legal redress if this, or other rights, are not conferred on the patient. Furthermore, we would urge the DH of the need to ensure that choice is underpinned by a robust Choose and Book technical infrastructure. Given the existing inherent operational and delivery problems NHS Trusts are not able to enhance the patients’ or the GP’s experience to any degree .Without these arrangements in place they warn that there is a risk that the right to choice will not be realised in practice.*

Several organisations highlighted that this right was crucially dependent on the connected pledge that the NHS will strive to offer you easily accessible information to enable you to participate fully in your own healthcare decisions and to support you in making choices. Two groups suggested that the pledge should be part of the right to choice. A national third sector organisation requested that the right to information should include a reference to *‘in an appropriate format’*.

A number of comments were made about the existing right that patients have to choose a GP. Further clarification was sought about the term ‘reasonable grounds’. The Royal College of GPs noted that a majority of their members were concerned about the practicalities of implementing this

Consultation question 8 (“Is this list of pledges right? Which are most helpful?”)

In addition to the comments referred to earlier concerning the terms ‘pledge’ and ‘strive’ there were mixed reactions to this question. The pledges were broadly supported by



patient groups, third sector organisations and staff groups, with recommendations for different wording and some additional pledges proposed.

Additional pledges proposed

- The NHS will commit to implementing and monitoring national (or evidence based) guidance and standards
- The NHS will strive to be prepared for the future needs of the population including threats to population health
- The NHS will commit to ensuring that staff providing services are trained to the highest possible standards
- NHS will commit to limit its impact on the environment in light of the draft NHS Carbon Reduction Strategy.
- There should a pledge to ensure that NHS primary dental services are available locally to all who need them.
- A supportive environment which promotes the best possible physical and mental health
- Strive to provide you with information to help you to remain healthy
- The pledges in the End of Life Care strategy should be included or referenced (supported by several organisations)
- A commitment to providing single sex wards
- Several organisations argued that a patient's 'right' to a second opinion should be included as a pledge

Respondents who commented on the relative importance of the pledges indicated particular support for:

- the pledge to work in partnership with patients and their carers.
- pledge relating to a clean and safe environment, with some respondents asking for this to be strengthened
- pledge relating to vaccinations and screening, with a number of respondents calling for this to be made a right (see also comments above)

Consultation question 9 (“Are the responsibilities and expectations of patients and the public appropriate? Which are most helpful?”)

There was considerable support for strengthening the ‘two-way’ street between the public and the NHS. However, there was also a good deal of support for strengthening the statements of responsibilities and for describing them in a more accessible way. The RCGP for example, went as far as suggesting that the term ‘should’ be replaced with ‘must’, particularly around treating NHS staff with respect. Similar points were made by SHA respondents. Unison felt that this responsibility should mention explicitly bullying, harassment and acting violently to NHS staff. Staff responding to the consultation organised by NHS East of England felt that the Constitution *“should stipulate some kind of automatic action against those patients/visitors who physically abuse staff. It should not be left to individual Trusts to take action.”*



A comment from a Local Government source suggested that it was *“laudable to suggest these notions of responsibility..but actual enforcement of these obligations would be difficult to achieve”* was typical of many.

The responsibilities that were felt to be most important were a) treating staff with respect b) keeping appointments and c) providing relevant and accurate information about your health, condition and status d) making a significant contribution to your own and your family’s good health and e) following a course of treatment discussed with your clinician.

Further responsibilities for patients and the public were suggested.

- You should let NHS staff know your end of life preferences and any treatment options that you would not consider
- You should recognise that NHS resources are finite and must be used optimally
- You should consider participating in approved research if invited to do so

Consultation question 10 (“Are the mechanisms for complaint and redress clear and sufficient?”)

The majority of responses to this question suggested that there needed to be better explanation of the mechanisms for complaint and redress. NHS South West noted that this section of the Constitution should not be changed until a new complaints system is introduced in 2009.

Several third sector organisations advised that the Constitution does not make it clear how citizens can seek redress if a right or pledge is not met. Action Against Medical Accidents suggested an additional right that would strengthen the proposals – “the right not to have treatment or care adversely affected as a result of a complaint or seeking redress.

Some professional groups felt that the inclusion of this section of the Constitution might encourage litigation. Help the Aged similarly felt it was appropriate to have limited detail about complaints and redress in the Constitution itself but more explanation in the Handbook. Among the practical suggestions for improving this section were the following:

- *“The information must indicate that there is a hierarchy that people need to comply with in order to progress a complaint about NHS services and provide information that would help someone choose between making a complaint to the person or body responsible and seeking ‘judicial review of the decision’ and all points in between”.*
- On a similar point it was suggested that there should be more detail about what the NHS should do to avoid concerns escalating into complaints.



- The role of PALS should be emphasised as the first point of call
- The Constitution or Handbook should note that Welsh residents who use English services can access the Complaints Advocate in Wales
- A reference to how people can get support if they need help in making a complaint should be included.
- The Constitution should encourage patients to assert their rights and to encourage Trusts to deliver what is expected. This is preferable to the focus on concerns and complaints.

NHS East of England suggested that the wording of the right to compensation should be amended to read. 'You have the right to compensation where it has been proven that you have been harmed by negligent treatment'."

Specific comments on rights and pledges

In addition to the points above some suggestions were made about specific rights and pledges.

- **Involvement in your healthcare and in the NHS.** NHS London suggested that the reference to the right to be involved in 'decisions to be made affecting the operation of services' is potentially too loose. Healthcare providers need some autonomy to make decisions about internal operations without the need for full consultation and engagement. There are risks that service improvements may be delayed if each and every decision needs a process of consultation. However, other groups, particularly those from LINKs and Health Overview and Scrutiny Committees welcomed this and felt that the pledge to give the information should be a right.
- **Respect, consent and confidentiality.** While confidentiality is set out as an absolute right for patients, this should be qualified by a statement that there will be certain limited exceptions, such as child protection.'
- Several organisations indicated that for people treated under the Mental Health Act these rights may not apply. A helpful amendment was the addition of the following; *"If you are being detained or treated under the Mental Health Act, consent must be sought from your nearest relative or Independent Mental Health Act Advocate. Where you have made advanced decisions about your care these will be consulted by your clinical team"*. On a similar theme, one group recommended 'as part of having their views respected people with mental health problems should have a right to a second opinion'.
- **Nationally approved treatments, drugs and programmes.** Several NHS organisations as well as patient groups raised concerns about the continuation of the so-termed 'postcode lottery' in decisions about drugs and treatments that



have not been NICE approved. Others also wanted to see PCTs having clear transparent decision making processes and results of their decisions published.

Staff

Most of the unions and the national and local third sector organisations supported the list of staff pledges and responsibilities. Some general points were made about terminology. For example, one of the professional bodies suggested that it should be clear that the pledges are for all staff not simply those who work with patients. NHS London indicated that the reference to 'duties' should be replaced with 'responsibilities' mirroring the section for the public and patients. Unison raised specific concerns that this section of the Constitution felt historic and did not acknowledge the significant achievements of the NHS in good people management, which go beyond minimal legal rights. "*The government has spent considerable time and money working up from the minimal legal rights outlined in the handbook to the Constitution.*" They suggest that adding a pledge that NHS Organisations will strive to be local employers of choice.

Consultation question 11 ("Is the list of staff pledges right? Which are most helpful?")

Of the NHS staff responding to the NHS choices questionnaire 70% said that the pledges covered what was most important to NHS staff; 67% agreed/strongly agreed that they were relevant to them and their job and 82% said they were easy to understand. 14% of staff disagreed that the pledges covered issues that were of greatest importance to them. One of the professional bodies noted that some of the pledges undermine the guidance from professional regulatory bodies.

The majority of comments received were about strengthening individual pledges. These suggestions included:

- The pledge about providing staff with well-designed and rewarding jobs could be enhanced by a reference to supporting staff to achieve a good work-life balance.
- The pledge around staff development received a number of comments from professional groups and NHS respondents. One suggestion was that it should be extended to refer to clinical supervision, mentoring and other development opportunities that go beyond training. This was echoed by the PGMDE who felt that 'training' was too narrow a term and overlooked the wider requirements for doctors to undertake continuing professional development. A further point was that this pledge must be backed by action, funding and enforcement.
- NHS London and others argued that the term 'engage' staff in decisions that affect them might be more appropriately worded 'involve'.



- Several organisations felt that the NHS should pledge to protect staff from violence and harassment and safety issues around staffing levels.

Additional pledges proposed

- Several suggestions were made by the unions and professional bodies around pledges relating to pay. These included references to pay will be fair, consistent with the principles of equal pay, for pay awards to be based on the assessment of independent bodies and the right of access to an NHS pension. A reference to Agenda for Change was also recommended.
- There was a recommendation from one of the unions that the Constitution should spell out the right that staff have to join a trade union.
- The NHS will strive to deliver 'Practice Plus' status of Improving Working Lives.
- The NHS will strive to support those who report sub-standard practice.
- The responsibility for staff to act in accordance with their contracts should be mirrored by a similar responsibility on employers
- That staff should have the equipment necessary to do their job most effectively
- The right not to be expected to work beyond scope of professional practice
- The right to work in an organisation that is representative of the local community and a model corporate citizen

Apart from the points on pay, these suggestions were made by just one or two respondents.

Consultation question 12 (“Is it useful for the Constitution to set out staff responsibilities? Is the description right?”)

There was broad support from across all groups for the inclusion of staff responsibilities. Only 20% of the staff respondents to the NHS Choices questionnaire felt that the responsibilities for staff would not drive improvements in the quality of services – 42% felt the opposite was true. However, some noted the strength in language “you have a duty” as opposed to the NHS “will strive to” and patients “should”.

As with question 11, the main focus for respondents was in strengthening or clarifying staff responsibilities. There were several comments about strengthening the reference to team working. Also a suggestion that this would include working in partnership with other organisations.

Few comments were received about which pledges are most helpful. Those who did address this question highlighted personal development and training and engagement in decision making.

Additional responsibilities



A small number of suggestions were made for additional staff responsibilities:

- Staff have a duty to treat patients as individuals and in a way that they would want to be treated themselves. An alternative proposal on the same lines was to treat patients and carers with dignity and respect.
- Staff should take responsibility for the wider aims of the NHS relating to the promotion of public health and wellbeing
- You have a duty to make care of patients your first concern. While laudable this does not quite fit with comments made earlier about the focus on health and wellbeing as well as healthcare.
- Staff should have a responsibility to understand and improve the environmental impact of their work and that of their team or service
- Staff should have a duty to communicate and collaborate with colleagues to provide well-organised patient care

- NHS London recommended that the Constitution should require staff should strive to understand and respond to the different cultural needs and circumstances of local communities and to consider the part that they can play in environmental sustainability and corporate social responsibility.
- NHS East of England suggested *'The duty to protect confidentiality should extend to other information including Trust information which may also be confidential.'* The reference to 'information that you hold' was felt to be overly narrow.
- The responsibilities should refer to abiding by professional codes of conduct

One patient organisation felt that the suggestion that staff should 'strive' to take up training and development should be included in the list of duties/responsibilities.

Accountability

Consultation question 13 ("Do you support the proposal to publish a separate statement of accountability? How can we make this most helpful?")

There was support in principle for a separate accountability statement in the responses from the Unions, academic institutions, most professional bodies, and third sector organisations. 70% of the non-staff and 61% of staff responding to the NHS Choices survey supported this proposal. However, some respondents suggested they could not support a statement that they had not even been drafted.

Views from the other organisations and SHAs were more mixed. For example one organisation argued that there was a risk in a statement of accountability *'the Constitution will be most effective if it is used as a set of guiding principles for patients, staff and the public rather than being used dogmatically to hold the NHS to account, for example by setting targets'*.



One organisation felt that it would be difficult for a statement of accountability to do much to address the lack of local accountability which currently exists *“At a community level there is little opportunity for delivering local accountability and in many places little local involvement. The system of responsibility and accountability for taking decisions in the NHS should be transparent and clear to the public, patients and staff. But the system is not clear and we have not seen any effective proposals for making it so”*. Some Foundation Trusts felt that there was no further need for information about accountability as their own arrangements were already transparent.

Some organisations provided guidance on how the statement of accountability could be made most useful. While the comments did not appear to contradict each other no clear consensus was apparent. The comments included ensuring that the statement is free of NHS jargon, easy to understand and unambiguous and providing a simple easy to read version as well as a detailed document. It could explain simply the structure of the NHS and accountability processes. Some felt that accountability should be explained locally or that there should be a framework for individual SHAs and PCTs to complete. Others felt that the role of national bodies such as Monitor the CQC, NHS Institute and NICE should be included in the statement. There were also suggestions that the statement of accountability should explain the role of HOSCs, LINKs, Foundation Trust Councils and Governors.

Several organisations indicated that if there was to be a separate accountability statement this too should be subject to public consultation in the same way as the Constitution.

There were a few comments that it would be helpful to have a simple statement in the Constitution itself with further detail in the supplementary document. NHS London, however provided the following suggestions (based on the accountability chapter in the consultation document that accompanied the Constitution).

- Section 6.5 (a). This section should highlight the important role of PCTs as local leaders of the NHS, in line with the expectations of World Class Commissioning. There may be an opportunity within this section for PCTs to add details about the local menu of services available
- Section 6.5(b) needs to refer to decisions that are made on behalf of populations as well as decisions about individual patients and within the confines of the allocated budget
- Section 6.5 (c) should clarify responsibility for the scrutiny of decisions as well as the decisions themselves.
- Section 6.7 – the Local Involvement Networks referred to here are an important development but they are the responsibility of local government not the NHS. We suggest that there could be more detail included here about the



roles and responsibilities of these non NHS bodies.

- Section 6.8. There are ways in which greater democracy can be brought into NHS Appointments. However, this should be through encouraging applications from the public and from different sections of the community, including seldom heard groups, rather than through political appointments.

The Local Government Association responded

“The statement of accountability should not only make clear who is responsible for what decisions but should, on a regular basis, review whether the reformed accountability mechanisms are delivering:

- *Greater public awareness of the local health service and how to affect it*
- *Greater transparency of the local NHS decision making process*
- *Evidence of local influence over local health service and decisions affecting health in general, and*
- *A stronger role for the local population and its elected representatives in the mechanisms of local accountability of the NHS “*

Values

Consultation question 14 (“Should values be included in the Constitution?”)

The vast majority of respondents supported the inclusion of values in the Constitution but few comments were received on their actual content. Particularly positive comments were received from the unions.

“Values are sometimes difficult to express, but those set out on page 32 are comprehensive and cover all aspects of the NHS.”

“The values included may help to implement a positive ‘human rights approach’ to healthcare

There were varying suggestions about the appropriate location for the value statement. The NHS Confederation for example felt that they should be included alongside the section on Principles. Another suggestion was that the value statement should be the first part of the Constitution so they informed the rest of the text rather than being seen as a something separate. *“The values are currently devalued by being at the back of the document. Either have them at the front – or not at all.”*

While the majority of NHS organisations appear to have welcomed the inclusion of the values some did not. One NHS Trust made the following point. *“The creation of value statements is a significant and important part of any organisation’s internal development... Our preference would be for these value to be omitted from The NHS Constitution but for organisations to be encouraged to be explicit about their value*



statements driven by the purpose and principles of the NHS included in The NHS Constitution.”

The Constitution Handbook

Consultation question 15 (“Is the level of detail in the *Handbook to the NHS Constitution* right?”)

There was general agreement that a handbook was required but many commented on its target audience feeling it was too lengthy for the public but probably useful for the NHS. Many commented that a handbook should be a “how to” guide. A large majority of the respondents who commented on this question argued a number of guides should be produced that would be targeted at different audiences. There were also calls for a web based interactive document

Raising awareness of the Constitution

Consultation question 16 (“How can we best ensure that there is widespread awareness of the Constitution among the public, patients and staff?”)

A wide range of suggestions were made about ways of raising awareness of the Constitution and there was a fair degree of overlap in the responses. The ideas included:

- A nationwide publicity campaign and communications in the local media ;
- Reference to the Constitution in all NHS policy documents;
- Information in leaflets at hospitals, information screens and on hospital websites;
- Copies posted to send a copy to every household, patient and member of staff. For example copies could be sent with admissions letters or to staff attached to their pay slips
- The Constitution should be included in staff induction programmes and into leadership and management development initiatives
- Foundation Trust Governors, the PALS and other existing channels for patient and public involvement have an important part to play
- Copies of the Constitution should be available in all health and social care outlets, including GP and dental surgeries
- Department of Health, NHS Choices, NHS Direct and individual Trust websites should have a link to the Constitution and to organisations who can help with particular elements eg concerns and complaints.

In addition to these traditional communication methods some respondents identified imaginative methods such as ‘publicity material in large supermarkets, shopping centres or sports venues, advertising on the back of cigarette packets, including the Constitution in Citizenship classes and tests, inserts in community organisation newsletters, and



entries into Facebook. The development of a credit card sized summary was also suggested.

The NHS East of England who had been particularly successful in engaging a large number of staff, patients and the public in the consultation process warned that circulating information is not the same as raising awareness. The best ambassadors for the Constitution will be NHS Staff and the Local Involvement Networks. *“We should not expect a document such as a Constitution to be ‘easy to sell’. It is a text with legal status that provides an underpinning framework for the NHS in order to secure its purpose, principles and values for the future. Awareness raising amongst the public is therefore best carried out through the intermediary of healthcare professionals who can as necessary explain to patients why the constitution is important for them and for the institution they value.”* The SHA also noted that while a well timed launch for the Constitution will be helpful, as important is making sure that the Constitution is ‘mainstreamed’ as a permanent feature of the NHS rather than being seen as a temporary campaign.

Implementation and monitoring

Consultation question 17 (“How do you think implementation of the Consultation should be monitored?”)

The comment most often repeated was that monitoring should be incorporated into existing systems. Respondents appear to have interpreted *monitoring* in two ways. On the one hand, there were those who interpreted this as monitoring how well the Constitution is working generally and on the other there were respondents who concentrated on ensuring that there are appropriate incentives for NHS and other bodies were to implement the Constitution and deliver on the pledges.

Evaluating the impact

- Ensuring that the review of the Constitution is undertaken by an independent body such as the CQC or a cross party select committee

Securing effective implementation

- The Care Quality Commission expressed disappointment that their role in monitoring the implementation of the Constitution had not been given a stronger emphasis in the text. They recommended that the Constitution should be included as an additional standard in the Annual Health Check. By having the Constitution built into the regulatory framework for the NHS and healthcare provided funded by the NHS there was far less likely that patients and the public would see the Constitution as a license to take legal action. Having an independent body reviewing the Constitution was felt to be critical to its power



and authenticity. The CQC suggested that the public would not want to see the DH and NHS '*mark its own homework*'. They included an analysis of the requirements in the Constitution and those in the system of registration (include as an appendix?).

- This point was echoed by one of the bodies representing patient interests. They argued that there '*should be sanctions for non-compliance so that the results are reflected in the performance ratings for institutions and the pay and promotion prospects for individuals.*'
- Other references to incentives for compliance and delivery of the Constitution included:
 - Ensuring that Commissioners include a reference to the Constitution as part of the standard contract with health care providers
 - Assessing compliance with the Constitution in Ombudsman reviews of patient complaints
 - Including a reference to the Constitution in the NHS operating framework

Other suggestions:

- Locally and nationally
- Government to report annually to Parliament
- National advisory panel
- LINks
- National patient survey
- Staff survey
- **Annual review through satisfaction surveys and feedback;**
- **at staff appraisals;**
- **telephone surveys;**
- **community consultations;**
- **monitoring complaints letters;**
- **inhouse patient experience feedback;**
 - independent Ombudsman.
 - Parliamentary and legislative reviews
 - Bottom-up mechanisms
 - Focus on self-improvement rather than external monitoring



Some organisations made other comments on the issue of implementation and monitoring of the Constitution, a sample is provided:

“We are concerned that if there is not on-going, independent monitoring of the draft Constitution, it may be seen as a charter for litigation and expose the NHS to inappropriate claims, with all the financial and reputational costs that would imply.”

“We want clear guidance to care providers of how Trusts satisfy these patients rights and pledges so that bodies such as the Care Quality Commission are assessing care providers against clear targets, and not relying upon subjective interpretation of the Constitution.”

“The Constitution is not a conventional policy document that is designed to bring about measurable change across the NHS. Its implementation can be monitored only by how patients, public and staff respond to it.”

. This would be a useful mechanism by which the implementation and adherence to the Constitution is maintained – this could be through a ‘comply or explain’ type declaration in each organisations annual report.”