



Brent Patient Voice

A Critique of

The draft NHS NW London
Sustainability and Transformation Plan
(as submitted to NHS England on 30.06.2016)

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Brent Patient Voice Critique of the Draft North West London NHS Sustainability and Transformation Plan (STP) of 30 June 2016

Chapter 1: Introduction

1.1 This document is a commentary by Brent Patient Voice (www.bpv.org.uk) on aspects of the North West London NHS Sustainability and Transformation Plan of 30 June 2016 as published on the NWL website on 5 August 2016(www.healthiernorthwestlondon.nhs.uk/news/2016/08/05/north-west-london-sustainability-transformation-plan).

1.2 As a voluntary body we have not had the time or resources to work through all 67 closely printed pages of the STP but we welcome its publication and now offer this contribution to the urgently needed public debate about it. This is not a commentary on the “Brent STP” which has not been available in the same way. To the best of our knowledge NHS NW London have not invited the views of the public directly on the draft Plan of 30 June. There has been an online engagement process inviting answers to a limited set of questions, as well as some public meetings such as the one at Brent Civic Centre on 26th September which presented a “Brent STP” (see 2.8 below).

1.3 It must be recognised that the NW London STP is an extremely difficult document for the public to analyse for a whole number of reasons. These include the presence of diagrams and graphics not always directly related to the text, absence of numbered paragraphs following on from one another, the very small size of the font on many pages, use of acronyms, footnotes referring to unpublished documents and, most significantly of all, financial presentations using figures “plucked out of the air”, i.e. not backed up by logical steps from figures which are stated in other accepted documents. Readers are in effect being asked to sign up to articles of faith.

1.4 Apart from the complexity of the document in itself, it refers to numerous initiatives not known to outside readers – for example,

- *"People's Health & Well-being Charter"*;
- *"Healthy Workplace Charter"*;
- *"healthy living programmes"*;
- *"Healthy Living Pharmacies"*;
- *"Healthy Living Champions/Leaders"*;
- *"NHS Learning Disability Employment Pledge"*;
- *"Work and Healthy Programming"*; [bids for funds from the joint]
- *"Work and Health Unit"*;
- *"Age of Loneliness application"*;
- *"Like-Minded"*;
- *"Future in Mind Strategy"*;
- *"Connecting Care for Children GP hubs"*;
- *"HENRY"*;
- *"Healthy Living Partnership"*;
- *"HLP's Transforming Cancer Programme"*;
- *"Right Breathe Respiratory Portal"*;
- *"Right Care Commissioning for Value" packs*;
- *"Transforming Care"*;
- *"WSIC"*;
- *"PAM"*;
- *"Planned care"*;
- *"HLP's Transforming Cancer Programme"*;
- *"NWL Productivity Programme"*;
- *"Getting It Right The 1st Time"*;
- *"Change Academy"*;

- "GP Emerging Leaders";
- "Transformation Network";
- "Streamlining London Programme"

to name but a few!

1.5 In adopting this style the STP document follows the approach of Shaping a Healthier Future of 2012 which made proposals for reducing the number of acute hospitals in NW London. No lessons seem to have been learned from that flawed consultation exercise which was so roundly condemned by the Independent Healthcare Commission for North West London of 2015, chaired by Michael Mansfield QC and supported by five of the NW London borough councils.

Chapter 2: National and Local Background to STPs

2.1 Everyone, especially the media and the wider public, should appreciate that STPs are not a routine feature of the running of the NHS, though the NHS is not short of forward plans.

2.2 Their origin lies in Simon Stevens, Chief Executive of NHS England, ordaining in Planning Guidance issued to all Clinical Commissioning Groups (CCGs) and NHS Hospital Trusts in December 2015 (Delivering the Forward View: NHS Planning Guidance 2016/2017 to 2020/2021) that Sustainability and Transformation Plans for the 5-year period from October 2016 must be produced for 44 areas of England (known as "Footprints") by 30 June 2016. The areas to be included in each "Footprint" were determined centrally, not by local agreement. The CCGs were to involve the Trusts and, if they could, the relevant local authorities – although the NHS has no power to instruct local authorities to co-operate in such an enterprise. This STP covers eight North West London Borough areas.

2.3 The Planning Guidance (in the public domain) explained that the STPs had two main purposes:

- To achieve NHS financial sustainability by eliminating deficits – these were reported by NHS Improvement as amounting to £2.5 billion nationally in 15/16;
- To speed up implementation of the "Five Year Forward View" issued by NHS England in 2014, which called for "transformation" of primary care and its links with hospitals.

2.4 There were two subsidiary aims, less clearly stated:

- To achieve integration with local authority social care by offering some extra funds from the NHS budget, i.e. an inducement; and
- To introduce streamlined governance by moving CCGs out of the driving seat in favour of a small number of regional bodies with whom Simon Stevens could deal direct.

2.5 On the orders of NHS England the process of compiling the Plans has been confined so far to work by officials and the submission of 30 June 2016 has not been formally endorsed by Councillors and NHS Governing Bodies. At Appendix A of the Plan six of the NW London Councils involved enter express reservations relating to the outcome of negotiations about the funding which may be available for social care budgets. The Leaders of the two other Councils have made public statements distancing themselves further from the STP in connection with the continuance of hospital closure proposals under the Shaping a Healthier Future programme. It is understood that five of the Councils have commissioned a report (Ernst & Young) on some aspects of the STP. Clinicians have hardly been involved. It is not thought that the STP – or components – has been referred to the London Clinical Senate (<http://www.londonsenate.nhs.uk/>) although this has been done in other parts of the country. Brent Patient Voice has throughout pressed hard for public involvement. This may have been part of the reason why the NW London STP was among the first to be published, though apparently without the express approval of NHSE.

2.6 NHS England has rushed out a September 2016 "Engagement Guide", which sets out clearly the statutory duties on each of the Local Authorities, Clinical Commissioning Groups, Hospital Trusts and other NHS bodies forming part of the STP Board to consult or engage with local residents. The STP board is now described as simply a "discussion forum". The Guide is helpful in specifying how each of these bodies must consult with and explain to the North West London population.

2.7 Since publication of the June 2016 STP, Brent Council Community and Well-being Scrutiny Committee of 20 September has considered a report described as "NHS England Feedback", which presumably does "what it says on the tin". This has given a little more information about the many – sometimes apparently random and scattergun – initiatives set out in the STP. Any information helps in trying to make informed comment on these major health and social care reform proposals and financial cuts. However the relationship between the few figures given and those in the published STP is not easy to determine.

2.8 Additionally there has been a public meeting about the STP at the Civic Centre on 26 September. Representatives of Brent CCG and Brent Council gave presentations based on a "Brent STP". We pointed out that this Brent STP was not on the NW London CCG Collaboration website as part of the STP submitted on 30 June and there did not appear to be any cross references between the two documents. Nor were there any costings for Delivery Areas in the Brent presentation and there were differences in content. As stated earlier, BPV's comments are addressed to the NW London submission published on 5 August.

There is a national funding problem

2.9 It has become increasingly clear, since the Planning Guidance was issued, that although nationally NHS Trusts have been given a further £1.8 billion in 2016/17 to address their deficits and to resume a trajectory towards financial sustainability, few inside or, like the King's Fund, close to the NHS believe that this can be achieved. Recently Mr Chris Hopson, the Chief Executive of NHS Providers, has said that "the gap between NHS funding and delivery has become a chasm: something has to give" and wrote in these terms on 5 September to Dr Sarah Wollaston, MP, Chair of the Health Select Committee of the House of Commons. A hearing was held on 11th October (see 8.4 below). At a local level Sir Richard Sykes, Chair of Imperial NHS Trust, has said the equivalent about his own Trust and trusts across the country. Put simply the growth in demand for NHS treatment is seriously outstripping the funds to pay for it.

2.10 This means, in our view, that it is completely unrealistic to imagine that the organisational and methodological changes envisaged by the NWL STP can close the accumulated £1.3 billion gap foreseen for the end of the Plan period "if we do nothing" (see Finances table on p.8 of the STP). We do not consider it reasonable to suggest that some deficiency on the part of the hospital trusts will be responsible for it. For the most part, therefore, we examine the proposed activities and organisational changes and their realism to see what they mean for patients' quality and availability of care and to leave a national funding problem to a national response – or otherwise.

2.11 Much of the attraction of the STP to our Local Authorities is the hoped-for receipt of NHS monies (i.e., monies taken away from the already deeply inadequate NHS budget) to close the gap for social care funding for local authorities. The social care system is in crisis: chronic underfunding, poor quality services, ignoring of the rights of those in care to be treated in a dignified way. None of this is helped by the complexity of the system, the consequent lack of public awareness, the application of means testing, the postcode lottery funding, the financial surcharge placed on self funders, the meagre support for family carers, inadequate length care visits, training, remuneration and conditions of the paid care workforce, and the lack of robust and effective regulation and monitoring of care providers. According to the BBC on 11th October, "The whole care market for older and disabled people in England could be at risk, the official regulator [the Care Quality Commission] says" (<http://www.bbc.co.uk/news/health-37620989>).

2.12 Against this background we examine some aspects of the STP, focussing on the Executive Summary for convenience of structure, though drawing on supporting pages where appropriate. Where appropriate our chapter headings are those used in the STP.

Chapter 3: STP Foreword

3.1 We think that the Foreword to the STP (p.2) is less than candid because, among other things, it does not mention:

- The expected growth of the NWL population
- Public concern about access to GP appointments
- The adverse situation in A&E at two of our major hospitals
- Pressure on occupancy of acute beds despite increase in provision
- The fact that public health budgets have been cut by the Government
- The radical changes to the way that GPs work buried in the Plan itself.

3.2 The Foreword is signed off by:

- Dr Mohini Parmar, Chair of Ealing CCG and the STP “System Leader”,
- Carolyn Downs, Brent CE,
- Clare Parker, Chief Officer Central London, West London, Hammersmith & Fulham, Hounslow & Ealing CCGs,
- Dr Tracey Batten, CE Imperial NHS Trust,
- Rob Larkman, Chief Officer, Brent, Harrow & Hillingdon CCGs.

All of these are full time officials, except for Mohini Parmar who is a GP and elected by fellow GPs as Chair of Ealing CCG. There are no hospital consultants or elected councillors, although the next "version" of the governing body for the "STP discussion forum" will include elected councillors which – it is suggested by the NHS England Feedback Report – will "add to" the democratic accountability of the plan. None of the councillors will be from Brent.

3.3 The Foreword begs many questions and frequently makes unsubstantiated assumptions. In order to illustrate this we offer some quotations (in italics) and add our comments:

3.4 *“The NHS is one of the greatest health systems in the world saving thousands of lives each year. However we know we can do much better.”*

The clinical workforces are under huge strain. They cannot do much better without more resources and realistic forward plans to deliver a qualified workforce to meet increasing demand. We note that on 4th October the Secretary of State for Health announced plans to allow for 1500 new training places for doctors from 2018, which would be expected to produce qualified practitioners by 2025. This is well beyond the STP planning period. The announcement appeared to be Brexit-related.

3.5 *“We want to move to a service that focuses on keeping people well, while providing even better care when people do become ill.”*

Such a shift has been talked about for many years but expenditure on public health education does not produce an immediate payback. There has been evidence of the impact of public health measures designed to change behaviour in the case of smoking and excessive alcohol consumption. In view of recent findings (*Understanding the Health Impacts of Air Pollution in London*, King’s College London 2015) that outdoor air pollution, much of it from diesel vehicles, is causing 9,400 premature deaths a year in London and significant conditions requiring hospital admissions we do not understand why public health officials and CCGs are not campaigning hard

to improve air quality. Measures to prevent Type 2 Diabetes developing into a serious stage need to be intensified.

3.6 *“The NHS is a maze of different services making it hard for users to know where to go to when they have problems. We want to simplify this, ensuring that people have a clear point of contact.”*

This is not a big issue among patients. A patient handbook could help. The GP is the normal point of access for diagnosis and routine treatment. The Accountable Care Partnership plans (see 6.21 and following paragraphs below) could damage this bedrock of the NHS by restricting access and, contrary to their name, being less accountable than direct providers who are part of the NHS.

3.7 *“The quality of care varies across NW London. We want to eliminate unwarranted variation to give everyone access to the same, high quality services health is often determined by wider issues such as housing and employment - we want to work together across health and local government to address these wider challenges.”*

Variation in provision within NW London is not generally an issue. Nor does the Plan produce evidence that there is such variation. We believe that this is code for reducing costs to the lowest common denominator under the “Right Care” scheme. London is an area of high employment but low wages in some sectors, while the provision of additional social housing is minimal, arising directly from the absence of government subsidies. Even “affordable housing” at 80% of market value is of little help to those likely to be affected by “social determinants of health” in a high cost area such as Brent. It is an illusion to suggest that the NHS or even local councils can solve this without a major change in Government policy. However, we support NHS and Council assistance to patients whose condition may make employers or landlords reluctant to take them on, such as sufferers from sickle cell disease.

3.8 *“NHS England has published the Five Year Forward View. Local areas have been asked to develop a Sustainability and Transformation Plan (STP) to help local organisations plan how to deliver a better health service that will address the FYFV “Triple Aims” of improving people’s health and well being, improving the quality of care that people receive and addressing the financial gap.”*

The 44 Footprint areas (of which 8 NW London boroughs is one) have no basis in NHS or local government legislation and are seen by “old hands” as an attempt by NHSE to bypass CCGs and resurrect regional health authorities.

3.9 *“Clinicians across NW London have been working together for several years to improve the quality of the care we provide and to make care more proactive, shifting resources into primary care and other local services to improve the management of care for people over 65 and people with long term conditions.”*

This is misleading if it is meant to suggest that there is clinical support for the STP. If it refers to the Whole Systems Integrated Care (WSIC) process our view is that this has been driven by highly paid management consultants to pave the way for ACPs and capitated budgets. Considering that “Better care, closer to home” was the key mantra of *Shaping a Healthier Future*, launched in 2012 with such fanfare, it is astonishing that so little has been achieved over four years in shifting care into the community, at least in Brent.

3.10 *“The NHS and local government have worked closely together to develop a mental health strategy to improve well being and reduce the disparity in outcomes and life expectancy for people with serious and long term mental health conditions.”*

We believe that the mental health care system is still a Cinderella in NW London and note that at the end of the STP it is scheduled to receive only 8% of the healthcare budget, as now.

3.11 *“a NW London STP that addresses the Triple Aim and sets out plans whilst increasing local accountability.”*

We find it laughable to suggest that the complexity of the governance proposals set out in Appendix B will increase accountability. We know that originally NHSE wanted officials from the CCG and local government to be delegated to take STP decisions in meetings without reference to Governing Bodies or Council Committees. This would be the very opposite of increasing accountability. It is reminiscent of the “doublespeak” so memorably described in George Orwell’s novel *Nineteen Eighty Four*.

3.12 *“The STP provides the drivers to close the £1.3bn funding shortfall.”*

We need to remind all readers that a funding shortfall means that more patients are being referred or are turning up for treatment than are provided for in the budget. We are not aware of evidence of large scale duplication or waste in the system. See also paragraphs 2.9 and 2.10 above.

3.13 *“Concerns remain around the NHS’s proposals developed through the Shaping a Healthier Future programme. All STP partners will review the assumptions underpinning the changes to acute services and progress with the delivery of local services before making further changes. We recognise that we don’t agree on everything.”*

It is hard to find anyone who is not on the NHS payroll who supports the SaHF strategy. Secrecy about the implementation plan has seriously eroded whatever readiness there might have been on the part of councils and the public to engage. While faster discharge from hospitals of patients who no longer need acute care will benefit them and help A&E through-flow, the notion that more specialist services can be consolidated with advantage has not been demonstrated. The failure of the NHS in NW London to convince the public and local councils that SaHF is a responsible and viable plan must hugely dent the credibility of the next iteration of a major NW London healthcare plan in the form of the present STP.

3.14 However the STP makes clear what the lead accountable officer for SaHF stated at the Councils’ Joint Health and Overview Scrutiny Committee in May of this year: that the Treasury wishes to take at least a proportion of the capital receipts from the land sales required to fund the capital investments envisaged by the SaHF business case. The STP sets out failure to retain or realise capital receipts as a risk to the STP programme, and its only mitigation of that risk is to ask for the assistance of NHS England to pressurise the Treasury.

Chapter 4: Health & Social Care in NWL not sustainable

Absence of state-pressure-response analysis

4.1 If the document of 30 June 2016 was a proper plan and not a selective presentation for NHS England purposes, it would need to follow the classic pattern of “state-pressure-response”.

4.2 In other words, starting on page 4, it would describe the situation: the population of the area, broken down by borough and by age, sex and ethnic group, the numbers of people by these categories who are using the different health and social care services, acute, community, GPs, residential care etc, the differences in use of services and outcomes if known, the numbers of staff in the various sectors; the pressures: expected changes in population; expected financial and human resources, including the NHS budgetary plans for slower growth, outputs from medical and professional training; followed by the gaps to which the pressures might give rise and the possibilities for filling them, along with the consequences of not doing so.

4.3 This is the kind of information the Joint Strategic Needs Assessments (JSNAs) for each borough provide as the basis for healthcare planning. If NHSE want planning across the 8 NWL boroughs (and similar areas elsewhere) then the STP would be expected to contain an analysis and amalgamation of the 8 existing JSNAs, plus new factors such as the potential effect of Brexit on staff recruitment and retention. There is no sign of any attempt to do this. Page 4 of the STP contains a mass of compressed information but not in systematic form. The STP therefore amounts to forward planning in a fog.

Absence of serious forward population projections

4.4 An important omission in the STP is the absence of serious assessment of the current population of the area or statement of expected change by 2020.

4.5 The ONS (Office of National Statistics) who conduct the Census are the official public agency responsible for providing these figures consistently at national and lower levels but they do not seem to have been asked to supply them. ONS is assisted by the GLA in the case of London but there is no evidence of input from them. Instead we are aware of a request to the 8 boroughs by the NWL Collaboration of CCGs in a paper for the Joint Health Oversight and Scrutiny Committee on 10 May 2016 to comment on an assortment of figures for each borough culled from various sources. We wrote to the Chief Executive of Brent for clarification of the factors taken account of in the figures for Brent. In response we were then shown a letter from Brent to NWL CCGs sent before the paper was submitted. This did not clarify the situation.

4.6 All that is provided on gross population figures in the STP is on p.14 where the numbers are "2.1 million residents and 2.3 million registered patients in 8 local authorities". These numbers presumably relate to the present. The question that follows is what are the estimates by borough and in total for 2020? This is not academic but essential if the STP is to be a credible exercise.

4.7 As far as Brent is concerned we know from the JSNA that births are more than twice deaths annually. We also believe there is net inward migration as Brent receives its share of the 300,000 annual national growth in inward migration and a presumption that a significant number of the occupants of new flat developments around Wembley Stadium and elsewhere will be from outside the Borough. We find it surprising that a five-year forward plan should lack population estimates for the period of the plan. This kind of forward planning is commonplace in education, where it is necessary to calculate numbers of school places needed in the short and medium term.

4.8 However, in response to written questions submitted to the STP team in connection with the Civic Centre meeting mentioned earlier we have now been advised that the ONS population estimate for the 8 NW London Boroughs in 2020/2021 is 2,188,680, which implies an increase of some 88,000 (an average of 11,000 per borough) over the period. We have not been given figures for individual boroughs. We are not in a position to challenge the ONS but the projected increase looks to be on the low side, bearing in mind the factors we have cited.

4.9 Instead of providing a comprehensive overview of the population and its expected growth up to 2020/21, pages 4 and 16 of the STP offer a selective menu of facts and generalisations, presumably designed to support the measures proposed as priorities.

Other issues arising from page 4 (not exhaustive)

4.10 No particular justification is offered for the 9 "segments" into which the current population is divided. Some are very small. They do, however, link to the population segmentation approach set out in Whole Systems Integrated Care, and the national NHS initiatives on data collection. Surely a debate is needed about whether the segments are the best basis for planning future healthcare or are being highlighted as a convenient financial planning tool?

4.11 In our view it would be more useful to detail the main conditions which cause people to go into hospital for emergency or planned care, be treated in community settings or by their GPs.

4.12 We would wish to see the main conditions causing death and a serious impact on personal health set out in order of importance.

4.13 Why is cancer singled out but heart conditions not mentioned? Why are arthritis and other musculoskeletal conditions not mentioned when they are cited by patients as the long term conditions which give rise to up to 60% of days off work, i.e. the largest category of such conditions? (See *the Musculoskeletal Services Framework – A joint responsibility: doing it differently*. Department of Health 12 July 2006, Gateway ref: 6857.)

4.14 Why do the graphics show future population at 2030 when this STP is for the period up to 2020 and is supposed to deliver immediate improvements in patient outcomes and immediate savings? Do the forecasts for 2030 take account of proposals in this and other NHS plans for improving health outcomes or not? Or is it assumed that everything will get worse?

4.15 What is meant by “potential market failure in some sectors”? If it means that the provision of care homes by the private sector is not meeting demand, this should be stated and alternative strategies discussed.

4.16 At present the STP does not define “long term conditions”. The term is constantly used as an indicator of complex needs on the part of older patients, for example the over 65s, but there are various long-term conditions affecting hearing or eyes, for example, which do not prevent people living active and otherwise healthy lives. This is crucial to the understanding of Delivery Area 2 especially as its delivery will include a capitated budget and – as illustrated by the sickle cell pilot project budget discussions referred to below – when decisions are made to fund certain long-term conditions, money will not be available for others.

4.17 In response to our questions to the STP team on this matter we have been advised that for a definition we should look to the list on p.19 of a 2014 document from the London Health Commission: “Better care designed around people: New Models of Care for London’s population.” This document appears to be archived and not readily available, although we have been sent a copy. We quote from p.19: “Conditions included are: hypertension, chronic obstructive pulmonary disease, heart failure, stroke, coronary heart disease, cardiovascular disease, asthma, diabetes, chronic kidney disease, epilepsy and depression. This does not include physical disability, severe and enduring mental illness, learning disability, cancer, or dementia.” We think it would be helpful to include this list in the next version of the STP, if indeed it is definitive. We note that the list does not include neuro-degenerative diseases or musculoskeletal conditions.

4.18 What is the basis for projecting a 36% increase in people with long-term conditions by 2030 (from 338,000 to 458,000)? What is the estimate for 2020?

4.19 What is the basis for the extraordinarily sweeping statement “Over 30% of patients in acute hospitals do not need to be in an acute setting and should be cared for in more appropriate places”? This is referenced by note 5 “System-wide activity and bed forecasts for ImBC”. The implementation business case is an unpublished document and in any event not independent because it represents the NHS’s own view of the need for acute beds for the population of NW London. It does not provide evidence of current needs. However, [a new study](#) by the Health Services Management Centre and Department of Social Policy and Social Work, at the University of Birmingham, shows that only 9% of a cohort of hospitalized older people felt that they could have been cared for elsewhere. Even in these cases their GPs disagreed and considered that all were appropriately treated.

Chapter 5: The North West London Vision

5.1 Page 5 adds little value to the Plan. If taken literally it is untrue. At best the graphics are misleading.

5.2 The green triangle shows that “pro-active” care will be 4 times greater in 2020/21 than it is now and that “acute and residential care” will be 4 times smaller. This is not credible and cannot be intended.

5.3 By way of contrast the expenditure pie-charts on p.45 show no expenditure on “pro-active” care and spending on acute decreasing from 42% to 36% by the end of the period. Even this is hardly likely when acute specialisms are constantly developing and spending on acute services is on an upward trend (see regular Trust performance reports to Brent CCG Governing Body).

5.4 The aspirational statements on the right hand side of the page that the authors claim patients will be making by 2020 are totally unrealistic and merely inspire cynicism. For one thing nobody talks like this. If these are the aims there are far better ways of expressing them.

Chapter 6: The five Delivery Areas

6.1 This is the “substance” of the clinical part of the STP. Are the nine priorities ones that patients would recognise or choose? Have clinicians contributed to or approved these texts? Have local GPs and hospital doctors been involved? Who has decided that the five “Delivery Areas” are appropriate or a useful concept? What is a patient with a condition that does not seem to fall within one of these areas to think about the priority they may receive? How much commissioning activity/expenditure falls outside the “Delivery Areas”? Why is there no total picture of health service activity in the area and trends included in the Plan? Where is any overall budget? We have asked the STP team the last four of these questions in connection with the 26 September “engagement” event but received no answers.

6.2 Below we comment in varying detail on the projects mentioned in the Delivery Areas.

Delivery Area 1: Radically upgrading prevention and wellbeing

6.3 More details of what is proposed under DA1 can be found at page 22 of the Plan. DA1 is divided into 4 sections:

6.4 **DA1: Section A:** Supporting healthier living. This includes setting up a Primary Care Cancer Board to improve public messaging/advertising around preventing cancers and producing a “People’s Health & Wellbeing Charter” and a “Healthy Workplace Charter” to improve the mental health and wellbeing of NHS staff – all this in 16/17.

6.5 During the rest of the period there will be

- training GPs and other staff in Health Coaching,
- delivering an enhanced 111 service,
- case finding to identify those at risk of dementia, diabetes and heart disease,
- promoting a community development approach to improve health,
- supporting Healthy Living Pharmacies to train champions to promote smoking cessation,
- annual health checks for people with learning disabilities.

6.6 The investment in Section A projects over five years and eight boroughs is £200,000 or £5,000 per borough per year. The projects may be very worthy, though without more detail judgement is impossible. The STP then claims that this very modest expenditure will save £2.5 million over the five-year period. Where is the evidence?

6.7 **DA1: Section B:** Wider determinants of health interventions. This includes in 16/17 signing the NHS Learning Disability Pledge to promote the employment of people with learning disabilities; co-designing the new Work & Health Programme to support people with learning disabilities and mental health problems in work; and bidding for funds from the Work & Health Unit to support social prescribing for people with the conditions mentioned.

6.8 For the rest of the period there will be working with local authorities to reduce alcohol consumption, to provide supported housing for vulnerable people and partner with organisations like the London Fire Brigade to tackle social isolation and poor quality housing. BPV comment is that according to a Fire Brigade Union survey in 2015 the personnel of the London Fire Brigade were reduced by 13.9% over the previous five years. Have the LFB agreed to their inclusion in this STP programme? When the STP describes the “workforce” on p.35 of the Plan the Fire Brigade seem to have been forgotten, although at the same time 103,001 (sic) unpaid carers have been recruited as “NW London Staff FTE”. Did anyone ask them?

6.9 The cost of these Section B measures is given as £3.3 million over five years, equivalent to £82,500 per borough per year, while the saving resulting is put at £6.5 million. Our comment on this is that if the whole of the £3.3 million was devoted to housing it would provide very few units in total over the five years. It is also ironic that co-operation with the London Fire Brigade is highlighted when their application to join the Brent Health & Wellbeing Board was brusquely rejected quite recently.

6.10 **DA1: Section C:** Addressing social isolation. In 16/17 this includes enabling GPs to refer patients to non-clinical services such as employment support and piloting the “Age of Loneliness” application in partnership with the voluntary sector. Later “we” will ensure all socially isolated residents who wish to can increase their social contact, enable GPs etc to direct socially isolated people to support services and through Like Minded make a “no health without mental health” approach real”.

6.11 The cost of these services is given as £500,000 or £12,500 per borough per year, while the estimated saving is £6million or £150,000 per borough per year. While this all looks very desirable we must question whether GPs have any spare capacity to take on wider social advice roles or whether the savings figures are remotely credible, particularly bearing in mind the statistic quoted at the most recent meeting of the 8 CCG's Joint Primary Care Co – Commissioning Committee in Marylebone Road that 3 – 5 GP practices are closing per week in Northwest London.

6.12 **DA1: Section D:** Helping children to get the best start in life. At present the various measures and possible savings are un-costed, making comments superfluous. As at 12th October 2016 the STP team have not provided the missing financial information.

6.13 Our overall reaction to Delivery Area 1 is that the measures listed on p.22 of the Plan cannot realistically be described as they are in the title “*Radically upgrading prevention and wellbeing*”, even if they could all be achieved which looks most doubtful. The total expenditure projected over 5 years (ignoring Section D) is £4million and the gross savings are given as £15.6million, making net savings of £11.6million. We question whether such derisory expenditure will have a measurable impact, while the savings suggested look extremely optimistic. We find it astonishing that there is no suggestion of a major effort to persuade the thousands of people at risk of developing Type 2 Diabetes to change their lifestyles. This is one measure which in the relative short-term could deliver radically improved health and save the NHS money.

Delivery Area 2: Eliminating unwarranted variation and improving Long Term Conditions management.

6.14 The programmes in this Delivery Area are not strongly related but include improving cancer screening, better outcomes for people with mental health and long term physical health problems, reducing (cost) variation using the Right Care tool, and improving self-management and use of the patient activation (PAM) tool.

6.15 The first and second of these programmes are not costed, though both are highly desirable.

6.16 The third and fourth require spend of £5.4million and are set to save £18.5million, a net saving of £13.1million. We comment that the Right Care initiative (comparing by cost what other purportedly comparable CCGs pay for a range of treatments) is hotly contested as a reliable statistical tool. Moreover we ask, is “cost” alone an appropriate comparator when talking about health outcomes? In addition the benefits of PAM must be very hard to quantify, particularly at this early stage in its use in the UK. We have yet to see a concrete example of a PAM tool in action applied to a particular Longer Term Condition, despite requests. Interestingly, at page 19 of the 27 May 2016 paper by Shona Fearn & Ant Scott “NW London Transformation Paper 3.1” in Appendix C (rationale of initiatives not recommended for prioritisation) PAM is included because “PAM is an enabling tool with no direct benefits”. We suggest that these measures need much more work before reliable estimates can be derived from them and before confidence can be placed in them as positive instruments for improving healthcare.

6.17 More generally there is significant overlap between Delivery Area 2, Long Term Conditions, and Delivery Area 3 Better Outcomes for Older People, whereas “eliminating unwarranted variations” is general in character and not related specifically to long term conditions.

6.18 We must highlight there is no definition in the current draft of the STP of what a " long-term condition" is. However we have now been given the information set out in 4.16 and 4.17 above. Having now been advised as to what conditions that terminology covers, how can the public be reassured that the data set out on page 23 of the STP is correct - 338,000 people with long-term conditions, as defined, account for 75% of total healthcare spend? At present the STP contains no statement of total healthcare spend in NW London.

6.19 It is apparent from the September 2016 meeting of Brent CCG Governing Body that the STP is moulding the view of how patient health will be paid for – those residents suffering from long-term conditions (LTC) will be allocated an overall budget, and essentially the health care system will have to be "fought over" for a share of that LTC budget.

6.20 This was starkly illustrated by the recent furore over the Brent Sickle Cell Advice and Support Service pilot project. At the CCG meeting, reference was made to the conundrum that, if the £74k annual budget for the Sickle Cell pilot was given to this group of patients with that LTC, it had to come off the total budget for Brent LTC's. The response of the CCG to our MPs' queries contained the chilling sentences "The pilot has spent roughly £1700 per patient. A hospital inpatient episode – i.e. the sort of crisis the pilot is designed to prevent – is roughly half that the cost" – i.e., because it is cheaper, the CCG would prefer sickle cell patients to go into crisis and hospital – the complete reverse of what the stated purpose of the STP is. We can only hope that this was an unfortunate sentence and does not truly represent the philosophy of the Brent CCG.

6.21 Is it surprising that patients struggle to see the benefit of the segmentation approach of the STP - where the principal concern of the project appears to be to collect detailed data for the purpose of business intelligence, averaging the cost of care episodes of defined sections of the population, so that it can hand over to Accountable Care Partnerships lump sums for the care of that entire section of the population, on which such partnerships can either save money to keep for themselves, or absorb the excess costs actually expended?

Delivery Area 3: Achieving better outcomes and experiences for older people

6.22 This is the section of the STP where the model of the segmentation approach referred to in the above paragraph appears most starkly. It is also a substantial concern that major parts of the STP savings come from this Delivery Area.

6.23 According to page 26, the "better outcomes and experiences for older people" will be achieved:

In Section A, by developing what is articulated as the inadequate in numbers and financially failing care homes market "alongside a Northwest London market position statement" (whatever that is) - certainly, no analysis is undertaken about whether it might be cheaper to re-provide a local authority based care homes sector.

In Section B by commissioning “the entirety of NHS provided older people's care services in North West London by outcomes based contract(s) delivered by Accountable Care Partnerships with joint agreement about the model of integration with local government commissioned care and support services. All NHS or jointly commissioned services in North West London contracted on a capitation basis with the financial model incentivising the new proactive model of care". It is not reassuring to find that, in order to do this, NO investment will be made at all but a saving of £25.1m is anticipated. How can this be? Some further explanation is needed.

In Section C by the creation of GP federations, “enabling the delivery of primary care at scale” seen as another means of achieving better outcomes and experiences for older people, whereas, instinctively older people are best cared for within the "old-fashioned" concept of GP "family doctor"

practices, which have known them for many years. In addition there is to be development of older persons frailty service at Ealing and Charing Cross Hospitals.

6.24 In terms of social justice, older people are likely to be the ones who have contributed most to the NHS over the years, and therefore – ethically – entitled to "cradle to grave" care on the that previous NHS basis.

6.25 On a positive note, no one could object to the concept of taking whatever is evidenced to be the best of the "STARRS" - type discharge and rehabilitation services across the 8 CCG's to improve care across North West London. (Sections D & E)

6.26 However, very big savings are envisaged – £64.9M, for example in Section D – but with no indication of how this will be achieved, on an evidence basis. It is inescapable, therefore, to conclude that the major part of these savings come from the reference to "improve the rate of return on existing services reducing non-elective admissions and reducing length of stay through early discharge" and "enhance integration with other service providers" – which are both such nebulous concepts that it is impossible to comment on them.

6.27 The only measures to achieve better care for the elderly are articulated as: ACPs and contractual routes to better care. Creating ACPs with new "contracting & commissioning approaches "to change the incentives for providers". These will be commissioned "on an outcome basis" – our experience of workshops intended to create "outcomes" for contractual KPI's are that these are vague and aspirational, and unlikely to add strong enforceability to contracts which will in reality secure benefits for older people.

6.28 The reference to "incentives for providers" is concerning. Even if these new contracting ACPs do not work to save money on the provision of care for the elderly, there will inevitably be a suspicion on the part of their patient cohort that that is what they are doing. The reality is that if they save money on providing services – of all descriptions – to that segment of the population represented by "older people" – they will keep it. If, on the other hand, the exercise of creating a budget for this segment of the population and all its care results in the care for all this population costing more, the ACP bears the risk. What does "bears the risk" mean in practice? It may mean that the ACP goes bust – who then provides the care? What will be the effect on the component organisations forming the ACP? Will GP practices go under? What happens if individual "component elements" of the partnerships just wish to extract themselves? The paper 'The multispecialty community provider (MCP) emerging care model and contract framework' at <https://www.england.nhs.uk/wp-content/uploads/2016/07/mcp-care-model-frmwrk.pdf> refers in terms to preserving the flexibility for GP's to the possibility of their returning to their GMS/PMS contracts.

6.29 What will be the loss to the NHS generally of all the time and money that will be taken in constituting these ACPs, advising the constituent bodies (including individual GP's making up the federations) and paying for the numerous consultants? Paper 5 on new models of care presented to the 8 North West London CCG Joint Primary Care Committee in June 2016 set out £8.5m in costs – mainly professional, legal etc – but without any formal "costs/benefits" analysis. As above, NHS Providers have expressed total doubt that these new models of care can be implemented within a timescale of 15 years. Yet the whole STP is predicated on their formation.

End of Life Care – now renamed "Last Phase of Life"

6.30 Page 25 of the STP states – without any apparent evidence – that "4 in 5 people would prefer to die at home but only one in 5 currently do".

6.31 Whilst that may be the wish that many people articulate, it ignores the fact that – at the end of life – many interventions will be needed in terms, for example, of palliative care – which can only be delivered in an acute setting. It does not bear thinking about if the elderly or terminally ill are to be delivered to home, without, for example, appropriate community Nurse support for morphine pumps, change of continence pads, turning every couple of hours, etc.

6.32 In view of the fact that – under current circumstances – the type of care is likely to be delivered by the "social care" part of the STP – which is chronically underfunded – these proposals risk an increase in suffering for those in the "last phase of life".

6.33 There is one reference on page 26 which is puzzling to the uninformed reader. That is in respect of "identifying when someone is in the last phase of life". Section F on that page states that they will "Improve care in the last phase of life" by identifying "the 1% of the population who are at risk of death in the next 12 months by using advanced care plans as part of clinical pathways and the surprise test". In fact, we now gather the "surprise test" (in which the GP is asked "would you be surprised if this patient died in the next 12 months?") is part of the Golden Framework for end of life care planning – but looking at the detail of the test, it does not save money, as indicated might be the case in section F on page 26.

6.34 By 2020/21, "every patient in their last phase of life is identified" and "every eligible person in North West London" will have a "Last Phase of Life care plan". In addition, the STP will "reduce non-elective admissions for this patient cohort by 50%". With no evidence-based support for how that reduction will be achieved, the natural suspicion is that – to achieve this – we will simply be allowed to die earlier! A cautionary note is sounded by The Commissioning Review News which highlights that the doctors are often inaccurate when predicting how long terminally ill patients have to live <http://www.thecommissioningreview.com/article/doctors-frequently-fail-predict-death-terminally-ill-patients-research-finds>. In any case reducing non-elective admissions by 50% for any patient cohort is likely to be very hard to achieve.

Care homes and the "market"

6.35 It is not particularly aspirational to note that, on page 26, the aspiration by 2020/21 in section A is that the STP will "implement market management and development strategy to ensure it provides the care people need, and ensuring a sustainable nursing and care homes sector, with most homes rated at least "good" by CQC". Does "**most**" mean at least 51%? What is the present percentage?

6.36 A further concern arises in relation to care homes, and the Digital aspect of the STP. Paper 5g of the Digital Primary Care Transformation Fund 2016/17 bid document presented at the 8 North West London CCG's Joint Primary Care Co – Commissioning committee in June refers to a bid summary for investment in "care homes" "to improve the Digital maturity between primary care and care homes through the use of technology to provide a structured and proactive approach to care, complemented by mobile working for primary care".

6.37 It is worth quoting this bid document because it refers to the "funding sought £222,000 will initiate a pilot project to fund 16 care homes through an expression of interest process to develop systems process and information governance for digital communication information; provide terminal equipment to support video consultations and make available clinical software and training to qualified staff to access patient records".

6.38 This worthy sounding project in fact suggests visits to care homes by GPs should be substituted by consultation by video. This appears to be potentially dangerous, e.g. how would you carry out a dehydration test remotely? Yet dehydration is a common occurrence among the elderly.

6.39 At the same co-commissioning meeting, Dr Tony Grewal – then London wide medical director for the LMC – asked to be minuted as saying not only that "if nothing is done by NHS England, in 6 months in North West London, there will be NO GP practices" but also that, in his experience, about 10% of the information gleaned in a patient appointment is obtained from the words issued by the patients, and the rest is from their body language, and examination. How – in any sensible analysis – can it benefit of patients in care homes if GPs are no longer to go and see their patients in a care home setting? No doubt we are old-fashioned but – in the case of care home patients – surely their vulnerability would require actual physical visits to ensure their health (at the positive end of the spectrum) and prevent possible abuse (at the negative end)?

Availability of social care provision to the patient at home

6.40 On page 25 "increasing intermediate care to support people to stay at home as long as possible and to facilitate appropriate rapid discharge when medically fit" is instanced as one means by which the care offered to older people will be fundamentally improved. The difficulty with this is that it requires substantial investment in social care – which, of course, is also largely self funded, and, where not self-funded, critically limited in accessibility. If savings are to be achieved by keeping people out of hospital who simply cannot access care in the community, then the STP savings will be at the cost of real but hidden suffering in the elderly community.

Economic benefit of older people

6.41 It may not be surprising but the STP makes no explicit attempt to explore the economic benefit of the elderly, retired community to the nation. Of course, as referred to above, this cohort/segment of the population provides the "unpaid carers" section of the "Workforce" but otherwise "older persons" are simply a segment of the population which "costs". Some attempt should be made to quantify the positive/invisible balance in the equation. Older persons also crucially provide a large proportion of the volunteers in the 3rd sector on which many parts of the STP rely.

6.42 This is particularly true, where almost everything in Delivery Area 3 relates to issues of contracting and outcomes, rather than a real attempt to address how to achieve better outcomes for this section of the population. There is no attempt in the STP to undertake an equality analysis of this group – but this is equally true of other sections, such as Mental Health.

Delivery Area 4: Improving outcomes for children and adults with mental health needs.

6.43 The programmes cover implementing the new model of care for people with long term mental health needs, addressing wider determinants of health, delivering the "Crisis Care Concordat" and implementing "Future in Mind" to improve children's mental health and wellbeing.

6.44 Spending on the first programme is put at £11million with a gross saving of £16million, making a net saving of £5million. There are no costs for the remaining three areas but, somewhat strangely, savings of £6.8million for two of them. It is not clear how gross savings can be estimated when costs are not stated. Normally benefits are harder to quantify than costs. In the detail of DA4 on p.28 it is stated "The benefit to the patient will be a fuller, happier way of living". Precisely, but how do you turn this outcome into a saving of £5million?

6.45 DA4 describes a number of desirable initiatives but with so many financial gaps and puzzling statements it does not seem to be a reliable component of the financial strategy at this stage.

6.46 Whatever the aspirational wording of this particular Delivery Area 4, the reality is that – even in a disability conscious employer environment like Brent Council – the proportion of employees identifying themselves as disabled is very low, and the number identifying themselves as affected by mental health issues is tiny: see recent report to the Equalities Committee. Conventionally, the trite expression in society is that one in four citizens is likely to suffer from some form of mental health condition in their lifetime. The STP does not deal with the difficulties of those suffering mental health conditions likely to require treatment by secondary care. IAPT (Improving Access to Psychological Therapies) strategy is neither suitable for those with more serious mental health conditions nor contractually available.

6.47 Anecdotal reports of recent mental health patients discussing their situations with BPV of extreme difficulties in accessing crisis care. Both have resulted in attendances in A & E to avoid suicide, and police intervention. Discussions with these patients have revealed: problems in the provision of follow-up services; constant turnover of care coordinators/agency staff leaving with no notice; turnover of psychiatrists and only locum staff attention; arrival at meetings with vulnerable patients without any notes; non-arrival of referral letters; patients contacted "threatened" with discharge because of non-attendance at meetings referred to in those referral letters; discharge of vulnerable patients made homeless; and having to access homeless accommodation outside usual Borough, with no assistance by referral to the Borough where patient's hostel is based.

6.48 Beds for patients requiring inpatient services are critically few in number and patients are being sent many miles away. A report at Brent Council's Extremism event on 3rd October refers to Central North West London MH Trust having only one permanent clinical psychiatrist. The recent Centre Forum report highlights Brent a having 6 months CAMHS waiting list
<http://centreforum.org/live/wp-content/uploads/2016/04/State-of-the-Nation-report-web.pdf>.

The Brent CCG June 29 2016 Finance & QIPP Committee minutes refer to funding for Mental Health Transformation work being reduced and that the CCG could no longer access Like Minded funding which had to be accessed via Central North West London MH Trust. So the STP is dealing with a situation where budgets have already been reduced, and evidence from important service areas such as CAMHS shows that Brent was already in crisis at the time of Centre Forums report in April 2016.

6.49 We have a query over the validity of picking of "segments" of mental health care, such as eating disorders/conduct disorders but with no overall aspiration to deal with, for example, nationally media acknowledged mental health issues for children. The problem is particularly exacerbated because of, for example, the issues affecting school nurses. Again, a recent edition of The Commissioning Review News refers to school nurses.
<http://www.thecommissioningreview.com/article/paperwork-prevents-school-nurses-identifying-abuse-says-children%E2%80%99s-commissioner> .

6.50 Again, anecdotally, how is the provision of School Nurses affected by the different types of school provision – maintained/academies/free schools? There is no reference in the STP as to whether the category of school provision in any way affects the work of school nurses.

6.51 The graphics in Appendix D, *Further information about our Mental Health and Wellbeing Transformation*, are hard to follow and do not appear to tie up with the suggestion that there is only likely to be a 1% increase in serious medical conditions over the period covered by the STP according to the "segment" graphics on pages 4 and 14. Generally the world depicted in the "Like Minded" Appendix seems to be a long way from the reality experienced by patients as recorded in paragraphs 6.47 and 6.48 above.

Delivery Area 5: Ensuring we have safe, high quality sustainable acute services.

6.52 This area is about large savings. DA5 is planned to contribute savings of £208.9million to the financial gap. There are 4 sections:

- Specialised commissioning to improve pathways from primary care & support consolidation of specialised services;
- Deliver the 7 day service standards;
- Reconfiguring acute services;
- NW London Productivity Programme.

6.53 The Specialised Commissioning section covers:

- Hepatitis C programme,
- Service reviews of HIV work, Paediatric transport, CAMHS (Children and Adolescent Mental Health Services) and neuro-rehabilitation,
- Increasing tele-medicine
- Implementing the Clinical Utilisation Review
- Being active in "Like Minded"

All the above are in the current year. For the rest of the period the activity described consists of vague generalisations such as "To have met the financial gap we have identified of £188m over 5 years on a "do nothing" assessment" and "To actively participate in planning and transformation work in NW London and Regionally." These words do no more than repeat the overall objectives of the Plan and add nothing to public understanding. There are no numbers for expenditure or savings. "Like Minded" has already been assigned to Delivery Area 4, so it is not clear what it is

doing here. We have been advised that the STP includes activity commissioned by NHSE and we therefore assume that this section on specialised commissioning is part of it.

6.54 Delivering the 7-day standards consists of plans to work towards 4 of the required standards this year and to continue work on the remaining 6 during the remaining 4 years. While it must be accepted that the Government have stated repeatedly that the 7-day service is a manifesto pledge, the medical profession have repeatedly responded that no adequate description has been offered as to what is meant by a 7-day service and that the Government have given no indication as to where the necessary staff are to be found without reducing treatment from Mondays to Fridays.

6.55 The STP costs this work at £7.9million and claims it will result in a saving of £21.5million. It is far from clear that there is public demand for all acute hospitals to provide elective as opposed to emergency care at the weekend. Take up of extra GP appointment at “Hubs” in Brent at weekends suggests that demand falls off after Saturday mornings. This is clearly an area where direct public consultation to see if demand exists would be desirable. BPV does not believe that this is a priority for the public, nor that it will yield savings.

6.56 Reconfiguring acute services in this STP is essentially about ending the role of Ealing as an acute hospital, thereby closing an unspecified number of beds and the A&E Department. Instead there would be (presumably elsewhere to allow the Ealing Hospital site to be sold) “a network of ambulatory care pathways, a centre of excellence for elderly services, a GP practice and an extensive range of outpatient and diagnostic services.” In addition there would be a reduction of up to 40% of face to face outpatient consultations by using technology.

6.57 During the early stages of the STP process the NWL Collaboration used a figure of 592 beds for closure in a paper for the local authority Joint Health Oversight and Scrutiny Committee but this was removed from the text before the June STP was finalised. We imagine that this was a tactical move rather than a change of intention. The cost of “reconfiguring” is given as £33.6million and the savings as £89.6million. There is no evidence that clinicians consider that such a large closure of acute beds would be safe or that the alternatives are realistic. The proposed closure of Ealing Hospital or radical re-configuration of its functions appears to be financially driven and unacceptable in a situation where demand for both secondary and primary care NHS services is growing. See also our commentary on page 7 of the Executive Summary.

6.58 The fourth and final component of DA5 is “The NW London Productivity Programme”. The sub-sections (which seem to be unrelated) are patient flow, orthopaedics (Getting it Right First Time – just as for Hamlet “a consummation devoutly to be wished”), procurement and Bank & Agency (hiring of temporary staff). This all comes out as being very cheap: £4.1million, explained by “This is investment in the Delivery Architecture to achieve cross-provider CIPs – see Section 6.” We will not discuss Section 6 in detail but we notice the sentence **“We will ensure human and financial resources shift to focus on delivering the things that will make the biggest difference to closing our funding gaps.”** This is, in our view, the true purpose of the STP. As patients we would like to see resources allocated to the things that will make the biggest difference to saving lives and improving care.

6.59 However the saving from the Productivity Programme is a whopping £143.4 million, so by far the biggest item in the 5 Delivery Areas. The public have no means of judging whether this is credible and we can only ask for it to be spelled out in sufficient detail to be understandable. If there is a hidden reference to the oft-repeated criticism from NHS Improvement that hospital trusts use too many expensive agency staff we feel bound to ask what trusts are supposed to do when the alternative to using agency staff is to close a ward?

6.60 Overall on Delivery Area 5 the net savings being proposed are £208.9 million. This is without any numbers for the first component, specialised commissioning, while the biggest element is the so far mysterious NW London Productivity Programme, with the closure of Ealing Hospital being the next largest. The general strategy is the closure of acute beds at a time when demand

continues to grow to be replaced by community provision with no explanation of precisely how that provision can replace the ever-increasing sophistication of acute hospital services.

6.61 We cannot fail to be reminded of the scenario set out in 2012 by the *Shaping a Healthier Future* document. We were told that some £190million worth of community services would be in place by 2015, i.e. three years from the start of the programme, to enable hospital reconfiguration to take place. Instead two A&Es and a Maternity Unit have been closed and the NHS have steadfastly declined to produce any list showing what progress has been made towards fulfilling the promise of alternative provision. It is small relief that the slogan of 2012, “better care, closer to home”, has now been dropped.

6.62 **Summing up this analysis of the 5 Delivery Areas** we note that out of 22 sub-sections there are 7 where the investment is not costed and 5 where the estimate of savings is not provided. We asked on 23.09.2016 for these missing figures to be supplied but we were told that they will not appear until the next version of the STP is published.

6.63 While some of the acute and primary care programmes in the Delivery Areas appear desirable, subject to more detail being made available, we can say categorically that the estimate that these programmes taken together will achieve savings of £446.3million is frankly incredible. If that is correct then the STP overall is not a realistic plan. No doubt if funds were available individual CCGs could pursue many of the individual projects in so far as they are likely to improve the health and care of the population, but why do they need endorsement and joint decision making at NW London level when there is no system of governance or accountability in place to oversee them?

6.64 In any case the Delivery Areas are only part of the picture of health service provision in the area. How can judgments be made without an across the board description of what is going on and a budget or budgets which cover the whole spectrum of spending? We can only conclude that much of the Plan, obscure as it is, represents a cloak for smuggling in the patient data collection initiative of Whole Systems Integrated Care (WSIC), devised by expensively remunerated management consultants over the last few years for the purpose of providing healthcare on a “capitated” basis to selected segments of the population.

Chapter 7: Existing Health Service Strategy

7.1 This is a strange title for the material assembled on page 7 of the STP because that material is about the aspirations of the STP, not where we are now. What we presume to be the new strategy is set out as having three prongs:

- Firstly the transformation of general practice through networks, federations...or super-practices working with partners to deliver integrated care (Delivery Areas 1-3);
- Secondly a substantial up-scaling of intermediate care services offering integrated care outside of an acute setting (Delivery Area 3);
- Thirdly acute services to be configured at a scale that enables the delivery of high quality care seven days a week (Delivery Area 5).

7.2 It is unclear as to what has happened to Delivery Area 4 but no matter. Much of the rest of page 7 relates to plans for Ealing Hospital.

A resident of Ealing who follows NHS issues closely has contributed the following:

“Ealing Hospital is certainly smaller than it was in 2012. Since then the Shaping a Healthier Future initiative has removed Maternity, Paediatrics and Children's A&E Services at Ealing Hospital. SaHF proclaimed loud and clear that Ealing would in the near future no longer be a ‘Major’

Hospital. Given this is it any wonder that it is proving impossible to hire doctors and consultants to fill permanent posts at Ealing Hospital? The STP statement that Ealing Hospital will in future 'serve the community with an A&E' is inaccurate. All that will be provided will be an Urgent Care Centre (UCC) with no acute care beds and no acute care consultants. The STP then goes on to talk about 'changes to A&E'. An A&E service is immutable. If the change is to a UCC then it is no longer an A&E.

7.3 It seems the future for Ealing Hospital is to 'meet local, routine health needs' (including potentially a "centre of excellence for elderly services" (page 31). On that basis calling the future facility a 'hospital' is at best misleading and at worst life threatening. The availability of local, easily accessible adequately resourced acute hospital care should be a given for all UK citizens. If Ealing Hospital is effectively eliminated, this directly impacts the sustainability of peoples' lives. This sustainability truth far outweighs the artifice of financial sustainability."

Chapter 8: Finances

8.1 Page 8 purports to show the overall financial position starting from a "Do nothing June 2016 position". It shows CIPS/QIPP savings of £569.7M and our reaction to that figure is complete scepticism as the report does not describe how these agreed savings will impact on patients. Our experience of the Brent CCG contract figures is such that we are doubtful whether such savings can in fact be achieved. They come under the umbrella of nationally driven plans in the Five Year Forward View to achieve "efficiency savings" of £22billion by around 2020. This was following on from a previous round of cost-cutting when Sir David Nicholson was the NHS Chief Officer and when the mid-Staffs scandal erupted.

8.2 The public may not appreciate that much of the "efficiency savings" programme has been realised by CCGs paying hospitals reduced amounts for the same treatments rather than by improved but still safe methods of working. Such so-called efficiencies in the end run out of steam and produce the massive trust deficits of £2.5 to 3billion nationally in 2015/16. As mentioned earlier in this critique, authoritative voices within the NHS are now saying publicly that this gap cannot be closed by more illusory CIPS/QIPP efficiency savings.

8.3 The Finances table then shows an investment of £118.3M, which assumes receipt of that sum from the government, an assumption that is fraught with risk in the current financial climate, despite a change in the Chancellor. This figure is followed by further savings of £446.3million in the local area Health Service (arising from the five Delivery Areas previously analysed) and £62.5million amongst the area Local Authorities Social Care budgets. We simply do not believe such savings are possible without huge detriment to local populations.

8.4 Our incredulity at the NHS NWL savings of over £1billion by 2020/21 has been confirmed as a realistic assessment by Chris Hopson, Chief Executive of NHS Providers, (see paragraph 2.9 below) who on 11th October told the House of Commons Health Select Committee oral hearing that he had not spoken to any of the leaders of the 44 STPs being prepared who actually believed that the savings required by 2020/21 were achievable. Mr Hopson advised that NHS England had ruled that no Plan would be accepted unless it showed the books as being balanced by 2020/21, with the clear implication that the Plans were going to be dishonest. We regard this as unacceptable.

8.5 Our earlier analysis has shown how shaky the presumed savings from the Delivery Areas are. Nor can we see where they are offset by the likely growth in demand on present trends. The local authority budget figure savings do not reflect reality since the level of cuts already made is one of the principal reasons why elderly people are not being moved out of hospital into the community fast enough to free up beds for new acute patients. The care home sector will go into meltdown if more savings are required from them. Their budgets are detrimentally affected by the imposition of revised minimum rates of pay for their staff, which are desirable but which have to be funded by higher and not lower charges. The next three lines are incomprehensible except to the highly paid

Management Consultants who helped prepare the report. The net result is a deficit of £30.6million assuming application of business rules or a surplus of £50.5million excluding those rules.

8.6 Assuming that the schedule figures are valid, the report simply glosses over the fact that, in the five years to 2020/21, the CMH Private Finance Initiative(PFI) contract will absorb £61million in repayments and the Willesden Hospital PFI contract will absorb £23million of repayments. We are astonished that the CMH PFI contract cost £69million and will incur total repayments of £376million over its 30 year term, and that the Willesden PFI contract cost £21million and will incur £138.6million repayments over its 30 year life. We wonder if any consideration has been given to renegotiating these contracts to provide a sum certain in Government debt now, which ought to be substantially less than the outcome figures for both contracts? Such a renegotiation would significantly improve the schedule total outcomes, assuming it was possible to renegotiate. The problem for the local area health service is that the PFI figures are real whilst the rest of the figures are in our view speculative. We suspect that few members of the public will appreciate that, egged on by Central Government; those approving the PFI project as "Value for Money" in government had saddled the local Brent population with such poor deals, which will detrimentally affect the provision of healthcare for us residents for an unnecessarily long time.

8.7 Overall we do not find the table on p.8 purporting to show how £1.3billion can be saved from the health and social care budget across NW London by 2021 remotely convincing. We understand why the NHS members of the STP team have felt obliged to produce it, though not why the local authority officers have signed up to it, if indeed they have. Would any truly independent financially competent body endorse this as a true and fair view of the likely outcomes for the next five years? We think not – and this has now been confirmed to the Health Select Committee.

Chapter 9: How we will make it happen? (sic) – page 9: More general comments by BPV

9.1 Patients and public cannot reach conclusions about the overall merits of the STP because the draft appears to be deliberately obscure and incomplete about key details: either because they have not yet been formulated, or to make public opposition difficult during the transformation. The main NHS Project Initiation Document (PID), the Business Case, Management Consultants' reports and other key documents have not been disclosed even to the small number of 'lay partner' patient representatives hand-picked to attend some NW Collaboration meetings.

Are New Models of Care swimming against the tide?

9.2 From a patient perspective from the time the NHS Act 1946 came into force on 5 July 1948 the model has changed remarkably little. Most NHS medical care is still obtained by visiting your GP who will refer you to hospital for specialist investigation and treatment when required. Most of the GP practices remain the same, and the hospitals mostly remain the same. Social care has been provided separately by the local council. The multiple NHS administrative shake-ups of Health Authorities etc. have barely been noticed by patients including the Health and Social Care 2012 Act introduction of CCG's. The STP proposes the most radical changes to this structure since 1948 that appear to introduce a model that most GP's and almost all patients do not understand and are mostly unaware of. There is, however, no White Paper and no new legislation is proposed.

9.3 The NHS Five Year Forward View and STP projects are major 'top down' policies that are clearly mostly focussed on reducing NHS costs to keep within a Government cost cap fixed by HM Treasury. It is an old joke that is funny because of its element of truth that the NHS is the last great Stalinist institution in Europe. On some measures the UK allocates about 9% of its GDP on the NHS and related care where other developed countries obtain better outcomes as measured by survival rates for serious conditions on allocating about 11 % of GDP to healthcare. It is arguable that this is really the main problem.

9.4 In seeking to transfer so much healthcare out of hospital into community services the NHS England Five Year Forward View plan and the STPs are swimming against the international tide of healthcare improvements obtained with new sophisticated investigations and treatments provided by increased hospital doctor specialisation. In 1948 hospital consultants were mostly general surgeons and general physicians. Initially antibiotics delivered the great improvement in medical care.

9.5 All over the world the secondary hospital landscape has changed out of all recognition since 1948 with increased medical and surgical specialisation and sub-specialisation for both investigations and treatment. Granted, many special investigations such as resting ECG can now be carried out by the new generation of hospital trained GP's with machines that have become much smaller and cheaper. Many routine low-tech mass numbers hospital services such as diabetic clinics can be transferred out of hospital to be provided in the community. It remains to be seen whether they will prove to be cheaper and more efficient. But it appears that the STP attempts to swing the pendulum much too far. We recognise that this is a response to extreme pressure from NHS England but our quarrel with that body is that they have not produced any serious analysis underpinned by academic research to justify a radical experiment with healthcare in England at a time when the workforce is under huge pressure and cash resources are hugely overstretched.

9.6 It is not clear what will happen to the traditional GP family doctor practice model under the STP. It has become fashionable amongst NHS England executives and their business consultants to decry them as a 'cottage industry'. The core of structural change is the new Multi-Speciality Community Provider (MCP) contract for over-arching primary care with 'intermediate' out-of-hospital and new primary services provided at 'hubs' leading on to full ACPs by 2021. It is said that primary care will be delivered through networks, federations of practices, or super-practices working with partners. The NHS England publication 'Multispecialty community provider (MCP) emerging care model and contract framework' published July 2016 at page 30 says:

"New models of Accountable Care Provision will move the boundary between what is commissioning and what is provision. We are working with a number of MCP vanguards to establish which activities must always remain with the CCG (or other commissioners), and which activities an MCP would perform under contract."

9.7 No detail is provided of how MCPs and ACPs will work - or how they will affect the traditional NHS GP practice delivered by GMS, PMS and APMS contracts. No experience from any existing whole population state-funded model is identified. The King's Fund March 2014 paper on Accountable Care Organisations in the US and England pointed out that the US models on which this concept is based are all much smaller and with different sources of funding. It is arguable that the STP disregards the excellent value for that we obtain from our traditional GP practices – for all their faults – for about 9% of the total NHS budget. It appears that in these new over-arching structures the traditional GP contracts may be left to wither on the vine by re-allocating funding to make them unviable. It is arguable that a better, more achievable, and more cost effective solution could be achieved by simply putting more resources into the existing GP network. If the current STP is implemented in full it seems likely that in 10 years time the pendulum will swing again back on a new slogan 'Small is beautiful'.

Chapter 10: Sharing patient records is central to the STP but where is the consent?

10.1 The STP integrated medical and social care proposals depend heavily on the limited individual patient information sharing duties in the Health and Social Care (Safety and Quality) Act 2015. These exclude the position where the party sharing ("the relevant person") reasonably considers that the person whose information is being shared objects or would be likely to object to that sharing, and the Act does not permit the relevant person to do anything which would be inconsistent with any provision made by or under the Data Protection Act 1998. NW London and

Brent CCG posters have already been put up in Brent GP practices. No date is stated for the start of the sharing, nor exactly what will be shared, nor with whom. The section on Integrated Care Record says:

"The Integrated Care Record (ICR) will display a range of test results, medication, allergies and social or mental health information relevant to the care of that person. Information around people's cost of care may also be included as part of the ICR. It is expected that this will be a key enabler in improving decision making when determining people's care needs."

10.2 The last sentence is disingenuous. When it speaks of 'care needs' it clearly does not mean investigation and treatment 'needs': it means cost controlled investigation and treatment 'allocation'. Under the heading Service User Consent the poster says that "people are able to opt out of their information being shared at any point" and goes on to claim that if you decide to opt out later the ICR will be re-created. We can find nothing in legislation that authorises this 'opt-out' model of purported implied consent by default. This appears to be an attempt to re-introduce the opt-out model on which the 'Care.data' initiative failed.

10.3 Doctors' misgivings about this 'opt-out' model are revealed by Brent CCG providing them with an indemnity against claims for breach of their doctor patient duty of confidentiality, and penalties under the Data Protection Act 1998. But the indemnity will not protect them against strengthened criminal responsibility under this Act as data controllers. Nor will it protect them on misconduct complaints to the GMC disciplinary committee for breach of their common law duty of patient confidentiality. Brent Patient Voice has sent representations to the National Data Guardian's Review of the "Consent/Opt Out" model on these lines.

10.4 An important under-pinning for the financial viability of the ASTP ACP and MCP model is the choke being introduced on GP clinical independence on hospital referrals and patient choice. The new Brent Referrals Optimisation Service that started on 1 September 2016 attempts to impose a CCG supervised clinical triage service through its provider Bexley Health Limited on all NHS GP patient referrals designed to steer all patients into cheaper relevant out of hospital community healthcare services where available. The patient information letters produced for this service do not inform patients about their NHS statutory and NHS contractual patient choice rights, and Brent CCG have rejected public consultation proposals that they be inserted. Without this under-pinning the CCG will not be able to assure providers that they will reliably deliver enough patients for their service to be viable financially.

10.5 The STP Delivery Areas whose savings are dependent on the service provision being by way of Accountable Care Partnerships, sharing risks and rewards through capitated payments, are of deep concern to BPV. As far as we can ascertain (an answer from Rob Larkman, CCG Accountable Officer and member of the STP Board at our Brent event not having been forthcoming), the capitated payments rely on the aggregation of data on patients in particular segments of the population, on the overall "cost" of their respective care and treatments (in accordance with the variable tariff and other systems for attributing individual items of costs of care in force at any time) so that an averaging exercise can be undertaken and payment to the responsible overall provider made based on multiplying that average by the number of patients in the target segment. There also appears to be an element of predictive activity - with the underlying question of whether treatment will be limited to those (predicted by some algorithm) to be likely to become seriously ill within the relevant "segment's" categories.

10.6 So the data use will be for purposes well beyond those allowed in common law and current data protection and human rights law. The Information Commissioner's Office has done considerable work on necessary and justified data sharing across health and social care, and the "excuse" often proffered for wider automatic data sharing is the mistaken view that medical professionals cannot share data in relation to patient care. However, the provisions of the law are complex, and have been modified piecemeal, and a summary would not be easy. BPV is carrying out separate work on the data sharing issues under the STP and WSIC, which is incomplete.

10.7 However, BPV believes that the data uses described in the STP (and WSIC which underlies the STP) such as "business intelligence" and "risk stratification" will be for purposes well beyond those allowed in common law and current data protection law. For this kind of use there is a need for explicit consent with an **understanding** of the purpose for which the information is being sought - in other words, **informed** consent. To BPV, it is notable that the STP does not even mention the position of children, and those lacking mental capacity to give such consent in this context.

10.8 The Caldicott 3 National Data Guardian's Review consent/opt out model (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/535024/data-security-review.PDF) published in June 2016 proposes new wording to allow sharing of patient data "for the running of the health and care system". This wording has been the subject of recent consultation - BPV sent a response - and the Government response to the consultation is still awaited. Legislation would be needed to give it effect.

Whole Systems Integrated Care and Privacy Impact Assessments

10.9 BPV's understanding is that the Privacy Impact Assessments carried out in relation to Whole Systems Integrated Care in NW London expose deficiencies which remain to be remedied by actions yet to be implemented by the WSIC component bodies and/or legislation to implement Caldicott's recommendations - an outcome which is by no means guaranteed, especially in the light of the Information Commissioner's comments on the Caldicott review referred to below. The broad wording, suggested by Caldicott, of "running of the health and social care system" might allow use for health and social care-related business intelligence. However, BPV does not believe this broad sweep of "automatic consent" accords with what the general public would be happy to have their "sensitive personal data" shared for - nor the category of personnel within the system with whom all or part of their information may be shared. Instead of the concept of explicit informed consent, the NHS now speaks in terms of requiring the "permission of the public" for data sharing, and "convincing the public to trust" for this purpose, according to a recent presentation by Andy Williams, Chief Executive at NHS Digital (UK Healthcare Show 28 Sep 2016 <http://media.ukhealthshow.com/#hett-conference> <http://media.ukhealthshow.com/wp-content/uploads/2016/10/09.35-Andy-Williams.pdf>).

10.10 The sweeping wording of the general posters and leaflets currently in Brent GP's surgeries does not explain the legal position properly and gives BPV no confidence that data will be properly protected. BPV is pleased to see that the comments made by the ICO in response to the Caldicott Review (<https://ico.org.uk/media/about-the-ico/consultation-responses/2016/1625007/ndg-review-consultation-ico-response-20160907pdf>) - especially on pages 8 -10 in relation to the "opt out model" - entirely support BPV's concerns.

10.11 The Caldicott Review proposes that no patient consent to opt out needs to be available for anonymised data once it gets to a "safe harbour" within the Health & Social Care Information Centre (now rebranded "NHS Digital" to "promote trust" among the public). Again the ICO comments referred to in paragraph 10.6 (at pages 10-12) cast real doubt on the legalities of this extraction of data from GP surgeries, and the woolly references to "anonymisation" as broadly set out in Caldicott. In addition, the latest NHS Digital report "Making IT Work" (September 2016) headed by Dr Robert Wachter makes it very clear that this is not entirely a wise course. <https://www.gov.uk/government/publications/using-information-technology-to-improve-the-nhs/making-it-work-harnessing-the-power-of-health-information-technology-to-improve-care-in-england> : *"While the idea of a fully wired, integrated, cloud-based system in which a patient's complete information is stored in one place is tremendously attractive, it also means that an intruder could gain access to all the information about a single patient, or millions of patients, with a single breach."*

10.12 Data protection is an important part of UK law, and the principle of medical confidentiality a cornerstone of the doctor/patient relationship. The issues have not been made part of an explicit public dialogue. Without that and with such question marks over an essential part of the capitation based savings on which the STP financial plan is based, BPV fails to see how the programme can perform what is required of it.

Data and health inequalities

10.13 The approach also bears a risk of increasing health inequalities by dividing the nation into 44 separate footprints, the "costs" of whose patients' treatment can reasonably be expected to vary according to, e.g., the socio-economic profile of the footprint area. The same is true of patients within an area. What happens to those footprint areas (or areas within a footprint) with the more expensive patients? The Right Care programmes already operate on comparisons of costs of programmes/initiatives/treatments with comparable "best" (actually cheapest) CGG's. What happens when those areas with more complex patients begin to show as underperforming on the data? According to "Making IT Work", the rationale of the "Footprints" appears to be dictated by data - specifically the experience of previous attempts to introduce digital inter-operability across the nation, in particular, the infamous failed National Programme for Information Technology (NPFIT) which started in 2002 and was closed down at a cost of £ billions in 2011.

10.14 The STP refers to digital solutions to financial and workforce shortages, and promotes self-care and self-management via information technology heavily as the proactive and preventative elements on which the STP will succeed in its aims (see pages 37 and 38). The papers presented at the 8 North West London CCG Joint Primary Care Committee in June 2016 referred to in paragraphs 6.29 and 6.36 above refer to various IT/digital bids for a £30million fund. BPV has strong equalities concerns about this move to digital. None of the fund is available to the patient/consumer end of the digital link. Incidentally BPV has noted with bewilderment that at a time when the NHS is running out of funds the Secretary of State for Health announced in February 2016 the availability of £4.2billion investment to help bring the NHS into the digital age.

10.15 The "vision" articulated in these papers rely on the statistics such as "66% of adult population uses a smart phone and 61% uses their mobile to access the Internet". (Figures from Q1 2015, OFCOM, <http://media.ofcom.org.uk/files/2015/facts-figures-table15.pdf>) It does not, however, analyse those figures critically in the context of North West London and its population:

- Poverty – availability to a significant proportion of our population of Smart phones and/or Wi-Fi; and
- Age/Disability – the physical ability of the people easily to use their mobiles (if they have them) for the functions suggested – e.g. limitations on use of handsets or keyboards through physical difficulties/sensory disabilities; and
- Linguistic difficulties – learning difficulties or the high percentage of residents who do not have English as their first language; and
- Training on an individual basis – to make these digital technologies accessible (followed by the availability of readily accessible help, when the initial training is forgotten)

10.16 It is telling that the "Engagement Guide" referred to in paragraph 2.6 above specifically refers to engagement exercises: "online methods can often be useful but are unlikely to be accessible for all audiences, for example, older persons from more disadvantaged socio-economic groups "(page 10). If that is true for engagement and consultation, then it is even more true in the case of the delivery of self-management training and of care (whether self-care or otherwise). We note that in *New Models of Care for London's Population*, The London Health Commission 2014, p.21, it is made crystal clear that health spending per individual rises steeply between the ages of 70 and 75 and stays high thereafter. The latest national survey of internet use by the Office of National Statistics is accompanied by the following highly relevant quotation: "While we have seen a notable increase in internet usage across all groups in recent years, many older and disabled people are still not online, with two-thirds of women over 75 having never used the internet." Pete Lee, Surveys and Economic Indicators Division, Office for National Statistics 2016.
<http://www.ons.gov.uk/businessindustryandtrade/itandinternetindustry/bulletins/internetusers/2016#main-points>

Chapter 11: Risks of more haste less speed

11.1 There are very big risks with pushing ahead so fast with such a big programme of new models that are as yet untried and untested since the few Vanguard pilots have only recently started. It is reckless to put so much into new models that have foreseeable but unquantifiable risks of financial insolvency and bankruptcy liquidations when all the responsibility would fall back onto the NHS for expensive crisis management. Indeed such crises have already occurred in recent NHS major procurements as in the Uniting Healthcare fiasco in Cambridgeshire where liabilities were not properly established before new and complex organisations got under way.

11.2 It appears unrealistic to think that the whole NW London Collaboration STP project can be delivered by 2020/21. Its parallel *Shaping a Healthier Future* became stalled when the capital costs of about £1 billion required to deliver it became clear. When Brent CCG on commencing in 2014 tried to develop an ambitious Planned Care project for about 13 medical speciality 'out of hospital' community services this project too stalled on attempting to introduce an integrated multi-disciplinary MSK service as the third of the new services. Both these big projects have remained stalled. The Chief Executive of NHS Providers has recently advised that the Accountable Care Partnership model may take 15 years to implement rather than the 5 apparently envisaged by NHS England. <http://www.thecommissioningreview.com/article/new-care-models-will-take-15-years-implement-says-nhs-providers-chief>

11.3 The STP proposes to transfer a large part of hospital care into community services commissioned by the CCGs through the new vehicle of one of the variants of the new ACP model by the new MCP contract model. This appears to seriously weaken the statutory CCG governance model of the Health and Social Care Act 2012 just by administrative action without fresh statutory approval. The 2012 Act created major conflict of interest problems with GP members of the local CCG involved in providers tendering for contracts from the CCG. This conflict of interest is likely to be enormously increased with GPs encouraged by the STP to form large ACP variant healthcare providers to tender for £multi-million community healthcare contracts from themselves wearing their CCG hats. Large public money scandals are predictable. We have seen no attempt by NHS England to show how this problem is to be handled.

11.4 It appears that there are major financial implications of the STP move to ACP and MCP that have not been disclosed. Why go to all the trouble of setting up the ACP and MCP structures? It now appears that again this is may be largely about an attempt to get big future financial liabilities off the books for pensions and clinical negligence. All large employers are desperately seeking advice from lawyers and management consultants on how to do this. What Sir Phillip Green did for BHS pensions it seems the NHS now wants to do. Similar considerations apply to clinical negligence liability. The NHS clinical negligence compensation bill in 2015 was about £4 billion - up £1 billion on the previous year. It is very difficult to investigate these queries through the obscure finance sections of the draft STP. It was the same story with the ill-fated PFI initiatives. When such liabilities are transferred to new contractors they inevitably have to increase their tender figure and add a safety margin. It is foreseeable that commercial professional liability insurers will quote very high premiums for such a large and fast growing contingent liabilities.

11.5 A great deal of the projected cost savings of the STP are highly suspect as unreliable and unrealistic. Much of the cost savings are projected from projects to reduce long time and increasing obstinately intractable conditions such as obesity and Type II diabetes, and from preventive medicine projects. The projections of the NHS accounting formulae for booking such projected savings are highly speculative. You can insert almost any figure you wish.

Loss of confidence of the clinical workforce

11.6 The problems of rushing through such large structural changes are likely to be aggravated by the increasing loss of confidence of the clinical workforce: as evidenced by the current industrial action by the junior doctors. For 68 years the NHS has traded on exploiting the vocational commitment of its doctors. The NHS appears to be losing much of this goodwill. In our experience neither hospital doctors (junior or consultants) nor GPs are at all aware of the radical changes

implied by the ACP model. We have seen no attempt to explain it to them, much less to convince them that it will improve the quality of care for patients. Doctors' representatives in the London-wide Local Medical Committees have complained at their lack of involvement.

11.7 The STP itself refers to changes to the workforce in nebulous terms by reference to other "strategies" such as "North West London Productivity Programme", the introduction of physician associates and care navigators - although, in the latter case, the contract terms offered appear (at least in Brent) to be limited to a year. Page 31 offers only the solution of "strengthening recruitment to reduce vacancies"; "optimise scheduling to reduce demand" and "reducing unit costs for agency by using framework agencies and reducing rates by volume contracts" (while in the last case, the downward pressure on agency spend is enforced through penalties on provider trusts which breach, an outcome unlikely to help reduce those trusts' deficits - and to risk incurring more penalties for breaking deficit reduction plans). Then there is "bespoke project work that is guided by more advanced processes of workforce planning." Apart from its focus on a great part of the workforce being its 101,301 unpaid carers - not designed to endear the STP to many of Brent's population who are those "unpaid carers" looking to some support in any new overarching plan - and the plans to take away the concept of individual GP practices looking after their patient lists, there seem few practical measures in the STP to solve the diminishing workforce problem.

11.8 On 12 September 2016 the King's Fund Chief Executive Chris Ham published a commentary with muted criticism of what on what has been published to date about the STPs including his analysis that the ACP and MCP model is swimming against the statutory set up tide of the Health and Social Care Act 2012 with CCG local GPs made responsible for promoting competition within the NHS healthcare economy. http://www.kingsfund.org.uk/blog/2016/09/stp-leaders-challenges-care-budgets?utm_source=linkedin&utm_medium=social&utm_term=thekingsfund

Absence of informed public scrutiny

11.9 It is very unfortunate that there is so little informed public scrutiny of the STP. Because the changes are being introduced entirely by administrative action there have been none of the automatic debates in Parliament and committee scrutiny that would accompany primary legislation. The BMA and doctors' Royal Colleges have remained strangely silent about the STP. There is just no equivalent of academic expert peer review scrutiny. It is being left to a very few concerned individuals to provide devil's advocate scrutiny of the proposals from the limited and late information released, and to identify weaknesses and voice public concern. In the fable it was only the naive little boy who dared contradict the court conspiracy of silence and speak out that the Emperor had no clothes.

11.10 A major criticism of the NW London Collaboration STP process is the failure to publish enough of the plans to enable the public to understand the radical changes afoot for delivery of NHS primary care. In the last analysis the default to be criticised is by the local Clinical Commissioning Groups, the acute hospital trusts and the Local Authorities. They all have their statutory duties to consult (as pointed out helpfully by the Engagement Guide referred to in paragraph 2.6). For example, under section 14Z2 of the National Health Service Act 2006 (as amended by section 26 of the Health and Social Care Act 2012) the statutory duty remains with each CCG to involve and consult its patients and public in the planning of its commissioning arrangements and in the development and consideration of its proposals for changes in its commissioning arrangements where they would have an impact on the manner or in the range of health services available to them.

11.11 Consultation is compulsory. The next version of the STP is due in on 21 October. Yet the NW London STP is no different from anywhere else in England: all STP contracts must be contractually signed by 23 December 2016 according to NHSE. <https://www.england.nhs.uk/wp-content/uploads/2016/09/NHS-operational-planning-guidance-201617-201819.pdf> Where will the time for meaningful consultation - as detailed in the Engagement Guidance - on the content of the STP be found?

11.12 To show that BPV is not alone in its fears for the haste of this process, we would like to share some words of Julia Simon, until earlier this month the head of NHS England's commissioning policy unit and its co-commissioning of primary care programme director. She warned 'forcing health and care organisations to come together so quickly to draw up the complex plans was likely to backfire. Up against tight deadlines, organisations were likely to make unrealistic financial forecasts and claims about benefits to patient care.' Ms Simon added: 'Everyone will submit a plan, because they have to. But it means there is a lot of blue sky thinking and then you have a lot of lies in the system about the financial position, benefits that will be delivered - it's just a construct, not a reality.' <http://www.gponline.com/shameful-pace-stp-rollout-risks-financial-meltdown-warns-former-nhs-commissioning-chief/article/1410546>

Chapter 12: Some brief conclusions

12.1 Those who are providing healthcare in North West London, both as paid staff and volunteers, are working very hard, often under great pressure, to keep us well and to care for us when we are ill. We appreciate this and thank them for it. It is important that they are not asked to do the impossible or to risk providing unsafe services.

12.2 The team who have put together the NW London STP have also worked under pressure to produce it to a ridiculous deadline and in conditions of semi-secrecy for which they are not responsible. **We hold NHS England responsible for this. We want them to slow down, ensure that the Plan is recast so that it can be properly scrutinised and to encourage an honest and open public debate over the coming months.**

12.3 Nevertheless the view of BPV, based on the analysis in this critique, is that **the Plan so far published is not fit for purpose.** We do criticise the NW London team for the obfuscation in its presentation and for the omission of key financial information. If it was a plan for NW Londoners to live well and be well, as it claims, it would present a budget with supporting financial inputs and an across the board description of the services provided now and how the plan wishes to change them.

12.4 It does not offer convincing evidence that £1.3billion can be cut from healthcare budgets in the 8 NW London Boroughs by 2021 without significant damage nor is it persuasive in suggesting that it will be wise to "transform" primary care that is the way we relate to our GPs, at high speed via so-called "Accountable Care Partnerships".

12.5 We do not consider that the patient data sharing arrangements which are an essential part of the capitation based savings on which the STP financial plan is based have yet complied with UK data protection law or the principle of medical confidentiality which is a cornerstone of the doctor/patient relationship. That being the case we cannot see how the programme can perform what is required of it.

12.6 We do not see the case for trying to overcome the current organisational structure, embodied in law, in favour of the so-called NW London "Footprint", though we welcome all steps towards collaboration between the local NHS and local authorities, especially in public health and social care. For most purposes the local borough provides the best focus for collaboration and accountability.

12.7 We believe that while all public bodies should act economically and efficiently there are no **major** efficiency savings available to fill the gap between increasing demand and current budgetary constraints in the healthcare arena. Filling the gap is a matter for national political choice.

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