



c/o 7 KIMBELL GARDENS, LONDON SW6 6QG

## **RESPONSE TO**

### **The draft NHS NW London Sustainability and Transformation Plan**

October 2016

## 1. INTRODUCTION

*Save Our Hospitals: Hammersmith and Charing Cross* is a resident-led non-party political campaign group made up of people from all sections of the community, campaigning against the closure of vital acute services at Charing Cross and Hammersmith Hospitals and other NW London hospitals such as Ealing, and against damaging reconfigurations of local NHS provision across NW London.

We have carefully studied the published Draft STP for NW London. We hope that this critique of the STP will receive careful scrutiny by both the local CCGs and by NHS England, and that we receive, before the final submission date for STPs of December 23<sup>rd</sup> 2016 a detailed response to the issues we raise.

What is clear, in reading the document, is that the STP is essentially about *cuts*. The STP aims to cut a notional deficit of £1.3bn and turn that into a surplus of £55m by 2020 and all of the policy options put forward claim to produce this financial outcome. The driver is clearly financial rather than clinical. The demand is that NW London footprint will contribute to NHSE's objective to cut £22bn+, at the behest of the Government, from NHS budgets by 2020. All clinical proposals etc have to work within that financial 'cage'.

## 2. SUMMARY

The team who have put together the NW London STP have worked under considerable pressure to produce it to a risible deadline under conditions of semi-secrecy for which NHSE is responsible.

We believe this STP cannot achieve the significant financial savings it sets out to achieve without significantly damaging the health of local people. Further, we note the lack of detail across all the delivery areas. We are deeply concerned at the lack of clinical and financial evidence to support the plans.

STPs in fact have no democratic mandate, and this STP has involved minimal engagement and no effective consultation to date.

## 3. CONSULTATION

There has been NO public consultation on the formative stages of the NW London STP and, indeed, it has only been seen by local residents as a result of a Freedom of Information request, following which it was published. Our critique, therefore, relates to a document in which the public had no say.

In September 2016, NHSE published a document, *Engaging local people: a guide for local areas developing Sustainability and Transformation Plans*, ironically well after the June submission date for CCGs to submit their draft STPs. It is worth quoting from this document:

... we need robust local engagement plans as part of the STP process (p4)

It is essential that the STP partners in every area have an ongoing dialogue with patients, volunteers, carers, clinicians and other staff, citizens, the local voluntary and community sector, local government officers and local politicians ... And local areas may wish to consider how to engage people who live outside the footprint area but access health and care services within it and may therefore be affected by footprint proposals. (p.7)

Consultation must take place when the proposal is still at a formative stage ... sufficient reasons must be put forward for the proposal to allow for intelligent consideration and response ... adequate time must be given for consideration and response ... decision makers must properly consider the material produced by the consultation. (p.11)

And, of key importance:

Service change must be evidence-based, and this evidence should be publicly available during the consultation and decision-making stages. (p.12)

STPs have been submitted, in June, to NHSE without any sort of consultation. Indeed, it took a FOI request to get the NW London STP into the public domain and it is still the case that most parts of England have yet to see their STP.

Since NHSE's document stresses the need for consultation at a *formative* stage, it is difficult to know how this can be the case when there has been no input from the public, or anyone, to plans to date. Further, the second draft of the STP is to be submitted by Oct. 21<sup>st</sup>, the engagement (not consultation) has been limited to a few 'town hall' type meetings where the agenda has essentially been a sales job, without any evidence being presented to the public to back up any assertion in the STP. In effect, the public have been asked to take the proposals in the STP as a matter of faith. Indeed, an officer of H&F CCG said in a Patients Reference Group that we needed to have faith – this was in response to a request for evidence!

We concur with the response to the STP from Brent Patient Voice that 'the STP is an extremely difficult document to analyse for a whole number of reasons ... Many sections are based on unpublished documents and, most significantly of all, financial presentations using figures 'plucked out of the air'. Readers are in effect being asked to sign up to articles of faith.' (p. 3)

We have also learned from a councillor in RBKC that the scrutiny committee members there were invited on Friday 14<sup>th</sup> October to comment on the draft STP by noon on Monday 17<sup>th</sup>. As pointed out by the councillor:

This is typical of the lack of effective consultation over this plan which threatens the future of Charing Cross and Ealing Hospitals, is expected to lead to the loss of at least 500 acute beds, and to 'save' £1.3 billion from health budgets over the next 5 years.

The revised plan is 58 pages long and is a complex document. Less than three days over a weekend is clearly insufficient time for busy Councillors to absorb and comment in detail on the proposals.

The councillor is pointing to the fact that one of the largest changes in the history of the NHS is being rushed through behind the backs of the public and their elected representatives.

## **4. EVIDENCE**

There is a long history in NW London of the local community asking for evidence – initially for the proposals in *Shaping a Healthier Future* and now in regard to the draft STP. We have attended CCG and Imperial Trust board meetings and also had a meeting with the management of Imperial in order to have our questions answered about evidence. We have been promised, repeatedly over four years, that we will be provided with the evidence to back up claims that acute services can safely be reduced. We have never received this evidence. At the ‘engagement’ meeting held by H&F CCG on October 3<sup>rd</sup>, we were promised that the Chair of SOH would be sent the background papers showing evidence that, both financially and clinically, the proposals were safe. Yet again, the evidence has not arrived.

We can only conclude that this evidence does not exist. When public bodies know that things will work, they produce the evidence!

In commenting on some of the detail of the draft STP, we will include key examples where no clinical evidence is referenced to show how a transformation might work. Nor is there referenced evidence that some of the changes in clinical strategy would, of themselves, reduce the need for acute beds within a footprint. We will also indicate some of the (many) areas where there is no evidence to support the financial ‘savings’ or expenditure on ‘transformations’.

In what follows we focus on the core delivery areas as outlined in the STP. We have not, however, commented on every detail but have concentrated on examples of the issues that we are concerned about.

## **DELIVERY AREA 1: RADICALLY UPGRADING PREVENTION AND WELLBEING**

What is clear is that no one is going to be opposed to preventing illness and maintaining wellbeing!

From the outset, the STP recognises that poverty (which has to include those in badly paid jobs), lack of work, poor housing, and social isolation are at a higher risk of poor health and that these factors can cause poor health.

We do not see how poverty, low pay, unemployment and poor housing can be ameliorated by any of the particular proposals in the STP. These areas need to be

tackled by both central and local government. But this is in the context of continual austerity cuts from central government, which also include huge cuts to local government expenditure over the next 5 years. How can the factors that are implicated in poor health be addressed significantly in this context?

Further, there is no evidence presented to show that encouraging people to adopt more healthy ways of living is feasible within a short time frame. 'Lifestyle changes' take time and concerted action. Only recently Public Health England pointed out that figures for those smoking had fallen to their lowest figure in 50 years, but that it is still the case that 1 in 6 adults is still a smoker. To achieve this reduction has taken decades of education, media coverage, tax rises on smoking products, legislation to prevent smoking in public places, etc. The admirable objective to cut obesity figures, for example, will require a similar concerted public programme addressing complex questions of poverty, regulation of the food and drinks industry, taxing of unhealthy foods, education as well as health provision. There is no clear clinical evidence that the aims for healthier living, however worthy, can be achieved in the time scale presented or at a local level.

The STP aims to invest a modest amount of money to enhance prevention and well-being while making vast cuts to the budget – in fact, a net saving of £11.6m in this area. Where is the evidence that the small investment in preventive and well-being budgets can deliver so that there are savings of £11.6m? To be convinced, we need to see detailed financial modelling of this, together with the clinical evidence that the strategies can work within the required time scale. Without this, it seems we are living in cloud cuckoo land!

Social isolation is mentioned as an important determinant of ill health. We accept this, but also would like it recognised that poor mental health may itself be a determinant of isolation – it is not always a one-way process! The financing of services which might help to mitigate social isolation is given as £500,000 – or £12,500 per borough per year, while the saving is given as £6.6m. It is extraordinary that an investment of so little could accomplish so much, both in reducing social isolation and saving such an enormous sum, and over such a short period of time. This seems like fantasy. Could we please see the evidence – clinical and financial – that such a turnabout could possibly happen. (We might also ask why it hasn't already been done, given that SaHF has been around for more than 4 years.)

## **DELIVERY AREA 2: ELIMINATING VARIATION AND IMPROVING LONG TERM CONDITION MANAGEMENT**

There are several difficulties in understanding what is meant in parts of this DA. What is the evidence for clinical variation and for its costs to the NHS in NW London? Indeed, what are the variations being addressed? Here we are given bland and rather meaningless statements.

How do you know that people have a mental health problem if it is not diagnosed?

Further, 'long-term condition' is never adequately defined. What is meant by this?

Where is the evidence that services can be delivered effectively within budget constraints – a cost of £2m and a savings of £124m for 'Right Care' priority areas? What pilots have been carried out for this and how can small pilots be rolled out to a vast population? The discrepancy between investment and vast savings is such that one wonders if the second figure is a misprint!

Further two core areas in this DA have no costing or savings listed.

In terms of improving self-management, the use of personal care budgets is promoted as a core way forward. These are highly controversial and there has been no public consultation about whether this is an appropriate way forward. A key question here is what happens if someone with a personal care budget exhausts the budget without ameliorating the condition. Will this lead to patients paying for additional, necessary, treatment? Is this a back door method of introducing charging?

### **DELIVERY AREA 3: ACHIEVING BETTER OUTCOMES AND EXPERIENCES FOR OLDER PEOPLE**

A substantial saving envisaged in the STP (£132.7m) seems to come from this segment of the population – ironically the segment of the population that has paid into the NHS for an entire working life. Further, the tone of this section will rightly alarm many older people and their families and neighbours.

A further irony is the statement that a 'market analysis of older people's care' will be undertaken at a time when private providers are withdrawing from the care home market on the grounds that they cannot make sufficient profit. Indeed, the CQC has very recently pointed out that the care sector as a whole is at risk (see The Guardian 13 October 2016; also in BBC and Telegraph on same day). As well as closures of private care homes there has also been a steady decline in the number of local authority places for older people. There have also been a seemingly unending number of reports of poor and maltreatment of older people in care contexts over the last few years.

The entire NW London provision for older people's care services is proposed as being provided by a single Accountable Care Partnership, with joint agreement about the model of integration with local government commissioned care and support services. This is to be provided on a per capita basis. What evidence might be being used to determine the population included in this, the variety of conditions covered (is it all health needs for older people), the relationship with individuals GPs etc? It is a cynical exercise to suggest that £25.1m can be saved in this area, without any investment at all.

What is the relationship between an ACP and GPs? As this is not explained, it is difficult to know just how care for older people is to be delivered!

Will the market analysis also include an evaluation of the costs to older people of care outside hospitals? This is an issue which has never been addressed in the more than four years since SaHF was mooted.

Key to the implementation of new models of local services is the downgrading of Charing Cross and Ealing Hospitals as sites for 'the older persons (frailty) service'. Despite repeated questioning, the CCGs have given no detail of the kinds of care offered to older people at these sites, the number of older people to be treated in these institutions, the levels and kinds of staffing to be available which could be anything from consultants to care assistants, what the budget for such provision would be, ETC! It is hard not to think that these are simply seen as dumping grounds for older people. This is even more the case when other services which might exist at these hospitals have not been made clear. The definition of a 'local hospital' has not been clarified over the past 4+ years despite repeated requests, let alone the services for the elderly which now seem to have been prioritised for these two hospitals.

It is absolutely correct that people at the end of life should be able to spend their last days in their preferred place of care. For many this will be home, for many a local hospice and for some an acute hospital bed. It is very useful to ensure people in their last stage of life are able jointly to make care plans. However, end of life care in the community cannot be delivered on the cheap and cannot not be viewed as an easy way of making savings.

The STP fails adequately to plan and cost for the increased numbers of district nurses, palliative care specialists, GP cover, Marie Curie services, equipment and necessary skilled carers. The issue of a lack of capacity in our local hospices is not addressed. The lack of detail here is very concerning. There is no data provided on current demand and current provision – another failure to provide evidence. Finally, the problem of how to recruit to these specialist roles, given current vacancy rates, has not been addressed. Indeed, it is not even clear that NW London will *retain* its current staffing level in this area, leading to a possible further deterioration.

The STP seems to believe that non-elective admissions for patients in their last phase of life can be reduced by 50%. As we have shown above, this seems to be highly unlikely without substantial investment in care outside an acute hospital. Yet the plan seems to indicate that the savings will be significantly greater than the cost. Given the 'cost cutting' theme throughout the STP it is not surprising if some people fear community palliative care is seen primarily as a way of saving money.

We also have strong reservations about the link between care for the elderly and use of digital technology. Many of the services required by older people require the expertise of trained nurses to check, for example, dehydration – a common cause of death and suffering for older people. Digital technology is not good at recognising how people, particularly older people, signify health problems through changes in body language and actual physical examination. Further, there seems to be no account taken of the fact that older people are not as digitally minded as younger cohorts and further, that with greater levels of dementia, use of technology becomes problematic.

## **DELIVERY AREA 4: IMPROVING OUTCOMES FOR CHILDREN AND ADULTS WITH MENTAL HEALTH NEEDS**

It is widely recognised that care for mental health needs is in a sorry state across the country. There is little in this delivery area to give any confidence that there will be much additional help in NW London for those with mental health conditions, whether children or adults. The stated aims are unspecific and, more worryingly, uncosted.

While more support in primary care would clearly be helpful, there seems to be no account taken of earlier attempts to provide care in the community for those with mental health problems. As reported by the BBC on 6<sup>th</sup> Oct '16, the suicide rate for patients with mental health problems cared for in the community is three times the number of those cared for in hospitals. Further, there is anecdotal evidence that beds are not available for patients going through a crisis when needed and that they are shunted around various hospitals across London. On the same day as the BBC report, the Metropolitan Police complained that they were having to detain people with mental health problems in police cells without any training as to how to provide adequate care as no hospital help was available.

That three sections of DA4 are uncosted is a clear indication of the inadequacy of planning to meet actual needs, whether in acute or primary settings.

While, at the H&F engagement meeting (3<sup>rd</sup> Oct, 2016), Dr Spicer, Chair of H&F CCG, stated that the actual % of monies to be spent on mental health (8% of total budget) would not be reduced, this is hardly reassuring when this does not take into account inflation and when it is absolutely clear that MORE is needed to provide even adequate care.

It is also the case, as explained to us by Dr Tracey Batten in late 2014, that a high proportion of those who seek treatment for physical conditions in A&E also have high levels of mental health problems. There is no indication of what might happen to this group if the A&Es at Charing Cross and Ealing Hospitals were to close.

Because of social pressure, not least from the digital environment, increasing numbers of young people are experiencing mental health problems. There is, despite this and despite the title of DA4, very little that explicitly addresses the problems of/for younger people.

The 'promise' to extend out of hours service initiatives for children, providing evening and weekend specialist services (CAMHS) hardly seems adequate to meet the dramatic rise in the number of children needing mental health support, as shown by NHSE figures (see *The Guardian*, 24 Oct '16), following many other detailed reports over several months across all responsible media. The NHS recognises an immense rise in self-harming, suicide attempts, and dramatic rise in the number of people needing A&E and then acute care. Sarah Brennan, quoted in *The Guardian*, refers to cuts in social workers, educational psychologists, parenting

classes and mental health services in schools as reducing support for under-18s in distress. She goes on to say:

The pressure on CAMHS has forced services to raise the bar for access to treatment. About a quarter of young people are being turned away and this will include many who self-harm. At the moment too many vulnerable children go to A&E because no other help is available.

Even Jeremy Hunt has severely criticised NHS care of troubled young people! CAMHS were the 'biggest single area of weakness in NHS provision' and were beset by 'big problems' including failure to intervene early enough when problems such as eating disorders emerge, which meant 'too many tragedies'. (Also reported in *The Guardian* article.)

This whole delivery area is woefully lacking in detail, clinically and financially. Children and adults with mental health needs deserve much better than this.

## **DELIVERY AREA 5: ENSURING WE HAVE SAFE, HIGH QUALITY SUSTAINABLE ACUTE SERVICES**

It is shocking but not surprising that acute services are subsumed under sustainability i.e. cuts. It is equally shocking that the proposal to downgrade two acute hospitals is still envisaged in this report.

Following the closure of Central Middlesex A&E and Hammersmith A&E, there was a significant deterioration in A&E performances at other hospitals. The argument that this was a result of a national trend can, at best, only be partly the case. The other A&E departments in NW London, which had previously been top A&E performers in meeting targets, fell to the bottom of the league table.

Further, these problems have not been resolved! Hospitals across NW London are already working to and beyond capacity. There have been occasions when not a single bed has been available in NW London. Moreover, this problem has been acknowledged publicly, at Board meetings of Imperial, by Dr Tracey Batten, CEO. There is no sign of any improvement on the horizon, let alone evidence that unproven out of hospitals care can reduce the need for acute hospital beds.

We have been told that neither Charing Cross nor Ealing Hospitals will close until there is clear evidence that alternative provision is available and can work. This would be reassuring if it were not the case that the STP clearly signals that Ealing hospital is under imminent threat of closure. Over the last 18 months several departments (Maternity, Paediatrics) have been closed down resulting in a blight effect on staff recruitment. To then claim that the hospital is 'unsafe' is a disingenuous strategy to get rid of the hospital regardless of need.

The closure of Ealing Hospital would be a major loss to the local health community. In addition, the closure would add to the stress on other hospitals across NW London, as well as putting more pressure on existing primary care. For a document

that claims to address the social determinants of health, there is no recognition that users of Ealing Hospital will have further to travel, with additional travel costs. There is also little recognition of the specific communities that live in Ealing borough, for whom local services are crucial. There is a passing mention of ethnic and cultural diversity in the STP, but this is then simply ignored in the plans for provision.

Four years of questions from local residents, council leaders and local MPs have failed to elicit from the CCG what they envisage doing with Charing Cross. Indeed, it was claimed that Charing Cross is not part of the STP plan because any reconfiguration involving Charing Cross will take place post-current STP plans. Yet its closure as an acute hospital remains within the plan. We know that it was only at Dr Batten's insistence that it has been stated that reconfiguration of Charing Cross will not take place until appropriate alternative provision is in place.

It is worth quoting here from the Royal College of Emergency Medicine (Feb. 2016):

Any reconfiguration proposal must start by considering the needs of the communities served. Thus the key issue is the impact on patients and patient care at site from which services will be removed or reduced. Secondary, though important, are the consequences for services at sites that would be required to absorb the diverted patient flows. The additional stress on local primary care systems must also be considered.

Save Our Hospitals believes that none of these concerns have been adequately addressed.

The RCEM statement continues:

Relocating services has a disproportionate effect on the very young, the very old, patients with mental health issues and those with chronic illness or reduced mobility.

Relocation also has a greater impact on poorer socioeconomic groups through difficulties with transport....

Increased travel times are associated with worse outcomes for some patient groups with serious illness.

The increased demands on ambulance services brought about by longer transport times are seldom properly modelled....

Short-term staffing shortages cannot be a rationale for permanent reconfigurations. Longer term patient outcomes will be compromised....

The amount of traditional A&E work that can be undertaken by the replacement unit (such as a GP- or nurse-led urgent care centre) is likely to be grossly over-estimated. This is especially true of patients who arrive by ambulance, the majority of whom will require the resources of the parent department.

The King's Fund have demonstrated that the cost efficiencies associated with such reconfiguration are largely illusory.

It is worth noting that much of the rationale for closing acute services at Ealing and Charing Cross is based on limited pilots of schemes to transfer care into the community. While we have received at various meetings reports of some of these limited pilots, there has been no evidence presented that their success will lead to less need for acute provision, particularly in a context where NW London is experiencing population growth and where there is a significant increase in older people who have more care needs. Nor have the cost implications of these pilots been provided when they are rolled out to large communities. We do not believe that they will either reduce the population needing acute beds or cut costs.

Like most of the public, we know that health care is already available 7 days a week at hospitals, A&Es and UCCs. We do not understand how a full 7 day service can be rolled out without major investment in staff, in hospital equipment, in back-up services including cleaning and ensuring that hospitals are not a source of infection themselves.

In the rest of the paper, we take up specific issues rather than responding to the STP as structured.

## **POPULATION GROWTH**

The STP does not supply sufficiently robust data on population growth and potential patient growth across NW London. On p.14, the STP notes that there are currently 2.1m residents and 2.3m registered patients. We would also like to note that part of the population may not be accounted for. This includes homeless people, a rising number, who frequently have physical and mental health conditions. In addition, there are large groups of migrant workers who live in various boroughs in NW London for significant periods of time and may not have registered with NHS services.

Additionally, there is significant population growth across the footprint area. For example, in H&F it is estimated that c. 25,000 additional people may be living at the Old Oak site by the end of this decade. There is also significant growth expected at Earls Court and around the Wembley area. In fact, each borough will undergo population growth over the period of the planning for the STP, and thereafter. There is no evidence that this growth has been taken into account. This has been a major issue from the inception of SaHF and still evidence has not been presented to indicate that the health needs of a growing population can be met. It is not the case that these figures are not available. Local authorities use this population data to plan their own services e.g. education.

## **GP SERVICES**

The STP is opaque about the place and organisation of GP services in the future. With primary care central to moving patients out of hospital or preventing

hospitalisation, we need to be much clearer about the organisation of GP services and how patients will access these.

We understand that GP services are currently under great stress, as elsewhere in London. We know that locally a large number of GPs are aged 55 or above which means that they are coming up to retirement. Furthermore, we know that recruitment to GP practices is very difficult. At the H&F consultation meeting, Dr Spicer, Chair of the CCG, stated categorically that there is unlikely to be an increase in the number of GPs, despite the assumption that more care will be provided outside acute hospitals. There is a national shortage of GPs. The increase (25%) in trainees promised by the Secretary of State for Health will not provide enough GPs or other doctors once trained, let alone in the short term. Patients will also not be confident that their needs are being met as 'physician associates' are trained and moved into GP practices and seeing patients to relieve the pressure on GPs. This is a cost-cutting device.

For a very high percentage of the population, a GP surgery is the first port of call for someone who is feeling unwell. And we know that bonds of trust between patient and doctors and practices are built up over a period of time. A doctor familiar with a patient is best placed to recognise changes in physical and mental health conditions.

It is unclear from the proposals for strengthening GP federations and increasing health care 'hubs', whether there is to be a reduction in the number of actual surgeries across the footprint. If this is the case, then the local knowledge build up by GP surgeries of their local population will be lost, as a surgery generally draws its patient group from its immediate locality. This means GPs will recognise key social determinants of poor health. Ironically, social isolation is mentioned as a social determinant of wellbeing. Yet there seems to be a case being put forward in the STP for cutting off or diminishing the direct contact between patient and GP. Contacting an 'anonymous' hub will discourage many patients for making appointments etc sufficiently early.

As indicated above, we are deeply concerned that reorganisation of GP services will mean the loss of the link between an individual patient and his/her GP or GP practice. What evidence is there that GPs would be happy about this? Have they been consulted as individual GPs rather than through so-called representation on the CCGs? We have noted the concerns raised by the London LMC about GP provision. Dr Michelle Drage, LMC Chief Executive, has said recently:

Our general practices are the backbone of the NHS - providing for 90% of patients' needs on a paltry eight percent of its budget - and falling. The NHS Five Year Forward View provided a vision of transferring investment from acute trusts to primary care, more GP training posts, better premises and above all "stabilising core funding for general practice nationally over the next two years". To secure the future of general practice for Londoners we need more resource and more support. And we need it now, before it is too late.

It is also well established that doctors base their diagnoses not simply on what the patient says, on notes and technical data, but also on body language and actual

examination (Dr Tony Grewal, former London director, LMC). We do not at all underestimate the advances to medical care provided by video, computer analysis, smart phones etc. But for many patients, face to face contact with a doctor is a prime way of developing trust. This is particularly the case in NW London which has a highly diverse ethnic population, speaking many languages, with a diversity of cultures and a growing number of older people. A strengthening of GP services should be a prime aid to 'wellness' in our area.

It is also worth noting here not just that appropriate access to digital facilities is not available to everybody and also that digital systems have a habit of breaking down – not useful if GP consultations, to save money, take place electronically.

## **STAFF AND CARERS**

SOH has consistently expressed its huge appreciation of NHS staff who find themselves in the frontline of providing services under increasingly difficult circumstances. As Sir Richard Sykes has told us in public (see [https://www.youtube.com/watch?v=IhYva5\\_0API](https://www.youtube.com/watch?v=IhYva5_0API)), there is no scope for further efficiency savings in hospitals and we are 'killing' our NHS staff through overwork. It is good to see such a frank appreciation of NHS staff from somebody so highly placed!

The STP recognises serious workforce shortages and problems in recruitment and retention, with overdependence on agency staff (p.35). But there seems to be little detail of how shortages, a London-wide problem, can be tackled locally. Nothing is said, for example, about the costs of living in London – a major deterrent and a cause of skilled staff moving elsewhere or to better paid agency work. Levels of pay for nurses and other ancillary staff are not addressed. Nor is workload.

What is also disturbing is the statement that there will be 'a 50% reduction in workforce development funding for staff in Trusts'. Does this reduction depend on the reconfiguration of acute trusts? Does this mean that this sum will only apply to Ealing, if it ceases to be an acute hospital, since Charing Cross is not to be downgraded in the short term? It is not clear what the figure refers to, but it is alarming. Further, it is not clear just what the spend will be on 'Workforce Transformation to support new ways of working'. This entire section is written in corporate obfuscatory prose when detail is needed to indicate that the STP has a strategy rather than a pious wish.

NHS staff and patients deserve better than this.

We find it extraordinary that UNPAID CARERS are included in the workforce! Indeed, with 103,001 unpaid carers, they are a majority of healthcare 'providers' in NW London. There is no analysis of who these unpaid 'staff' are, what support they receive or what pressures they face. Indeed, the thrust of the STP closing acute facilities will pile additional pressure on carers without medical training, often at breaking point, so many will feel unable to cope. It would also seem to imply that the number of such carers should increase. A much more detailed analysis, with

clear evidence, needs urgently needs to be provided about carers, their dependents, the work they are doing and the support they receive, including costings. It is also important to recognise that these carers are often the most vulnerable to other cuts in social care and welfare budgets.

We also note that, while there are currently 1,284 pharmacists mentioned in the STP, and these are seen as a front-line service that could reduce pressures on GPs, it is also the case that the government is set to cut 12% funding from community pharmacies over the next two years. This could lead to the loss of up to 3,000 pharmacies (see <http://www.pharmaceutical-journal.com/news-and-analysis/up-to-3000-pharmacies-could-close-after-government-cuts-mps-warn/20200553.article>) - and undoubtedly would affect NW London where costs are higher.

More generally, there is no evidence provided that health care staff have been consulted on the STP proposals in any meaningful fashion.

It is shocking that it seems that NHS staff are to be pressurised into becoming 'advocates for the STP' (see the presentation by Dr Mohini Parmar at the JHOSC, 14 Oct '16 at Ealing Town Hall). We are not clear that an employer has a right to require staff to undertake this; staff need to feel able to be critical and when necessary to be whistle blowers. We need assurances that staff will not be required to be advocates for the STP either as a condition of employment or otherwise.

## **CARE IN COMMUNITY COSTS – WHO PAYS?**

One of the key thrusts of the STP is the movement of health provision away from acute services and into 'the community'. It is not at all clear whether this is a move to primary care or to social services care – or a mixture of each. We have already, above, noted the intense pressure on primary care and we are alarmed if the STP entails putting people back into social service care at a time when it is widely recognised that social service budgets have been systematically cut in recent years and are due to be cut further each year up to 2020.

Neither the Better Care Fund nor promised transfers of monies from the STP developments to social care can make up for the heavy cuts which all social care budgets face under the current austerity regime.

Nobody expects there will be sufficient additional money from central Government to pay for a significant expansion of social care eventuating from cuts to acute and other hospital care.

In fact, there are fundamental worries here. Patients treated within the NHS acute, hospital and primary care services currently receive treatment 'free at the point of delivery'. However social care is customarily means-tested and payment or co-payment by patients/clients. Is there an attempt, in the STP, to move care away from 'free at the point of delivery' to make patients pay, or part-pay, for services?

This would be a fundamental change to the NHS. Again, this is an issue which SOH has been asking local health authorities to clarify since the inception of SaHF. We still don't know! In other words, there has been no specific information published about which services might be means-tested and which services will be provided free of charge under the STP.

It is also worth noting that the move to standardise provision across the footprint area has not taken any note of differences between local authorities in charging policies for various forms of social care. Surely this is also a key element if unnecessary variation in outcomes is a desired aim.

## **TRAVEL**

As noted in the section on Sustainable Acute Services, there are major issues around the effects on patients of having to travel further for care – this applies both to acute care and more generally to other hospital care and primary care. It is an issue that has consistently been ignored by both H&F CCG and Imperial College Health Care Trust. Put bluntly, closures of services and reconfiguration will have damaging effects on the most vulnerable who will have to travel further to and from health care services and, in many cases, will have to pay additional sums for travel. This may also affect large numbers of unpaid carers.

## **THE DIGITAL ENVIRONMENT**

We will not repeat concerns we have expressed earlier in the paper about over-dependence on technological services for health provision.

We do, however, want to raise key issues of security, privacy and patient agreement to sharing data (and who it is shared with). Some of the proposals involve very large numbers of people being able to access and use data on individual patients. This of course can be a very positive aspect of team work with the patient but there is nothing in the STP to show sufficient security both for individuals and of databases from hacking, nor to ensure informed consent. We would also note that there have been cases of anonymised patient data being sold on to private corporate bodies. This is something that should also have patient consent.

It is clear that governance of data is already a genuine concern with some of the initiatives taken in NW London. For example, in April 2015 the Nuffield Trust conducted an evaluation of the NW London WSIC since its inception in April 2013 ([http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/integrated-care-north-west-london-experience\\_0.pdf](http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/integrated-care-north-west-london-experience_0.pdf)) and concluded that there were serious governance issues including those in relation to consent, that it was deviating from its purpose and it was seriously behind schedule and over budget (actual cost: £25M).

## **GOVERNANCE AND ACCOUNTABILITY**

Already in NW London there is a very complex governance system which the public finds difficult to understand or engage with. The STP is to cover 8 boroughs and is to have an executive group at the peak of the STP which does not appear to be accountable either to local government or to the public. It is not clear locally, and even less so in the STP, who is responsible for decision-making, who will carry the can if and when things go wrong. How can the public, as apart from small selected groups (e.g. voluntary groups who depend on the CCG for funding), influence decision-making and seek redress? Even the small number of elected councillors on the overarching STP body seems more decorative than involved as actual decision-makers – it is not clear that they can speak for each and every council caught up in the STP.

We are deeply concerned that this overarching body may be given delegated powers. This is undemocratic and reduces even further accountability.

As the planning, to date, of the STP has been carried out in semi-secrecy, we can have no confidence in the management structure being able to respond to the health demands of the public and questions raised by residents in the NW London area. Indeed, it is significant that at the JHOSC meeting on 14<sup>th</sup> October '16, core questions asked by councillors and by the chair were treated evasively and no clear answers were given.

## **ACCOUNTABLE CARE PARTNERSHIPS**

The first thing we would like to note here, is that ACPs are an importation of Accountable Care Organisation in the USA. These have been a key mechanism for attracting private corporations to provide health care and boost their profits.

As we understand it, ACPs will be consortia of NHS Trusts, CCGs, local authorities, GP federations and private and charitable care organisations. It seems that, by 2021, all healthcare and social care services are to be delivered by ACPs who will be given long-term fixed price contracts which will be based on a 'capitation' method.

At the Imperial Board AGM in September '16, held at St Pauls Church, Hammersmith, a 'pilot' of collaborative work was presented to attendees. Quite apart from the limitations of the pilot, because of not getting informed consent to share data from an overwhelming majority of patients approached, it was also significant that Prof. Tim Orchard stated that, from this study, it was clear that the integration of medicine and social 'can be fiendishly difficult'. This was a very small scale study with high staff to patient ratio. It seems that there has been little work done to see how ACPs can be rolled out across the footprint effectively by 5 ACPs and within a limited budget.

Within the STP, it is proposed that there be 5 ACPS in NW London, servicing specific populations of 500,000 – 1 million people. What is not provided is either a clear

financial plan for how this might work or how, if budgets are exceeded, care will continue to be provided. It is also the case that nothing in the STP explains how patients with a variety of conditions could be catered for within one ACP. Does this imply that more than one ACP might be responsible for a single patient? Some patients have complex conditions – or their health needs change. How is the continuity of care ensured?

These ACP proposals have been introduced in an almost clandestine way. None of them has been discussed in Parliament; no Act of Parliament mandates any of these STP/ACPs. There is no clear indication of how they can be held both responsible and accountable, or of how they might be managed if they overspend their budgets. (It is important to note that a number of privatisations of care have collapsed because of financial issues.) Why has such a massive transformation of NHS provision not been put to the public nor even debated in Parliament?

## **FINANCE**

It's all about the money, isn't it?

Chris Hopson, Chief Executive on NHS providers, told the House of Commons Select Hearing on 11th October that time constraints and unprecedented financial deficits facing NHS trusts risked 'blowing up' the STP schemes. Noting that the funding is going to drop, he pointed out that the set of figures just look completely undeliverable. He went on to say,

Our members are saying to us that they are spending quite a lot of time creating plans that in their view are not deliverable and usually involve major structural service changes, because that is the only way where they can create a balanced plan.

In NW London, plans to reconfigure health services have been on the agenda for more than four years. The public and local councils have been promised an Implementation Business Case for more than 2 years. This has yet to be provided and, at the JHOSC meeting in October, it was clear that one will not be seen for some time (if ever). It is also worth noting that this plan now relates only to estates and capital expenditure, whereas we were initially told that it would provide a business case for Shaping a Healthier Future in its entirety. Just knowing about 'estates' does not convince anyone that plans are going to be effective!

And even in considering 'estates', it is known that in the NW London area a register of NHS property deemed 'surplus' to requirement for health has already been drawn up. This register has never been published, the public are not aware of what estates are being considered for sell-off, nor whether sell-off will inhibit future health provision, in a context of a growing population, being developed. We DO know that the downgrading off Ealing and Charing Cross Hospitals involves plans to sell off hospital land, but as yet there are no details of which parts of the hospitals are to be

sold, of plans for redeveloping the land, nor of where the capital from the sales will go – how much is to be returned to the local health economy? Will these sales remove NHS land from public ownership, to the advantage of private developers?

The STP, much of which was also in SaHF, seems also to be based on an absence of sound financial planning. Although there are enormous ‘savings’ listed in the published draft STP, there is no clear evidence to say that ‘costs’ (where given) can be limited to the figures given and ‘savings’ (where given) can be achieved. It is virtually impossible to make more than broad general comments because of the lack of any working out of costs in relation to programmes. Taking the figures ‘on trust’ is not something we, or the public more widely, should be asked to accept.

When there is mention of savings by further efficiencies, the public knows that this is impossible because the NHS has reached the limit of saving possible from this route. No evidence is presented to indicate just where ‘efficiency savings’ can be made.

Nor is there any evidence presented to indicate that the switch to services outside acute care and the reconfigurations of primary and social care can be provided more cheaply than current services. Indeed, even if there was such evidence, innovations in their formative stages, always involve additional investment and even long term don’t always lead to savings.

One additional factor needs to be looked at. Unbelievable as they are, the figures rushed out by the NW London STP were produced in a zero inflation era which is now finished. Already, post the Brexit referendum, inflation is heading to 1% and the Bank of England expects inflation to rise to 3% over the next year or so. This throws the hastily produced figures further into question.

## **CONCLUSION**

The STP was produced under enormous time pressure at the behest of NHS England to cut an enormous amount of money from the budget.

The STP offers NO evidence that £1.3bn can be cut from the NW London area between 2017 and 2021 without significant damage to our health.

The STP offers NO evidence, clinical and financial, that an enormous transformation of acute and primary care can be rushed through over such a short period of time.

The STP offers NO evidence as to how closing two acute hospitals and losing more than 500 beds can enhance provision for local people.

The STP offers NO evidence that enormously complex ‘lifestyle’ changes can be engineered to improve the health of the local community within half a decade.

The STP gives NO explanation as to how ACPs can work in practice without turning great parts of our NHS over to private corporations.

The STP has neither been put before the public, nor before Parliament, and therefore lacks legitimacy.

The STP should be withdrawn.

It would be more helpful if CCGs demanded of their paymasters that spending on the NHS be raised at least to the average level of spending across the European Union.