Public voices, public service

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Listening to the people of North Central London

NCL STP watch

September 2017

www.islingtonkeepournhspublic.org

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Executive Summary

'NCL STP watch' is an umbrella organisation for various health campaign groups across the boroughs of Camden, Islington, Haringey, Barnet and Enfield. We have been working for more than a year to try to ensure that the voices of the public are heard in the face of drastic changes currently being planned and executed for the NHS in this area of North London.

This work uses publicly available documents for the STP:

- all draft versions of what was the North Central London Sustainability and Transformation Plan (hence 'NCL STP watch') up to the recent 'North London Partners in Health and Care sustainability and transformation plan June 2017';
- 'High Level 5 Year Delivery Plans and Detailed Plans for 17/18' of the following Work Streams: 'Urgent and Emergency Care (UEC)'; 'Health and Care Closer to Home'; 'Workforce'; 'Mental Health'; 'Prevention'; and 'Planned Care'.
- 'NHS Property and Estates- Why the estate matters for patients. An independent report by Sir Robert Naylor for the Secretary of State for Health (March 2017)'.

We set out questions that were drawn from a group of archetypal characters who we believe have a right to be heard as public services are changed. We then answer the questions from our research of the documents. The characters are:

- older people, who may have more call on health resources than their younger peers;
- people on low incomes who already have difficult decisions to make about basic needs;
- people who have grown up trusting that their GP uses their own clinical judgement to decide on a patient's need for any treatment;
- people who need both health and social care, who are concerned that their community health care may not be met out of the publicly funded NHS;
- staff members who work for the NHS in North Central London;
- people with severe mental health problems who might sometimes need access to acute beds;
- children, whose mental health is compromised by poverty and poorer life-chances than their peers in better off families, and who need to be able to access services.

In doing this we endeavour to fill the hole that has been public consultation.

The key findings in our investigation are that:

- healthcare for older people will be downgraded, indeed older people may feel that they are to become second class citizens;
- major health inequalities will not be addressed, people with low incomes may have to look in vain for any evidence that anything substantial will be done to change health inequality;
- individual patient need/medical judgement will become less important as centralised control is imposed;
- the involvement of Local Authorities in STP plans appears to be an after-thought and this deficit in planning is going to make integration of services difficult, and the poor state of social care finances means it is likely that people will have to fund some of their community health care themselves;
- there has been little consultation with, and preparation of, the staff needed to provide the new model of care, and therefore staff have not been able to contribute to the plans that will require them to adapt rapidly with the imposition of the new model of care;
- parity of esteem for mental health is unlikely as the number of acute beds is to be further reduced, and even by 2019 evidence-based services will only be available for 32% of children who need them; extra funding appears to require savings elsewhere.
- the delivery of the STP is too dependent upon the NHS estates strategy, as discussed in the Naylor report, and there is great concern that our NHS assets will be sold off quickly and cheaply to make up for Government underfunding.

Our recommendations to North Central London's MPs, Council leaders and top decision-makers within the NHS are to:

- seek to have the STP process (not only in North Central London but also across the whole of England) paused to allow for a searching review;
- cease service cuts that may harm older and other vulnerable people;
- demand to see full health impact and equality impact assessments that may be used to guide the STP developments;
- ensure that any future major change programme be conducted with the full involvement of staff who work in the NHS and Social Care, and that members of the public are enabled to play their part;
- seek to create by statute a new organisational structure that would give effect to a more collaborative approach;
- ensure that no irrevocable changes in the NHS estate occur until proper statutory bodies exist within the sub-region that can be trusted to make decisions in the long-term interests of the public.

1 Introduction

This document has been written by members of NCL STP watch, an umbrella organisation for various campaigning groups across the boroughs of Camden, Islington, Haringey, Barnet and Enfield. We have campaigned for nearly a year now to ensure that the voices of the public are heard about the drastic changes currently being planned for the NHS in this area. Despite the fact that the planners of these changes admit that they are going ahead without proper public involvement and consultation, the juggernaut of planning rolls on, with a new version of the plan published in June and several priority work-streams publishing their own sub-plans, working away at fundamental changes without hearing the voices of the public.

This is uncharacteristic behaviour for the people who plan our NHS, who have previously been more open to consultation, and we can only assume that this is because there is something to hide. The planners acknowledge that the financial position of the area is very challenging, but they also tell us that by adopting new models of care, they can in effect provide the same quality of NHS for us, even though they have insufficient money. Because we are sceptical about this, we have undertaken to write this report.

We have taken the trouble to read all of the publicly available documents for the STP, including six of the priority work-streams operational planning documents. Additionally, we have read the Naylor Report on the NHS Estate, since changes in the use of NHS land and property play a part in these changes. As we completed our work, we became aware of the government's Capped Expenditure Process (CEP), which applies to North Central London and 13 other areas. According to leaks of the CEP document, it calls for health planners to 'think the unthinkable' in order to make cuts, which in North Central London amount to £183m to be cut within the year 2017/18. We believe that this document was written during the election campaign and was predicated on the government increasing its majority. In the event, the election has demonstrated that there is no mandate to shred the NHS, either in North Central London or anywhere else. Our campaign continues.

2 What are the main proposals in the Sustainability and Transformation Plan (STP)?

We do not propose to give a detailed summary here. Anyone who wishes to can use the following links to reach our source material

- summary of STP June 2017 (northlondonpartners.org.uk)
- 6 work-stream links (see below)
- Naylor report (www.gov.uk)

- For assured access to these documents, they have all been downloaded and placed on the website of Islington Keep our NHS Public (www.islingtonkeepournhspublic.org)

In brief, the NHS and social care system in Camden, Islington, Haringey, Barnet and Enfield is required to save £1.2bn per year by the year 2020/21, compared with what would have been spent on the NHS and social care if the current levels of spending continued and were increased to take account of the expected increase in population, including in the population of frail older people. The STP includes the following:

- Cut £900M per year by 2020/21 from the NHS budget in North Central London-a cut from that required to meet the projected level of need given predictable changes.
- Recognise that the shortfall in funding from Government for social care, which goes to local government, is in the region of £247m.
- Savings made by diverting people from A&E and preventing them from becoming hospital in-patients through creating better community-based services
- More preventative work to stop people getting ill in the first place
- Better community-based mental health services to release resources from acute mental health beds.
- Consolidating hospital services where community provision has developed.
- Fewer people to meet their deaths in hospital, rather than at home or in their care home

At the end of this report we will draw out lessons for policy-makers and those who lead the decision-making process on these matters, but the bulk of the report focuses on the questions people would ask if they had the chance, the evidence about the answers that is drawn from the official documents of the STP, and our commentary on what we think this evidence means in practice.

In the main part of this report, we set out the questions these groups of our fellow citizens might ask, and answer them using the evidence in the documents that we have cited

- The questions and related points appear under numbered headings - as in question 1 below (**Q 1. How does this affect older people - do I become a second-class citizen when I reach 65?**)
- These are followed by i) answers to the questions in the left hand column, based on evidence quoted from the official documents; ii) the quotes from the STP and other official documents in the right hand column in this format and; iii) our comments on the answers appearing as *indented statements in this italic format with a red line.*

3 Public voices

The next section sets out the archetypal characters whose questions we draw out. We call them public voices and strongly believe that they have a right to be heard as public services are changed.

Members of our campaigning group are not a representative sample of the population of the five boroughs, but we do have our roots in the community and have decided to put ourselves in the shoes of different kinds of our fellow citizens, to ask the questions that those people would ask if they could. These archetypal characters are the following:

- Older people, who might feel as they read the STP documents that they were becoming second class citizens.
- People on a lower income that they have to make stretch a long way, who may be pleased with high level words about overcoming health inequality, but then look in vain for any evidence that this is being done.
- People who have grown up trusting their GP to use his or her clinical judgement to decide on the treatment they need, and may find that centralised control is being imposed on supposedly independent GPs.
- People who need both health and social care, whether young and disabled or older and frail. Can they be confident that their health care will still be met out of the publicly funded NHS, or in the name of integration, are they likely to have to fund some of their health care through means-tested social care services, where they will have to pay out of current income or the sale of their house or flat?
- Staff members who work for the NHS in North Central London.
- People with severe mental health problems who might sometimes need access to acute beds.
- Children, especially those being brought up in poverty, and whose health is compromised by poor diet, inadequate housing, depleted youth services - poorer life-chances than their peers in better off families.

3.1 Q 1. How does this affect older people - do I become a second-class citizen when I reach 65?

- Your emergency choices will in effect be constrained. You will be asked to avoid calling an ambulance if at all possible because they will be dealing with 'real emergencies', instead you will be encouraged to call NHS111 for advice. If an ambulance is called to see you, paramedics will be told to divert older people like you if at all possible to "Care Closer to Home" and away from A&E, these 'barriers' inevitably mean that it may take you longer to get to A&E as they need to determine when you really need to receive the expensive care it provides.

  You will be rapidly discharged from hospital so your care-needs assessment will be done at home. The decision to discharge may not be made solely by doctors but also by administrators, you may need to move from your home once more after assessment at increased risk to your health.

- The routine operations for painful but not life threatening conditions that you would have got a

Urgent and Emergency Care (UEC) Work Stream: High Level 5 Year Delivery Plan and Detailed Plan for 17/18

Page 3 **Cost:** Delivery of all projects requires a shift of resources within the UEC system….Costings do not…….capture the cost of Social Care

> *Despite the fact that it is known that Councils are being underfunded for the provision of care in the community and in residential care, the NHS is also cutting its budget and making sure that it does not provide a safety net for people who could be discharged from hospital if social care was available.*

Page 6**: An Enhanced Community Based Admission Avoidance (ECBAA)** model is planned to support care being provided closer to home. ' joining up of all community-based admission avoidance services ……..patients to receive their acute care at home……developing services in acute trusts to provide same day emergency care to patients to support assessment, diagnosis and treatment'

> *This means you go to hospital anyway for tests and examination, but as a lesser priority, and then they are very keen not to admit you to hospital because it is expensive, and you may become a problem for them by taking too long to get well or you end up needing to wait in hospital for more help at home- there is a shortage of money to pay for this home care.*

year or two ago may be denied you, or you may have to wait longer depending on the financial pressures on the new Health system. It will only have a fixed amount of money to look after the whole of NCL and emergencies and life-threatening conditions clearly are the priority.

- Social care staff in care homes will provide care paid for from your pocket rather than through general public funds, unless your assets, including your home, are valued at less than £23K. This includes caring for you when you are dying. Caring for the dying is a specialised task and there is no evidence that the authorities will be able to train enough social care staff to take on these new tasks, especially as there is a big turnover of staff in social care.

Page 6: **Acute Frailty Pathway** treatment of frail older people by standardising services, processes and pathways across NCL to ensure that only those requiring admission are admitted to hospital; enabling rapid discharge of medically optimized frailty patients.

> *See above- once labelled as 'frail' your care will follow a particular course when you become very unwell, this part of the 'pathway' means that once your medical observations and tests are acceptable, you will be discharged from hospital asap for a lower level of care at home, which will be cheaper. But Councils in NCL are having to cope with a loss of £247 million for their services including social care by 2020/21, so may not be able to provide this care.*

Page 6: **Last phase of life**: identify…… and record care planning information for care and nursing home residents in their last year of life; reorganise services around two hubs (north and south) to provide Specialist Palliative Care advice…..remote (senior) nurses will support 3-5 (junior) nurses who visit patients(across the whole of NCL). (*The hope is to)….. reduce A&E admissions… improve end of life care….. improve the knowledge and care of the social care workforce*

> *3-5 nurses for **all** 137 care and nursing homes in NCL- current internet enquiry- with lack of money for social care provision as above.*

Page 6 **An Integrated Urgent Care (IUC) model** This… brings together current urgent care services such as 111, GP out of hours, Pharmacy, Urgent Care Centres and Minor Injury Units

> *They all need to coordinate to work together but it takes a lot of time to develop collaborative working between separate organisations*

Page 6 **Simplified discharge**: involves establishing a Trusted Assessor Model wherein health and social care professionals complete a single assessment of patients' needs, which can be shared

> *Trusted Assessors need not be medical or nursing staff. They will be subject to the requirements of their senior managers to ensure that hospital beds are freed up to ensure increased 'throughput'*

All older patients will have a 'senior review' before midday by a clinician

> *To see if they are ready to leave yet. But there is no evidence in these documents that this demand has been put to senior clinicians and we cannot know whether they will consider it right to change their working practices in this way. They might think their time would be more usefully spent doing other things, like seeing patients in outpatients clinics.*

All patients will have an expected discharge date…..set within 14 hours of admission….and clinical criteria for discharge. A systematic review of 'stranded' patients

> *With extended lengths of stay (> 7 days) with a clear 'home first' mind set.*

….supporting shorter hospital stays by ensuring that, where appropriate, an assessment of on-going care and community support needs takes place in an environment familiar to an individual, either at home or by using 'step down' beds

> *They send you home and then assess your care needs.*

Key expected benefits include reduction in delayed transfers of care, improved patient flow….reduction in excess bed days.

> *These are benefits to the system, making it cheaper, rather than to you, the patient.*

Page 13 **LAS Green Ambulance**: Cat 3/4 activity….. enable the IUC service to deal with category 3/4 calls that originated by a call from a patient to LAS. …..Therefore some G3/4 activity would be 'warm transferred' from LAS to IUC for clinical assessment

> *Some people who make 999 calls will not be taken to A&E but referred to community services for assessment- the mechanism to do this is not clear but it depends on a paramedic being skilled enough to assess rapidly that this is safe to do. We have seen no evidence of investment in staff training to enable them to take on such decision-making tasks.*

Page 14 **Care Homes**: Posters – a visual tool placed in/around all care homes advising staff on how to access the above shortcut function with IUC as opposed to immediately requesting an ambulance. The poster…. gives a range of information and alternative options to staff.

> *Staff need good training in order to make the right decision in an emergency. A poster on the wall, even if it stays there, will not suffice.*

Page 57 Improving the quality of peoples' care within the last phase of their life, to support them to die in the place of choice.

> *This first choice may be hospice, then hospital and finally at home for many older people in London-see Catt et al Palliative Medicine 2005 (islingtonkeepournhspublic.org).*

Planned Care Workstream - High Level 5 Year Delivery Plan and Detailed Plan for 17/18

Page 4 single point of access for advice and navigation and referral management
Page 7 Standardisation of thresholds and policy across NCL to ensure parity of care provision. This will be broken into two sections: Application and monitoring of adherence….Extending the scope. …….Revision of the number of procedures in scope.

> *This promises to reduce the scope for your GP to refer you to treatment he or she thinks you should have. It imposes administrative controls over the discretion of doctors.*

Page 38 Providers may need support to reduce capacity and take cost out….the funding mechanism needs to distribute the rewards of these interventions effectively, to ensure that costs do not disproportionately fall on acute providers

> *Because of rationing, hospitals will do less work and earn less, as they are currently paid per procedure. This will make it difficult for them to continue without some financial help.*

3.2 Q2. Will the NHS be clinically led or will decisions be made that are about saving money – Can I still trust my GP will do what is best for me?

- Your GP is likely to lose their discretion to do what is best for you. Administrators will be posted in surgeries to make sure that any GPs with higher levels of referrals to hospital are forced to reduce to the 'right size' (as judged by the people in charge of the NHS's money)
- More GPs will be encouraged to give up their independent practices and move into big expensive hubs, where they will be paid on salary rather than being self-employed. As such, they will lose some of their capacity for independent clinical judgement. These hubs will be large and will be contracted out. Small GP practices may not be able to bid successfully and the likelihood is that more of the country's GP practices, and the primary care they deliver, will be under the control of the private sector.

Health and Care Closer to Home Workstream - High Level 5 Year Delivery Plan and Detailed Plan for 17/18

Page 15 Quality Improvement Support Teams (QIST).....to ensure a consistent quality standard and offer to all patients.

Page 5 The QIST team will work closely with the Referral Management Service that already reviews all secondary care referrals and identifies and addresses variation in referral practice

> *Anyone who makes too many referrals will be investigated.*

Page 6 Strategic Narrative – Improved Access Enfield CCG Our model for extended access in Enfield CCG will be delivered from three hubs in 2016/17 increasing to four hubs in Q2 of 2017/18 and….Page 3 Care Closer to Home Integrated Networks (CHINs) will most likely cover a population of c.50-80,000 people… will be home to a number of services…. including health and social care integrated multi-disciplinary teams (MDTs)……Interventions focused on the strengths of residents, families and communities

> *GPs who are motivated to provide care for patients that does not fit the new model will be squeezed out. Friends, family and volunteers will be expected to take on more care.*

Page 5 Integrated networks , or BILT, as they are known in Barnet, are a whole health and social care economy approach which is directly linked to the NCL STP ambition. The ambition in Barnet is

These private companies will deliver the service and make a profit, and in order to do that they will need to make decisions that save money, and as we know from past experience such as with GP out of hours cover, this is not always in our best interest.

for networks to evolve into capitated, accountable care organisations.

> *Capitated, accountable care organisations undertake to provide all care for a given population for so much per head. Services will be rationed to fit the budget, even if your clinical needs are not being met.*

Page 42 GPs will be working "at scale" Page 7 Services are intended to be planned and commissioned by the CCG via the Hubs

> *Private providers will be able to bid to provide all or some of the services in the Hubs*

Page 36 NCL has good services, the health and care closer to home model will focus on scaling these services up, reducing variation and making this the CHIN model the default approach to care and place based commissioning of services.

North London Partners in Health and Care: Sustainability and Transformation Plan June 2017

Page 54 In 2017-18 we will: develop detailed business cases for the care closer to home estate to support the developing CHIN framework by working closely with the Care Closer to Home and the Planned Care workstreams; and use devolved powers and other avenues to secure capital to deliver these much needed improvements and reduce the running costs of this estate

> *They will sell off NHS property and encourage private investment. This is also likely to mean that some of the NHS's property will be used to subsidise the service that is being under-funded. This will let the Government 'off the hook' of public disapproval for under-funded services without them having to pay for it by providing more revenue. Privatisation of public assets will make us poorer in the long run.*

NHS Property and Estates Why the estate matters for patients An independent report by Sir Robert Naylor for the Secretary of State for Health (March 2017)

Page 16 'We conclude that this estimate [of capital from selling NHS assets] could rise significantly if the NHS adopts a more commercial approach to obtaining planning consent,

negotiating affordable housing quotas and maximising value from the highest value sites in London.

Page 20 'add the additional opportunity from the non-acute estate and additional opportunities in London (to reach a total of £2.7bn)…… Steps 8 and 9 show how the estate could deliver significantly greater value if more radical reconfigurations were undertaken particularly within London, or if the risks associated with planning permission and affordable housing could be mitigated. This offers a potential upper bound opportunity of £5.7bn.'

Page 28 Given the independence of the primary care sector which is largely already privately owned, active consideration should be given to how GP practices can be given incentives to move into new facilities, supported by substantial private sector investment

> *The independence of GPs partly comes from the fact that most of them are partners in their own practices rather than employees of the NHS or private companies. Some of the younger doctors in GP practices will be employees of the practice, and may become partners in time. Most practices own the property where their surgery takes place. Once that autonomous position is lost, the way is open to much greater involvement of the private sector in GP services, and that would constrain the clinical autonomy of GPs*

Ref: **"Harmoni out-of-hours GP service putting patients at risk, say doctors" Felicity Lawrence The Guardian Monday 17 December 2012**

> *A local incident where a private out of hours GP service was so unsafe that doctors refused to work for it*

3.3 Q3. Health inequality is a major issue, with better off people living much longer than poorer people - I am on a low income. How will I fare under these new plans?

- You may have to travel further to go to the GP and to hospital. Despite the STP's emphasis on 'care closer to home', both GP services and

North London Partners in Health and Care: Sustainability and Transformation Plan – June 2017

Page 38 we are developing the case for a single provider model for radiotherapy in North London, to help achieve financial sustainability, reduce variation in clinical protocols and improve patient access to research and clinical innovations.

hospital services will be 'consolidated' on fewer sites. This will include some forms of cancer care when you have to visit every day or so for a period of time. There is no mention of increasing the funding for patient transport, so you will have to pay for it yourself. Some of the journeys for appointments will be difficult unless you have a car.

- The plan makes high-level statements about reducing health inequality, but there is no evidence of planned service changes being linked to analysis of inequality. What they say and what they do, are not the same thing. Indeed in neighbouring North West London it appears that A&E downgrades have occurred in the areas with the most people on low incomes.
- For people living very pressured lives, on low incomes and with a lot to cope with, turning the

This is being explored between the North Middlesex University Hospitals NHS Trust, the Royal Free NHS Foundation Trust and University College London Hospitals NHS Foundation Trust.

> *Research and Innovation are good things but this proposal makes them a higher priority than accessible patient care*

Page 64 We will identify clinical areas that would benefit from being organised differently (e.g. managing multiple services as a single service)……. providers collaborating and / or configuring in a new way in order to deliver…….changes to major services…..changes of this sort can be challenging to implement and controversial with the public.

Page 58 North London Councils will face a budget pressure of £247m for social care and public health by 2020/21, even when all additional funding announced by the Government has been taken into account.

Urgent and Emergency Care (UEC) work stream High Level 5 Year Delivery Plan and Detailed Plan for 17/18

Page 45 Modelling a significant impact on ED attendance activity… in particular CC2H and UEC on ED attendances…. this will then require review across NCL…to consider options…result in required consolidation of Urgent Care provision.

> *If the community care diverts people from hospital use then they will downgrade another A&E. Such a downgrade is not mentioned in the documents, but about half of the other 43 'footprints' in the country are recommending such downgrades or closures.*

Ref: **Transfer of local public health functions from the NHS to local authorities. The Lancet UK Policy Matters, May 11, 2011**

Ref: **Dr Gurjinder Singh Sandhu. The Centre for Health and the Public Interest (CHPI) April 2017."Can we afford to close any more A&E departments? Evidence from North West London". CHPI.org.uk**

Ref: '**Working for health equity. Professor Sir Michael Marmot, Pages 14-15. Commentary Magazine, RCP February 2014 (1)'**

whole system upside down as the STP will do is likely to be very discouraging, and people will be less likely to seek help. They may lose contact with the one person who seems to know them.

- One reason why health inequality is so great in this country is that poorer people do not report symptoms early enough, making recovery less likely or more difficult. Losing touch with your GP and then being heavily discouraged from going to A&E, which some people do as a backstop, will make this problem worse.

- The plan wants you to stay healthier for longer, but many of the services that help people to do this - smoking cessation, exercise classes for weight control, availability of drop-in centres - have all been cut because they are funded out of the reduced local government budget rather than through the NHS.

3.4 Q4. New models of care are supposed to be the main purpose of these changes - Integration of health and social care - Will my NHS care and my social care work well together?

- The STP wants patients discharged from hospital more rapidly - by people in a new role called 'trusted assessors'. Like so many of the new terms in this plan, the name obscures the change they want. We trust doctors not to do anything that may harm us, and that includes discharging us only when our illness and our circumstances are right. 'Trusted assessors' are likely to be administrators with little choice but to obey senior managers who will be extremely concerned that 'throughput' is fast enough.
- This plan does not include the funding for social care within its scope, although it makes many assumptions about the continued availability of both residential and home care. These services are currently only available to people with very high levels of dependency rather than for all patients who need help to cope after illness. The fact

Ref: **Social Care Funding: Understanding the reality behind the manifesto commitments. Election Briefing Note May 2017. The Centre for Health and the Public Interest (CHPI) May 2017 CHPI.org.uk**

See 'Trusted assessors' above

that the NHS is free at point of use and funded out of general taxation, whereas social care is not, means that it is not easy to join up the service, despite the plan's expressed good intentions. The government went into the election with an aim to increase the payment by individuals for home care, and even though that proved very unpopular and was dropped, it just adds to the general sense of unresolved problems in this plan.

- While the NCL STP does not involve closing existing beds, if we continue to use beds at the same rate during the next five years as we have in the past, and with the expected increase in our population, we will be 550 beds short (statement from the lead finance person in the STP planning team, during a meeting with campaigners, November 2016). That means that the pressure to get you out of hospital quickly will intensify and it seems likely that it will be rushed and hurried rather than integrated.

3.5 Q5. Where will the money come from for investing in new community facilities? - is this just another opportunity to sell off the 'family silver' - NHS property - instead of funding the change properly through government funding?

- The Naylor Report, (NHS Property and Estates Why the estate matters for patients. An independent report by Sir Robert Naylor for the Secretary of State for Health 2017), focuses attention on land and buildings owned by NHS organizations. In North Central London these are very valuable. The risk is that the most commercially attractive sites are sold off to the private sector, rather than being used for public

North London Partners in Health and Care: our sustainability and transformation plan June 2017

Page 65 In addition, we will continue to engage with the work being led by Sir Robert Naylor in relation to property strategy across the NHS, to further understand how being a pilot area in this can help North London make best use of its current assets to support the delivery of our vision

> *It seems that NCLSTP were ahead of the game as the Government had not yet accepted the Naylor Report findings while they were continuing to engage with the work. Developing the new community- based services in the plan will require investment, and the investment funding originally set aside by the government for this purpose has mostly been diverted to cover the deficits incurred by our under-funded hospitals. Selling off NHS assets is an alternative way of getting the money, but once they have gone, they have gone*

benefit e.g. social housing or community facilities.

- To encourage the sale of NHS assets, the Government is introducing a special fund that doubles the proceeds from early sales. The risk is that in the rush to sell buildings to get this extra funding, the buildings will be sold cheaply and, yet again, the private sector benefits at public expense.
- The STP sets out a building programme costing £400m, the bulk of which is the move of Moorfields to a new site at St Pancras. Even though much of this funding is available, there is still a shortfall of some £75m. Yet another argument for increased Government funding.

> *for ever. Decisions about investment and disposal should not be skewed by two-for-one offers.*

NHS Property and Estates. Why the estate matters for patients Naylor Review (March 2017)

Page 15 Firstly, the cost of implementing the 5YFV is unknown …….Some commentators have informed us that this may be between £8-10bn. Secondly, we believe that the backlog maintenance figure of £5bn is a substantial underestimate. We conclude that the likely additional capital requirement to be around £10bn, in the medium term this could be met by a combination of three sources, **property disposals**, **private investment and public funding.**

Page 25 Given the independence of the primary care sector which is largely already privately owned, active consideration should be given to how GP practices can be given incentives to move into **new facilities, supported by substantial private sector investment.** [our emphasis]

Page 26 STP estates plans and their delivery (selling off buildings and land) should be assessed against targets informed by the benchmarks developed for this review (by Deloitte). **STPs and their providers, which fail to develop sufficiently stretching plans, should not be granted access to capital funding either through grants, loans or private finance….[**our emphasis]

> *Capital funding is the money needed to keep the hospital, and the equipment used to care for patients, up to date.*

Page 23 This review calls for additional capital to address backlog maintenance and incentivise providers to dispose of property. This should take the form of a 2 for 1 offer in which providers are given additional capital to match their disposal proceeds.

Page 24 This 2 for 1 offer should be time limited with a fixed funding pot and allocated on a "first come first served" basis. This will encourage STPs and providers to act quickly to take advantage of this opportunity and discourage them from holding on to land with the

hope of taking advantage of this offer later. We envisage that this would initially be offered for a period of 5 years.

Page 24 providers need to be incentivised to support integration between primary, community and secondary care. This review is encouraged to see plans to develop accountable care, whereby an individual organisation becomes responsible for the health needs of a given population, rather than the fragmented system that currently exists.

Page 24 The creation of accountable care organisations (ACOs) would overcome the conflict of interests that currently exist between the "advisory" role of STPs and the statutory responsibilities of NHS provider trusts. Primary care services could either be incorporated into ACOs or contracted to them via confederations of primary care providers.

> *The Government believes that the changes to our health service HAVE to happen for financial reasons; to allow the Government to spend less on us and enable them to give out tax cuts etc. to make us more competitive internationally. They need to stop doing expensive things such as you going to hospital to be seen by consultants. If they put up barriers to hospital care and provide cheaper community care then they hope hospitals will do less work, some of the money has to move out of these downgraded hospitals into the community and the ACO helps persuade them do this. However not all the money will come to the community otherwise no savings will be made. The money they save will be £1.2 billion, that's about £1000 per person by 2020/21, but they reckon the care will be just as good!*

Page 24 The establishment of ACOs would incentivise acute providers to invest their property assets in primary, community and mental health services

> *Money from hospitals, selling off our assets, will go to support private investments to build community facilities.*

3.6 Q6. When is anyone going to tell the staff? Fundamental changes in the way the NHS functions are planned, and all to be implemented at short notice. But staff consultation has been virtually absent.

- Many NHS staff joined to work at a particular hospital, and base their place of residence and their children's schools

North Central London Sustainability and Transformation plan Workforce Work stream - High Level 5 Year Delivery Plan and Detailed Plan for 17/18

Page 2 Define and adopt new ways of working, enabling working across health and care settings….Maximise workforce efficiency and productivity

on that area. If this plan goes ahead, there will be job losses in hospitals and new roles in community-based care. Nationally, the NHS has 10% fewer nurses than it needs - likely to be higher in high-cost areas like NCL. What proportion of staff will retire early or leave rather than undergo this major transition?

- Will there be the money to pay for 'double running' while new staff or those who have previously worked in hospitals learn the new pattern of work, or will staff be just thrown in at the deep end? What will this mean for patient safety and for peace of mind?
- We already have a GP shortage and only half of training places were filled last year. These plans intend to proscribe the scope for professional judgement of GPs, which is one reason people opt for this career. How will we fill the vacancies?

Page 4 changes to workforce resulting from the new models of care covering capacity changes, new roles, changed roles, skills, training, competencies, recruitment and professional and career development.

Page 5 Pooling resources across NCL and developing shared capabilities for in house delivery of education, training and workforce development

Page 24 We will work with NCL organisations across all care settings to support them to deliver the new care models in a range of settings and train people currently working in hospitals to gain the skills and confidence to work across the care pathway in community settings and delivering care closer to home.

North London Partners in Health and Care: our sustainability and transformation plan June 2017

Page 48 Since the inception of the STP, we have commissioned 446 postgraduate career development programmes and rotations for our nurses to develop the skills required to fulfil our vision of an agile, highly skilled, North London workforce.

> *We think this is the figure for the ongoing training programme with some awareness-raising elements on the STP, rather than a special set of programmes designed to enable people to make a major professional transformation.*

Page 49 we will also help to establish a number of new roles such as physician associates, care navigators and advanced clinical practitioners. We will support strategic workforce planning and redesign and commission training for skill enhancement, role diversification and new role implementation. Much of this work has begun, but others will be contingent on the definition of new clinical models. …. In addition, we will train everyone in a single approach to continuous quality improvement to deliver sustained clinical excellence and high quality care.

> *Recent headline in the Daily Mail on Physicians Associates 'the (cut-price) doctor will see you now'*

- New roles, which are watered down versions of doctor and nurse, are coming on-stream. What will happen to the quality of the service and the public's trust in staff when they realise they are not seeing a proper professional?

Page 50 These initiatives, together with work on creating common employment policies and procedures, will improve employment portability and further the aim of achieving more integrated employment across North London.

> *There are a large number of groups of staff with different and often nationally negotiated terms and conditions. Even navigating through this is difficult and creating a single North Central London workforce looks like a pipe dream.*

3.7 Q7. I have a serious, long-term mental health difficulty. How will the STP changes help me when I need acute intensive care?

- The STP is planning to eliminate the future need for 129 extra psychiatric beds by using community care. Professor Louis Appleby who audits suicide nationally is very concerned about 'community only' services, which he states are associated with a much higher rate of suicide than services that use beds. There is no detail as to how the STP planners are going to ensure that the community provision is as safe as it possibly can be.
- When there are not enough beds, the pressure to get people in crisis through the inpatient units can be terrible. With so few beds, actively suicidal people who require inpatient care may find that there are not enough resources, so their care will be rushed and there is no time taken

North Central London Sustainability and Transformation plan Mental Health Workstream - High Level 5 Year Delivery Plan and Detailed Plan for 17/18

Page 17 Under acute pathway 'realisation' of bed occupancy maintained at 95% over period; reduced Acute Length Of Stay; reduce admissions to secondary mental health they state 'If not done would require 129 additional beds'

North London Partners in Health and Care: our sustainability and transformation plan June 2017

Page 31 By investing in community based care, we aim to reduce demand on the acute sector and mitigate the need for additional mental health inpatient beds.

Page 31 The provision of appropriate social care is a key success factor for people with long– standing mental ill health and this will be central to the success of the stepped model.

to understand and deal with them as individuals with unique needs including social and domestic difficulties.

- The plan to move your 'place of safety' out of the hospital means that if you have a physical health problem that is mistaken as a relapse of any mental health difficulty, then it may not be as easy to get you the timely medical help you need. Also some people with severe physical health problems may present with mental health symptoms, and if they are sent to a 'place of safety' away from the hospital, they will also be put at increased risk.

> *But social care is terribly under resourced.*

Page 34 In the southern part of North London a plan is being developed to close the A&E HBPoSs, [Hospital Based Place of Safety] and move to a purpose built suite at Highgate Centre for Mental Health, this is expected to open in 18/19. In the north section of North London there is the potential to develop a complex rehab ward

> *Neither is in an acute medical hospital*

Ref: **Safety in crisis resolution home treatment services in England: an investigation of suicide trends 2003-2011. Hunt IM, Rahman MS, While D et al Lancet Psychiatry 2014; 1: 135-41**

Ref: **Suicide under crisis resolution home treatment- a key setting for patient safety. Hunt IM, Appleby L, Kapur N. BJPsych Bulletin 2016, 40, 172-17**

3.8 Q8. I am an unemployed, single parent and my daughter has depression, what help can I expect to receive with the STP changes?

- Mental health problems in children are increasingly common especially in the poorer areas of London. The STP plan aims to increase these specialist services but even so **ONLY ONE THIRD** of children who need them will get them by 2019.
- If your daughter becomes so unwell that she needs to be admitted to an inpatient unit, then she may have to go to a unit

North London Partners in Health and Care: our sustainability and transformation plan June 2017
Page 35……32% of children with a diagnosable condition being able to access evidence-based services by April 2019

Page 36 Release estates across the trusts, to enable development of community-based integrated…..facilities

> *The money is not just for psychiatric care.*

outside London, possibly as far away as Leeds. It will be very difficult to decide if it is right for her to go so far away from you. The STP is trying to get more money so that children can be cared for locally, but this money seems to depend on them making savings elsewhere in the service. Many people are just not aware of this totally unacceptable state of affairs and would expect the STP to deal with it immediately so that no more children and parents are put in to this position.

Page 36……Bid for local commissioning of Tier 4 CAMHS…..develop core 24 hour mental health liaison services at UCLH and North Middlesex…..plan the development of a local female PICU to be put in place in 2018/19…..seek to identify further investment funding to take forward implementation of other priorities in line with the plan

> *Having been underfunded for many years, mental health is meant to be a priority, and yet it seems that investment is very difficult to find and it seems that realisable savings from within mental health are essential before patient needs can be met- see below as well- rather than resources coming into mental health from other parts of the budget.*

NCL Mental Health Workstream – CAMHS (Child and Adolescent Mental Health Services) 21st April JHSOC

"Crisis Pathway. In June 2016 we bid for local commissioning of Tier 4 CAMHS, were shortlisted but **unsuccessful due to level of savings anticipated** and the plan for a phased roll out with an initial small footprint, however were encouraged to reapply. Since then we have been working across to develop the model and the bid ready to submit when the guidance is issued which is expected shortly. Evidence from NWL has shown that local commissioning of Tier4 CAMHS can deliver 10% savings through reduction in Length Of Stay and admissions. We would invest these savings back into the outreach offer."

> *Tier 4 CAMHS is inpatient care for children*

4 Findings and Recommendations to the top decision makers in North Central London - our MPs, council leaders, CCG chairs and Provider trust chairs.

Carving England into 44 Footprints and requiring health service planners across the country to devote significant time to developing detailed plans to implement the ideas in the document the Five Year Forward View, but with no legislative foundation and insufficient finance, has proved to be a fool's errand. While there are undoubtedly efficiencies to be found in any large organisation, it simply is not the case that a shift to a predominantly community based system will yield big savings. No properly validated research suggests that this can happen. Instead, if the required savings are to be made, this will be done to the disadvantage of some of our fellow citizens.

4.1 Key findings

In preparing this report, we pored over the official documents, including the operational planning documents from six of the priority work-streams. Our key findings were as follows:

1. **Healthcare for older people will be downgraded.** They will have less access to A&E, less access to properly qualified health staff, and are more likely to be treated in social care settings, rather than in the NHS. Social care settings will require them to pay at the point of service or, if their assets are below £23k, they will be paid for out of the public purse, but this has insufficient money in it to pay for everyone in need. Older people are in fact to become second-class citizens.
2. **Major health inequalities will not be addressed**. In North Central London there are big disparities between the life expectancy of rich and poor. While this is recognised as a reason for change, we find no evidence that it has figured in the detailed rationale for the changes proposed. Both primary care and hospital care are likely to be consolidated on fewer sites. These may be negligible changes for car owners but more difficult journeys and higher bus fares await those who are least able to cope with them. Additionally, the preventative and early intervention public health work which would do something to narrow health inequalities is now based in local government, whose budgets have been hit the hardest through central government's austerity policies.
3. **Individual patient need/medical judgement will become less important.** A key motif in the changes is standardisation, with the demand that resources are spent in a way that does not differ from the average and which is therefore the 'right size'. At first sight this seems reasonable, but what it means in practice is that your doctor - whether GP or hospital doctor - has reduced discretion to use his or her professional judgement about what you need. There might be a combination of factors making your case different, and it will be harder to get this recognised. One

of the precious assets the NHS has is that people trust their doctors to do what is best for them. In the future it will be the government and NHS England who are calling the shots. We note that an Enfield document discussing this issue was originally entitled 'Hard Choices' - at least an honest title – but this was subsequently changed to 'Adherence to Evidence-based Medicine' at the behest of NHS England employed staff.

4. **Parity of esteem for mental health is unlikely**. There is widespread agreement about the need for parity of esteem for mental health services and treatment for physical illness in the NHS. We were therefore surprised and alarmed that in order to create the funding for more community based mental health service, there were to be reductions (compared with what is needed) in the availability of acute beds. When NCL has some of the highest young male suicide rates in the country this is alarming and betrays an unwarranted confidence in the capacity of community-based services to prevent acute episodes. Also, in NCL by the end of the STP period only 32% of young people needing evidence-based mental health care will be able to receive it. This is not good enough.
5. **The involvement of Local Authorities in STP plans appears as an after-thought**. One of the fundamental weaknesses of the STP is that it does not bring together NHS and Social Care spending to be considered together. This clearly should have been negotiated first at the national level. Its omission reinforces the idea that this whole exercise is about reducing demand in the NHS to fit the finance the government has made available. This is demonstrated by new approaches to preventing delayed discharge from hospital, with deadlines set at the start of your in-patient stay, and discharges happening so that you can be assessed at home rather than in hospital - making the change before it is known whether it is suitable to discharge you. And a new role, the 'trusted assessor', who will not be a doctor, nurse or social worker, will be the person assessing your needs - another Orwellian term. It is true that the NHS has provided a safety valve for the social care system, and the safety valve is about to be stoppered up.
6. **There has been little consultation with, and preparation of, the staff needed to provide the new model of care.** Hundreds, if not thousands of NHS staff will need to change their place of work and the way they work if the STP is to be realised, and yet the amount of staff consultation and preparation is risible. Any serious initiative at managing change would involve staff in pooling their knowledge and working on how to improve the service. Some top-down direction is needed to put change on the agenda, but the pace of the STP, the baffling secrecy with which it has been conducted and its very obvious nature as a cuts exercise means that it is bound to achieve sub-optimal results. Since the NHS is struggling to find enough qualified staff and is working with a high vacancy rate it is quite bizarre that staff have been kept out in the cold. Have those who run NHS England and NHS Improvement not heard that 'management is getting things done through other people'?

7. **The delivery of the STP is too dependent upon the NHS estates strategy as discussed in the Naylor report**. It is clear that North Central London is the home of substantial property assets, and devolution to the London Mayor seems likely to make it easier to unlock those assets, with a great sell-off offering profits to developers, money to invest in new NHS facilities and also probably money to use to ease the pressure on current expenditure - this going against the principles of good public finance, which defends the separation between capital and current expenditure. Selling off our land is a once and for all decision and it is vital that this decision is made by people who can be trusted to act in the public interest and with proper democratic oversight.
8. **Voluntary agreements to form partnerships seem to be the only current development option, where legislation is necessary.** Most of the land and property held within the NHS belongs to Foundation and other hospital Trusts. The Naylor report referred to above was written in order to streamline the process of disposal. It is clear that senior policy makers in NHS England would like to draw on these assets to help to fund the implementation of the STPs, and even possibly to augment the funding available to run new community-based services, but as things stand Foundation Trusts have no incentive to give up their assets. NHS England is promoting the idea of Accountable Care Organisations (ACOs), new bodies that bring together commissioners and providers (Trusts) in a given area. ACOs would combine the resources of those bodies within a single governance structure, so the assets could be used for current plans. NHS England has been 'working round' the existing statutory duties of NHS organisations like CCGs, but that cannot be done when transferring the ownership of land and property. To do that, and create ACOs, new legislation would be required and the government does not have a majority in Parliament. So they are attempting to do the same thing by voluntary agreement through the creation of partnerships often called Accountable Care Systems. The public needs to be vigilant about this idea.

4.2 Recommendations.

In the light of these findings, we suggest to those who make or influence strategic decision in North Central London that they:

- **Seek to have the STP process (not only in North Central London but also across the whole of England) paused** while there is a searching review to ensure the right way forward for the NHS. Also, that they require that no further resources should be expended to bring about the STP changes-including payments to management consultants and the appointment of senior staff on high salaries to new bodies being set up under the aegis of the STP- and that the national staff working for NHS England and NHS Improvement be redeployed to something

more useful. Given the latest judgement from the think-tank the Commonwealth Fund that the NHS is the best performing health system in the developed world, senior staff time should be spent tending and nurturing it rather than suggesting that it cannot serve us well in the future without a radical overhaul. Such suggestions should be seen as the career-enhancing ventures they actually are.

The NHS is a public institution and should not be subject to fundamental change without the full involvement of parliament. It was founded because MPs voted it into existence, and over time changes have come about after parliamentary debate and voting. We might disagree with some of those decisions but we argue that public accountability is a requirement when significant changes to a beloved institution are proposed. We find it hard to believe that such changes in the quality of service could be planned on the authority of appointed officials, and nodded-through by the Secretary of State who makes it clear he does not feel accountable for them. In a representative democracy, people make their voices heard through their MPs and councillors and it is shameful that an initiative like the STP can take place outside the statutory decision-making basis agreed by parliament. This 'Banana Republic' process must be ended.

- **Cease to make service cuts** that bear disproportionately on the old and on those who are otherwise vulnerable, and that they admit that the STP is essentially driven by the need to make financial cuts, with the positive changes which are proposed being a smokescreen to hide the impact of these cuts, thus making them easier to implement.
- **Demand to see full health impact and equality impact assessments** for the changes in the STP, covering not only people in protected categories but also older people and children. While the document 'The Clinical Case for Change' does make reference to equality, work undertaken after the point that was written seems to have lost sight of it. As required in the statutory guidance, health impact and equality impact assessments should not be produced as post hoc rationalisations but the principles should guide action right through the planning process. We do not believe this had been done so far, but it should be done from now on.
- **Ensure that any future major change programme be conducted with the full involvement of staff who work in the NHS and Social Care, and that members of the public are enabled to play their part.** We do not argue against change but do insist that it involve the people with the best interests of the NHS and Social Care, and needs to be grounded in the real experience of the people who try to make the services work and know where the real failings are. This kind of change takes longer but it will be soundly based and generate support rather than suspicion and hostility, so it will achieve more in the end. Staff at operational level should be encouraged to develop collaborative arrangements across organisational boundaries where this will prove useful (as was already taking place before the STP was announced).

- **Seek to create by statute a new organisational structure that would give effect to a more collaborative approach**. While we agree with the argument implicit in the STP that the market reforms brought in under the 2012 Health and Social Care Act have been costly and unworkable, and have militated against a collaborative and integrating approach to service, the answer is to change the law. This could be done in such a way as represented in the NHS Reinstatement Bill, which has been presented to Parliament several times as a private member's bill. This would ensure that adequate public representation took place at sub-regional level and that decisions affecting areas like North Central London were made by people trusted by the public and on their behalf, rather than through a centrally directed plan driven by people with no roots in the area.
- **Ensure that no irrevocable changes in the NHS estate occur until proper statutory bodies exist within the sub-region that can be trusted to make decisions in the long-term interests of the public**. The Naylor report on disposing of NHS estates exercises a hypnotic enticement to money-starved NHS managers, wishing to redevelop their facilities. There are strong echoes of the capital rationing that led to many unwise Private Finance Initiative deals made in the last couple of decades, which are now pushing some NHS providers into crisis through their crippling repayments and problematic contracts. Let us not make the same mistake twice. Above all, decision-makers should ensure that revenue and capital are kept separate, and the NHS is not forced to cash in on the family silver in order to survive. Decision-makers should lobby to ensure that enough money for the NHS is made available through the taxpayer, aiming to achieve at least the European average for levels of trained health professionals and technical resources per head of population rather than well below average as they are at present.