Dear Mr Easton,

Meeting to discuss the South East London Sustainability and Transformation Plans (SEL STP)

Thank you for agreeing to meet us to discuss this. As the publication date for the final version of the STP recedes, we welcome this opportunity to voice some major concerns about its content and processes. We hope they will be given consideration when the final document is drawn up.

NHS Underfunding.

No discussion of the STP makes sense without first acknowledging chronic NHS underfunding. The NHS needs around a 4% annual increase to cope with cost pressures from demographic changes and modernisation of service provision. Since 2010 the average real terms annual increase in funding has been 1%. This is set to continue to 2020/1. If funding matched the 11% of GDP which countries like Germany and the Netherlands spend, then we would have an additional £46bn a year for the NHS. Despite this, the NHS has performed cost- effectively, as recognised in the OHSEL Issues Paper.

In addition, 4 years of cuts to the funding of social care has a well-understood knock-on effect on NHS expenditure.

It is in this context that the Treasury expects the national STP programme to save the NHS £22bn by 2020/1. It is providing a budget increase of only £8bn plus a contingent Transformation Fund of £10bn. Because of the Government's political commitment to austerity economics, the priority is clearly to save money rather than provide resources for a sustainable NHS based on good patient care.

On 7 April 2016, Chris Ham of the King's Fund told the Government it was in denial in insisting that services could be maintained and even improved in this context. He also said that there was no prospect that 'efficiencies' worth £22bn can be achieved by 2020/1.

The SEL STP is required to save £1.015 bn by 2020/1 as part of these national cuts. It has one of the three highest predicted deficits in the country. Apart from the sparsely populated and poorly annotated graph in the STP Briefing Paper, no information is available on any financial model that may form the basis of the STP and drive the proposed programme of £1bn of 'efficiency' savings. We are concerned at your expectation that trusts will deliver annual 2.9% productivity (despite having to have done that for some 10 years). We think that it is highly irresponsible to try to make these cuts and this letter we hope will go some way to explain why we think they are not possible. They would not be required if the NHS was funded at 11% of GDP. ***We urge you to publicly raise these very serious financial concerns with NHS England*.**

In contrast to your wildly optimistic assessment of STP savings, the Financial Risk Assessment of the Lambeth CCG Operating Plan 2016/17 shows many anxieties about 'over-performance against contracted levels of activity' and the need for 'material increased investment' and the 'financial challenge' of essential

QIPP savings which might necessitate evaluating 'the pace of implementation of service redesign changes'.

'Provider Collaboration'
A 'place-based approach' means that individual 'organisational aspirations' become secondary. Huge attitudinal changes amongst staff will be necessary to overcome the current culture of market competition which has been the driving force behind the creation of Foundation Trusts and latterly the Health and Social Care Act 2012. (See example in section on Community Based Care).

However, collaborations are crucial, for example, if savings of £190m are to be realised in specialised services and the presentation of the STP report to the Lambeth CCG Board in July showed a large degree of uncertainty about this crucial aspect of the plan.

We are concerned about the risks of double or even treble counting of savings. 'Central programmes' are projected to make huge savings but the assumption is that they are not overlapping with savings from 'provider efficiencies', and specialist commissioning savings (pathways of course involve *all* the providers). Provider 'business as usual efficiencies of 1.6% p.a.' (an estimated £339m) are assumed to deliver savings discrete from system-wide programme changes. But trusts are likely to be calculating their 2.9% 'saving' from the same areas of cost, the greatest of which are clinical and support staff. ***We would like to hear your response on this issue.***

There is also the worrying assumption that adult *social* care funding cuts will not be a problem because 'there is considerable scope for achieving a substantial quantum of these savings through collaborative work across the OHSEL partnership.**'** Thi*s* is dangerously optimistic and is a denial of the overlap in impact between health and social care in joined-up care pathways, when there is a South East London (SEL) funding reduction to adult social care budgets of £242m (30%) by 20/21. ***We would like to hear your response to this also.***

'Optimising the workforce' is calculated to save £64m according to the July presentation to the Lambeth CCG Board. This is included in the £230m savings estimated for provider collaboration and is 22.7% of £1.015bn. The Carter Review estimated nationally that back office systems' collaboration could save £5bn of the £22bn savings required by the 5YFV nationally ie 22.7%. ***This seems to us to be a strange coincidence of identical figures.***

Also 'optimising the workforce' does involve human beings. Below are quotations from a letter sent to Harriet Harman MP from an administrative worker at one of the acute trusts earlier this year:

'Staff members appear to be working in poor working conditions and the workload is atrocious. There has been at least 12 members of staff who has left in the last year and their post were frozen…. our health is slowly deteriorating and the excessive workload is going on the same pay scale. There are a lot of staff members who are currently doing 3 jobs in one although this is not apart of their

job description…. We are also being told that due to the economic crisis there has to be a set back and the trust as to save a lot of money. In making these decisions they do not take into account how this is affecting us in the lower bands were posts are frozen…'

Estimated savings
The evidence for the 'anticipated saving' in different clinical areas has not been provided. For example one of us was centrally involved in the OHSEL work on services for children and young people (CYP) up to January 2016. At the first meeting CYP clinicians were asked to prioritise which ideas would save 20% of funding. They refused to do that, stating that they were asked to use their expertise to design better and safe care. They repeatedly warned that good CYP community-based care (CBC) would be labour-intensive and may well not save money; and that, while there is evidence of good services in the community delivering good outcomes, there is scant evidence that those services significantly reduce the need for hospital-based care. ***There is no evidence to support the proposed net savings of £11.5m in childrens' services funding.***

It is also surprising that £17m Cancer Services savings are identified, since the NHS is judged to be performing badly in comparison with health services in similar countries and currently Trusts are failing to meet the NHS Constitution target for cancer.

Community-Based and Primary Care
We would like to see your evidence base for the stated aim of saving 700 additional hospital beds and providing 'lower cost, higher value care' via estimated net savings of £48/£50m from Local Care Networks (LCNs) with a total of £110m across CBC and physical and mental health.

The Southwark and Lambeth Integrated Care (27) projects (SLIC) provides evidence that this aim is unlikely to be realised.
Integrating care in Southwark and Lambeth' – is an 'end of grant' report by the Guy's and St Thomas' Charity on the impact of its £10.6m grant to SLIC. The charity: 'supports projects that intend to build an evidence base by testing hypotheses' p42.
https://www.gsttcharity.org.uk/sites/default/files/FINAL%20Full%20End%20of%20SLIC%20Report.pdf

The project has just ended its first phase after 4 years and nearly £40m spent:

* 'The envisaged cost savings in wasted/duplicated effort were not met' p3.
* P7: 'what was also ambitious in the business case was the trajectory of change and the financial targets: the stakeholder consensus now is that these were unrealistic'.
* NB A local McKinsey report recommended an 18% shift in resources from hospital to community and primary care - which was not realised in this project.
*There were only some signs of a slowing down of increase in service demands.

* The changes in culture and relationships required to get inter-professional cooperation inherent in service integration was harder and slower to achieve than estimated.
* the longer periods needed to produce lasting and beneficial change are an anathema in the 'pull towards priorities that reduce costs in the short term' p41
* 'There is a pervasive culture in health and social services that almost overstates the potential benefits subconsciously and this should be guarded against' p43.
* There was no evidence that integration works where individual services are struggling – district nursing was a specific example.

We wonder if any lessons have been learned by SELSTP, from this local project.

With regard to primary care, £50m has been allocated for the establishment of Local Care Networks (LCNs) requiring re-organisation on a considerable scale. New IT systems will be required, so that information can be properly shared. Adequate staffing levels will need to be ensured (the £61m to be saved by 'optimising the workforce' would equate to losing 1525 nurses overall). But at the moment there is a considerable shortage of both GPs and District Nurses across SEL. It is hard to imagine that all these things can be provided within a £50 million budget cut, and certainly not within the timescale required. We also understand that in Lambeth the three LCNs are still discussing structural changes after 3 years and are not yet active.

The other way of reducing staffing costs is to downgrade or downband staff so that, for example, GPs' work is done by nurses or physicians' assistants and nurses' work is delegated to support workers. For example within SEL we have been told that the shortage of health visitors, because of public health cuts, has forced them to delegate some child assessments to support workers or nursery nurses. Health Visitors are worried that their professional registration is at risk because they can't be sure that these staff are competent – yet they remain responsible.

We are also worried about the idea of GP Federations becoming Multidisciplinary Community Providers(MCPs)*:*
https://www.england.nhs.uk/wp-content/uploads/2016/07/mcp-care-model-frmwrk.pdf
This document states that MCPs are about integration, focusing on prevention, redesigning care, improving health and wellbeing, reducing avoidable hospital admissions and making care more efficient, 'backed up by a new financial and business model'. They must show 'a return on investment through a combination of demand moderation and provider efficiency, that are consistent with agreed STP financial assumptions'. They are a new model for accountable care provision and appear to be based on private US Accountable Care Organisations (ACOs). Many health sector analysts conclude that STP delivery structures such as these will facilitate private companies' takeover of large sections of the NHS.

Here, GP Federations are the obvious structures from which to create MCPs. However, a legally qualified, fellow campaigner in NW London is concerned that

MCPs' legal structures will need to be extremely complex with a risk that GPs will not fully appreciate the extent of their 'corporate' responsibilities nor have the expertise to set up and oversee (ten-year) contracts - a great risk if things go wrong. This happened after nine months into a five-year, £725m Cambridge and Peterborough ACO (UnitingCare) contract for the area's health services.

A recent Nuffield report includes an intensive study on large-scale federations of GPs:
http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/large_scale_general_practice_web.pdf
The paper concludes that there is no evidence for large-scale GP Federations being either cheaper or more effective. In Lambeth we have been told anecdotally that the two GP Federations are not popular with those GPs who were asked to invest £5000 in developing them. The fear is that, although they have been constructed as business entities, the contracts being offered to them are not big enough to incentivise participation.

'There is little evidence that moving to new care models will release rapid or sufficient savings. It is pretty clear to us that it is much more complicated and difficult than we had thought. The view that this was to take three to five years is profoundly mistaken, for us this is a five to 15 year journey,' NHS Providers chief executive Chris Hopson, Westminster Health Forum 12/09/16.

Elective care
We acknowledge the public and patient involvement in the OHSEL proposals for two Elective Care Centres but **question the validity of this consultation** when the alternative – an enhanced status quo - has not been examined. This was a criticism by the London Clinical Senate Review, which found that insufficient work had been done to promote this cheaper, more feasible option for elective care. We further question the frequent assertion that elective orthopaedic care is one of the biggest challenges facing provision in SEL. ***We think that urgent care, cancer care, primary and community care should be prioritised.***

In a context of acute NHS underfunding, we query whether OHSEL should indulge this project, distracting the public from the deterioration of services elsewhere. Worryingly, it could encourage private sector takeover of potentially profit-making services. The recent awarding of the musculoskeletal contract (including elective care) to Circle by Greenwich CCG highlights the issue.

Consultation and governance
NHS England's guidance on consultation (NHS, Sept 2016, Engaging local people) states that (a) the STP footprint itself is not a statutory body and (b) that CCGs, local authorities and hospital NHS trusts all have a 'variety of legal duties including to involve the public in the exercise of their statutory functions'. Formal consultations with the public and local authorities are likely to be needed in the case of proposed 'substantial changes in the configuration of health services'.

The paper 'Communications and engagement forward plan' (supporting paper for the April '16 JHOSC meeting) outlines OHSEL's communication and engagement plan. The paper states that the elective orthopaedic centre is the only one likely to require public consultation.

We are concerned that we do not know what criteria are being used to decide whether proposed changes are 'significant', 'substantial', 'having an impact' (hence requiring formal consultation) nor who would make those judgments. We are concerned that other aspects of the plan will not be formally consulted on and that the tone of the Guidance suggests that consultation will be about <u>how</u> rather than <u>whether</u> to do them.

Within the governance structure of the SEL footprint, the extent of public, patient, NHS and social-care staff involvement appears to be very limited:

- patient input seems to be limited to the PPAG chair having 'in attendance' rights at Strategic Planning meetings;
- there is no staff/union representation nor are unions or clinical staff associations listed as partners/stakeholders.

Capital Funding

We mention briefly here an important, additional concern about the need for capital funding. It is unlikely that the Government will provide adequate capital to meet the cost of proposed new buildings and IT systems. If, in SEL, the Lewisham 'Devo Pilot' and the One Public Estate programme do not deliver as hoped, there will inevitably be a need for private finance. The health services in SEL already carry a heavy financial burden of PFI debt and further debt would inevitably have a destabilising effect.

In summary we are very concerned about the SELSTP:

* the overall context of national and local underfunding which appears to be accepted and acceptable to you
* the evidence-free, over-optimistic estimate of savings
* the workability of the proposed new delivery structures and the potential for private sector takeover of these new organisations
* the questions which hang over the governance and consultation processes.

Yours sincerely,

Wendy Horler

on behalf of Lambeth Keep Our NHS Public and Save Lewisham Hospital Campaign.