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## Evidence from KONP for the Overview and Scrutiny Committee on Cornwall's STP

### Cornwall's Sustainability and Transformation Plan

#### Submission to Cornwall Council Scrutiny Sub-Committee from Keep Our NHS Public Kernow (KONP)

#### Introduction

KONP Kernow is a group of people who care passionately about the NHS and the provision of excellent care to the people of Cornwall. We have members from all over Cornwall and liaise closely with the separate group West Cornwall Health Watch. Members regularly attend relevant meetings of Council bodies, KCCG and the Health Trusts.

This Executive Summary starts with some overall comments on the STP and the engagement process and continues with comments on each section. Some sections are supported by more detailed evidence contained in appendices as shown.

#### The STP and the Engagement Process

KONP notes and welcomes the numerous meetings arranged to discuss the STP and the very active involvement of so many members of the public. It should be clear to the STP sponsors, as reported to Council by the Leader, that very many members of the public: -

- were highly critical of current underfunding of Health and Social Care services
- regarded the STP as unrealistic and unachievable in the absence of better funding
- regarded the STP paper "Shaping our Future" as inadequate, not giving a clear view of what services will be available and where in the future. This made the engagement process meaningless
- believed decisions had already been taken, that the process was "going through the motions"

It has been suggested that much of this was politically motivated and involved "grandstanding" in advance of the local elections. As an active and long-standing campaigning organisation, we should emphasise that the clear majority of those attending and participating were unknown to us. We also take the view that politicians should expect the public to care about these issues and should welcome their interest.

Politicians are often ready to condemn public apathy and it was scarcely the public's fault that these meetings took place shortly before the elections.

Numerous comments were made in plenary or group sessions about the detail of the STP. Our own comments are noted below. Many issues (such as Mental Health and Technology) came up in more than one section – we have responded where it seems to make most sense.

We have also received several strong criticisms of the survey about the STP with which we agree. We attach (**Appendix A**) a detailed critique from Dr Peter Levin posted on the website for [Social Policy Research for Cornwall](http://spr4cornwall.net) (<http://spr4cornwall.net>). *We invite Councillors to agree that the survey is poorly designed and to confirm that they will not rely on its results as the basis for their decisions.*

## **Prevention and Improving Population Health**

As the Plan says “focusing resources on preventing ill health is simple common sense”. This begs the very obvious question as to why cuts in Government grants have forced major (and continuing) reductions in Council spending on Public Health in recent years. This section starts with a bald statement “what if we invested a minimum of £20m in preventing...?”. Councillors will note that there is no indication of the source of this £20m – which (later) is spread over 5 years leading to an – equally un-evidenced - £17m of savings from the overall budget by 2020/21.

*We argue that Councillors must ask some searching questions: -*

- *About the funding for this section – not only the source of the £20m but also for funding of the affordable housing and insulated homes referred to.*
- *How does this £20m compare to reductions in the Council's Public Health budget since 2013?*
- *Regarding how long it will take for these preventative measures – desirable in themselves – to generate the savings claimed and if the evidence that they will do so is robust. Anti-smoking campaigns have been going on for decades yet many people still smoke.*
- *About why this section appears to blame the patient? We question whether it is helpful to describe what seem to us to be the effects of long term social disadvantage as “behaviours”. In particular, it seems inappropriate to describe the social isolation of people, often elderly and widowed, in a rural area, poorly supplied with public transport, in this way. Patients – for example young mothers with new babies – go to the GP because they are rightly unable to decide how serious the condition causing anxiety is.*

The section also refers to other issues such as the use of technology and mental health which we refer to elsewhere in this paper.

## **Integrated Care in the Community**

This section covers much ground so we have divided our comments into 2 parts – Care in the Community and General Practice.

### • **Care in the Community**

We start by noting: -

- the intense pressure on Adult Social Care, notably on care home provision and domiciliary care, arising from funding cuts

- that the UK has many fewer hospital beds than most other European countries.
- that Cornwall Foundation Trust has already closed 29 in-patient beds and that Edward Hain Hospital remains closed.
- regular statements that many beds in both Acute and Community Hospitals are occupied by patients who are clinically ready to move on.

*We invite Cornwall Council to say unequivocally: -*

- *that the current restrictions on Council budgets render it impossible to deliver a proper Adult Social Care service. Among other effects, this places cost and strain on to private individuals and their families.*
- *that there should be no closures or reduction in hospitals beds until they have seen robust evidence that Cornwall really has too many hospital beds*
- *That safe and properly funded alternative facilities must be in place and tested before any further reductions.*
- *That more District Nurses, Community Matrons, and Therapists of all sorts are required if the aspiration of more and better care in the community is to be achieved*
- *That improved social care also implies changes in the way primary care and General Practice work (see next section)*
- *That it is disgraceful that NHS Property has neglected its hospitals to such an extent that several of them are either unsafe or require costly repairs to bring them up to an acceptable standard and that this situation is driving calls for closures rather than any considerations of patient need.*

*Finally, we believe Councillors will wish to see a clear statement of what provisions will be available for patients moving on to later stages of treatment, where they will be and how they will be funded and staffed.*

- **General Practice (Appendix B)**

A strong primary care system is critical. Primary care accounts for 90% of all patient contacts – but only 8% of the NHS budget. High levels of satisfaction are reported. It is, therefore, a matter of great concern that General Practice faces major challenges of recruitment, underfunding, rising workload, and low morale.

As the STP says, over 20% of GPs and 31% of Practice Nurses are due to retire within 5 years. The Government commitment to recruit an additional 5,000 GPs by 2020 is failing and actual numbers too are falling as GPs retire early or move overseas.

Real terms spending has declined, the GP/patient ratio has worsened and 1 in 20 Practices have closed since 2010.

At the same time the STP intends to load more pressure on GPs and their Practices by asking them to coordinate community teams and hubs; to cope with more patients discharged earlier from hospitals; to avoid hospital admissions and to offer an expanding range of services.

*We hope Councillors will: -*

- *Insist on more detail of how clusters of GP Practices will actually work for patients*
- *Ask if it is planned or expected that Practices will close*
- *Insist on a proper plan and vision from KCCG for how people will access primary care in future covering such aspects as distance to surgery (by various means of transport and especially if closures are envisaged) and opening hours, all bearing in mind the aspiration to provide more care closer to home.*

- *Ask for realistic proposals regarding the recruitment of more GPs and other clinical staff to replace those leaving*
- *Ask for evidence as to whether these proposals are supported by our GPs bearing in mind that a recent Guardian Survey found that around 2/3 of GPs nationwide had not been consulted about STPs and only 14% firmly supported the changes.*

## **Transforming Urgent and Emergency Care**

The location, number and nature of urgent care centres is of critical importance and the failure to offer clarity about this gave rise to much anger at the recent engagement meetings. As the Council's own website (mapping section) makes clear many communities are already well over 30 minutes (by public transport) from any hospital of any sort.

*Councillors should insist on full details being provided to the public and to Council of where the proposed network of Urgent Care Centres will be and what services they will offer. In the absence of this, Cornwall is being asked to sign a contract without seeing any of the small print.*

*Councillors may wish to question how the 30 minute figure works – is this by car, public transport (and, if so, at what times of day) or by blue light ambulance? These are very different things.*

*Councillors will wish to be absolutely clear that there will be no diminution of the range of services at the acute hospitals used by Cornish patients.*

An effective 111 and Out of Hours Service would, of course, be welcome and should be in the public sector given the disastrous experience with SERCO.

## **Redesigning Pathways of Care**

This section is very short on both evidence and detail. It gives rise to numerous questions. Our comments separate “pathways of care” from mental health issues

### **a. Pathways of Care (Appendix C)**

Different pathways of care may produce better treatment and outcomes and should, of course, only be adopted if they do. However, the evidence for this is not contained in the STP. *We believe Councillors should seek much more clarity about how any changes will be funded and assurances: -*

1. *That changes to existing pathways will only be introduced after robust scrutiny of the evidence and its applicability in Cornwall involving consultation with those directly affected including front line staff, family carers and patients. We note that a 2013 Review of the Liverpool Care Pathway concluded that “there was often too much pathway and too little care”.*
2. *That GPs can manage the additional workload on top of other demands on their time. If we understand the paper correctly, there is an intention to move more care away from hospital settings, increasing pressure on primary care.*
3. *That extended use of technology will be an option not a requirement for the patient. We note that 20% of people in Cornwall have never been on line (Inclusion Cornwall web-site) and would expect many of these to be exactly the section of the population making most use of health and social care services. Mobile and broadband coverage is not universally available and can be unreliable.*
4. *That increased use of private sector providers does not form part of this Plan. Use of private providers in health provision has far too often failed (e.g. SERCO, Winterbourne View, Morleigh Care) with dreadful consequences for both patients and costs.*

## b. Mental Health (Appendix D)

Many public figures have stated that more attention (and funding) needs to be given to Mental Health – without, unfortunately, action to match. In Cornwall 5% of people report long term mental health problems which is above the national average. We also have high rates of suicide, self-harm, and intentional injuries. People with mental health problems tend to die younger than others.

*We believe Councillors should seek evidence and assurances: -*

- *That there is a robust, urgent, and properly funded plan to reduce admissions of Cornish patients to mental health beds outside Cornwall to an absolute minimum by provision of more Mental Health beds within the County. Detained Mental Health patients have no choice in where they go.*
- *That plans are in place to reduce the number of delayed transfers of care for Mental Health patients who, because of their circumstances, may have no home to return to when psychiatrically fit.*
- *That plans are in place to establish and fund child and adolescent Mental Health beds in Cornwall, including for those with learning disabilities.*
- *That staff will be fully involved in any proposed reforms.*
- *That there is a strategy for the recruitment and training of psychiatric nurses in Cornwall*
- *That small voluntary sector support organisations will continue to be supported. These provide valuable assistance to people with Mental Health problems and allow those responsible for health and social care to gain the insight of experts by experience. We are concerned that KCCG has cut financial support to a number of these recently (e.g. Carrick Mind and Restormel Mind)*

## Improving Productivity and Efficiency (Appendix E)

The underlying issues within this section are those common to the whole of the Plan. There is insufficient detail to comment in detail or with any certainty. It raises several significant and extremely worrying possibilities.

*Specifically, Councillors will wish to seek more information regarding: -*

- *Job losses and consequent Redundancies*
- *the impact on the remaining workforce particularly about pay and conditions of service and about unknown/unfunded retraining requirements.*
- *Outsourcing and privatisation of shared services and building ownership and/or management.*
- *Closure of existing hospitals and other NHS and social care facilities.*
- *Funding for investment in buildings, IT&M, training, and staff retraining.*
- *The ability of health and social care providers to recruit a sufficiently skilled workforce, particularly GPs, other Drs, nurses, and pharmacists.*
- *Insufficient detail and capacity for implementation. Councillors may want to consider establishing a structure, to give clear direction and focus to workforce planning across health & social care.*

Health and Social Care are funded very differently at present. Whilst evidence from elsewhere (e.g. Plymouth) indicates that integrated budgets are key to well-integrated care, we believe *the Council should insist on a clear understanding of how this would work in practice* – such factors as the overall budget, who pays what and what happens in the event of any overspend.

We argue that *the Council must be assured in advance that the proceeds of any rationalisation of the estate will be available to fund care in Cornwall*. At present, much of the estate is owned by NHS Property Services or by others under PFI deals.

*The Council should be assured that front line clinicians and others will be able to spend more of their time using their professional skills*. Whilst waste and duplication is obviously undesirable, an effective “back office” is essential to enable them to focus on their core activities and any changes which impede this should be resisted.

We agree that better sharing of information and records is over-due.

### **System Reform to Achieve Better Care (Appendix F)**

We agree that better coordination, elimination of disputes over “who pays” and reduction of cross referrals are all desirable.

Shaping our Future refers to “various organisational models we could adopt ... and we need to do further work on the options....” However, the letter from the various Chief Executives dated 19/12/16 says “Our thinking now is that we will need to move with pace to establish an Accountable Care Organisation ....” It appears that this decision has already been made without consultation.

Evidence regarding ACOs from the USA is mixed and a pioneer in the UK (in Torbay) has already run into financial difficulty with a substantial overspend in the first year. Torbay Council papers indicate that this presents “a substantial financial risk to the authority”. A report dated 4/1/17 to Cornwall’s own H&ASC Scrutiny Committee noted “significant financial risks” in Cornwall.

- • *What Evidence is there that an ACO is the right way forward?*
- • *What alternatives have been considered?*
- • *Who is an ACO accountable to – Cornwall Council? NHS England? The Department of Health?*
- • *What are the financial risks? Are they acceptable?*

## **Appendix A – The STP Survey**

### **The STP survey: Why am I finding it so difficult to have my say?**

**A letter to the ‘Transformation Board’ by Dr Peter Levin (17/01/2017)**

**Posted on the website for [Social Policy Research for Cornwall](http://spr4cornwall.net) (<http://spr4cornwall.net>)**

Dear Transformation Board

I’ve been reading your document ‘Have your say on the Cornwall and Isles of Scilly Health and Social Care Plan 2016-2021’, the STP. It invites me to have my say and comes with a questionnaire which is supposed to enable me to do that. I’m finding it a real struggle to have my say using your questionnaire. Eventually I worked out why.

The questions all ask to what extent I agree with their ‘priorities’. Question 1 listed the following six priorities:

- **Preventionandimprovingpopulationhealth**
- **Integratedcareinthecommunity**
- **Transformingurgentandemergencycare**
- **Redesigningpathwaysofcare**  
(bestpractice treatmentforspecificconditions)
- **Improvingproductivityandefficiency**
- **Systemreformtoachievebettercare**

As you can see, some of these so-called priorities take the form of ‘motherhood and apple pie’ objectives, with which no sane person could possibly disagree: e.g. ‘improving population health’, achieving ‘better care’, ‘improving productivity and efficiency’. And others have no built-in objectives at all: e.g. ‘transforming urgent and emergency care’ and ‘redesigning pathways of care’. Transform and redesign with what objective, I asked myself. I didn’t get an answer. Why not? Because this is looking like gobbledygook.

The very idea of ‘priorities’ is a nonsense in this context. We need everything here that contributes to keeping the population in good health, and a spread of resources among them. ‘Priority’ implies that you deal with the highest priority first, then the next: that is clearly not appropriate here.

Maybe managers have a different view of the world, and are comfortable with the language of priorities. But in asking me questions framed like this, they are asking me to put myself in the position of a manager, and to take an overview of the whole system. I am just a member of the public, not a manager, and ‘management-speak’ is not my language.

I can only judge your ‘priorities’ and recommended approaches by envisaging how they would work out in practice. You aren’t giving me that information, information that I need in order to ‘engage’ in the planning process.

Finally on Question 1, you ask ‘To what extent ...’ but you aren’t offering me a scale to register ‘extent’, just the two extremes of ‘Agree’ and ‘Disagree’ and the indeterminate one of ‘Neither agree [nor] disagree’. It’s looking as though you are deliberately trying to confuse me!

Question 2 opens with the statement: ‘Health and care services must be delivered within the budget available.’ That is so objectionable! It implies that we must accept whatever that budget is: I want to see a case made, by demonstrating the impact on the ground, for increasing the budget to meet the needs of the people of Cornwall. So, I have a question for the Transformation Board: ‘Whose side are you on?’ If you were on our side you would be showing us the impact of the cuts you’re saying we must face up to.

Question 3 says: ‘We recommend investing a minimum of £20 million over 5 years in preventing people getting ill, supporting self-care and targeting citizens who are most likely to have health problems. We believe that focusing resources on preventing ill health is simple common sense and we can do more to keep people healthy, happy and well. Fundamentally, we must also ask people to do more for themselves and support each other in their community. To what extent do you agree with our recommended approach and our prevention priorities?’

Well, I have no way of telling whether £20 million over 5 years is the right amount or not. You are not giving me the information that I need to make a judgment about this: for example what you would spend this money on, whether it represents an increase on last year’s spending, whether the money would come from another programme.

Question 4: ‘We recommend changes to community hospitals so that they become community hubs which offer multiple services to prevent or reduce acute hospital visits. Community hubs will be linked to GP practices providing co-ordinated care and personalised support to keep people well, help people stay out of hospital or leave hospital quicker. Better community and home care should mean less need for community hospital beds and sites so we may reduce these over time, particularly if they need major financial investment. ... let us know if you have any alternative suggestions to reducing community hospital beds and sites.’

No-one could possibly object to providing co-ordinated care and personalised support to keep people well’: this is another ‘motherhood and apple pie’ goal. But I have heard so much from senior executives at KCCG and RCHT about the ‘outdated bed-based model of care’ that I suspect that agreeing with your recommended approach will be taken as consenting to your closing community hospitals and continuing your policy of running these down by minimizing maintenance until ‘they need major financial investment’ when – in their blighted state – they will be ‘ripe’ for closure.

This recommendation takes no account of the valuable function that community hospital beds perform by allowing patients who are recovering from acute treatment to ‘step down’ to recuperative care.

Question 5: ‘We recommend changes to General Practice and grouping more GP practices together so they can better meet rising demand and expand the range of services. Right now GPs are spending too much time on administration and their work load could be reduced through targeted actions such as more effective self-care, early detection, better use of technology and a more flexible workforce. ... let us know if you have any alternative suggestions to improve the sustainability of GPs.’

I can only judge these recommendations by envisaging how they would work out in practice. You aren’t giving me the information that I need. But agreeing with your approach could be taken as assenting to closing single practices in outlying places (e.g. St Just), which I would strongly disagree with.

If GPs are indeed ‘spending too much time on administration’ surely what should be done is to identify how the burden of administration can be reduced, and take steps to achieve that. And what would ‘a more flexible workforce’ look like in practice? You don’t tell me, so how can I possibly say whether I agree or not?

Question 6: ‘We recommend an urgent care service that is accessible, reliable and co-ordinated with clinicians at the end of a phone if you need advice. With clinicians visiting you when essential or in Urgent Care Centres so that you only need to visit an Emergency Department in an actual emergency. Better location of Urgent Care Centres (accessible within 30 minutes from homes in Cornwall, on average) should mean we can provide a better, more reliable service than Minor Injury Units but would probably need to be on less sites (*sic*) so that we could afford them and resource them. To what extent do you agree with our recommended approach and our urgent care priorities?’

Again, I am being invited to agree with ‘motherhood and apple pie’ objectives (accessible, reliable etc), but not told how these would work out in practice. The STP and draft Outline Business Case propose closing all 13 Minor Injury Units and having just three Urgent Care Centres, a reduction of more than three-quarters in places where one can go for treatment. This can only mean a severe reduction in accessibility. Not good!

Question 7: ‘We recommend changing our approach to caring for people with specific conditions such as diabetes, heart disease, stroke, cancer, joint problems and dementia so that citizens get equitable access to high standards of care regardless of where they live or their individual clinician, within the resources available. We want to reduce the number of out of county mental health placements. We also want to explore what other services we can provide locally or what makes sense clinically to provide outside of Cornwall and the Isles of Scilly. To what extent do you agree with our recommended approach and our

priorities for redesigning pathways of care?’

‘Equitable access to high standards of care’ – more ‘motherhood and apple pie’ stuff. You don’t say how you would change your approach to caring for people, so – again – I have no idea what the impact on people would be. Why does it take an STP for you to make such changes? And ‘within the resources available’ gives you an easy way out of doing anything genuinely constructive. By all means aim to reduce the number of out of county mental health placements, but – once more – why does it take an STP for you to do that? And you are asking us to comment on your ‘priorities for redesigning pathways of care’, but not actually telling us what you mean by ‘pathways of care’ (if they are just best practice treatments for specific conditions why not just call them ‘treatments’?) or how you would redesign them.

Question 8: We recommend that local care providers change the way they work together to enable joined up care, share expertise and information more effectively and use public sector properties efficiently. A large proportion of the savings we want to make can come from the way we operate and function. Our aim will be to modernise and change organisational form with minimal impact on clinical staff and services. To what extent do you agree with our recommended approach and our priorities for system reform and improving productivity and efficiency?’

Clearly joined-up care, effective sharing of expertise and information and efficient use of public sector properties have to be good things – how could they not be? – but what does it take to bring these about? If I agree to efficient use of public sector properties’ am I consenting to closure of certain (as yet undisclosed) facilities? I need to know what the likely impact ‘on the ground’ would be if I am to be able to answer your questions.’

## **Appendix B - Primary Care**

Primary care has arguably been one of the most successful and cost effective areas of the NHS . GPs account for 90% of patient contact but just 8% of the NHS budget. It is highly valued by patients. The Patient Satisfaction Study results, published in July 2015, show that 85.2% of patients reported a good overall experience of their GP surgery. In addition to the GP Patient Survey, from December 2014 it became a contractual requirement for GP practices to offer the “Friends and Family test” (FFT). The latest results for May 2015 shows that 88% of patients would recommend their GP practice to their friends and family

Currently general practice faces major challenges: recruitment, chronic underfunding, rising workload and low morale. The proposed solutions are: working at scale, a reliance on new technologies and a change in skill mix meaning that patients will no longer see GPs as a matter of course but may be directed to other members of a multidisciplinary team.

### **The Problems**

#### **GP Recruitment**

It is clear from the STP outline business case that there will be less GPs, with additional roles and a significant transfer of workload from secondary care

"Over 20% of GPs and 31% of practice nurses are due to reach retirement in 5 years time"  
( in a previous document it was 30 % of GPs in 3 years- perhaps 10% have already gone )

"The supply of practitioners will not be able to meet current or future demand". The STP aspires to recruit more GPs. The question is how given that most areas are reporting a severe shortage of GPs some of as much as 50%. The new model will also require the recruitment of other scarce professionals- practice nurses , district nurses, community matrons, physios, pharmacists etc.

Health Education England (HEE) data which showed that "NHS England estimated demand for GP services equivalent to around 35,500 FTE for 2014 – almost 3,000 FTE more than the recorded level" (Evidence given to Health Select Committee). And plans to recruit 5,000 extra GPs are failing - see <http://www.pulsetoday.co.uk/your-practice/practice-topics/employment/gp-workforce-shrunk-over-the-past-year-in-major-blow-to-5000-target/20033720.article>

## Funding

Primary care funding has been falling in real terms and as a proportion of total NHS spending. Practice income has been falling for ten years. The evidence given to the Health Select Committee in 2016 from The Department of Health was that "there has been a decrease in investment in general practice of around 0.8% per cent in real terms since 2008/09". The King's Fund added that:

"Relative to other health services (e.g. the acute hospital sector), General Practice's share of NHS funding has been declining: between 2005/6 and 2013/14, total investment in General Practice fell by 6 per cent—equivalent to nearly £560 million. This is in contrast to a real rise in total NHS spending of 4.4 per cent since 2010/11.97 (Evidence given to health select committee 2016).

As real terms spending on primary care has declined, so have practice incomes. The Government's evidence showed that "between 2004/05 and 2012/13 there has been an annual average percentage decrease of 2.1 per cent per year" in practice income. Shrinking funding is a major factor in rising numbers of practices nearing closure. Figures obtained by Pulse show more than 160,000 patients across the UK having to register with another practice as a result of their practice closing over the past two years. There has been a 500% jump in the number of practices seeking advice from NHS managers about closure or merging.

There are now 66.5 family doctors per 100,000k people in the UK, down from 70 in 2010.

Reference:

<http://www.theguardian.com/society/2014/jun/14/gp-numbers-fall-recruitment-crisis-bites>

There are now 7,962 GP practices in England – one in 20 has disappeared since 2010. The rate of loss of local surgeries has speeded up. NHS figures show that 656 surgeries have been merged, taken over or closed completely since 2010

Reference: <http://www.theguardian.com/society/2015/jul/05/gp-surgery-closures-london-crisis-refugee-patients>

## Workload

GPs now see 370 million patients – 70m more than 5 years ago. The crude annual consultation rate per person increased by 10.51%, from 4.67 in 2007–08, to 5.16 in 2013–14. Consultation rates were highest in infants and elderly people. The greatest increases in age-standardised and sex-standardised rates were in GPs, with a rise of 12.36% per 10,000 person-years, compared with 0.9% for practice nurses. GP telephone consultation rates doubled, compared with a 5.20% rise in surgery consultations, which accounted for 90% of all consultations. The mean duration of GP surgery consultations increased by 6.7%, from 8.65 min (95% CI 8.64–8.65) to 9.22 min (9.22–9.23), and overall workload increased by 16%. These results suggest that English primary care as currently delivered could be reaching saturation point.

Reference: [http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736\(16\)00620-6.pdf](http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(16)00620-6.pdf)

A 2015 British Medical Association (BMA) survey of more than 15,000 GPs found that 93% felt their workload was negatively affecting patient care, while a third were considering leaving the profession as a result in the next five years.

Reference: <http://www.theguardian.com/healthcare-network/2015/may/21/general-practice-permanent-decline>

The main reasons for doctor dissatisfaction are excessive workload, un-resourced work being moved into general practice, and not enough time with patients.

Reference: <http://www.bbc.co.uk/news/health-32307459>

## **Morale**

A survey of 1,001 GPs working across the UK published by the Health Foundation in February 2016 underlined just how fragile morale is amongst GPs. GPs in the UK report higher levels of stress and lower satisfaction with practising medicine compared to primary care doctors in other countries. 67% of UK GPs report being satisfied, compared to an average of 79% across the other 10 countries featured in the survey. 59% of GPs in the UK describe their job as extremely or very stressful, higher than anywhere else.

## **The Proposed Solutions**

### **Working at Scale**

The new model will centralise GPs services into "clusters" with 15,000-40,000 and a larger tier - Multi-Speciality Community Providers serving 80,000-100,000 patients. GPs will be encouraged to merge into larger practices and "new funding mechanisms" will make this attractive.

According to the STP plan, NHS Kernow deem practices with <9,000 patients to be unviable. In Cornwall there are 40 such smaller practices in Cornwall with <9000 patients. In fact this is the majority of a total of 64 Cornish Practices- 62.5%.

According to the emerging models of care it is unclear what the status of GPs will be in future. Will they be employees, shareholders or sub-contracted independent practitioners? Or a combination of these options? What is the model envisaged in Cornwall?

<https://www.bma.org.uk/-/media/files/pdfs/practical%20advice%20at%20work/doctors%20as%20managers/managing%20your%20services/po-focusonlocalimplementationnewmodelscoreg2-20-11-2015.pdf>

### **Increased investment in Primary Care**

The General Practice Forward View promises more money for Primary care- some directly from NHS England and some from the STP boards. It promises £2.4 billion a year by 2021 into General Practice services, meaning that investment will rise to more than £12 billion a year by 2021. Capital investment is included – this will amount to £900 million over the next five years. A Sustainability and Transformation package of more than £500 million over the next five years will support struggling practices, develop the workforce, tackle workload and encourage care redesign.

Much of the new money promised for General Practice in the Five Year Forward View will be distributed via the CCG to ensure that the commitments in the Forward View are met and will be subject to conditions e.g. Extra weekend and evening appointments , more appointments overall and CCG monitoring of practice activity. The latest guidance to Sustainability and Transformation areas is that between 15 per cent and 20 per cent of their allocation should be spent on investments to support General Practice

There is evidence that the money currently allocated to General Practice is not being spent to improve

primary care. In her speech at the Annual Primary Care Conference, Dr Maureen Baker, chair of the RCGP, said: "The failure to spend money earmarked for General Practice on General Practice is a national disgrace

<http://www.nationalhealthexecutive.com/Health-Care-News/general-practice-at-risk-of-losing-760m-under-stps-warns-rcgp-chair>

General Practice risks losing £33m this year and £760m by 2020 due to CCG underspends and the roll out of Sustainability and Transformation Plans (STPs), the Chair of the Royal College of General Practice (RCGP) has warned. RCGP analysis of CCG budgets shows that they are due to underspend their budgets for general practice by £33m this year. In the GP Forward View, NHS England promised £2.4bn more funding for general practice by 2020 in a bid to ease pressures on the sector. But Dr Baker said that College research has found that few of the 44 new STPs have drawn up plans to boost investment in general practice.

### **GP Recruitment:**

The GP 5 year Forward View promises to double the rate of growth of the medical workforce to create 5,000 additional doctors working in General Practice by 2020/21. However last year the numbers of full time equivalent GPs fell by 2% and this year (despite a rise in the number of trainee GPs and £20,000 inducements to join practices in under-doctored areas) the number of FTEs fell again due to failure to retain GPs .

<http://www.pulsetoday.co.uk/your-practice/practice-topics/employment/gp-workforce-shrunk-over-the-past-year-in-major-blow-to-5000-target/20033720.article>

The plan is to recruit 5,000 additional health service workers into General Practice- mental health therapists, practice nurses, pharmacists, physiotherapists etc. Importantly this includes investment by HEE in the training of 1,000 physician associates to support General Practice and the introduction of pilots of new medical assistant roles.

<http://www.rcgp.org.uk/policy/~media/Files/Policy/General-Practice-Forward-View/RCGP-NHS-England-General-Practice-Forward-View-2016.ashx>

Patients will no longer see their GP as a matter of course.

The STP claims that the new model will be better as "Fragmented support results in uncoordinated Care, missed opportunities for prevention , risk of falling through the gaps, higher costs and negative impact on outcomes". However the model appears to increased the risk of fragmentation and impose multiple appointments on the patient. A "change in skills mix" could result in, for example, a patient seeing a physio for their musculoskeletal problem; a pharmacist to review their medication and a mental health professional to assess the depression resulting from this chronic illness - a typical scenario dealt with daily by GPs in a single 10 minute consultation. We are not aware of any evidence that this model would be cheaper or deliver as good or better outcome.

The STP asserts : " We will improve ...early identification". However discouraging patients from seeking help by "moderating demand" and relying on consultations by less experienced, less well trained practitioners may hinder earlier diagnosis.

There is an assumption that GPs " playing a leading role in planning co-ordinating and delivering care and support in communities" " leading and coordinating Integrated Care Teams " will be a positive development. However, this will result in the scarce resource of GPs being diverted from face to face contact into organisational/managerial roles when they are uniquely trained as generalist clinicians - 8 or 9 years training in medicine and almost no training in administration and management.

It is claimed that "new technologies can help us better meet demand" meaning " triage,telephone consultations, online tools and apps". There was a "15% increase in patient contacts between 2010/11 - 2014/15" and "63% increase in telephone consultations ". This latter probably reflects the widespread introduction of telephone triage during this period - which unfortunately did not reduce workload. A large study, published in The Lancet on 4 August 2014 and funded by the UK National Institute for Health Research (NIHR), concluded that patients who receive a telephone call-back from a doctor or a nurse following their request for a same-day consultation with a GP are more likely to require further support or advice when compared to patients who see a doctor in person. The research concluded that 'telephone triage' systems did not reduce overall practice workload.

## **GP Premises**

As most GPs own their premises the STP " strategy will provide options for practices wishing to divest from their estate and move to co- located points of delivery". Buying the premises of practices and adapting or building new premises will cost millions. Where is funding to be found?

Will the money for capital investment pledged in the GP Forward View materialise and will it be enough? Is PFI proposed? In many parts of the country struggling practices are being referred to Virgin Care or other tax haven based private health companies

## **Closure of GP Practices?**

The STP does not explicitly refer to the closure of practices but this can be inferred from the references to small practices being deemed unviable, funding measures to encourage mergers and encouragement for practices to divest of their properties. Co-location explicitly means closure of small practices. It seems likely that many smaller communities will lose their local practice although some will persist as branch surgeries. Closure of surgeries is at direct odds with the aspiration to provide services closer to home. It is likely that regarding small practices as unviable will be a self- fulfilling prophecy - GPs will be a scarce resource and young doctors will not choose to join small practices.

## **Potential Benefits of Centralisation**

Centralisation will allow economies of scale, an increase of out of hours and weekend provision and specialisation of GPs. What will be lost? A recent article in The New England Journal of Medicine describes UK General Practice as" The Jewel in the Crown" and concludes "In 10 years' time, General Practice in England may look very different from how it looks today, but it would be a disaster if the assets that General Practice has historically brought to the NHS are carelessly lost in the name of reform."

<http://www.nejm.org/doi/full/10.1056/NEJMp1411429>

It would be a matter of great regret if there was to be a loss of continuity of care making it much less likely that the patient will see a personal physician whom they know and trust, who has overall responsibility for their care and has a long term relationship with them, who is aware of their past history and may have insight into their psychosocial circumstances and who provides care for them close to home.

General Practice is making a leap in the dark – “New Models of Working Risk Throwing the Baby out with the Bathwater” -

BMJ 2016;355:i5698 doi: 10.1136/bmj.i5698 (Published 28 October 2016)

Martin Marshall professor of healthcare improvement 1, Denis Pereira Gray emeritus professor 2

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We know that health systems with a strong focus on General Practice deliver better outcomes at lower cost than those that are more specialist oriented. Starfield and others have shown that effective General

Practice is associated with better outcomes (including life expectancy, early detection of cancer, and reduced deaths from cardiovascular disease), better system performance (including fewer hospital admissions, lower cost, and reduced health inequalities), and better patient experience (including high rates of satisfaction and trust).<sup>4 5</sup> The evidence, although observational, seems consistent over time and across different health systems.

What are the likely mechanisms by which General Practice achieves such important outcomes?

1. it provides accessible care to all communities, including those with the greatest need and the greatest scope for improvement.
2. given that a large proportion of health is socially determined, the “whole person” orientation of General Practice care is more likely to be effective than the disease orientation of most medical specialties.
3. in dealing with uncertainty and managing risk, General Practice reduces the likelihood, consequences, and the costs of overmedicalisation.
4. while specialists are generally better at adhering to single disease guidelines, generalists are more effective at dealing with the growing epidemic of multimorbidity.
5. general practice care is more likely to focus on prevention and on enabling patients to look after their own health.

A commitment to continuity of care and general practitioners’ sense of responsibility for individual patients underpins these mechanisms.

### **Do GPS Support STPs?**

NHS Kernow claim that health professionals are overwhelmingly in favour of proposed STP changes. A survey of BMA members reported in the Guardian regarding STPs found that around two-thirds said they had not been consulted and a third had never heard of the STPs. Only 14% firmly supported their introduction with 64% undecided and the rest against. Those who must deliver these changes may not be not much better informed than the rest of us.

### **Appendix C - Pathways of Care**

This section raises more questions than it answers. Our major conclusion is that is that we are presented with much too little information to accept or reject the general direction. It contains some very welcome proposals, particularly the view that mental health must be given as much attention as other parts of the NHS; the recognition that people with mental illness and those with learning disabilities tend to die at a young age and the realisation that all health services have a responsibility to make sure this improves. The proposals to streamline out-patient services are also welcome - as long as this can be shown to improve outcomes for patients as well as saving money. We are concerned that the document contains so little detail about how the proposals would be funded, how they would be staffed and which parts of the service might have to disappear to fund other developments. We are concerned that using pathways to move care away from hospital increases the pressure on primary care services, and on GPs in particular. We are also concerned that some of the proposals appear to be taking provision out of the public sector altogether.

If we have understood this very abbreviated and optimistic document correctly it proposes reducing the amount of routine out-patient appointments in order to free up time for more urgent appointments. It argues that some of what currently happens in an out-patient visit could be managed by the GP or with

self-care by the patient or is not needed at all.

Unnecessary visits waste the time of patients as well as the NHS and to the extent that pathways can be used to prevent this, we welcome them, but want to see the evidence. Have local GPs been fully involved in drawing up this section? It does seem to imply substantial extra work in a part of the NHS that is already overstretched. GPs are both the first point of contact for most patients and provide regular medical care to most people with long term health problems. Their active co-operation is essential if pathways are to work. Is GP involvement needed at every stage of each pathway? Shouldn't it be possible for a person to move from one stage to another of the pathway without needing to return to the GP for re-referral or investigations?

**“Redesigning pathways of care is about identifying and following the best approach to treat or manage specific conditions based on the best available evidence” –**

Will service pathways really respond to each patient's particular needs or will they become a series of tick boxes, where people whose illnesses do not fit the model no longer qualify for particular services?

We would like to know much more about the evidence for each pathway the STP proposes to introduce. Only those pathways that have been shown to be effective and that can be safely implemented in our rural area should be introduced. The draft business case helpfully distinguishes between changes that will save lives, those that will save emergency and elective hospital admissions and those that save prescribing costs. Pathways can be a good way to reduce costs and attempt standardisation but the primary focus must always be the overall quality of the care the patient receives. We must not go the way of the Liverpool Care Pathway where it was concluded in the 2013 review “there was often too much pathway and too little care”.<sup>1</sup>

Will services be levelled up or planed down? When the document talks of reducing the variability between practices in different parts of the county can we assume that in every case this will mean improving services? Or, if a patient is lucky enough to be with a GP who offers an exceptionally good service, for example for diabetes, might the service be down-graded to meet some notional national “bench mark”. We want to be able to learn from the best practice, not to see standards fall.

We have looked at the Right Care pages but are still not certain what changes to existing Pathways are proposed. <https://www.england.nhs.uk/wp-content/uploads/2015/12/nqb-oct15-5.pdf>

**“Technology is a growing part of improving care pathways, putting citizens in control of their treatment and their communication with care professionals. The digital age can also help us save money so that citizens can access specialist care online and don't necessarily need to visit a doctor or nurse”**

What services would make use of this? Using what technology?

20% of people in Cornwall have never been on line, according to the Inclusion Cornwall website. Probably many of those are the very older, frailer, disabled or socially isolated people the STP hopes to reach in this way. Mobile coverage is poor and Superfast Broadband is not universally available despite what BT might have us believe.

Allowing people to opt in to using technology is welcome. Insisting patients use technology could put older people, disabled people or those experiencing poverty at a disadvantage. There must be wide consultation involving those who are experts by their own experience of illness or disability on this matter.

**“We are working with clinical experts to develop and standardise specific pathways of care and we want to involve patients to get the services right. Technology, innovation and citizen education will**

## **be central to our approach”**

- who are these experts? Do they include experts by experience? Do they include patients’ relatives? Are local GPs, District nurses, members of Community Mental and Learning Disability teams and specialists from RCHT involved? The Draft Outline Business case also refers to ‘system leaders’, ‘relevant stake holders’ and ‘enablers’. It is hard to be sure exactly who they mean in each case. The STP represents a major change in the way services are run and will need the best local as well as national advice.

To what extent has the STP considered the needs of family members and neighbours who, it seems, will increasingly be called upon act as carers, often on an unpaid basis? They are also citizens and there are important equality issues here. Though many men can and do act as carers, service change that relies on self-care and family care will have a disproportionate effect on women who will feel constrained to give up work to pick up the care. Many family carers are themselves elderly. Care pathways must be designed to minimise the negative impact on carers as well as patients.

**“Specialised commissioning are engaging with providers to understand the opportunities for changes in service delivery. NHS England has stated their intention of working with Cornwall as one of two rural STPs to understand where and how we can link with neighbouring STPs ensuring a viable population footprint on which to plan future services. Service reviews will be clinically led and involve all relevant stakeholders, including the strategic networks and operational delivery networks, in determining the best value option for the local population.**

**We will work with ‘system leaders’ to build new models of care with other providers such as operational networks, spoke and hub models or hospital chains with the ambition of bringing the best specialist services within reach of our population that are appropriately governed and resourced.”**

KONP opposes increased privatisation of services. We are extremely concerned that it appears the STP is considering using providers whose first interest will necessarily be in securing profit for their shareholders rather than good to the wider public. The plan for these more specialist pathways is to focus on cancer services, child and adolescent mental health and dermatology, adopting national best practice to improve pathways of care. The use of ‘other providers’ and ‘hospital chains’ means you are seriously considering privatising services to some of our most vulnerable citizens. We assume it is the specialist services, rather than the population, that you require to be appropriately governed and resourced. The experience of Winterbourne View and more recently Morleigh Care confirms us in the view that services for vulnerable people must be governed only for the good of those who use them, rather than for private profit. We also believe that it is very difficult to manage governance and safety issues in distant placements, especially in the private sector. We must emphasise that people detained under the Mental Health Act are uniquely vulnerable because they have not chosen to be in hospital at all. They are not in a position, as cancer patients may be, to make choices between providers or to balance the benefit of earlier or more specialised treatment against the distance from their homes and families. They are, quite literally, a captive population.

We note that CFT and NHS England are already in negotiation, indeed may already have made commitments, to the private Elysium Group (formerly Partnerships in Care and the Priory Hospitals) about secure beds for Cornish patients in a new private hospital near Wellington, Somerset.

<http://www.elysiumhealthcare.co.uk/locations/wellesley/> How does this fit in with the STP’s aspiration to reduce the use of out of area mental health beds and treat people closer to home?

<https://www.cornwall.gov.uk/media/22983857/taking-control-shaping-our-future.pdf>

Cornwall and the Isles of Scilly: Sustainability and Transformation Plan. Draft Outline business case. 21<sup>st</sup> October 2016 <https://www.cornwall.gov.uk/media/22984634/cornwall-ios-stp-draft-outline-business-case.pdf> See especially pages 51- 57

RIGHT CARE <https://www.england.nhs.uk/wp-content/uploads/2015/12/nqb-oct15-5.pdf>

## Appendix D - Mental Health

### Why is mental health so important?

The pain of mental illness is no less real than the pain of other illnesses.

Mental health problems are disabling. They can prevent people from enjoying their lives, forming and sustaining relationships and from working. This harms them and the people they are close to.

Mental health problems are common, affecting most people at some time in their lives, either directly, or through a close family member. Most of these problems, however are relatively mild. Severe, long-term complex mental health problems are much rarer. 5% of people in Cornwall report long term mental health problems, this is more than the national average.

Mental health problems can be fatal. In Cornwall, we have high rates of suicide, self-harm, and intentional injuries. Though Cornwall's suicide rate is higher, a lower proportion of Cornish suicides had been in touch with mental health services before they died, than would be seen nationally.

People with mental health problems tend to die at a younger age than others. The average reduction in life expectancy in people with bipolar disorder is between nine and 20 years, while it is 10 to 20 years for schizophrenia, between nine and 24 years for drug and alcohol abuse, and around seven to 11 years for recurrent depression. People with learning disabilities also tend to die young. On average about 20 years younger than the general population. Some of these early deaths are due to the poverty that goes with mental health problems and disability: people have worse housing and a poorer diet. Some is due to smoking drug and alcohol use, but there is also good evidence that people with these problems do not get a good service from the NHS for their other health problems. Some of the deaths would have been amenable to good treatment. So, preventing premature deaths is a matter for primary care and acute hospitals, not just Mental Health and learning disability services.

Mental Health services and services for people with learning disabilities have not been given an equivalent level of attention or funding in comparison with other parts of the NHS <sup>2</sup> (<http://www.rcpsych.ac.uk/policyandparliamentary/whatsnew/parityofesteem.aspx> ). The mental health services we have now are only dealing with the most serious problems and at a very late stage.

Mental health services are staff and time intensive. Good mental health treatments require trust, respect, and the ability to develop long term relationships. How can that happen in Cornwall's overstretched services?

**“Involving citizens in developing the best pathways of care is critical and we still have work to do before we can say more about proposed reforms” –**

It is hard to disagree with this statement but we would like to know who will be consulted.

We believe that you must listen carefully both to experts by experience and to the staff who deliver primary care, community, mental health, and learning disability services.

**How will the STP bring in experts by experience** - the people who know about mental health problems and services because they have experienced them- to help design more effective, more reliable, more accessible services? Small voluntary sector organisations that respect this expertise of people are one way of gaining the views of people with mental health needs. Why did KCCG cut grants to Pentreath, Nightlink, Carrick Mind, Restormel Mind, Penta Health and Wellbeing, Sea Sanctuary, Women's Rape and Sexual Abuse Centre, and Cornwall Rape and Sexual Abuse Centre?

These are services whose work is recognised, for example by Inclusion Cornwall  
<http://inclusioncornwall.co.uk/what-is-inclusion/social-inclusion-2/health-and-inclusion/>

People at KONP's recent conference told us how important these organisations are to them and pointed out that these bodies need support so that the group can still function when particular members are not well. This is a real issue in self-help organisations for people with mental health problems whose state of health can fluctuate.

### **Are staff being asked about proposed reforms?**

Community Mental health services were drastically reformed recently and have developed into something that wasn't the suggested model. There was no consultation or involvement of affected staff, staffing levels have now reduced and recruitment is proving difficult.

There is considerable expertise in services that would help the STP achieve its aims, for example existing Mental Health and Learning disability services operate liaison and in-reach to secondary care. Their experience would be helpful in working out how to reduce the number of people with these problems who die prematurely.

### **Who will be providing the new Child and Adolescent Mental Health Services?**

Better community and inpatient services for children and adolescent mental health in Cornwall are badly needed and we welcome the commitment in the STP to investing in them. How will this be funded? Will they be provided by an NHS organisation or in the private sector? Will there be in-patient services in Cornwall? Any services that are developed must include provision for Children and young people with learning disabilities because they are more likely than others to develop mental health problems.

**“Care closer to home is our goal but only when it makes clinical and financial sense..... At times we will need to ask people to travel to get the best care.”**

It is disturbing that the STP does not appear to recognise that people admitted to mental health beds in or outside the county have no choice in where they go. Most of them will have been detained against their will under the Mental Health Act because they are so distressed that they pose an immediate danger to their own health, their own safety or to the health and safety of other people. In these circumstances, Local Authority staff have a legal duty to make an application for hospital admission if it is needed. It is the responsibility of the CCG to ensure provision of such services. When people are detained under the mental health act they are not making a decision about where to receive services: they are not being *asked* to travel; they are being forced to travel to undergo assessment and treatment against their wishes

The STP wants to reduce the number of people in out of county mental health units. This begs the

question of why people are being admitted out of county.

Usually it is because they needed admission in a crisis and there were no beds available in Cornwall at the time. If we had enough Mental Health beds to meet demand, out of county beds would not be used.

Delayed discharge from mental health beds can be because of a lack of social care but housing is probably an even more pressing problem for people with mental health problems. Will more housing be made available to facilitate discharge from mental health in-patient care in and outside the country? Where will the funding come from?

CFT hold regular Bed Management meetings involving managers, nurses, Consultants, and other clinicians. Despite this there are delayed transfers of care (DTCs) from the adult wards: the numbers are not detailed in the CFT annual report.

It would also be interesting to know why transfer is delayed. Anecdotal evidence from clinicians suggests housing and homelessness are important. <http://www.cornwall.gov.uk/media/11488953/CornwallHomelessnessEvidenceJanuary2015pdf.pdf>

6% of people on the housing list require housing because they had left an institution or council care and mental illness or learning disabilities came second only to households with dependent children in the numbers allocated priority by the housing department.

The story often seems to be that person develops a mental illness, because of which they fall behind with their rent or develop bad relationships with their neighbours or family. They are admitted to hospital and lose their home at about the same time. When they are psychiatrically fit to leave hospital, they have no home to return to. People who are already homeless have high rates of Mental Health problems and account for about 1 in 40 completed suicides.

A few people have to be sent to out of county placements because they need highly specialist treatment regimes, for example in-patient eating disorder services, mental health services for the Deaf that are rare and where it may be unrealistic to provide services locally. It does however seem surprising that there are no child or adolescent beds in the county.

People who are admitted via the Criminal Justice System to a secure unit can, at present, only be treated in Cornwall if the Court agrees they can be treated under conditions of Low or no Security. People who are deemed to need Medium or High Security are currently treated outside the county. The STP does not mention collaboration with providers, but we note on the Elysium Group website that they have opened a new 75 bedded Medium Secure unit in Somerset. They state that “the unit will be one of NHS England’s pilot sites to test new approaches to delivering mental health issues and will be working alongside Devon Partnership NHS Trust, Avon and Wiltshire FT, Cornwall FT, Dorset FT, 2gether FT, Cygnet and Livewell.” How is this consistent with the STPs stated aim of reducing the number of people in Mental Health beds outside the county?

The Mental Health Act code of practice says that if people are admitted this *should* be admitted to as close as reasonably possible to the place they identify they want to be near, usually their home or that of a family member or carer. The practice of out of country admissions could be considered a Human Rights issue.

The experience of learning disability services in Cornwall shows that it is possible to bring people back from out of area placements and to minimise the need for hospital admission but that this takes funding, detailed planning for each individual and sustained commitment from health and social care commissioners as well as providers.

The MHA code of practice is also clear that commissioners must respond to issues raised about delays in

placing patients when planning services. Those responsible for admitting have a duty to try to find alternatives to an admission bed but few such alternatives are available at the moment. How much money will the STP make available for alternatives to hospital admission, such as crisis houses, drop in centres and time intensive home support? Where will this funding come from? Money will only be saved from out of county placement budgets once people move. Services need to be in place before they move. Is any bridging finance available? How much funding does the STP estimate will be needed to reduce the number of people placed in Mental Health beds outside Cornwall? Is the intention in future to admit them to a new facility in the county, or to reopen some of the CFT wards that are currently closed?

Cornwall's use of out of county beds has increased as the number of beds in county have reduced.

<https://www.kernowccg.nhs.uk/about-us/what-we-spend-and-how-we-spend-it/services-review-update/decisions-from-4-october-2016/>

We support the case for more intensive community support but recognise that it is not always available, and of course is potentially risky. It depends crucially on staff with the training, experience, and time to build and sustain relationships with the people who use the service. It is not simply a question of staff numbers. People in acute mental distress repeatedly mention the need to see someone they feel they can trust, to have a named key worker and to see the same health care professionals regularly. Have patients, carers and staff members been approached about whether in their view it is safe to try to reduce the number of out of county beds?

There is a major shortage of psychiatric nurses and difficulty recruiting them, both in the county and nationally. [https://www2.rcn.org.uk/\\_data/assets/pdf\\_file/0004/600628/004772.pdf](https://www2.rcn.org.uk/_data/assets/pdf_file/0004/600628/004772.pdf) This shortage was predicted by the Government's own centre for workforce intelligence: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/507491/CfWI\\_Future\\_nursing\\_workforce\\_projections\\_acc.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/507491/CfWI_Future_nursing_workforce_projections_acc.pdf)

Department of Health (2015) Mental Health Act Code of Practice

In Cornwall, we used to have 'assertive outreach teams' who worked with highly complex patients to reduce hospital admissions. Now they no longer able to work in the same way. Is this one reason 'High complexity patients' need repeated admissions?

Mental health services are already integrated in terms of health and social care funding and staffing. Are integrated mental health services working well currently? Are the services offering a good balance of health and social care? Currently, social workers seconded to the NHS from Cornwall Council do not always have the opportunity to offer social work/care act assessment due to high caseloads. Exactly what is the STP proposing to change?

1. Neuberger J, Aaronovitch D, Bonser T, et al. MORE CARE, LESS PATHWAY A REVIEW OF THE LIVERPOOL CARE PATHWAY. London: Department of Health, 2013.
2. Bailey S, Thorpe L, Smith G. Whole-Person Care: From Rhetoric to Reality: Achieving parity between mental and physical health. London: Royal College of Psychiatrists, 2013.

<http://www.cornwall.gov.uk/media/11488953/CornwalHomelessnessEvidenceJanuary2015pdf.pdf>

## Appendix E - Improving productivity and efficiency of system enablers.

This section impacts on support functions and the interaction between organisations and providers within the current system.

The proposals fall into 4 key areas

#### “Key enablers (page 60 OBC)

Significant investment to establish shared service – Funding will need to be secured to cover redundancy payments, other potential amendments to terms and conditions, office and accommodation costs, business process reengineering costs and investment in technology and systems.

- • Technology – Current systems will need to be replaced or integrated to support the shared service, requiring considerable developer capacity and supplier support.
- • Workforce – While many current staff would transfer to our shared service, in many instances a substantial level of retraining and skills development will be required.
- • Similarly, the shared service will need to build in organisational development capacity of its own to help develop a coherent culture and approach.
- • Estate – Depending on the decisions we make about using existing providers and/or collaborating with other footprints and organisations, we may need to remodel aspects of our shared estate to facilitate the centralisation of key functions.”

#### The major concerns which this raises are

- • **Unspecified numbers of redundancies** of existing staff, with no specific costings or identified budgets.
- • **Cuts and alterations to the terms and conditions** of remuneration of existing and future staff directly employed in the public sector or outsourced.
- • **Outsourcing** of shared services to a private sector provider with the transfer of staff out of the public sector.
- • A major requirement for a “substantial level” of retraining for staff without any identified funding streams or Further and Higher education sector involvement or support.
- • **Closure and sale of existing hospital** and health care facilities to fund investment in new facilities which have not been identified or costed. No funding for new facilities is identified in the OBC. At the engagement sessions it has been indicated that the NHS cannot prudentially borrow money for capital expenditure to facilitate new NHS buildings. It has been stated that Cornwall council can. We can find no evidence that Cornwall council has considered capital investment in new NHS facilities as part of the STP or what the funding streams or governance arrangements would be to facilitate such proposals. The sums involved could be significant and alternative provision would have to be in place before closure of existing facilities could take place. It is also unclear whether there would be restrictions on contracting new NHS facilities arising from restrictions imposed in existing PFI and LIFT contracts.

In addition, the OBC sets out a further major challenge on Workforce planning: -

***“We will develop a whole system Workforce Plan for Cornwall and the Isles of Scilly with clear implementation timescales and joint governance to oversee delivery. We will undertake workforce modelling aligned to new place based models of care and financial constraints” (Page 62)***

The term “whole system” implies that this will be coordinated across the NHS, Local government, private, not for profit, CIC and community and voluntary sector organisations. There is currently no structure in place which has the capacity, capability, or resources to undertake what is a massive and formidable task. This would pose a significant logistical and practical challenge as many of the organisations within the sector are currently in competition for contracts and/or for recruitment into and within the sector.

Without clear structures and significant resources, which are not currently identified, this would be difficult if not impossible. We strongly recommend that a structure is established to give direction and focus to workforce planning. This could for example take the form of a “Clinical Workforce Board” under the leadership of the Chair and Chief Executive of the STP This piece of work is essential regardless of whether the STP progresses in its current form or not.

**Technology.** The OBC sets out the key issues (page 60)

“Current systems will need to be replaced or integrated to support the shared service, requiring considerable developer capacity and supplier support.”

It then sets out the vision for IM&T

*“One Person, One Digital Record*

*By 2020/21, all care professionals will have immediate access to an integrated digital care record underpinned by an information sharing solution that removes ambiguity, confusion, and barriers to “safe sharing” between care professionals, organisations, and local people. Information Management & Technology will provide an innovative, flexible, and collaborative set of technologies that will deliver commissioning priorities and be a key enabler of new models of care to meet the needs of our population. We will have a “whole system” approach to our Enterprise Architecture based on common open technology standards set across the Cornwall Footprint”*

The aims and vision are laudable.

However, both the Council and NHS have invested heavily over recent years in new IM&T systems. For example, Cornwall Council implemented an ERP system in 2012. That contract runs until at least 2020 and the initial cost was over £6m. The NHS similarly has been involved in national and local IT projects which have had mixed success but have all involved significant financial investment over recent years much of it with outsourced providers and constrained by contractual agreements.

The OBC says “current systems need to be replaced” this would mean one or more of the current organisations abandoning their current systems which have had considerable recent investment and may also be subject to existing legal obligations. It would then mean further unidentified and unknown expenditure on a replacement system. Whilst the OBC talks about potential national funds being available the scale, scope, and value of this is not quantified and the investment required could be vast.

The report then says

“Or integrated to support the shared service, requiring considerable developer capacity and supplier support.”

The issue of integration or shared services implies that this could be outsourced into an existing shared service or strategic partnership with the private sector or collaborative arrangements within the NHS but outside the Duchy in the peninsula. This could be with either an existing NHS/Council organisation or establishing a new arm’s length cross provider organisation.

We base this conclusion on the issues which the OBC sets out as follows. (Page 60)

*“We understand that we will need to consider the volume of activity that our future shared service will be*

*dealing with and will consider whether this warrants greater cross-border collaboration with other footprints in the South West or whether one of the existing national shared service providers might be the right option for our future plans”*

Cornwall Council and local NHS have recent experience of “strategic partnerships” or “shared service providers” with the early termination of the BT Cornwall contract. The other major strategic partner in the South West “South West One” with IBM was also terminated by Somerset council and the largest such contract in the UK “Transform Birmingham” with Capita won’t be renewed. These kinds of arrangements have a problematic history of being non-compliant, expensive, inefficient and have often ended in contract failure, termination, and recrimination. Despite this woeful record there are still some existing national shared service providers. One of these is NHS Shared Business Services (SBS), is a joint venture with Sopra Steria which describes itself as “... **a global IT company, one of the Top 10 in Europe for business process transformation**”.

The idea that existing services be outsourced to a private shared service provider would be wholly unacceptable given the track record of such ventures.

### ***Estates.***

The vision for estates in the OBC says. (Page 65)

*“By 2020/21, our estate will be collectively planned and organised to effectively support the new ways of working that we are developing across the whole system in Cornwall and the Isles of Scilly. Our enhanced focus on community-based care will mean we need to consolidate and use our existing estate differently with properties that are fit for purpose and adaptable. By working collaboratively together, we will maximise the efficiency of our estate, ensuring it is utilised as much as possible and configured to best meet the needs of the local population.”*

We have referred earlier to the future of Community Hospitals. This is probably the most complex and sensitive of all with the public in every local community. The potential closure and replacement of cherished local assets by as yet unknown, uncosted and significantly different provision will be extremely contentious.

It is important to accept and widely supported that there will be many occasions when the most appropriate care and support can only be provided in a hospital, nursing, or residential facility. Determining the right number of “beds” of different types and their locations is as fundamental to the STP gaining public support and acceptance as the provision and location of urgent and acute care facilities.

The OBC says (Page 66): -

*“We will aim to integrate strategic property management functions through the development of our shared back office proposals.”*

If our observations earlier in respect of “shared back office” are correct this could mean that the management of existing NHS and council owned property will be outsourced to a private sector provider. The potential sale of some existing properties to fund the provision of new facilities means there will by necessity be a time lag unless there are alternative funding models. This could be either Cornwall council undertaking prudential borrowing which is repaid on the sale of the original property or entering into agreements with the private sector through PFI, LIFT or similar arrangements.

The OBC goes on to say

*“We will explore opportunities to devolve assets locally to assist with the delivery of the STP plan as*

*opposed to them being retained by NHS property services.”*

It is currently unclear if the monies arising from the sale of properties if devolved from NHS Property Company will be as part of the devolution deal or the STP. Who will be the accountable body for the receipt of those monies? **Put simply who would be responsible for receipt of the any monies and how they are spent?**

## **APPENDIX F - System Reform**

Has a decision already been made about System Reform?

The booklet *Shaping our Future* says “There are various organisational models we could adopt ... and we need to do further work on the options before we can engage more fully.” However, a letter dated 19/12/16 and signed by Kate Kennally, Kathy Byrne, Jackie Pendleton and Phil Confue states “Our thinking now is that we will need to move with pace to establish an accountable care organisation (ACO) for Cornwall and the Isles of Scilly and one focal point for the strategic commissioning of health and care.” It seems that a choice about which option to adopt has already been made, which reinforces widely held fears that the engagement process is not genuine. The same letter also states “We envisage the ACO will also include within it the Royal Cornwall Hospitals NHS Trust and Cornwall Partnership NHS Foundation Trust and Adult Social Care services.”

If a decision has been made, what is the evidence that has led to the conclusion that establishing an ACO is the right option. An article by the King’s Fund in March 2015 states that early evidence on ACOs in the United States is mixed. Furthermore, a pioneer of the model in England, the Torbay, and South Devon ICO (Integrated Care Organisation) which came into being in October 2015 has already run into financial trouble according to a BMA News Report on 19<sup>th</sup> January 2017. “Torbay and South Devon NHS Foundation Trust has this month told the two councils involved in the ICO that it is withdrawing from a ‘risk-sharing’ agreement, which splits liabilities for unexpected costs. [Torbay Council papers indicate](#) that the ICO has overspent by £12m in its first year, sparking fears that the organisation presents a ‘substantial financial risk’ to the local authority.”

These fears seem to be shared by at least some people with Cornwall Council. The report *Transforming Adult Social Services; The Cornwall Offer* to the Health and Adult Social Care Scrutiny Committee on 4<sup>th</sup> January 2017 states “ Significant financial risk exists from the financial recovery plan of Kernow Clinical Commissioning Group and the wider financial deficits within the local and national health systems – as such any Adult Social Services transformation plan needs to ensure that the council is not exposed further to the financial pressures within the health system”. Perhaps Peter Tempest and Claire Leandro, the authors of the report, are not altogether in agreement with Kate Kenally.

There is another implication of integrating Health and Social Care, which is a possible cause for concern. Currently there are often disputes between the two services, probably largely driven by budget pressures, about who should pay for a package of care. The outcome of such disputes can have serious financial implications for the person receiving support because Health Care is free but Social Care is means tested. At present the disputes are between two large, equally powerful institutions. However, if Health and Social Care budgets are integrated, any dispute about which category someone’s support falls into will be between an individual and the holder of the integrated budget. Plainly this is a very unequal contest and there will be a financial incentive for the integrated budget holder to categorise care as ‘social’ rather than

'health' because the person receiving the care can then be charged some or all the cost. It is already very difficult to qualify for Continuing Health Care and it seems it will only get harder if Adult Social Care are no longer fighting for Health to pay their share.

[The Kings Fund report on delivering the STPs](#)

[West Cornwall HealthWatch update on Cornwall March 2017](#)

[Evidence from KONP for the Overview and Scrutiny Committee on Cornwall's STP](#)

[Patients on Wheels Report from 2000](#)

[Evidence on Integrated Care](#)

[The Cornwall STP survey: Why is it so difficult to have your say](#)

[NHS Kernow's 111 and Out of Hours Survey](#)

[Design and Use of Questionnaires](#)

[Health and Social Care at risk in Cornwall](#)

[Cornwall STP from planning to implementation, a presentation](#)

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