Joint Response of Newham and Waltham Forest Save our NHS and Tower Hamlets Keep our NHS Public
to
Transforming Services Together (TST)

We note that Sustainability and Transformation Plans are being imposed by Government, and that there are major financial penalties if the 44 areas in England fail to cut deficits and deliver on their plans.

North East London is one of the most deprived areas in England, and has been underfunded for years. It is our view that the signatories to the Transforming Services Together Document – Newham, Tower Hamlets and Waltham Forest CCGs and Barts Trust – are attempting, in three documents of nearly 300 pages, to present a shift of demand from hospitals to primary care, and cuts to provision in our hospitals, as if they were achievable, desirable, and in the interests of local residents. We contend that if these bodies were serious in their responsibilities to the residents of North East London, they would make it very clear to the public, local politicians, and to Government and NHS England, that what they are being required to do is untenable, and represents a threat to the future health and well-being of this area of London.

1. General Points:

- According to the Transforming documentation, the population is expected to increase by 270,000 over the next 15 years. An increase of population of that scale would normally require, in the next 10 years, 550 additional hospital beds, a million more GP appointments, 195 additional GPs and 92,000 additional A&E attendances. Moreover King George Hospital A&E is due to close, and social care budgets have been decimated. It is simply not credible that, in this context, the TST programme can achieve 180,000 fewer outpatient appointments, keep A&E attendances at existing levels, and make overall savings of between £104m and £165m over 5 years. Such a programme is a major reorganisation of services – something that not only the Government insisted would not happen, but would also require a higher than usual level of public and patient consultation.

- There is a significant disconnect between the strategic intent of the programme, and the inevitable failures in operational delivery, which will arise as a consequence of the major increase in demand, occurring at the same time as cuts in funding imposed by the government.

- We consider that very drastic changes have been lost within impenetrable and long documents, with large amounts of jargon, that, in effect, prevent members of the public and patients from grasping the key points. We consider that there has been a failure to adequately advertise these plans to the public, and that the consultation process is a flawed one.

- TST proposes a major reconfiguration of surgical services across East London's three hospitals, which will affect every person in the three Boroughs. The proposals threaten A&E and Maternity at Whipps Cross and Newham, and will result in Tower Hamlets residents having to travel to Newham and Whipps Cross for low risk and non complex operations.

- It is our view that reducing the capability of 24 hour a day consultant supervision and availability at Newham and Whipps Cross will call into question the accreditation of junior doctors' posts by Royal Colleges in surgery, medicine and A&E services. Where junior posts are not accredited the A&E at both hospitals would have to close. This poses a threat therefore to both hospitals which is unacceptable.

- A major shift of "demand" is proposed from the hospitals to primary care. This despite the fact that the UK as a whole has a lower bed to patient ratio (2.8 beds per 1000) than the OECD average (4.8 beds per 1000)(OECD Health Statistics 2014). And despite the fact that primary care is underfunded, and there is a general crisis in recruitment and retention across all health professions, which will be exacerbated by cuts to bursaries.

- The models proposed in Part 3 lack overall coherence. They appear untested and flawed. The most striking being that the impact of the shift of complex care from hospital to general practice has not been accounted for in the primary care proposals. There appears to be no attempt to evaluate the cumulative effect on primary care of so much operational responsibility being shifted from secondary care.

- Time-scales are unrealistic. There seem to be no plans to pilot, double fund, or evaluate each proposal.

- The shift proposed to primary and community care, and improved prevention, makes no reference to the fact that social care budgets have been cut by up to 30% since 2010, that local authority health prevention budgets have been cut and pharmacies are being closed.

- The shift to care in the community is predicated on patients having good family and community support. The burden of care invariably falls on women. There is no reference to the impact on carers, despite the fact that improved support to carers has been a focus, for decades, of both policy and legislative change.

- Although passing reference is made to deprivation, the emphasis on "self care" makes no reference to the negative effects of poverty on life span, disability, mental health, and substance misuse, and how these factors all compound so called " self management".

- The efficacy of the plans, and of improved partnership working, are premised on interconnecting IT systems and records. Not only does this raise data protection issues, but it is an unfortunate fact that over the years millions of pounds have been wasted in attempts to improve IT systems across

all public services. As a consequence it is difficult to have any confidence in this aspiration, especially given the time-scales involved and recognition in the papers that some of the current IT systems are " not fit for purpose".

- Inter-hospital transport is a key part of the document especially under the 'stabilse and transfer' proposals for emergency surgery at night at Newham and Whipps Cross. The London Ambulance Service is currently in Special Measures due to failure to meet its emergency standards. Previous experience transferring patients, both emergency and non-emergency, makes this aspect of the plan very problematic.
- The plans state that 'Consultant supervision' of Acute hubs at Newham and Whipps Cross will not be available for up to 10 hours a day. It is not clear whether this will apply to the Surgical Hubs nor what the level of medical supervision will be. A 'senior decision maker' is mentioned as being present in both hubs but there is no clarity regarding the grading of the medical personnel, if not a consultant. There is no reference to national standards of care.
- We would agree with many of the aspirations expressed in the plans. However, to try to implement them with budgets cut, and to unrealistic time-scales, will put an already stretched and stressed workforce under even greater pressure, is likely to further destabilise struggling services, and put patients at risk.

Our response focusses primarily on sections in Part 3 High Impact Changes

2. Integrated Care:

- The documents describe expanding integrated care to include, not only those at very high and high risk of admission to hospital, but also those at medium risk. 20% of patients are described as accounting for 80% of healthcare costs. The extended model assumes a reduction by 20% of non-elective spend in hospitals, which is also represented as a reduction, in

5 years, of emergency bed days by 21,053. It is planned to achieve these by 2017/18, and to achieve net savings of between £4.2m and £6.6m over 5 years.

- Costings could not be found. The reader was directed to Part 2 for costings which said (Pg 32) : " East London Commissioners are committed to piloting a capitated budget in "shadow form" from April 2016. A simulation exercise between commissioners and local providers is currently taking place. Across East London, CCG's and local authorities are committed to developing a common methodology for calculating a capitated budget, including common approaches to gain and loss sharing and to outcome-based payments". This reads as a proposed process, not costings.

- An article in January 2016, written as the Researcher in Residence Evaluation of the Waltham Forest and East London Collaborative (WELC) Integrated Care Pioneer Programme, demonstrates the complexities of integrated care. A number of points are made, for example:"The integration of health and social care has been central to the thinking of policymakers in the UK since the 1960s"."Many questions about integrated care remain, particularly in relation to the processes by which integration can be most effectively achieved.""A significant disconnect has been identified between the strategic intent of the programme and the operational delivery of integrated care".

- The research highlights, as we have in the section on End of Life Care, how the complexities of home based services can be minimised, especially in the context of pressure to find cuts in hospital admissions.

- **Bearing in mind the cuts to local authority budgets, and that integrated care relies on an overburdened primary care sector, we have no confidence that the financial and bed space savings can be achieved.**

- **Additionally we have very real concerns that this cohort of people could be subject to premature discharges, as identified in the Health Ombudsman's report, described in the End of Life Care section below.**

3. Urgent care:

NHS 111

- Population growth and the closure of St George's A&E are projected to raise A&E visits by 92k a year. The expectation that this can be reduced by integrating urgent care, so that far fewer people attend A&E/urgent care is, in our view, unrealistic.
- **The high risk rating for lack of providers and IT underlines this. Despite this, savings of between £2.5m and £5.8m over the next five years are being projected.**

- NHS 111 is central to the plans as a single point of entry, providing phone triage. Despite the risk rating, it's planned that boroughs will go live with a new provider by 2017, providing 70% of access to urgent care in 2017/18, and achieving 90% phone triage first by 2020-21.

- There have been various alarming reports of staffing in NHS 111, of inaccurate data entry, over-reliance on computer generated advice, and of the harms caused as a consequence.

- Following the death of 12 month old William Mead in 2014, the BBC reported in February 2016 an interview with the president of the Royal College of Paediatrics and Child Health, Prof Neena Modi. Prof Modi said "It is uncertain – because studies have not been adequately conducted – whether or not the telephone triage service, such as NHS 111, is really going to be safe and effective for very small children." She said 111 had been brought in at huge cost without proper evaluation of whether it was a safe service. "We are saying that the time to do an evaluation is not after you've spent millions of pounds in introducing a system. You want to do that up front, beforehand."

- **We are concerned about the risks to patients of using NHS 111 as a single point of access. We believe it will, in fact, become a barrier to appropriate medical interventions, especially for residents whose first language isn't English, and bearing in mind the multiplicity of communication impediments that are compounded in any communication that is not face to face or assisted.**

- **Despite the fact that, to date, private providers of NHS 111 have caused more visits to A&E not fewer, the plan projects a reduction in hospital activity of 26%.**

Primary care will give more same-day access

- This is proposed although there will be 195 fewer GPs across the area than needed to cope with population growth. Primary care will be expected to deliver improved end of life care, integrated care, pre and post operative support, and support more home births. District nurses nationally have been cut by 28% between May 2010 and December 2014, and it is projected that the supply of nurses – nationally – will not meet demand until 2019–20. (Managing the Supply of NHS Clinical Staff in England Public Accounts Committee 2016 pg 5). Ending bursaries will exacerbate recruitment problems across all health professional groups. All this is exacerbated by the specific problems of London – the high cost of living, excessive housing costs and chronic recruitment and retention problems.

We consider this planned outcome to be unrealistic

Meeting unmet mental health need – all ages

- It is recorded that 5% of urgent care visits are people with mental health problems. In the acute section it is proposed that acute care hubs are established for people in mental health crisis. **In the footnote it is acknowledged that this has not been costed.**

- Nationally mental health services have been devastated, with an 8% cut in real terms against a 20% rise in demand. Mental Health gets 13% of the funding; mental ill health causes 23% of health disorders.

- It is known nationally that insufficient support from Mental Health Crisis teams is driving people to A&E. This cannot be stopped without more resources.

- In Tower Hamlets, GPs tell us that cuts to mental health have stripped the service back to where it was in the 1980s. A whole series of specialist teams have been dismantled, pushing the whole service back onto the Community Mental Health Teams. Support for people with less acute problems is being cut short or withdrawn altogether.

- **Against this backdrop, these targets are unachievable**

Meeting unmet mental health need – CAMHS

The document states they will achieve:

- *Single call access for children and adolescent mental health (CAMHS) (or adult mental health services with paediatric competencies for children over 12 years old) referrals to be available 24 hours a day, seven days a week with a maximum response time of 30 minutes. Psychiatric assessment to take place within four hours of call*

- Experienced GPs tell us that targets like these have never been met by these services. CAMHS services nationally and locally have already been massively cut. As teams move to local authorities, they are now facing yet more cuts – for example the recent dispute over £200k transfer of CAMHS responsibilities to Tower Hamlets.

- Anecdotally, we have heard of local schools that now take children in crisis direct to A&E, because they can no longer get a child seen by the emergency CAMHS teams. The NHS Benchmarking report for 2013, stated that the wait for an emergency appointment with CAMHS nationally was three weeks (median) or nine weeks (mean average). **Achieving**

psychiatric assessments within four hours of being called presents as purely aspirational, and not a realistic goal for a serious proposal.

4. End of Life Care:

- The TST reports that 1 in 3 emergency admissions are palliative care patients. The TST plans for End of Life Care aim to reduce unplanned admissions by 50% by 2020/21 and to completely achieve a 32% reduction in the final length of stay in the same year. The projected net savings are £1.6m to £3.4m over a five year period. **For all the reasons identified below, we say this is not only untenable, we fear it is unsafe and could result in patients experiencing painful, lonely and undignified deaths.**

- The plans for end-of-life care set out in 12 pages of the TST document indicate a major change in the care of 'palliative patients' from hospital to the community. Such a massive change requires detailed planning, review of the evidence and consultation with experts, as well as informed patient and public involvement. There is not enough information here to properly review and comment.

- This is a relatively untested model which needs to be fully researched and evaluated. The aim of Dame Cicely Saunders and her colleagues in setting up the modern hospice movement was to have a tri-partite model of multi-disciplinary end-of-life care based on high quality clinical care supported by research and education. This requires time and investment. **We consider the time-scales in this document to be untested and unrealistic.**

- The review published in July 2013, and the subsequent abandonment of the Liverpool Care Pathway, is indicative of just how complex caring for people at the end of their life can

be. The review made 44 recommendations, including that the term pathway should be avoided (Recommendation 3); we note "pathway" is used in the TST. It also recommended "funding should be made available to enable palliative care teams to be accessible at any time of the day or night, both in hospital and in community settings, 7 days a week". (Rec 33)

See:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/212450/Liverpool_Care_Pathway.pdf

- The TST end-of-life plans are premised on patients being identified as 'palliative patients' and labelled as such. It is clear from the research literature that this is extremely difficult to do. For example see Gott et al, BMJ 2011. It is not clear from this document what the difference between 'palliative' and 'end-of-life' are. 'End of life' can mean any period between the last year of life of a person with a chronic and progressive disease to the last hours or days of life. Unless this lack of clarity is addressed, there is the very real risk that a person deemed to be at the 'end of their life' may be placed onto the LCP too early. (More Care, Less Pathway, 2013)

- High quality home care is resource-intensive. It is notoriously complex to provide, requiring sophisticated systems to assure quality and reliability of service. Factors such as the home environment, the availability of informal networks, the capacity and frailty of the patient, all compound this complexity. Detailed analysis of these operational issues and costings need to be set out.

- TST emphasises the need to reduce the number of bed days currently taken up by 'palliative patients'. Frequent reference is made to the savings to be made by reducing hospital admissions (£272 a day) but the corresponding cost of providing high quality end-of-life care in the community (stated as ideally at home or in a hospice) is not stated. The

costs mentioned are for staff training and IT support (staff training needs to be set out in detail and fully costed). Staff training and IT are important but only part of the resource picture. Caring for very sick people at home involves equipment such as hospital beds, commodes, incontinence pads etc. It also involves organisation e.g. ordering and delivery of such equipment. It is likely that 24 hour nursing care will be required for at least part of the time. We need to know the daily cost of such care for comparison purposes otherwise we have a very skewed picture of the resources involved. Palliative medicine is a medical speciality and if more patients are to be identified as 'palliative' more palliative care consultants will be needed.

- It is not at all clear what exactly would be commissioned as end-of-life care and where and how the staff would work in the new care model (p31). Who would be responsible for the care? Is the plan to transfer the provision of palliative and end-of-life care to St Joseph's Hospice and local primary care teams? Given the strain primary care teams are currently under, this would be a concern for both professionals as well as patients and carers.

- Care plans are highlighted as key to providing end-of-life care. Producing a care plan in line with best end-of-life practice depends upon the resources being available to support such care.

- This plan is predicated on people at the end of their lives having a network of family/friends to support and advocate for them. There is no reference to the significance of the home circumstances of patients in providing end of life care, nor to the implications for partners, or carers. **This is a major omission, particularly in the light of the legislative and policy focus on carers over the last few decades.**

- The report in May 2016 by the Parliamentary and Health Service Ombudsman:"Investigations into Unsafe Discharge from Hospitals" makes chilling reading in the context of this End of Life plan. In 2014-15 they investigated, as the final tier of the NHS complaints system, 221 complaints about discharge, a 6.3% increase on the previous year. **We have concerns that these plans, if implemented as they stand, will result in increased pressure on the hospitals to discharge, prematurely, some of the most vulnerable patients in our community.**

- **The high risk ratings in the report for an under-skilled and insufficient workforce, for unreliability in identifying patients, and lack of care co-ordination/access to care signify, we believe, the enormity of the task, and underline how unrealistic the plans and time-scales are.**

- We are not advocating that people at the end of their lives die in hospital. However, the TST end-of-life care plan is clearly driven by the intention of keeping patients out of hospital and cutting hospital bed costs. High quality care at home is resource-intensive. If such resources are not made available it is highly likely that we will witness the same negative consequences of under-resourced care, as happened with the Liverpool Care Pathway.

5. Primary Care:

- With population growth, the report projects that 589k extra appointments will be needed over the next 5 years. It notes that Newham and Waltham Forest have below average numbers of GPs compared with the rest of London, and that in these boroughs up to 38% are due to retire. In all three sections of the Document the chronic recruitment and retention problems are described across all health professions.

- The solutions proposed include larger primary care hubs, catering for 10-15,000 patients on the same site or as part of a network, and hubs of 30,000 patients providing a range of services, including minor surgery. **There is no reference, however, to how this is at odds with the key objective of providing care closer to home, nor how this will disadvantage the highest users of primary care services – children and families, and those with long-term conditions, people with disabilities and mental health needs, and the frail elderly.**

- It is proposed to provide extra staffing in primary care hubs, to cater for the increased demand, with allied health professionals, and new physician associates, cheaper than GPs, representing a net saving of £16m over 5 years.

- Most practices already have nurse practitioners, who can assess and prescribe, but the practices are still under stress and unable to offer appointments as early as they would want. Most work closely with pharmacists, and have access to other professionals, including counsellors. Pharmacists already give advice to the public, hence the opposition to many closures.

- There appears to be an assumption that better use of IT will free up GP time. It will, undoubtedly, work better for some patients, but any contact, whether face to face or on Skype, will generate work – at the least record keeping – and the likelihood of a range of follow up actions.

- Despite cuts to pharmacies and to local authority health prevention budgets it is projected that 24% of attendances at surgeries can be catered for by patients being "supported to self care" and being referred to pharmacies and counsellors.

- Despite the current crisis in primary care – largely due to underfunding for many years - the whole document is predicated on shifting demand on the hospitals to primary care. The sections on urgent care and integrated care assume, together, a 46% reduction in hospital emergency "activity" and admissions – largely through improved primary care. It is

expected that primary care will absorb pre and post operative care, and will reduce outpatients appointments by 20%.

- **Two telling references in the document underline how flawed these plans are :**
- a) **" The following factors have not been accounted for within modelling; the rising levels of average attendances that primary care services are experiencing from patients; the expected 10% rise in LTC during the next ten years; rising life expectancy meaning more people are likely to require managed care for longer; *more complex care being shifted into general practice from hospital* " (Pg 59, Part 3)**
- **b) Delivery risks : " Workforce supply will not be sufficient to implement new care model and meet future demand" Rated high risk (Pg 60 Part 3)**

6. Surgical Hubs:

- The plans propose developing surgical hubs, providing core services at Newham, Whipps Cross and The Royal London to support emergency, A&E and Maternity. There are contradictory messages regarding core plus surgery, requiring some specialisation, but it is noted that specialisms will be different at the hospitals. Complex surgery will be delivered at the Royal London and Barts.

- A key message is that RLH needs to be freed up – from non-complex operations - in order to treat the sickest and most complex cases. This contradicts the expressed intention to deliver care locally,"with patients only travelling further when it leads to better outcomes" (Pg 65 Part 3). An article in the BMJ June 2015, based on US research, highlights the importance of patient and family engagement in improving clinical outcomes. Providing non complex surgery, for Tower Hamlets residents, at Newham or Whipps Cross, is bound to have a negative impact on family contact with patients. **This proposal will significantly disadvantage Tower Hamlets residents, many of whom experience high levels of deprivation and exclusion, in particular the Bangladeshi and Somali communities.**

- One of the reasons given for creating specialisms in particular hospitals is that currently surgeons in some hospitals see low numbers of patients, and that higher numbers are associated with better outcomes. There is no detail as to which hospitals or specialisms this refers to. Some common procedures will no longer be carried out on some sites, for example hip and knee replacement will no longer be provided at Whipps Cross but centralised in Newham. The research evidence referred to as justification for larger numbers actually shows that, for example, if a surgeon carries out 32 hip replacement operations a year this is classed as 'high volume'. It is likely Whipps Cross surgeons currently carry out many more.

- We are concerned about the adverse impact on deprived communities because of increased travelling, and the effect on patient experience and recovery if visits from those close to them are reduced.

- We are also concerned about the loss of expertise on the sites impacting on A&E and maternity. On page 67 Part 3 there is acknowledgement that 'consolidation of services' could undermine delivery of high quality, local emergency and maternity services. How will this possibility be evaluated?

- Differentiating between core and complex is not always easy or possible when a patient initially presents. Without consultant cover at Newham and Whipps this is a problematic issue and much more detail is needed if patients are to have confidence in the proposals.

- One aim is to free up emergency capacity at RLH for complex work 'without delays'. We consider RLH's capacity could easily be compromised if it has to provide complex care for its entire population base and life saving surgery at night. Additionally there is no reference to the impact on other integral support services – such as therapies and radiology.

- **Life saving surgery is to be available at RLH, only, 'out of hours'. Emergency surgery at Whipps Cross and Newham will be provided for 12-16 hours only.**

Acute Hubs at both hospitals will 'stabilise and transfer'.

- How will maternity services be safe without access to a general (abdominal) surgeon to assist with bowel injury at caesarean sections? Transfer to RLH in this situation is not an option. Life threatening chest and abdominal injuries, for example, usually require surgical interventions in order to stabilise. It is not exceptional for patients to arrive at A&E by car and present with serious bleeding for example from an abdominal knife wound. How will this situation be managed?

- We note that national recommendations state that, as a minimum, an emergency department must have support 24 hours a day, seven days a week from the "seven key specialities":critical care, acute medicine, imaging, laboratory services (including blood bank), paediatrics, orthopaedics and general surgery". (NHS London Health Programmes 2013, Quality and Safety Programme Emergency Departments, Key Message, Pg 24).

- What will happen to in-patients at Whipps Cross and Newham if they need emergency surgery during the night, especially given their distance from the Royal London? Has Barts Trust considered the increased risk of litigation if an in-patient cannot receive emergency surgery in the same hospital?

- Transfer to RLH assumes a rapid LAS response. As this cannot be guaranteed, there must be concerns about the impact of this proposal on patient safety.

- We have concerns about the obstacles to recruitment, retention and training of high quality staff into the local sites, if out of hours emergency surgery is removed from Newham and Whipps Cross. This may particularly affect Whipps Cross staffing due to the combined impact of this and the lower level of London Weighting payments at this site.

- **The proposal to reduce emergency surgery hours directly threatens the future of A&E and Maternity at Whipps Cross and Newham.**

- The statement that there will be new surgical on call rotas is at odds with in hours consultant supervision only. This needs an explanation.

- GPs and community services are to be required to help with pre- and post-operative services. The Primary Care section of the document makes it clear that the GP workforce is below national norms and that recruitment is a national problem. The District Nursing service is similarly under establishment locally and nationally. The document refers to up to 70% of this work could be done outside of hospitals, **This is not a viable proposal even with redirection of some current hospital staff into the community.**

- Similarly the creation of 'Hot Clinics' and attendance of consultants in A&Es is in our view beyond the scope of the current establishment posts for consultants (the most expensive members of the general workforce).

7. Urgent/Acute Hubs:

- In the diagram on page 84 there is mention of the availability of consultant supervision for 14 hours only. Who supervises the work of the Hub beyond these hours and would junior doctors receive accreditation from Royal Colleges (as raised in our general points)

- Reference in this section to 24/7 stabilise and transfer capabilities at all 3 sites is at odds with consultant supervision not being available at all 3 sites 24/7. This needs explanation.

- To repeat, life saving surgery is to be available at RLH only 'out of hours'. Acute Hubs at Newham and Whipps will 'stabilise and transfer'. The issues raised in the section on surgical hubs apply here. Life threatening chest and abdominal injuries, for example, usually require surgical interventions in order to stabilise.

- The public are already confused about which service to use at night. Having various levels of capability at the three A&E

sites would compound this problem and make the scenario above more likely.

- The document says there will be 24/7 availability of psychiatric services. How is this to be provided? Sectioning under the Mental Health Act is to be 'timely'. Are local authorities able to provide Social Worker availability to this standard?

- Whilst acknowledging the lack of suitable workforce recruits nationally the document expects these shortages to be addressed locally within 3 years. **We seriously question this optimistic view.**

- GPs are to be 'upskilled' to take some of the work from these Hubs. Yet it is stated that there is a national shortage of GPs and the document seems to state in the Primary Care Section that the area will have to manage with 195 GPs fewer than needed because of population growth. There is an inherent contradiction in this proposal.

- Workforce shortages are not shown as a risk in the Risk Assessment diagram.

8. Natural Births:

- The TST document states that maternity services are struggling with a population whose health complexity is increasing, rising birth rates, staffing levels below recognised standards, and an estate that does not meet the needs of users. Over the next ten years it is predicted that there will be another 5,000 births per year across north east London, in particular in Tower Hamlets and Newham.

- The document cites national evidence – for straightforward pregnancies – that obstetric–led settings result in unnecessary interventions, and that too many births are in such settings in the Barts Health Trust area. It is proposed that, by 2020/1, births in obstetric-led settings are reduced from 86% to 64%, births in Midwifery Led Units are increased from 13% to 31%, and home births from 0.6% to 5%. It is also proposed that all women have continuity of care from a named midwife

throughout their pregnancy, starting from their first appointment with the service. It is aimed to reduce the caesarean section rate by approximately 5% by the end of 2021, from 28% to 23% across the trust.

- We would agree with the intention of moving towards safe, midwife led births in Out of Obstetric-led facilities where this is **practicable, safe, well funded, and with well resourced facilities and highly skilled clinical staff. It must also be appropriate to the mother and baby's health and there must be adequate, suitable and completely reliable emergency contingency provision. We do not see evidence in the TST document that all of these will be in place by 2021.**

- Highly skilled experienced midwives should be the lynch-pin of this Out of Obstetric Unit model, especially as greater reliance is placed on the role and expertise of the midwife. The TST document acknowledges the problem of recruitment, but states that it will reduce if Barts Health capitalises on the predicted over-supply of newly qualified midwives.

- We are concerned that this may be both potentially unsafe and overly optimistic, bearing in mind the most recent report from the Royal College of Midwives: The State of Maternity Services (Autumn 2015). The RCM report states that the UK requires 2,600 more midwives to cope with current birth numbers. It acknowledges that the number of midwives working in England increased between 2005 and 2014, but highlights that 98% of that increase occurred amongst older women and that the midwifery service in England is facing a **"retirement time bomb". It suggests that" there may not be time for newly qualified midwives to gain experience and confidence before their more senior more experienced colleagues leave the service"**

- The report also emphasises that a service that is short of midwives "operates under stress and strain and cannot possibly provide the quality of care that women deserve" Recruiting and sustaining an adequate number and appropriate mix of seniority and expertise among midwives is

predicted to become even more difficult once training bursaries are removed. The RCM report mentions that midwives already in training often do not complete due to constrained financial circumstances. The TST document however provides no realistic detail about how to ensure sustainability of the midwife workforce, especially given the problems of recruitment and retention referenced throughout.

- Workforce Competence and Skill Mix: It is recommended nationally that the number of Full Time Equivalent of Maternity Care Assistants required to deliver high quality maternity care should be 10% of the midwifery establishment. **It has been highlighted that at one Barts site the FTE of MCAs is as high as 30% of the midwifery total.** In an Outside of Obstetric Unit setting, it is even MORE important that those attending to women in the ante natal, delivery and postnatal periods are highly skilled. We are very concerned that 30% of current midwifery staff are unqualified MCAs. We are also concerned that skilled midwives might be deployed for more complex pregnancies, leaving straightforward antenatal and postnatal care to MCA's. This could pose a significant risk when identifying early post-natal depression or post partum health problems. **There is no evidence that Barts Health has carried out a thorough Risk Assessment of the workforce challenges intrinsic to the proposed new model of maternity care.**

- **Emergencies**: there is no reference to contingency planning for rapid transfer to an Obstetric Unit if things go wrong with a planned home delivery, especially given the current strain the LAS is under. Nor is there reference to the impact of reduced emergency surgery hours at Whipps Cross and Newham in the event of an obstetric crisis. There seems to be no risk assessment for obstetric emergencies, given the model proposed and the other "High Impact Changes".

- **Delivery Risks**: A number of delivery risks are recognised. Particularly concerning is that redeveloping the Midwifery Unit at Whipps Cross has been "repeatedly deprioritised". The document generally says less about Whipps Cross, including its neo-natal unit, than the other sites, and **we have grave**

concerns, therefore, regarding the commitment to a full maternity and consultant led obstetric unit at Whipps Cross.

- **Personal budgets**: There is no reference to the introduction of personal budgets for maternity care across the three CCGs. We consider personal budgets reduce healthcare to a commodity, and introduce a mechanism, under the auspices of choice and control, for "topping up" NHS provision via insurance or, for those who are wealthy enough, from people's own funds. They will divert funding from underfunded NHS facilities, and divert funding to those, with the means, who only ever use private healthcare facilities. We consider personal budgets represent a very real threat to the core principles of the NHS, and are shocked that our CCGs are "pioneering" this, with no meaningful public consultation.

9. Outpatients and Referral Pathways:

- The document projects an increase from 1.4m outpatient appointments in 2014/15 to 1.55m by 2020-21 without the plans proposed. Not only is it the aim to cut appointments, by 20%, by 2020-21, but there is an expectation that savings of between £64.9m and £82.3m will be made over the next five years.
- The red risk shows the extent of the challenge and our concern : **"lack of resources to take change programme forward across organisational boundaries"**

- GPs/primary care are expected to reduce outpatient referrals by 10%.

- **GPs, together with Public Health services, are meant to bring down outpatient referrals by 5% through a focus on early identification/prevention. This despite the 3.9% a year cut to Local Authority Health Prevention budgets, on top of £200m already cut from the 2015/16 budgets** (Kings Fund "What the Planning guidance Means for the NHS 2016/17 and beyond ")

- For example, in Tower Hamlets, there have already been huge cuts (reported as being £2.2m from January 2016 – see http://www.independentnurse.co.uk/news/cuts-to-public-health-budget-will-hit-london-the-hardest/88404/). These have had a massively negative impact on sexual health and family planning, healthy living/obesity programmes, substance misuse and alcohol services, and smoking cessation. These cuts are ongoing. The level 2 smoking cessation payment has been completely cut by Tower Hamlets Public Health, despite it having efficacy of just over 20%, compared with 5% for brief advice. The service has identified that, on current projections, they will need to achieve total savings of up to £5m to keep spending within their grant allocation for 2017-18.To add to the pressure, they are now being expected to divert money from these programmes to plug local authority gaps, such as universal free school meals.

- Community pharmacist contracts are being cut too – affecting their contribution to services like chlamydia screening, smoking cessation and supervised methadone programmes.

- **These problems will be mirrored in all the boroughs. We simply do not see how Public Health can realistically be expected to contribute to a significant reduction in outpatient referrals as well.**

- The plans assume the existence of massive primary care hubs, some of which will 'specialise' to take on high-volume, low-risk work eg physiotherapy, gynaecology, dermatology clinics. **The level of reorganisation, buildings needed, staffing changes is stunning; to plan to do all this in five years, with significant GP shortages, while saving money, is completely unrealistic.**

- The workforce requirements section fails to acknowledge there would need to be more GPs and other health professionals – it only allows for additional allocations of time from consultants available for GPs to phone.

Reduce 'DNAs' (Did Not Attends)

- The proposal that patients reschedule appointments online appears to be a positive one. But currently we know patients are finding only one or NO available appointments in some specialities – eg ENT. We also know, anecdotally, that some local GPs now avoid referring patients to some Royal London clinics altogether, because the appointments system is so poor and waits are dangerously long.

- For this to be a realistic way to reduce DNAs, patients will need access to multiple appointments – not a stretched service that is going to be cut by another 20%.

Focus on self-management and Skype to reduce appointments

- Both this section and the one on primary care place an emphasis on self care or self management. It is assumed this could account for a 10% shift from GP attendances. There is only passing reference however to the high levels of deprivation, poor and overcrowded housing, unemployment, all of which exacerbate health inequalities. The Royal College of General Practitioners report on Health Inequalities in March 2015 highlights the very real health problems of obesity, smoking, alcohol related diseases, as well as multi morbidities. A document that makes only passing reference to this, particularly with its emphasis on self care, inspires very little confidence.

- Similarly there is nothing in this section of the document to say how this will work for people who have no internet access and/or speak little English. This is a particular problem in Tower Hamlets; it is essential that bi-lingual health advocacy continues to be properly resourced.

10. Physician Associates:

- The TST proposes introducing Physician Associates to address the current and future shortfall of GPs, across North East London. It is planned to recruit 85 PAs across primary and acute care over a ten year period, with an overall annual saving of £1.3m.

- **Where are PAs going to come from?** The document refers to a number of universities delivering, or intending to deliver, diploma and masters courses by the next academic year, with 400 PAs expected to graduate nationally in 2017/18. It also states that there is work going on with QMUL to develop a course for PAs – in other words, this is not up and running yet. Is QMUL expected to be the main source of PAs for the area and if so, when will they be in a position to introduce the first PAs?

- **How will adequate training be ensured?** The model for the PA role comes from the US where, in addition to a first degree in a relevant subject, most students are expected to have 45 months of health care experience *prior to starting training*.

- In the UK, preparation for the role varies, but the Physician Assistant Managed Voluntary Register (2012) calls for 90 weeks at Masters level, followed by a 6-12 month internship under close supervision after initial training to consolidate knowledge.[1]

- The document states that PAs will have a first degree in a relevant subject and then undertake a 2 year diploma. This does not seem to meet the guidance set out in the Voluntary Register.

- **How will adequate standards of practice be ensured?** There appears to be only a voluntary Register for PAs.
- PAs are dependent (ie not autonomous) practitioners, requiring on-going, direct supervision. They are currently unable to prescribe. The document proposes PAs will carry out 83% of primary care visits, without direct physician supervision, suggesting a considerable degree of autonomy and an assumption about PAs ability to prescribe.

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1 http://bmchealthservres.biomedcentral.com/articles/10.1186/1472-6963-13-223

- How senior do senior medical staff need to be to take on supervision of PAs?. Given the shortage of GPs and physicians that is driving the introduction of PAs, will there be enough appropriate staff to provide proper supervision? A systematic review of the contribution of PAs to primary care found that in several studies, PAs potentially increased the work load of other staff due to the need for supervision and (in the UK) for prescribing support.[2]

- What structures will be put in place to ensure that the use of less qualified PA's does not negatively impact patients, especially within deprived and disaffected areas, such as the boroughs that this plan relates to. How will outcomes and patient satisfaction be measured of this new and largely untested workforce?

- **How will the use of PAs be implemented?** There is little experience of using PAs in the UK. The DoH has recommended piloting. There is no reference to piloting the use of PAs, especially those "working across all healthcare sectors and a number of patient pathways".

- Physicians are ultimately responsible for the practice of those PAs they supervise. How will it be assured that doctors understand their responsibility for the PAs they supervise? Who will be responsible for a PA's practice if the PA is working across a range of healthcare sectors/patient pathways?

- **Recruitment and retention** The *Strategy and Investment Case* document acknowledges the problems in recruitment and retention, partly due to the high cost of living. It aims to address such issues by, for example, introducing financial and other incentives for hard to fill vacancies. This appears inequitable. Is this being considered for PAs? If so, how will

2 http://bmchealthservres.biomedcentral.com/articles/10.1186/1472-6963-13-223

organisations ensure this will not reduce morale among existing staff or affect acceptance of the PA role? And if it is not intended to introduce such incentives, why should there not be the same problems of recruitment and retention as with other staff?

- **Acceptance of the role** Research suggests that there can be some conflict between PAs and physicians and a negative response from healthcare professionals more widely where PAs are introduced to cut costs.

- Has Barts discussed the introduction of PAs with existing staff? Has it considered the impact of this new role on potential colleagues, such as Advanced Nurse Practitioners who may have significantly more experience but are paid considerably less than the salary identified for PAs in TST?

- **We have concerns that this is not a well tested model, especially given the enhanced role of primary care described in the TST documents, and the assumption that PAs could undertake at least 83% of primary care visits without direct physician supervision.**

11. The "Estate":

- In Part 2 of the TST (Pg 21) it is written:"There are opportunities to consolidate and dispose of parts of the estate that are not efficient, and/or which are sited in locations where they hold considerable value to a residential or commercial market". Given the current boom in development, it is hard to imagine anywhere in our three boroughs that would not be snapped up by private developers.

- The land and buildings are public, NHS property. The signatories do not have proprietorial rights over the "estate". We say that before anything is sold principles for sales must be agreed, including, for example, that the land usage proposed will be of benefit to the community – for example social housing, key worker housing. That any sale likely to impact on health service provision, as at Whipps Cross, must be part of the specific plan for that service. That any sale must

be the subject of full and proper public consultation and any sale proposed should be subject to fully independent scrutiny by a body that is not associated with city finance or consultancy.

- Too much NHS land has been sold, over decades, with limited benefit to budgets and massive benefit to private developers. **Given the pressure of the time-scales we believe there is a real risk of ill planned and ill costed sale of public land and the NHS will be further stripped of its assets.**

12. Conclusion:

- The Sustainability and Transformation Programme is, in our view, driven by an untenable political agenda, that presents serious risks to the health and well-being of residents in North East London.

- Not only are we one of the most deprived areas of London, but both our hospital trusts (within the full "footprint") are on special measures and, in 2015-2016, had a combined projected deficit of approximately £170m. It is no coincidence that both have significant PFI debts. In 2015/16 Barts Trust had the biggest deficit in NHS history; its deficit has increased each year roughly in line with the interest payments made on its PFIs.

- We believe that implementing the plans described, in the time-scales demanded, while making the "savings" outlined, and eliminating the deficits as required, will push an already stretched and stressed workforce to breaking point. We think it is bound to further destabilise struggling services, and put patients at significant risk.

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