NW London Group of Local Authorities' Enquiry Chaired by Michael Mansfield QC.

Impact of NHS 'Shaping a Healthier Future' policy on acute care for NW London patients.

WRITTEN JOINT EVIDENCE BY FOUR BRENT CCG LOCALITY PATIENT PARTICIPATION GROUP CHAIRS.

(This submission is endorsed by the Steering Group of Brent Patient Voice.)

Dated 21 February 2015

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1. Context.

1.1 NHS Brent Clinical Commissioning Group (CCG) constitution sets up the 5 locality Patient Participation Groups (PPGs) for Harness, Kilburn, Kingsbury, Wembley and Willesden of which we are four of the chairs elected by the local patient/public members. The constitution of Brent CCG establishes an Equality, Diversity, Engagement and Diversity (EDEN) Committee of which we are ex *officio* members.

1.2 Both before and after the commissioning of Brent CCG on 1 April 2013 we have closely followed the attempted implementation of the SaHF policy by Brent CCG and its implications for the NHS hospitals used by Brent NHS patients. We have extensive joint experience of public administration and cross party political views. Nan Tewari is a former NALGO Trade Union official and Human Resources specialist. Robin Sharp CB is a retired Under Secretary at the Department of the Environment. Irwin Van Colle is a Chartered Accountant and former Conservative Party Executive Councillor on Brent Council. His Honour Peter Latham is a retired Circuit Judge who sat at civil and criminal courts in Central and NW London, and previously had a specialist medico-legal practice as a barrister. We all fully support the Nolan Committee report principles of public life. None of us have any financial interest in healthcare issues other than as patients.

1.3 We have seen the Terms of Reference of the enquiry.

1.4 This written evidence focuses on our knowledge of the local impact in Brent on acute care for local NHS patients since the adoption in 2012/13 of the strategic health policy for 8 NW London boroughs, known as 'Shaping a Healthier Future' (SaHF). This policy was promulgated in the name of the 8 Clinical Commissioning Groups (CCG) (then in formation) for these boroughs, but was clearly backed at national level by the NHS and the Department of Health. Its

essence was to reduce the number of acute hospitals and their A&E departments from 9 to 5, to make those remaining more highly specialised and to promote more health provision “out of hospital” and “in the community”. Many regard the consultation exercise as deeply flawed and the strategy has never had whole-hearted community support. SaHF was pushed through at a time when the governance of local health provision was also undergoing major change as a result of the Health and Social Care Act 2012, though the latter is scarcely mentioned in the SaHF consultation paper.

1.5 In addition it should be noted that planning for a national programme called “Whole Systems Integrated Care” (WSIC) began as an initiative of the 8 NW London CCG’s in 2013 and that aspects of it are supported by the Care Act 2014. The intention is to provide integration of health and social care at the point of delivery, involving among other things the transfer of funds from the NHS to local authority social services to compensate for cuts to the latters’ budgets. Although Brent has two pilot areas for WSIC, Harlesden and Kilburn, the initiative does not so far appear to have progressed from planning to implementation. We note in passing that if successfully implemented it could be highly relevant to the need to prevent vulnerable older people from unnecessary hospital admission and speedier discharge when in-hospital treatment is no longer required. In our view current problems in this area are a major factor in the current A&E crisis.

1.6 This paper should be read together with our separate written evidence from our correspondence with London North West Healthcare Trust (LNWHT) about the crisis of delayed response times at Northwick Park Hospital Accident and Emergency Department, and with Imperial College NHS Healthcare Trust included as Appendices 2 and 3. We will not repeat our analysis and representations here that are set out in that correspondence, but we note that the Trusts and the CCG have yet to back up their claims that the initial deterioration in local A&E performance is not connected with the closure of the Central Middlesex and Hammersmith A&E’s in September 2014. Indeed we have been

advised that NHS England have conducted a special study into why the modelling for the closures went so wrong so quickly. To date it has not been made public. We consider that full transparency should apply to this exercise.

1.7 On 29 January 2015 LNWHT replied to our questions about the A/E funding 2009 workload marginal rate cap by a letter dated 27 January 2015 from Tina Benson Director of Operations for the Trust. This includes reference to the December 2014 Monitor/NHSE paper on the 2009 patient numbers baseline for 30% marginal rate for A/E funding by their CCGs. Some of us had the opportunity to discuss the A&E situation and measures being taken to improve it with the Trust Chief Executive Mr David McVittie, Chief Medical Officer, Dr Charles Caley and the Director of Operations on 29 January at their invitation. At that time performance figures against the 95% '4 hour' response time target were showing small improvements over each of the preceding 3 weeks after having been the worst in the country. See also paragraph 1.17 below.

1.8 It was not suggested at the 29 January meeting that there had been any significant adjustments to the Northwick Park Hospital A/E marginal rate baseline on their taking over the acute A/E work from Central Middlesex and Hammersmith Hospitals. The Trust leaders were adamant that they treat patients presenting to A&E according to their needs and not to conform to the marginal rate cap funding. They accepted that this cap serves to increase the Trust deficit, while having no value as an incentive to better performance.

1.9 The Northwick Park Hospital marginal rate cap issue is reflected in the December 2014 Monitor/NHSE paper which shows that there has been a major tug of war going on behind the scenes about the setting of the A/E patient numbers baselines by CCGs, and lack of transparency about what CCGs do with the 70% marginal rate retention money intended to be applied on community measures to control A/E demand.

1.10 It is clear to us that NHSE are on the back foot in this paper. They try to defend the merit of the marginal rate cap as an effective tool to control A/E workload. But they have had to concede increased A/E funding by proposing to cut the marginal rate reduction from 70% to 50 %. This is obviously because too many localities are simply not coping with their A/E funding on the 70% marginal rate reduction.

1.11 The tensions between LNWHT and Brent CCG are vividly revealed by the minutes of the 17 December 2014 Brent CCG Quality, Innovation, Productivity and Protection (QIPP) Committee meeting:

> 'The Clinical Directors stressed the need to use financial penalties and decommissioning to achieve better services from LNWHT and expressed great concern that despite assurances over the years from LNWHT there was still a deterioration in performance and services and that additional funding under Winter Pressures may not improve performance. A broader debate was called for to bring to the attention of the LNWH Trust the frustrations and anger the GPs had at the service provided to their patients over the last 20 years. The GPs had no confidence in the LNWHT managerial side, nor in the manner its clinical teams run their departments, nor in the A&E service.' http://brentccg.nhs.uk/en/publications/governing-body-meeting-papers/cat_view/1-publications/3-governing-body-meeting-papers/356-28-january-2015 : Item 18 2.32

1.12 In the Brent situation this is one of the many factors underlying the severe pressures on Type 1 Accident and Emergency Department response times at Northwick Park Hospital since the Central Middlesex and Hammersmith Hospitals acute A/E departments were closed on 10 September 2014. Even if the Trust deficit is not permitted directly to affect the day to day emergency care being delivered it is clear to us that the marginal rate cap has been skewing the

projections relied on in fixing the establishments for A/E staffing and other facilities including the number of back-up in-patient beds for A/E. This must be very bad for staff morale because it conveys the message that there is a shortfall in performance, when this shortfall lies outside the Trust's control. In view of the current substantial annual financial surplus of Brent CCG it seems to us opportune to consider a re-balancing which would in due course feed through to the benefit of patients.

1.13 Whatever measures the Trusts and their funding CCGs are now putting in hand to remedy the immediate problems (see paragraph 7.6 below) the current situation represents a major failure in planning, an activity to which the NHS devotes substantial resources. No-one has so far cited any significant extraneous factors which could not have been known or forecast when closure plans were made. This suggests that over-optimistic assumptions were built into the projections used for planning.

1.14 We recall that as early as 2006 severe staffing and financial cuts were made to the establishment of Central Middlesex Hospital, formerly a teaching hospital with an international reputation in gastro-enterology, and which had been highly regarded by its patients in one of the more deprived areas of Brent. We include as Appendix 4 material from newspaper reports from this period showing that several commentators saw this as a cynical attempt to induce poor performance at the hospital, so that at a later date it could be characterized as failing and unsafe and then planned for downgrading. In our view this is exactly what happened under SaHF.

1.15 All developed countries are struggling to cope with the cost of state funded healthcare and have different models. The UK structure of NHS healthcare free at the point of delivery for the people of the nation was preserved by the Health and Social Care Act 2012 combined with the Care Act 2014. At the same time there was a new structure for commissioning and more scope for and

encouragement of competition. The main change is that the responsibility for assessing and buying secondary and community medical care for local patients from a nationally allocated budget is transferred to CCG panels of local GP's and others subject to NHS England supervision and with an array of national and local scrutiny bodies. The adjusted competition model permits a mixed state/private enterprise provision of healthcare. NHS healthcare contracts may be awarded to the successful provider bidder. In parallel under the Care Act 2013 'Whole systems integrated care' policy (WSIC) local authorities and CCGs are required to work together to provide integrated state funded non-medical care especially on patient admission to and discharge from hospital.

1.16 'Shaping a Healthier Future' in NW London can be said to reflect an NHS national policy of transferring as much as possible of NHS hospital out-patient care to local community NHS services ostensibly to provide 'Better Care Closer to Home' but also on a cheaper basis. The other side of the same coin is the policy promulgated especially by Lord Darzi under the previous administration of concentrating treatment of certain acute conditions such as strokes, heart attacks and cancer in very specialized units in a few major London hospitals. This policy has been shown to be successful in London in relation to strokes and possibly the other acute conditions mentioned. However it does not follow that other common conditions needing urgent admission to hospital will benefit from some form of concentration, yet this thinking seems to underpin the whole SaHF strategy. In our view it should be examined against the evidence, something that 'SaHF' conspicuously failed to do.

1.17 In NW London the attempted implementation of the SaHF package has begun, as far as the public are concerned, with a highly controversial nationally approved closing of the full acute Accident and Emergency services at Hammersmith and Central Middlesex Hospitals on 10 September 2014. The strain on the remaining local NHS hospital Accident and Emergency Departments especially for Northwick Park Hospital in Brent and the patients

assessed there as Type 1 with the greatest need is revealed by the weekly NHSE published statistics on meeting the national guidance of 95% of patients being discharged or transferred within 4 hours from arrival. Wembley PPG chair and Brent Councillor Keith Perrin has been producing regular analyses summarising these figures for LNWHT and Imperial Trust from the middle of 2014 and showing the ranking of performance compared with the national position. We include the latest analysis for the week ending 15 February 2015 as Appendix 5. (NB. Ealing and NWLHT are shown separately up to 28 September 2014 and then combined thereafter as LNWHT.) Several points about these figures are noteworthy. The first is the steadiness of the attendance figures for all the trusts and for both Type 1 and Type 3 cases throughout the period. The second is the deterioration of the Type 1 performance figures from late August/early September for both Trusts, with LNWHT ranking worst or among the worst in the country for several weeks and Imperial falling as low as 7th worst. In the week ending 15th February, 689 patients at LNWHT and 473 at Imperial waited more than 4 hours for discharge, transfer or admission. If the figures for Northwick Park and St Mary's were disaggregated from those from other hospitals in their respective trusts they would almost certainly show an even worse performance for Type 1 cases at these major hospitals.

1.18 Many who responded to the SaHF consultation argued that no acute hospitals should lose their A&E departments or be downgraded to elective or local hospital status until the community facilities and treatment arrangements were put in place. The NHS gave assurances that this would be the case. For example it is stated on p.38 of the SaHF document that:

> "Up to £120 million will be invested in these services (i.e. out of hospital) over the next three years, paid for out of savings made from working differently, to make sure that we can care for people outside hospital. **We have promised that services will be in place before changes are made to hospital-based services."**

A parallel promise was made in Brent PCT 2012 -2013 Annual Report bottom of p. 13.

> "This is a large programme of change and final implementation will take between three to five years in total. Improvements to services outside hospital – such as GP and other local NHS facilities in the community –will happen first. **The major changes to hospital will not happen until these community facilities have first been improved."**

(NB bold type ours).

Manifestly these promises have not been delivered. It is in any case extremely difficult for the public to monitor the extent to which "better care, closer to home" is actually being provided, not least because the hard copy SaHF document devoted only 3 of its 80 pages to out of hospital proposals (chapter 11) and provided no clear baseline against which change could be measured.

1.19 A table on p.39 of the same document lists five types of out of hospital provision under somewhat nebulous headings such as "Easy access to high quality care". The third column in the page 39 table lists the reconfigured position with 5 acute hospitals, 9 urgent care centres open 24/7, clinics in the community for common specialties etc., while a fifth column provides estimates of the reduction in hospital activity from the changes described. These reductions include 110,000 hospital stays, 48,000 avoided emergency admissions and 600,000 outpatient appointments. The key question therefore is what progress has been made in providing specific new facilities outside hospitals as described in the table and how many hospital stays and appointments have been avoided as a result of them. We cannot find this information on the SaHF website and we have had no reply to our email to the SaHF team asking these questions. Yet progress in this area is central to the whole rationale of SaHF. Furthermore the

lack of response to or acknowledgment of our enquiry raises the issue of to whom SaHF is accountable? Who decided that 8 NW London CCG's should combine to produce a strategy that to date does not appear to be working and who can decide that it needs urgent reconsideration?

1.20 It is outside the scope of this evidence to review the wisdom of the legislation and national NHS policies, unless they bear especially harshly on the NW London situation. It is outside the scope of this evidence to review the current mixed state/commercial provider/bidder model. It is outside the scope of this evidence to review the proportion of national GDP or the actual budget allocated nationally for NHS medical care and for non-medical care. We do however comment on the adequacy of state funding for local NHS and care needs. We have seen the King's Fund paper published on 6 February 2015 Part 1: '*The NHS under the coalition government'* dealing with the Health and Social Care Act 2012 http://www.kingsfund.org.uk/publications/nhs-under-coalition-government. The general thrust of the critical conclusions in this King's Fund paper in our view match our own experience locally in Brent, while we endorse the call for an emphasis on care and patient safety for the future.

2. Brent CCG attempted implementation of 'Shaping a Healthier Future'.

2.1 The Brent Primary Care Trust developed a 2012 SaHF business case for 13 medical specialist hospital adult out-patient services to be transferred to community out of hospital clinics. The strategy was to start with the services thought to offer the biggest projected savings to release funds for later parts. These are all proposed as GP referral services: not walk-in. Unfortunately the 2012 business case, which is essentially about how much money could be saved by moving clinics around, does not contain any discussion of the performance of existing clinics or of the clinical pros and cons of moving specialized clinics out of acute hospitals or indicate whether there is any patient

demand for changed locations for these clinics. In these crucial respects it does not follow the elementary logic required for a public sector planning exercise, which NHS England gathered together in the guidance document '*Planning and Delivering Service Change for Patients'* (December 2013): http://www.england.nhs.uk/wp-content/uploads/2013/12/plan-del-serv-chge1.pdf

2.2 Brent CCG has virtually completed implementation of its SaHF Wave 1 project with most adult out-patient services for Ophthalmology taken over by the private BMI provider starting in Autumn 2014, and most adult out-patient Cardiology taken away from other hospitals (largely Northwick Park Hospital) by the NHS Royal Free Hospital with the frequently postponed start-up date currently planned for 2 March 2015. It is much too early for us to comment on how effective these 2 new community services are, though take up for the Ophthalmology service appears to be slower than hoped for. We have no information yet as to any cost savings achieved or projected for Brent CCG, or as to actual impact on the local secondary hospitals specialist Ophthalmology and Cardiology departments or these hospital trust finances. We note that Brent CCG have had to make a substantial adjustment to their QIPP (Quality, Innovation, Productivity and Protection) financial projections through the delay of about 2 years before obtaining any projected cost savings from these new services. This delay has presumably had knock-on effects through delay in releasing funds to finance the subsequent parts of the project.

2.3 Brent CCG are still preparing their 2 Wave 2 SaHF projects:-

2.4 The proposed community Gynaecology adult out-patient service was originally to be procured through competitive dialogue like all the other 12 services detailed in the 2012 Business Case paper but in 2014 the CCG decided that no such dialogue was needed but that its design should reflect the model tested in a pilot community service in Willesden and Wembley, which seemingly began in 2010 and involved a hospital trust and a local network of Brent GP's. No

report of this pilot was made public nor was it clear what led to the change of direction. In late 2014 consultants for the CCG, Mott McDonald, produced a consultation paper which contained no hard information about the strengths and weaknesses of the existing outpatient clinics, but instead produced views from an earlier survey in 2014 of the general public which had a very low response (about 120). A report of the pilot project made in 2012 was released to one of us at the end of January 2015, after much delay, and suggested that the pilot showed relatively slight improvements on existing hospital outpatient clinics in aspects where comparisons were made. The consultation period closed before this could be taken into account and the next step will be final tendering. It is an open question as to the extent to which this project will provide a more accessible service, clinical benefits for patients or financial savings or what impact it will make on the viability of the hospital clinics who will lose patients to it.

2.5 Brent CCG propose a new integrated multi-disciplinary MSK (musculo-skeletal) adult community out-patient service. This is a completely new concept for Brent and reflects thinking in the 2006 Department of Health '*The Musculo-skeletal framework*' paper. The proposed Brent service would cover most Orthopaedic, Rheumatology, Podiatry and associated Physiotherapy adult out-patient cases, but not the most complicated. This project has also slipped by at least two years. We have repeatedly been very critical to the CCG of their illogical methodology for planning this MSK project and their failure to follow NHSE December 2013 published guidance on methodology in '*Planning and Delivering Service Change for Patients'* already referred to.

2.6 The Brent CCG delay in producing a draft MSK specification has much delayed the project together with the Integrated Impact Assessment (IIA) commissioned from Mott MacDonald. The IIA was due to be received by the CCG on 6 February 2015 but has not been disclosed at the time of writing. There has been an inexplicable reluctance by Brent CCG to examine existing models,

and until recently a regrettable preference for leaving it to bidders to design the service in a competitive dialogue process. Very recently we have been most concerned to see reports that the West Sussex CCG proposed new NHS out-of-hospital MSK service may be on the brink of collapse after the preferred bidder BUPA has announced that it intends to pull out in the light of the independent and belatedly commissioned impact assessment, which indicates that an unacceptable degree of local hospital destabilisation would be caused by the new service as so far designed. There also appear to be problems with the Circle Holdings plc Bedfordshire CCG-commissioned community MSK service which may be close to the lead provider model proposed by Brent CCG. It was reported on 7 November 2014 that Bedford Hospital NHS Trust refused to sign a contract to become a sub-contractor to Circle for MSK services in the area and proposed to compete with Circle.

2.7 The West Sussex debacle confirms our concerns about the impact of this new service on removing revenue from existing secondary hospital providers. For example it could be potentially serious especially for Northwick Park Hospital even if this Trust were the successful bidder, and more so if not. Although some of us have been members of a Stakeholder Engagement Group and a Clinical Service Redesign Group, we were not able to persuade Brent CCG to have open discussion of the proposed clinical design of this service with all interested parties well before any commercial tendering was to begin and have been openly critical of their excessive secrecy, not least because it hinders constructive discussion of problematic aspects of the changes under consideration.

2.8 We had to pursue an appeal to NHS England (London) over the limitation of patient choice and associated attempt to grant a monopoly to the successful bidder in the Brent CCG draft MSK service specification. Brent CCG have been required by NHSE to amend the draft to clarify that statutory patient choice is preserved. This has been confirmed in a letter dated 26 January 2015 from the CCG Chief Operating Officer which also confirms that Brent CCG now with the

approval of NHS England propose to abolish GP clinical freedom to refer eligible NHS MSK patients direct to the hospital of the patient's choice without any hindrance. We make this inference because in the revised draft specification we have been sent the CCG are still planning to hedge patient choice about by requiring patients to be referred to the hospital of their choice via the successful MSK provider's internal triage service.

2.9 The second part of the public consultation on this MSK project has been postponed from September 2014 to after the May 2015 General Election. Estimates of a proposed start date have been repeatedly postponed and we no longer regard them as reliable. There are important as yet unresolved issues of competition and interface between this new community out-patient service and the proposed new NW London NHS elective secondary Orthopaedic surgery service to be based at Central Middlesex Hospital.

2.10 We have no definitive news from Brent CCG of progress towards establishing their other 9 community out-patient services: paediatrics; gastroenterology; clinical haematology; trauma; dermatology; general surgery; ENT; urology and medical oncology. However, ENT, Urology, Spinal, Dermatology, Gastroenterology & Paediatrics are mentioned in Brent CCG 'Commissioning Intentions 2015/16'.

2.11 In view of the delays and unanswered questions surrounding the Wave 1 and Wave 2 projects for creating new specialist clinics in the community it would be highly desirable for Brent CCG to publish a document showing how the case for moving the remaining services out of hospital stands up against the processes and criteria set out in the primary NHSE guidance *Planning and Delivering Service Change for Patients.* It is far from clear that the clinical and alleged access benefits for patients or the possible savings justify the upheaval and frictional costs of making the changes.

2.12 Nor is it clear that patient attendance at out-patient clinics “in the community” (which means in practice Wembley Health & Care Centre, Willesden Health and Care Centre, Central Middlesex Hospital, now proposed for the southern MSK clinic, or Sudbury Medical Centre) will prevent hospital admissions in the way that attendance at clinics at acute hospitals will not. A much more challenging aspect of care closer to home would be the provision of more minor specialist treatments at GP practices by consortia or networks of local doctors with the appropriate skills. There is little sign of this developing so far but if Brent CCG had done more to promote it instead of putting such a large effort into moving consultant-led hospital type clinics to alternative locations it might well have made a contribution to preventing admissions and pressures on A&E.

2.13 Mental Health community out-patient services have never been included in the Brent CCG SaHF out of hospital transfer programme. On querying this we have never received an answer from Brent CCG as to the rationale.

2.14 Brent CCG has access to 2 modern PFI initiative hospital buildings that are seriously under-used: Central Middlesex Hospital that is a LNWHT responsibility, and Willesden Centre for Health and Care which is a Brent CCG financial responsibility.

2.15 Initially Brent CCG formed part of an NHS NW London administrative group of Brent, Ealing, Harrow and Hillingdon CCGs (BEHH). Within a year of commencement Ealing CCG decided to leave to join a more central London NHS group and did so during 2014.

2.16 Until late 2014 Brent CCG delegated much of its healthcare commissioning executive management to a NW London Commissioning Support Unit (CSU). One of our frustrations was that we could never find out much about the functioning of this unit. Brent CCG were themselves dissatisfied with the CSU on grounds we do not fully know other than that the CCG were very critical

of its communications role, and its value for money. We know very little about any changes to Brent CCG commissioning management following this change, other than that it is yet another big shake-up for a new institution now struggling with a new internal administrative set-up on top of being charged with organising the major SaHF healthcare re-organisation.

2.17 As argued by the King's Fund report already mentioned, the NHS in recent years has been very burdened with such administrative re-organisations that inevitably are distractions from managing healthcare, and disrupt consistency of long term local healthcare planning and its implementation.

2.18 We recognise the validity of the 'Shaping a Healthier Future' concept of care closer to home which is widely shared across the health community, but this means significant involvement of GP's and the resources to go with that. Our criticisms above are as to the management of the design and implementation of this policy, in particular the concentration of effort on moving outpatients clinics around. In our view this aggravates the overall defects in the delivery of acute and non-acute NHS patient care in NW London.

2.19 Any attempt to co-ordinate the closure of the Accident and Emergency Departments at Central Middlesex and Hammersmith Hospitals with the introduction of SaHF community out-patient services has been undermined by Brent CCG's delays in planning and delivering their 13 new community out-patient services and the relative neglect of community services based on GP practices or groups of practices.

2.20 The impact of attempts to implement 'Shaping a Healthier Future' policy on acute care for patients include those on local hospitals. The delays in implementing Brent CCG SaHF policy mean that the majority of the 13 relevant hospital adult out-patient services continue as previously.

2.21 Northwick Park Hospital faces the triple whammy of losing the revenue from its out-patient cardiology service, having to provide a greatly increased A/E service that it has no control over with A/E funding subject to the NHS 2009 workload cap with only a 50% pro-rata uplift for excess patient numbers, and the potential destabilisation of its other specialist services as Brent CCG progressively withdraws specialist out-patient services under its SaHF programme. This will be mitigated if LNWHT bid for this work and are successful: aggravated if they lose it. It is a major anxiety that such hospitals may not be able to sustain their more highly refined speciality services, and associated clinical training if much of their routine out-patient service revenue is taken away. This is the so-called hollowing out effect.

3. Brent CCG Staff Turnover Issues.

3.1 As members of the EDEN Committee and in a variety of working groups, and PPG meetings we have had some productive dialogue and collaboration with Brent CCG Governing Body members and individual staff members notwithstanding our concerns about the Waves programme and the CCG culture which inhibits more meaningful patient engagement. However, overall Brent CCG appears to us to have staff problems. There has been a grossly excessive staff turnover which probably reflects poor morale and staff management or unsound funding rules. For example in the Wave 2 MSK and Gynaecology project there have been four changes of Clinical Director, three changes of Senior Responsible Officer and two of Programme Manager in the last thirteen months, completely destroying any understanding of the chequered history of the initiative. The only constants are the patient “stakeholders”. Too many of the staff are inexperienced and poorly trained. Turnover is so great that many junior staff have little understanding of the work of the CCG except for the specific area of work assigned to them. It appears to us that at senior management level there is still evidence of an approach derived from a state monopoly bureaucratic

mentality. In theory CCG's are answerable to a Governing Body on which local GP's have a majority, but it may be that there are still hidden top down pressures on the CCG from the administrative hierarchy of NHSE and the Department of Health.

3.2 The recent November 2014 independent report Brent CCG commissioned from a panel chaired by Dr Angela Coulter (non-medical) on delivery of its statutory patient/public engagement functions was critical of the CCG and reported that a change of culture was required. They were critical of the lack of any budget for engagement functions, and very critical that too many temporary staff were employed.

3.3 We have found it impossible to get Brent CCG fully to recognise and deliver its statutory duty under s.14Z2 of the NHS Act 2006 as amended by the Health and Social Care Act 2012 to involve and consult its patients and public on all its proposals for healthcare commissioning and changes to it. It is our clear view that Brent CCG from top to bottom regard these statutory patient/public involvement and consultation duties as no more than a token public relations gesture. We regret to say that although Brent CCG does not itself treat patients, we have found that the CCG continues to show the same resistance to patient/public challenge as that criticised by Robert Francis QC in his public enquiry reports on Mid Staffordshire NHS Foundation Trust and which required a complete change of culture. In our view the CCG present a complacent relentless 'good news' face to the public which loses them credibility when patients contrast it with their own experience of the shortcomings of NHS care in Brent.

3.4 Such is Brent CCG's resistance to face up to independent public interest criticism of its working in its EDEN Committee that it has embarked on a rushed procedure without adequate consultation for amending its constitution to abolish EDEN although its constitutional role was never much more than advisory as a

patient/public ‘sounding board’. When a head of steam builds up it is rather a short -sighted remedy to tie down the safety valve!

4. Inadequacy of NHS Brent availability of GP appointments.

4.1 From our patient participation groups we know that the most common complaint about local NHS services has been the difficulty in obtaining early GP appointments, compounded by complaints about difficulties in getting through to the surgery receptionist on the telephone.

4.2 Brent CCG introduced in 2013 the temporary expedient of a pilot ‘Hub’ supplementary GP appointments scheme funded by them. This provides extra GP appointments at local centres on referral by the patient’s own GP. The pilot scheme has been extended and changed pending the commissioning of longer contracts which are shortly to be awarded. Feedback from patients using the scheme has generally been positive but they have expressed concern about the loss of afternoon Hub slots. These have been removed because NHSE say that they should be covered under the GP contract which they administer and not from extra funds supplied by the CCG. Initially Brent CCG declined to publicise the scheme. Even now a small survey by Healthwatch Brent reported to the Brent Council Health Scrutiny Task Group in January 2015 found that many patients had never heard of it. Practices providing Hub appointments have been concerned at low take up for certain times of day. There has been resistance by some GP practices to referring their patients to the Hub scheme.

4.3 Brent CCG have at least one ‘walk in’ GP centre but inconveniently located for many patients. Barnet CCG have a ‘walk in’ GP centre at Cricklewood on the boundary with Brent. Very few Brent NHS patients know about this facility open to all NHS patients, and Brent CCG do not publicise its availability for Brent patients, presumably for financial reasons. The same applies

to the urgent care centre located at St Charles's Hospital off Ladbroke Grove. It is used by many patients in the south of Brent and is popular.

4.4 The result is that in our experience very many Brent NHS patients are frustrated when they or their family need to see a doctor, and cannot obtain an early appointment at their own NHS GP practice. One available facility is the 24 hour 'walk-in' 'Urgent Care Centre' at Central Middlesex Hospital (CMH). We are told by Brent CCG that this service has been very under-used since the full acute A/E service was removed on 10 September 2014. We are not surprised. In our experience and as reported at the launch meeting of Brent Patient Voice on 10th February 2015 very many Brent NHS patients do not know that any emergency services survive now that the former full A/E service at Central Middlesex Hospital is closed. Many of those who do know are confused about the distinction between 'Urgent Care' and full acute Accident and Emergency Department care. It needs little imagination to understand why a sick patient or a parent with a sick child decides to play safe and go straight to A/E rather than risk going to 'Urgent Care' only to be sent on to A/E with delay before start of medical investigation on top of what at the best of times may be a 4 hour wait at A/E. Indeed it was reported by a patient at the Willesden PPG meeting on 11 February that a patient with a serious problem had been mistakenly taken by a relative to the CMH Urgent Care Centre who after tests called an ambulance but the patient died before treatment at the Northwick Park A&E could get underway. There is a common view that the nomenclature, "Urgent Care Centre", gives the impression that these facilities are able to deal with a wider range of cases than they can. A preferable alternative could be "Minor injury centres".

4.5 The other resource for a sick patient who cannot get an early GP appointment is to phone 111 or 999. In our experience very many patients have little confidence in the 'pro-forma questionnaire' approach used by the unqualified 111 call centre staff. Again, it is not surprising that many decide to go to their nearest hospital Accident and Emergency Department where they can be certain

of seeing a doctor, even if it takes more than the target 4 hours.

5. NHS Brent CCG Finances.

5.1 Brent CCG's budget for 2014/15 is about £375 million reduced from £400 million. The Department of Health have required that this part of the former funding for Brent CCG be transferred to Brent Council to help finance the new 'Whole Systems Integrated Care' policy.

5.2 Another financial handicap for Brent CCG is that national QIPP policies require annual 'salami slicing' from its budget for 'efficiency savings'. Brent CCG currently has a substantial annual surplus projected to be eliminated by about 2018.

5.3 The NHS National Trust Development Authority (NTDA) in its report on the merger of the Ealing and North-west London Hospital (NWLHT) Trusts in October 2014 set out the financial position of the merged trusts in somewhat opaque fashion: http://www.ntda.nhs.uk/wp-content/uploads/2014/09/The-merger-of-The-North-West-London-Hospitals-NHS-Trust-with-Ealing-Hospital-NHS-Trust.pdf**.** The 2013/14 reported deficit of NWLHT was some £23 million but this was projected to grow to £35 million unless action was taken. The deal offered to the merging Trusts was to inject £144 million over 3 years to smooth the path of the merger. This included some £30 million of capital expenditure for the purpose among other things of additional beds to assist with emergency provision. It is not clear how this strategy is unfolding but the LNWHT leadership still appears to consider that it is saddled with a deficit, mostly not of its own making, and that this affects the morale of senior and middle grade staff. (see 1.12 below).

6. Conflict of Interest Issues.

6.1 Both nationally and locally in Brent conflict of interest issues are proving to be a fundamental problem for the Health and Social Care Act 2012 concept of putting local GPs in the driving seat for buying NHS healthcare for Brent NHS patients. Increasingly local GPs are being encouraged by NHSE and Brent CCG to form groups to acquire provider legal status with a view to bidding to obtain CCG healthcare contracts either as main provider or as sub-contractors.

6.2 This local potential conflict of interest issue is illustrated by the position of the GPs in the local Harness GP healthcare co-operative which has a complex corporate set-up including healthcare provider entities. At least 4 of the Brent CCG Governing Body GP members are Harness GP co-operative practitioners including the Brent CCG Chair, Deputy Chair and Clinical Director. Harness already have provider contracts with Brent CCG and may be a bidder for other Brent CCG healthcare contracts. This must create difficult issues of healthcare planning for Brent CCG, and on conflict of interest management. There have been occasions at Brent CCG Governing Body meetings held in public where on some issues all the GP members (forming a majority of the CCG) have had to leave the room on declaring an interest leaving important decisions to be made just by a few Governing Body lay members and executives with voting rights.

6.3 The extent and seriousness of this potential conflict of interest problem is well focused in the NHSE 18 December 2014 revision of its mandatory guidance for CCGs *'Managing conflicts of interest: statutory guidance for CCGs'* : www.england.nhs.uk/wp-content/uploads/2014/12/man-confl-int-guid-1214.pdf. This includes issues on compliance with Regulations 6 and 9 of the National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013. Risk management includes the risk that a healthcare contract tainted by conflict of interest may be set aside with serious financial consequences for the CCG but more important potential disruption of patient

care.

7. Gaps in Brent NHS Healthcare.

7.1 The Brent Joint Strategic Needs Assessment (JSNA) which provides statistical and other information on which to base health and social care planning appears to have been updated in December 2014 under the leadership of Brent Council, though little if any publicity has been given to the revised document. We have not had time to analyse it, but one important finding from the previous JSNA needs emphasis: Brent has a relatively young population. Therefore the CCG has no reason to cite an "ageing population" as a general justification for its policies. This is still happening. The link for the summary of the new JSNA is: http://brent.gov.uk/media/11085556/BrentJSNA-Health-and-Wellbeing-in-Brent-Dec-2014.pdf .

7.2 For reasons of space we give no more than some examples of gaps in local Brent healthcare as we see them.

7.3 Diabetes is said to use up about 10% of NHS resources nationally. It has a high risk of mortality and irreversible serious morbidity. Brent is said to have one of the highest incidences in the country probably in part through large numbers of Indian sub-continent ethnic origin populations recognised as having a high incidence of diabetes. Type ll diabetes is a preventable condition. Brent CCG and Brent Council have adopted a policy of priority for dealing with diabetes. The practical implementation of this appears to us to be mainly the addition of a small number of specialist community nurses. While we recognize that there is a strategy for public education we cannot see that it is being implemented. We suggest that a sustained major local prevention campaign is needed to make people aware of the need to reduce and avoid obesity and avoid the onset of metabolic syndrome, the precursor of type ll diabetes,

supported by offering tests such as HbA1c across the whole community and at early middle age. This should increase awareness of the danger of metabolic syndrome at a stage when type ll diabetes is still preventable by simple self-help measures. A successful campaign would prevent avoidable serious illnesses and save money in the medium and longer term.

7.4 Brent CCG say that a majority of local patients will have mental health problems at some time in their life. This may be less dramatic than it sounds because many will have needed no more than a short course of tranquillizer or anti-depressive medication at some difficult time in their life. Brent CCG have made mental health care a policy priority, including increased resources for cognitive therapy that is recognised as effective but very labour intensive. In our view mental illness has been the Cinderella of NHS healthcare both nationally and locally. Anyone with experience of the civil and criminal courts will be aware how many fall through the safety net of so called 'Care in the Community' and end up in court, quite apart from the misery of their own situation and its impact on their families. In our experience this mental health 'Care in the Community' is little more than a healthcare slogan. Many are unable to be allocated a Community Psychiatric Nurse (CPN), and those who are find their CPN has such a heavy case-load that the care is ineffective. We are very surprised that the Brent CCG SaHF proposals do not include any new out of hospital community psychiatric service either for adults or children and adolescents.

7.5 NHS stroke acute care in London has improved greatly in recent years through concentrating acute care into highly specialised units. The weakness is in local provision of high quality integrated specialist recuperation care and therapy, both in-patient and out-patient after discharge from acute hospital unit. Although continuing such intensive therapy is expensive it can improve quality of life and reduce dependence on carers. We have seen no proposals from Brent CCG for such a new community out-of-hospital service as part of its SaHF progamme together with its new WSIC obligations with Brent Council.

7.6 It appear to us that the well-intentioned Whole Systems Integrated Care project exists as yet mainly on paper and may not be sufficiently resourced to achieve its laudable ambitions, not least because of the current pressures on adult social care. Although the intention was to reduce demarcation disputes as between the NHS medical care and local authority social care territories it appears that this is still a major component of the Northwick Park Hospital Accident and Emergency department response times crisis. Northwick Park Hospital Chief Operating Officer and Brent CCG previous Chief Operating Officer have reported that a bottleneck at the Northwick Park Hospital A/E department is that many patients admitted through A/E have been treated for the acute condition for which they were admitted within 72 hours but remain too frail to be discharged. These 'bed blockers' cause a back-log awaiting admission from A/E. Brent CCG have tried to reduce this problem by transferring such 'bed-blockers' after 72 hours to Central Middlesex Hospital or Willesden Community Centre for Health and Care. But it is clear from the recent A/E response times statistics that this stop-gap resource has not solved the problem. The Northwick Park Hospital Director of Operations reports that a business case has been put to NHSE for an extra 60 beds by December 2015 in addition to the 50 provided since November 2014 and has received nearly all approvals required. This is an expensive remedy and seems to amount to an admission that one of the fundamental elements of the SaHF strategy was misguided, at least in the short and medium term. A 'bed' is shorthand for a whole package of additional resources from scaled-up medical and nursing establishment, through cleaning staff, IT, consumables including drugs, and catering resources. Uncertainty continues until this business case is approved and in any case implementing it by December 2015 will be an ambitious target if new construction work is involved. Meanwhile Northwick Park Hospital has the worst Type 1 A/E response time in the country: the crisis is here and now.

7.7 Brent CCG have introduced a GP 'peer to peer' hospital referral advisory service, and repeatedly emphasise their wish to eliminate unnecessary hospital

referrals in accordance with SaHF policy. They have promoted a US commercial 'Referral Facilitation Service' (RFS) to monitor referrals by individual GP's. This steer for GPs appears to contribute to patient resorting to A/E departments on a self help basis. We have heard from various members of the CCG staff that the RFS in its original form is to be abandoned. If true we welcome this.

7.8 NICE guidance advises that all between the ages of 70 and 90 be offered NHS immunisation against shingles because about one per thousand cases prove fatal and post-herpetic neuralgia is very painful and distressing. The NHS authorise GPs to approve such immunisation. Brent NHS follow national cost control guidance by offering this immunisation only to those reaching age 70 and 79 leaving the intervening year groups unprotected. This appears to be a form of age discrimination in the face of the NICE guidance, and statutory prohibition of such inequality.

8. Hospital A/E: an NHS Success Story

8.1 NHS Accident and Emergency departments locally and nationally are a success story. The increasing numbers of patients attending of their own accord reveal that the NHS has 'built a better mousetrap'.

8.2 There is patient confidence in hospital special investigation evidence based medicine. Patient sophistication has increased. There is TV familiarity with hospital emergency services.

8.3 This trend is the mirror image of decreased satisfaction with the NHS GP service with the continuing erosion of the traditional family doctor/patient relationship.

8.4 The discreet NHS choke on secondary referrals in the absence of an

available relevant community out-patient service leads to increased presentations at A/E departments, both for immediate symptoms, and in the longer term from delayed investigation and treatment of conditions that become acute.

8.5 London Ambulance Service (LAS) lack of resources contributes to the dangerous delays before investigation and treatment at Accident and Emergency departments. It seems on the face of it absurd that the LAS should have to resort to major recruitment initiatives in Australia and elsewhere when training and people with the necessary aptitudes are available in this country

9. Conclusions.

(i) It is clear to us that there is a crisis at Northwick Park Hospital Accident and Emergency Department on response times especially for the Type 1 most serious cases as assessed by the A/E department. Nor should performance at St Mary's Hospital have deteriorated so badly in national ranking terms for a hospital that describes itself as world class. LNWHT, Imperial College Healthcare Trust and Brent CCG are not fully admitting the seriousness of this situation and the consequent risk of avoidable excess mortality and morbidity. The workload and staff establishment projections on which the provision for increased workload following the closure of the full A/E acute facilities at Central Middlesex and Hammersmith Hospitals were based have turned out to be grossly over-optimistic. We suspect that these projections were unduly influenced by over-optimistic hopes of reduced demand dictated from above in a situation where national projections showed increases in the number of babies being born and older people living longer. A major factor glossed over by planning is that the NHS can deliver closure of hospitals and beds by simple decision, but providing for the vulnerable elderly to leave hospitals promptly rests on the decisions and efforts of a range of institutions, carers and patients

themselves who are not under the control of the NHS.

(ii) There has been serious mismanagement by Brent CCG of its 'Shaping a Healthier Future' programme of transferring about 13 hospital specialist out-patient services to local community services, and as to the design of the programme. This has resulted in serious delays on the implementation of this programme with adverse financial consequences for Brent CCG but more important adverse consequences for the provision of acute and non-acute care for Brent NHS patients, and for the under-pinning of the projections for A/E care for Brent patients.

(iii) Brent CCG may have been saddled with unrealistic expectations for what they could reasonably be expected to achieve so quickly as a new scaled-down administration with teething problems. In the last 2 years they have had to bed down a new organisation, continue the routine healthcare commissioning, plan, and opted to attempt to implement the Waves 1 to 5 Out of Hospital programme, plan without reviewing its viability. They have linked with other NW London CCG's to implement an early phase of the new WSIC project, and faced further administrative re-organisations. In our view this does not excuse the over-optimistic projections for Northwick Park Hospital A/E workload signed off as recently as August 2014.

(iv) In the last 20 years the NHS has suffered from a series of major administrative 'reforms'. Successive governments have claimed that their administrative changes will solve many of the problems of the NHS. These have all resulted in disruption of existing management and distraction from long term planning and delivering healthcare. Views may differ as to the wisdom of some of the concepts on which the 'Shaping a Healthier Future' policy is based and the optimal order for implementing them. The strategy needs review in the light of experience so far and of realistic and honest assessments of the speed with which the aspirations of WSIC can in practice be achieved.

STATEMENT OF TRUTH

The facts stated in this statement are true to the best of our knowledge and belief. The opinions are our own genuine opinions.

Signed:

Nan Tewari, Chair Harness Patient Participation Group and Brent CCG EDEN Committee Member;

Robin Sharp CB, Chair Kilburn Patient Participation Group and Brent CCG EDEN Committee Member;

Irwin Van Colle, Chair Kingsbury Patient Participation Group and Brent CCG EDEN Committee Member;

His Honour Peter Latham, Chair Willesden Patient Participation Group and Brent CCG EDEN Committee Member.

Dated 21 February 2015