Dr Onkar Sahota AM (Chair): This brings us to the main discussion this morning. We have two panels of experts this morning. Can I please welcome our first panel. First is Dr Gary Marlowe, Chair of the London Regional Council of the British Medical Association (BMA); Dr Victoria Tzortziou Brown, Chair of the London Region, Royal College of General Practitioners (GPs); Grainne Siggins, Member of the Association of Directors of Adult Social Services; Neil Tester, Director of Policy and Communications at Healthwatch England; Amber Davenport, Head of Policy, NHS Providers; and Vivek Kotecha, Research Officer at the Centre for Health and the Public Interest. Thank you. You are all very welcome.

We will probably direct questions to some of you at the beginning but if you feel like you need to contribute something or you want to contribute to them, please feel free to come in. Hopefully, this session will last about one hour. We will then have a five-minute break and go into the second panel. Some of the answers you give us will inform the discussion we have later on with the second panel.

First of all, let me start the ball rolling to ask all of you, but let us start with you, Gary. What are Sustainability and Transformation Plans (STPs) and what do you expect them to deliver? How do you see STPs? What are they and what are they expected to deliver, from your point of view?

Dr Gary Marlowe (Chair of London Regional Council, British Medical Association): STPs grew out of many transformation plans across London which had been in gestation for some time. Those plans were, primarily, clinically driven and were around looking at reconfiguration that was most appropriate, looking at better pathways of work, looking at how we might blend or change some of the secondary case-based work because we were aware that there was a problem, especially in the face of the fact that London’s population is growing, especially in East London, which has quite a large projection.

However, the STPs that then came out of that foundation, we very much feel at the BMA, is a plan primarily based around finance based upon trying to close the funding gap and so the focus, we felt and I certainly feel, has shifted from being about what is best for the population, how to best construct clinical pathways that provide patient-centred care that is efficient and cost-effective but not necessarily cost-saving, to one that is primarily about control totals. The control total is about the funding gap that has been established amongst all the various STPs. We very much feel that the shift, although there is still a clinical underpinning, the focus is about the funding gap. I probably should stop there.

Dr Victoria Tzortziou Brown (Chair of London Region, Royal College of General Practitioners): I agree with Gary [Marlowe]. In terms of the focus of the STPs is really on collaboration among providers. STPs are placed-based plans and they want to bring together providers from mental health, community services, the acute sector and general practice but also social care to work together. They talk about integration, person-centred care, improving access and GP federations.

When I talk about ‘person-centred’ care, it is important to think about it with its three elements, really, the physical, mental and also social elements that contribute to a person’s wellbeing.

All of these have been championed by the Royal College of GPs and so we very much support such an approach.
From the College’s perspective, the main anxiety on STPs is that, during this effort of transferring a lot more care from the hospital or the acute sector to the community, we need to make certain that general practice, which is the main element of this community delivery, is adequately funded in order to respond to the increasing demand that is going to be created.

Dr Gary Marlowe (Chair of London Regional Council, British Medical Association): Thank you. Just quickly, all of the plans are hugely predicated on a shift of work from secondary care to primary care and some of the plans do not even mention primary care. For example, the North Central plan does not mention the GP Forward View at all in the whole of the document, as far as I am aware. These plans are hugely predicated on shifting work to general practice without any real fleshing-out of how that happens, how that is funded and the time period over which that will happen.

Grainne Siggins (Member, Association of Directors of Adult Social Services): From the Directors of Adult Social Services perspective - and I will also give some views today about just general local government because I notice that I am the only witness with that background - and in terms of STPs, there is generally broad support for STPs from local government and also the relevant professional groups: [the Associations of] Directors of Adult Social Services, Directors of Children’s Services and Directors of Public Health.

It is based on the principle that we were not necessarily planning strategically at a larger footprint. We have many of our local residents who use different hospitals. It has recognised the importance of having the right clinical care in the right place within acute settings but, equally, preparing people for going into acute settings and then getting them out quickly and providing enhanced care and support in the community with improved quality community services that can wrap around our local residents with social care support. The emphasis and drive and desire within STPs is something that is generally welcomed.

Colleagues have already spoken about the financial element and that is something that does cause us some concern and, also, the fact that it actually came from a health-driven requirement. Just as a reflection looking back, it would have been quite useful if, when people were thinking about establishing that, they had fully engaged with the Government departments responsible for local government so that it was something more of a shared agenda and something that we were part of the initial stages of.

From the perspective of the people that I have engaged with as part of providing the evidence today, there has generally been good engagement, but in the very initial stages of the preparation of the first elements of the draft STPs, I think that is where there was not sufficient attention placed on local areas and a local focus to get local government. Also, I do not think there has been a full appreciation of the democratic accountability of local areas in the decision-making elements of that. STP leads now fully embrace and understand that requirement, but it has been a slow burn in actually getting that emphasis and focus.

Generally, we are all planning already at a local level, through what we call our Better Care Fund (BCF), to plan for integration, integrated health and care, driving activity out of acute hospitals, providing more care and support at a local level, but we already had some concerns about how this different model of care is going to be funded when there are various different agencies that are involved in the delivery of that.

Neil Tester (Director of Policy and Communications, Healthwatch England): I am absolutely acknowledging what has been said about STPs being a mechanism for managing financial pressures. I will not add to that.
It is worth also reflecting that they are or tend to be delivery vehicles for the aspirations set out in the Five Year Forward View. As the more detailed plan for the next two years emerges from NHS England very shortly, it will be really important to note how STPs are built into that two-year delivery plan.

From our point of view at Healthwatch, with our role being to hear what people are experiencing and what people think about local services both in terms of health and social care, which is very relevant to STPs, for us STPs are a massive opportunity if they are planned and implemented well to deal with a lot of the frustrations that people have in current services. That requires some genuine honesty and a bit of humility on the part of the whole system and everyone within it to acknowledge what does not work well at the moment and to build a shared case and a shared plan for handling some of those frustrations. Given that people absolutely acknowledge and understand the resource pressures and are often frustrated that things happen in a way that is not sufficiently joined up around them individually and them as their communities and that they think could be done much more efficiently and cost-effectively.

The big ‘if’ is that this can only be done well if people are genuinely engaged with and proper adult conversations are had with communities. That is the big challenge. There are some green shoots there, but that is the big challenge remaining for STPs.

**Amber Davenport (Head of Policy, NHS Providers):** The perspective that we are coming from on STPs -- I am from NHS Providers and we are a trade association representing trusts and foundation trusts. That spans across acute hospitals, mental health, community services and ambulance services. While I will not be commenting on London-specific plans, I can comment on the STP process from a national level and as a whole. We see STPs, as others have said, as a really good opportunity. It is one of the first times that commissioners, providers and providers of social care have really come together locally to develop a plan over a medium period of time to transform services and reach sustainability.

We would say that there were some challenges with the process from when the concept of STPs was first established. The process was challenging. It was very quick. Some areas have very strong historical working relationships with their local partners already; other areas were coming together for the first time. What we have seen -- and I am sure it is true of London -- is that STPs are all in different stages. Some might be a bit further on than others. That is OK and, actually, they should be supported going forward to progress at a rate that is right for them. Also, we need to be realistic on what they can actually achieve given where they are in their planning process.

I would agree with what everyone has said about meaningful engagement with local communities and engagement with social care as well. By ‘meaningful’, we do not mean just public consultation when we have to go to public consultation. We are talking about engagement both with frontline staff and clinicians and local communities throughout the process, testing what is going to work for them and how we can achieve the vision in the Five Year Forward View. It is a great opportunity, but there are some challenges going forward.

**Vivek Kotecha (Research Officer, Centre for Health and the Public Interest):** The Five Year Forward View, which set out what a lot of the STPs are driving towards, has some quite well-meaning ideals and intentions in there, but I feel that since then the financial issues have become a lot worse, worse than they envisaged at that time in 2013. STPs have been put in this position, as Gary [Marlowe] has said and as other people have said, where they have good clinical ideas in them and some untested ones as well, good ideas, but this financial situation is starting to envelope a few of them, and generally is a challenge for the whole system. What we worry about with STPs is that you have a very short timeframe in which to achieve quite a lot of savings. You are also having limits on how much capital funding there is available and there is a lot of complaints about that and worries about that. This makes it harder to invest in all of these changes.
At the same time, you have this system where it is great that different parts of the National Health Service (NHS) are collaborating with each other to varying degrees, but there is not really that structure in place to actual accountability, legal or otherwise. These are still memoranda of understanding. They are still based on a trust-based agreement. While it is working for now in most areas, as those issues develop and as it gets financially tougher over the coming years as the funding gap widens, I would worry about how those relationships and trust between providers, commissioners, other parts of the NHS and the social care system, will stand up. If things start to not deliver at the speed or in the way they expect, what does that mean for STPs going forward?

You can see potential risk issues just based on the assumptions that the Five Year Forward View said were going to be used to close this funding gap. The assumptions that they used were quite optimistic - even they admitted that - and yet we are now implementing them across STPs to the extent that they have to also take that share of the funding gap and close it. Finances are starting to take over a lot of the issues with the STPs and they are influencing them across the system.

**Dr Onkar Sahota AM (Chair):** Firstly, thank you very much for your opening contributions. We are going to explore those concepts you have talked about: finance, accountability, public engagement, the democratic deficit. We are going to explore those themes for a bit longer. I am going to ask my colleague Assembly Member Andrew Boff to explore them, but we will be exploring these concepts. They are of concern. Just to let you know, they were flagged up in our own research before we came here this morning and so we are aware of those.

**Andrew Boff AM:** Can I just say? I have not heard from anyone that the STPs are a really poor idea. Is that correct? The criticisms seem to be valid criticisms about the way in which they perhaps are running, being managed and engaging with you, but the core concept seems to be something of which there is a general consensus. Stick your hand up and say, “No, you are wrong”.

**Dr Gary Marlowe (Chair of London Regional Council, British Medical Association):** It is subtle. It is not binary. It is not and black-and-white good/bad. The problem with the STPs, just to caricature it, is that potentially what we are creating across England are 44 health republics. If we create 44 health republics, what is a ‘national’ health service?

One of the directions of travel - and already Simon Stevens [Chief Executive, NHS England] has been talking about this - is Accountable Care Organisations. Since the Health and Social Care Act was passed, it removed the Secretary of State’s responsibility for health. That means that, potentially, we could have Accountable Care Organisations that are in their own health republic and are able to then set up their own terms and conditions. They have always said that this is not the case, but there is the potential for that and, from the BMA, we are very concerned about things like national terms and conditions --

**Andrew Boff AM:** You would prefer a more centralised approach?

**Dr Gary Marlowe (Chair of London Regional Council, British Medical Association):** What we are anxious about is that there is equity across England. Do we have a national health service or do we have 44 individual services that then become Accountable Care Organisations? That is the worry. It needs to be properly explored with the public because, if that is the direction we are moving in, we need to be honest and discuss that. The other thing, as Vivek [Kotecha] has talked about --
Andrew Boff AM: Is there, in any of these STP plans, a plan to depart from a health service that provides free care at the point of delivery?

Vivek Kotecha (Research Officer, Centre for Health and the Public Interest): I have something there, actually, as well. It has already happened. Clinical commissioning groups (CCGs) already have criteria on what, say, non-emergency care their patients in the area can access and that varies across the country. Some have been criticised recently for the fact that they have set eligibility criteria that are stricter than, say, other national criteria. We already have a disparity of access across the country.

Andrew Boff AM: Eligibility for care?

Vivek Kotecha (Research Officer, Centre for Health and the Public Interest): Yes, for non-emergency care. It already exists and that is due to funding issues at CCG level and their own financial problems, but that is already happening to an extent for certain types of care --

Andrew Boff AM: That is not an issue with regard to the STPs; you are talking about CCGs there.

Vivek Kotecha (Research Officer, Centre for Health and the Public Interest): That rolls into the STP. The CCGs and all of the financial issues are rolled into each STP area and so these problems are already boiled into a lot of them.

Andrew Boff AM: A lot of the public would be quite surprised to hear about this process because the STP was not something that was announced early enough, as was alluded to earlier. In the early stages, there was not a great deal of engagement. How engaged do you as organisations now feel with the STP process?

Neil Tester (Director of Policy and Communications, Healthwatch England): It has been really interesting to watch the development of the relationship between local Healthwatch and their STPs, let alone communities and STPs. Therefore, the first thing to say is that for most people, most clinicians and a significant number of NHS managers, all the research is showing that the ‘STP’ label has not even got through as a concept. What most people are experiencing are a set of individual discussions about particular changes where the grand vision has not been communicated and discussed with people anyway. There is often a trap for those of us who do spend a lot of time obsessing about this policy issue to forget that sometimes the language in itself does not mean anything to other people.

As the Committee has already identified in its pre-publicity for this hearing, there was significant criticism of the perceived secrecy at the start of the planning process and I think everybody, NHS England included, has acknowledged that it would have been much better not to have started from that point. Given that it has and in our conversations with local Healthwatches at that stage, they were hugely frustrated, particularly those who had been developing really effective relationships with their local health and social care economies about major change programmes and conversations about the BCF and conversations across the country about the new models of care vanguard programmes and, often, engagement was really starting to motor. It felt to them - and I think to their counterparts in their system - that a guillotine had come down.

I am pleased to say that we have been able to work closely with the new team at NHS England to start to improve that and to help to get a shared sense between local Healthwatch and those responsible for driving communications and engagement across STP footprints so that there is a shared understanding of the things that matter to people about this. As Amber [Davenport] said, it is not about just consulting at the end but about helping to get a shared understanding of what the point of change is and a shared view about what the options are, really understanding how people’s views have been taken into account and that being fed back to
people so that they can see what difference their views have made or have not made. If there is an overriding reason why people simply cannot provide what is being asked for, they need to be upfront about that.

What we have done there is to develop a range of support for local Healthwatches to help them engage in those processes because, on this point of local variation, different STPs are taking different approaches. Some have asked local Healthwatches to be on programme boards. Some have asked if they can play an assurance role. Some are commissioning local Healthwatch to do additional pieces of engagement. Some are asking them to help broker relationships with the voluntary and community sector to do that, all of which is welcome.

However, the key thing that I have noticed, really, from the autumn to now is that from the point where in September NHS England issued some very helpful new guidance, which we were able to help to shape, it really set out clearly what the expectations are around engagement and the difference between engagement and formal legal consultation which, frankly, is there just to avoid judicial review and does not get the full benefit that engagement does in terms of getting a better set of decisions and a better range of services for people. That enabled a different conversation to start to take place.

It is variable. I have to say that there are more challenges in London than there are in quite a few other parts of the country because of some of the historical challenges there have been around issues with the location of acute hospitals and some of the other big service-change programmes that there have been over the last couple of decades in London. London carries that baggage with it into this process. Nonetheless, there is still variability within London and even within STP footprints. In half of the boroughs who are in STP footprints, things are less controversial and if we can get into that adult conversation. In the other half of that footprint, there is a cycle of fear because people are terrified they are going to lose the local accident and emergency department (A&E) and decision-makers are terrified of having a conversation about that.

We are increasingly, I am glad to say, able to find ways to position local Healthwatch to be the bridge between the people in the system and the bridge across health and social care, to take that fear factor out it and to get some honesty and constructiveness into those discussions. I am cautiously optimistic about the prospects for engagement as a result of that.

**Andrew Boff AM:** Are we too late, though? The parameters have already been set with the professionals talking amongst themselves, pretty much. Are we too late in terms of getting those parameters influenced by the public?

**Neil Tester (Director of Policy and Communications, Healthwatch England):** It is never too late, I would say, with the process because, firstly, it is going to take years to implement the things that are included in this piece. The plans are still at a high enough level that a massive amount of detailed work and planning needs to go on. The point was made right at the start that, whatever the timeframe of the STPs, the Five Year Forward View or the two-year delivery plan, some of the changes that they are predicated on will take decades to see through. If you look very narrowly at this process, it looks potentially like too little too late, but in the grand scope of where will London’s health and care services go in the future, it is never too late to get the engagement right.

**Amber Davenport (Head of Policy, NHS Providers):** I just wanted to echo some of what Neil has said. One of the challenges with engagement in the initial stages of the process was how quickly the first drafts of STPs had to be developed and the time that it takes to develop and build some of the relationships that need to happen at a local health economy level. The engagement in terms of engagement with the public is really stepping up and I would echo what Neil has said there.
I just wanted to come back on something that Gary [Marlowe] talked about earlier about STPs threatening a national health service. I would say that at the moment, commissioners, providers and social care providers are independent organisations that can be seen to be acting in isolation sometimes from each other, whereas the STPs are an opportunity for them all to come together as a collective to discuss and develop what is best for that local health economy. Really, I see them as an opportunity for ensuring that there is equity and there is a shared plan and that organisations do not continue to act in competition with each other. That can sometimes end up to the detriment of patients. I just wanted to make that point.

Dr Gary Marlowe (Chair of London Regional Council, British Medical Association): I just wanted to come back to some points that were made earlier. Sorry, I could take over the whole thing. I will try not to.

About the legal issues, we have not really explored the legal side of things at all. Simon Stevens has alluded to the fact that we are going around. Whatever one believes, whether one is for or against or ambivalent about the Health and Social Care Act 2012/13, it did go through Parliament and it is an Act of Parliament. It has set in place procurement laws. As I see it, the STPs are potentially trying to get around the Act. I am not a fan of procurement, but it is there. If we are going to have an STP that removes a purchaser/provider split, we are in essence going against the actual legal definitions of the Act. We are moving around procurement law. I know that we are about to come out of Europe and therefore we will not have to adhere to European procurement law, but there is equivalent British procurement law. The legality of what we are trying to do has not been very clearly defined. Perhaps NHS England knows what it is about and has some definition around that, but --

Andrew Boff AM: When you talk about procurement, you are talking about procuring for the whole service? We were specifically focused on consultation and the legal aspects.

Dr Gary Marlowe (Chair of London Regional Council, British Medical Association): Yes. This is the legal issues around procurement. In essence, the STPs are trying to go around the Health and Social Care Act. From a legal point of view, there is the legality about consultation, but on the legality about procurement and about the purchaser/provider split - and I would welcome seeing that go - we do not have enough clarity or definition about what is going on. There is a potential for legal challenge and judicial review around that purchaser/provider split. At the moment we have memoranda of understanding, but I do not know how well they would stand up to a legal challenge.

Grainne Siggins (Member, Association of Directors of Adult Social Services): In terms of local government engagement, to begin with people had to work really hard really quickly to develop the plan, the governance structure and the process. There was naturally an inward-looking focus, which has improved as time has progressed. I just felt that we needed to enhance the balance that was identified by Lucy.

Local government was engaged often in the programme boards and so was part of the process, but often with between 20 and 30 clinical leaders. In terms of the influence and ability to shape, we have ended up with something that is not embedded. It has not been coproduced. It is something that we now have, which is a plan, the core focus of it being, in my view, clinical redesign, which was essential as part of the element that we supported. However, at a local level, people have initially missed the importance of that political engagement and accountability and now, in some areas, they are struggling because of that where politicians are being challenged by scrutiny and are not supporting the plans as the currently stand. That is because, if you do not engage at the very beginning in a very open way, you end up where you are now.

From a perspective of our local residents, there has been this veil of secrecy, which means that people do not then trust the plan. The outline, I suppose, ambition of the plan could be very positive in what it means for
people and the shape of people’s care on the ground, but there is going to be an awful lot of work required by the STPs to start engaging in a meaningful way with those local communities.

Andrew Boff AM: Is it unrecoverable? Mr Tester indicated that --

Grainne Siggins (Member, Association of Directors of Adult Social Services): If we take it in the spirit of what consultation means, then there should be a way of shaping what those local services look like. I agree with Neil [Tester] as part of that.

In terms of the clinical redesign of services and what that actually means, where there is the ability to say, “Hips and knees are at that hospital and specialised colectomies are at another hospital”, whether or not there will be the opportunity to shape that, I do not know. In terms of the emphasis on what it will mean for local residents personally to be able to shape and input in a meaningful way, I am hopeful in the spirit of what consultation means.

Dr Victoria Tzortziou Brown (Chair of London Region, Royal College of General Practitioners): STPs at this stage are much more high-level strategic documents and the principles that they want to promote are very much based on interventions and innovations that have happened locally, in a patchy way, but in response to a lot of the time to what patients have asked; that is why they have been successful.

It is about really bringing together the successful but patchy innovations and making them the standard at a bigger scale. It is very difficult to engage when you have to write something at such a high level. More meaningful engagement for frontline staff and also patients and the public can happen when you talk about more specific issues. Therefore, there is a huge opportunity to start this now because now we move into the implementation phase.

When we talk about engagement, perhaps we should talk more about co-design. We should not see this as a one-off event. It needs to be a continuous process which is informed by data. The opportunity that STPs can offer is by collecting data at a much bigger level and by investing in information technology (IT) infrastructure can really assist people, the public, providers and frontline professionals to make a lot more informed decisions and choices.

Neil Tester (Director of Policy and Communications, Healthwatch England): Could I just add to what Victoria said? I absolutely agree and that was beautifully put: meaningful engagement will come around the subsets rather than around the STPs.

However, there is a point of principle and it is something that local Healthwatch have said to me almost unanimously. There does need to be a translation of the jargon-filled plans that currently exist into shorter, snappier, plain-English documents. Also, very disappointingly, a fairly low proportion of STPs - probably because of the time and speed they have been working at – very few have made the information available in a way that is accessible to everybody. That needs to be rectified because people need to be able to look back to those documents as they go through the more detailed discussions that Victoria was talking about.

Andrew Boff AM: As soon as you throw a three-letter acronym at the public, they switch off anyway. Perhaps we should stop calling them ‘STPs’.

Jennette Arnold OBE AM: To come in after - if I can call you – Victoria, in that I would challenge what you have just said because it did not make sense to me. You talked about it being a strategic tool and then there were, did you say, innovation projects that were already coming out of this strategic tool or documents or
whatever framework. Then, we heard previously about this impact. You talk about the public and elected responsibility lies within elected leadership within boroughs, and yet we have heard that there is a gap between those people who are held accountable to the public for many of the services that you are aiming to configure or do whatever with. Therefore, it did not make sense to me what you have just said.

Dr Victoria Tzortziou Brown (Chair of London Region, Royal College of General Practitioners): What I said was that a lot of the time what STPs have done is to try to take good examples of what has happened locally in certain areas in a very patchy way. I know that I am biased, but what we have achieved in Tower Hamlets by working together with the local authority on integrating care locally is a good example that probably STPs have used across the country; and they want to replicate this example on a bigger footprint.

In order to develop this integrated care approach in successful local areas, we responded to what patients and Healthwatch wanted and told us that we had to address. The success of these local innovations was a result of responding to local need and what people had asked us to achieve. It could only be successful by working with the local authority and local government. The point of the STPs is to work with the wider stakeholders and also the voluntary sector, not just local government, and other healthcare providers and patients.

Jennette Arnold OBE AM: Thank you.

Andrew Boff AM: Thank you. Can I just ask? The remit of the London Assembly in terms of health is about addressing inequalities in health in London. Perhaps you could let me know if you have seen any evidence - perhaps Mr Kotecha could give us an example - of engagement with under-representative groups such as London’s deaf community, older people and homeless people and other groups as well.

Vivek Kotecha (Research Officer, Centre for Health and the Public Interest): That is a very good point. With the Equalities Impact Assessments, some of them have been carried out and some have not. They are really not very detailed.

What I would say is that there are going to be big changes, potentially, for groups that are vulnerable. With the way they are changing access to services and some of the move to maybe shift access to appointments to telephones or internet services, that does affect people who may not speak English as their first language, the elderly, people with disabilities or people who do not have access to the internet regularly. Any changes to access to care impact them.

One of the other areas that has not been looked at in a very detailed way across all STPs is female carers or female family members in particular, who often have to care for the elderly or frail or family members with learning disabilities. A lot of them have not considered the impact on them. If, say, there is a funding gap in social care still or if, say, things do not work out as planned with STPs and we end up with people in between social care and the NHS, then there is an impact on family members. That has not necessarily been taken into account very clearly at the moment in these STPs.

Andrew Boff AM: Mr Tester, have you encountered any good practice or bad practice of engaging with hard-to-reach groups?

Neil Tester (Director of Policy and Communications, Healthwatch England): In terms of the STPs, there is variation but it is variation with a band in the middle. We have not seen anything absolutely atrocious with people just ignoring the issues completely but it still feels like it is on their to-do lists. Equally, we have not seen anything that stands out as a shining star.
Reflecting on what Vivek [Kotecha] has just said, one of the opportunities it is vital that STP planners do not miss is the chance to really look at population need at a level of detail that will highlight the needs, the differential needs and the different delivery and access needs of groups that often fall through cracks in systems. I do not have confidence from what local Healthwatch have seen in the plans so far that that is being picked up consistently. That is another opportunity that good engagement will deliver.

We need to get a shift in culture and mind-set where people stop thinking about this as another administrative chore that they have to do when they have big plans to deliver and start seeing it as a source of insight that will help them to get decisions right and help them to make sure ahead of time that they do not miss out vital services, that they think through things like the transport implications for different groups of people and that they think about language needs and all of the other needs. They can get some of that thinking into the planning through the engagement activity if it is done well and early.

Andrew Boff AM: I am a bit worried that you cannot come up with any examples of good practice with regard to that.

Neil Tester (Director of Policy and Communications, Healthwatch England): I am worried as well.

Andrew Boff AM: What suggestions would you make? How should the STPs identify the requirements in their geographical areas? How should they go about doing that, briefly if possible?

Neil Tester (Director of Policy and Communications, Healthwatch England): I should say that just because I have not seen it, it does not mean that it does not exist. I am looking at the national level rather than knowing the detail of all of the London STPs. I am not saying that it is not there, but I have not seen it.

How should they go about it? There is, again, a huge opportunity here to bring in the voluntary and community sector, social enterprise and community groups across boroughs across the capital. That ecosystem and infrastructure is there, but I have to say that if people do not build it into this thinking and do not ensure the support is there for it, it will not be there forever. There is a narrowing window of opportunity to build those mechanisms for involving all of those groups into these plans and making them permanently part of the system in a way that will benefit people and also make life easier for decision-makers in the future.

Andrew Boff AM: Thank you. Could I just ask perhaps Dr Tzortziou Brown whether or not you have seen engagement of frontline staff in the construction of the STPs and whether or not that needs work? Is it important that frontline staff are involved in these plans?

Dr Victoria Tzortziou Brown (Chair of London Region, Royal College of General Practitioners): Absolutely because if STPs are going to be successful is if they change the behaviour of professionals and patients, really. In order to change behaviour and do things differently and add value to what you offer to patients, you absolutely need to believe that it is the right thing to do and also see it as feasible. Frontline professionals - and especially coming from the Royal College of GPs, GPs - are absolutely paramount to being engaged and leading the change. Also, we need to think of the wider teams that we need to develop and train and how we can develop this distributed leadership across all frontline staff, involving also the voluntary sector and patient leaders within that. We need to work together. It is not necessarily about one group or one representative professional leading the whole thing. We need to engage and inspire all frontline staff and patients to work together on this.

Andrew Boff AM: Thank you. Does anybody want to add to that?
Dr Gary Marlowe (Chair of London Regional Council, British Medical Association): At the BMA, we did a survey - I cannot remember the exact figures, but Andrew probably knows - of GPs and of hospital doctors across London. I would say that less than 20% or less than one in five - obviously even less than that - were even aware that there was such a thing going on. There is no real engagement on the front line. There is no real engagement. I will just emphasise that again. All of the STPs are clinically led but the clinical leaders tend to be an individual or a couple of individuals or a small handful of clinicians who are maybe doing a few sessions a week in the work but are very heavily involved in healthcare management and are not on the ground working. That is absolutely right and they cannot do both things together, but there is really no clinical engagement.

With all respect to Healthwatch, in terms of patient involvement, that is also very poor. None of the STPs really have any patient involvement committees. Some of the STPs have commissioned Healthwatch to go out and get the information but there is no actual detail co-production going on there.

Dr Onkar Sahota AM (Chair): Dr Marlowe, it says in our briefing that in November 2016 the BMA ran a survey of 615 GPs --

Dr Gary Marlowe (Chair of London Regional Council, British Medical Association): Yes, that is the one I was referring to.

Dr Onkar Sahota AM (Chair): -- and consultants in London, they found that 53% had not even heard of STPs and 88% felt unable to influence decisions. Is the survey you are referring to?

Dr Gary Marlowe (Chair of London Regional Council, British Medical Association): Yes, that is the survey. Thank you for the figures. That definitely is the survey. That feeling continues with very little engagement and very little feeling of being able to influence them. That is because they are very, very high-level documents. If I can, just quickly, because I know we are about to finish; from a BMA point of view, I am going to really return to this. As Bill Clinton [former President of the United States] would have probably said, it is about the money, stupid. It really is about the money. This is not my data; this is purely taken from the STP documents. Across London, the capital funds needed to implement the STPs as they stand is about £1.9 billion. That is just to implement them. That is not getting around to the health. We cannot do nothing because the gap is so huge and so we have to do something, but we need to be realistic about these figures. The STPs are basically a prospectus of false promises.

Andrew Boff AM: All right. Do you think it is all about the money or is it not all about the money? Earlier you were saying that the STPs --

Dr Gary Marlowe (Chair of London Regional Council, British Medical Association): There is a great deal of good work that the STPs have been built on and there are a lot of good ideas around them, but it is really all about the money at the moment. I am also a board member of a CCG and so I am aware of some of the financial pressures that we are under.

Andrew Boff AM: Yes, every single Government - with the exception, I think, of the Callaghan Government - has increased expenditure on the NHS. I am hoping that these STPs can clear their view of just saying, “More money”, and realise that there are some structural issues. Is that really what --

Dr Gary Marlowe (Chair of London Regional Council, British Medical Association): There are definitely some structural issues, but we need to be honest with the public about this.
Jennette Arnold OBE AM: You cannot have structure without the money.

Andrew Boff AM: Yes, and the honesty is that we have constantly shovelled money into the NHS and increased it with every Government since.

Dr Gary Marlowe (Chair of London Regional Council, British Medical Association): We put in less than demand. We put money in, but the money that we put in is up about 1% whereas demand is increasing by 3%. We are not keeping up. We have to contain demand. The STPs are a way of containing demand and so I would totally agree with that.

Andrew Boff AM: Yes. Nobody is cutting it. Nobody is cutting the NHS. Can we just now move on, if possible, to your idea of what role the Mayor could play in helping Londoners to engage with local STPs as well? What could the Mayor do? Whom shall I ask? Everyone. Is there something that the Mayor can do to encourage people to get involved in their STPs?

Dr Gary Marlowe (Chair of London Regional Council, British Medical Association): A debate around estates would be a way of involving people. It is very unclear exactly what is happening around estates. To go back to the money, that is a significant part of the funding of the NHS and we need clarity around what happens to estates. Does that money go back into the local community? Does it go back into the local STP? Does it go to the London-wide region? Does it go to the Treasury? The Mayor could be a very powerful voice in helping us to work out exactly where that goes. If we all agree that we need to close a local hospital because it is not performing and we could consolidate the services better, what happens to that hospital capital fund when it is sold or developed? Does it go back into the local community? Does it go back into local government? That is a really quite important thing that the Mayor could get involved on.

Dr Victoria Tzortziou Brown (Chair of London Region, Royal College of General Practitioners): If we see STPs as a plan to improve the health and wellbeing of our population, focusing on London, there are lots of common objectives with what the Mayor is trying to do. We need to think about the wider determinates of health and wellbeing from air pollution to inequalities to mental health to Healthy Schools. The Mayor has plans to address some of these issues and we absolutely need to work together on these.

Neil Tester (Director of Policy and Communications, Healthwatch England): That is a really helpful frame for this because, if the Mayor simply went out and started talking about STPs, he would repeat the problem with talking about something that turns people off because it is a three-letter acronym, as Mr Boff said. Whereas the Mayor thinking for each of the areas that relate to the health and the wider determinates of health that he has responsibility for, “How is this relevant to STPs and how do I get a debate going across London in relation to this issue?” He can do that in terms of air quality. He can do that in terms of the London is Open agenda and the workforce issues, which are some of the massive pressures that the London STPs need to deal with. There is space for the Mayor there.

Also, in terms of service reconfiguration, the Mayor controls transport and people’s ability to move between services and access services. This is something that he can influence and perhaps identify barriers where people might assume that transport is easier than in reality it will be. Building those conversations and those opportunities for people to engage through the Mayor and the Assembly’s consultation mechanisms alongside health and social care’s engagement and consultation mechanisms is a very practical way of taking us forward.

Dr Gary Marlowe (Chair of London Regional Council, British Medical Association): In our local hospital, about 20% of our non-doctor medical workforce are European. There is considerable anxiety
amongst those workers and so that is quite an important thing. Just being a little bit flippant, he can license fried chicken shops and obesity is a really big problem across London.

Andrew Boff AM: We are coming to the obligatory Brexit question later on. Can we just move on? If I can ask Ms Siggins, you did allude to the fact - and tell me if I am wrong in misunderstanding what you said - that there was perhaps a heavy clinical lead on the development of the original STP plans. I am wondering whether or not you think that the requirements of social care have been adequately considered in the draft plans?

Grainne Siggins (Member, Association of Directors of Adult Social Services): My observations are that we had the BCF previously and then we have had the STPs and there is very little conversation about the BCF and the work. That means that the work we are operating at a very local level with our health partners collaboratively as local systems. There is not much talk about that at an STP level because it is something that is viewed as detailed and operational and on the ground, but it is essential in having those local conversations about how you are planning and delivering services at a local level.

The danger of the STP footprint is, “And what next?” There is concern from politicians and from local authorities about what the next level of decision-making is going to be taken up to STPs. Planning for acute care at an STP footprint in the main, from the feedback I have had, everybody is comfortable with that, but what does that mean about local democratic accountability for poor planning?

The STP was about health sustainability financially and the social care resource and the impact on that was not a core part of the original STP guidance and so some areas have built the impact on social care into their STPs; other areas have not. What I would argue is that things like the National Living Wage and the challenge to local authorities of that is not part of the STP anyway, but the shifting model of care from less hospital to more community-based care and enhanced care in the community will impact on social care. There does have to be a local conversation.

At the moment, the majority of the STPs only look at the health sustainability because that is all they were tasked with doing. If the social care conversation about the impact on social care in many areas if it has not been dealt with within the local BCF plans and if we have had not had the shift in resource there, then there is no opportunity within the STP to get it realised because it is not viewed as part of the deficit.

Andrew Boff AM: What needs to change now in order for local government to achieve what the STPs have set out to do?

Grainne Siggins (Member, Association of Directors of Adult Social Services): It is about being clear about what the parameters of the STPs and how far they are going to meet the financial requirement of that shifting landscape. At the moment, people are still not arguing about it but it is a known area where it is not always funded because it is not included and so you then have a separate conversation about social care. For me, it is an open and honest debate in the STPs about the full impact financially across health and care, what it means for the health system and also what it means for the social care system. In some of the STPs, that is covered and more at a local level, but it is not a uniform position across the board. How are STPs fully embracing the cost impact on social care of the changing models of care and support? That would be the question that might be posed.

Andrew Boff AM: Just for the sake of clarity, your criticism earlier of the starting point of the STPs. Does that apply to each of the footprints in London or is it just one or two of them?
Grainne Siggins (Member, Association of Directors of Adult Social Services): In many areas, there have already been conversations about how we make the hospital system more sustainable and, clinically, how we shift care out of hospitals with enhanced primary care. Those conversations were already happening in local systems. The STP did not suddenly start that. In local areas, you have your clinical conversations and you have your local conversations with social care and so what does that mean for us on the ground. That was already underway.

It is about the broader configuration of acute care and what that means and specialities going to other hospitals where there has been high-level conversation, but the ability to build in what that means at a local level at the moment in the plans is not clear because they are high-level. I would be really interested to see what the next level of detail is on the plans to say how this is going to be delivered at a local level.

Andrew Boff AM: That is quite interesting because you have actually answered the next question I was going to ask, which is really about this idea of integration between the health service and social care services. It has been around for ages. We have wanted to achieve it and for all sorts of administrative reasons we have not been able to. To my knowledge, it has been going on since 1982 when I first became a councillor. We have been talking about how to integrate social services and the NHS. Do you think that the STPs give an opportunity of giving that a boost?

Grainne Siggins (Member, Association of Directors of Adult Social Services): It will enhance it a little bit further, but we do need to accept that we have been working towards this now for many years. There are already integrated health and care teams around the community already delivering services for people. One of the other areas of concern has always been the capacity within primary care to help to support that. In many areas now, there are social workers working around the patient and so there are individuals who are having very proactive and supported care at a local level with the social care input as well as the clinical care input there. It is about embedding that and making sure it advances to the next level. Generally, it is included in the plans at a high level, but you will not see the local.

What we are worried about is if these STPs become decision-making bodies with delegations from CCGs. We are already seeing CCGs merge as management structures. What does that do for the planning and delivery at a local level if our ability to plan at a local level with our local CCG and local authority is taken up that one step further? Already all of the money in the transformation funding goes to STP level and does not come down to the local CCGs anymore, albeit they are engaged, and so there is a significant challenge.

Dr Gary Marlowe (Chair of London Regional Council, British Medical Association): I would just like to follow up on that. I work in Hackney and we have an integrated commissioning project going at the moment. It is one of the key local projects. We have looked at integrated commissioning. We have joint boards for urgent care, planned care, etc, which are being chaired by someone from the local authority and from the CCG. We are worried that that project has just about hit a brick wall because we have been recently given notice that our plans for integrated commissioning with a good governance structure and that has been more or less stopped in its tracks.

That goes on to your point about the amalgamation of CCGs. What are CCGs for? What role do they provide if they are all being amalgamated? We already have North Central and I think South West has amalgamated. You have someone who is chief officer of an STP who is also chief officer of those combined CCGs. It is a very unclear position. Certainly in our particular case of Hackney, we were well along the way of progressing integrated commissioning with a good governance structure and that has been more or less stopped in its tracks.
Andrew Boff AM: Thank you very much.

Dr Onkar Sahota AM (Chair): Can I just pick this up on the BCF? Earlier on this year, Sir Amyas Morse, the head of the National Audit Office (NAO), said:

“Integrating the health and social care sectors is a significant challenge in normal times, let alone when both sectors are under such severe pressure. So far, benefits have fallen far short of plans, despite much effort. It will be important to learn from the over-optimism of such plans when implementing the much larger NHS sustainability and transformation plans.”

He is really saying that there is no evidence to suggest that integrating social care and healthcare is any cheaper than previously. The NAO is saying:

“Whilst there are some good examples of integration at a local level, evaluations have been inhibited by a lack of comparable cost data across different care settings, and difficulty tracking patients through different care settings. The NAO today reiterates its emphasis from its 2014 report on the Better Care Fund that there is a need for robust evidence on how best to improve care and save money through integration and for a co-ordinated approach.”

The whole emphasis of STPs is, if we integrate healthcare, we will save money. Where is that evidence?

Grainne Siggins (Member, Association of Directors of Adult Social Services): When we first entered into the BCF, there was never any evidence that integrated care would save money. If we look at the narrative behind it, it was all about improving patient outcomes. Somewhere along the road, this conversation about, “And it saves money”, came in.

Dr Onkar Sahota AM (Chair): Where did that come from?

Grainne Siggins (Member, Association of Directors of Adult Social Services): The BCF came in but there was never, in any of the policy guidance or the policy framework, there was never the comment about it needing to save money. It was about providing seamless care for people so that they had more proactive care.

What there is the potential to do is to reduce demand management. In social care, what we do know is that if people go into hospital in an unplanned way and come out, often, if they have been having a package of care and support previously, their care needs significantly increase. It is about the demand management element, but it was never about efficiency and saving money as a system.

Dr Onkar Sahota AM (Chair): Thank you.

Vivek Kotecha (Research Officer, Centre for Health and the Public Interest): Can I just add to that? When they talk a lot about shifting care into the community, often community care is more expensive because you have higher-level staff and you tend to have more one-on-one support. Compared to a hospital where you could have multiple patients per staff member and the costs are spread out and there are economies of scale, you do not necessarily get that at community level. That is not necessarily a bad thing because you can get better outcomes for the patients and it is generally preferable, but it does not necessarily save any money.
There is a lot of mention in STPs about this as if shifting care to the community is going to save money. What they are trying to say often is that if we can get people to be treated in the community, we do not have to build extra beds for future population growth and demand needs. That is often where the saving is being made.

However, there is a question. If these moves to the community either do not work or if they do not deliver the improvements in healthcare that avoid people going into hospital, given the bed shortage we already have, if we do not build that extra bed capacity because we have assumed these are going to work, that is where the real risk is going to come in. We are going to end up with patients trying to enter a system that cannot handle that many patients. The report by the NAO hit the nail on the head when it comes to that assumption.

**Jennette Arnold OBE AM:** I want to get some answers to some questions about prevention and this whole idea about care closer to home.

Let me just read you some information that I have been provided with. I am told that all London STPs list prevention as a priority and here are some examples. North West London has work and health. South West London wants to work with local authorities on alcohol pricing and both South East and North East aim to improve early-years support. North Central London will be accrediting Healthy Schools.

Let me just go into this last one I just mentioned, accrediting Healthy Schools. We do not have anyone from North Central and so I am trying to get from you some ideas about what you understand by that. In my world, representing the community of three boroughs in North East London, the Healthy Schools programme there is, in some boroughs, absolutely very active. They have partnerships. Some of them have been having Healthy Schools programmes for at least eight years that I know about; in other parts of boroughs, less so.

I do not understand and I appreciate that you might not be able to tell me but I just wanted to get some sense of what do you understand the STP in this particular locality will actually do to enhance Healthy Schools and improve early-years support. Neil, from your Healthwatch perspective?

**Neil Tester (Director of Policy and Communications, Healthwatch England):** I am sorry. I just cannot pretend to be across the detail of every STP in London and so it would be wrong of me to comment.

**Jennette Arnold OBE AM:** It would be wrong for you to say that?

**Neil Tester (Director of Policy and Communications, Healthwatch England):** Yes.

**Jennette Arnold OBE AM:** That is fine. Let us go and see Victoria, a great advocate. You think that they are wonderful and will solve all of our problems. Can you tell me if you have insight into the next level? Just give me something so that I can go away and say to my constituents, “STPs are really going to be good this time around”.

**Dr Victoria Tzortziou Brown (Chair of London Region, Royal College of General Practitioners):** From what I understand about Healthy Schools and --

**Jennette Arnold OBE AM:** It was just an example.

**Dr Victoria Tzortziou Brown (Chair of London Region, Royal College of General Practitioners):** -- from a clinical perspective, we see an increasing level of diabetes and obesity in our population. This puts on a huge amount of demand and need. We need to address this issue. Starting from the early years, we can
have a much larger effect because we can potentially reduce the amount of obesity in children and the future problems associated with obesity. Also, there is some evidence that by targeting children, we can also influence their family’s habits and lifestyle choices. There is that potential by trying to educate children at schools.

**Jennette Arnold OBE AM:** Yes, I would support you there, but why is this not then a common goal for all of the STPs? Surely that would be appropriate for North East or South West. Is it statistically based? Do you have anything concrete? Are these goals based on evidence?

**Dr Victoria Tzortziou Brown (Chair of London Region, Royal College of General Practitioners):** I suspect that the set of priorities that has been set in each STP depends on the local population’s needs, perhaps. That is an assumption. At North Central, perhaps they identified that their younger population has increased levels of diabetes and that is a priority locally. I assume that this has been discussed with local public health representatives and has been identified as a need and a priority in the area.

**Dr Onkar Sahota AM (Chair):** Jennette, maybe you can pick this up with the second panel.

**Jennette Arnold OBE AM:** We can pick that up with the second panel.

**Dr Onkar Sahota AM (Chair):** We can pick it up with the second panel, which will have more details on this.

**Jennette Arnold OBE AM:** OK. Vivek, can you tell me? Let us go back to what Andrew [Boff AM] brought up. We know from evidence that it is those people who are most disadvantaged who are outside the ‘circle of action’, if you like. If we are going to target and do some work on prevention, then really this would be an opportunity to do this.

Do you see that prevention, working with disadvantaged groups and marginalised communities? Has that come up in your review or your understanding of the STPs for London?

**Vivek Kotecha (Research Officer, Centre for Health and the Public Interest):** I would say that, for London, London faces a particular issue even just reaching these people partly because there is a large population churn in some areas. There are people moving around a lot. A lot of people who then walk into A&E are not registered with a local GP, for example. It is hard to reach people when they are not even registered with a local GP.

Public health budgets have been cut across quite a few councils in London over recent years. If that continues and our national-level public health budgets are being cut, it makes it very hard to figure how they are going to help people reach these groups if they have less money to do so. Some of the proposals I have seen so far in STPs, which have been detailed, seem quite optimistic. I am a bit sceptical so far about how they are going to end up reaching these people and whether they will be able to given the shortage of funds available, if anything, to just spend on that.

**Jennette Arnold OBE AM:** Gary, on prevention, when I think about prevention, the GP’s role and the whole primary healthcare team is critical. I am a former health visitor and I am a nurse. Once a nurse, always a nurse. It concerns me when you say from your survey that local GPs were unaware when you asked them about STPs given their role in prevention.
Dr Gary Marlowe (Chair of London Regional Council, British Medical Association): I should just say that it is not just that GPs across London were. STPs are supposed to embrace local authorities and I do not know what the engagement or knowledge is across local authorities, much less GPs.

Just going back to the prevention issue, even if all of the prevention plans – but I do not think they are plans but prevention aspirations because they are aspirations and they are often with a fairly loose evidence base – if they are all achieved, they will have an achievement in maybe 10 or 15 years. These are long-term goals. Every single STP that I have read starts off with the word ‘prevention’, which is very laudable, but actually they are something that we need to work towards for the future. How they are able to be deliberate even within the STP, which as I see it is something that is looking over the next two, three, four or five years, it is very difficult to square that. As I said, they are purely aspirational. If we are looking at public health, it would be much better to have a public health plan across the whole of London rather than the individual five STPs.

From my point – and you talked about health visitors and nurses - we need to be engaging with schools really very strongly. My particular interest in prevention in schools is around mental health. That is something that is very important. We are seeing increased levels of anxiety and depression amongst adolescents and that will be a very important aspect of prevention.

If you look at other things, I made a flippant comment about chicken shops, but across London we need to think about obesity. In North East London we have some of the most obese children and we have a very active public health policy to try to address that, but it is very very difficult to implement that in the face of free-market food and alcohol as well. We rejected the minimum pricing of alcohol. Maybe the Mayor needs to resurrect a London minimum alcohol price.

Jennette Arnold OBE AM: Just staying with you, Gary, no, I would not argue against the focus we are putting on young people, but what about disadvantaged older residents of London? They do not ever seem to feature when people are talking about prevention because it is never too late to bring prevention to an older person with whatever programme that you can.

Dr Gary Marlowe (Chair of London Regional Council, British Medical Association): We have a project locally around social prescribing, which is very much focused on older, isolated people with the very active involvement of the third sector and trying to bring social prescribing in. I suppose there is a bit of preventative work involved in that. As I said, there is lots of good stuff in the STPs and in the detail about it being locally implemented. Social prescribing to prevent isolation would be a very powerful way of doing that.

Jennette Arnold OBE AM: Let me just finish with prevention. Anyone can answer this. Could STPs, over a three-year period, given the partnerships they are working in, be able to tick the boxes because one or other of their partners are going to be doing something towards an aspiration?

Grainne Siggins (Member, Association of Directors of Adult Social Services): STPs do see prevention within the wider context. Health and wellbeing strategies is about supporting people in the general population to think about how they manage their health and wellbeing and quality of life. The majority of health and wellbeing strategies are being refreshed at a local level.

It is important that the STPs that health leaders continue to engage with a whole range of people within local authorities and communities about making health everybody’s business and thinking about how each of us individually engage with our own health and wellbeing and then thinking about how we utilise the health service. There are some behaviours that are not necessarily supportive and hence we see lots of people going into A&E and those sorts of things. Whilst you have your key priorities in your STP where they have tried to
look at some common themed areas - diabetes, for example, which every area is trying to focus on, reducing the increase in diabetes and how effectively it is managed at a local level - they need to think about how that fits in with the health and wellbeing strategies and changing population behaviours. But also many areas have joint prevention strategies, which focus then on specific things where areas are working together at a local level.

In relation to your query about older people, again, this will not be in STPs necessarily but it will be in the borough-level plans that we are working on together collectively as a partnership. For my own local area, we have focused very heavily on how do we engage with our communities to reach socially isolated older people and support them to engage more proactively within the community and think about their health and wellbeing. There is an external reaching into the communities, but you will not see that in STPs because it is too detailed. Many areas across London have the same type of approach where supporting older people to manage their health more effectively and making them have an improved quality of life and feel part of the community is a core part of keeping an older person healthy and active. They will be in the more focused borough-level plans rather than the STPs.

**Jennette Arnold OBE AM:** If we did not have STPs, this work would be going on where it is?

**Grainne Siggins (Member, Association of Directors of Adult Social Services):** Yes.

**Jennette Arnold OBE AM:** An STPs really is like a great big Hoover that will pull up all the information of good practice that is going on in an area?

**Grainne Siggins (Member, Association of Directors of Adult Social Services):** That is my view and I know that we are doing that in our area. That has worked really effectively in tackling diabetes at a local level. Your observation is correct that that is the intention, but recognising that there is a lot more activity happening at a local level.

**Amber Davenport (Head of Policy, NHS Providers):** There are a couple of things around prevention. One thing is that, as others have mentioned, it is a long-term strategy. One of the challenges for the STPs in the process that they went through was that there was quite a lot of focus on short to medium-term sustainability and that may be why prevention has not been as detailed in STPs as they might have been as the focus was more on sustainability.

Colleagues have raised important questions about what STPs should be responsible for delivering and what is better delivered at more of a local level. I do not know the detail about London, but I know that there are some STPs that have high-level aspirations and strategic plans and the detail is delivered at more of a local level. Sometimes footprints are quite large and so it is difficult for them to deliver all of the detail.

One of the key things as well in terms of prevention and STPs, as we mentioned earlier, is that a lot of additional funding is now coming through the STP. The focus on prevention and the need for adequate prevention needs to be raised in STPs so that prevention strategies are invested in in the long term and it is not just focused on short-term goals.

**Neil Tester (Director of Policy and Communications, Healthwatch England):** One of the opportunities here is that, as Grainne has said, all this very local work will have been going on and will not be visible in the STPs, but what the STPs can and should look at is where there is an overlap between the different agendas they are looking at. There are some issues that there is a preventative aspect; there is also an aspect in terms of cost efficiency; there is also an aspect in relation to access to services. The best example I can think of that
is not a London example; it is what has happened up in West Yorkshire, where for a really long time now there has been quite poor access to NHS dentistry for a number of boring contractual reasons. They have had a real impact on people, both in terms of crisis care, but also children’s oral health and also access to oral health services for people from more marginalised groups in those communities.

The STP has finally been the vehicle, because the work that a number of the local Healthwatch have done there was fed directly into the STP lead, who immediately saw the potential and that has gone into the plan, because that ticks an access box, it ticks a preventative box. There is potential for STPs to be able to look at some of these wicked issues slightly differently.

Jennette Arnold OBE AM: Thank you. Let me just briefly move on to care closer to home. As Andrew [Boff AM] mentioned, it is one of these aspirations that have been around for years and no one would argue about that aspiration. It is about how realistic it is to achieve. Grainne, all five London STPs want care to be closer to home, providing better quality care in a more comfortable setting and preventing unnecessary and costly hospital visits. Is there not a problem if the infrastructure has not been set up, if there is a lack of funding to enable this transfer?

Grainne Siggins (Member, Association of Directors of Adult Social Services): As I mentioned earlier, all areas are working towards delivering care closer to home. The financial pressures within local authorities to deliver that within new models of care is a significant challenge. It does not seem to be impacting negatively yet, because local councils are going into overspend positions. We are hoping that the budget position last week will have assisted that slightly, but Child and Adolescent Mental Health Services (CAMHS) are still reporting a significant deficit in the ability to be able to do it, hence my comment previously about the STPs and what they should include. It is just health and sustainability or should it also include the impact on social care? That is not for me to answer.

In terms of other elements of resource, I know you probably have a question on workforce, but it is making sure we have the right workforce in the right places. The challenges on local systems, especially inner and outer London differences, Tower Hamlets you pay £6,000 more for a social worker, and so it is the ability for every area to be able to have the adequately resourced staff and be able to recruit the staff and the same with primary care. Also, you have to have a fit-for-purpose estate in order to actually deliver these from. What we do know is that historically there was a lot of money available for primary care investment in terms of fit-for-purpose primary care.

Dr Onkar Sahota AM (Chair): I am very mindful of the time and I am also very mindful of the fact that we have another panel and so I want to skip some of the questions. Unmesh, come over to workforce, OK?

Unmesh Desai AM: That is right, yes. You just started talking about that, Grainne. I have two sets of questions, Chair, and I am conscious of the time. My first set of questions is to you, Dr Marlowe, Dr Brown and Ms Davenport.

STPs are now moving into their delivery stage. Is the workforce, who, after all are the enablers of change, at the stage where they can deliver the proposals as they stand now? If not, what changes would be required to deliver the proposals and are these achievable within the STP timetable?

Dr Gary Marlowe (Chair of London Regional Council, British Medical Association): As I said, many of the STPs are predicated upon shifting care from hospital to primary care, and I am pretty sure primary care teams are not ready for this. Victoria may disagree with me. Certainly we have a workforce crisis in terms of doctors. Certainly in my own area, it is very difficult to get new partners, it is very difficult to get locums and it
is very difficult to get salaried doctors. It is almost impossible to get practice nurses. Health visitors, where are they?

**Jennette Arnold OBE AM:** It is turning into politics, can I say?

**Dr Gary Marlowe (Chair of London Regional Council, British Medical Association):** Yes. The workforce issue has not been properly addressed in terms of primary care. That is probably my main sort of concern, really. I alluded to the fact that - and probably NHS Providers have a different view - in terms of NHS Providers and certainly in terms of London, we have a very high percentage of European professionals working here, physiotherapists and occupational therapists (OTs), as well as doctors. They continue to be concerned about this.

**Dr Victoria Tzortziou Brown (Chair of London Region, Royal College of General Practitioners):** The workforce and the degree of the financial challenge are probably the two main challenges that STPs face. It is absolutely important for STPs to work with the local Health Education England (HEE) departments and the Royal College and obviously the BMA to ensure that there will be in place the extended teams that are required to deliver this shift of work from hospital to the community. We need to also think seriously about training and how we ensure adequate funding goes into training for all these new roles that are appearing, like pharmacists and physician associates, and also extra GPs, and also think a little bit more creatively about how we use existing staff working currently within hospital environments, the acute sector, and how we bring some of these out in the community if the work shifts that way.

**Unmesh Desai AM:** Can these changes be achieved within the timescale? Organisational changes always take time to see the very best --

**Dr Victoria Tzortziou Brown (Chair of London Region, Royal College of General Practitioners):** We need to be realistic. I see the STPs - and I know I have been described as very optimistic before - as the beginning of the work that needs to be done, but we need to be realistic. We need to be honest about how quickly changes can happen, but at the same time we should not lose hope and give up.

**Dr Gary Marlowe (Chair of London Regional Council, British Medical Association):** Can I just make a quick comment before we move on? Just going back to a project that I was involved in, the one thing I have to say is about moving specialists from hospitals to communities is that it has not been shown to be cost-effective or a good use of their time.

**Amber Davenport (Head of Policy, National Health Service Providers):** We recently surveyed our members on what their top concerns are at the moment. Workforce and finance, as others have said, are top of their concerns, whether that is at institutional level or at the STP level. STPs offer an opportunity to think about how we can use our workforce more effectively. Our members’ concerns are about having the right numbers of workforce with the right skills in the right place, as others have talked about. Again, it will take time. My opening comments earlier were around being realistic about what the STPs can deliver. I would echo what Victoria [Tzortziou Brown] has said in that this is the start of a journey and the STPs offer an opportunity to look at some of the workforce challenges that we have, but we definitely need to be realistic about what can be achieved in the timeframe.

Coming back to shifting care into the community, we are very clear that we need to have adequate investment into community services and ensure that those services are available before we start to shift things out. No one is ever really keen on double-running because it is double the cost, but if we are going to do with safety and if we are going to do it effectively, then that is something that needs to happen.
Unmesh Desai AM: In terms of the timescale, London has doubled the percentage of non-British staff in comparison to the national average, 22% to 10%. With the uncertainty of Brexit and the negotiations and so on, how do you see that affecting the timescale?

Amber Davenport (Head of Policy, National Health Service Providers): I do not know about timescales. NHS Providers is part of a coalition of different organisations looking at the specific workforce challenges that Brexit may pose. As an organisation, we would be keen for our European Union (EU) staff who are working in the NHS to have the right to remain, but I would not be able to comment on timescales.

Unmesh Desai AM: We could be here all day talking about Brexit. My final question is to all of you, very briefly, bearing in mind the time. We have the STP leads following you. What do they need to do to reassure the public that the STP process and proposals will not have a negative impact on the care they receive?

Dr Gary Marlowe (Chair of London Regional Council, British Medical Association): Be realistic about the savings and not come out with figures. I know that I keep going back to this, but they all talk about savings. Be realistic. Shifting care into the community probably does have much better outcomes, but it is not necessarily a cost saving.

Dr Victoria Tzortziou Brown (Chair of London Region, Royal College of General Practitioners): I say three things: be honest, engaging and reflective.

Grainne Siggins (Member, Association of Directors of Adult Social Services): From my perspective, it is about explaining things simply and being very clear about what this means for people at a local level.

Neil Tester (Director of Policy and Communications, Healthwatch England): Everything everyone has said already and also, if the people can convince clinicians, that is who the public will listen to.

Amber Davenport (Head of Policy, National Health Service Providers): Again, I would say be realistic, implement plans at an appropriate pace for that local area and operate within the current institutional and democratic structures that allow you to have that engagement.

Vivek Kotecha (Research Officer, Centre for Health and the Public Interest): I would say just to add to the ‘be honest’ point that they have to be honest about, if these do not work out, with their optimism and the assumptions they have made, what that means for the local services. What is the plan B? A lot of them do not talk about it, but what is the contingency if things go wrong? People want to know that at least so that they are aware of what could happen.

Dr Onkar Sahota AM (Chair): Thank you. Thank you, all members of the panel. I know it has been rushed towards the end, but we do have a second panel to go to. You have given us a lot of substance to work on and so thank you very much. If you think that we have missed some point you wanted to make, please feel free to write to us. We are still taking evidence.

You are welcome to stay for part 2, but I am going to take a short adjournment for about five minutes for us to restructure. Thank you very much for coming along and thank you very much for your input.

(Adjournment)
Thank you very much for bearing with us. Sorry we are starting late, but can I please welcome the second panel? Mohini, if you start introducing yourself from there?

**Dr Mohini Parmar (Chair, Ealing Clinical Commissioning Group and STP Lead, North West London):** Thank you. I am Mohini Parmar. I am a GP. I am Chair of the Ealing Clinical Commissioning Group (CCG) and I am also the North West London Sustainability and Transformation Plan (STP) Lead.

**David Stout (Programme Director, North Central London STP):** Good morning. I am David Stout. I am the Senior Programme Director for the North Central London STP.

**Steve Russell (Executive Regional Managing Director (London), NHS Improvement):** Good morning. My name is Steve Russell. I am the Regional Director for NHS Improvement in London.

**Jane Milligan (STP Lead, North East London STP):** Good morning. My name is Jane Milligan. I am the Chief Officer for Tower Hamlets CCG and am also the North East London STP Lead.

**Mark Easton (Programme Director, South East London STP):** I am Mark Easton, Programme Director, South East London.

**Daniel Elkeles (Chief Executive, Epsom & St Helier University Hospitals Trust, attending on behalf of South West London footprint):** Hello. My name is Daniel Elkeles. I am the Chief Exec of Epsom & St Helier Hospitals and I am here for South West London STP.

**Dr Onkar Sahota AM (Chair):** Great. Thank you, everybody, for coming this morning. You may have heard some of the discussion in part 1, but I am going to open it up with a general question to all of you. What are the specific challenges for London STP footprints as you see them? Mohini, shall we start with you?

**Dr Mohini Parmar (Chair, Ealing Clinical Commissioning Group and STP Lead, North West London):** Thank you, Onkar. The STP delivery across health and social care will be a challenge. The specificity in the challenge for us is the scale of change and the timelines of what we need to deliver to ensure that we have quality of care and sustainable services, both from a workforce and from a financial perspective. The big challenge within health is that for the day job we still have to deliver high-quality services while we undertake transformation for what is right to address the needs of our population.

The other challenge is of course especially in London, we are working across multiple organisations. As you know, in North West London we have already been working together, the CCGs, for a period of time and as providers. Now we have our local government colleagues with us working very closely and we are working across multiple interfaces with the workforce. Therefore, the change management and how we take our workforce with us is a challenge.

**David Stout (Programme Director, North Central London STP):** We all face fairly similar challenges. I suppose I would start with how the STPs are intended not just to be about money but are also about improving quality of care and improving health outcomes. The challenge is to do all three, not just one of those. The panel you heard earlier talked about workforce challenges. They are real, the challenges around how we manage, as Mohini says, the transition at the same time as keeping the show on the road and focusing on delivery rigorously, not just thinking that the STP is a plan that we write and submit somewhere, but focusing on actually delivering the change for real at a local level, not simply at an STP level.
**Steve Russell (Executive Regional Managing Director (London), NHS Improvement):** Great question. I would probably draw on four or five key challenges. The first is very common to all of the STPs, which is the changing needs of the population across London. It is very different now than it was years ago and that is what many of the STPs are trying to address, fundamentally.

The second is workforce. Notwithstanding the changes that STP areas are trying to make, I think all of us would recognise that London and indeed England faces quite significant workforce challenges across all professional groups. The third is trying to achieve all of that change and deliver good services for our citizens within the resources that are available. You heard the earlier panel touch on some of those challenges.

There are two that I might just call out. One is to build on Mohini’s point, there is a lot to do in delivery of the STPs. In their ambitions, they have positive and compelling arguments for change, but those things do not happen overnight and do not happen without very very significant effort and time commitment of people who are very busy treating and looking after people who become ill across London.

Then the last one that probably I expect you will probe us on later is taking people with us. STP is an acronym. It does not mean very much to people, but STPs are made up of health and care professionals who are trying to fundamentally change the system that serves residents across London. Trying to make sure that that is owned, understood and believed in by citizens across London and elected representatives is a big challenge for us all.

**Jane Milligan (STP Lead, North East London STP):** In North East London specifically, we have clear challenges in terms of our population growth, real pockets of change in boroughs such as Newham and Tower Hamlets, but also in other areas such as Havering and increasingly also Barking and Dagenham. Over the next 15 years we have a projection of about an 18% increase. That is already on a population which has quite a high level of variation with pockets of real deprivation in health inequalities but also pockets of wealth and to some extent a real churn of people across the patch often not necessarily moving out of North East London but moving between boroughs, which for a number of practices means that they have a turnover of about 40% to 50% each year. That is a significant issue.

The other thing is that, as I said, workforce is a real challenge for us. Grainne [Siggins] made the comment that we have perhaps areas where it is easier to attract staff, possibly in inner North East London as opposed to outer North East London. Part of that opportunity is to do something about that, but the other thing is that we have quite a large variety or variations in care, whether it is at an acute hospital base, social care or in primary and community care, but we also have some fantastic examples. For us, it is about how we really draw that across and do that sharing. As I say, we have had a long history of partnership working in the patch, but this is the first time that we have really tried to bring local authorities with us as well.

The other challenge I would say for North East London is when the STPs popped out of the system, we had three systems already working towards transformation. Trying to knit together the Barking, Havering and Redbridge devolution pilot and the City and Hackney devolution pilot together with the Waltham Forest, Newham and Tower Hamlets Transforming Services Together transformation plan, as I say, is also part of the challenge, but an opportunity as well.

**Mark Easton (Programme Director, South East London STP):** If we go back to what STPs are designed to do, they came out of the plans to implement the Five Year Forward View, and in particular to address three gaps that were identified in the Five Year Forward View. There is the health and wellbeing gap with an emphasis on prevention, there is the quality gap addressing questions of variation, and thirdly, there is the financial gap. Most STPs have three broad strands that try to address those gaps and South East London is no
different. We have one strand which is improving access to primary and community care with the development of things like local care networks across South East London and the expansion of access to primary care.

Secondly, we have a productivity strand, which is about getting our providers to work together in ways that are more efficient to reduce costs and, thirdly, we have a work stream that is about secondary and tertiary care pathway redesign. We have eight clinical leadership groups, as the name implies they are led and generally run by clinicians, aiming to improve pathways of care and aiming to hit quality standards. That is the STP in a nutshell.

Daniel Elkeles (Chief Executive, Epsom & St Helier University Hospitals Trust, attending on behalf of South West London footprint): My answer is very similar to the rest of the panel. In South West London, we have a growing population and it is an ageing population. There are a lot of diverse health needs. Lots of people who live in South West London would say that they do not experience the quality of healthcare both in hospitals and in community settings that they would like to receive. There are lots of workforce and estates issues. There is clearly delivering all the healthcare that people expect within the money that we have available. Then we need to also acknowledge the complexity of the landscape that healthcare is provided in and also the complexity of the conversation that we need to have with people about the future of how healthcare should be provided to enable them to live the best lives that they can.

Dr Onkar Sahota AM (Chair): Great. Thank you very much. There is consensus that we all want people to have better healthcare and we want it to be better delivered and to be integrated. Let us take that for granted. There are three things that came through that we need to explore. One is finance, the second is engagement and the third is the workforce. We will explore these in a bit more detail.

I want to talk about the finances. The STPs, when I read them, sit on the premise that, first, more healthcare can be shifted away from hospitals into the community and that this is cheaper and, second, by shifting this hospital care from the hospitals into the community, we can close some of the hospital beds because if you could not close those hospital beds you would not have the savings.

Can you first off tell me what the evidence is to say that shifting healthcare into the community is any cheaper than doing it in the hospital sector? What is the evidence on which your premise bases upon?

Dr Mohini Parmar (Chair, Ealing Clinical Commissioning Group and STP Lead, North West London): Thank you, Onkar. What is important for us to deliver is that the patient or member of the public has the right care at the right care setting that is appropriate to their needs. That has always been the premise: that it is right for the patient, right for the family and right for the system. There are times when it is absolutely correct that the hospital is the right care setting for that patient but, but there are times for example, the evidence for that is for older people who get dementia, who get a minor illness and go to hospital. We know that day on day, after day 2, there is a stark deterioration. Therefore, the hospital is not the right care setting for that patient and it is appropriate to provide care for them, in the same quality care, in an out of hospital setting. That is what we are trying to do.

The question of whether it is cheaper is a good question because if you are going to provide the care and give the evidence and the assurance to the public and to the workforce that it is the same high quality, it may save money in certain settings and it may not save money in other settings, but it is also around the workforce and the sustainability of that. It is important for us to recognise that it is the right care setting for the individual rather than it being hospital or out of hospital and being that binary.
David Stout (Programme Director, North Central London STP): Let me give you a specific example from my hospital. We now have a team of 60 clinicians who are made up of GPs, council social workers, reablement staff, the community nursing staff and our own staff. The purpose of this team is to see who could we look after in their home rather than admitting them to the hospital and, if you are admitted to hospital, how can we ensure that you spend only the appropriate time in the hospital and then your care is provided in your home. This team is looking after now 20 patients a day in the community. It is run based in the hospital. The impact on those patients is very profound. We have done lots of video blogs about what is it like for those patients to have their carer at home and they say, “This is so much better to have the reablement and the rehabilitation in my house rather than the hospital. I am getting better more quickly”. We have looked at the cost of providing that care and it is half the cost of someone being in a hospital bed.

Perhaps the most important thing about is that it has enabled us to have a much better flow through our hospitals, so that we are delivering the accident and emergency (A&E) standard, because we can admit the people who need to be admitted because we have the beds. Also, we have managed to bring back all our planned care surgery that last year we could not fit into the hospital because it was full and was done in the private sector. It is now all being done back in the NHS. The impact on the local NHS is huge. It is about improved quality for the patients and much better staff satisfaction. The people love working in the team and also we have improved the finances. It is a really good example of how everyone working together makes a big impact on improving healthcare and sorting out financial issues.

Steve Russell (Executive Regional Managing Director (London), NHS Improvement): Could I just comment on your premises? Because the first premise we work on is whether there is actually going to be money in the NHS in five years’ time. The resources available to South East London go up by something like £1 billion over the course of the next five years. Our problem is that if we are not careful, our costs will go up by more than the £1 billion that is available to us. It is about how we cope with the increase in work with the amount of extra money that is available. Our hypothesis is the way not to deal with this is simply to continue to expand secondary care as we have been doing, because if we do, we will need to build another hospital in South East London. We do not have a site to build a hospital in South East London and we do not have the workforce for another hospital in South East London.

Probably more fundamentally, that would not be the right care model because if you look at 100 years of investigations into the London health service, what they all say is that the London health service is too skewed towards secondary care and does not have enough primary and community care. Primary and community care has always been relatively underdeveloped in London compared to the rest of the country, so what our proposal is, we cope with the expansion in demand by improving access to primary care and community care and associated social care. We have lots of examples in London of how there are people currently sitting in hospital beds or sitting in A&E departments who could more effectively be treated in the community. Daniel has given you some examples of that.

The third premise we have is that the system can be more efficient. There are good examples of hospitals paying different prices for basic standard stuff. That is why we think it is a good thing for hospitals in South East London to work together on things like procurement, on things like back office, doing the kind of things that councils in London have actually been doing for quite a long time. If you do that, then the STPs can make a contribution to the funding gap that we are going to have in the Health Service over the next five years.

Dr Onkar Sahota AM (Chair): South East London is expecting £1 billion in the NHS budget or the social services budget or the combined budget together?
Steve Russell (Executive Regional Managing Director (London), NHS Improvement): The amount of NHS resources available in South East London will go up by about £1 billion over the next five years. Health service budgets are going up in cash terms and those bits of the NHS that rely a lot on access to specialist commissioning, as we do in South East London, have a bigger increase. The increase in funding in specialist commissioning is actually bigger than the increase in funding for baseline CCG funding. One of your Members pointed out earlier that the health service budget is getting bigger. The problem we have is that the rate of increase in demand will outstrip the increase in funding if we are not careful.

Dr Onkar Sahota AM (Chair): There has been no cut in the social services budget - 40% right across the country - and you are not aware of any cuts in social services?

Steve Russell (Executive Regional Managing Director (London), NHS Improvement): Our STP sets out the reductions that local government is facing. We all know that local government is facing funding reductions and part of the work of the STP is to find ways of mitigating that. The bulk of the work actually takes place at borough level, because the borough relationship between CCGs and local authorities are clearly very strong. Local government does not particularly work on a six-borough basis in South East London, but there is lots of work we can do together between health and social care to mitigate the impact of the cuts. There is the Better Care Fund; there is the integration both of commissioning and provision of health and social care. Clearly, it is incredibly important we work together to try to address some of the issues that are coming up because of the reductions in social care funding.

Jane Milligan (STP Lead, North East London STP): I was just going to add that I suppose we just need to be a bit clear about what we mean by shifting care into the community. In many respects, that is where 90% of health and social care happens already. As other colleagues have said, it is about ensuring that we have got the whole system aligned to help support that. Daniel made reference to the fact that healthcare particularly - and social care to some extent - is delivered in quite a complex way. One of the opportunities with the STP or working in a partnership approach is to be working much more closely with our acute colleagues and the service models that do support primary and community care and social care to deliver that care back at the ranch. Essentially that is, as Daniel says, the same for everyone: people want to avoid hospital at all costs.

Again, we have models and I talk about hospitals having osmotic or leaky walls whereby clinicians and consultants do what they are supposed to do, which is to consult and reach out into supporting community teams in the locality model that wraps around, whether that is a diabetologist or a geriatrician, and mental health is another good example where we can help provide a way of managing risk, sharing expertise and really supporting patients and families back in their communities. When we talk about the definition of shifting care, it is not about lifting, shifting and dropping; it is about working across the whole pathway.

David Stout (Programme Director, North Central London STP): Just one point I would add is that, coming back to where Mohini started, we have done a bed audit across our acute and community beds. Like every other part of the health service in this country, we have hundreds of people who are in beds and do not need to be there. Not only is that bad for them and bad for the taxpayer because it is not very efficient, it is also bad for the individual who is losing independence, who is having muscle wastage and whose prospects get worse by being in the wrong place at the wrong time. If we can plan and deliver services in a better way, we will achieve better outcomes and better quality of care.

Dr Onkar Sahota AM (Chair): Your assumption is those people who are in beds will be provided for somewhere in the community and so there is a need to put the services in the community before you can do the change. You accept that?
David Stout (Programme Director, North Central London STP): Yes, we need to invest in the capacity to enable people to move out when they are ready to go. There is a gap in capacity currently and so we need to invest upfront, absolutely, to achieve the change that we are --

Dr Onkar Sahota AM (Chair): Is there enough funding in the system to give you the opportunity of building the community services and the services in the community before you close the hospital beds down?

David Stout (Programme Director, North Central London STP): Yes. We have no plans to close hospital beds down. We plan to avoid having to --

Dr Onkar Sahota AM (Chair): Of course there are plans. I mean that we have had bed closures in my part of the world.

David Stout (Programme Director, North Central London STP): I am not in your part of the world.

Dr Onkar Sahota AM (Chair): My part of the world is North West London.

David Stout (Programme Director, North Central London STP): In North Central London, we are planning to invest upfront in increasing primary care capacity and community capacity – that could be health or social care – to enable us to achieve what I just described.

Dr Onkar Sahota AM (Chair): Yes, Dr Parmar, talking about North West London, there are hospital bed closures there.

Dr Mohini Parmar (Chair, Ealing Clinical Commissioning Group and STP Lead, North West London): As you can see from the North West STP, there is a clear shift of resource from the acute to community and mental health. I cannot remember the exact percentage shift. There is a complete recognition that over the last ten years, we have not resourced primary care and community effectively. As Mark pointed out, there is a skew in London towards the secondary care sector and this is about resetting some of that. From a patient perspective, the care that they should receive, whether it is primary care, community care, the hospital, it should be the same. It should be streamlined and should work across the system. It is fair to say as clinicians, it feels fairly fragmented at this point in time.

The STP allows us an opportunity to aggregate that up and to make it more streamlined. The investment in the community and primary care absolutely needs to happen. We have done. As you know, in Ealing, our integrated care service is a jointly-commissioned service with Ealing borough, where we have social workers and intermediate care service therapists sharing under one management team to provide a seamless service. That is absolutely the piece of work that needs to happen. There is a complete recognition that there will be absolutely no bed closures until such time as we can demonstrate we have the capacity, the capability, the workforce, the pathways and the assurance to the public that it is right to do so. I have already said that.

Dr Onkar Sahota AM (Chair): The challenge that the STPs have is that there have to be efficiency savings made. That is one challenge the STPs have. At the same time, the challenge is of course how you provide the good quality care reassurance for the public. Do you see this as fitting a round peg in a square hole or can this be achieved, in your views?

Dr Mohini Parmar (Chair, Ealing Clinical Commissioning Group and STP Lead, North West London): It is a really important question, actually. How do we continue to deliver business as usual? Our business as usual is about safety and quality and about people’s lives, and we have to do that all the time. It is really
Dr Onkar Sahota AM (Chair): Does it save you money?

Dr Mohini Parmar (Chair, Ealing Clinical Commissioning Group and STP Lead, North West London): In the plans, we are saying that if you do streamline some of these services and take some of the handoffs off, we may be able to drive some efficiencies within the system. There is an active recognition in the GP’s Five Year Forward View that we need to invest in primary care because there has been a real reduction in that over the last eight years.

Steve Russell (Executive Regional Managing Director (London), NHS Improvement): It is a very good question and it is not the case that every single part of the patient population that we treat in hospitals could be treated in the community. It would be absolutely more expensive and probably inappropriate to treat somebody who needs intensive care in their own home— that would be much, much more expensive — but there are good examples where it is more cost-effective in an alternative setting because hospitals are generally the more expensive part of the health and social care systems. For patients who do not have a life-threatening illness or an immediate serious health problem, it is more cost-effective for someone to be seen by their GP than in an A&E department. That is relatively well rehearsed. It is not as straightforward as A equals B, if that makes sense. You have to look at it in a slightly different way.

To your question of whether you can do both at the same time, there are some good examples where this has happened in the past. Stroke services have changed across England. I remember being a service manager of a stroke service in 1998. Stroke services now look very very different. In the northeast we were able to make changes to an old model of care that was a hospital bed-based model of rehabilitation after someone had a stroke and replace that with a community-based team. Which first and foremost, was what patients wanted because they preferred to be at home. Secondly, it led to better outcomes because people tended to get better faster in their own environment. Thirdly, it did save some money. It was not a huge cost saving but it did make better use of the resources we had. And all hospital systems, all health and care systems will have done that and do that every year. However, the challenge you are nudging at is that STPs have to do that faster and on a bigger scale. In some cases it will absolutely be more cost effective to look after patients in their own homes. In some cases it might not be, but it will still be a better thing to do for the patient than it is to look after them in a hospital setting.

Dr Onkar Sahota AM (Chair): The Nuffield Trust said the Government’s plan to save money by shifting care into the community is built on sand. The Royal College of Physicians said financial demands and severe pressures on services have acted as a barrier to transformation despite good collaboration between local authorities and NHS organisations. It then goes on to say:

“This background resulted in a double jeopardy, not having enough staff and resource to introduce new parallel services to see if they can really work in integrating health and social care, improving patient’s experience and producing efficient savings and the danger of any potential investment being siphoned to meet the acute crisis.”
The experts are saying you need to run a parallel service and that transformation is being hampered by a lack of funding and human resources in the system. You have quoted examples of stroke care and heart centres. The Assembly agrees with them.

However, we are talking about a large-scale transformation of a service that is under pressure on resources and has a lack of human resources. At the same time you have been charged with saving money. How can you deliver it? How can members of the public living in London be reassured that these changes will work for them and that they can be delivered safely?

**Mark Easton (Programme Director, South East London STP):** It might be helpful to give a couple of examples. Two of the most common things people are admitted for are diabetes and asthma. How do we reduce the number of people admitted for that? One good way for asthma is the Mayor’s strategy on cleaning up London’s air. That is primary prevention and is a very good thing to do. That will, in the long term, help tackle admissions for asthma. A lot of modern medicine is managing long-term conditions in the community and managing them well so people do not have an exacerbation of their condition and end up needing to be admitted. I have gone on visits with specialist chronic obstructive pulmonary disease (COPD) nurses who have a caseload of people at high risk of admission. They visit people in their homes, monitor their condition very carefully and pick up when the patient’s condition is deteriorating so they can intervene before they need a hospital admission. That is the way medicine in the 21st century needs to be delivered. The population is getting older. People are living with multiple long-term conditions. We need to intervene directly earlier with the aim of preventing hospital admissions. That is a good example of how you can both reduce the number of admissions and help people live better and more productive lives in the community.

**Dr Onkar Sahota AM (Chair):** The converse evidence is that the demographic of the population is changing and that people admitted to hospital have more complex conditions. We are not talking about asthma or diabetic admissions. We are talking about more complex patients with multiple morbidities. What is clogging our hospitals are not asthma or diabetes patients.

**Mark Easton (Programme Director, South East London STP):** With respect, if you look at the admissions there are very, very large numbers of people being admitted for those conditions. I absolutely agree there are people coming in with multiple morbidities but they are the people who really need to be in hospital. It is the people we can prevent getting into hospital, with moderately simple conditions. That needs to be targeted.

**Dr Onkar Sahota AM (Chair):** That implies more investment in social and community services. There is a lack of 6,000 doctors and 10,000 nurses in this country and we cannot even find a health visitor. How do you address those issues?

**Daniel Elkeles (Chief Executive, Epsom & St Helier University Hospitals Trust, attending on behalf of South West London footprint):** Building on Mark’s example of how we can look after people with chronic conditions before they come to hospital, we have had lots of conversations in our hospital with the clinicians and asked, “What does it look like to get it right for the patients when they come to hospital? What does a good service look like?”

We ended up having a conversation with GPs. You might refer a patient you have seen in practice to our hospital. They come to A&E and are seen by the most junior doctor in A&E. You are a senior decision-maker and you think they need to come to hospital. In the conventional system they would come to hospital, be seen by a junior doctor in A&E, then a middle-grade doctor in A&E who would say, “Actually, this is a medical patient”, and then refer them to a medical middle doctor and finally you get to see a consultant. That is a whole heap of money to do all those consultations but it is not getting the patient the decision they need.
made quickly and by the right person. In our hospitals we have completely changed it and said, “If a GP is referring someone to the hospital the GP wants the patient to be seen by a really experienced senior doctor”, and so they are now all seen by consultants directly. Because the consultants are senior decision-making doctors and they know the GPs, very often what happens now is the consultant picks up the phone to the GP and says, “I think we can look after your patient like this”. Very often that is by putting more support into their homes or, “Let us arrange this diagnostic on an out-patient basis”, or, “Let us do it like this”. A third of the patients do not get admitted to hospital. You have made a much better patient experience and also saved the NHS a lot of money.

If you couple that with the pathway Mark was talking about, letting us provide much better long-term condition management in the community in the first place, that is how you begin to make what the STPs are talking about, a real shift of, “Let us not make everything in hospital but make a joined-up health and care system real”. You can do it now with the resources we currently have.

**Dr Mohini Parmar (Chair, Ealing Clinical Commissioning Group and STP Lead, North West London):**

Building on that, one is the rapid response, the front-end of the door. The second is the flow within the hospital. We know we have 300 people in North West London waiting for diagnostics. It is not a good use of resources. That is absolutely where health and social care work to take people out in the right care setting. That impacts very quickly in a mental health setting that is completely the wrong thing for patients. It is all three parts of the system coming together. The STP allows that opportunity for us, as providers and commissioners across a geographical footprint, to say “we are providing care for the needs of our population to look at the front-end, the middle and the back-end”. As you know, in North West London we have adopted the seven day. We are just starting to get some data coming through on that. However from the workforce perspective they find it much better to come to work a Monday morning and not feel they have to take over all the stuff that did not happen over the weekend. It is also better for patients. All parts of the system need to work together, including social care.

**Dr Onkar Sahota AM (Chair):** The other thing, of course, with the argument about shifting care into the community is that there is the assumption in the system that we can reduce the number of hospital beds. We are talking about right across the system. The argument seems to be that if you give better care in the community we need less hospital beds and that hospital beds can be closed. We already run an occupancy rate of 95% in this country and demographics show it is particularly in London. How do we justify that?

Last week a report was produced by Sir Brian Jarman [Emeritus Professor, Imperial College School of Medicine] who said that hospital beds and the number of doctors in the system are a great determinant of morbidity and here we already have a system that is running on this. How do we justify that argument that we can close more beds?

**Dr Mohini Parmar (Chair, Ealing Clinical Commissioning Group and STP Lead, North West London):**

There have been two other similar reports that have come out recently, The King’s Fund on the STP and the Nuffield report. It was a very good document, saying what actually works in a hospital.

Regarding the whole issue around beds, if we work on what every day-of-care audit is telling us there are people sitting in hospital beds who could be cared for in a better care setting. Therefore, how do we improve the flow - as Daniel quite correctly said - so that we can get some of our planned care stuff? If we are using all our beds for non-elective, people are not getting their elective hips done. That is the report that came out yesterday from The King’s Fund. Therefore we would improve that system as well. People are waiting for diagnostics across the piece. Reduction in the length of stay is where you could start to look at how you would use beds differently.
Also we are, in a lot of ways, providing care differently. We have moved away from people being admitted to hospitals for three days to an ambulatory care setting. Every hospital is now looking at a frailty assessment, recognising for older people we need to assess them in a different way. We have paediatric assessment units that are saying we can look at children and they do not necessarily need to be admitted, you can treat them and send them out. Different models are coming up. People used to be admitted for seven days for a cholecystectomy, they now go out in 24 hours. We are changing the way we provide care because of technology and different ways of working.

David Stout (Programme Director, North Central London STP): None of us thinks the current system is perfectly efficient. I am sure you, in your clinical experience, do not think the current system is perfectly efficient. There are plenty of things we can do to improve the way we deliver care. You would not start by taking beds out of the system. None of us are proposing that. We are proposing to improve the way we deliver care and monitor its impact on demand. The plans would seek to mediate the growth that would otherwise happen. We are assuming if we did nothing there would be 3% growth in demand on hospital activity. The things we are seeking to do initially are to avoid that happening through better co-ordinated care better invested out of hospital and to mediate against growth, and then if we can get to the point where we need fewer hospital beds and we can use those resources in a better way that is a great thing. If we cannot then at least we have maintained current activity without having to have massive capital investment in sites that we simply do not have, as we have already said.

Jane Milligan (STP Lead, North East London STP): Just to add to that that a part of the STP partnership is about sharing where it works well. In North East London we have the East London Foundation Mental Health Trust and the North East London Foundation Mental Health Trust. That is obviously a specific population but their bed occupancy levels are under 80%. The reason for that is because of the whole pathway approach, working with social care and voluntary organisations such as housing associations. There is a very clear place for people to move in and out of acute care when they need it and also supported, with health and social care, care into work and back to their homes. That is a really good model. In many respects from a physical health perspective some of the challenges we are trying to crack, mental health have already had a good go at it. It is about, “What do they do that we could share?”

Dr Onkar Sahota AM (Chair): The other thing was the upfront funding. I know North West London asked for £500 million to be upfront. Do I have the figure right, Mohini?

Dr Mohini Parmar (Chair, Ealing Clinical Commissioning Group and STP Lead, North West London): That is our capital ask.

Dr Onkar Sahota AM (Chair): What we have been given is £250 million for the whole of the country. How does this lack of upfront funding affect the implementation of STPs?

Dr Mohini Parmar (Chair, Ealing Clinical Commissioning Group and STP Lead, North West London): I probably have to take it in three parts. There is some stuff we could be doing in any case. We have discussed this, as you know, across North West London. We have a joint health and social care transformation group where we have leaders of the councils, NHS chairs and chief executives sitting together. That is starting to form a governance structure and saying, “There are places where we need to invest differently. Let us do it now because the evidence suggests that.”

We also know that as part of Shaping a Healthier Future and our consulted programme that we require capital investment to make some changes at scale. That requires investment both in the acute sector and in the
community. There are almost £150 million worth of requests for investment in GP premises and hubs to deliver that integrated model of care. It is very much linked to the primary care at home that has been talked about where you are wrapping services around a population of between 50,000 and 100,000. Yes, we need the capital to make that happen. Are we going to stop starting the delivery for that? No. We have been doing that for the last four years as part of our Shaping a Healthier Future whole system integration work and the Better Care Fund. That work continues irrespective. Yes, we do need the capital.

Dr Onkar Sahota AM (Chair): I will be handing that over to one of my colleagues later on. In a recent speech by Simon Stevens, Chief Executive of the NHS, when he was speaking to the Nuffield Trust Health Policy Summit, he said:

“More older patients inevitably means more emergency admissions and the pressures on A&E are being compounded by a sharp rise in patients spoke in beds awaiting home care and care at home places. There can no longer be an automatic assumption that it is okay to slash many thousands of extra hospital beds unless, and until, there are really better alternatives in place for patients.”

Why are there proposals to slash hospital beds? Is the system going to now stop and think about can we do this right? He has put a three-pronged test to be applied. The Shaping a Healthier Future relies upon slashing hospital beds at Charing Cross and Ealing. Are we going to put a stop to that, according to what Mr Stevens has now said?

Dr Mohini Parmar (Chair, Ealing Clinical Commissioning Group and STP Lead, North West London): What Mr Stevens said is that there should be a clear process of assurance that we have the capacity, capability, workforce and pathways before we make the changes. That is absolutely right and correct. As you know, we have done that with the maternity and children’s services changes. We have ensured capacity in maternity. We have capacity in North West London to take 36,000 deliveries. We currently only deliver 29,000. We have built in capacity. Similarly with paediatrics, we went for 127% of capacity before we made the changes on the Ealing side. There is complete recognition that we need to have that in place. We have also agreed across our STP that when we do the assurance, and as and when the time is right, we will work with our local government colleagues because the impact that came out in the previous plan was the impact on social care. In North West London we have determined that and that is part of our STP that when you move care out of hospital it has an impact across the entire health and social care economy that needs to be taken into account. What Simon Stevens was saying is absolutely correct. That is exactly the principles we will be following in North West London, and have done in the two changes we have made.

Dr Onkar Sahota AM (Chair): I do not want to be dissecting North West London here because this would turn into a North London meeting. I want to put it on record that the STP is not signed by the London Borough of Ealing and also Hampstead and Fulham for obvious reasons. Those two leaders have refused to sign up to the STP. The amount of work in between those things is not ideal but I do not want to dissect that in detail here. As a principle it is well established that there will be no hospital closures unless there are provisions in the community, as outlined by Mr Stevens.

Dr Mohini Parmar (Chair, Ealing Clinical Commissioning Group and STP Lead, North West London): Although I completely recognise that Ealing, and Hampstead and Fulham have not signed up to the STP, but I can say that on a local level of delivery in Ealing I work hand-in-glove with my local government colleagues and we have jointly commissioned and delivered services and I do not see that changing.

Andrew Boff AM: The public know there needs to be transformation and would welcome any efforts to transform the NHS to be right for the 21st century. It really is not at the moment and the public realise that.
How would you respond, bearing in mind that the public are probably sympathetic to transformation in the NHS, to the criticisms about the lack of engagement with patients, frontline staff and wider stakeholders? How have you responded to that criticism? Do you think it is not deserved?

Steve Russell (Executive Regional Managing Director (London), NHS Improvement): It is a fair challenge. It is not an unfair criticism of the process we have been through. Although STPs arrived at a point in time, lots of health and social care systems already had arrangements in place to discuss the future of health and care services with their local populations. I would accept the point that they were sometimes variable and some were more effective than others. However, the health and social care system does have a history of talking to its local communities, imperfect though it has been. The STP process has brought into focus the need for a more coherent and stronger dialogue with local communities. I think all of us sitting around this part of the table would probably accept the challenge that we could always have done those things better. I am sure the STP teams will chip in but in many of those areas, in fact in all of them across London, there is now positive and constructive engagement going on - using existing forums where possible, to your earlier challenge that citizens do not recognise what a STP is - to discuss what the ambitions of the STP plans are and to get people’s views on them across the five STPs in London. It is not an unfair challenge.

Mark Easton (Programme Director, South East London STP): It might be helpful to set out some of the things we are doing. Of course, engagement, strategic planning and transformation did not start with the invention of STPs. Quite a lot of the STPs are building on a legacy of work that has happened over the last few years. In South East London we started a programme called Our Healthier South East London in 2013. The STP is a recognisable development of the work we started in 2013. Before the STP was even thought of we had embarked on a series of public engagement events. We had over 2,000 citizens in South East London involved in those. We have a joint overview and scrutiny committee. We were one of the first to publish our STP last year. All of our plans, delivery plans and all of the background work is available on our website.

We work with a patient and public involvement group. One of your previous witnesses said they were not aware of any groups of that kind. We have been running one in South East London for a couple of years. They have been involved in the design of all the clinical leadership groups. One of our most high-profile projects is on changes to orthopaedics and the possibility of centralising orthopaedic services. We have had patient representatives on the groups that have been designing that work. We have also established things like stakeholder reference groups where we have had particular services we wanted to get public engagement on. The next phase we are going into is what we slightly grandly called a period of civic engagement, whereby we are planning to hold a public meeting in every borough. We are taking advice from the local voluntary sector and from Healthwatch on how we access hard to reach groups, making sure we go both through digital channels and conventional channels to make sure we get as broad a scope as possible. We work very closely with Healthwatch. Healthwatch have provided a critique of our STP. We have responded to that critique. We are meeting with them again on Friday to develop discussions about how the STP is evaluated. I give South East London as an example of the kind of work that probably all of my colleagues in London are doing to make sure that we get the best possible public engagement.

I am not sure we should necessarily be too worried by surveys which say that people do not recognise the STP brand. It is an acronym that sounds like management speak. I suspect there are lots and lots of people whom we have involved in the STP who do not realise it is the STP, including some clinicians. When we have meetings about expanding access to primary care it is quite possible a lot of the people in that room do not realise that it is a STP initiative. They just think about extending the hours..
Andrew Boff AM: The problem there, as was alluded to in our first session, is if people do not get the whole connected plan they might come to a view on one of the strategies that may change if they saw it as part of a whole.

Mark Easton (Programme Director, South East London STP): We have to recognise there is a branding issue with STPs. If you Google STPs what comes up is secret plans for cuts. That is not what I think a STP is but it is a public narrative that is out there.

Andrew Boff AM: Everyone should avoid three-letter acronyms (TLAs). They are very bad and not very transparent.

If there is significant political opposition to those STPs do you see room for the plans to be revised rather than completely abandoned?

Mark Easton (Programme Director, South East London STP): There is a long track record of the NHS revising its plans in the face of engagement with stakeholders. We have had some experience of that in South East London.

Andrew Boff AM: The Chancellor of the Exchequer has just had an experience of that as well.

Mark Easton (Programme Director, South East London STP): The important point I would make is that STPs are not blueprints chiselled out in stone. They are plans which will change and develop over the course of the next five years (a) as we engage more with the public and clinicians, and (b) as we get experience of what works and what may not be working so well. When I am challenged and people ask if I can guarantee that every line of the STP will work, my response is that it is not 100% going to work but over the course of the five years we will work out what is not working so well and try to fix it.

David Stout (Programme Director, North Central London STP): Picking up that point, we very explicitly published our plan as a draft. We published it as a draft because (a) it was not finished, and (b) we wanted it to change as we wanted to engage with stakeholders - be they politicians, local people or our staff - to improve our plan. Our plan in October undoubtedly was not finished. It is absolutely not chiselled in stone. It is set out there as something to work from. It is the first cut of a plan, not the final version.

Unmesh Desai AM: I have three questions, my first question is to all of you on the workforce. What steps need to be taken to ensure there is a workforce that can support the delivery of all these STPs?

Dr Mohini Parmar (Chair, Ealing Clinical Commissioning Group and STP Lead, North West London): Across North West London - because we have a long history of working together, both as commissioner and providers - we have a workforce transformation programme that was set up three or four years ago. We have looked at the various changes we have done. For example, in maternity we recruited a whole lot of new midwives. From our paediatric changes we got 16 new paediatric nurses. We changed the way people work and it made it attractive for people to work there. We are working on a Capital Nurse programme. We are looking at clinical pharmacists and so across North West London we are looking at clinical pharmacists working in primary care. For example, in my practice we never had a clinical pharmacist. I now have one working five days a week. It has completely changed the way we work.

We are looking at recruitment and retention. We are working very closely with Health Education North West London, which is pretty much part of our delivery team, to map through what the workforce is, what the gaps
are and how we need to address them. That workforce is one of the biggest challenges. The other thing is that it is not about numbers, it is about the work we do and how we work differently.

**David Stout (Programme Director, North Central London STP):** We have a workforce work stream, as we call it, which is linked into Health Education England. It has social care input. It is looking at both the changing roles we are going to need as we change clinical models, but also how we can work effectively as a whole system to attract new and retain existing staff and how we can reduce reliance on locum and interim staff so we get productivity gains without making any change to staff numbers. It is one of the biggest enabling programmes in our whole programme because we recognise it is probably the most limiting factor to change. If we get this wrong then the speed at which we will be able to implement the sorts of ambitions we have will be restricted. It is a very similar story.

**Steve Russell (Executive Regional Managing Director (London), NHS Improvement):** You will probably get a very similar answer from all of us. One of the key things that Mohini talked about was Capital Nurse. That is trying to co-ordinate the workforce for nursing much more effectively across London and to try to retain staff within the NHS. We are quite good at recruiting in general terms. What we are less good at is retaining people. That is for a whole combination of reasons. Most health and care systems will have quite a clear focus on how to make people’s working lives better so that there is better retention. Some of that is about working with local government and the Mayor on housing because housing is a very big barrier to workforce supply in London. The other thing that many systems are working on is new roles. With Health Education England there is a very significant programme of physician associate and nurse associate training going on across London in an attempt to try to manage the fact that both will need new roles and also that workforce supply of the traditional roles is perhaps not going to keep pace with historic demand.

**Jane Milligan (STP Lead, North East London STP):** As David said, it is the same for us. If you stripped everything else away and we had to just concentrate on one area this would be the key thing. It is also recognising that part of what we need to be putting in place is the change to the cultural aspects of workforce. I am a physiotherapist by trade. I have worked in multidisciplinary teams. I have managed multidisciplinary teams. Bringing people together in the same room, even in the same organisation, does not necessarily get what you actually need, which is about a holistic approach to managing or looking after patients, carers and their families. There is recognition of that organisation or system development that is required.

Thinking about North East London, given we have a lot of building going on we do have a real opportunity to be working with our local housing providers. We are establishing a Housing Forum to do some of this. We really need to be working with our local authority colleagues and the housing providers to look at supplying some really significant and actual ‘affordable’ affordable housing. Part of our approach is wanting to attract people to come and work and stay in North East London. We then need to wrap around and start to provide the career pathways to do that.

The GP workforce is a good example. The days of partners are pretty long gone. A shift has happened significantly in North East London, as I know it has elsewhere. For a budding young GP coming to North East London, what is going to keep them and light their fire? Part of that is working with our consultant colleagues in the acute hospitals to provide that sort of portfolio career. It is not just the technical numbers; it is about how we then support this. That is, as I say, pretty critical.

**Mark Easton (Programme Director, South East London STP):** I would agree with everything that you heard before. The only thing I could probably build on is that the relationship with Health Education England is very very important in two respects. One is in helping their workforce planning. They have helped us with modelling work and survey work on key skills gaps and key gaps in professions that we need to think about,
either boosting the workforce training numbers or thinking about other roles that can substitute for some of that work. That leads into the second thing they have been helping us with, designing new roles and thinking, for example, of the support that nurses and doctor’s assistants can give to increase capacity in primary care.

Daniel Elkeles (Chief Executive, Epsom & St Helier University Hospitals Trust, attending on behalf of South West London footprint): Just to echo what everyone else has said, the STPs are describing a different way of delivering health and care. It means you need your workforce to work differently and there are lots of examples going on about it. In South West London you have people going into people’s homes and providing care. It might be a therapist and a junior doctor working together in doing things that a social care person might traditionally have done. We have paramedics working in A&Es and we have new medical rotations that go between hospital and the community mental health services so that we are training people in physical and mental health at the same time.

Dr Onkar Sahota AM (Chair): Again, a question to all of you. How confident are you that all these STPs can be delivered within the defined timescales? We heard about some of the problems that we talked about earlier, post-Brexit and so on.

Dr Mohini Parmar (Chair, Ealing Clinical Commissioning Group and STP Lead, North West London): The NHS will adapt and change and modify things. As we go into the mobilisation and implementation, things will change. We will have to wait and see. The ambition is there but we need to make the scale of the change. We recognise that from a sustainability perspective, not just money but the workforce, we have to work differently. We are going to continue to deliver the NHS, which is our most valuable asset. We are all going to work differently.

David Stout (Programme Director, North Central London STP): Yes, I am confident we are doing the right things. I am confident we have leadership of the organisations working across North Central London, working together in a way that collectively they have not before, which gives us greater optimism that we will be able to achieve what we are seeking to do. But we should not shy away from recognising that the scale of what we are trying to achieve is phenomenal and the timeframe we are trying to do it in is probably more than we have achieved in the past. Could I guarantee it will work? No. Am I sure it will lead us to a better place than if we did nothing? Yes. Our job is to push this as far and as fast as we can and make sure we achieve what we can.

Steve Russell (Executive Regional Managing Director (London), NHS Improvement): I will repeat a little bit of what David said. I am confident that the STPs will deliver improvement and they will make much faster progress towards the ambitions that are set out than would have been the case otherwise. I have observed a very significant change in the five STPs in London over the last five months while I have been in this particular role. I think, though, David is right that we should not underestimate the challenge that we are facing. If you were to ask the question a slightly different way and ask what the alternative is, I am not sure, and you heard that from this morning’s panel as well. The stuff that is in the STPs, there is good consensus that it is the right thing to do.

If you were to ask the question a different way and ask how I could be more confident that they will deliver, my answer would be that we need to now move to backing the STPs and collectively supporting them to implement some of their aspirations, rather than constantly going around asking, “Can we develop the plan a bit further?” As others have said, that plan is not set in stone. It will change. I am perfectly confident that what David sets out for North Central London in year 2 today in year 2 will look slightly different and that is OK. That is absolutely fine. If in year 2 we are still talking about the plan, then we have lost two years. There
is a piece about reflecting that they are not perfect but if they did not exist, we would need to design something else. There is consensus around what is in them. We need to collectively back them.

**Andrew Boff AM:** That sounds like the way Microsoft issues new software releases.

**Steve Russell (Executive Regional Managing Director (London), NHS Improvement):** Patch 22.

**Andrew Boff AM:** They get it out the door first and then they worry about whether or not it is perfect. I get the point.

**Jennette Arnold OBE AM:** You would not want them to be building your house, would you?

**Jane Milligan (Lead, North East London STP):** I am not sure I can talk about building a house. The critical thing is being clear of those things that can be put in place relatively quickly, and that might be how providers work together on a more comprehensive approach to delivering trauma and orthopaedic elective care. In relation to some of the ambitions around prevention, we all know - for us the focus is around diabetes and smoking - that that is a long game. We just need to be clear about the things we want to sprint towards and the things we want to put in place for that longer-term marathon. That is the way we describe it.

It is being clear about what the STPs are and about what they are not. For our STP, everyone is involved in that but it is about what the collective partnership can do to really drive through those ambitions, as I say, being really clear about what is going to be achieved when. As always, the ambitions are going to be in different layers.

**Mark Easton (Programme Director, South East London STP):** It is always a challenge going fifth, is it not? Yes, it could be worse. The NHS is generally better at planning than it is at delivery. When I speak to the public in South East London, there is less of a challenge about, “Are you doing the right thing?” and it is much more of a challenge about, “Is it really going to happen?” Steve [Russell] gave a very good response, which is that the direction is right. Undoubtedly the details of some of the things we are trying to implement will change as we learn and as circumstances change. Trying to predict what the British economy will be like, where we are, with Brexit in 2020, we are going to have to be adaptive. I am thinking about the house metaphor. If I give you the metaphor of a bridge, we are not trying to build a bridge, where you would want a precise blueprint before you started laying down steel —

**Mark Easton (Programme Director, South East London STP):** This is much more of a house renovation, where you might have a 1930s semi and you think there are some improvements you can make to make it more fit for your modern family.

**Daniel Elkeles (Chief Executive, Epsom & St Helier University Hospitals Trust, attending on behalf of South West London footprint):** I would say the thing that gives me confidence, after my 20 years so far in the NHS, is the degree of collaboration that the STPs have produced. It is collaboration between providers. I spent all of yesterday afternoon with my colleagues, general hospital chief executives from South West London, working together on how we were going to ensure that we could provide the care collectively that people expect of us. It is collaboration between different parts of the NHS. Who would have thought a few years ago that my hospital would be in two provider alliances with all the GPs with whom we serve? Perhaps most importantly of all, it is the collaboration between the NHS, social care and local authorities. I have never seen it so positive. That will be the secret as to how the STPs are successful in delivery, because of all those new collaborations.
Dr Onkar Sahota AM (Chair): Name one thing that the Mayor could do to support the delivery of STPs in London.

Dr Mohini Parmar (Chair, Ealing Clinical Commissioning Group and STP Lead, North West London): London is one of the world’s premier cities.

Dr Onkar Sahota AM (Chair): The premier city in the world.

Dr Mohini Parmar (Chair, Ealing Clinical Commissioning Group and STP Lead, North West London): The premier city. Absolutely. It deserves and needs to be championing the best health and social care that exists. The Mayor could really work. He has some great assets in terms of Transport for London and the NHS. We own most of the estates in London. There is his influence and his impact on that, his influence on transport, his influence on workforce and how we are able to retain the workforce. We have huge training opportunities. We do not retain people. How do we make London a more attractive place for people to work? The Mayor could really champion that.

The other important thing is the conversation with the public. We all work in the NHS. We all use the NHS. What is our honest conversation.

Dr Onkar Sahota AM (Chair): Two things. David?

David Stout (Programme Director, North Central London STP): I agree with all of that. What else? We have already talked about workforce and housing. The Mayor has powers and influence in terms of affordable housing that could be one of the parts of the solution to our workforce challenge we talked about earlier.

Steve Russell (Executive Regional Managing Director (London), NHS Improvement): I was going to use the estates example but that has been taken. The public health agenda: air pollution, the point that was raised around fast food outlets and so on. That would make a very significant impact on both message and health impact and outcomes in later years.

Dr Mohini Parmar (Chair, Ealing Clinical Commissioning Group and STP Lead, North West London): There are a lot of commonalities across our five STPs that it makes sense sometimes to do once for London. A number of those relate to some of those that are part of the Healthy London Partnership programme anyway, but around mental health - I co-chair the Mental Health Transformation Board and so I will do a plug for that - and particularly some of the work we need to do around stigma, which often leads to people accessing mental health services not necessarily in the right or timely way. There are some key areas: mental health, cancer and prevention.

Mark Easton (Programme Director, South East London STP): In London, 10% of journeys are health-related. There is clearly a huge co-planning agenda around health and transport. The more we can make that transport operating on a clean air basis, the better it will be for those of us who suffer from asthma and other respiratory diseases in London.

Daniel Elkeles (Chief Executive, Epsom & St Helier University Hospitals Trust, attending on behalf of South West London footprint): I would just add two points. In many of the London boroughs, the NHS is by far the biggest employer. Making the boroughs really good places to work and using all your powers to help that happen is very important. Secondly, we have a shared endeavour in London, which is, “How do you get the many millions of people who live in the capital to have the best lives that they can have?” That is about how they live healthy lives, how we ensure their families work well, the education system, social care,
transport. It all comes together about how we make London a great place to live. We have a shared
endeavour on that.

Dr Onkar Sahota AM (Chair): Thank you.

Jennette Arnold OBE AM: Chair, I have a whole heap of questions about prevention and health inequalities
that we are not going to get through and so I would suggest, through you, Chair, that we send our questions
out to our panel members.

I would just like to thank them for reminding us that historically London’s healthcare has been skewed towards
hospital sickness and not enough towards primary and preventative care. So much I have heard this morning,
especially from this panel, is that you have decided what is immediate and what you can get to and that there
are some things that will come later. It seems to me that yet again prevention is something we will get to later.

Can I just say why I say this? We have looked at the STP plans. I will look at you, Sir David. Your plan had
two pages about prevention compared to 18 pages of service transformation. I understand you need service
transformation but prevention and health inequalities are as impor-
tant at this time. From what you have said, I
guess your answer is going to be that this is a draft and you will come to prevention and health inequalities
later. Is that what is going to happen?

David Stout (Programme Director, North Central London STP): First of all, I am not -- you knighted me.

Dr Onkar Sahota AM (Chair): You heard it here first, people.

David Stout (Programme Director, North Central London STP): That is someone who is not here rather
than me, but thank you very much. Our plan starts with prevention because we think it is important. Do not
judge the plan by its length of content.

Jennette Arnold OBE AM: Sturdiness.

David Stout (Programme Director, North Central London STP): The point made in the earlier panel and
indeed reiterated here was that STPs were constructed with a five-year timeframe. A lot of primary prevention
clearly operates over a considerably longer period. Remember, public health and health promotion are a local
government statutory responsibility, and they continue to be responsible for those things. The STP is looking
to say, “What are we going to do on top of what is already in plans?” not simply replicate everything that every
local authority is already doing.

I would still be keen to protect some added work on prevention in our plan. There is a financial challenge to
that. We have not yet landed the money. It is a draft, you are right, and we will by the beginning of April have
an updated version of the plan. If we are successful, we will have still emphasised elements of prevention,
some of which do have quite quick benefits. Not all preventative interventions take years to deliver. Some are
pretty quick in terms of return on investment, using an economic phrase.

Jennette Arnold OBE AM: One last question about health inequalities, Chair. Can you just nod if you have
completed your Health Inequalities Impact Assessment? Is that everybody nodding or is there somebody who
has not done it? Steve, you are not nodding. You have not done one?

Steve Russell (Executive Regional Managing Director (London), NHS Improvement): That is because
I am not the author of an STP.
Jennette Arnold OBE AM: OK.

Dr Mohini Parmar (Chair, Ealing Clinical Commissioning Group and STP Lead, North West London): The Health Equalities Impact Assessment will be done at any time that there is a service change going to be instituted. It is done with that. Any change that happens, however small, will have a Health Inequalities Assessment. The STP as a planning document is just a planning document.

Just taking your previous point about prevention, for example in North West London diabetes and alcohol are two big things and so we are working with our local government colleagues. We have just got a whole pile of money to roll out education for pre-diabetes. Forget the diabetes. We do not want people to get there. That is about investing in pre-diabetics.

The other big issue is alcohol with health and social care. Considering most of it is commissioned through local government, it is about how we work together to deal with some of the alcohol issues in North West London.

Jennette Arnold OBE AM: On the point that you can say you are going to do it in the next stage, what I would have a problem with is if you are not mindful of the health inequalities that it is known you are dealing with at a strategic stage. I would say to you that is absolutely too late when you go to the implementation stage to be saying to people at that level, “We did not bother with this but now you can”. Is that not a big hole in your overall strategic planning?

Dr Mohini Parmar (Chair, Ealing Clinical Commissioning Group and STP Lead, North West London): No. Sorry, I got that. Absolutely, according to our joint strategic needs assessment in Ealing - and that has been aggregated across North West London - we have a clear idea of the demographics and what the needs of the population are. Therefore our services are commissioned to reflect that. As and when the services are commissioned, each and every service has an inequalities assessment. It is standard practice. It is part of our governing board’s standard papers and our Joint Strategic Needs Assessment (JSNA), which comes to our Health and Wellbeing Board, absolutely reflects that.

Daniel Elkeles (Chief Executive, Epsom & St Helier University Hospitals Trust, attending on behalf of South West London footprint): I just wanted to go back to prevention, to end on a positive. Let me give you an example of a fantastic healthcare prevention scheme. There is the nursing home Vanguard. It is running in Sutton. In every nursing home there is now a team of GPs, social care, therapists and, when needed, hospital consultants who go in and do, every week or every month depending on how frequently the patients need, a proactive assessment of their health and care needs.

That means that more of the people in the nursing and residential homes and have their care delivered in the nursing and residential homes rather than coming to the hospital. They get better care, you are stopping them getting acutely unwell and you are releasing pressure on hospitals. It is a brilliant scheme. It is not only going to be rolled out right across the South West London STP, I suspect all the STPs will say, “This is a really good thing. Here is how it was piloted in this borough. Let us do it in 32 of them”.

Jennette Arnold OBE AM: Daniel, thank you for that. I have said it on a number of occasions across the table: I want to go and live in your area because when you look at health indicators, when you look at everything, you guys are in a much better position to where I am in North East London. Thank you for sharing. We will be writing to you about the other questions and concerns that we have about prevention and health inequalities. Thank you.
Dr Onkar Sahota AM (Chair): I just want to pin something down before we wind up. I will ask each one of you this question. Has an inequalities impact assessment been done for the whole plan? You refer to bits of it but I am talking about the whole plan. Has anyone done an inequalities impact assessment on the whole plan of the STP in their area? Mohini?

Dr Mohini Parmar (Chair, Ealing Clinical Commissioning Group and STP Lead, North West London): For Shaping a Healthier Future, we absolutely did one as part of our consultation.

Dr Onkar Sahota AM (Chair): Shaping a Healthy Future was part of the STP?

Dr Mohini Parmar (Chair, Ealing Clinical Commissioning Group and STP Lead, North West London): In North West London, the STP, we already had --

Dr Onkar Sahota AM (Chair): The question is a yes/no. Has an inequalities impact assessment been done for the whole of the plan?

Dr Mohini Parmar (Chair, Ealing Clinical Commissioning Group and STP Lead, North West London): Again, I am going to come back and say that the acute reconfiguration plans absolutely had their equalities impact assessment done and that was done as part of the consultation when that happened. As and when the service -- the plan is --

Dr Onkar Sahota AM (Chair): The whole STP has not had an equalities impact assessment?

Dr Mohini Parmar (Chair, Ealing Clinical Commissioning Group and STP Lead, North West London): I am not sure that we have had the whole plan go through a -- we have had it in engagement, we have had the discussions --

Dr Onkar Sahota AM (Chair): An inequalities impact assessment has not been done for the whole plan?

Dr Mohini Parmar (Chair, Ealing Clinical Commissioning Group and STP Lead, North West London): No.

Dr Onkar Sahota AM (Chair): Thank you. That is what I wanted. It was a yes or no answer. David?

David Stout (Programme Director, North Central London STP): Yes. We have done the high level. We have done inequalities impact assessments of every element of the plan and then we have collated that into an overarching report, which we are looking at on Friday, funnily enough. Yes, a very initial one has been done. Mohini is right that as we get into finer detail of implementation --

Dr Onkar Sahota AM (Chair): I understand that, but no one has done an impact study --

David Stout (Programme Director, North Central London STP): We have done. We have, yes.

Dr Onkar Sahota AM (Chair): You have? OK. Jane?

Jane Milligan (Lead, North East London STP): Yes, we have.

Dr Onkar Sahota AM (Chair): Mark?
Mark Easton (Programme Director, South East London STP): Yes, it is on our website.

Jane Milligan (Lead, North East London STP): Yes, it is on our website.

Dr Onkar Sahota AM (Chair): Daniel?

Daniel Elkeles (Chief Executive, Epsom & St Helier University Hospitals Trust, attending on behalf of South West London footprint): We had done one before we submitted the plan. I would also say to you that we have engaged with 88 different groups in South West London. We have covered every single protected group more than once to ensure that we have properly reflected in the plan what each of those groups thinks.

Dr Onkar Sahota AM (Chair): Your answer is yes, Daniel?

Daniel Elkeles (Chief Executive, Epsom & St Helier University Hospitals Trust, attending on behalf of South West London footprint): Yes.

Dr Mohini Parmar (Chair, Ealing Clinical Commissioning Group and STP Lead, North West London): Onkar, on that, North West London has. I think I am describing it in a very detailed way when you go to the service chain and, on the strategic level of the plan, yes. As you know, the devil is in the detail. When you get the detail, that is when it really needs to happen.

Dr Onkar Sahota AM (Chair): Great. Thank you. I know this has gone longer and we could have made it go on even longer. We cut out a lot of questions we wanted to ask. Thank you very much for your time and for your effort and for your appearance with us.
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