

Implementing the NHS Long Term Plan at local level: a new approach in Cornwall

Dr Peter Levin

formerly of the Department of Social Policy, London School of Economics and Political Science
Committee member, West Cornwall HealthWatch

A utopian vision, a planning process shrouded in mystery, and a 'shopping list' attitude to public engagement are not the way to go about implementing the NHS Long Term Plan at local level. Cornwall is about to try a new approach.

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1. The recent history of NHS planning

Over the past five years NHS England has issued four edicts prescribing the shape and form of the NHS. In October 2014 it published *Five Year Forward View* [1] in which it argued that the NHS needed to change and listed a range of new models of care that it would support. These included:

- The Multispecialty Community Provider (MCP), which would permit groups of GPs to combine with nurses, other community health services, hospital specialists and perhaps mental health and social care to create integrated out-of-hospital care.
- Primary and Acute Care Systems (PACS), where hospital care and primary care are integrated, so 'combining for the first time general practice and hospital services'.
- Urgent and emergency care services redesigned 'to integrate between A&E departments, GP out-of-hours services, urgent care centres, NHS 111, and ambulance services'.

- Help for smaller hospitals to remain viable.

All these models of care were described in language easy for a lay person to understand.

In December 2015, Sustainability and Transformation Plans (STPs) came on the scene. They were announced in *Delivering the Forward View: NHS planning guidance: 2016/17 – 2020/21*.^[2] Every health and care system – comprising clinical commissioning groups, provider trusts and local authorities – was asked 'to come together, to create its own ambitious local blueprint, an area-based five-year STP.

But how was the plan to be created? The 'planning guidance' did not provide any kind of manual: there was no step-by-step set of instructions. All it had to say on the subject was this:

Producing an STP ... involves five things: (1) local leaders coming together as a team; (2) developing a shared vision with the local community, which also involves local government as appropriate; (3) programming a coherent set of activities to make it happen; (4) execution against plan; and (5) learning and adapting.

Success also depends on having an open, engaging, and iterative process that harnesses the energies of clinicians, patients, carers, citizens, and local community partners ...

Essentially, then, the STPs were to be 'vision-driven', in contrast to the down-to-earth, practical models of care previously advocated: 'The best plans will have a clear and powerful vision ...'^[3]

In March 2017 NHS England published another policy document, *Next Steps on the NHS Five Year Forward View*.^[4] It described itself as 'this plan', but primarily it amounted merely to a list of actions that NHS England was committing itself to take in the next two years. Prominent among these was taking new models of care forward, especially those that had been developed in fifty localities (as part of the 'Vanguard' programme). So practical developments, notably Multispecialty Community Providers and Primary and Acute Care Systems, were once again at the forefront of NHS England's thinking. 15 months after their launch, the vision-driven Sustainability and Transformation Plans were quietly dropped. Thinking had seesawed once again, from visionary back to practical.

But this was not to last. In January 2019 *The NHS Long Term Plan* was published.^[5] Among other things, this document says:

- We will boost 'out-of-hospital' care, and finally dissolve the historic divide between primary and community health services.
- The NHS will reduce pressure on emergency hospital services.
- People will get more control over their own health and more personalised care when they need it.
- Local NHS organisations will increasingly focus on population health – moving to Integrated Care Systems everywhere.^[6]

This is essentially a vision of the world as those running NHS England would like it to be. What we see here is the resurrection of visionary thinking. It is hard to see what qualifies it as a 'plan'. It is not a blueprint for action so much as a list of aspirations and intentions – some of them of the unassailable 'motherhood and apple pie' variety.

Some user groups – such as patient participation groups, leagues of friends of hospitals, and groups campaigning against hospital closures – will have their suspicions raised by these ambitions. Will 'boosting' out-of-hospital care be used to justify closing hospital wards and beds? Will giving patients more control over their own health and care be taken by health and social care professionals to justify leaving them to take care of themselves? And importantly, we know that money is tight – indeed, providers are to return to 'financial balance'^[7] – and change always incurs costs: so will cuts be made to find the money to pay for these changes?

2. Health and social care planning in Cornwall: what is being done?^[8]

Health and social care planning in Cornwall is overseen by a 'Transformation Board'. It is not of itself a decision-making body, but currently its leading members – known as 'system leaders' – are the four chief (executive) officers of Cornwall Council, NHS Kernow (the Clinical Commissioning Group for Cornwall), the Royal Cornwall Hospitals NHS Trust and Cornwall Partnership NHS Foundation Trust,^[9] so they have decision-taking roles in their own spheres and they are publicly committed to working together as partners. Their ambition is to be endorsed as an Integrated Care System by 2020.^[10]

In order to implement the Long Term Plan at local level, NHS England has asked local health and social care bodies to plan the changes required, but it has provided no guidance for them on how to do this. It does say that local health systems 'will be expected to engage with their local communities ... in developing plans',^[11] but makes no suggestions as to how to do this either.

So how is the Transformation Board setting about its task? Literally, how is planning being done? And what engagement with local communities has there been in Cornwall?

Three reports to the May 2019 meeting of the Transformation Board help us to piece together answers to these questions. We have an *Operational Plan Executive Summary*,^[12] *Development of the Long Term Plan*,^[13] and *Healthwatch Cornwall – Health & Social Care Public Engagement*.^[14]

3. A utopian vision, courtesy of management consultants

The *Operational Plan Executive Summary*^[12] shows that, like NHS England with the Long Term Plan, the Board's members have a vision, and strategic objectives too. These are reproduced in Box 1. Like those of NHS England, they take the form of utopian aspirations.

Box 1. 'Our vision and strategic objectives'

Our vision

- 'We will work together to ensure the people of Cornwall and the Isles of Scilly stay as healthy as possible for as long as possible.
- We will support people to help themselves and each other so they stay independent and well in their community.
- We will provide services that everyone can be proud of and reduce the cost overall.'

Our strategic objectives are derived from the quadruple aim to

- Improve health and wellbeing.
- Improve people's experience of care.
- Reduce the cost of care per capita as a consequence of people using services less frequently and needing less expensive help.
- Improve people's experience at work.

As we see, these are again all very much of the 'motherhood and apple pie' variety. They are not presented as the conclusions of a research project or reached through political consensus. There is no indication that they arose out of discussions with local communities – groups of local residents or service-users, or campaigning groups, drawing on daily experience. We get no sense of the decisions that have to be made in real life about allocating resources between competing needs. The vision and objectives are what one might expect to be the outcome of a brainstorming exercise conducted by management consultants with senior executives who don't have daily contact with patients or social care clients.

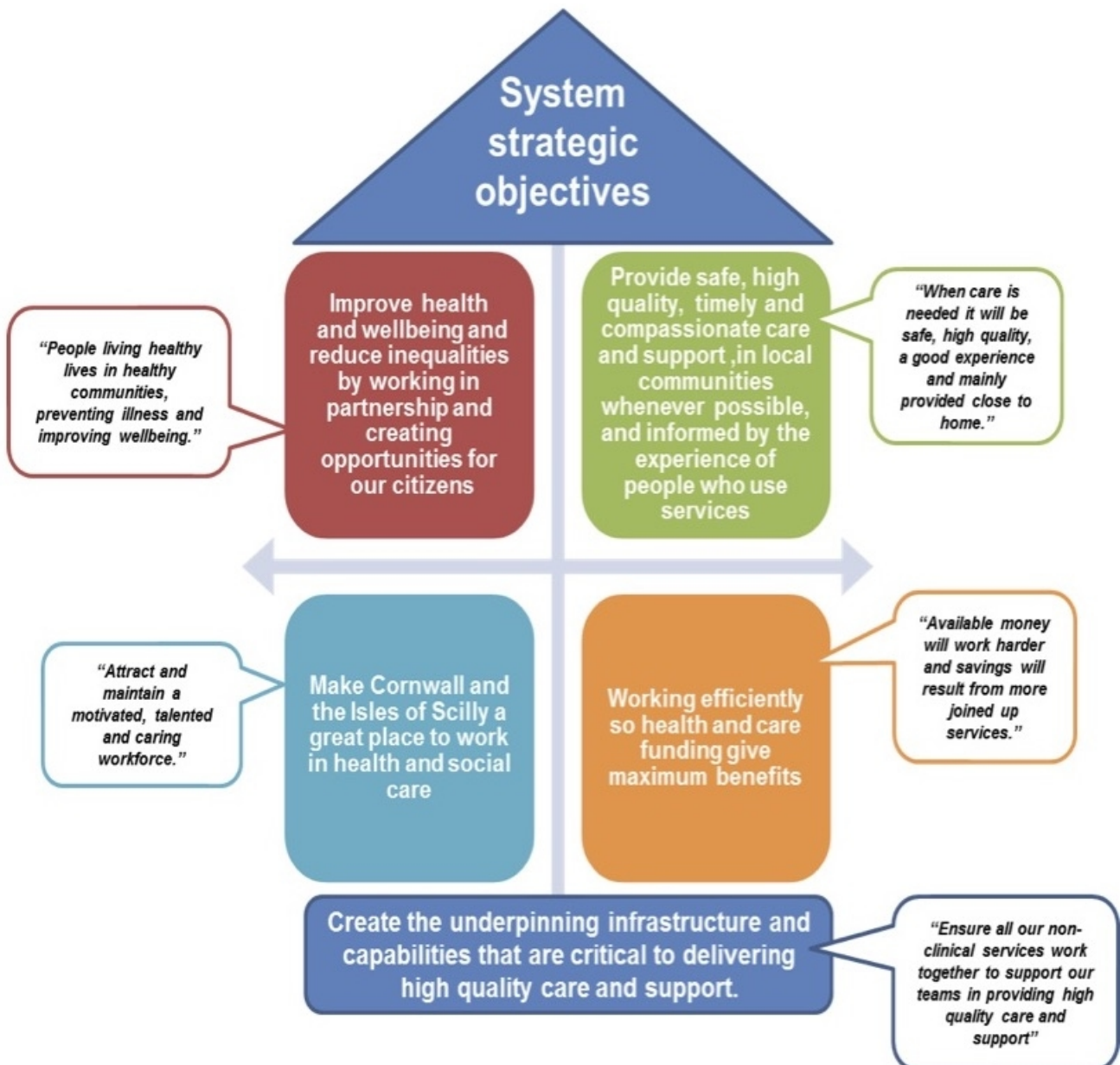
4. Bad language: 'system' and 'strategic'

My surmise as to the involvement of management consultants is supported by the inclusion in the document of a diagram (untitled) reproduced below showing 'System strategic objectives' that 'create the underpinning infrastructure and capabilities that are critical to delivering high quality care and support': this presentation and language, like the 'target operating model' featured in Box 2 below, are straight out of the management consultants' playbook, as was much of Cornwall's Sustainability and Transformation Plan of 2016.^[15]

The language used here tells us a great deal about the perceptions and thinking processes of those who wrote and approved these documents. The word 'system' is being used, very loosely, in the sense of 'entirety', the system as a whole. This usage distracts attention from the other, more useful, sense of the word: a 'system' is made up of interconnected parts. By directing our attention to the interconnections, this definition helps us to analyse how systems work and what processes take place within them. As we shall see below, applying this approach to delayed transfers of care may suggest that significant changes are needed to organizational structure.

The words 'strategy' and 'strategic' are similarly being used in a very loose way, in that they relate to utopian objectives. Typically, we are offered no way of telling when such an objective has been realised. Nor do we get any sense of coherence, how the various elements of the strategy will fit together and combine to realise the objectives.

The term 'system strategic objectives' sounds impressive, but on closer inspection we can see that it is meaningless.



5. A planning process shrouded in mystery

As to the process of planning, a useful source document here should be, to judge by its title, *Development of the Long Term Plan*.^[13] It contains two lists, reproduced below: 'Box 2. Our approach to long term planning locally' and 'Box 3. What we need to do'.

Box 2. 'Our approach to long term planning locally'

- Welcoming the opportunity to refresh our local ambitions for improving health and wellbeing, and demonstrate how we plan to make the required shifts to more place-based care with a greater focus on prevention;
- Using 2019-20 as a platform from which to deliver transformation;
- Aligned plans between the NHS and councils;
- Shaped by a new Health and Wellbeing Strategy, which will identify local priorities for improving the health and wellbeing of our population, based on local health and care needs;
- A two-way relationship with the placed based (bottom up) local Integrated Care Area plans and local operating models;
- Working with HealthWatch on engagement;
- System transformation programmes for prevention and population health, integrated care in the community, planned care, urgent and emergency care, and care and support for children and young people will contribute to development of the plan;
- System enabling plans will develop the resources needed for the target operating model and ensure the workforce, IT, estates and finance are available as needed to underpin the transformation programmes;
- Operational plans will identify what each organisation will contribute.

As we see, in Box 2 there is nothing in the 'approach to long term planning locally' that can be seen as a progression over time, or as a step or stage in a planning process. No role for public engagement is identified. 'System transformation programmes' and 'system enabling plans', whatever these are, by their very language exclude those who aren't members of or working for the Transformation Board.

Likewise, there is nothing in this approach which can visibly be seen as playing a part in realising the vision, in translating it into practice.

The activities listed in Box 3, below, under the heading 'What we need to do', are similarly not helpful in gaining an understanding of the planning process. They are a strange mixture: visionary ('Make a positive difference'), visionary/descriptive ('Describe how our system will be operating in five years' time'), self-evident ('Have a timescale, plan and resources') or simply unspecific

(‘Build on our engagement and co-production to date’). There is no sequence, there is no programme of work. Notably, none of the activities listed offers an invitation or opportunity for outsiders – members of the public, or a group of service users – to get involved, or stipulates a point in time by which contributions need to be received.

Box 3. ‘What we need to do’

- Make a positive difference for our local populations:
 - Expand our evidence base used for the 2019-20 Operating Plan to cover five to ten years and to have a good understanding of trends in population health – this will be informed by the Joint Strategic Needs Assessment;
 - Increase our understanding of how different groups of people use our health and care services as needs change and society and technology develops and our capacity to respond over the next five to ten years, which will require expanding our modelling work;
- Describe how our system will be operating in five years time, what will be different to what we have now and what improvements in outcomes for people, the quality of care and in system performance the changes will deliver – this will include delivery of the commitments in the NHS Long Term Plan;
- Describe how delivery of new ways of working will be shaped in integrated care areas and by primary care networks and have a strategy within the plan for how integrated care areas, out of hospital care and primary care networks will develop over the five years;
- Have an implementation timescale, plan and resources identified for delivery of the changes;
- Build on our engagement and co-production to date.

Given the haphazard nature of these bullet points, and especially the fact that they are not presented in any discernible sequence, it is difficult to resist the conclusion that, despite the much-vaunted ‘systems’ approach, the process of producing the local plan is not a logical, clearly structured one. The picture presented in this report to the Transformation Board is one of confusion. The process of translating visions into reality may be a difficult one, but it has not been disclosed to the Board. Moreover, as long as this situation prevails the course that the process takes will be entirely hidden from view: there will be zero transparency of the process.

6. A ‘shopping list’ on a PowerPoint slide: is this all that public engagement produces?

NHS Kernow, Cornwall’s Clinical Commissioning Group, tends to publish what it learns from its consultations as slides in PowerPoint presentations, such as that shown in Box 4:[\[16\]](#)

Box 4. 'What have people told us is important?'

- Focus on prevention and proactive care
- Personalising care and support to help people achieve what matters to them
- Coordinating care and support locally
- Developing the role of local communities in providing support
- Improving care home quality and resilience
- Improving dementia care
- Improving support for carers

This list tells us a number of things.

1. It is simply a list of aspirations.
2. Given the sheer improbability that any individual told NHS Kernow 'I think you should focus on prevention and proactive care' or 'You should be developing the role of local communities in providing support', the list of aspirations must have been compiled by somebody – we don't know who – interpreting individual, 'raw' responses and aggregating them as he or she or they saw fit. We don't know either whether the order of the seven items in the list is significant, or – if so – how the order was determined.
3. We aren't told how many people mentioned each of the seven aspirations in the list, or how the sample of 'people' was drawn up. A list like this leaves it entirely to the organization to place them in an order of priority and determine how resources, necessarily limited, should be allocated among them. The reader has no way of contributing to that element of the process.
4. It is striking that whatever survey was carried out treated respondents as sources of information about their needs, but, so far as we can see, it ignored the crucial fact that service users are also sources of information about how systems work. Such information can't be elicited by asking someone to jot down on a Post-It Note what their top concern is.
5. It is very surprising that, according to the list in Box 4, nobody mentioned what we know to be a major cause of concern, the long-lasting 'temporary' closure of beds in three of the community hospitals in Cornwall.

This example demonstrates the limitations of the 'shopping list' approach to public engagement. It takes careful investigation by researchers trained in social enquiry and survey methods to ensure that a statistically valid sample of respondents has been identified, to elicit respondents' stories, explore how they feel about their experiences, and make sure those experiences have been properly understood and recorded. There is no evidence that any of this has been done.

7. Why the planning process needs to be transparent

We have seen that the local NHS planning process in Cornwall is extremely difficult to uncover. Undoubtedly things are happening, as they are during all planning processes, to narrow down the range of options that will be available when choices are made at the end of the process. NHS England expects local health systems to engage with their local communities in developing plans^[17] but if that engagement comes only at the end of the planning process, some options which would find favour among the public may already have been ruled out. There are a number of behind-the-scenes mechanisms through which this can come about:

1. At the very start, terms of reference for the decision-making process are decided, especially in the form of assumptions that are to be taken as read. For example, it may be assumed that alternative provision to community hospital inpatient treatment will be made available, allowing a hospital to be closed and sold off, whereupon the planning team works on that assumption. So even if the alternative provision does not actually come into being and is not there when needed, the hospital may be closed and sold off regardless.
2. Time and staff resources get used up. Once a deadline has been set, as is often the case, there is simply not the time and manpower available to permit going back to square one and starting again. If certain alternatives have not been investigated and considered, there is no time now to investigate and consider them: the phenomenon of 'running down the clock'. Even if alternatives have been considered, these will have been reduced to a shortlist, and it won't be possible to resurrect any that did not make it on to that shortlist.
3. The staff working on the plan become psychologically committed. They take decisions about the kind of plan they want to see, and about working methods, i.e. how they are going to produce the plan: to go back on these decisions, and write off some of the work that has been done, will generate stress and involve loss of face. Similarly, people make assumptions and become wedded to these: even if evidence turns up that shows that their assumptions were unrealistic or – like budgetary limitations – could have harmful consequences, they may disbelieve and deny that evidence (this is the phenomenon of cognitive dissonance).

And the staff working on the plan will have their own motivations. They will have personal ambitions, such as advancing their careers, and typically will want to produce something distinctive and striking. Such ambitions too generate commitment.

4. The in-house planning team may have a budget to employ management consultants to research and develop a plan, and agree a contract with a firm of management consultants for them to do this work. This contract will set out terms of reference for the work, and a deadline by which the firm has to submit final proposals for the plan. However, as the deadline approaches it may become apparent that the terms of reference have been drawn too narrowly, and that if they had been relaxed it would have been possible to produce another, superior, plan. But by then the budget has all been used up, and there is no money to explore and develop the

superior option. So that option gets ruled out by default, long before a point of formal decision is reached.

5. Some people, particularly members of entrenched interest groups, will have 'preferential' access to the planning process, easier access than others. For example, in the NHS and local government senior managers may get together privately to find and agree a bundle of courses of action that has something for all of them. Once that agreement has been reached, it will be very difficult for others – such as members of the public – to get it reviewed and altered.

6. The situation on the ground changes. A facility may be closed for repairs, and it happens that staff drift away, local people at first protest and then find ways of coping, the building gets starved of maintenance and begins to decay, so the option of restoring it to use becomes increasingly expensive and consequently difficult to justify (the 'planning blight' syndrome). Or a service that up to now has been provided at local level gets abruptly withdrawn, to be replaced on grounds of economy by centralized provision: staff then leave the district, making it difficult to restore the service, and costs are placed on patients who have more travelling to do.

The effect of these mechanisms should not be underestimated. By closing off options they preempt formal decisions. As a former very senior civil servant has put it:

The experience of anyone who has worked in Whitehall is that there is an early stage in any project when things are fluid; when, if you are in touch with those concerned and get hold of the facts it is fairly easy to influence decisions. But after a scheme has been worked on for weeks and months, and has hardened into a particular shape, and come up for formal decisions, then it is often very difficult to do anything except either approve it or throw it overboard.[18]

He might have added that there is invariably a huge penalty attached to throwing it overboard at that stage.

We have to be alert to the fact that managers who are familiar with these mechanisms can deliberately take advantage of them. Thus they can limit the number of staff working on the plan and impose unrealistic deadlines, they can impose stringent budget limitations, they can reach deals with the more powerful interest groups, and they can change the situation on the ground. Indeed, they may have reached their present positions in their organizations precisely because they are skilled in using strategies like these.

So while managers may say, perfectly correctly, that no formal decisions will be taken before the public are consulted, they may have a host of strategies at their disposal, all aided by zero transparency, to guarantee that they get the result they want. We have seen that the mysterious planning process in Cornwall is the very opposite of transparent. Patients and the public, indeed everyone who benefits from NHS services, have every reason to be concerned.

8. A test case: community hospital beds for Penwith

In West Cornwall we have had an example of some of these processes at work in the treatment of Edward Hain community hospital in St Ives, located in the Penwith district in the far South-West of Cornwall. Inpatient beds at this hospital were ‘temporarily’ closed to new admissions in February 2016 due to fire safety concerns: more than three years later they are still closed, despite the required remedial works having been carried out by NHS Property Services, the owners of the building. Cornwall Partnership Foundation NHS Trust, which leases the building, is now stipulating that further conditions must be met before it will reinstate beds.^[19] Meanwhile the medical and nursing staff and allied health professionals have of necessity moved on. The hospital stands on highly valuable land and it is widely felt that the intention is to sell the building and site to realise its value, as was done in 2014 with Poltair hospital, near Penzance. There is now no community hospital with inpatient beds in Penwith.

Prior to the closure of the inpatient beds at Edward Hain hospital they were intensively used: on an average night 93% of them would be occupied. In the 12 months before they closed 174 patients were accommodated in inpatient beds: 111 of those people (64%) were Penwith residents.^[20] They were used mainly to accommodate patients who had been treated at the main acute hospital in Cornwall, the Royal Cornwall Hospital at Treliske, near Truro, and were well enough to leave Treliske but not well enough to go home. At present some patients are sent to other community hospitals in Cornwall. The nearest is at Helston, some 18 miles from St Ives.

The latest Integrated Performance Report to the Royal Cornwall Hospitals Trust shows that in April 2019 nearly 600 bed days were lost on account of delayed transfers of care caused by waits for further non-acute NHS care. ‘These will be patients waiting for onward care, including community hospitals, for rehabilitation.’^[21] Evidently the desirability of selling off Edward Hain Hospital is taking precedence over the need to make best use of acute beds at Treliske as well as recovering patients’ wishes to recuperate close to home.

Losing 600 bed days in one month is equivalent to having a ward of 20 acute beds continually out of use for that month.

How could this situation have been avoided? To answer this question we need to take a (genuine) systems view of a patient’s entire ‘trajectory’ through his or her episode of ill-health. What we see when we do that is that this trajectory can be divided into three stages: treatment, recovery and re-ablement.^[22] The trajectory needs to be treated as a whole.

But that is not how the system works. The hospital at Treliske – organization, facilities, staffing and ancillary functions, buildings – is designed to provide for the first two of these, but the third requires the facilities of a community hospital, and in Cornwall community hospitals come under a completely separate organization, the Cornwall Partnership NHS Foundation Trust. This body has its own goals and incentives, which currently appear to motivate it to sell off the land and buildings of its community hospitals and make a name for itself as a source of funds for the NHS.

Much is heard these days of the need to integrate health care services provided by the NHS with social care services provided by local authorities. What the situation in Cornwall demonstrates is a need for the NHS to integrate its own services. There is clearly a strong case that

responsibility for community hospitals should be transferred from the Cornwall Partnership NHS Foundation Trust to the Royal Cornwall Hospitals NHS Trust.

Currently a new wellbeing/re-ablement day service is being trialled in the Edward Hain hospital building: it is due to close at the end of June 2019. These activities are led by Age UK and other community and voluntary groups. Preliminary findings from this trial were that no referrals had come from the acute hospital at Treliske and that many people who had been discharged from hospital were too unwell to attend. An unmet and unanticipated need for physiotherapy provision was also identified. (It was apparent too that the services being provided were very similar to those already being offered at day centres in Penzance and Hayle.) It is clear that this service does not compensate for the loss of community hospital beds at Edward Hain hospital.

9. A new approach: outsourcing public engagement

The third relevant paper submitted to the Transformation Board at its May 2019 meeting, *Healthwatch Cornwall – Health & Social Care Public Engagement*, was written by the Chief Executive Officer of Healthwatch Cornwall.^[14] It makes it clear that the leading members of the Transformation Board have effectively outsourced their responsibility for engaging the public to that organization.

The generally understood role of the local Healthwatch organizations across England is essentially to promote and support the involvement of local people in the commissioning, provision and scrutiny of local care services. They do this chiefly by providing information for local people about local care services and standards of provision, and obtaining the views of local people about their needs for, and experiences of, local services and making those views known. They can also recommend that special reviews or investigations be carried out, and recommend that their parent body, Healthwatch England, publish reports on particular issues.^[23]

How does Healthwatch Cornwall see its role? According to the Healthwatch paper, the organization ‘has a remit to ensure health and social care services in Cornwall are the best they can be for people in the county’. This is not entirely correct. That remit is of course the remit of the commissioners and providers of services. But Healthwatch Cornwall, which has a seat on the Transformation Board, is explicitly positioning itself as a partner to commissioners and providers:

Healthwatch Cornwall seeks to work in partnership with commissioners and providers across the system to complement and enhance public engagement undertaken by them. To model best practice in public engagement, to support colleagues and to act as a critical friend highlighting positive performance and holding organisations to account where public and patient views have not been sufficiently considered.

The language here is firm but carefully non-confrontational. It employs no quasi-military metaphors to do with campaigning or defending the interests of service users. The reference to

holding organizations to account is balanced by references to supporting colleagues and highlighting positive performance. So Healthwatch Cornwall has been willingly co-opted into the institutional structure, alongside its ‘partners’ on the Transformation Board.

Healthwatch Cornwall’s recent annual reports show that the issues with which it has concerned itself have until now stemmed primarily from individual patients’ experiences with services. On major contentious issues, such as the proposal in Cornwall’s Sustainability and Transformation Plan ‘to replace the current Minor Injury Units with a new model of strategically located Urgent Care Centres across the spine of Cornwall’^[24] and the total absence of community hospital beds in Penwith since the ‘temporary’ closure of Edward Hain Hospital more than three years ago, Healthwatch Cornwall has so far been noticeably uninvolved.

However, we read in the Healthwatch Cornwall paper to the May 2019 Transformation Board that as part of its existing work plan for 2019/20, it will

- Develop and launch a new systemwide engagement tool (a Virtual Citizens Panel)
- Deliver part of NHS England’s NHS Long Term Plan engagement
- Deliver an Appreciative Inquiry into Mental Health Services
- Deliver a conference for Mental Health professionals
- Carry out research into the needs of End of Life Carers
- Carry out research with mental health service users
- Facilitate Cornwall Council partnership boards to contribute to system engagement
- Advise on engagement plans for Community Hospitals and Public Health 10 year priorities.

At first sight, the approach being adopted by Healthwatch Cornwall has some very promising aspects. It is positioning itself as an interlocutor between patients/clients and the providers of services, which could enable it to perform a very valuable function. And the Transformation Board badly needs to be able to draw on the services of qualified and capable researchers.

10. The tests that a new approach must meet

How will we be able to assess how well Healthwatch Cornwall is fulfilling the brief set out above? Here are some tests that we can apply. They take the form of questions which need to be answered in the affirmative for the test to be passed.

1. When Healthwatch Cornwall is advising on ‘engagement plans for community hospitals’, will it be able to present the public with a clear picture of the steps and stages in the process? Will it be able to identify commitments to closing hospitals that have already been created, e.g. in assumptions made about alternative provision, and will it be in a position to insist that such commitments should be held in abeyance while alternatives are being explored?

2. Will Healthwatch Cornwall employ specialists in engagement, people who are able to identify issues through dialogue with local people. (An issue can be defined as a ‘What should be done about X?’ question.) Issues are subjective – they exist in the eye of the beholder – so identifying them necessitates not only in-depth surveys of the population, as opposed to ‘tick-box’ questionnaires, but also discussions with local people who have some insight into issues.

Engagement specialists need to be knowledgeable about planning processes and prepared to explain to local people how positions harden and options get shut off. Only through being honest about these will they earn their co-operation. It follows that they need to act as interlocutors, facilitators of dialogue, not as public relations officers for public bodies.

3. When faced with a controversial issue, will Healthwatch Cornwall be prepared to engage with it while being able to avoid taking sides, to resist being ‘nobbled’ by its partner organizations?

4. When Healthwatch Cornwall has reached a judgment as to whether ‘public and patient views have [or have not] been sufficiently considered’, will it tell the public what its judgment is and what criteria it has used in reaching it? Will it publicize what it can actually do by way of ‘holding organisations to account’?

5. When Healthwatch Cornwall has formulated research proposals, will it publish these and invite comment on them? Will it enquire into how the system works as well as merely asking people what they want? Will it publish ‘proper’ research reports (as opposed to PowerPoint presentations) and invite comment on them from local people? Will it call on and take advantage of the research experience that can be found among Cornwall’s population and of course its health and social care workforce? Will it be prepared to listen to the concerns of whistleblowers? Will it have the resources to call on outside specialists when needed?

Research is everyone’s business: the research mindset involves nothing more complex than paying attention to what is going on and trying to make sense of it. For example, there needs to be a much more sophisticated understanding of patients’ trajectories through the healthcare system than we have at present: the issue of how to reduce delayed transfers of care will not be resolved until the gulf between decision-makers’ perspectives and criteria on either side of the transfer is addressed.^[24]

6. Healthwatch Cornwall will be well positioned to monitor edicts emanating from NHS England. To judge by the variations already noted, it would be prudent to treat NHS England as an unreliable and capricious paymaster, harbouring crude and unsophisticated ideas about what planning entails. Will Healthwatch Cornwall treat NHS England as a subject for research, and carefully examine its publications and behaviour? They could perform a valuable service by

- Studying instructions that NHS England issues, and asking if they are derived from appropriate objectives and methodology, and whether such justification as is put forward for them is free of ambiguities and unwarranted assumptions.

- Analysing funding pronouncements, identifying the criteria on which funds are being allocated, looking for underlying assumptions and any contradictions between allocations and stated aims, and asking if those aims might be achievable by other means.
- Suggesting strategies that local bodies can employ for negotiating with NHS England rather than simply accepting what they are given and doing what they are told.

Healthwatch Cornwall deserves support and encouragement in its endeavours.

Notes and references (All websites last visited on 31 May 2019)

1. NHS England, *Five Year Forward View*, October 2014
<https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>
 No author stated, but the Foreword says: 'It represents the shared view of the NHS' national leadership, and reflects an emerging consensus amongst patient groups, clinicians, local communities and frontline NHS leaders.'
2. NHS England *et al*, *Delivering the Forward View: NHS planning guidance: 2016/17 – 2020/21*, Dec. 2015
<https://www.england.nhs.uk/wp-content/uploads/2015/12/planning-guid-16-17-20-21.pdf>
3. *Delivering the Forward View ...*, Para 13
4. NHS England, *Next Steps on the NHS Five Year Forward View*, March 2017
<https://www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf>
5. NHS England, *The NHS Long Term Plan*, January 2019
<https://www.longtermplan.nhs.uk/>
6. *The NHS Long term Plan*, P.3
7. *The NHS Long term Plan*, Para 6.3
8. Cornwall & Isles of Scilly, *Development of the Long Term Plan*. Report to Transformation Board, 9 May 2019
<http://doclibrary-shapingourfuture.cornwall.nhs.uk/DocumentsLibrary/ShapingOurFuture/TransformationBoardMeetings/Minutes/1920/201905/Item9App7LongTermPlanProcess.pdf>
9. Shaping our Future, *System leaders*
<https://www.shapingourfuture.info/about/whos-who/system-leaders/>
10. Shaping our Future, *An integrated care system for Cornwall and the Isles of Scilly*
<http://doclibrary-shapingourfuture.cornwall.nhs.uk/DocumentsLibrary/ShapingOurFuture/TransformationBoardMeetings/Minutes/1819/201810/Item7ICSSlideDeckSeptember2018.pdf>
11. *The NHS Long term Plan*, Para 7.3
12. Shaping our Future, *Cornwall and Isles of Scilly Operational Plan Executive Summary 2019/20*
<http://doclibrary-shapingourfuture.cornwall.nhs.uk/DocumentsLibrary/ShapingOurFuture/>

TransformationBoardMeetings/Minutes/1920/201905/
Item4App3iiiExecutiveSummarySystemOperationalPlan.pdf

13. Shaping our Future, *Cornwall & Isles of Scilly Health & Care System, Development of the Long Term Plan*,
[http://doclibrary-shapingourfuture.cornwall.nhs.uk/DocumentsLibrary/ShapingOurFuture/
TransformationBoardMeetings/Minutes/1920/201905/Item9App7LongTermPlanProcess.pdf](http://doclibrary-shapingourfuture.cornwall.nhs.uk/DocumentsLibrary/ShapingOurFuture/TransformationBoardMeetings/Minutes/1920/201905/Item9App7LongTermPlanProcess.pdf)
14. Amanda Stratford, *Healthwatch Cornwall – Health & Social Care Public Engagement*
[http://doclibrary-shapingourfuture.cornwall.nhs.uk/DocumentsLibrary/ShapingOurFuture/
TransformationBoardMeetings/Minutes/1920/201905/Item7App5HCEngagementPaper.pdf](http://doclibrary-shapingourfuture.cornwall.nhs.uk/DocumentsLibrary/ShapingOurFuture/TransformationBoardMeetings/Minutes/1920/201905/Item7App5HCEngagementPaper.pdf)
15. *Cornwall and the Isles of Scilly: Sustainability and Transformation Plan: Draft Outline Business Case*
<https://www.cornwall.gov.uk/media/22984634/cornwall-ios-stp-draft-outline-business-case.pdf>
See also Peter Levin, Six bungalows and no funeral: The short life, unmourned death and high cost of
Cornwall's Sustainability and Transformation Plan for the NHS
[https://spr4cornwall.net/wp-content/uploads/Six-bungalows-and-no-funeral-Cornwall-STP-FULL-
REPORT.pdf](https://spr4cornwall.net/wp-content/uploads/Six-bungalows-and-no-funeral-Cornwall-STP-FULL-REPORT.pdf)
16. Shaping our Future, *Integrated Community Services Review*, WorkshopSlidePack.pdf, via
[https://www.kernowccg.nhs.uk/get-involved/engagement/integrated-community-services-plans/edward-
hain-community-hospital/](https://www.kernowccg.nhs.uk/get-involved/engagement/integrated-community-services-plans/edward-hain-community-hospital/)
17. *The NHS Long term Plan*, Para 7.3
18. Lord Bridges (Cabinet Secretary 1938-46, Permanent Secretary to the Treasury and Head of the Home
Civil Service 1946-56), 'Whitehall and Beyond', *The Listener*, 25 June 1964. Cited in Peter Levin, *Making Social
Policy*, Open University Press 1997 (p.44) and in Peter Levin, 'Opening up the Planning Process', in Stephen
Hatch (ed), *Towards Participation in Local Services*, Fabian Tract 419, 1973
<https://digital.library.lse.ac.uk/objects/lse:hol622dav?page=2>
19. Peter Levin, *Five kinds of nonsense are keeping a community hospital closed*
<https://spr4cornwall.net/five-kinds-of-nonsense-keeping-a-community-hospital-closed/>
20. Shaping our Future, *Edward Hain community hospital: Case for change*
[http://doclibrary-kccg.cornwall.nhs.uk/DocumentsLibrary/KernowCCG/EngagingWithServiceUsers/
StrategicReportsAndPlans/PenwithCaseForChange.pdf](http://doclibrary-kccg.cornwall.nhs.uk/DocumentsLibrary/KernowCCG/EngagingWithServiceUsers/StrategicReportsAndPlans/PenwithCaseForChange.pdf)
21. Royal Cornwall Hospitals Trust, *Integrated Performance Report*, 6 June 2019 , p.42
[https://doclibrary-rcht.cornwall.nhs.uk/DocumentsLibrary/RoyalCornwallHospitalsTrust/ChiefExecutive/
TrustBoard/Minutes/1920/201906/App14CommitteeSummaryAssuranceReportsandIPR.pdf](https://doclibrary-rcht.cornwall.nhs.uk/DocumentsLibrary/RoyalCornwallHospitalsTrust/ChiefExecutive/TrustBoard/Minutes/1920/201906/App14CommitteeSummaryAssuranceReportsandIPR.pdf)
22. Peter Levin, *Don't close community hospitals: use them as re-ablement centres*, 24 January 2019
[https://spr4cornwall.net/wp-content/uploads/Dont-close-community-hospitals-use-them-as-re-ablement-
centres.pdf](https://spr4cornwall.net/wp-content/uploads/Dont-close-community-hospitals-use-them-as-re-ablement-centres.pdf)
23. A useful list of the statutory duties of Healthwatch organizations can be found in Healthwatch Leicester
and Leicestershire, *How we work*
<http://healthwatchll.com/how-we-work/>
24. As Note 15, *Draft outline business case*, p.47