Draft, Daft or Dangerous? What's the reality of STPs?

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STPs won't do what they say on the tin: they are not sustainable, there's no capital to finance any serious transformation, and many of them plainly don't add up: but they are seen as the future of England's NHS.

Just 38 of England's 44 STPs have been published, in varying states of completion.

Some are June drafts, some October; some contain financial, workforce and other essential appendices, some don't. Some have radically increased targets for savings just months after first estimates.

But all STPs have one thing in common: just weeks before they are scheduled to begin implementation, none of them has been subject to any serious public engagement or consultation.

Indeed some plans were only published by irritated council leaders, allegedly 'partners' in the STP process, who lost patience with the secretive process decreed by NHS England.

Most of the later drafts have some approval from NHS England, but it's not clear why some of the vaguest and least convincing plans have got through. However one element among many unidentified "savings" plans is "Specialist Commissioning" – controlled by NHS England. In NW London alone the gap on this is £189m.

Campaigners and the local public have been understandably suspicious and hostile.

Local councillors, as perhaps potentially the most politically vulnerable to public anger over cutbacks, have emerged in some areas as unexpected vocal challengers to the latest controversial plans – after decades of council abstention or gullible connivance on NHS policy and resource issues (for which they are not formally accountable, and have little knowledge). Councils have largely failed for decades to use the powers they still potentially retain on health.

But some reactions have been delayed and muted by confusion over the contradictory content of STPs, which manage to talk abstractly about some positive objectives, and getting commissioners and providers collaborating together, even while developing more concrete and questionable plans to save money.

An aspirational window-dressing of positive ideas camouflages the unpleasant content of STPs like a sophisticated air-freshener masking the real scent of sewage.

Every STP, following the new orthodoxy of Simon Stevens' *Five Year Forward View*, uses words for which nobody would consciously choose the opposite: better "integration" of the under-funded, fragmented and largely privatised 'social care' system outside hospital with under-funded, fragmented and in some cases arbitrarily privatised NHS hospital, community and primary care services, for example.

Who doesn't want more effective preventive and public health measures to keep people from needing the NHS in the first place? Who rejects action to address the "social determinants" driving ill-health?

Who would say no to fresh new resources to support and enhance primary care, easier access to GPs – and the option wherever possible of care nearby or even in your own home rather than trekking miles to overstretched, overwhelmed "centralised" hospital services?

But these sections, in each STP, are a smokescreen for unpopular changes, and ignore facts on the ground.

Public health programmes are being actually cut back across the country after government funding cuts. There is no money for worthy projects on social determinants – which in any case would take years to show any measurable reduction in pressure on the NHS.

Primary care is floundering, not flourishing: with many busy practices unable to cope with ever-increased pressure, many GPs are leaving and increasingly hard to replace, and Jeremy Hunt's promises to recruit 5,000 more GPs are simply bogus. Many STPs merely seek to paper over the cracks, with other – yet to be recruited – less qualified staff, to take over some roles from GPs.

As for community health services, some rural STPs are looking to close community hospitals, expecting patients to travel up to 50 miles on hazardous roads when they need a hospital. None of them address travel issues for the elderly, less mobile and single parents.

In town and country alike there is little plausible hope of developing properly-resourced systems capable of delivering complex care in individual homes, with no funding, no staff, no plan – and no public acceptance.

Even where community and home-based health or care services can be shown to be effective in enhancing patient care, they don't save money, but cost more.

STPs have to *save money*, close a total gap in excess of £22 billion by 2020.

Where the fancy plans don't deliver savings, old-fashioned cuts and measures will be wheeled back out. At least half of STPs' planned savings in most areas are already expected to be squeezed out of the hospital sector, through relentless, enormous "efficiency savings", ruthless reductions in "back office" support staff and staffing levels, and unpopular closures of beds, services and whole hospitals.

With no alternatives and no capital available to build new or extend existing hospitals, this is a recipe for a chronically under-resourced, chaotic and scandal-prone NHS. The "transformation" might even be services declining to the levels that triggered the major alarm in Mid Staffordshire Hospitals a decade ago.

When the time comes to implement the STPs and there are howls of public rage and protest, rocking local politicians, NHS England has nobody to blame but themselves – for a secretive process forcing rapid adoption of often flawed plans with no consensus.

STPs may seem easier than to speak truth to power and warn Mrs May that if the cash freeze begun in 2010 is extended to 2020 many services will be reduced to a state of collapse.

But STPs cannot solve this problem. Ministers must fund the NHS – or take full political responsibility for triggering its collapse.