

## STPs – cuts dressed up in wishful thinking

**John Lister, Secretary Keep Our NHS Public** – full text of speech to ‘Challenging the STPs’ conference, organised by Health Campaigns Together, Birmingham September 17 2016. [www.healthcampaignstogether.com](http://www.healthcampaignstogether.com)

It can be difficult to decide how to pitch a talk to a conference like this where so many people already know so much about the subject. I had a detailed talk worked out, with facts, figures, and warnings about STPs – making clever plays on the initials STP such as ‘Slash Trash and Plunder’ or ‘Squeeze Till the Pips squeak’.

But many of you are already fully aware of the local and national issues in relation to STPs. That's why you're here. And I have only limited time. So I want to put STPs into perspective. Because we need to see these plans in context: we need to be confident enough to deconstruct them, and expose them for what they are. They are no so complicated. Let's start with a story.

A sales rep is looking out of his hotel room one morning and he sees two men working along the side of the road opposite. One of these men digs a hole, the other fills it in. Time and again, a hole is dug and filled in. Eventually curiosity gets the better of the sales rep, and he has to go over and ask them what they're doing. One says “I'm Bill and I dig the holes: that's Trevor, and he fills them in. We're a team.” But then he adds ... “of course normally Eric works with us as well: he plants the trees – but he's off sick today.”

Teams only work with all the members working together. Plans only work when all the elements are brought together. One factor or person missing, and even the simplest plan goes horribly wrong.

On STPs the question for us is to spot what's missing amid all their talk of ‘systems’ and ‘partnerships’ and ‘multidisciplinary teams’ and ‘vision’ and ‘accountable care organisations’ that we see in every area of the NHS. Why is it that the teams can't deliver? What is it they're not telling us?

Of course for the NHS we know there are three missing elements:

- the money,
- the staff to do the job,
- and the evidence that the policies can deliver the expected results.

There is a profound reluctance in all the STP documents we've seen to engage with this harsh reality. Nobody wants to talk about money. Everybody pretends it's possible somehow to get by without using so many agency staff – even while fearing that the current problems with recruitment and retention could soon get even worse. Some of the tens of

thousands of EU nationals who are playing vital roles as health professionals and support staff throughout the NHS may soon be effectively driven out by the Brexit vote.

And nobody, but nobody seems able to supply any evidence that any of the plans will work.

When I was growing up in the 1950s and 60s on Sundays my parents used to listen to the Light Programme on the BBC, and one of the more irritating songs that used to be played again and again from that classic of patronising, racist stereotyping South Pacific was a song called Happy Talk: I am quoting here from memory:

“Happy talkie talkie, happy talk  
Talk about things you like to do  
You got to have a dream  
If you don't have a dream  
How going to have a dream come true?”

What we have in the STP plans is happy talk – wishful thinking, pie in the sky. The authors choose to live in a fantasy world where dramatic changes in working patterns and cultures can be achieved at breakneck speed – as a result of publishing a plan, a strategy, or even a diagram.

NHS England has over a hundred directors and senior staff who are paid more than the Prime Minister. What do they do?

I've been to the offices of NHS England in London, and was led through a huge office in which dozens and dozens of smart, bright people, apparently well-paid, sat at computers, or had left jackets over chairs. What are they all doing, what happens to what they do, and does it help?

We know what they're NOT doing, and that is addressing some key issues arising in STP plans. The North-West London plan identifies a target saving of £188 million from Specialist Care, which is controlled and commissioned by NHS England. Except nobody knows how these savings can be achieved. No problem, they say. According to the STP:

"NHS England Spec Comm have not yet developed the 'solution' for closing the gap, however *it is assumed that this gap will be closed*".

More happy talk. Assumptions with no evidence. Hoping for the best. Plans with bits missing. Teams with people missing. Bill and Trevor – but no budget for Eric.

We all know these plans are not written to be read. How many of you have seen the famous NHS management 'plan on a page' – which begins perhaps with a childlike graphic, but gradually expands to the point of an enormous A3-page or poster, jammed full of tiny type?

Or in some cases they set the pages out as PowerPoint slides, but then use type so small that even when projected large on a screen they hope nobody can spot what's missing. In

North West London the STP has page after page crammed with six point type. But it still doesn't add up.

The same refusal to confront reality means that NHS directors bring in McKinsey or another management consultancy to write a plan – since no NHS managers ever seem capable of writing a plan themselves any more.

But despite being lavishly paid for their work the management consultants don't finish the job. Why would they when there's more money potentially available? There are bits missing, and vague suggestions of additional research or information to be produced. So then the NHS pays them more money to finish the job. But they still don't finish.

In North-West London the plan known laughingly as 'Shaping A Healthier Future' has been running since 2012, promising for the last several years to publish a Business Case to explain how the money and services can work. The latest promise was a Business Case to be published this month: we didn't hold our breath waiting. It's just been postponed again to the New Year – we're not sure which year they mean. The consultants have already been paid tens of millions of pounds for this work, with millions more still to come: for some reason it's exempt from the normal limits on procurement of external consultancy. Nobody seems to have evaluated what the NHS has got for all this money apart from 2,500 pages of repetitive and largely unreadable (and unread) early and incomplete drafts of the Business Case.

And in any case the plan, like the STP which has pinched much of its content from it, is full of the same wishful thinking, happy talk: the same assertions with no evidence, the same aspirations for rapid, miraculous improvements in public health that would somehow magic away the requirement for front-line hospital beds, despite the absence of alternative services in the community, in primary care, or and social care – and despite the lack of any capital or substantial revenue investment available to establish such services.

Nor indeed have these management consultants – for all their purported expertise and with all the resources that they have available – offered any real evidence to support the assertions and proposals they've made.

In North-West London the STP is 54 pages in total, three pages of which appear to be references. Most of these are spurious: some are so vague it's impossible to identify what they are referring to; some are references to other management consultant documents by the same authors in North-West London, or to statistics and data which are not publicly available and internal to the NHS (so not checkable); some others are uncontested statistics.

But some lead to bizarre internet pages, such as the tiny url that takes us to an obscure and highly technical article by a team of Swedish academics about a specific project in Sweden: another points vaguely to an international survey of evidence assessing over 100 articles, only seven of which have anything to do with the UK.

What is glaringly obvious is that throughout the 51 pages of text there is not one example of a working model of the type of new systems that are proposed to replace hospital bed provision in North-West London, or anything to indicate that the new proposals might save anything like the amounts they hope to save. According to another document prepared by management consultants 'intermediate care' is supposed to enable the NHS in North West London to dispense with over 400 beds – but the document lacks any definition of intermediate care, let alone any plans to establish or expand it.

We should say of course that there is absolutely nothing wrong with expanding Public Health programmes, improved health education, or preventive programmes aimed at keeping people healthy and limiting the ill effects of lifestyle choices like smoking. We support such plans – although it's worth noting that Public Health budgets, never generously funded, have been heavily cut since 2010.

There is nothing wrong with wanting to integrate health services better with services outside of the NHS such as social care – which has also been brutally cut back since 2010, and is now very substantially privatised, completely fragmented, and desperately underfunded. Integration seems a long way off here, no matter what the plans may say.

But if it is not just going to be happy talk, then plans that hinge on expanding intermediate care, on improving GP services and primary care, on previously impossible levels of success for smoking cessation and other prevention programs, and generous provision of social care, need to be upfront about the need for increased funding and capital.

Instead, the STPs are presented as ways of curbing health spending to live within the impossible spending limits imposed since 2010, even while the population and its needs for health services continues to grow.

In fact we could reasonably ask whether the real threat does come from STPs. Is our real problem these fanciful documents we keep seeing, which set out the ambitions and aspirations, the vision, the dreams of NHS managers?

Or is it in fact the cuts that are being driven through now on the ground, and already happening even as we plough through the small print?

Is the real problem the visible decline in the performance and quality of care the NHS is able to deliver with the level of staffing and resources available? Is it the gaps emerging in the NHS workforce – gaps which are now being used in some areas as an excuse to close services on safety grounds for the lack of staff – effectively pushing through closures of hospital services without any consultation? We've seen this beginning in Lancashire, in Oxfordshire, in Lincolnshire and in London: this is a real threat that we have to confront, regardless of what's in the documents.

These issues are crucial, but not always at the centre of attention. NHS England, the CCGs and the trusts have resources at their disposal that we don't have: they can decide to publish or to leak plans, to make statements that get reported and to set the public agenda – while in the main we have to respond to these things. Our reports struggle for coverage: theirs can easily make headlines.

Their information is largely relayed uncritically in the news media by journalists many of whom know no better, and accepted by millions of listeners and readers who also know no better. So if the NHS is able to create the impression with the public that their plans are central, we have to deal with it.

If they get the editors and the chief correspondents and the journalists all passing down the stock NHS line that "no change is not an option" and acceptance that the NHS must be cut back to the austerity levels established by budgets since 2010, we have to combat those arguments.

The chief executive of NHS providers, Chris Hopson, has been all over the media in the last few weeks stating the obvious case that many trust bosses fail to make: that there is not enough money to sustain services on the current level and meet increased demand over the next four years.

He has spelt out a grim series of options in the likely event that no further funding is forthcoming from Theresa May's government. He warns:

"No trust board wants to depart from the key principle of NHS care being available to all based on clinical need not ability to pay. But, faced with this clear, national level gap, the logical areas to examine would be:

- reducing the number of strategic priorities the NHS is currently trying to deliver [such as seven-day services]
- formally rationing access to care in a more extensive way
- relaxing performance targets
- closing reconfiguring services
- extending co-payments or charges
- or reducing or more explicitly controlling the size of the NHS workforce which accounts for around 70% of the average trusts budget."

In other words 'Hopson's choice' is effectively whether to abandon NHS principles ... or cut the NHS to vanishing point. It's a choice between being hung or garrotted.

In fact, as he writes, most of these things are already being done in some form at local level by CCGs or trusts. They have effectively abandoned serious discussion on 7-day services, many CCGs are beginning to ration care, starting with soft targets like IVF, performance targets are routinely being missed, even for cancer care, reconfiguration plans are being

hatched up, and some trusts are planning to slash their workforce while NHS Improvement has set new limits on nurse staffing levels.

Only the charges remain the taboo policy, and Hopson is demanding a public debate that could enlist the ill-informed to create conditions to undermine this principle.

All the while, in the background, the private sector is wondering – six years into a decade of unprecedented real terms freeze on NHS funding, designed to reverse Labour's decade of increased investment and reduce the share of GDP spent on health – whether there is enough money left in the NHS elective care kitty for them to scoop up profits from picking up the pieces.

Many STPs will plan to establish Accountable Care Organisations, the new magic incantation from Simon Stevens Five Year Forward View that is seen as the way forward. ACOs are an American model, in which a provider accepts a contract paying a fixed amount per head of a given population to provide an agreed package of services. If they can do so inside the budget they can make a profit: but they take the risk that if the money runs out, they will carry the excess costs. These schemes have been losing a packet in the US because a number of them have taken on delivering the low grade 'bronze' subsidised insurance plans to people on low incomes; and these people tend to get sick, and run up costs of treatment – which is not what the insurance companies want or expect. Many have gone bust.

How could all this apply to England? The nearest equivalent we have seen so far was the Cambridgeshire CCTG plan for a single £150m a year contract for Older People's and Community Services. It was very controversial. They put it out to tender: but a number of the key private bidders withdrew as the contracting process went on, arguing that there was not enough money in it. The contract eventually went to two local foundation trusts: and within 8 months the contract collapsed – because there was not enough money in it. In Staffordshire attempts to develop a cancer care contract have also struggled because most private bidders pulled out, and once the contract had been allocated even the local NHS trust pulled out ... because there's not enough money on the table to sustain services.

These schemes don't save money – especially if they are to draw in the private sector. They are just a new type of cash limit. So if there's not enough cash in the pot, there won't be a sustainable service. Nor will ACOs be accountable in any real sense to the communities they are supposed to serve.

Hopson says we should have a public debate on how the NHS should be sustained. I say no – let's not have a debate in which one side, backed by the right wing media, Reform and other right-wing think tanks, and the backwoods Tory right that is now dominant in that party will be urging us to turn the clock back to the 1930s, drop the NHS principles and adopt some combination of charging for treatment and private health insurance.

Let's not debate, let's fund the NHS properly from general taxation: it's already underfunded compared to almost any comparable country, with fewer staff fewer beds and less modern equipment than almost any developed economy.

Hopson puts the points bluntly, but the cash squeeze is the reality behind the happy talk and charades of STPs. We can't choose between fighting the cuts on the ground and challenging the STPs and other reconfiguration plans – because they come from the same source.

We have to fight both, and demand proper funding and the renationalisation of the NHS to strip out the crazy, wasteful, fragmented, bureaucratic market system that was massively expanded by Andrew Lansley's 2012 Health and Social Care Act.

So are we crying wolf too early? Should we wait until the end of the year before we begin to raise the alarm over the new proposals in the STPs, and demand consultation on the proposals where they threaten local access to services through reconfiguration and centralisation of hospital care?

We know that the consultation in any event will be a token effort after the decisions have been taken: we know that the plans all rest on the same series of evidence free assertions and assumptions.

Rather than wait to raise these issues in the public domain until we reach the point where cuts are being driven through, we're here today to raise public awareness of the danger of STPs, and the need to challenge them consistently while still keeping a close eye on the cuts taking place.

That's what we're here for. I'm delighted to see that Diane Abbott, shadow Secretary of State for health, is here today and very clearly here on our side, and for the first time in a long time we finally have an opposition that is willing to oppose the cuts and privatisation and stand up for the NHS.

Together we are strong. Let's develop fighting policy at local level and national level to challenge the cuts that are being proposed through STPs, to expose the happy talk, the doubletalk and a hot air of the STPs, while keeping our services together – and keeping our NHS public.