UNISON
Eastern Region

UNISON update on Sustainability and Transformation Plans and Partnerships in the **East of England**

Whatever happened to the STPs?

Sustainability and Transformation Plans emerged from the situation in the aftermath of the Chancellor's Autumn Statement in 2015.

That had underlined the tightening financial squeeze on the NHS, with funding rising substantially less each year than the estimated 4% annual real terms increase in cost pressures up to 2021.

NHS England faced a tough task in delivering the projected £22 billion of cost savings to enable the NHS to balance its books by 2020/21.

In this context, just before Christmas 2015, NHS England sent out a directive (*Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21*) to every NHS provider and commissioning body setting out proposals for a rapid, substantial change in the way the NHS was to work.

Less than 3 years after the complete reorganisation of the NHS as a result of the Health & Social Care Act, it called for a fresh reorganisation.

The NHS had been carved up by the Act into smaller geographical areas defined by 207 Clinical Commissioning Groups: NHS England now called for the creation of a more strategic 'place-based' system. The proposals effectively attempted to sidestep existing legislation, and establish new structures capable of driving forward NHS England's 2014 *Five Year Forward View* (FYFV).

Collaborate

Commissioners (CCGs) in each "local blueprint" were supposed to collaborate not only with local government, but also with local NHS providers, who in turn were expected to collaborate rather than compete with their fellow providers:

"Planning by individual institutions will increasingly be supplemented with planning by place for local populations. For many years now, the NHS has emphasised an organisational separation and autonomy that doesn't make sense to staff or the patients and communities they serve."

This fresh change had to be done to a very swift and demanding timetable:

"We don't have the luxury of waiting until perfect plans are completed. So we ask local systems, early in the New Year, to go faster on transformation in a few priority areas, as a way of building momentum."

Each local area was left to organise urgent discussions to establish the areas that would be covered in the Plans, their own "footprint," to be approved by NHS England, and each needed to secure the support of local government:

The result of this process was NHS endorsement in March 2016 of proposals dividing England into 44 "footprints", each of which began the process of creating a local leadership team and drawing up Sustainability and Transformation Plans (STPs).

This has created a certain degree of ambiguity in the language, since the acronym STP is now used interchangeably to mean the Plan itself, the people implementing it (the Programme Board), or

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as a generic term to embrace the various proposals for cost-savings within the Plans.

The Plans, most of which failed to appear promptly to the prescribed rapid schedule, and none of which were developed through any inclusive process of public engagement but through confidential discussions in meetings behind closed doors, first began to emerge into the public domain from the end of October 2016: the last few were not published until that December.

It was clear from the start that even after this extra time in drafting, many STPs were still a work in progress rather than a finished plan: few published the detailed financial appendices, workforce plans and implementation plans that would be required to make any assessment of how realistic and viable the proposals might be.

Many developed their own distinctive jargon and their own interpretation of the "new models of care."

Secrecy

The secrecy and obscure language have contributed to a palpable widespread public ignorance over STPs and what they represent: while the documents themselves appear incomplete and unconvincing.

However this does not mean that the Plans themselves are unimportant. If NHS England had got its way, they would have potentially represented a landmark moment in the development of the NHS in England.

This brief survey of what has transpired since in the six STPs in UNISON's Eastern Region shows that many of the hopes for what STPs might represent and achieve have proved unrealistic.

Few have progressed to any extent down the path of genuine collaboration and local partnership.

Much of the "integration" that has taken place has in fact been alliances and mergers of commissioners on the one hand and providers on the other – leaving the NHS "purchaser/provider split" substantially intact.

Most of the proposals for developments in service that have emerged from STPs depend for their implementation on availability of capital (in desperately short supply), increased revenue funding (while STPs seek cash savings) and of course adequate numbers of suitably qualified staff (while vacancy rates have continued to increase, and with them spending on agency and bank staff to fill the gaps created).

But another crucial weakness has been exposed as this introduction is written – the limited engagement with local government. Three of the four council participants in the Bedfordshire, Luton and Milton Keynes (BLMK) STP (see page 3) have warned that they will pull out of their limited engagement with the process unless there was more serious attention paid to the issues facing councils and a more realistic timetable for implementing changes.

This is even more significant in view of the 'vanguard' role of BLMK in what NHS England wants to be a drive of STPs to develop "Integrated Care Systems". If NHS leaders have got things so wrong in this area, how far adrift have the others gone in the implementation of the STP project?

Few STPs have progressed to any extent down the path of genuine collaboration and local partnership.

Much of the "integration" that has taken place has in fact been alliances and mergers of commissioners on the one hand and providers on the other – leaving the NHS "purchaser/provider split" substantially intact.

Finally it is worth drawing attention to the near-universal deficits facing acute hospital trusts across the six STPs, while some of the CCGs have built up substantial surpluses – and show no inclination to move towards any genuine integration or sharing of resources and decision-making.

Some of these financial problems will be somewhat relieved by Theresa May's announcement of a limited increase in planned NHS funding through to 2024.

However almost all observers agree that the fundamental imbalance that has emerged from 8 years of virtually frozen real terms funding for NHS services since 2010 will not be rectified by such a limited and belated adjustment, nor will it provide the necessary capital and revenue investment required to implement ambitious STP plans.

The pressure continues to apply to front line staff in all sectors of the NHS, compounded by what are clearly often unrealistic plans and assumptions.

UNISON has developed this analysis in order to ensure our members and representatives are fully updated with a realistic analysis of the local situation in each area, and able to offer a positive but informed response to genuine proposals for partnership and collaboration to improve services.

In its 70th year, UNISON wants to see an NHS that is properly funded, staffed and equipped to meet the growing needs of a growing population: but we are also determined to ensure that in the process our members are treated with proper respect and given the right resources, training and support to deliver safe and high quality care to their patients.

Report researched for UNISON by John Lister, June 2018

NHS England boss Simon Stevens

NHS England sets course for "integration"

February Guidance from NHS England sets out a concept of Integrated care Systems, stressing that they are supposed to be working closely with councils

"All Integrated Care Systems are expected to produce together a credible plan that delivers the system control total, resolving any disputes themselves, and no 'shadow' Integrated Care System will be considered ready to go fully operational if it is unable to produce such a plan"

(*Refreshing NHS Plans*: p12).

The guidance also stresses the importance of "integration" with local councils, even though this is a consistent weak spot in all of the 44 Sustainability and Transformation Plans which were endorsed by NHS England and published at the end of 2016:

"We will reinforce the move towards system working in 2018/19 through STPs and the voluntary roll-out of Integrated Care Systems. Integrated Care Systems are those in which commissioners and NHS providers, working closely with GP networks, local authorities and other partners, agree to take shared responsibility (in ways that are consistent with their individual legal obligations) for how they operate their collective resources for the benefit of local populations."

However it's clear from this survey of progress in implementing the six STPs in Eastern Region, with their various quite different trajectories and ambitions in terms of integration that these guidelines are at odds with most of the work that has been done so far at local level.

As can be seen from the latest warnings from local government in the Bedfordshire, Luton and Milton Keynes area, liaison and collaboration with local government has been low down if at all on the agenda of hard-pressed NHS management seeking quick fixes to deliver cash savings for the NHS.

This is clearly controversial with the local government bodies, which face their own, onerous cash pressures and may have seen the STPs as a way of drawing in NHS cash to underwrite some of the growing gaps in funding for social care.

Bedfordshire Luton and Milton Keynes

The BLMK footprint is mainly located within East of England, but Milton Keynes has for some time been viewed as an East Midlands trust.

Despite following on years of debate and controversy over proposals to reconfigure services between Bedford Hospital and Milton Keynes, with one or even both Emergency departments being downgraded, and patients from either trust or both being redirected to Luton, the STP avoided making any clear proposals.

Indeed what seemed to be lining up as a possible merger between Bedford Hospital and the Milton Keynes Foundation Trust was effectively abandoned in favour of subsequent plans for merger between Bedford and Luton, which has developed a Strategic Outline Case and a Full Business Case (FBC), neither of which has been published in full, or presented for consultation.

This merger has already been delayed well beyond the initial planned timetable, because of financial problems besetting both trusts.

Implicit in the current merger plan of a trust and Foundation Trust, each running substantial underlying deficits, is the prospect after the merger of a swift process of rationalisation and centralisation of specialist services.

Bedford Hospital, 2/3 the size of Luton and a junior partner as the NHS Trust, but also facing the larger deficits, would inevitably be the loser in any transfer of services between the two hospitals, which are 19 miles apart – with resultant problems for Bedford patients accessing services, and NHS staff whose jobs might be moved from one site to the other.

The FBC Executive Summary is evasive on the likely changes that would follow and keen to emphasise they would not be immediate:

"it is likely that any service changes will take place from Year 2 onwards and co-designed proposals which have been identified through clinical integration planning as bringing significant clinical benefit will be subject to the usual engagement/ consultation processes and implemented as quickly as practical." (p18)

Predictably there are hints in the FBC summary that Bedford's A&E would be at least partially downgraded in favour of Luton:

"A&E services are provided both at L&D and BHT, with the potential for the highest risk emergency activity out of hours being supported by the L&D site;" (FBC p11)

"Care of high dependency emergency paediatric patients would be supported by the L&D site" (p12)

Ominously for Bedford Hospital:

"Work has already started to identify challenges and opportunities arising from the integration of the following key services: Emergency Department; Maternity Services; Paediatrics; Frailty and Complex Care; Emergency Surgery" (p21)

There appears to be no proposal to open up the FBC to any public consultation, so any proposals that do emerge along these lines would likely come as a surprise to local people, with any subsequent consultation posed more as a fait accompli than a choice.

STOP PRESS

As this report is completed the Health Service Journal has reported a threat to pull out of the STP by three of the four council leaders.

Pete Marlan, leader of Milton Keynes Council; Hazel Simmons, leader of Luton Borough Council; and Dave Hodgson, mayor of Bedford Borough Council have written to their local CCGs stating that they "are prepared to disengage with the BLMK STP and withdraw our resources from the process" after becoming "increasingly frustrated" that the views of local government are being "overlooked".

This is not surprising in view of the track record of the STP/Integrated Care System progress so far, as can be read in this unchanged analysis completed at the end of May.

Plans for 'Integrated Care'?

The decision to establish some form of 'Accountable Care System' (since rebranded "Integrated Care" by NHS England) had already been taken in the secret early stages of the STP, leaving a brief discussion over how, but not whether to implement it.

This is despite the previous history of Bedford CCG, which far from pressing for integration of services has gone out of their way to carve up MSK and dermatology services, mental health and community services, and put them out to tender, bringing in external providers, whether NHS or private sector, and undermining the position of local trust services.

Bedfordshire and Luton CCGs have contracted out mental health and community services to trusts from outside the area (East London FT and Cambridgeshire Community Services) while Milton Keynes has opted for a provider from Central and North West London, making local integration less likely than ever.

This has already caused problems for Luton and Milton Keynes CCGs seeking a coherent approach to the procurement of community services.

The STP however proposed a swift march to the establishment of an 'Accountable Care Organisation' in March 2018 (p24).

Clearly this timetable has slipped significantly, even though BLMK has already been included as one of ten advanced 'Integrated Care Systems' which have been promised extra funding to support improvement to services as well as "more freedom" to decide how to run health care in their area.

On April 30 BLMK published a 'Single System Operating Plan': this revealed that the area is "still determining its ultimate status as an Integrated Care System."

The SSOP's emphasis on the role of private businesses and the private sector in the prevention programme is less than impressive, while the vague wording in the section on complex care leaves more doubts than it resolves.

However there is more clarity in the Finance Headlines, which note how far the STP is away from its financial targets.

"The BLMK system has an extremely challenging financial outlook at present. […] At STP aggregate level, a surplus control total of £9.7m is required … This represents a £15.7m actual year on year improvement, and would necessitate efficiency savings of at least £80.5m. […]

"At this point in the planning process the STP believe that the system is likely to see an actual deficit of £13.4m …" (p43)

The financial consequences of becoming a "full or partial Integrated Care System" are "potentially significant": missing the control total would mean a loss of £29.5m funding if BLMK was a full Integrated Care System, or £8.8m if it accepts interim status.

As a result, with no certainty over whether any compromise deal could be negotiated with NHS England the STP "is not in a position to confirm or otherwise its agreement to any control total".

The SSOP also reveals serious unresolved problems in relation to the workforce. BLMK has higher rates of agency usage (14-16%) than the average in Midlands and East trusts, along with the 2nd highest proportion in East of England (26%) of GPs aged over 54, and huge vacancy rates of 56.6% in mental health and community, 21.5% in mental health nursing and 19.9% in adult nursing. Vacancy rates in social care are also very high.

Promise of consultation?

One thing that seems to unite all of the parties to the STP is a reluctance to consult publicly on their proposals. On page 31 the STP boasts that

"A total of 16 STP partners have taken part in the development of this BLMK STP. This is the first time this group of organisations has worked together." (p31)

But ten pages further on we find the admission that no elected councillors had even been made aware of the work so far, and that it had been shared with few clinical and no non-clinical NHS staff. The plans which will be most controversial have not been given any wider support: the STP admitted:

"BLMK's local Council colleagues have yet to activate their democratic processes, by which officers can fully and formally engage their elected members, and relevant scrutiny mechanisms (such as HOSCs), to consider, scrutinise, debate and opine on the STP." (p41)

On the next page the extent to which councils have been sidelined was explained:

"Up to October, BLMK's Priority 5 workstream has proceeded largely without Council input. The shift to an accountable care system, and the associated changes to commissioning, are being observed by Councils with interest. (p42)

Nor had there been to any actual consultation with staff:

"Clinical, staff and public engagement on our STP proposals and plans contained in our STP has, to date, been relatively light-touch. This now needs to accelerate if we are to benefit fully from input from these crucial constituencies."(p41)

The SSOP in April 2018 makes clear that this attitude to consultation has continued: all of the proposals have been developed by a handful of people without any attempt to seek any wider responses or engagement:

"BLMK's local council colleagues have not had sufficient time to fully engage with their colleagues and councillors either informally or formally and, in particular, councillors have not been able to meaningfully contribute to, comment on or scrutinise this document."

Plans to link up the three CCGs with a Joint Accountable Officer, Joint Chief finance Officer and a Joint Executive Team were greeted with anger and dismay by councillors who had not been warned or consulted, even though suggestions that

this was tantamount to a merger were strenuously rejected.

Cllr Louise Jackson, responsible for health issues for Bedford Borough Council, told Bedford Today:

"I am really cross about this. There has been no engagement with us about this – and that's simply a bad idea. If you're going to make such a huge change like this then you want the public and the elected members on board."(April 19 2018)

But it's not just councillors that have been left in the dark since the process began in 2016:

"Nor have NHS partners necessarily taken the completed document through their own governing processes." (SSOP p4)

As noted above there have also been no moves to open any public consultation on the Full Business case for merger of Bedford & Luton trusts. The word "consultation" is absent from Section 6 of the SSOP outlining plans for "communications and engagement" with residents, or with 'Statutory Partners' who are clearly seen as subordinates.

The STP leaders seem to think "consensus" can be established without consultation, and that "engagement" consists in selectively lecturing on proposals which have been hatched up in secret and only partially published. (pp17-18)

The only references to trade unions come in the moves that have been made towards "partnership" on workforce issues – but unions' views have not been sought on the STP or plans for an ICS.

Perhaps most bizarre of all in the variety of bodies emerging as part of the STP process across BLMK is the "Integration Board" that was set up in February 2018 – as a sub-committee of Milton Keynes council's health and Wellbeing Board.

It is to be composed of 12 people from NHS and council bodies, with a brief that includes a facility to divide the meeting and exclude trust representatives where necessary to discuss "commissioning issues which should not be shared with providers" – and, perhaps predictably "meetings will not be held in public".

This very curious notion of "integration" was accompanied by a statement from the chair of the local CCG to insist that "the success of the Integration Board would be down to openness and transparency".

Timetable for implementation

With delays to the merger plans and to progress towards an ICS, it's clear that the timetable for implementation has been hugely over-ambitious since the first moves to establish the STP early in 2016.

The uncertainty over the financial performance of providers and commissioners within the footprint means that there can be no certainty over the next steps, while the lack of any genuine consensus or serious collaboration with local government means that any attempt to push forward is likely to be met by political resistance and local opposition from unconvinced campaigners.

Current/recent financial issues

In 2016 the STP began by identifying a potential "do nothing" spending gap between resources and predicted costs of £311m (£203m NHS bodies and £108m local government – although in common with most STPs no proposals were put forward to address the local government deficit).

However the "do nothing" figure was a deliberate ploy to impel local NHS bodies, and to some extent the local public insofar as they were informed about the process at all, to accept the need for drastic measures.

It was never realistic to assume either that government would not allocate any additional resources for winter pressures or in response to growing public unease at the manifest crisis in the NHS, or that the NHS organisations which for the last 35 years have been required to generate savings through "cost improvement programmes" (CIPs), or more recently Quality Improvement and Productivity Programme (QIPP) savings would abruptly cease to do so.

It's clear that there is still a considerable underlying financial imbalance in BLMK, with Bedford and Milton Keynes trusts facing the toughest struggle to balance the books, while Bedfordshire and Luton CCGs are also carrying cumulative deficits that have not been resolved.

The most recent Board papers show two of the three acute trusts ended 2017-18 in deficit: Bedford by £8.5m, Milton Keynes by £16.1m. Luton & Dunstable managed

Missing the control total of +£9.7m would mean a loss of £29.5m in extra funding if BLMK was a full Integrated Care System, or £8.8m if it accepts interim status

– through securing additional payments totalling £19.9m – to transform a £9.4m loss of the year into a £10.5m surplus: the trust has already bid for another £9m of support for 2018-19.

The CCGs are also facing problems: Bedfordshire CCG ended 2017-18 with a cumulative deficit of £55.9m (HSJ 24 April 2018). Luton CCG delivered a £5m surplus for 2017/18, but is carrying a cumulative deficit of £16.5m which is not mentioned in the narrative of financial reports (May papers Finance Report p3).

The minutes of Luton CCG's March Board (May Board papers, page 6) heard that while the target for 2018-19 is to deliver a "control total surplus of £4.8m" there are problems that could easily wipe out that surplus."

There is a net risk of approximately £6m which includes a £4.8m gap with Luton & Dunstable Hospital, a £3m gap on the CCG's QiPP target and £1.5m cost pressures.

Milton Keynes CCG by contrast has been more or less breaking even, and carrying forward a surplus which last year increased to £7.9m (May papers, Finance report, p8).

Whether Milton Keynes CCG would be willing to share out its surplus to help cover the deficits of the provider trusts in the STP/ICS area, as required for genuinely "integrated care", remains to be seen, if the process towards the ICS ever advances that far.

Even if that did take place, the limited surplus in Milton Keynes is not enough to outweigh an overall deficit across the footprint, a result of under-funding for which no clear solutions have been proposed.

Winter pressures/beds/DTOCs

The winter 'sitrep' reports from NHS England for the BLMK footprint show a health care system under considerable strain. Even at the end of the winter period, on March 3, Bedford and Milton Keynes hospitals were running at crisis levels, with 100% bed occupancy. Luton & Dunstable was not far behind on 99.5%.The hospitals only scraped through thanks to opening additional beds (44 in Bedford, 36 in Luton and 11 in Milton Keynes.

Added pressure on services came from Delayed Transfers of Care – in March alone accounting for 206 bed days in Bedford, 477 in Luton and a massive 1156 in Milton Keynes. In early March each of the trusts still had more than half their beds occupied by patients who had been in hospital over a week: Bedford on March 3 had 238 compared to its regular complement of 352 beds; Luton 334 patients over a week out of 620 regular beds; and Milton Keynes 272 from a normal bed provision of 483.

Smaller but significant numbers or patients had been marooned in the three acute hospital for over 3 weeks (such patients are now newly designated by NHS England as "superstranded"): Bedford had 77, Luton 126 and Milton Keynes 76. These numbers confirm that as of the spring of 2018 any STP ambitions to have integrated services and relieved the pressure on hospitals had yet to make an impact.

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Partnership with local government?

There is little evidence that despite appointing Richard Carr, chief executive of Central Bedfordshire council as the 'senior responsible officer' for the STP, the NHS organisations have any real aspirations to work more closely with local government.

The fact that serious engagement with elected councillors has still not yet taken place, after 18 months of furtive talks and covert plans, suggests that at best their involvement might eventually be seen as useful window dressing for the proposals that are being lashed up. It's more likely their involvement is seen as unwanted and – especially if any were to raise criticisms – even unhelpful.

The Single Operating Plan narrative document published on April 30 also makes very clear that there is no intention to consult the public on any of the proposals, and that the new 'Integrated Care System' would emerge as a body outside of the main structures of the NHS and local government, without any accountability whatever to local people, while the de facto plans to fuse the 3 CCGs together under a single accountable officer means that there would be even less prospect than before of residents in any one CCG area making their concerns heard or influencing any decisions.

The consistent failure to seek any genuine partnership with local government does not of course mean that council leaders and officers, sniffing eagerly for the merest hint that the less heavily cut NHS might offer some possibility of extra funds to bolster flagging social care budgets, have been any less keen to lend support.

The question is whether this enthusiasm would survive sustained pressure from campaigners willing to point the finger at those responsible for endorsing flawed plans, and demand their elected representatives speak up for local communities rather than being drawn in to supporting unelected NHS managers who show them little respect.

Cambridgeshire and Peterborough

Cambridgeshire and Peterborough STP is coterminous with a single CCG, which last year was upgraded by NHS Improvement from a bottom-grade rating of "inadequate" to "requires improvement".

However the improvement has yet to take place, and a June 2018 report on the CCG by PWC is described as "scathing" by the *Health Service Journal* (June 7), whose correspondent has received a leaked version of the report. It describes the CCG's problems as "among the broadest and deepest we [PWC] have ever seen".

The CCG reported a deficit of £42m for 2017-18, £26.6m worse than planned: but PWC points out the underlying figure is £49.2m.

Of the STP leadership PWC notes chronic problems of "instability at leadership level"; "a lack of experienced leadership and capacity" and "lack of direction at the STP delivery unit". The CCG has until July 2018 to get an improvement plan signed off by NHS England.

The STP, drawn up in 2016, was focused primarily on balancing the NHS (trusts' and CCG's) books: "the 'do nothing' scenario […] includes specialised and ambulance services but excludes Peterborough City and Cambridgeshire County Council figures, on which work is ongoing, and primary care" (p9, emphasis added). Nonetheless, even before implementation began the STP implausibly claimed:

"We have been able to close the £504m 'do nothing' gap to a small NHS system surplus position of £1.3m." (p42)

It is perhaps no surprise that the actual situation has not turned out anywhere near as positive, with both major acute trusts and the CCG running substantial deficits for 2017-18 (CUHFT £42.1m, NWAFT £38.9m).

In the case of North West Anglia the deficit was unexpectedly reduced by a bonus Sustainability and Transformation Fund payment – which the Trust joyfully notes in minutes of its April (May 1) Board meeting came as a result of NWAFT meeting their 'control total' deficit … while "other trusts" had missed theirs.

This does not look much like a new culture of integration or sharing.

Bed closures/ rationalisation? Reconfiguration? Mergers?

The merger of Peterborough & Stamford Hospitals Foundation Trust with Hinchingbrooke Hospital NHS Trust to form the North West Anglia Foundation Trust was being lined up before the STP and went through in parallel rather than as part of it.

There are surprising claims from NWAFT that it has – unlike most hospital mergers delivered all the anticipated savings and possibly even more.

However the ongoing subsidies that have propped up the Peterborough Trust and compensated for the excess costs of a disastrously expensive PFI hospital contract mean that the financial regime is far from transparent.

The STP's service improvement plans are left completely unclear: in fact the STP itself admitted its management team was still trying to work out what would be needed:

"We are systematically working through existing service improvement plans to see if more community and social care capacity needs to be commissioned …." (STP p3)

There are ongoing concerns over the future of A&E and maternity services at Hinchingbrooke Hospital.

Despite this suggestion that more capacity might be needed, there is also a vague mention of the closure of community beds, with no details on numbers or location:

"This transition would result in a reduction from the current total community bed stock by 2018" (p18, emphasis added)

However the conclusion from this is that there would be a resultant reduction in costs, "releasing funds for reinvesting in home base services for local people…"

This suggests that community hospitals would be closed altogether, otherwise the savings from piecemeal closure of beds would be relatively limited. Indeed this is followed (p21) by discussion of plans to effectively close and "redevelop" local community hospitals into polyclinic-style "urgent primary care hubs and primary care at scale … in modern purpose built premises over the next 3-5 years".

The Discharge to Assess plan will see hospital staff being moved from working in an acute setting into the community.

NWAFT have tried to start this already and are asking 3 staff to work in the community: however there is only one pool car, and staff have been advised they are expected to see 5 patients. In the trust setting they see 12.

If they go into a patient's home and find they shouldn't have been discharged staff will have to wait with them until an ambulance arrives to transport them back to the trust. Decisions on whether to 'discharge to assess' will be made on a white board basis by a nurse.

One relatively accurate assessment in the STP is that staff numbers were not going to be reduced but increased.

However the STP does not discuss how the extraordinarily vague plans for "horizontal integration" of so-called "back office" services can save the proposed £12m (p64) without cutting jobs.

It's not clear to what extent this is the same proposal as "Shared services" which are supposed to save £24.2m a year (chart p46) or the "system support cost" savings of £23.3m in the chart on p42.

The STP seems also to assume the availability of £800m of capital, along with NHS England agreement to waive a series of rules, ignore several years of unbalanced budgets and agree specific additional funding. None of these appeared realistic in 2016, and they all seem even further from the mark in 2018.

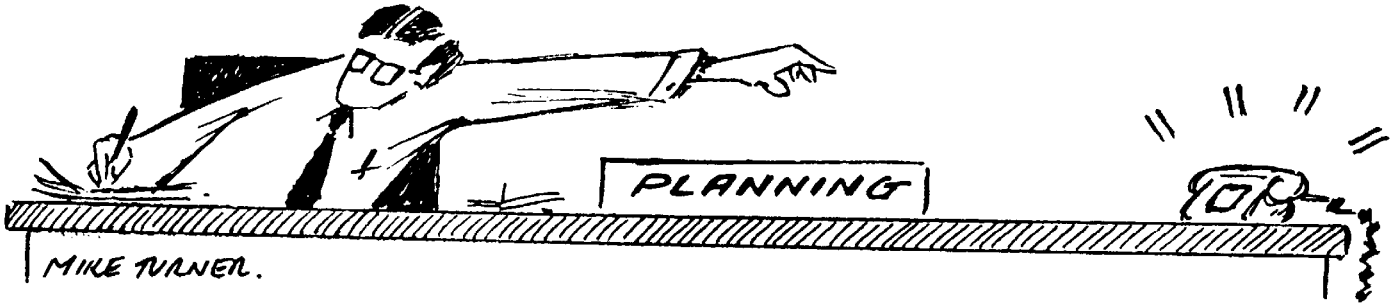
Plans for 'Integrated Care'?

The plan was for the entire STP footprint to begin to "behave like an ACO" [Accountable Care Organisation] and to work across organisational boundaries to a single "control total" budget:

"As a local health economy, we are attracted to the beneficial concepts of an Accountable Care Organisation (ACO), with one set of leadership, one set of financial incentives, and one set of clinical motivations.

"However, through the lessons learnt from UCP, and from a strategic outline case for organisational form changes conducted last autumn, we recognise that it is the behaviours of successful ACOs we find appealing including, in time, adopting their contractual or organisational structure.

" … Our ambition for the Cambridgeshire and Peterborough health and care system is to develop the beneficial behaviours of an ACO on the way to becoming a value-based system which is jointly accountable for improving our population's health and wellbeing, outcomes, and experiences, within a defined financial envelope." (STP p11)



Heavy emphasis in the STP was placed on the development of a "Memorandum of Understanding", which has been exhaustively debated, revised and referred to for the past 2 years. In November 2017 an updated version of this was published, still without any of the content having been opened up to any public scrutiny or consultation.

A repeated theme in the Memorandum of Understanding is the need to develop a "new set of behaviours" among "System Partners" that would "replicate those of an accountable care system", although at no point is there any information on what they mean by this.

There is an evasion over whether the chosen model is the US-style ACOs, and if so which ones, or the various other models of care that have been generally lumped together by such bodies as the King's Fund under the heading of Accountable Care.

The MoU accordingly "describes principles of behaviour and action which pertain to the implementation of the Sustainability and Transformation Partnership". However the four bullet point generalised "motherhood and apple pie" ambitions set out in Commitment 1 on page 3 appear to have little to do with Accountable Care.

Commitment 2 in similar vein calls on all Partners to "agree explicitly to exhibit the beneficial behaviours of an accountable care system" which also seem to be generalised, all-purpose statements of principled behaviour, again with no obvious connection to accountable care – itemising 'People First; Collective decision making; Common messaging; and Open book transparency'

The MoU goes on (p6) to make clear the ambition that:

"Financial and operational plans will be aligned across health and social care; the Partners agree to plan finances and operational capacity together, neutralising any inclination to cost shift or not to invest in one part of the system to save elsewhere.

"This will involve working to common assumptions, producing plans for regulators that are not works of fiction …"

For years UNISON and campaigners have called on local health management to produce plans based on reality rather than works of fiction.

Even if that's now only coming as a result of the STP, it's a welcome and belated step forward. But what a confession on the way they have run things up to now!

It's also clear that the significance of some of these commitments has not been properly taken on board by the STP Partners, not least the commitment to stick to decisions.

One of the early decisions made by the STP was that it would continue to pay providers on the existing "payment by results" system, maintaining the purchaser-provider split, rather than behave like an ACO, where a single capitation-based block budget is agreed by the providers, who then accept the financial risk of costs exceeding the budget:

"Providers will be paid for the activity they undertake, against an agreed activity trajectory, and commissioners will be responsible for taking decisions about what services can be provided affordably …. Due to the lack of incentive to do more activity, even where it would be desirable as it would reduce overall system costs, block contracts should be avoided for all services." (MoU p 6)

That was November 2017. Just six months later, in an update to the NWAFT Board on the implementation of the STP, we find this decision has been reversed:

"The STP is refreshing its plans and the way it works. A notable change for this financial year is a move to Guaranteed Income Contracts for the two acute providers. A Guaranteed Income Contract is alternatively known as a Block Contract, rather than the payment by results or activity that has been in place in the NHS for many years.

"As a result the Trust has accepted a risk in relation to activity growth above that agreed, in return for no fines and a benefit if the activity was below plan".

(Chief Executive's report to May 30 Board)).

However the really big hostages to fortune in the form of over-ambitious plans come in Commitment 3, which commits the partners to delivering a major increase in frontline care by the end of 2018-19 (the current financial year):

"fully staffed integrated Neighbourhood Teams will be operational across C&P, providing a proactive and seamless service. General practices will have received support from partners to be sustainable. Social care will be functionally integrated" [the MoU does not say what it should be integrated with]

"hospital flow will be improved, with a reduction in annual growth rates in non-elective admissions, a fall in bed occupancy and Delayed Transfers of Care (DTOC). … All acute services …will be clinically sustainable seven days a week."

The same Commitment goes on to promise to address structural system deficits "by securing additions system income …" including: "specific structural deficit funding (PFI support, CCG allocation increases, etc.)".

However these issues require decisions by NHS England or government to allocate the necessary additional funding, not the unilateral signing of a document by local management. If not, why have they not done it before?

But while it might yet prove to be a way of drawing much-needed extra money into the local system, the STP's main product so far seems to have been a constantly growing volume of repetitive, dull and unremarkable documents explaining the roles of its burgeoning network of committees, which in turn seem to be a formula for distracting management from their real jobs rather than taking forward new projects.

The MoU identifies a minimum of six groups reporting to the STP Board and the Health & Care Executive, but there could be more, since the list includes an undefined number of "Clinical Communities and Delivery/Enabling Groups" (MoU p7). The MoU goes on to admit that drawing out the leading personnel to run these groups is likely to impact on other work:

"These 'aligned' staff will be expected to allocate the bulk of their time to the system work – with up front negotiations about what may need to be stopped as a result." (p7 emph added))

As time goes on, with evidence of the work, usefulness and achievements of these groups vanishingly hard to find up to

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now, many will begin to question whether sensible savings and greater efficiency would flow from scrapping one or more of them and spending the money and management energy on front line services.

Promise of consultation?

Promises that the STP Board was about to meet in public have proved empty, despite a clear statement on the 'Fit for Future' website:

"The STP Board will be holding its meetings in public. You will find details of the meeting venues and timings as well as the meeting agenda and papers on this page.

"Although the STP Board is not a statutory NHS body we want to ensure openness and accountability to the public in the business of the Board and, therefore, our meetings will operate in a similar manner to Statutory NHS body Boards. STP Board meetings take place every two months, schedule of meetings to follow."

However despite publishing minutes of Board meetings up to November 2017, no subsequent meetings have been advertised, and the public has yet to be invited in to witness any proceedings.

Current/recent financial issues

The starting point of the STP was the serious financial plight of the local health economy:

"We are more financially challenged than any other footprint. Our organisations have a combined deficit of 11% of turnover, with our CCG and three general acute trusts all facing severe financial problems. While Cambridgeshire and Peterborough received approximately £1.7bn to spend in 2015/16, our collective deficit was more than £160m.

"By 2020/21, despite our income increasing to £2.05bn, we expect our collective deficit, if we do nothing and including the ambulance trust and specialised services, to be £504m." (STP p8)

The latest figures on 2017/18 confirm that few of the STP's aspirations to meeting control totals seem close to being achieved. The CCG narrative explained why its deficit came out at almost treble the planned level:

- Growth in acute activity over and above the level assumed in the CCG's plan
- Under delivery of QIPP schemes
- A rise in individual placement and backlog costs; and
- Drug cost inflation (Governing Body Finance Report May 1 2018)

Meanwhile the STP Update from the CCG on May 1 reveals that all of the progress that is being made implementing aspects of the STP appears to involve employing additional staff to expand existing services, and incurring extra expense:

- 70 extra staff for the Joint Emergency Team which has made some improvement in admission avoidance;
- £4.8m and 155 additional staff required to deliver the STP's Discharge to Assess scheme;
- 35 additional posts to provide the promised Stroke early Discharge service;
- 22 FTE extra staff to run the System delivery Unit required to oversee and support delivery of the STP.

Many of these plans to enhance services are clearly to be welcomed as a good thing for patients, and likely to improve the quality of care, but they are scarcely "new models" since they rely on expanding services and filling in gaps rather than any qualitative innovation.

So it seems unlikely that there will be any savings in the short run.

"The councils participate in the programme through their officer representatives, recognising that their policy and financial decisions are subject to the constitutional arrangements within their respective authorities." (p5)

In other words there is no formal commitment of either council to support a plan which only peripherally even mentioned the financial challenge facing social care. Just £0.6m out of a total target saving of over £500m was expected to come from "closer working with councils"

Winter pressures/beds/DTOCs

Both acute trusts found their capacity strained to the utmost last winter, with CUHFT having the largest numbers in Eastern England of beds occupied by "stranded" patients in hospital for over 7 days, and of "super-stranded" patients not discharged after 21 days, and NWAFT not far behind. Both hospitals had 95.1% of beds occupied on March 3 2018.

CUHFT also cancelled non-urgent adult elective operations for January – forgoing valuable income as a result, indicating that clinical services are not currently sustainable 12/12, let alone 7 days a week. However we have already been warned by NHS England that there will be no additional funding for the forthcoming winter.

Partnership with local government?

From the outset this STP has given little sign of serious commitment from local government: the commentary was careful only to claim the support of the councils' officers, noting that:

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In other words there is no formal commitment of either council to support a plan which only peripherally even mentioned the financial challenge facing social care. Just £0.6m out of a total target saving of over £500m was expected to come from "closer working with councils" (p46)

There is no statement in the STP to indicate established opposition, but there has been public and political (local council and MPs) criticism of the plans – especially in Fenland, for reconfiguring the community hospital and Minor Injury Unit provision in that area. The risk was made clear by packed meetings opposing the plans, which were bizarrely reported in the Appendix in STP Engagement as if they were a great success because a lot of people turned up! (p51)

There also appears to be some reluctance to engage, if not outright opposition, from GPs. The STP admits: "… the question remains … how we can encourage local GPs to engage more fully with the system's challenges." (p44)

The STP structure is centred on a single Health and Care Executive, headed by an "independent chair":

"We have established a Health and Care Executive (HCE) and appointed an experienced independent chair to oversee this group. The HCE membership consists of the CCG's Chief Officer, provider CEOs, the chair of the Care Advisory Group (CAG), the GP Chair of the Sustainable Primary Care Strategy Group, and the Joint CEO and Director of Public Health for Cambridgeshire County and Peterborough City councils."(p10)

Since this body is the centre of information and policy making we might conclude that it would be taking and "driving" central decisions.

But it is made clear that there is some way to go before this is even seriously discussed. Indeed there is little evidence of the existence of the Health & Care Executive other than occasional passing mentions in the sheafs of documents that appear to be the main product so far of the STP.

Timetable – likely to slip

Early in the STP came a confession that the full range of changes that are outlined were always unlikely to be achieved by 2020/21:

"We have not always worked together as a system as efficiently or as effectively as we might have done and we have a lot of catching up to do. As a result our journey will take longer than the five years covered by the STP." (STP p11)

With the MoU not agreed until November 2017, inadequate capacity in both acute trusts, and a slow process of recruitment of additional staff for the proposed new services, there is even less chance now of sticking to anything like the timetable aspired to by NHS England back in December 2015 when they announced the move to establish STPs.

Hertfordshire & West Essex

The STP was not published until December 14 2016, and is the skimpiest of all 44 STPs, with just 32 pages, watermarked "Draft" throughout, dated October 2016 and marked "commercial in confidence".

Almost nothing is explained and no details supplied, raising far more questions than answers. The STP asserts (p4) that a new governance structure has been created:

"We now have in place a robust and rigorous governance structure. The planning and development of our STP plan has been overseen by Chief Executive Officers from partner organisations, who also lead the key workstreams.

"We have also increased the resourcing of a Programme Management Office dedicated to supporting the development and implementation of the STP, and have engaged analytical experts to support us in the development of our plans to change the way that patients use services in the local health economy." (p4)

This sounds much more dynamic and proactive than appears to have been the case.

There is little evidence of the activity of the STP or its Programme Management Office in the recent board papers of the footprint's trusts and CCGs. The mentions that can be found amount to little more than passing comments, or initiatives which are obvious attempts to plug gaps or remedy deficiencies in existing services rather than bold innovations.

£200,000 has been allocated to speed up treatment for people suspected of having lung or prostate cancer. CCG pharmacists have been brought together to identify potential savings from cheaper, unbranded or 'biosimilar' drugs. And there has been a gathering of experts to draw up a single plan for frail patients.

The main focus of the STP, as with most others, is on seeking ways to bridge the largely hypothetical "do nothing deficit" by 2021.

"The financial plans for Hertfordshire and west Essex are based on the need to manage the demand on the health and care system and introduce efficiencies to prevent an overspend that, if no action is taken, is calculated to rise to £548M by the end of 2020/21. Of this, £397M is attributed to the NHS, and £151M to social care." (p8)

No detailed figures are available for any of the local providers, CCGs or the STP project itself.

A request to the STP communications team for a completed version of the STP and/or appendices outlining financial proposals and workforce strategy received only a bland and evasive reply.

The STP's savings targets are presented in broad brush terms, with most of them unexplained, and not allocated to any specific provider. Some of them appear to overlap with each other. For example Provider "back office", provider "estates", provider "other Carter" savings and provider "productivity" are each entered separately, adding up to £157.2m of the £351m total target for savings – but some of this could be double counting.

Bed closures/ rationalisation? Reconfiguration?

The STP has areas of rapidly growing population and a rising demand for hospital and emergency services, plus at least two major hospitals in need of rebuilding or replacement (Watford General and Harlow's Princess Alexandra). However the main tangible proposals of the STP are for acute care to be cut back, with the implication that primary and community services and mental health might be expanded, although there are few details or commitments.

The proposed acute service reductions are very substantial: however the likelihood of achieving them is open to doubt.

The STP hopes to reduce admissions of frail patients by a very precise 11,231 [!] within 3 years and 24,451 in 5 years, requiring 28,222 fewer bed days.

Plans also involve reducing admissions for Respiratory, CVD, Diabetes, Musculoskeletal and elective treatment, cutting a total of 16,000 in 3 years and 36,000 in 5 years – almost 52,000 fewer bed days.

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The plans also look to cut activity among "well adults" and cut hundreds of thousands of outpatient appointments (186,000 in 3 years and 456,000 in 5 years).

The service implications of such large reductions in admissions and bed days for the for the acute trusts are not discussed, other than stating the need to "support colleagues working to transform acute service to release capacity and 'right size' their overall bed base" (p20).

The greatest pressure on beds is at Princess Alexandra, a small hospital built in the 1960s for a much smaller caseload and which ended winter 2017/18 with bed occupancy above 99%, and just 67% of A&E attenders treated or discharged within the target 4 hours.

According to the STP West Essex could wind up with either a patched up Princess Alexandra Hospital in Harlow – or the promise of closure and its replacement with a new £450m hospital on a "new" site, which may or may not be close to PAH.

An earlier draft outline of the STP in April 2016 had been more explicit, requesting:

"Air cover" support to make reconfiguration change

"Transitional funding to support the management of implementation" (p 11/11)

The reference to "air cover" (which appears to relate to political support from government and pressure to overcome opposition from local MPs and councillors) would be to facilitate a hugely controversial "reconfiguration" leading to the downgrading or closure of the Princess Alexandra Hospital in Harlow, the sole, financially troubled and over-stretched

West Essex provider in what is clearly a Hertfordshire-led STP.

It faces a large backlog of maintenance on a similar scale to the decrepit Watford General Hospital.

A Commons adjournment debate on PAH on June 5 2018 brought news from Health Minister Stephen Barclay that the STP bid for £500-£600 million to develop a new hospital and health campus on a greenfield site to replace the old hospital had been sent back to the trust as "unsustainable."

The trust and CCG were also told to develop additional plans for redesigning services to reduce the use of hospital services – a clear indication that any future capital allocation towards the new hospital will fall far short of the amounts requested for a replacement on similar or larger scale.

Meanwhile long-nurtured dreams of a massive redevelopment and a PFI-funded new hospital and health campus to replace Watford General – for which the same STP apparently bid for another £600m of capital – have also been brutally killed off.

With them have perished the hopes of determined campaigners in Hemel Hempstead and other parts of the county for an alternative scheme: a new major hospital, in a more central and easily accessible location than the often congested and steeply angled Watford General site, which is right next door to the Vicarage Lane football ground.

Campaigners for the alternative site for a new hospital have published evidence to the CCG to show that building the hospital on the Vicarage Road site would cost at least £220m more, take far longer and pose more risks.

They also point out that in the obsessive focus on developing the new hospital where it is, the trust and local CCG have focused resources exclusively on acute hospital services, and failed sufficiently to develop local community health services.

However Watford campaigners have understandably focused on keeping their existing local access to services.

The problem is a real one. In other West Hertfordshire towns, St Albans and Hemel Hempstead, previous hospital services have since the mid 2000s been steadily closed or downgraded to be "centralised" in Watford, despite the discomfort, delays and inconvenience many have faced from the extra journeys to a Watford site which even the Trust has admitted is difficult for staff to access by public transport.

None of the plans drawn up for the new Watford Hospital pay any serious attention to the travel problems to be faced by patients and their visitors (issues which are also omitted from the STP).

In May furious Hemel Hempstead campaigners finally had confirmation that the "temporary" reduction in opening hours of the Urgent Treatment Centre – the service that was supposed to replace the A&E at their hospital after it closed in 2009 – had become permanent.

The local Dacorum Borough Council had backed calls for the unit to be open 23 hours a day. Instead since December 2016 it has

been limited to 14 hours a day – 8am-10pm, meaning that patients at other times have to travel to Watford.

To rub salt into the wounds, in June 2018 ministers also rejected the proposal for a new, more central hospital. Instead they rubber-stamped the down-sized Strategic Outline Case for rebuilding the crumbling Watford General Hospital, in a marathon project that will not complete until 2030 at the earliest.

There is no workforce plan, and no explicit proposals for reductions in staff, but it's hard to imagine the achievement of savings of £351m, including "back office" savings, without the loss of jobs.

Current/recent financial issues

The financial plight of the three acute trusts remains a serious problem.

In East and North Hertfordshire the CCG has been merrily stacking up unspent surpluses (CCG underspent by £4.4m last year, to bring their cumulative underspend to almost £19m) – only to discover now that it is forbidden to spend this money for the foreseeable future.

Meanwhile the East & North Herts acute hospitals trust, after being relentlessly squeezed by the CCG, ended 2017-18 £27m in the red, even after £1.3m of STF funding.

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In West Hertfordshire, the CCG ended 2017-18 with a surplus of £100,000, and plans this year (April Board papers) to reduce acute service activity by over £15m:

"A&E attendances – the reduction in activity will be achieved by diverting patients from A&E to other types of contacts including signposting and advice. This means patients will still have contact with the health service, but not within A&E. The activity reduction is therefore valid."

This diversion of activity could impact on the already serious financial plight of West Herts acute hospitals trust.

Noting that after the experience of last year (which ended £42.6m in deficit) there is "limited potential for a significant reduction in the projected deficit," the trust was in any case projecting a 2018-19 deficit of almost £53m – nearly ten times the proposed "control total":

"The original control total for FY19 set as part of last year's planning process, which spanned two financial years, was a deficit of £5.4m. This included Performance Sustainability Funding of £15m."

(Finance Overview from June 2018 Board papers, page 61 of 225)

In West Essex, where the CCG was also in a comfortable surplus just short of £10m in 2017/18, PAH ended the year with a deficit of £32.6m, £3.7m of which was the result of the suspension of elective surgery in January as part of the government/NHS England response to the winter crisis, and appears to be aiming at a similar (£28.7m) deficit for 2018/19.

Hertfordshire Community Trust is expecting again to stay close to its agreed £2m control total annual deficit for 2018/19, while Hertfordshire Partnership FT registered a small surplus for 2017/18 and now has a control total of +£0.36m for 2018/19.

None of the financial reports appear to make any reference to the existence or involvement of the STP, and the extent to which it is detectably delivering any financial change is open to question.

Plans for 'Integrated Care'?

Plans for services in West Essex to evolve into an ACO are set out in the STP – without any real explanation of what they might mean in practice – on page 19:

"The Accountable Care Partnership (ACP) in west Essex – this is a natural progression of the West Essex Integration Programme that has been running for two years which has established neighbourhood teams, a new patient at home model and an integrated discharge model.

"The ACP includes elements of both the Multispecialty Community Provider (MCP) and Primary and Acute Care Systems (PACS) models of care and will inform the future ambition of an Accountable Care Organisation (ACO) in West Essex."

Promise of consultation?

The Herts & West Essex STP was delayed and one of the last to be published at the end of 2016. It still appears to be only a partial and

initial draft, and the only proposal for any consultation came in a list of Priority actions on the penultimate page.

These included a "public-facing document with which to engage our residents about the STP", a series of primary care workshops; developing a "pool of clinical leads and presenters to act as advocates for the STP" and identifying where "formal consultation processes will be necessary, and the resources needed to deliver these." (p31)

However the news that has emerged since – from an STP that covers over its lack of any detailed plans with a high level of secrecy – suggests that little has actually been achieved.

Bizarrely, the CCG review which has led to the Watford rebuild refers for its authority back to a 2007 consultation, from a different time and circumstance before the banking crash, with a rising health budget, and before the closure of A&E services at Hemel Hempstead Hospital in 2009.

Plans, proposals, state of play

Trust Board and CCG papers make occasional cryptic references to the role of external consultancies. The STP commissioned an Independent Consultant, Joe Gannon, who observed – as UNISON could easily have pointed out for nothing – that "in general localities were struggling with implementation due to capacity constraints and expressing associated frustration". (E&N Herts CCG May 2018 Board papers p356/487)

West Herts Hospital Trusts Board heard at its May 3 meeting that

"senior leaders of all of the STP organisations have agreed to work together with the help of independent advisors Carnall Farrar to make the organisations more integrated and fit for the challenges of the future. … Carnall Farrar has started to work with all of the STP organisations to gather information and suggestions … and will report back in the summer."

However Carnall Farrar, who are advising a number of STPs, don't come cheap, and their first impact on local financial issues is to make them worse. In Kent and Medway their bill for work in 2015-16 came to an eye-watering £2.97m, although the problems of the local health care system are nowhere near being solved.

Princess Alexandra Hospital Trust Board minutes also reveal the involvement of consultants: KPMG, and the lesser-known 'BCG' (initials not explained) have been brought in to draw up an Outline Business Case for a new build, which we now know is unlikely to happen on the scale proposed. This work appears to ongoing and/or fruitless, since no OBC has yet been completed.

Not even the Strategic Outline Case agreed in June 2017 by the Trust Board has been shared with the local public.

PAH also cryptically reveals in minute print in its Assurance Framework that US health corporation Centene, which has been controversially involved with

Nottinghamshire's STP/Accountable Care plans, and the Spanish company Ribera Salud (50% owned by Centene) have apparently been involved in "actuarial modelling", no doubt also for a fee. Here too any outcome of the work has been withheld from the public.

Partnership with local government?

The Executive Summary (p2) made a bold claim to have fully enlisted the support of local government for the STP:

"Through the creation of the Hertfordshire and West Essex Sustainability and Transformation Plan, the NHS and county councils have embraced the opportunity to work together to improve the health and wellbeing of our population.

"Building on the draft submission of 30 June and subsequent feedback, this plan demonstrates that NHS and social care in Hertfordshire and west Essex have come together as a single system, based on a robust governance structure, to deliver sustainable plans to achieve transformation and financial balance by 2020/21." (emphasis added)

East & North Herts acute hospitals trust ended 2017-18 £27m in the red, even after £1.3m of STF funding.

The West Hertfordshire Hospitals trust is projecting a 2018-19 deficit of almost £53m – nearly ten times the proposed "control total":

In West Essex Princess Alexandra Hospital ended the year with a deficit of £32.6m, and appears to be aiming at a similar (£28.7m) deficit for 2018/19.

However the published STP does not make clear which organisations have agreed to the proposals.

The STP's general statement on this was vague:

"Our Ambition: The three CCGs and two county councils will work together to provide a single standard for commissioning integrated services across Hertfordshire and west Essex; by commissioning health and social care together and collaborating with providers we will deliver more effective and personalised services to patients and service users." (p25, emphasis added)

So far there is little evidence of this promised collaboration with providers.

The STP changed leadership in January, with Deborah Fielding, chief executive of West Essex CCG taking over full-time from Tom Cahill, who had served as a part-time STP lead while remaining part time as chief executive of the Hertfordshire Partnership Trust.

No visible change can so far be detected in the consistently low profile of the STP.

The involvement of local government is not necessarily of any obvious benefit, either. The strong support of borough and district councils, who have pressed for a more accessible site than Watford in West Hertfordshire, and for a new build replacement for Princess Alexandra Hospital, appear to count for nothing with NHS managers or with ministers.

Meanwhile one Dacorum member has expressed a pretty scathing view of the "complacency" of Hertfordshire County Council despite the serious unfunded deficits in the finances of most of the trusts examined.

The frustrated councillor commented: "In my view local government has a duty to bring to the attention of Westminster the details of such inadequate financial problems …".

(JR Birnie, Feb 27 Dacorum Health Scrutiny Update).

Mid & South Essex

The first version was published in June 2016, with Annex: the final version, with additional Annexes, financial spreadsheets and a more readable summary (10 Things You Should Know) is dated October 2016 but was first available in mid November.

Subsequent to that one of the main proposals, to "centralise" A&E services in Basildon Hospital, effectively downgrading the full A&E services at Southend and Chelmsford, a plan which had been pursued both by the STP and by the "Success regime" which preceded it, was effectively abandoned.

Instead there was a pledge that full A&E units would remain at all three hospitals, with Basildon as the specialist centre for more complex cases.

The STP combines a number of discrete proposals for reducing the provision of key in-patient specialist services to one or two of the three major acute trusts:

• Broomfield Hospital, Chelmsford, would receive: emergency general surgery and complex gastroenterology patients, urological surgery patients and emergency orthopaedic patients from mid Essex, while Braintree Community Hospital, run by the same trust, would take planned orthopaedic patients from mid Essex.

• Southend Hospital would specialise in gynaecology, urological surgery (for cancer) and elective orthopaedic surgery for people in South Essex.

• Basildon Hospital would take the lead on a number of specialist services – dealing with emergency orthopaedic surgery for people in South Essex, lung problems, kidney problems, diseased arteries and veins, complex heart problems and also house a specialist stroke unit to cover the whole of mid and south Essex.

The finances remain unclear. The acute hospital reconfiguration is costed at £118m, although it is claimed this would bring an overall increase of 50 beds, as well as new operating theatres and improved technology to help work across all three hospital sites.

£41m is to be spent on Southend Hospital, £30m at Basildon and £19m at Broomfield, plus another £28m for "additional technology and facilities": no specifics are given on what the money would be spent on.

In exchange, according to a nice graphic on the consultation website, the expectation is for £31m "efficiencies from three hospitals working together", £26m from "reducing unnecessary hospital visits" and providing care at home and in the community," plus another £64m vaguely defined as "other efficiencies and economies of scale."

These figures all convey a strong impression of being based on guesswork or wishful thinking – and quite possibly double counting.

Also part of the STP is the plan to run down and close services at Orsett Hospital, to be replaced by new "integrated medical centres" to be built in Tilbury, Purfleet, Corringham and Grays – although no costs or funding have been revealed to provide any reassurance that the new centres will be built. The new centres are supposed to open in 2020/21 – far enough in the future to make their completion seriously questionable.

In the Basildon, Brentwood and Billericay areas the STP notes "an opportunity to develop buildings at Brentwood Community Hospital, a new location in Basildon town centre and St Andrew's at Billericay."

We now know that the Joint Committee could only be formed after by NHS England issued firm orders to Castle Point and Rochford CCG at the end of March 2017, signed personally by NHS England chief executive Simon Stevens, ordering the CCG to participate .

The STP is insistent that: "No clinical services will be stopped as a result of these proposals," and that:

"Only when new services are up and running, would it be possible to close Orsett Hospital which, although valued by many local people, is difficult to access by public transport and is an ageing site.

"Our intention is not to move services from Orsett Hospital until they can be moved to new or alternative facilities in the Thurrock, Basildon and Brentwood areas."

However the process is more complex. The STP consultation is being led by the 5 mid and south Essex CCGs, which last year formed a Joint Committee.

We now know that this Committee could only be formed after by NHS England issued firm orders to Castle Point and Rochford CCG at the end of March 2017, signed personally by NHS England chief executive Simon Stevens, ordering the CCG to participate .

The tough wording of NHSE's "directions," which took effect from March 31, suggests strongly that the CCG had been less than enthusiastic in joining forces with Mid Essex, Basildon & Brentwood, Southend and Thurrock CCGs.

They were required to begin "within 2 weeks of the date of these Directions" to begin work to develop the committee and "within 6 weeks" to produce a joint Commissioning Plan.

The CCG was also instructed that, regardless of the views of its Governing Body and the impact on local services:

"Castle Point & Rochford CCG shall at all times engage with the establishment of the Joint Committee and the subsequent participation in its operations.

[…]

"Castle Point & Rochford CCG shall within 2 weeks of the completion of the Joint Commissioning Plan together with the CCGs agree a detailed implementation plan … and shall subsequently implement that plan.

"The [NHS England] Board may direct Castle Point & Rochford CCG in any other matters relating to the Joint Commissioning

Plan and any variation to it. (emphasis added)

The Joint Committee into which at least one of the five CCGs had been press-ganged has appointed its own Independent Chair (Prof Mike Bewick), and since taken over part of the implementation of the STP, especially the public consultation, which concluded in March 2018.

However the STP itself has also retained a separate structure, with a Programme Director (Andy Vowles), Lead Accountable Officer (Caroline Rassell) and its own Independent Chair, Dr Anita Donley. Dr Donley is a far from local appointment, as a practising consultant physician in acute medicine at Plymouth Hospitals NHS Trust. She is clinical vice-president of the Royal College of Physicians, and on behalf of the RCP, chairs the Future Hospital Programme.

It is not clear what has happened to the apparatus, chair and lead officer of the Success Regime, which pre-dates the STP and was running in parallel with it, although – despite the name – strikingly lacking in success.

The hopes of the STP hinge on primary care taking on a much bigger caseload, with the plan hoping that by 2019/20:

- Primary care (wider than GP) consultations increase by 2,600
- Average face to face consultation time increased from 12-15 mins
- Increased GP time on telephone consultation 6-12%
- Reduced admin time 11-5%
- OPD appointment delivered in community from acute setting 250k
- Reduction in OP volume in acute setting -25%
- Patient experience of primary care +5% (June draft p24)

The June Annex (p49) indicated that proposals also seek a shift of mental health caseload to primary care.

However despite all this additional workload, and the financial spreadsheets showing an increase in staffing, the STP outlines no plans to increase the primary care workforce beyond the 2015 level (June Annex p 62), and there is little indication of any additional funding resource targeted at Primary care.

Small wonder that there are unresolved "talent gaps" and problems recruiting GPs, with many of the current workforce close to retirement age (June Annex p78).

For hospital care there is no clear breakdown of savings targets by provider, although a large component is described as "business as usual" and refers to the CIP programmes that have run in all trusts for the past 30 years or more.

There will no doubt be some disagreements over which trusts carry what share of the proposed significant reductions in workload (and hence in funding) up to 2020/21:

Acute hospitals 484k fewer attendances

- 424k fewer outpatients (-16%)
- 13k fewer EL admissions (-6%)
- 36k fewer A&E attendances (-13%)
- 11k fewer Non- elective (NEL) admissions (-10%) (STP p5)

Bed closures/ rationalisation? Reconfiguration? Mergers?

Meanwhile in what they insist is a completely separate process and without any attempt at public consultation or engagement with staff, the three acute hospital trusts in January 2018 began their own process of 'merger' to create a new single trust covering 1.1 million people, with 14,000 staff, and no obvious local accountability to anyone.

The STP claims that the plans for the acute trusts would create an extra 50 beds and more operating theatre capacity: the plan is largely silent on mental health and community services.

The expectation is for £31m "efficiencies from three hospitals working together", £26m from "reducing unnecessary hospital visits" and providing care at home and in the community," plus another £64m vaguely defined as "other efficiencies and economies of scale."

These figures all convey a strong impression of being based on guesswork or wishful thinking – and quite possibly double counting.

Plans for 'Integrated Care'?

There is little sign of any system-wide integration in Mid and South Essex: instead the local commissioners and local providers are linking up on either side of the purchaser/provider split, alongside a confusing proliferation of ineffective footprint-wide organisations that have emerged.

Promise of consultation?

Even the STP's commitment to "consultation" has been little more than cosmetic; in March Healthwatch Thurrock complained to Thurrock Councils health overview and scrutiny committee that it had been unceremoniously removed from a crucial meeting of the STP Programme Board, despite having been part of it for 18 months.

It appears that the problem was that Thurrock Healthwatch wanted to challenge and ask questions. Its chief operating officer Kim James complained: "It seems like they don't want any challenge".

The STP has said it plans to have a range of health professionals working with GPs, and to educate people to stay healthier. Sadly the proposals lack any evidence they can yield the results hoped for in Essex, and this weakness has been compounded by a lack of consultation or engagement with GPs and practice staff. Indeed when campaigners visited 14 GP surgeries to check how the plans were implemented they found 12 of them had no information or awareness of the proposed changes.

The STP response was that the GP

practices "should have received leaflets", but sending out batches of leaflets is clearly no substitute for any practical engagement and discussion with the staff involved to ensure that the plan is at least known and understood.

The consultation concluded on March 23, but as yet no summary of the responses or reply from the STP has yet been published.

Despite occasional warm words there has yet to be any serious engagement with staff or unions on the plan, proposed changes affecting staff or any plans that might be forthcoming for a workforce plan that could bridge the gap between staff numbers in post and the numbers needed.

Current/recent financial issues

The merging acute hospital trusts are all running substantial deficits, totalling almost £100m. Mid Essex Hospital Services trust wound up 2017-18 with a deficit of £55.9m, reduced by a "bonus" payment of £1.8m from the STF.

Basildon & Thurrock ended the year £29.3m in deficit, and received a £3.1m bonus from the STF. Southend University Hospital ended £14.4m in deficit prior to a £6.4m STF bonus.

All three trusts are red rated on their recruitment and retention of staff, with Mid Essex doing worst, and Basildon the only Trust rated green on consultant vacancies.

The prospect for a merged trust combining all three is that it will inevitably be plunged immediately into a crisis situation on both finance and staffing, and with barely enough bed capacity to cope.

Winter pressures/beds/DTOCs

Even with 76 escalation beds still open as "winter" ended on March 3 NHS England figures show Basildon hospital that day on 99.6% occupancy, Mid Essex on 98.5%, and Southend on 93.9% – all well above even the increased "target" levels of occupancy raised this winter by NHS England.

On that same day the three hospitals had 734 patients between them who had been in hospital for at least 7 days, and 231 of the patients who have now been branded as "super-stranded" by NHS England – because they have been inpatients for more than 3 weeks.

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Proposed timetable

The STP (p25) publishes a hugely optimistic high-level implementation timeline showing the various STP proposals and processes of transformation complete by 2020-21: however this assumes the successful completion of a range of measures during 2016/17 – which are nowhere near completed.

Partnership with local government?

As the various NHS bodies jockey for position, there is little sign of any attempt at integration with, active engagement by, or attention to local government. In April the Joint Health Overview and Scrutiny Committee comprised of Essex, Southend and Thurrock councils raised a whole series of concerns over the plans that had been put forward by the STP, warning that were neither the staff nor the funding needed were available to implement the proposals.

Local health campaigners responding to the JHOSC findings told the local *Gazette*:

"Their plans to reduce the number of people visiting hospitals by anything up to 35 per cent are ridiculous and are bound to fail with the lack of investment they are willing to put into primary care."

Predictably the criticisms were immediately brushed aside by the STP's independent chair.

"Integration" with social care is repeatedly referred to in abstract terms: however there is little in the way of concrete proposals to help address the social care funding gap projected at £123m for Essex County Council alone by 2020-21 (STP p15), and most of the ideas on the page headed Delivering Closer Integration With Social Care (p15) are vague, generic and abstract.

The June Draft made clear from the outset that: "There are not yet firm plans in place for colleagues in social care to get to overall balance" (p2).

The Local Authority "financial bridge" (June Draft p28) failed to address the gap: instead it wound up with a £156m deficit. This approach is unlikely to create strong bonds with any of the local authorities who are left to carry the can.

Norfolk & Waveney

The Financial section and the Workstream Milestones set out a highly ambitious quarter by quarter schedule for changes (Milestones pp19-23, Financial targets pp30-31).

This included plans for the rapid recruitment and organisation of four Out of Hospital Service (OHS) teams by Quarter 3 of 2017, with the target of reducing A&E attendances by 20% by 2021, and also reducing non-elective spells in hospital by 20% (p32).

These teams have to be ready to take on a host of issues, including case management & care planning, improving palliative & end of life (EoL) care, signposting to community and VCS resources & linking with acute multidisciplinary teams (MDTs).

The hope is to "support reductions in acute activity from both the "front end' and 'back end'. (STP p12)

There appears to be no subsequent mention of this plan: it is not clear how much of it, if any, was implemented. However it was obvious that the teams, aiming to integrate health and social care, would involve new roles, to which staff had to be recruited to enable other aspects of the STP to proceed.

The teams were to be funded as part of the £52m investment in "prevention, mental health, and out of hospital services" (p6).

However it was unclear how the STP footprint area was to be divided up, which teams would come on stream first, and more importantly, who, in which organisation(s) would be responsible for recruiting, training and managing them and ensuring they were properly located in a suitably equipped and staffed base, with sufficient admin support to ensure efficient working.

Who would be tasked with allocating and monitoring their work? Whose budgets would the team resources come from?

Neither the financial cost of the STP project itself, nor the number of personnel required to deliver the Plan was identified. It appears that a number of the leading roles were to be taken by existing senior executives and directors from the NHS and local government, suggesting that the costs of secondments would need to be factored in to the STP's total costs.

The STP also aimed to expand and improve primary care, although the proposed £15m investment to cover the funding commitment of the *GP Forward View* (p26) was quite modest, and principally aimed at financing specific initiatives including reduction of A&E caseload and non-elective spells in hospital by 20%.

Prevention (including restrictions on "Procedures of Low Clinical Value") to deliver a "shift left" in caseload from hospitals to primary community and social care services was supposed to deliver £16.7m savings in 2017/18, £64.3m in 2018/19, £72.2m in 2018/20 and £81m in 2020/21 – when it is supposed to represent 20% of gross system saving (p31).

There are various STP initiatives in "shifting left" potential caseload from acute services to community health, primary care or social care, aiming by 2020/21 to avoid/prevent:

- 10,080 A&E attendances through Out of Hospital Services,
- a hefty 4,497 through using "telehealth" systems in residential and care homes,
- 8,755 through getting GPs to support 111 services,
- 9716 through "front end streaming" in A&E to divert attenders into primary care,
- a massive 13,528 through "individualised medical care planning"
- 6391 through prevention
- and 395 through mental health complex care patients

These add up to a total of 64,571 potentially avoided hospital attendances: in other words the plan would actually reduce the current caseload of the acute hospitals, both in A&E and also in non-elective spells in hospital, where the reduction would exceed the projected increase by almost 20,000, cutting non-elective caseload by 25%.

Bed closures/rationalisation? Reconfiguration? Mergers?

As Health Secretary in the mid 2000s, Patricia Hewitt was infamous – and triggered widespread local protests – for attempting to force through hospital closures and rationalisation. However in her new incarnation as Independent Chair of the Norfolk & Waveney STP she has publicly committed to trying to avoid such measures, and to generate savings through prevention and demand reduction.

The three acute providers have formed the Norfolk Acute Hospital Providers Group, but this too seems focused on collaboration and possibly shared recruitment opportunities, and does not look to achieving organisational mergers.

The plan aims to reduce the current caseload of the acute hospitals, both in A&E and also in non-elective spells in hospital, cutting these numbers by 25%.

However a May 8 report to the STP Stakeholder Board does discuss possible "efficiency opportunities" through sharing office support staff. It also makes the point that some functions are already "in the lowest cost quartile nationally", so the focus is claimed to be on "service and function sustainability" rather than seeking to cut jobs. This will need to be closely watched by the unions.

The STP is carrying out a "wide-ranging review" of mental health services, to determine the best models of delivery. The STP has assured the Norfolk & Suffolk FT that this is not about making savings, but rather about the long term plans for the future.

Plans for 'Integrated Care'?

There is no mention of ACOs, and only one (unexplained and unelaborated) reference to MCPs in the original STP Plan. However the focus has shifted in the past 12 months towards a concentration on what is now called "Integrated Care Systems".

In February 2018, despite very little evidence of having achieved any level of integration, the STP submitted an application to become one of a second wave of Integrated Care Systems, which in theory could mean that the health and social care system across the whole footprint would have only one combined budget.

This must have come as some surprise to the Governing Body of at least North Norfolk CCG, whose January 2018 minutes meeting indicate little awareness:

"SB queried the Accountable Care Systems with ASL [Antek Lejk, then STP chief executive] and what is happening moving forward.

"ASL advised SB that these are emerging ***and there is a lot of confusion around what they mean.*** However Norfolk & Waveney STP do want to head towards this and do the work that is required.

"ASL confirmed that the STP are looking at having a singular system to cover the whole county but recognising our local systems where relationships need to develop."

(March Governing Body papers, p10/236)

The ICS application document submitted by Antek Lejk the next month suggested the confusion had swiftly turned to enthusiasm.

However the weakness of the local situation was largely ignored. Lejk bizarrely listed under "System Progress to date" the fact that:

"Full year forecast for 2017-18 is off plan by £66.2m at month 9, predominantly within the provider sector although CCG pressures are emerging. Full year CIP/QIPP off forecast by £17.7m."

Even Lejk's own North Norfolk CCG was missing savings targets and registering a Red rating on four of its QIPP proposals.

The document went on to boast that "Net value of control totals in 2017/18 is a surplus of £6.7m" – even though it was already obvious that only a few of the CCGs could hope to achieve their control totals.

ST chair Patricia Hewitt has now admitted that the STP footprint missed its savings targets by £70m in 2017-18.

Not only that but as of March 2018 the STP had failed to make basic progress on a range of issues for the main health service activity: an STP Programme Governance table shows that only Maternity and cancer transformation had a Comms and Engagement Plan or a Resource Plan (revenue) in place; only Mental Health had a workforce plan; and only Cancer Transformation had a Resource Plan for capital. Acute services, Urgent and Emergency Care, Primary and Community Care and Prevention had none of these – hardly indicative of integration or planning.

Nonetheless Lejk's document went on to commit to a seemingly impossible objective:

"By September 2018 develop a new financial plan and new contracting mechanisms that ensure than the system achieves financial balance by 2020."

To do this would mean persuading the CCGs currently in surplus to agree to a "full system control total" by 2019-20, which would mean that the CCGs share out their unspent surpluses to help balance the books of the providers, especially the acute providers whose tariffs have been cut in real terms each year since 2010, leaving two of them (Norfolk & Norwich and Queen Elizabeth Kings Lynn) dependent on loans to prop up their annual budget.

To "ensure" financial balance across the board could only be achieved by giving effectively dictatorial control to ICS officials to override trust boards and CCG governing bodies.

The proposal therefore commits to "strengthen finance infrastructure led by an ICS Chief Finance Officer".

It would presumably be up to this Officer to implement "new contracting mechanisms for implementation in 2019/20", and

"Work with ICS partners to determine how spending can be re-profiled and the system approach to PSF and CSF [Provider Sustainability Fund and Commissioner Sustainability Fund]."

Again it's not clear how many CCGs and trusts, if any, would agree to have their boards and existing financial directors subject to control of this type, from above, by an ICS Chief Finance Officer whose decision making and accountability for decisions would be outside of the existing legal structure.

Norfolk & Norwich Trust has rejected a proposed control total of a surplus of £10.7m, and instead set out plans to deliver a massive deficit of £55m, more than DOUBLE the 2017/18 deficit.

Even this figure "assumes that £30m of savings will be made in year," even though: "to date we have c. £10m of fully worked up plans for delivery".

The ICS bid admits that "A key consideration of [Norfolk county Council] will remain to ensure that the financial liabilities of the NHS do not pass to the local authority."

But if this guarantee is given, the illusion of "integration" and a single budget evaporates.

It's not at all clear that an ICS set-up is even consistent with existing legislation and statutory roles of trusts, foundation trusts and CCGs: such issues are even now being tested in a judicial review.

It's clear that the document proposing an ICS in Norfolk and Waveney shows no commitment or concern for accountability to local communities and the wider public, despite the vague proposal for a "more open book" approach.

While offering no democratic accountability, and apparently seeking to squeeze down spending regardless of the consequences, the ICS would also carry a heavy bureaucratic cost in the establishment of no less than TWELVE new committees to soak up management time and energy.

These include: a "strong ICS leader group"; an ICS Executive Board; a Joint Strategic Commissioning Committee; an ICS Delivery Board; FIVE "ICS localities"; a Clinical and Care Reference Group; an ICS Finance Board; and an STP/ICS Stakeholder Board (which involves a few local organisations, but no community groups or wider public).

In addition to the support staff needed for these bodies to function, the ICS would also require THREE new senior staff: a Programme Director, an ICS Chief Information Officer and the ICS Chief Finance Officer (each of these would in turn presumably need office and admin support).

No costings are put forward for this elaborate superstructure, which would be superimposed above the existing trusts and CCGs: its effectiveness, desirability and value for money are neither explained not apparently questioned.

However as the financial pressures tighten on the "partners" it is inevitable that some will question the wisdom of such lavish provision for administration of a new system that has yet to prove any worth.

Promise of consultation?

No timetable for consultation was revealed in the STP, and no commitment to consult on whole plan:

"Once we have developed more detailed proposals, we will conduct formal consultations about changes to services, where appropriate and following national guidance. We will coordinate our consultations, with the relevant commissioners and providers of services taking the lead.

Over the course of the next five years, we will continue to regularly update the public and our stakeholders with our progress, let them know what we've done with their feedback and explain our next steps." (p36)

This same indifference or resistance to consultation is indicated in the moves towards establishing an Integrated Care System, which again is proposed to take shape without any actual process of consultation, and with little evidence of support from local government, which is understandably suspicious of finding itself landed with a share of the deficits being run by one CCG and most of the trusts in the STP footprint.

Timetable for implementation

The commitment that has taken shape this year, to drive towards a system-wide control total and balanced finances across the STP footprint with the formation of an ICS by 2020 is extremely ambitious: it is also highly questionable whether it is achievable.

Current/recent financial issues

The end of 2017/18 saw provider deficits all round: Norfolk & Norwich hospital trust £27.3m – despite planning for a surplus of £3.6m; Queen Elizabeth around £20m and James Paget Hospital £8.3m. The mental health provider Norfolk & Suffolk Foundation Trust was £800,000 in the red, with Norfolk Community Health and Care trust also £1.7m-£2m in the red.

West Norfolk CCG was also in what its chair Dr Paul Williams described as a "dire" financial position as a result of "unreasonable assumptions made over several months", with a deficit of £10m in 2017-18 after finishing 2016-17 £7.8m in the red. Other CCGs, having passed on cash pressures to providers, notched up surpluses totalling over £12m: Norwich CCG £4.8m, North Norfolk £2.1m, South Norfolk £5.3m and Great Yarmouth and Waveney £0.4m.

Norfolk & Norwich Hospital chief executive Mark Davies argued that £20m of the trust's deficit this year was down to the excess costs of interest payments on its PFI contract, which are set to increase year by year until 2036, as well as the loss of £9.4m of Sustainability of Transformation Funding because the trust missed key targets.

During 2017/18 Norfolk & Norwich also borrowed £57.7m to prop up its finances.

This level of borrowing is expected increase in 2018/19, with plans to seek loans

of £70.7m during the year, bringing the total of borrowing to £128m.

This is set out in an astonishing financial report in the trust's May Board papers (Slide 46 p 90/96), which rejected a proposed control total of a surplus of £10.7m, and instead set out plans to deliver a massive deficit of £55m, more than double the 2017/18 deficit.

Even this figure "assumes that £30m of savings will be made in year," while at present that is little more than a faint hope, especially given that: "to date we have c. £10m of fully worked up plans for delivery".

The NNUH Finance report went on to state: "We are dependent upon continued deficit support from the DH. Funding is applied for on a monthly basis – not confirmed in advance for the financial year. Accordingly we do not have certainty over the availability of funds or the associated interest rates.

- "our capital expenditure plan for the year is c. £25m. The majority of which will need to be funded by DH. To date no funding has been secured for our plan.
- "Our activity plan for 2018/19 … is 3% higher than 2017/18 outturn.
- "No provision has been made for penalties attaching to key access targets. … The £7.5m 'penalty' relating to 2016/17 has not been resolved, which has not been provided for.
- "Full year CQUIN is c. £9.5m. No provision for non achievement or the cost to deliver has been made in the Annual Plan.
- "our plan assumes deficit support of £48m in year and capital borrowings of 322.7m. We do not have confirmation that the borrowings required will be made available."

In other words there are so many unresolved risks and unanswered questions that even the plan for a £55m deficit is not really a plan at all. This is the biggest trust in the STP: if these finances are so far awry (with QEH also in serious trouble financially) what hope can there be of agreeing or upholding a since ICS control total or achieving financial balance?

QEH itself is also forced to go cap in hand for loans to prop up the balance sheet, although at much lower levels. In March the trust submitted a request for a short term loan of £5.126m – was only available subject to subject to ruthless and rigorous conditions including: compliance with the limits on spending on agency staff, seeking ministerial approval before appointing very senior managers, and the trust agreeing to examine the cost of running its estates and facilities with "a benchmark group of similar NHS trusts" and if these prove to be above average, to take action to cut costs. They must also draw up an estates strategy "and consider options for rationalising the estate and releasing surplus land.

Moreover the Trust has to agree to commission NHS Shared Business Services – the partially privatised consultancy set up in 2004 – to assess the benefit of the use of an "outsourced service provider" for the trust's finance, accounting and payroll services and using or increasing the use of "an outsourced Staff Bank provider".

In addition the Trust must identify "non-EEA chargeable patients", bill them and collect charges for treatment.

All these strings are attached to a loan of just over £5m. The costs and management time of complying with these conditions are likely to outweigh the value of the loan, and certainly divert any attention from building an integrated care system.

Winter pressures/beds/DTOCs

Norfolk & Norwich hospital claimed to have treated 25% more patients aged over 75 over Christmas and New Year. In the first few days of March, as the "winter" officially ended, the hospital had over 400 patients who had been in hospital for over a week, and almost 150 "superstranded" patients who had been in a bed for over 3 weeks.

However while its beds were more than 94% occupied, they were not as fully stretched as Queen Elizabeth and James Paget Hospitals, both of which were almost full to capacity on 99.6% of beds occupied as "winter" ended.

Partnership with local government?

Norfolk and Waveney began as one of the few STPs to be led by a local government official, Wendy Thomson, managing director of Norfolk County Council. She who eventually stood down in August 2017 in favour of Antek Lejk, chief officer of North and South Norfolk CCGs.

The move came shortly after the Local Government Association raised concerns that councils were not being sufficiently engaged with the STP agenda. The documents and proposals in Norfolk STP underline the huge predominance of NHS issues and the marginal or non-existent role of local government as any more than a spectator.

According to Patricia Hewitt, Dr Thomson had expressed the view that the appointment of an independent chair, moves towards system-wide strategic commissioning and the shift in focus from set-up to implementation meant the time was right for her to hand over the lead to an NHS colleague. She remains on the committee, though her precise role and the involvement of the Council seem unclear.

There are no reports of the full County Council discussing the STP, and the publication by its Health and Wellbeing Board last September of a document identifying priorities for the STP underlined the fact that almost all of the actions, where defined, fall to NHS providers and commissioners.

The Norfolk and Great Yarmouth and Waveney Transforming Care Partnership has been established since 2016, consisting of both Suffolk and Norfolk County Councils and the CCGs of North Norfolk, South Norfolk, Norwich, West Norfolk and Great Yarmouth and Waveney and NHS England Specialised Commissioning. The TCP forms part of the STP, and has produced some documents, although it warns that without additional resources for investment there are limits to what can be achieved.

Despite the initial leading role of local government, there were few specific proposals to social care in the STP, other than £45.5m of cuts (p25): social care was expected to run in deficit every year of the STP (p30) – even though local government is forbidden by law from running a deficit year to year. The various proposals that include investment in social care almost invariably combine social care with primary and community health care, leaving the social care share, and how it is to be spent, unclear.

Suffolk and NE Essex

Overall the plan, published in November 2016, is not clear. However there are detectable suggestions that there should be additional investment in primary care and in mental health, in 7-day services, in cancer care and new technology (p18). It's clear that there are hopes of "centralising" and "specialising" the services at Colchester and Ipswich hospitals, despite the logistical problems for organising staff and the transport and access problems this will cause for patients.

Primary Care is not discussed until page 25 of the skimpy 46 page STP, and then only in the most generalised terms, even though "Taking Forward The Programmes Set Out In The General Practice Forward View and Delivering Extended GP Access" is budgeted to consume almost half of the total revenue investment for transforming services up to 2020-21 (p18).

Likewise there is no analysis of what "corporate commissioner efficiencies" might save £26m a year by 2020-21, especially when 'referral management' appears to overlap with other plans to reduce demand for treatment.

Given the positive commitment to improving mental health (p24) and the projection of £8.5m increased revenue investment and £1.5m a year increased spending on mental health, it's hard to see how the projected savings of £7.5m a year from mental health can be achieved by 2020-21.

Bed closures/ rationalisation? Reconfiguration? Mergers?

There is an implied plan for the acute sector to be scaled down ("right sized") as primary and community care take a greater role:

"A reordering of expenditure across care settings is likely by 2020/21 as care moves closer to the person and providers become 'right sized' to manage the changes in demand. The aim is that the solutions will deliver a balanced in year position by 2020/21 however a cash solution will still be required to address the historic deficit." (p12)

There is no discussion of such rationalisation in West Suffolk, where the hospital trust appears to be establishing a central role in the proposed ACO.

The STP makes a positive and welcome commitment that both Colchester and Ipswich will "continue to provide a full emergency department and obstetric-led maternity units." (p29) So there is no explicit threat to any such services: and although there is no equivalent guarantee for West Suffolk, its distance from any other major hospital and its relative financial health may be enough to secure its survival.

There is no discussion of staffing cuts: indeed the main focus of the limited STP section on the workforce is the high 9% vacancy rate for existing posts, and the likelihood that 18% of the existing workforce could reach retirement age by 2021. (p34) Despite these serious problems in maintaining viable and safe staffing levels there is little indication of concrete plans to make NE Essex and Suffolk "an attractive and enjoyable place to work" (p3).

Reducing the numbers of "Low clinical priority procedures" is a key component of projected savings of £19m by 2020-21 through (largely unexplained) Inpatient Pathway Changes: however the procedures to be scaled down are not listed or defined.

Year on year 2% annual savings from "provider efficiencies" are assumed but take no account of the net financial cost to providers if significant numbers of inpatients, outpatients and A&E attenders are in fact diverted away, taking the funding with them.

In practice the main focus of activity in east Suffolk and NE Essex has been on driving forward the proposed merger of Colchester and Ipswich hospital trusts. UNISON has commented that the 126-page full Business Case setting out the case for a "partnership" between the two Trusts (largely indistinguishable from a merger) is "Neither Full, nor a Business case". Even backed up by 88 pages of Appendices it retains many of the flaws UNISON identified in the Outline Business Case at the end of last year.

The FBC does not conform to the general notion of a business case, since it doesn't even come close to securing a sustainable financial basis for the new trust. As such it is less a strategy, and much more an interim, short term plan, setting out only part of the actions that would be necessary to bring the combined trust into financial balance, let alone any surplus. According to recent Board papers the trusts were currently estimated to be £42.3m in the red and facing a projected do nothing deficit of £133m by 2021 . Even the expected receipt of Sustainability Funding towards this deficit will not put the trusts into balance.

Indeed, even if the FBC's hugely ambitious targets, to save £109m over 5 years, were achieved, the underlying situation of the merged trust – AFTER receipt of STF funding – would be a deficit of £27.8m in 2024 (FBC p83). Nobody could regard that as stable or satisfactory as a basis for developing services. Despite the warm rhetoric it's clear that even in an "Integrated Care System" the acute trusts would still be left to deal with deficits themselves, and pull themselves up by their own bootstraps.

Nevertheless the proposed outcome – a single Foundation Trust, if NHS Improvement nods through the deeply flawed plan – has already been agreed and given a name, the East Suffolk and North Essex NHS Foundation Trust, the whole process having taken place without any public consultation or proper engagement with staff and trade unions.

Even if the FBC's hugely ambitious targets were achieved, the underlying situation of the merged trust – AFTER receipt of STF funding – would be a DEFICIT of £27.8m in 2024.

Nobody could regard that as stable or satisfactory as a basis for developing services.

Plans for 'Integrated Care'?

The STP itself in 2016 contained relatively little discussion of integration either between NHS bodies across the footprint or between health and social care (NHS and local government). The proposed Joint STP Committee and System Leaders Group (p43) set out no plans to take control of any system-wide plans.

The West Suffolk Hospital trust seems especially resistant to any proposals for integration that might oblige them to help bail out the deficit-ridden Colchester and Ipswich hospitals, and determined to plough its own furrow.

There were however separate plans for 'Accountable Care Organisations' in West and East Suffolk, each organised around the acute hospital trust (Bury and Ipswich):

"Two alliances will be formed, one in Ipswich and East Suffolk and the other in

West Suffolk. These alliances will integrate primary, community, mental health and social care services with partners working with each other and with the voluntary sector to take accountability for all health and care outcomes for their local populations. This will be carried out in a phased way with phase one focussed on community and primary based care and future phases focussing on mental health and social care." (p27)

"Two shadow boards comprising the CCGs, Suffolk County Council, acute hospitals, mental health trust and GPs have been meeting monthly since mid 2015. The system plans to commission community services through a structured dialogue process with services in place by October 2017." (p41, emphasis added)

The ACO in West Suffolk was seen as one of the ways to deliver 2% per year "provider efficiencies" (p16).

In addition the STP refers to the establishment of:

"a Multi-speciality Community Provider (MCP) community model in north east Essex, teams around the patient and practice." (p23)

[…]

"North East Essex CCG has directly commissioned an outcomes based community contract in a Multi-speciality Community Provider (MCP), providing care closer to the patient's home, including some consultant led pathways. Patients have their care case managed by, and can access support through, the community hub.

"Multi disciplinary teams are wrapped around GP practices and integrated with social care and voluntary sector support to reduce system demand. Care is based around localities and neighbourhoods, rather than around organisations.

[…]

"Approach The outcomes based, performance related payment seven year contract is delivered through a lead provider model of delivery, where the lead is the system integrator and drives out good performance for their own supply chain" (p28)

Despite this clear trajectory to two or more "integrated" systems, in May 2018 it was announced that the whole Suffolk & NE Essex footprint was to be one of four new potential 'Integrated Care Systems' to join NHS England's development programme, with, no doubt, high hopes of receiving additional funds to help drive forward improvements in services. STP Programme Director Susannah Howard argued that there would also be "more flexibility" over the way the system operates.

However the decision to press ahead with this application was taken behind closed doors by the STP, and there has as yet been no public process of consultation or engagement, and little engagement with the unions. The process towards the ICS bid seems to have taken shape in the early months of 2018. The NE Essex CCG's March meeting was told that:

"With the support of the STP Communications lead the CCG is undertaking a number of briefing sessions during the next 2 months for staff, member practices and stakeholder partners on the development of the Integrated Care System across North East Essex and Suffolk." (March Board papers p23)

While "integration" might be breaking down some divisions between primary and secondary care, it is leaving intact the gulf between purchasers (commissioners) who hold budgets on the one hand, and providers (NHS and Foundation trusts) on the other.

More detail was given in a more extended report, making it clear that while the "integration" might be breaking down some divisions between primary and secondary care, it is leaving intact the gulf between purchasers (commissioners) who hold budgets (and even surpluses) and take decisions on the one hand, and providers (NHS and Foundation trusts) – mainly in deficit and struggling to deliver services with a reducing tariff and rising demand for treatment on the other. There is no suggestion of the trusts getting any say on the commissioning, which is to be integrated, and no proposal to share out any of the CCG surpluses to ease the financial woes of the acute trusts:

"Within the context of the Suffolk and North East Essex STP and as part of the development of the wider Integrated Care Systems (ICS) there is now a compelling case for the three CCGs within this footprint to come together on a more formal basis, in order to strengthen commissioning capacity and capability as a single strategic commissioning body." (p 91, emphasis added)

The CCG claims, vaguely, there is a "local ambition" for an ICS:

"The NHS has a new shared vision for the future to transform the traditional divide between primary care, community and mental health services and hospitals, which is known to be an increasing barrier to the personalised and coordinated health services that patients need.

"Local ambition is to join up these services to establish by 2019-20 an ICS. This will bring together a number of providers to take responsibility for the cost and quality of care for our defined population and within an agreed budget. This forms part of the wider STP for Suffolk and North East Essex …"

[…]

"An Integrated Care System is defined as the operating model for collaborative leadership across commissioners and providers, in the NHS and local government." (pp91-92, emphasis added)

Promise of consultation?

It has not happened yet, and it's not at all clear whether there is any intention to consult over the proposed moves towards an ICS in the footprint. This is despite the fact that moving to a bigger commissioning body covering a much wider area than the current CCGs, and a single Accountable officer to be shared by the CCGs would significantly weaken or exclude any voice of local communities.

This concern is effectively brushed aside in the document presented to NE Essex CCG in March 2018, which goes on to offer an evasive statement that talks of "communicating with" and "engaging with" the local public and staff, but falls well short of committing to any commitment to consult, or be willing to adjust plans in the light of views that might be expressed to them:

"As the moves to organisational alignment and strategic commissioning are significant there will be the need for a comprehensive communications process in order to engage and communicate effectively with patients, public, trade unions, LMC, Member Practices, partners, staff and stakeholders across Suffolk and North East Essex, setting out in detail how we will work with them to improve and deliver the health and care needs through transformation." (p93)

Past experience tells us that where genuine consultation is not promised, it is

never offered. If UNISON and local people want to ensure there is consultation, the STP, CCG and other leaders of the process need to be put on the spot to specifically agree to it.

Timetable for implementation

The less than dynamic process of the STP has now been supplanted by the drive towards an ICS, with a series of deadlines to move towards a single strategic commissioner and single accountable officer for the CCGs by November 2018.

Current/recent financial issues

Local CCGs all ended 2017-18 in surplus, NE Essex £10m, Ipswich and East Suffolk £3.8m and West Suffolk £1.8m – with the two Suffolk CCGs exceeding their target QIPP savings.

However the acute trusts have found the going much harder: Colchester Hospital appears to have ended the year with a £17m deficit, which may be reduced by a 'bonus' STF payment of £8.2m.

Ipswich Hospital's Board however heard in January that it had lost one STF payment (£3.6m) and could lose additional STF payments, and was projecting an end of year deficit of £18m. No final figure appears to have been published, although the planned Ipswich deficit for 2018-19 is £15m.

The West Suffolk Hospital trust did better than its control total for 2017-18 and, with the help of a £9.6m payment from the STF for hitting targets, came in with a deficit of just £300,000 on a turnover of £254m. Much of this was due to an unexpected £6m surplus in March 2018 after 11 months of deficits. West Suffolk is however predicting a £16.6m deficit for 2018-19.

The mental health trusts each have deficits, although much smaller in scale than the acute trusts. Again there is no sign of any intention of the CCGs to assist them in balancing their books; mental health providers also remain outside the magic circle that will take commissioning decisions.

In April the Department of Health turned down a bid for an extra £5.2m to address safety issues raised by inspectors when they visited the Norfolk & Suffolk Foundation Trust and put it into special measures last October.

Winter pressures/beds/DTOCs

On March 4 2018, the last day of the winter pressures reporting from NHS England, all three acute trusts in Suffolk and NE Essex had over 99% of their beds occupied, despite having opened an additional 139 'escalation beds' between them.

Between the three hospitals on that date there were 684 patients who had been in-patients for over a week, and 226 who had been in hospital for over 3 weeks, the so-called "super-stranded" patients that NHS England now wants to see reduced in number.

However there is little indication in the STP or the plans for the Colchester-Ipswich merger of any additional funding being used to develop more capacity outside of the hospitals.

The majority of the additional £87m capital miraculously found down the back of the Department of Health sofa and allocated to the STP in March is to be siphoned off into the Colchester/Ipswich merger.

Local CCGs all ended 2017-18 in surplus, with the two Suffolk CCGs exceeding their target QIPP savings. However the acute trusts have found the going much harder

Plans, proposals, state of play

The March meeting of NE Essex CCG refers to the STP plans to improve cancer services, which appear to be entirely reliant on the trusts generating the extra resources, while NE Essex CCG alone sits on a surplus of over £10m (p97):

"There is strategic work being undertaken at STP level and a Cancer Programme Manager aligned to this which will focus on improvements that can be made across the footprint.

"There is a cancer transformation programme across the STP which has been developed with many of the schemes reliant on transformational funding being released when the acute Trusts meet the 62 day standard in February this now seems to be at risk for the system." (p121)

Partnership with local government?

The STP outlined plans for governance which include representatives from local government (specifically Essex and Suffolk County Councils: but there was no mention of the unitary councils of Southend and Thurrock, or the 12 district and borough councils) alongside all of the NHS bodies in the footprint (p43).

Selected council representatives were to come together in a Joint STP Committee and also in a System Leaders Group to meet fortnightly. However there was no specific statement of agreement from local government – or indeed NHS trusts to the STP plan itself, and the bulk of the document, as with almost all STPs, is centred exclusively on the NHS.

There were no specific plans or discussion in the STP on social care or the financial issues facing the two County Councils: but they do want to have "Social care colleagues embedded at the primary care front door as part of the multi-disciplinary team" (p25).

High on the list of potential risks to the STP we see the risk that:

"Social care plans and assumptions have an impact on health and have not been included" (p45 emphasis added)

It's clear that "integration" as a concept and as a reality are a long way off, despite the hyperbole of the press releases.