

**REPORT ON THE
SUSTAINABILITY AND
TRANSFORMATION PLAN
FOR LEICESTER, LEICESTERSHIRE AND
RUTLAND
FOOTPRINT 15**

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INTRODUCTION: PURPOSE OF THIS REPORT

This report examines draws attention to some of the concerns arising from the Leicester, Leicestershire and Rutland Sustainability and Transformation Plan (STP). The Plan is in draft form and this report responds to the draft published on 21st November 2016. It is not a comprehensive analysis but identifies a number of areas of concern warranting further investigation.

CONTEXT

Context – Five Year Forward View

NHS England (NHSE) has divided England into 44 areas or ‘footprints’ and has required each to produce a Sustainability and Transformation Plan. Leicester, Leicestershire and Rutland are Footprint 15. The plans are required to demonstrate how they will bring about two principal objectives: one is the implementation of ‘new models of care’; the other is achieving financial balance by 2020/21.

The focus on new models of care follows NHS England’s *Five Year Forward View* (FYFV) published in October 2014 and widely understood to reflect strongly the thinking of Simon Stevens, Chief Executive of NHSE. FYFV identified three ‘gaps’ to be addressed throughout the health system:

- The health and wellbeing gap: focussing on illness prevention
- The care and quality gap: focussing on restructured provision
- The funding and efficiency gap: focussing on reducing unit costs

The new models of care indicated in the FYFV are:

- **Multispecialty Community Providers (MCPs)** – GP practices will be able to come together in federations, networks or single organisations. They ‘could in future begin employing consultants or take them on as partners, bringing in senior nurses, consultant physicians, geriatricians, paediatricians and psychiatrists to work alongside community nurses, therapists, pharmacists, psychologists, social workers, and other staff’. They will target ‘services at registered patients with complex ongoing needs such as the frail elderly or those with chronic conditions, and working much more intensively with these patients’.
- **Primary and Acute Care Systems (PACS)** – these are forms of ‘vertical integration’ allowing ‘single organisations to provide NHS list-based GP and hospital services, together with mental health and community care services’. This can include a mature

form of the MCP running its local district general hospital. ‘At their most radical, PACS would take accountability for the whole health needs of a registered list of patients, under a delegated capitated budget - similar to the Accountable Care Organisations that are emerging in Spain, the United States, Singapore, and a number of other countries.’

- **Urgent and emergency care networks** – Reduced reliance on A&E through greater use of primary care, community mental health teams, ambulance services and community pharmacies, as well as the 379 urgent care centres throughout the country.
- **Small district general hospitals** – This allows for hospitals to be grouped into ‘chains’ under single management or to have some of their work (e.g. ‘back office functions’) managed by another organisation. Some services will no longer be provided by some DGHs though their site may be used by another, specialist provider
- **Specialist services** – This allows for greater concentration of specialist services onto fewer, larger sites.
- **Maternity services** – This allows for a reconfiguration of maternity services, for groups of midwives to set up midwife-led units and for greater sustainability of maternity services.
- **Enhanced health in care homes** – This allows for the provision of more services (such as rehabilitation and medical reviews) in care homes to try to reduce hospital admissions.

Context – Funding

The STPs are a response to the funding settlement for the NHS under the Coalition and Conservative governments. Government policy is to shrink the NHS into a smaller share of national income and STPs are seen as the mechanism for achieving this. To sustain services as they have been provided, the NHS needs a funding increase of around 4% a year after inflation and this was the historical average for NHS funding increases between 1950 and 2010. Between 2010 and 2020, the NHS is receiving on average *1% annual increases* after inflation. Sustained underfunding (relative to cost pressures) of this scale is historically unprecedented. Although efficiencies have been made, NHS finances have worsened and by March 2016 there was an underlying provider deficit of £3.7bn. STPs require each footprint to restore financial balance by 2020/21. The STP for LLR states that a £399.3m annual ‘gap’ between available funding and costs will open up by 2021 if its proposals for restructuring are not implemented.

There is strong political pressure to restore balance and as very limited funds are available for ‘transformation’, the financial driver behind STPs has come to be seen by many, including NHS Trust chairs and chief executives, as the principal driver. As the recent King’s Fund report¹ notes the financial situation of the NHS and the operational pressures upon the service are now substantially more challenging than they were in 2014 when the Five Year Forward View was published. (See Appendix I for more detail.)

Billions of pounds have been stripped out of the social care budget nationally with real terms cuts in local authority budgets since 2010/11, placing local authority funded social care, and the independent sector companies and organisations which provide it, under severe pressure.

¹ C Ham et al (2017) *Delivering Sustainability and Transformation Plans*. King’s Fund

Context – Joint planning and Better Care Together

The restructuring of the NHS along competitive market lines, from the 1990s onwards and most recently through the 2012 Health and Social Care Act, has led to a complex, administratively expensive and highly fragmented system. The STPs require local organisations within the health system to work together and this is broadly beneficial.

The STP builds on the reconfiguration work of ‘Better Care Together’, which also had a strong ‘financial gap’ rationale, although there are some notable differences. The STP is a reiteration of BCT plans but with a more selective focus and an even greater emphasis on eliminating the funding gap which has arisen in recent years under the post 2010 national funding settlements for the NHS and social care.

STP KEY PROPOSALS

- Increase self-care and encourage healthy living.
- Increase use of pharmacist advice (to reduce need for GP care).
- Increased prevention activity and screening for earlier detection.

- Home first – where possible look after patients in such a way they can remain at home/go back home rather than being in hospital. This involves ‘integrated teams’ or multi-disciplinary care in community settings, including the patient’s own home, overseen by GP practice. Where possible undertake procedures outside acute hospitals and in community settings.
- Care, including ‘intensive community support’, will be provided to more patients in their own homes to reduce the need for hospital admission and so that their discharge from hospital can be sooner than might formerly have been the case.

- GPs will focus on patient with complex needs. Where possible, patients needing primary care will see health care workers other than GPs.
- GPs will increasingly work in networks. Some services currently provided through general practice will be provided ‘at scale’ so that while some services will remain at a patient’s registered surgery, patients may need to travel to other surgeries for some services.

- Closure of all acute beds at Leicester General Hospital (LGH). Reconfigure services within UHL and achieve a net reduction of 243 acute beds².
- Close St Mary’s birthing centre at Melton Mowbray and consultant led maternity services at LGH. Concentrate all inpatient maternity services (consultant led and

² UHL have more recently said fewer beds will be closed than the figure given in the STP but have not said how many beds will be lost.

midwife led) at LRI or establish a midwife-led service at LGH (subject to consultation).

- Close Fielding Palmer Community Hospital in Lutterworth and Rutland Memorial Community Hospital in Oakham. Provide some outpatient services on these sites (in any remaining estate).
- Almost halve the bed provision at Hinckley and Bosworth Community Hospital.
- Achieve a net reduction of 38 beds across remaining community hospitals.
- Overall bed reduction of 12.9%.
- Provide more care through ambulatory emergency care at UHL; provide greater care in community settings to prevent emergency admissions; increase referrals to alternatives to A&E.
- Further reductions in delayed transfers of care (DTOC).
- Reduce out of area placements for patient with mental illness; increase peer support and peer skills to support patients with mental illness.
- Further efficiencies within provider organisations and within CCGs.
- Save £412m (annually); requires £350m of capital expenditure.
- Workforce (WTE) reduction of 5.7%; shift towards more generic workers and associates.

AREAS OF CONCERN

Poor public patient involvement and absence of key information

The STP for LLR has been developed by a small group of individuals, largely unknown to the public, and was reportedly published only after it was leaked to the BBC. There has been an almost complete exclusion of the public from the process despite the fact that the services at stake are used by the public and paid for by the public. The use of a public and patient involvement group in the development of Better Care Together, whose members were expressly forbidden from discussing evolving proposals with other members of the public, does not offer a strong case study in good PPI practice.

The STP –which, we are told, is still in draft form - is written using a mix of technical language, jargon and acronyms. Even the briefer ‘public-facing’ document assumes that much terminology will be understood by the public and fails to make some of the key issues and consequences explicit. The dubious statutory basis for the STP and the role of the STP lead has resulted in hastily put together governance arrangements which are also not understood by the public.

Although the draft STP was published in November 2016, STP leads have refused to place into the public domain the appendices (or ‘templates’) on finance and workforce. As a result,

it is impossible to gauge what the calculations are regarding the financial underpinnings of the plan. It is likely that these documents have been withheld from the public because they are either unconvincing or politically controversial or both. That the finances are still ‘fluid’, to quote an STP lead, does not inspire confidence. The shrinkage of the workforce and the shift to more generic workers and (unregistered) associate physicians and nurses at a time of growing need are also causes for concern and the refusal to share the assumptions embedded in the workforce appendix prohibits the effective scrutiny of the Plan. No comprehensive needs analysis is presented and the detailed plans for the estate are also not available in the STP.

An ‘unrealistic’³ timetable has been imposed on STP leads, leading to rapidly made decisions. Drawn up in conditions of secrecy and removed from wider scrutiny, STP proposals are now being presented to local authorities across England which are being asked to sign up to complex proposals on the basis of limited information and discussion. Effective and confident scrutiny of the STP is not possible without greater detail, including the needs analysis, and financial and workforce details which are being withheld from the public.

A number of engagement events have taken place across Leicester, Leicestershire and Rutland with varying degrees of uptake by the public. The February event in Leicester City was well structured and reflected much work by STP leads but failed as an exercise in public engagement due to poor turn out, perhaps reflecting insufficient prior advertising.

Finances: Savings Targets are at the centre of the STP proposals

The STP claims that LLR are facing a shortfall of just under £400m annually by 2020/21 (taking both NHS and social care funding into account) if action is not taken. The detailed calculations and assumptions underpinning this figure are not set out in the STP and so are not available for scrutiny and independent analysis. So while broadly consistent with previous estimates, it is difficult to know, therefore, how sound the £400m figure is.

The STP identifies a number of routes by which, it is claimed, savings can be made to the tune of £413m. However, no evidence is provided to convince the reader that these figures are more than wishful thinking. For example, on p63, the STP claims that £174m can be saved through provider operational efficiencies. As providers have had to make demanding and historically unprecedented operational efficiencies since the early Coalition government period and since they have developed substantial deficits following wholly unrealistic efficiency savings targets⁴, it must be asked whether it is realistic to expect provider operational efficiencies on this scale to be delivered. This is just one instance of optimism bias, a problem which runs through the STP.

Overall, the STP’s claims that the large-scale savings identified can be made are unconvincing but the consequences of failing to generate them are not explored and no Plan B is offered.

It is obvious that if services are to be transformed so that more care is given in community settings, more investment is needed in both hospital and community services but this

³ Former NHS director, reported in GPOnline

⁴ Public Accounts Committee (2016) *Sustainability and Financial Performance of Acute Hospital Trusts*

investment has not so far been pledged by the government. The STP states that around £350m worth of capital investment is required. However, the Department of Health has cut its capital budget and at present it looks as if at least some of required capital funding will not be forthcoming.

Even on its own terms, the capital plan looks problematic as ‘increased demand’ above that already assumed is stated as a key risk. It is quite possible that £280m is invested in reconfiguring acute hospital services – services which the STP admits are already under intense strain - only to discover in a few years’ time or even sooner that this has resulted in service provision which is entirely inadequate to address patient need. This would represent a substantial waste of public money as well as significantly reducing the quality of and accessibility to health care. It should be noted that, when looking beyond the local Plan at experience elsewhere in England, reconfiguration proposals have consistently failed to demonstrate businesses cases offering a convincing case.

In addition to this, the net annual saving resulting from this £280m of capital expenditure reconfiguration is just £19.2m. It will take the better part of 15 years of such savings before the accumulated savings match the initial cost. While there may be benefits in the new co-location of services, this looks an extraordinary sum to pay to achieve relatively modest savings, particularly when the danger of capacity reduction is taken into consideration. As the STP itself admits to the risk that it may have underestimated future need, these ‘savings’ may incur the non-financial costs of bed and capacity shortages compromising patient safety and timely access to necessary care or may trigger additional future expenditure to restore capacity. This points to the problematic character of a five year plan of this sort when a much longer time-frame is required for rational planning. Indeed, the pay back periods for some of the different capital projects do extend beyond the five year period.

Given the unpromising prospects of capital funding from public sources, UHL is considering a Private Finance Initiative (PFI) scheme. The Treasury Select Committee concluded in 2011 that the Private Finance Initiative does not provide good value for money⁵ and the modified version of PFI (known as PF2) is thought to be even more expensive than PFI⁶. Nationally, £2bn of the NHS budget flows out of the NHS into PFI debt repayments each year. It is difficult to see how adding to this through a substantial PFI project in LLR will be beneficial for LLR health finances in the coming years. The STP claims the capital cost of reconfiguring acute services is around £280m. It is likely that if any of this capital is secured through the Private Finance Initiative, the initial capital expenditure (and thus long-term capital costs) will be higher than it would have been had it been funded publicly.

It should be noted that no reference is made in the STP to the costs which have so far been incurred in the development of the Better Care Together proposals since 2012, including the management consultancy costs, or to the costs incurred in preparing the STP or projected for the public engagement and consultation processes.

The STP provides effectively only a Do Nothing or Do Something choice. Treasury guidance on investment appraisal stipulates a Do Minimum option and it is unclear why this has not been developed as an alternative to the £280m sought for hospital reconfiguration.

⁵ House of Commons Treasury Select Committee (2011) *Private Finance Initiative*

⁶ House of Commons Treasury Select Committee (2014) *Private Finance 2*; M Hellowell (2014) *The Return of PFI: Will the NHS Pay a Higher Price for New Hospitals*. Centre for Health and the Public Interest

Weak evidence base for the overall model of moving services out of hospitals and into community settings as a means of enabling hospital bed closures

The STP does not appear to take into account a growing body of evidence challenging its core assumptions.

There are a number of good reasons to make more care available in community settings, including the patient's own home, where appropriate. Historically, the NHS has under-invested in community based services. High patient satisfaction can be found where community services are of a high quality. However, this does not necessarily mean that the overall system will be cheaper or can reduce acute bed provision. Nor, with the STP as it currently stands, can we be certain community services will be of a high quality.

The STP is premised upon a belief that expanding community based services will permit the net closure of acute hospital beds. This is almost certainly a false premise and ignores a growing body of evidence. A study⁷ examining the findings of reviews which covered 18,000 different studies found that some community interventions do give rise to a reduction in unplanned hospital admissions. However, most types of community intervention either do not reduce hospital admissions or there is no convincing evidence to suggest that they do.

Research evidence on the hospital-at-home type initiative seen in intensive community support suggests it may even increase hospital admissions⁸. One report⁹ found that after investigating 38 different integration schemes across 8 different countries including 13 projects in England, not one had resulted in a sustained, long term reduction in hospital admissions. The model of integrated (multidisciplinary) teams described in the STP is unproven. A Nuffield Trust report¹⁰ noted:

“In the absence of well-accepted, evidence-based solutions to reducing emergency admissions, there is a need to subject promising new interventions and models of service provision...to thorough evaluation.”

The local experience reinforces the view that there is a fundamental flaw in the STP's assumption and suggests net closure is not feasible and should not be sought if patient safety is to remain paramount. The Strategic Outline Case (SOC) for Better Care Together¹¹, published in late 2014, pledged a net closure of 427 acute beds out of 1773 acute beds over the following five year period. This included 203 beds between April 2015 and March 2015 and 61 beds between April 2016 and end Sep 2016 (half the figure given in the SOC for April 2016 to March 2017 on p72). This would have left UHL with 1,509 beds by the end of September 2016.

However the STP (published in November 2016) says UHL has 1940 acute beds. This is a net increase of 167 beds, fully 431 more beds than had been planned in the BCT Strategic

⁷ S Purdy et al (2012) *Interventions to Reduce Unplanned Hospital Admissions*. University of Bristol

⁸ For example, T Georgiou and A Steventon (2014) *Effects of the British Red Cross 'Support at Home' service on Hospital Utilisation*. Nuffield Trust

⁹ Serco/HSJ (2014) *A Commission on Hospital Care of Frail Older People*.

¹⁰ T Georgiou and A Steventon (2014) *Effects of the British Red Cross 'Support at Home' service on Hospital Utilisation*. Nuffield Trust

¹¹ Better Care Together (2014) *Strategic Outline Case*

Outline Case despite an expansion of community based services over this period. Confusingly, the figures in the national beds database do not correspond to the figures in these local documents, raising questions about the reliability of data used by the NHS. However, when figures from the national beds database¹² are used, there were 49 more beds in September 2016 than in September 2014 (most of the addition being in day beds). This again points to the infeasibility of net reductions in beds where patient need is rising even where community services are expanding. The ‘reality on the ground’ means beds cannot close without the potential for dangerous harm to patients.

The importance of retaining enough acute hospital beds for safe patient care

As well as relatively low levels of investment in community services, the UK does not fare well in terms of hospital bed provision when compared with developed countries internationally. The most recent OECD figures¹³ for hospital bed provision (2014) indicate an average of around 4.8 beds per 1,000 population among developed countries. The figure is 2.7 for the UK and around 2.5 for England – in other words, little more than half the average. We are amongst the lowest in bed provision in the whole of the developed world. It is unconvincing to argue that cutting hospital beds will improve patient care and points to the finance driven character of the STP.

Table 1 OECD figures for 2014 – Beds per 1,000 population

	Beds per 1,000 people
Austria	7.6
France	6.3
Germany	8.2
Norway	3.8
Switzerland	4.6
UK	2.7

In 2014 the Nuffield Trust published¹⁴ national bed projections for 2022 and found that an extra 17,000 beds would be needed on the basis of existing trends by 2022 across England in order to cater for an extra 6.2 million bed days. The Nuffield allowed that speedier discharge and more day case treatment could mitigate this figure. However, many of these efficiencies have already been achieved and the steady fall in the number of general and acute hospital beds nationally (from 126,976 in 2006 to 101,582 in 2016) cannot be expected to continue indefinitely. Even allowing for some further efficiencies, it is unconvincing to suggest the

¹² NHS England (2017) *Bed Availability and Occupancy*. NHS England Statistical Work Areas

¹³ OECD (2017) *Hospital Beds indicator* OECD

¹⁴ P Smith et al (2014) *NHS hospitals under pressure: trends in acute activity up to 2022*. Nuffield Trust

Nuffield's projected *net increase* in required beds of about 13% can be turned locally into a *net reduction* in beds of almost 13%.

Bed occupancy figures also point to the clinical risks of bed closure. Where national bed occupancy figures are based on midnight measures, they do not reflect the day to day reality of bed use. Locally, bed occupancy is very high, often 95%-100% during the winter period when the safe level is 85%.

A 2016 analysis¹⁵ by the Nuffield Trust has underlined the clinical risks of these dangerously high levels of occupancy. These include the greater difficulty in finding beds for emergency patients, increased 'trolley-waits', further compromises to the 4 hour wait standard in A&E, disruption to sick patients, additional workload and stress for staff, difficulties in maintaining cleanliness and the greater likelihood of infection spread. Several studies have established a link between high bed occupancy and increased rates of infection.

Despite these dangers and despite the relatively mild nature of the winter, between Nov 2015 and Feb 2016, bed occupancy rates in England fluctuated consistently around the 95% occupancy level. The recent intense pressure on beds nationally was widely covered in the media and UHL was among those hospitals having to issue the most Operational Pressures Escalation Levels alerts. Sir Mike Richards, chief inspector of hospitals at the Care Quality Commission, also recently warned¹⁶ of the compromises to patient safety in a context of financially straitened circumstances relative to rising need where hospitals were confronted with problems often beyond their control.

According to the STP, a net reduction of 38 community hospital beds is proposed. It is difficult to see how reducing community hospital capacity simultaneously can do anything other than impede plans to close acute beds and it is noted that earlier Better Care Together plans did not entail the net reduction in community hospital beds which we find in the STP.

Reconfiguration of mental health services and bed reductions in recent years has resulted precisely in inadequate capacity and poor quality services across many parts of the UK. The reconfiguration of mental health services represented a move away from evidence-based approaches to approaches with a relatively weak evidence base¹⁷. It is important that these mistakes are not made again in relation to physical health. A high quality and accessible hospital with sufficient capacity is an essential part of safe community based care.

Finally, it should be remembered that social care provision in the communities into which services are being transferred is already under tremendous strain. The National Audit Office¹⁸ notes that local authority spending on adult social care has reduced by 10% since 2009/10. During this time demographic pressures have pushed up the cost of providing care for older and disabled people. Age UK¹⁹ reported in 2016 that around 1.2 million people do not receive the social care they need.

¹⁵ J Appleby (2016) *Winter bed pressures*. Nuffield Trust Winter Insight Briefing 1

¹⁶ N Trigg (2017) *NHS standing on burning platform*, inspectors warn. BBC News 2nd March

¹⁷ H Gilbert (2015) *Mental health under pressure*. King's Fund

¹⁸ NAO (2017) *Health and Social Care Integration*. National Audit Office

¹⁹ Age UK (2016) *1.2m older people don't get the social care they need*. Age UK News 17th November

Weak evidence base for the assumption that the model of moving services out of hospitals and into community settings will create a cheaper (per unit) health system

There is no robust body of evidence that expanding community services and enhancing service integration will result in cash savings or cheaper care. The Commission on Hospital Care for Older People²⁰ described as a ‘myth’ the notion that providing more care for older people in the community and pooling health and social care budgets will lead to cashable financial savings in acute care and across health economies. The National Audit Office²¹ concluded that:

“There is no compelling evidence to show that integration in England leads to sustainable financial savings or reduced hospital activity”.

Limited research has been conducted on this and different studies have been difficult to compare. An analysis²² of economic impacts of integrated care found 19 reviews of which 18 reported on cost-effectiveness. It found there is evidence of cost-effectiveness in selected integrated care approaches but the evidence is mixed with some studies suggesting higher costs. Overall the evidence base remains weak. The same study reported:

“Utilization and cost were the most common economic outcomes assessed by reviews but reporting of measures was inconsistent and the quality of the evidence was often low. The majority of economic outcomes focused on hospital utilization through (re)admission rates, length of stay or admission days and emergency department visits. Findings tended to be mixed within each review, which makes it difficult to draw firm conclusions. Also, results were commonly not quantified, making an overall assessment of the size of possible effects problematic. Seventeen reviews reported cost and/or expenditure data in some form, typically reporting cost in terms of health-care cost savings resulting from the intervention, most frequently in relation to hospital costs. There was some evidence of cost reduction in a number of reviews; however, findings were frequently based on a small number of original studies only, or studies that only used a before–after design without control, or both.”

A recent report by the Nuffield Trust²³ warned:

“...in the context of long-term trends of rising demand, our analysis suggests that the falls in hospital activity projected in many STPs will be extremely difficult to realise. A significant shift in care will require additional supporting facilities in the community, appropriate workforce and strong analytical capacity. These are frequently lacking and rely heavily on additional investment, which is not available.

“...NHS bodies frequently overstate the economic benefits of initiatives intended to shift the balance of care. For example, they may use prices to calculate savings rather than actual costs and can therefore wrongly assume that overhead or fixed costs can

²⁰ Serco/HSJ (2014) *A Commission on Hospital Care of Frail Older People*. HSJ

²¹ NAO (2017) *Health and Social Care Integration*. National Audit Office

²² E Nolte and E Pitchforth (2014) *Evidence of economic impacts of integrated care*. WHO

²³ C Imison et al (2017) *Shifting the Balance of Care: Great Expectations*. Nuffield Trust

be fully taken out. Similarly, many underestimate the potential that community-based schemes may have for revealing unmet need and fuelling underlying demand.”

The Nuffield Trust report concluded:

“While out-of-hospital care may be better for patients, it is not likely to be cheaper for the NHS in the short to medium term – and certainly not within the tight timescales under which the STPs are expected to deliver change.”

Reduction in unit cost may be driven by re-provision which is deliberately cheaper (e.g. less care given or care given by less qualified and experienced staff) as seen in social care. It is difficult to see how improved patient care is compatible with this.

Well-planned and coordinated delivery of services by cooperation across teams and agencies, hospitals and community is essential for those with complex and long-term needs. Substantial investment in developing services is required so that alternative provision can be tested before busy acute hospital beds can be safely closed.

Centralisation of services and removal of services from Rutland

The STP proposes a significant centralisation of services. The closure of Rutland Memorial Community Hospital in Oakham and the removal of acute beds from Leicester General Hospital leave a forty mile gap with no beds between Leicester and Peterborough. The Fielding Palmer Community Hospital in Lutterworth is also proposed for closure and beds at the relatively new Hinckley and Bosworth Community Hospital are to be all but halved.

Maternity services are also to be centralised on the site of the Leicester Royal Infirmary since provision is to be removed from Melton Mowbray with the proposed closure of St Mary’s and consultant-led care is to be withdrawn from the Leicester General Hospital where currently around 4,400 births take place each year. Current plans are to consult on the possibility of a midwife led unit at the Leicester General Hospital.

There is no specificity regarding the services to be offered to Rutland patients at Oakham once the hospital is closed and there is no ‘Plan’ specifically for Rutland which is expected to give up many of its health services without knowing in detail how primary and community based care is to be strengthened.

The STP does not appear to take into account the availability of residential and nursing home care, a sector already struggling with financial and workforce difficulties, or the difficulties of securing care packages in remote rural locations.

Workforce concerns

The NHS is facing a substantial challenge with problems in both recruitment and retention of staff across the range of professions. Alongside this, insufficient numbers are being trained. Workforce planning has been poor for many years.

The East Midlands has proportionately fewer doctors, administrative and ancillary staff when compared with England as a whole. Across all professional categories, it has fewer professionals per head of population than the national average. As the East Midlands trains more than its share of some categories of professionals (adult nurses, occupational therapists and physiotherapists), there is clearly a problem of retention.

Staff, rather than receiving support through an expanded workforce and avoidance of disruptive change, are caught in a maelstrom of unrelenting reorganisation, staff shortages, rising need and chronic underfunding. Staff are being forced to undertake higher band duties on lower band pay and to undertake additional duties when there are staffing gaps. These problems are exacerbated by 'cost improvement programmes' undertaken by providers and which are highly disruptive of staff morale.

The STP admits that the development of Integrated Locality teams will require significant change in how the workforce is organised and led. On top of existing pressures, staff face the prospect of new contractual and structural arrangements. In the context of a properly funded service where a shift towards a proven model of care is well resourced and staff properly supported, these sorts of changes are easier to bear. However, the new integrated model of care is unproven and may well not work. Imposing change on staff who are already under acute pressure runs the risk of alienating and exhausting even more staff and losing them as they give up their jobs or retire. In this way, the STP could well make staffing problems worse.

To some extent, services are being reorganised around workforce shortages rather than the workforce being planned around the health services that patients need. This is putting the cart before the horse. The STP justifies the closure of the Leicester General as an acute hospital and the closure of two community hospitals on the basis that staff are too thinly spread. However, it is difficult to see how moving patients out of hospital wards and into their own homes will result in more effective use of the workforce unless they envisage care given at home being delivered by cheaper and less qualified and experienced staff.

The STP says that staff lack the skills and confidence to maintain patients in the community. However, experienced staff have been leaving the NHS partly as a result of the increasing pressure on the service and on themselves. Yet, experienced staff are needed for work in community settings because they will be undertaking more lone work and thus must work more autonomously.

Workforce data are being withheld from the public but, despite an assertion that the workforce is essential for a successful health and social care system, early indications suggest the workforce is planned to shrink and to be restructured with overall a lower skill mix, meaning that more care will be given by staff who are less qualified and less experienced. Physician Associates may have a role but it should be remembered that they have just two years of training and may facilitate de-professionalisation and tighter management control over professional decision making. There is no mandatory registration for them, raising concerns about their regulation. Similarly, nurse associates will not be registered professionals.

It is important to consider lessons which can be learnt from social care. Privatisation of social care provision as a means to manage inadequate council budgets has resulted in the

depression of wages and the casualization of carers²⁴ so that the turnover of carers in the social care sector is very high and private providers complain of recruitment and retention difficulties.

With regard to the STP, the proportionate increase in the number of posts needed in the coming decade is greater than the increase in the population. The danger is that an increasing amount of 'health' care is going to be given by untrained and unqualified staff as CCGs turn to outsource the provision of services transferred to the community because independent bidders offer to provide services at lower cost. It is difficult to see how quality can be restored or upheld in this scenario. Poor quality of health care given in people's own homes will be as difficult to detect as poor quality social care currently is.

The lack of adequate numbers of staff to deliver the proposed new models of service could prove to be an even more important obstacle than the lack of funding and the lack of capital, both of which could potentially be addressed simply with a change in government policy. A lack of staff to deliver the new services could prevent the effective implementation of the Plan and yet the STP provides no proposals to address this unless the proposals are precisely to downskill.

Access to GPs

The STP plans to alter the GP model of care in place since 1948. The STP offers the prospect of longer GP appointments for some patients, should sufficient numbers of GPs be in place. However, this will not apply to all patients. The STP summary document speaks of 'strengthening GP surgeries', a wise redrafting of the original version which referred instead to 'strengthening GP *services*' since it is likely to become more difficult for patients to see their GPs unless they have multiple illnesses or complex conditions. Instead, patients can more frequently expect to see a health care worker other than the GP. The implications for quality of care will depend largely on the quality of the triage process and the suitability of the substitute worker for the health care need the patient has identified. This is not made clear in the STP or public summary of the STP.

For some time, research has suggested that continuity of care leads to better outcomes for patients²⁵; more recently, a Health Foundation²⁶ Briefing paper suggested hospital admissions could be reduced by greater continuity of care. However, it is possible that the plans to reorganise primary care could lead to greater discontinuity of care for some patients.

²⁴ CHPI (2013) *The future of the NHS? lessons from the market in social care in England*. Centre for Health and the Public Interest

²⁵ For example, J Haggerty, R Reid, G Freeman, B Starfield, C Adair and R McKendry (2003). 'Continuity of care: a multidisciplinary review.' *British Medical Journal*, vol 327, pp 1219-21.

²⁶ I Barker, A Steventon and S Deeny (2017) Association between continuity of care in general practice and hospital admissions for ambulatory care sensitive conditions: cross sectional study of routinely collected, person level data. *British Medical Journal*; Health Foundation (2017) *Reducing hospital admissions by improving continuity of care in general practice*. Briefing Paper

Weak risk analysis and the experimental nature of the new models of care

As the analysis above suggests, the new models of care incorporated in the STP proposals are of a somewhat experimental nature and this was admitted at the public engagement event hosted by Leicester City CCG in February 2017. The STP represents a shift away from a tried and tested a model of care which, while not perfect and while always subject to national funding policy, was able to offer good levels of access to high quality care provided by highly skilled registered professionals. Instead, the proposals push us towards unproven models of care. Although ‘vanguard’ projects are piloting a range of models across England, these have not been properly evaluated and, since they are relatively new initiatives, effective evaluation may not be possible for some time.

In relation to integrated models of care, the National Audit Office²⁷ recently concluded:

“The Departments [of Health and for Communities and Local Government] have not yet established a robust evidence base to show that integration leads to better outcomes for patients. The Departments have not tested integration at scale and are unable to show whether any success is both sustainable and attributable to integration. International examples of successful integration provide valuable learning but their success takes place in a context of different statutory, cultural and organisational environments”.

The NAO report added

“.. the new care models are as yet unproven and their impact is still being evaluated. NHS England plans to have evaluated the effectiveness and value for money of the new care models programme by the end of 2018. Despite this, the NHS mandate requires NHS England to roll out the new care models rapidly; achieving 20% coverage by the end of 2016-17 and 50% by 2020”.

In relation to the unproven and experimental nature of the new models of care and the potential deterioration in the quality and volume of services provided, the risk analysis in the STP is weak. In addition to this must be added the paucity of funding available for ‘double running’, that is to say, available to run both new services in the community and existing services in hospitals for the substantial period necessary to be certain the new services adequately replace existing services.

The risks posed are exacerbated by the absence of a detailed needs analysis from the document to underpin the proposals.

Conclusions

A five year period is a poor basis for NHS planning and the short-termism of the STP jeopardises rational service planning for the longer term.

²⁷ NAO (2017) *Health and Social Care Integration*. National Audit Office

The STP weakens its own case by omitting a large body of relevant detailed information. The assumptions on which the financial effects of the proposals are calculated are not transparent, making effective scrutiny impossible.

The STP establishes a number of aims but does not demonstrate how these will be achieved by the proposals suggested.

As the STP provides no detailed needs analysis, it is difficult to establish that, as it stands, it is fit for purpose.

While some of the aspirations which inform the STP are worthy, there is little to convince us that the proposals can safeguard quality care through the new models of care or can deliver the scale of financial savings claimed. The risk analysis provided is weak.

Community initiatives which work are to be welcomed but assessing their impact takes time and a buffer is needed during this period through 'double running' services.

Although the Plan includes some positive ideas, including expanding services in community settings and facilitating more self-care, the key challenge is to assess whether it is likely that patient and client care as a whole will be improved – or even maintained - while stripping out £400m every year from the system. This looks highly improbable.

The UK is one of the lowest bedded health systems in the developed world and the current proposals to reduce hospital capacity lack all credibility.

The new models of care are cost-driven where change in practice should be driven by a combination of clinical need, clinical quality and reasonable patient access. Service changes should be rigorously assessed against these criteria. The new models of care have not been sufficiently evaluated and are not supported by a strong body of high quality research evidence.

The Plan seeks to address problems of recruitment and retention but may, through further reorganisation and restructuring, exacerbate these problems, particularly where staff believe the quality of services is poor.

For a range of reasons, it is unlikely that the scale of financial savings promised by the STP will materialise. If the financial case were so clear we would expect the relevant information to be made available.

STP leads should produce a Do Minimum option which could remove a substantial layer of cost associated with the STP.

It is important that high quality replacement services are established and sufficiently tested for their impact in terms of both quality and quantity before existing services are closed. The development and expansion of high quality services in the community requires substantial additional investment. It is not clear at the time of writing whether announcements made in the March 2017 budget will be sufficient to address this challenge.

Investment decisions should be based on securing improvement in the quality of services and not on attempting to cut health care costs. A five year framework is inadequate for guiding investments with long term implications for services.

It is not clear from the STP whether the investments it proposes are economic (whether they could be achieved more cheaply by other means); realistic (whether the business case and underpinning evidence base for the proposals are sound); or deliverable (whether the assumptions about the capital available and staffing (for example) are sound given the scale of the plans put forward for savings and provision).

While there may be a good case for investment in service redesign to improve services, on the available evidence capital expenditure of £280m to move from three acute sites to two cannot be considered a worthwhile expenditure to achieve savings, particularly when likely deficiencies in the resulting services are taken into consideration.

The Plan will result in less accessible and poorer quality care and will achieve neither improved health outcomes nor the financial savings it claims it will make.

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Appendix I NHS Finances

The NHS requires around 4% a year real terms increase in funding to keep pace with cost pressures arising from

- Change population size and structure
- Changing profile of morbidity
- Health service specific inflation (higher than general inflation)
- Medical technology and innovation.

A real terms annual rise of around 4% a year was the historic average between 1950 and 2010, though Labour governments tended to fund more generously than Conservative governments.

Rather than 4% a year, the Coalition and Conservative governments have created a funding settlement for the NHS which gives on average just 1% a year between 2010 and 2020. At the same time, social care funding has been dramatically cut. Now that the majority of sizeable efficiencies have been made, radical restructuring to cut the unit cost of health care is being proposed.

Around £120bn is currently being spent on the Department of Health and NHS in England. Although around the middle of the ranking of OECD nations, the UK lags behind comparable rich nations in its funding of health care. The most recent OECD statistics²⁸ show the following (based on new definitions of expenditure which include social care expenditure)

Table 2: % GDP spent on health and social care (using the new OECD definition) and per person purchasing parity in US dollars for selected countries, 2015

	% GDP 2015	US\$ per person purchasing parity (current prices) 2015
Austria	10.4	5,016
France	11.0	4,407
Germany	11.1	5,267
The Netherlands	10.8	5,343
Norway	9.9	6,567
Sweden	11.1	5,228
Switzerland	11.5	6,935
United Kingdom	9.8	4,003

The proportion of the GDP spent on health care is falling year on year and is set to fall further before 2020. An analysis²⁹ of funding in Europe since 1980 found that the UK had spent around 20% less on health care than the European average over the period. An additional 20% in funding now would add around £24bn to the annual English health care budget.

²⁸ http://stats.oecd.org/index.aspx?DataSetCode=HEALTH_STAT

²⁹ J Harding and C Pritchard (2016) UK and Twenty Comparable Countries GDP-Expenditure-on-Health 1980-2013: The Historic and Continued Low Priority of UK Health-Related Expenditure. *Jnl Health Policy Management* 5(9): 519–523