Costly Savings

The impact of government policies on health & social care in the East Midlands: a survey

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The East Midlands (the five county areas and unitary councils of Derbyshire, Nottinghamshire, Lincolnshire, Leicestershire and Northamptonshire) has been among the areas most disrupted by the drastic top-down reorganisation of the NHS imposed by the coalition government since 2010: and it is facing drastic financial pressures, with local trusts already struggling – and some failing -- to meet targets.

Local health commissioners across the East Midlands have a combined allocation of £5.1 billion this year, rising fractionally to £5.2 billion in 2015-16. But this apparent stability masks the need for very substantial savings by commissioners, even more cuts in local government budgets and unresolved deficits among many of the main hospital trusts.

Across the five counties, the combined savings targets for health and social care over the next five years add up to more than £1 billion – almost 20% of the current budget. Meanwhile pressures and demands on front line services continue to increase, and the numbers of more vulnerable older people are growing even faster than the general population.

There is also a further pressure for cost "efficiencies" by the NHS in order to cope with substantial rising cost pressures on the NHS from general inflation, rising drug costs, medical innovation and other factors.

Two of the East Midlands acute hospital trusts – University Hospitals of Leicester and United Lincolnshire Hospitals were among the ten largest NHS Trust deficits at the end of the last financial year, while three Foundation Trusts – Derby Hospitals, Sherwood Forest and Kettering are also running substantial deficits.

But the problems also affect other parts of the NHS, and reach into social care. **Two East Midlands counties, Leicestershire and Northamptonshire have been singled out by Monitor, NHS England and the NHS Trust Development Agency for inclusion in a list of eleven "financially challenged" health economies,** which are to be given the dubious benefit of £800,000 extra funding to pay for management consultants[1] to deliver 10 weeks of "support".

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[1] To be selected from a predictable shortlist of large companies which have effectively monopolised the NHS market – such as McKinsey, PWC, Deloitte, Ernst & Young and KPMG.

It's not clear what such consultants can add: many of the areas and trusts in most trouble have already squandered large sums on fruitless consultancy work. The problems to be confronted are huge and not susceptible to any "quick fix": **Leicestershire alone needs to find ways to cut spending on health and social care by a massive £400 million by 2019, with the threat that if nothing is done this one county's combined deficits could rise to over £1 billion. Even as University Hospitals of Leicester Trust is investing to open up additional beds to meet constant levels of high demand, the plans point to the closure of 427 NHS beds.**

The implications of these enormous savings targets, and the far-reaching changes which would need to be made to secure them, will increasingly take centre stage as strategy documents and long-term plans are put out to consultation later this year.

However it is important that we do not allow ourselves to be stampeded or panicked into action which may do lasting and irreparable damage to health and social care services. The cumulative cash gaps that are being quoted cover a five year period: all this money does not have to be saved right away.

And it's important to remember Britain is not a high spender on health care by international standards: many other countries with successful economies spend much more.

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Across England, the extra to stabilise services would add up to an extra £2 billion or so this year – less than 2% of health spending, less than 0.25% of government spending and 0.14% of GDP. Even with this extra spending, the UK will be one of the lowest cost health care systems in the high income countries.

The decision to drive these "austerity" cuts rather than increase health budgets to maintain services is a political and ideological decision of the coalition government: they are working on a *political* and not an economic agenda.

This report attempts to develop an overview to put these changes in context, and to warn of the possible serious consequences if the present crop of badly-thought out, panic-driven, evidence-free proposals are pushed through by desperate NHS managers in the hope of securing short and medium term savings.

The biggest-ever reorganisation

In April 2013 the Tory-led coalition government's controversial Health and Social Care Act took effect in England, sweeping away the structures of the NHS that had been in place since 2006, and creating a much more fragmented and complex system – at the very point the NHS is being called upon to make huge and continuous savings from "efficiency".

The new Act had no electoral mandate, and had not previously been discussed openly by the Conservative Party, which had campaigned on a platform of no more top-down reorganisation of the NHS, and no more closures of A&E and maternity units. Andrew Lansley's Bill was almost unanimously opposed not only by UNISON and the other health unions, but also by almost every professional group of health workers, including a large majority of GPs – supposedly the ones to be empowered by the Bill – who consistently showed opposition to its principles in every poll.

The Bill was not based on any evidence: it has created an experimental model of a health care system. From the outset it was designed to create a ***competitive market*** in which the private sector would have many more opportunities to bid for contracts to deliver those services it sees as profitable – **regardless of the long-term cost to the NHS**, or the possible short-term knock-on impact on other services which might be left unviable.

Original estimates suggested the cost of introducing these changes could have been between £1.5-£3 billion: but now it is in place the full costs of running this competitive market, taking account of the hefty transaction costs and other overhead costs of putting increasing numbers of fragmented services out to tender, have yet to be fully revealed – or in many cases even calculated.

The new structure of the NHS

The Act abolished East Midland and nine other **Strategic Health Authorities (SHAs)** that had kept an overview of local plans of commissioners (Primary Care Trusts) and healthcare providers (NHS Trusts, Foundation Trusts and GP services).

In place of the SHAs (bodies which met in public and published at least most of their Board papers, and were clearly subject to the Freedom of Information Act) we now have a shadowy, confusing system of **"Local Area Teams"** of a new **NHS Commissioning Board, known as NHS England**.

These have highly paid directors, but are not public bodies: they meet and work in secret, publish no board papers, and although they may in theory be subject to the Freedom of Information Act, the lack of any information on their activity or discussions makes it difficult to frame any appropriate question that might secure an answer.

As a result of this, the East Midlands, until 2013 controlled by a single SHA, has now been carved back into THREE Area Teams (Leicestershire & Lincolnshire; Derbyshire & Nottinghamshire: and (for Northamptonshire) Hertfordshire & South Midlands).

The same fragmentation has taken place at more local level, where in place of the **NINE** Primary Care Trusts which held the budgets for health services in the five counties and the unitary authorities of the East Midlands, we now have a jigsaw pattern of **NINETEEN** "Clinical Commissioning Groups", some of them covering areas as small as 12 GP practices. In theory the CCGs are led by local GPs: it's not yet clear how far this is true in practice, as a new and fragmented system of 'Commissioning Support Units' is put into place.

The CCGs hold budgets for the care of the population registered on the lists of their GP practices, but do not commission local GP (primary care) services or specialist health care – both of which are controlled centrally by NHS England and its Area Teams.

The biggest-ever financial squeeze

This complex, new, fragmented and much less transparent structure has come under immediate and massive pressure from the unprecedented funding squeeze imposed by the coalition government.

In the aftermath of the banking crisis and public sector bail-out of failing private sector banks in 2008-9, spending on the NHS has been squeezed, and as a result has not risen measurably in real terms since 2010. However pressures on the NHS, including those from rising numbers of older patients, increased costs of drugs, services and new techniques, have continued to increase year by year.

The impact of these increasing pressures was estimated to be around 4% of NHS spending each year, resulting in a potential gap between funding and demand of up to £20 billion by 2015.

Attempting to get NHS Trusts to maintain services in the face of this gap by finding more and more "efficiencies" was branded the "Nicholson challenge" after the then chief executive of the NHS Sir David Nicholson.

But the projections of the likely deficit, and many of the plans that have become the basis of cost-saving efforts were developed by US-based management consultants McKinsey in 2009. McKinsey and other management consultants are now an almost ever-present feature throughout the NHS, advising both commissioners and providers.

The NHS overall has, despite the odds, up to now delivered surpluses, a large share of which have each year been clawed back from the health budget to the Treasury, rather than (as promised) reinvested in health services.

But individual trusts and CCGs have been increasingly struggling: 40% of NHS trusts are facing deficits, while NHS England has warned that as the financial straitjacket gets tighter, with 2014-15 "even more challenging" than 2013-14, only one CCG in four has a balanced financial plan.

Up to now the bulk of the "savings" that have been made have come from the government's imposition of a pay freeze and then below inflation pay increases for 1 million or so NHS staff, tearing up the recommendations of the Pay Review Body.

This has inflicted a real terms reduction in the value of NHS pay of upwards of 10 percent since 2010. The mounting anger and resentment of staff at shouldering this element of the costs of bailing out the banks in 2008-9 has been shown by recent protests by UNISON and other unions.

Indeed even the most hard-nosed management consultants are now warning the government that such a pay freeze cannot continue indefinitely without impacting on staffing levels and the recruitment of new trainee health professionals. So any further substantial "savings" will need to come from other means, and any further squeeze on the pay bill is likely to flow from job losses rather than cuts in real wages.

Indeed NHS England also vets the constitution, financial discipline and policies of all 211 CCGs.

Planning a ten-year freeze

Nonetheless the current government's spending plans propose a continuation of the spending freeze right through to 2021 – while still claiming that they are "protecting" the NHS from the much bigger, overt cuts which are looming for other public services.

If this policy is carried through it would amount to a TEN YEAR real terms freeze on health spending, and significantly reduce the share of GDP (national wealth) spent on the NHS, to below 6 percent.

This would reverse the investment made in the ten years from 2000 by the Labour government, which enabled the NHS to expand staff, improve performance, and reduce waiting times in A&E and for elective surgery, establishing for the first time a new maximum waiting time of 18 weeks from referral.

It was the continued impact of this investment which explains the recent findings of the prestigious US-based Commonwealth Fund, which declared the British NHS to be on most measures the best healthcare system in the world, with the costlier, private sector dominated US system coming in bottom of the league.

Indeed had Labour in 2000 not done as they did, and increased health spending, but instead followed George Osborne's projected path and limited any increases to the level of inflation, NHS spending in England would currently be around £30 billion per year, around 30 per cent, less than it is now. The system would be barely recognisable as the NHS we still have today.

Commissioners pass the buck

As a result of the continuing cash squeeze, all parts of the East Midlands face stiff targets for savings in the hopes of balancing the books: some areas appear to have a much more developed analysis than others of the savings they will have to make, because the targets published so far vary widely, and in some cases are far from proportional to existing health budgets. The totals are around £1 billion across the East Midlands.

The biggest target of all is the combined total for health and social care in the **Leicestershire CCGs**, some £400 million by 2019, from a current combined health budget of £1.1 billion.

The next largest, and proportionally by far the biggest target is for **Northamptonshire**, which has a much smaller current health budget totalling £740 million, but a spending gap in the next five years of £276 million.

Lincolnshire – divided into four CCGs – has a combined target and a joint plan aiming to address a £105m shortfall from a current budget of £900 million: however the plan that has been drawn up admits that the savings plans so far proposed would at a best case raise £74 million or possibly as little as £49m of this, leaving a substantial unresolved gap requiring further cuts.

Nottinghamshire is even more divided, into 6 CCGs, and is working on two separate plans under the heading 'Better Together': the Mid Nottinghamshire plan hopes to generate £35m of savings towards a target of £75 million. The South Nottinghamshire plan is aiming to address a spending gap of £140 million or more (the figure has not yet been finalised). This gives a county-wide total of £215m or more.

Derbyshire, too, is set to produce two separate plans – Northern Derbyshire (covering three CCGs) and Southern Derbyshire – for changes to bridge the looming financial gap.

If Labour had not increased spending in 2000, England's NHS budget would by now be 30% – £30 billion – smaller

However as this report is finalised there is no sign so far that either of the Derbyshire plans has been produced in anything more than the most aspirational outline form, or that any realistic projection has been developed of the gap to be bridged by future savings.

However while the commissioners appear to be delaying any real reckoning with the looming problems, at provider level the pressure is mounting: the largest hospital Trust, Derby Hospitals, is facing a massive £43m financial gap by the end of this year, and the Trust board has been warned that "the landscape continues to look challenging".

Silence on key issues

At present the lack of detailed information – on exactly how those with the most serious and urgent needs could be speedily treated in one location, and how the already hard-pressed and struggling East Midlands Ambulance Service could cope with the additional demand and how the recipient hospital could be expanded to deal with those in need of admission – means the debate cannot really begin.

But there are already grounds to question whether – even if a more centralised A&E service could be

The drive for savings

Those CCGs which are trying to get to grips with the consequences of the cash squeeze are all moving down well-trodden paths of hopeful cost savings and efficiencies, while each claiming that their version of the received template of policies represents some form of "local" solution.

One common feature of most of the 5-year plans outlined so far is that they remain **as vague as possible on the way in which proposals might actually save money** (fewer staff? More reliance on less qualified staff on lower (and cheaper) pay grades? Closing buildings to cut support costs and capital charges? Treat fewer patients? Pay less to providers – possibly by deliberately paying for less than the full caseload?).

Another common feature is the now almost universal assumption among NHS commissioners, for which there is still not a shred of supporting evidence, that it is somehow automatically cheaper to deliver care out of hospitals in "community settings", closer to, or actually IN patients' homes.

In fact, despite the rhetoric for this, and the evidence that such systems, if properly resourced, could potentially improve the quality of patient care and the patient experience, there are few if any instances where this policy has been consistently applied on any scale beyond small, well-funded pilot studies. Nor have concrete plans been developed for community-based resources capable of significantly reducing the caseload of hospitals.

The third exceedingly common feature of savings plans is the focus on reducing A&E caseload and proposals for centralising A&E to fewer, presumably larger, units. Despite the colossal amount of combined managerial effort and resources that have gone into discussing such policies, A&E caseloads continue at stubbornly high, often increasing levels.

Efforts to persuade the public that fewer A&E units, often at much greater distance, might offer enhanced specialist care for those with the most serious health needs have proved unavailing.

It's no surprise the idea has only won acceptance from sections of the public when explained in the most hypothetical and generic terms: it encounters universally stiff and bitter resistance as soon as it is translated into concrete plans to close services at a specific location and relocate them elsewhere.

The problem is especially intractable in most of the East Midlands counties, which cover relatively large rural catchments with many miles between hospitals.

The most extreme of these is **Lincolnshire,** the second largest county in England, where, nonetheless, the plan drawn up by the Sustainable Services Review (bringing together the 11 groups responsible for health and social care in Lincolnshire) proposes **a single A&E unit and a single maternity unit**, despite the fact that the existing hospitals are upwards of 28 miles apart, separated by an extremely poor road network.

Children's services, too would be "consolidated" from the current eight in-patient and outpatient units to **a single "purpose built" unit** at a "central location" – regardless of the situation of the parents who would have to travel with them across a large county to access treatment.

The starting point for these various plans has quite clearly been the needs of the commissioners and providers to meet cash limits, rather than the needs of the patient.

And with so many obvious losers and so little tangible benefit on offer from the changes, it's clear that health bosses will face a rocky ride if they attempt to win support for these ideas in any public consultation.

made clinically viable and logistically sustainable – it would generate any real savings, especially if the plan is genuinely to include any provision of alternative services in Urgent Care Centres and/or community-based and primary care services, all of which require spending and investment.

Some CCGs are at least up front in spelling out their intention to cut services to save money. In Mid Nottinghamshire, the Integrated Care Transformation Plan being developed by the two CCGs (Mansfield & Ashfield and Newark & Sherwood) rests on an explicit **reduction of 15% in A&E attendances**.

On top of this, the plan assumes an even more ambitious **19% cut in emergency admissions**, a **20% cut in paediatric admissions**, an even more dramatically ambitious **30% reduction in acute bed days** and a **25% cut in referrals to nursing and residential homes**.

All of these projections appear to rest on little more than wishful thinking. None of them is likely to enjoy any level of public acceptance or support.

Making things worse

It's clear that the CCGs discussing increasingly implausible plans to divert patients from hospital into undefined – and so far largely non-existent – "community settings" have taken little if any account of the financial impact on the hospital trusts.

Under the current system, the trusts are paid only for the patients they treat (the so-called "payment by results" system) and would therefore take a heavy blow if the new plans were in fact successful in diverting patients away from them.

This issue has been recently flagged up by the Commons Health Committee report *Managing the care of people with long term conditions* (July 2014).

One clear example of this failure to take the consequences into account can be seen in the drastic cuts in service proposed in Mid Nottinghamshire.

These are expected to raise only £35m towards the

PFI in East Midlands

Significant and rising sums of money are now flowing out of the NHS each year and into the pockets of shareholders and speculators, many of them now based in tax havens, who are the owners of binding long-term contracts under the Private Finance Initiative (PFI).

The Treasury website lists **eight** health-related PFI schemes in the East Midlands, totalling £803 million in capital value. The two largest of these are the **Derby City General Hospital (£312 million)** together with a smaller but disproportionately expensive reprovision of mental health services (£36 million), and the **£326 million modernisation of Sherwood Forest Hospitals Foundation Trust**, the largest part of which was the £302 million new King's Mill Hospital.

By the end of this financial year the two PFI projects for Derby Hospitals FT will have already repaid 150% of the initial capital value of the projects – but have almost £2.9 billion more to pay over the next 27 years before the contract is complete; the mental health project will cost a staggering ***10.6 times the initial capital investment*** before it is paid off in 2032.

PFI payments increase each year to 2032, from an estimated £65m on the two projects in 2015-16 to £98m, and then payments for the Derby City Hospital rise again to reach almost double the 2015 level (£106m) in 2042, bringing a total

£70 million cash gap over five years: but this would be at the price of further undermining any hope of financial stability in the already troubled Sherwood Forest Hospitals NHS Trust.

It is burdened with the rising PFI unitary charge payments for the £320m Kings Mill Hospital: even before they lose any more income through CCG-imposed cuts the trust was £21 million in the red last year, and is projecting another £26m deficit this year.

With more major trusts also struggling financially and already wrestling with annual reductions in the tariff price they are paid for each treatment, any material loss of income would compound the instability and raise questions over the viability of some services.

But now as this report is completed, the new chief executive of NHS England, Simon Stevens, has announced plans for a massive extension of the policy of "Personal Health Budgets" for up to five million mainly older people and those with long term mental health problems.

With many of these payments expected to be in excess of £1,000 per person, the total bill for this – which will fall on already depleted social care budgets, on top of other cuts, and on already inadequate CCG budgets – is likely to be upwards of £5 billion.

The consequences could be the near collapse, at least in some areas, of existing social care services – and a further massive destabilisation of already struggling community health service trusts, with random sums removed from NHS contracts.

It will seriously limit potential choices for patients, whether it be the holders of PHBs, steered by voluntary sector "advisors," seeking to negotiate their way through an array of opportunistic and profit-seeking private providers, or the many older, vulnerable people whose preference would be to opt to continue using NHS and existing social care. they will inevitably find that once the funding for PHBs has been removed, these are even patchier and lacking in resources than ever before.

Derby Hospitals Foundation Trust is currently spending 14% of its budget on PFI payments, Sherwood Forest Hospitals Foundation Trust, even more – over 19% of its £255m budget

PFI cost for the hospital to an above average 8 times the initial capital cost..

The Sherwood Forest PFI, which has so far repaid only 70% of the initial capital, also has almost £2.4 billion still to pay off, with payments rising relentlessly each year from £50m in 2015-16 to £111m in 2042. The total outlay on the hospital PFI and related services amounts to 7.3 times the initial capital value of the hospital.

Six smaller PFI projects in the East Midlands (South Holland Community hospital in Lincolnshire, Berrywood and Danetre Hospitals in Northamptonshire, Elderly and Mental Health units for Nottinghamshire Healthcare NHS Trust and a project at Queen's Medical Centre in Nottingham) have an initial total value of £128 million.

However their combined total estimated cost is £698m, with the final cost varying between 3.6 times the initial value (Lincolnshire) and a staggering 12.5 times initial cost (Nottinghamshire Healthcare).

The high cost schemes mean that East Midlands is in total paying a higher premium for PFI funding of new hospitals – with repayments averaging 7.4 times the initial investment – compared with the England average of 6.9.

Derby Hospitals Foundation Trust is currently spending **14% of its budget on PFI payments,** which rise each year, and are legally binding, meaning that any cash savings have to come from other areas of the Trust's spending – clinical services and staff.

For Sherwood Forest Hospitals Foundation Trust, the burden is even heavier, with **over 19% of its £255m budget** this year already committed to PFI payments**.**

The Trust calculates that over £18m of its annual PFI payment is a so-called 'premium payment', committing them to pay above the odds for the new hospital: but so far efforts to secure any support to cover these extra costs have been unsuccessful.

Both trusts are struggling financially – giving members of their current Boards and senior management plenty of time to regret the decisions of their predecessors to sign off on wildly extravagant and optimistic PFI projects at the height of Labour's ten year programme of increasing investment in the NHS, which has since come to a grinding halt.

Thankfully there are relatively few PFI schemes in East Midlands – just 7% of the England total – so while the extra financial pressures are a major headache for the trusts with the most costly schemes, other trusts across the East Midlands have so far avoided these problems, and onlly have to contend with the squeeze on NHS funding.

CCG plans summarised

East Midlands (19 CCGs)

DERBYSHIRE (4 CCGs)

NHS North Derbyshire

This CCG has a large budget £370 million for 2014-15, but is still uncertain of its financial situation following the transition from Primary Care Trusts in April 2013.

It is planning to cover itself against possible problems by keeping an inflated amount – £9.5 million, more than 2.5% of its budget – unspent or as a reserve, with up to £2 million of that available to cover extra activity in Acute Contracts.

The size of the CCG also brings a commensurately large requirement to set aside funds for the Better Care Fund, with a planned pot of £19.4 million by 2015-16, one third of which will be from reallocating money already spent by the CCG on integrated working, one third of which will come from further raids on other CCG spending, and one third from the local authority.

North Derbyshire is very much focused on 2-year and 5-year plans, and the delivery of its '5 year strategic vision', which involves a savings target of £5.9m (1.6%) in 14/15 and £9.7m (2.5%) in 2015/16.

It aims to reduce "avoidable emergency admissions" by 22% from the 2012/13 baseline by 2019: but the plan appears to say nothing about the rising levels of referrals of elective – and emergency – patients to hospitals by GPs.

This means that non-elective activity is overspent, while A&E attendances are running below planned levels, showing clearly where the problem lies.

Nor is there any detail about how services might be provided or reorganised to deliver the worthy

Acute pressure for hospital trusts

Derby Hospitals NHS Foundation Trust

The Trust ended 2013-14 with a **deficit of £9m**, almost £13 million short of the planned surplus of £3.8m. It began 2014-15 with a **projected deficit of £20.2 million**, and a total **cash gap of £43 million** for the year, with plans in place to generate only £19m of savings.

With services under pressure and waiting lists growing for seven successive months, Southern Derbyshire CCG has given the Trust an additional £6m to deal with the surge in demand.

The Trust reports a 10% increase last year in the number of referrals for elective operations, coupled with rising demand for A&E.

Chief Executive Sue James told the *Derby Telegraph* (April 3):

"the income we receive is not enough to pay the total cost of services we will need to provide next year, or meet the expected level of growth of demand".

Three of the first four months of 2014 were the busiest ever recorded in Derby City Hospital's A&E, and the Trust ended the year averaging well below a number of performance targets.

But it also incurred a massive £11m of financial penalties for treating above the planned number of emergency admissions.

PFI burden

The Trust does not appear to have made any calculation of the excess cost burden of the PFI contract on its £334m hospital, but with 14% or more of the Trust's revenue flowing out in index linked payments, the Trust is labouring under increased overhead costs.

It has bid for £28m in Public Dividend Capital to finance the revenue deficit and capital programme.

Sorting out the hospital's performance and finances will not be helped by substantial cuts of £60m from social care spending by Derbyshire County Council.

One effect will be to raise the eligibility threshold for people to access social care, so that only those with 'substantial' or more severe needs will get any support at all, cutting off care to 2,700 people of the 8,500 receiving council-funded care.

The cuts package also lowers to income threshold to ensure that more people are required to pay out of their own pockets towards any care they do receive. The charge for transport to adult care services has also been jacked up to £5 per day.

The result is almost certain to be an increase in the number of older people who can no longer cope at home, and wind up requiring NHS care and treatment.

aspiration of "highly responsive, effective and personalised services outside of hospital and as close to people's homes as possible."

Nobody would oppose the notion of a "responsive, safe and caring integrated urgent and emergency care system that is focused around the needs of the individual" – but nobody – least of all North Derbyshire – knows how much this would cost, how many staff would be required, and whether it is affordable.

It seems rash – given their lack of any concrete plans – for the CCG to commit itself to such an ambitious, if fine-sounding goal:

> "A range of services that will work together to increasingly manage people's urgent care needs in the community or where possible in the home and significantly reduce emergency activity in the hospital setting."

The actual plans are so vague that they give people no idea on precisely where "in the community" or how close to the scattered homes of potential patients such services might be located.

Kettering General Hospital NHS Foundation Trust

The Trust is forecasting a **£6.5 million deficit** for 2014-15, with the majority of the losses centred on its surgical services, with an expected £3.6m shortfall on income and increased pay costs as a result of the need to use agency staff to fill some of the Trust's 200-plus vacancies.

Like Northampton General Hospital, Kettering is part of the "challenged health economy" of Northamptonshire, which was singled out as one of eleven to face intervention from Monitor because of various factors.

These include the weakness of primary care services and limited effectiveness in reducing emergency admissions; acute trusts are struggling to make targets.

Current models of care are "unaffordable"; and there have been limited results from previous initiatives.

The Trust is seeking to make QIPP savings of £18 million, of which £16 million is expected to be delivered, and also trying to secure 'Public Dividend Capital' (effectively long term borrowing) of £25.4 million from Monitor and the Department of Health.

£15.4 million of this is to cover a long list of mainly minor maintenance and capital projects (including the replacement of an MRI scanner), and the remaining £10 million to pay off a loan.

The Board papers make clear that if this extra funding is not made available it will be a serious setback for the Trust.

The Trust has been under pressure from Monitor following repeated breaches of targets for the 4-hour maximum waiting time in A&E, with fears that these weaknesses may be symptoms of wider problems in the trust's management.

Nor is there any explanation of how it might be cheaper unless care currently provided by the NHS is taken on by unpaid relatives or friends.

The CCG's Strategy Template 2014-2019 spells out additional savings requirements in the financial years 2016-17 to 2018-19 totalling £37m (£8.9m, £6.7m and £6.2m, equating to 2.2%, 1.7% and 1.5%) of the CCG budget; however this is only part of the story.

The plan, again set out in aspirational terms, has not identified any costings, or means by which the required investment to ensure earlier diagnosis, swifter treatment and the delivery of a growing proportion of urgent care in alternative settings can be delivered.

Another plan, drawn up by NHS England's Derbyshire & Nottinghamshire local area team, ostensibly sets out a strategy for developing primary care across the two counties and changing the way their 284 GP practices deliver services. It offers few if any details.

And despite its incessant rhetoric claiming that this process is to be "patient-led" with "the patient voice at the heart of decision making", it appears to have been published from on high by secretive body that has no public accountability to any patients in either county.

This all makes for good soundbites – right up to the time that less than popular plans are drawn up, and the public – and even many local GPs who will be required to work longer and harder – become aware of what is being done behind the scenes.

NHS Hardwick

A relatively small CCG, Hardwick has a major concern because two of its major acute Foundation Trusts, Derby Hospitals and Sherwood Forest, are facing serious financial problems.

Chesterfield Royal and Sherwood Forest hospital trusts are also just failing on the two week target for treatment of patients referred with cancer, and Derby is failing more substantially on treatment

University Hospitals of Leicester NHS Trust

This Trust ended 2013-14 with a **£39.8 million deficit**, and is planning another £40.75 million deficit budget for 2014-15, as part of a plan 'to deliver financial balance within three years'.

Cost Improvement Plans add up to over £30m for the year. The Trust has been plagued with a succession of short-term, high cost directors, with one interim finance director costing the trust a staggering £1,250 per day.

Clearly payment by results has yet to be implemented in the most senior layers of management: at month 2, the Trust was already £8.9m in the red.

Trust bosses have been under fire for long-running failure to deliver targets in A&E, seeing as few as 76% of patients within 4 hours, well short of the 95% target.

However, the caseload in A&E has been exceptionally high, and as elsewhere in the East Midlands, there is little sign of any effective action being taken by CCGs to restrict or reduce the numbers needing immediate care.

640 patients more than usual were admitted by Leicester GPs in the first eight weeks of 2014, although an even bigger problem is the 670 patients who waited longer than four hours to be seen in one week in March.

At one point on February 17 EMAS ambulances were lined up outside Leicester Royal Infirmary, waiting to hand over emergency patients.

The Trust has been seeking £36m funding to expand its bed numbers, pointing out serious shortages of beds in

At one point on February 17 EMAS ambulances were lined up outside Leicester Royal Infirmary, waiting to hand over emergency patients.

the community and nursing homes that could help speed the discharge of patients who needed support after hospital care. Since April the proportion of delayed transfers of care have risen to 5%, with 4 out of 5 cases down to a lack of nursing home places.

The Trust points out in a report to the June Board meeting that 'if this does not reduce, the modelling suggests we will not have enough beds at times of peak activity'.

The plan is to open two acute medical wards in a new block, with some of the beds replacing older wards, and a net increase in beds of 32.

However staffing the new wards poses additional problems, since there is a need to give additional training to a new cohort of international nurses who have just been recruited to fill some of the large number of vacant posts.

The running costs of the new wards will also potentially deepen the trust's deficit.

times for breast cancer.

The CCG's summary of "extreme risks" lists as number one the danger that poor A&E performance at Chesterfield Royal FT, falling behind on the 4-hour waiting time target, could result in financial pressure for the CCG.

There are also concerns over the problems and service shortfalls in East Midlands Ambulance Service and the (privatised) patient transport services, fears over the shortage of community nurses, and crossed wires between commissioners and local providers of health care.

Other performance indicators show that Hardwick GPs are busily referring more and more patients for hospital treatment, regardless of the national mantra of switching care out of hospitals and "closer to home". Figures from April show almost double the planned number of outpatient appointments as a result of GP referrals, while the in-patient care running above target is not emergency cases, but electives – again referred by their GPs.

As this report is finalised, John Adler, chief executive of University Hospitals of Leicester NHS Trust has been the first boss of a major acute trust to float the suggestion that in place of a (futile) bid for Foundation Trust status – made impossible by its financial plight – the Trust may instead seek to pursue a "mutual" model, becoming a "social enterprise" – a non-profit business outside the NHS.

The pretext for this suggestion is that it might "bolster staff engagement" – although all of the main advocates of mutuals and social enterprises are politicians, academics or senior managers rather than front line NHS staff.

The NHS bodies that have been transformed into social enterprises up to now all did so without allowing any ballot of staff, and often against clearly expressed staff preference to remain NHS employees.

Where ballots have been held, responses show staff 90% or more against the idea, and unwilling to lose their NHS terms and conditions, pensions, and sick pay. Senior managers however are often attracted to the potential to raise their salaries in the new structure.

Interestingly, as the coalition government, with the assistance of the King's Fund's Chris Ham, attempts to promote the notion of "mutuals", perhaps the best-known organisation in the NHS which until now proclaimed itself as 'owned' by its employees has just scrapped the trappings of "partnership".

Circle, the company that manages Hinchingbrooke Hospital in Cambridgeshire, has just closed down the "Circle Partnership" through which staff were said to control 49.9% of the company. Instead the company – almost entirely owned by hedge funds and city investors – proposes to allot less than 10% of the company's shares to staff – on the basis of their performance.

Mr Adler does not explain how Leicester Hospitals becoming a "social enterprise" would resolve the Trust's £41m deficit, or how it would cope with the problem of paying 20% VAT.

Far from staff feeling engaged, the most recent staff satisfaction survey at Hinchingbrooke showed its management regime to be worse than NHS average on 19 of 28 key questions, and in the worst 20% for almost half of the questions – including the bullying of staff by their "partners" in management.

Mr Adler does not explain how Leicester Hospitals becoming a "social enterprise" would resolve the Trust's £41m deficit, or how it would cope with the problem of the 20% VAT that is payable by a social enterprise, but not by NHS or Foundation trusts.

Local plans could further worsen this financial nightmare.

It's hard to see what options are open to trusts to control their caseload when the excess numbers are being sent to them by local GPs.

Although there is little if any reference to it in the CCG's Board papers, Hardwick is linked with North Derbyshire in a Unit of Planning which has developed a rudimentary strategic view summing up aspirations for change, but with no costings so far in its 5-year "Strategy Matrix". It's clear that considerable savings will be required: for Hardwick CCG, the targets are £2.4m (1.8%) in 14/15 and a much larger £5.8m (4.2%) in 2015/16.

The latter figure includes the expected transfer of £3.3m into the Better Care Fund, in addition to the £3.9m from identified sources contributing to a total Better Care Fund of £7.2m. The QIPP targets for years 2016/17 to 2018/19 are "substantially lower".

NHS Southern Derbyshire

This CCG covering a population of 525,000 served by 57 GP practices has the second largest budget in the East Midlands, but is clearly struggling to deliver its stiff productivity targets: a quarter of the £15.7m target for last year had to be met through non-recurrent measures.

The target for 2014-15 is much larger, at £26 million, much of this being passed straight on to providers in reductions in contracts, although whether the hospitals' workload will fall by the same amount is a matter for conjecture.

Derby Hospitals FT is already struggling not

Northampton General Hospital NHS Trust

This Trust ended 2013-14 with a wafer-thin notional surplus of £197,000 as a result of £4.5 million of non-recurrent support from the Trust Development Authority, and began the financial year with **a £2.2 million deficit** and is forecasting a **£7.8 million deficit for 2014-15**.

It has a Cost Improvement Programme target of £13 million, although this is already forecast to fall short by £3.7 million.

Like Kettering, Northampton General is part of the "challenged health economy" of Northamptonshire, which was singled out as one of eleven to face intervention from Monitor because of a number of factors.

Among them are the weakness of primary care services and limited effectiveness in reducing emergency admissions; acute trusts are struggling to make targets; current models of care are "unaffordable"; and there have been limited results from previous initiatives.

Northants might also have legitimately been singled out because of the openly hostile attitude to the Trusts of the financially challenged Nene CCG.

Nene is relentlessly penalising Northampton General for exceeding target numbers of emergency admissions, while apparently doing little or nothing to reduce the numbers.

Emergency department attendances have risen by a dramatic 34% over the past five years (from 79,000 to 106,000 per year), while emergency admissions have risen slightly more, 36% (up from 19,000 in 2009-10 to 26,000 in 2013-14).

The Trust notes in its June Financial report that the CCG has decided that it is easier to fleece the Trust through penalties for caring for "too many" patients rather than find ways to minimise this inflated emergency caseload:

"the CCG has published its intention to recover its financial position through raising c.£3.5m of challenges to providers. Month 1 challenges have been received and are in excess of £3m alone."

The financial penalties may help balance Nene CCG's books – but only by throwing Northampton General, and possibly also Kettering into serious problems.

To make matters worse there is still no agreement from social care on reducing the numbers of patients whose discharge is delayed for lack of suitable accommodation or support.

More recently, Northampton General has been subject to unwelcome publicity in the *Daily Mirror* (July 6), which has highlighted the issue of the £2.5 million scanner which has not been used at the hospital for two months because of funding problems caused by a botched NHS England specialist commissioning contract.

The specialist SABR scanner, used to help target radiotherapy treatment onto smaller cancers, reportedly costs £10,000 a time to use.

only with financial targets, but failing on a number of important performance targets as emergency caseload runs at record levels.

Acute hospital services were also running above planned levels, and constrained by its own "very tight financial envelope" the CCG is also concerned by the financial plight of Derby Hospitals FT, which has been running at a substantial deficit, and seeking to increase prices for specific services.

However the CCG is aiming to **reduce referrals by almost £2.5 million** and **cut non-elective service use by over £1 million** this year to balance its own books: there is clearly a conflict of interest arising from the tightening cash constraints on the nHS.

The CCG Governing Body's April discussion of the Better Care Fund brings an unusual note of practical realism into the discussion on strategy, when it points out that "If care was provided in the community for patients not needing acute care, there would be significant savings in [the CCG's] acute care costs (£2-£11m) **but these would be offset by reprovision costs if existing models of care in the community were still being used**."

It is remarkable that so few CCGs seem willing to accept this basic point: services that are moved from one setting to another still have to be provided, and paid for.

There is, however no explanation or evidence cited to support the claim that up to £11m a year could be saved in this way: many of the hospital trust's costs are relatively inflexible, especially in the context of its costly PFI premises, and there is also no discussion at all of the scale on which community services would have to be established to make a switch of care from hospital a viable possibility.

The scale of the problem facing the NHS is underlined by the reference in the same document to the budget **cuts of £157m** (30% of its total budget) which must be made by Derbyshire County Council by 2018. Gaps in adult social services will be partly plugged by raiding the so-called 'Better Care Fund', leaving less money behind for its intended purpose.

Nottingham University Hospitals NHS Trust

The Trust ended 2013-14 with a surplus of £700,000, £4.6 million below its target, helped by a one-off support payment of £4 million.

The surplus also came after achieving a massive £39.9 million savings from an even more massive target of £50 million.

However NUHT has begun 2014-15 with **deficits from the outset,** reaching **£6m in month two,** and projecting **a year-end deficit of £19.1 million.**

One of the cost pressures on the Trust is the continued high level of emergency admissions, which reflect the failure of the CCGs to achieve their objective of managing these numbers down, but in the bizarre logic of today's NHS results in financial penalties being imposed on the Trust – not the CCGs.

The penalties this year already add up to £2 million.

The Trust has awarded a giant £200m 5-year Facilities Management contract to Carillion, the construction and infrastructure services giant.

Until now Carillion has been able to do very nicely from its NHS contracts, even when things go wrong: the £53 million NHS buy-out payment last autumn for their failed Surgicentre service at Stevenage's Lister Hospital (for which they had initially paid out just £2m) – gave them a return of 2,400%.

But the NUHT contract has strings attached,, not least the requirement spelled out in the pre-tender specification to generate "year-on year cost improvement without detriment to service quality, with a minimum expectation in year 1 of 10%".

This shrinks the £40m a year contract instantly to just £36m, with more savings expected each year.

Further cuts of up to 10% each year could reduce the contract value to less than £27m over the five years.

However the Trust also made clear its requirement for the successful bidder to create new "investment and commercial opportunities" – not least by exploiting the Trust's large laundry facility, catering resources and other possible openings.

This may offer Carillion some compensation for smaller margins on the main contract.

NHS Erewash

The third smallest CCG in East Midlands by budget allocation (£118m in 2013-14) Erewash shows little sign of the drive to cash savings and reconfiguration of services so widespread in other parts of the region.

It makes use of Nottingham University Hospitals Trust as well as Derby Hospitals, and its concern with stubbornly higher than planned levels of acute hospital activity appears to be solely from the point of view of the CCG budget and planned surplus.

Erewash's April Governing Body finance report notes 'overperformance' to the tune of £1.9 million in acute services and £446,000 in community – but appears satisfied to cover any extra costs from reserves and identifies no plans to reduce the numbers of acute referrals and emergencies.

The CCG also oversees the performance of East Midland Ambulance Service Trust on behalf of other CCGs, and the Non Emergency Patient Transport Services, run by a private company NSL Care Services Ltd, which have been persistently failing to meet required standards, with most complaints centred on timeliness.

Figures from the last 12 months show that NSL has delivered the required response to 80% of phone calls within 20 seconds in as few as 37% of calls, and is consistently falling far below target. They have also substantially failed to meet the requirement to answer 98% of calls within 60 seconds.

At the April meeting of the Contract Management Board commissioners apparently "expressed their disappointment with the lack of any definitive improvement in service delivery" despite the company being given extra funding to improve their performance.

The service is now being "re-procured," although it is not clear whether East Midlands Ambulance Service might be in a position to challenge for the contract.

Sherwood Forest Hospitals NHS Foundation Trust

Sherwood Forest ended 2013-14 with a substantial deficit of **£21.6m** after achieving cost improvements of £13.5m, and began 2014-15 with a projected deficit of £26.37m – 10% of its Total Operating Expenditure.

By month two it was already £5 million in the red. It has set a target of £8.7 million for Cost Improvement Programmes, but is expecting to deliver no more than £6.6m.

£18.85m of the trust's £28.7m underlying deficit is seen as the result of the extra 'cost burden' of the £320 million PFI contract – for which the Trust is seeking central support, so far without success.

The Trust's woes have been increased by under-achievement of a number of performance targets, including the 4-hour target in A&E, failure to meet targets for the time between referral and treatment, and C-Difficile.

It is also suffering from delayed discharges of care, delayed ambulance clinical handover times and reattendance rates after treatment.

United Lincolnshire Hospitals NHS Trust

This Trust ended last financial year with a deficit of **£26.3** million, and a larger underlying deficit of £37 million, partly concealed by one-off measures.

The Trust has a plan to get back into surplus over the next four years – provided large chunks of its core work for Lincolnshire's four CCGs are not removed. The planned budget deficit for this year is £25.4m, to be followed by £17.4 million in 2015-16.

However even to contain the deficit this year to £25.4 million, savings of over £25 million (5.5%) are required: this calls for 'substantial service redesign and transformation', and negotiating compensation for delivering loss-making services in the less populated areas:

'agreement on premiums above tariff where the Trust is still required to provide economically subs-scale services due to geographic necessity' (Annual Plan, p35).

The Trust is missing key performance targets, and has had to increase staffing in response to the Francis and Keogh reviews.

It's not clear just how the very large-scale savings required can be generated at a time of standstill NHS spending and with the CCGs looking to squeeze down their spending and use of hospital services.

LEICESTERSHIRE (3 CCGs)

Better Care Together project (health and social care in Leicester, Leicestershire and Rutland)

A summit meeting of 170 delegates on June 3 heard a full update on the programme, which is seeking to identify ways to **bridge a threatened £398 million gap** between resources and pressures on health, and another £177m in local authority-funded social care across the county by 2019.

The resultant LLR (Leicester, Leicestershire and Rutland) Five Year Strategy is one of the more ambitious of the plans published in the East Midlands, outlining proposals to deliver provider-level efficiencies of £238m, additional QIPP savings of £110m, savings of £11m from large-scale reductions in use of hospital beds, and other savings of £40m (page 7).

The health economy in Leicestershire is one of the 11 'financially challenged' health economies, compounded by the £40m deficit last year at University Hospitals of Leicester.

The finances of the hospital trust are unlikely to be improved by the various cost-cutting proposals that are outlined in the Strategy, which may reduce some costs to the Trust, but which will also drastically reduce its income under the "Payment by Results" system.

The Trust is expected to cut a quarter of its acute beds (a reduction of 427 beds from the current 1773)(pages 75-76), and reconfigure services to leave acute care on just two of the current three sites, most likely the Royal and Glenfield (page 86).

This would leave the Leicester General Hospital site with a mish mash of "integrated community services", mental health and ambulance services – raising doubts on whether it would remain financially viable for the Trust to keep it open. Indeed the Strategy raises the aspiration for a 40-50% reduction in "footprint" of LLR services in the county "including a reduction in acute and community hospital sites".

While the hospital trust would lose 400+ beds, Leicestershire Partnership Trust is supposed to take on 250 "beds worth of activity" with no additional bed capacity.

The acute sector faces a 40% shift of care into "the community" in the County and shorter length of stay for those who are admitted (p10), which the commissioners hope will result in (unexplained) financial savings of upwards of £5m a year from 2015-16 (p59).

Interestingly the other big area for proposed savings is Mental Health, which also looks to reduce reliance on acute services, reduce lengths of stay and delays in discharge, and to achieve savings of £5m a year from 2015-16.

Among the many proposals aimed to generate savings, the Strategy calls for a shift of:

- **25% of minor A&E attendances** from full A&E to urgent care settings,
- plus a **25% reduction in emergency admissions for chronic diseases**.
- They want **15% fewer admissions of older people** to hospital beds,
- **shorter stays** in hospital
- and **fewer delays** in discharge (p9).

In an overlapping proposal the Strategy calls for a reduction in length of stay for people with Long Term Conditions and frail elderly patients to **cut by 30% the number of bed days for those staying longer than 15 days in hospital.**

The Strategy plans to **"decommission" 10% of outpatient follow-up appointments**, which it regards as clinically unnecessary. The least ambitious target is a **50% increase in the tiny number of home births** – 50% equating to just 110 extra home births to be achieved by 2019.

Numbers of **children admitted** to hospital are **to be reduced by 10%,** and **children's outpatient attendances cut by 30%,** although these are some of the vaguest proposals in the 136-page document.

Mental health targets are also exceedingly vague, with no explicit commitments to numbers or percentages, and little explanation on how any of the objectives might be achieved. At present the county's CCGs are **spending over £4 million a year sending mental health patients out of the county** – sometimes hundreds of miles – for beds because of the lack of local capacity, and sufficient staff to deliver existing services.

A section on the impact of these changes (pp75-77) makes clear that while UHL would lose 400+ beds, Leicestershire Partnership Trust, which is supposed to take on the care of 250 "beds worth of activity" is expected to do this **without any additional bed capacity.**

Only half of them are expected to need beds, **with the remaining 80+ people to be "supported at home with a package of care",** along with 80+ of LPT's existing in-patients also to be cared for "in

community settings" by "expanded LPT and social care teams".

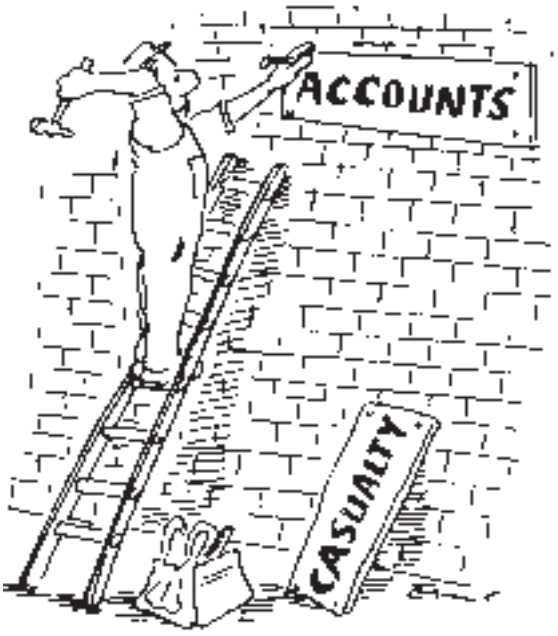
All this is supposed to be accomplished for a saving to the CCG of £11m, while the Trusts count the cost in lost revenue.

Nor is there any stability or security for LPT in taking over these new community-based patients: instead the CCGs are establishing "new contractual arrangements – the 'Alliance contract' – for the integrated delivery of planned care in a community setting".

The CCGs intend to explore "alternative procurement and contractual arrangements" which they argue could deliver a further saving of £16m a year by 2019 (p76) –quite possibly at the expense of bringing in private contractors, leaving LPT and UHL high and dry with substantial fixed costs and dwindling revenues.

It comes as something of a shock after ploughing through page after page of assertions to realise that the "evidence base" for many of these proposals is the largely evidence-free assertions of US-based consultants McKinsey, some of whose more extravagant claims have been toned down by the LLR Strategy (pp114-6).

Strikingly absent from all of these discussions is any serious consideration of primary care, despite the fact that the new formula for funding GP services dreamed up by NHS England threatens to cut funding in the county by £1.4m, affecting a quarter of the GP practices in LLR and constraining their ability to pay any increasing role in the delivery of reconfigured services.



NHS East Leicestershire & Rutland CCG (ELR)

Like Nottingham West CCG ELR has also been suffering problems in dealing with privately contracted Patient Transport Services from Arriva.

Delayed Transfers of Care for CCG patients had increased dramatically from 3-4% of patients to 9-10%, raising questions over the capacity to support patients out of hospital, and the need for improved systems to ensure lengths of stay could be reduced.

The CCG is proposing to open up a competitive tender under Section 75 of the health & Social Care Act for the provision of evening and weekend services in Melton Mowbray, Market Harborough and Oakham, and Urgent Care services in Oadby and Wigston.

NHS Leicester City

Financial reports from 2013-14 show that CCG has been guilty of under-funding acute services: spending at University Hospitals of Leicester NHS Trust was a massive £9 million (6%) above planned levels, and this inadequate commissioning has been a factor distorting the finances of the trust, which is struggling with a £40 million deficit.

One of the symptoms of this under-funding is the

Lincolnshire (4 CCGs)

All four CCGs (NHS Lincolnshire East, NHS South Lincolnshire, NHS South West Lincolnshire, and NHS Lincolnshire West) have been working with another seven organisations responsible for health and social care in Lincolnshire on a Sustainable Services Review, which has now rebranded itself as **Lincolnshire Health and Care (LHaC),** aiming to develop plans to tackle the projected £105 million gap between resources and local health needs by 2018.

Among the proposals, one which will give most concern is the idea of a single main A&E department for Lincolnshire in place of the current 3 A&E units (Lincoln, Grantham and Boston).

This would be "supported by a number of 24 hour "A&E Locals/A&E Care Centres" (consolidating

● **NB Lincolnshire Health & Care** comprises United Lincolnshire Hospitals NHS Trust, Lincolnshire Community Health Services NHS Trust, Lincolnshire Partnership NHS Foundation Trust, East Midlands Ambulance Service NHS Trust, NHS England Area Team and Lincolnshire County

and coordinating urgent care services provided by Primary Care (in an out of hours) centres, Urgent Care Centres and minor Injury Units). (It's important to note that "an A&E Local does not have beds" (p102)).

The location of the single A&E is left vague, but there are few options, since the focus "should be on co-location with available specialist facilities such as trauma and ICU" – effectively offering a choice between Boston's Pilgrim Hospital and Lincoln: however "analysis of these options would need to factor in impacts on travel times".

Any serious plan would also have to take account of the need to expand capacity in either Lincoln or Boston to cope with the combined demand for beds if services for the most seriously ill patients are concentrated onto just one of them.

The combined caseload of 115,000 emergency cases currently handled by the two hospitals would more than double the caseload at Pilgrim Hospital, or increase Lincoln Hospital's caseload by 74% if it became the centre.

The centralisation of A&E is hoped to generate the largest share of any savings (£36-£43 million), although the SSR recognises that 'In most cases consolidation has better cost implications, but lower public acceptability'.

Indeed the notion of a single A&E was promptly dismissed by Skegness campaigners as "horrific and disgusting," and councillors in Boston were quick to speak out against any threat to Pilgrim Hospital's A&E. Given the likely outcry, it would be no surprise to find Lincolnshire Health and Care opting for a plan that would defer the actual closures of A&Es until after the 2015 election.

The SSR also discusses **"consolidation and co-location" of acute, mental health and maternity bed numbers, closing between 324 and 404 maternity services (midwifery-led and obstetric-led) to a single site instead of the present two (Lincoln and Boston)**.

The plan is to close between 324 and 404 acute, mental health and maternity beds

This proposal makes no mention of travel times for parents who would have to take sick children for treatment or visit them while in hospital – but together with the change to paediatric services (below) the change is expected to save as little as **£2-£6 million.**

Two options are put forward to "consolidate" paediatric services, moving away from the local access to clinics in various centres, the three centres providing day case treatment and the two providing 24-hour cover, **to locate all children's services on a single site.**

This may either be at an existing hospital, or possibly mean building a new one "in a central location e.g. Sleaford to service the whole county" – although this option has not even been costed out. (page 79)

A drastic reduction in acute, mental health and maternity bed numbers, closing between 324 and 404 – equivalent to 22%-27% of the present total of 1496 – "driven by investment in proactive interventions".

The case for cutbacks on this scale is based on a purely abstract calculation of the imagined effectiveness of a system that does not yet exist, and then:

"converting the modelled benefits into bed days using the average cost per bed day and then converting up to number of physical beds assuming that a bed is fully occupied for a whole year" (p71).

It's not clear how many Lincolnshire residents would be convinced by this speculative approach to closing existing services in the hopes of delivering something better.

The proposed bed closures also rest on the assertion that the county's population of 700,000 "broadly represents the number of home 'beds' available in Lincolnshire that could also be utilised more efficiently" (p71).

This approach will come as some surprise to householders, who had mostly not seen their homes as an integral part of the health care system, and maybe expected some support from the NHS in caring for family members who fall ill.

Unusually, the Lincolnshire plan also involves reducing the numbers of care home beds by between 15-20% from the current total of almost 2000 available for those aged over 65 (SSR p72).

These too would apparently be rendered unnecessary by "proactive interventions" by a system that has yet to be created or tested.

On elective services the SSR suggests **a referral management system to second-guess the referral decisions by GPs ("support referring clinicians to decide the appropriateness of referrals"**.

This would be followed by decisions at "high level" to decide in which hospital services should be provided: **the aim is to save between £10-£26 million by cutting the numbers of referrals**.

At no point **is the impact on patient care, patient choice, or the viability of hospital services addressed** in the discussions on urgent, elective, paediatric or maternity services.

The CCGs and other bodies appear oblivious of the fact that United Hospitals Lincolnshire are already struggling financially, requiring a **£26.4 million government bail-out** last year to cover the costs of extra staff to meet some of the recommendations of the Francis and Keogh Reports.

A lop-sided plan

The Sustainable Services Review points out that the funding for NHS services in the county takes no account of the long term temporary population living there, which could be a case for an extra £22m in allocations. Instead it seems three of the four CCGs could potentially be losers and have funding scaled back under the NHS England 'fair formula'.

The SSR does presume that NHS funding will remain frozen for the five years from 2014, and in that context as the deficit mounts "there is no rescue fund and only radical rearrangement of the way health and care are provided will achieve financial sustainability" (p13).

From this starting point, LHaC proclaims the mantra of all reconfiguration plans – "no change is not an option" – but the solutions it is proposing are by no means the only or automatic choice in a large county, with a scattered population and poor road links. Even the proposals it has developed so far – if all worked out perfectly as hoped – would save only a maximum of £74m out of the £105m target.

By contrast to sometimes misleading, apparently accurate-sounding, estimates of how much might be saved by implementing its proposals, the SSR and the early work of Lincolnshire Health and Care is strikingly **devoid of any serious projection of the COSTS of reorganising services**, staffing alternative "proactive" services on a scale sufficient to deliver the hoped-for savings, and providing suitable premises and infrastructure for these services. There is an equally embarrassed silence on where the additional capital and revenue funds required might come from at a time when NHS funding is frozen for the foreseeable future.

To make matters worse, few of the proposals seem to take any account of the specific geographical, logistical and demographic challenges of Lincolnshire.

Travel times are discussed briefly in relation to Urgent Care, but remarkably the long distances and the poor quality of the road network are not mentioned at all.

Response times for East Midlands Ambulance Service in Lincolnshire are longer than the national target of 8 minutes for the most serious emergencies.

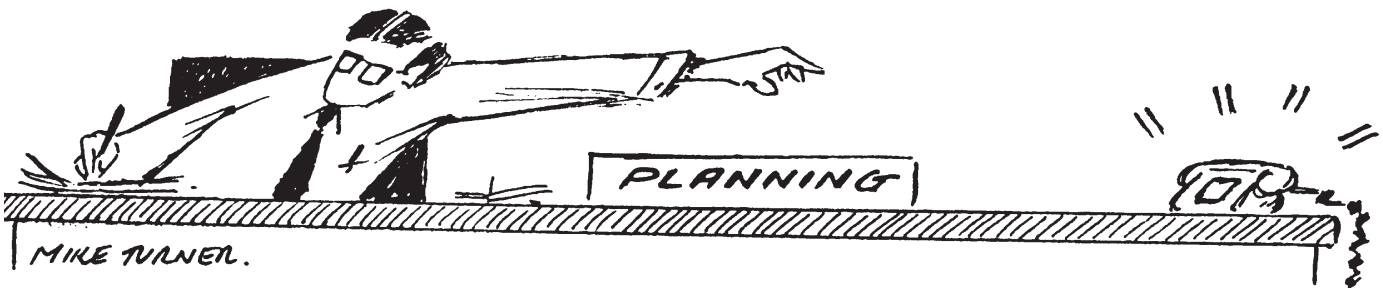
However in addition to the long distances and poor roads, this is also influenced by the pressures on the main hospitals in the county. which are failing to hit targets of dealing with 95% of A&E attenders within 4 hours, delaying the handover of 15% of ambulance patients to hospital care by 30 minutes or more, and keeping patients in "inappropriate clinical areas due to capacity issues".

The EMAS performance is therefore unlikely to be improved by the proposals to reduce from the current 3 A&E units and two maternity units to just a single centre to cover the whole of Lincolnshire.

Response times for East Midlands Ambulance Service in Lincolnshire are unlikely to be improved by the proposals have just a single A&E to cover the whole of Lincolnshire

And to complete an unsatisfactory picture, it seems that not only could local services be scaled down and centralised through Lincolnshire Health & Care, but many of them could yet be wholly or partially privatised under new plans for contracting, set out on page 142 of the Sustainable Service Review.

Yet again it is clear that these issues are being looked at purely from a commissioners' and accountants' point of view, with little or no regard for the potential impact major changes could have on the viability of the mix of services currently provided by NHS trusts in the county.



Healthier Northamptonshire Programme (NHS Nene CCG, NHS Corby CCG)

This county-wide programme brings together the largest and the smallest of the CCGs: Nene, with the largest budget, £679m in 2014-15, and Corby, the smallest, covering just 12 GP practices, and a budget of less than £80m.

Nene inherited a £40m underlying deficit and efficiency requirement from its predecessor Primary Care Trust, a figure which was reduced during 2013-14 to £14.9m, to be carried forward as an underlying deficit this year.

Nene CCG has calculated **the cumulative challenge to the health and social care economy in Northamptonshire over the next five years to be £276 million (24.6% of budget), £185m of which falls directly to Nene CCG** (Operational Plan 2014-15: 32).

Nene's response is structured around the **Healthier Northamptonshire** programme, which follows familiar lines discussed in other sections of this report.

This plan centres on the establishment of an enhanced Crisis Response Hub to support the avoidance of admissions, and Community Hubs in "all localities" including wellbeing and prevention services, promoting self-care and self-management "reducing demand on mainstream health and social care services" (page 35).

Nene CCG has calculated the cumulative challenge to the health and social care economy in Northamptonshire over the next five years to be almost a quarter of the budget, two thirds of which falls directly to Nene CCG

All this is hoped to generate savings which are optimistically estimated as rising to almost **£20m** in years 4 and 5 (page 85).

Nene CCG, along with Corby CCG also funds 204 community beds, where they hope to reduce length of stay: "the success of the community beds strategy will in part be measured by its ability to reduce occupancy of the acute hospitals, such that they are able to reduce their capacity" (p47). Savings from this are put at over £8m per year from year 3.

There are also plans to scale down Community Mental Health Teams and assertive outreach services in mental health – to achieve savings of £1.6m and enable Northamptonshire Healthcare FT to 'reduce its inpatient bed base'.

In a contradictory phrase, the CCG sums up its cash-driven motivation:

"We will continue to ensure *high quality care* and *reduced expenditure* on individual packages of care through effective case management." (page 50).

The Operational Plan also follows other similar plans in East Midlands by listing only the savings the various plans are supposed to generate, without addressing the costs of putting the new services in place.

Pages of the Operational Plan discuss the allocation of a "transformation reserve", but there is no itemisation of the staffing or financial and other resources required to establish the network of community hubs and deliver the required results.

But while there is little to convince Northants communities that genuine plans exist to develop alternatives to existing services in acute care and mental health, the CCG does go on to spell out a series of further economy measures.

These include action to limit or exclude access to "a number of procedures recognised nationally as offering limited clinical and financial value" (p86).

This presumably refers to the contentious list drawn up by McKinsey for the NHS nationally in 2009, which included elective hernia, cataract and hip and knee replacements, each of which has significant evidence of effectiveness.

McKinsey and Deloitte have been employed as a result of Northamptonshire being designated by Monitor for inclusion in a list of eleven 'financially challenged' health economies.

Both areas have been given the dubious benefit of £800,000 extra funding to pay for one or more of a predictable shortlist private sector management consultants to deliver 10 weeks of 'support'.

One less usual target for economies is to review the case-mix of patients having their operations in Independent Sector Treatment Centres, to reduce payment for the much less complex cases which are currently paid for at the current NHS tariff (which takes account of a mix of more complex cases that are not suitable for treatment in ISTCs) (p86).

Nene also wants to press ahead with more "referral management" in which the choice of patient and clinical decision of the GP is called into question, with a view to reducing the

numbers accessing elective care – to generate estimated savings of £5.5 million each year (p86).

The real pressures on the NHS in the county are tangible: over and above cost inflation in health service supplies, and rising costs of new drugs and treatments.

Northamptonshire's population is projected to grow by 13% in the ten years to 2021, and within the wider population a growing proportion are elderly (one in six are aged over 65), and large numbers are suffering from long-term conditions.

By contrast the Operational Plan is not so much a working document as a list of financial aspirations, decorated with clinical rhetoric, lacking any convincing blueprint or timetable for action and any source of the additional funds required to get new services up and running.

The CCG Governing Body's Finance and QIPP report on June 17 refers to a review of the local health economy being carried out by Deloitte, which was "expected by the end of June" – and appears to be working on different figures from the ones already set out by the CCG.

It is hoped this will "identify the size of the financial gap facing the health economy over the next 5 years and identify the best solutions."

The Board was not given any explanation for this considerable expenditure on external consultancy.

it is unlikely to achieve more than belatedly tell the CCG what it already largely knows, or should have known for the past year or more.

The document does not yet appear to be in the public domain.

It's clear from Nene CCG Board papers that alongside the various initiatives likely to be proposed with the aim of cutting costs, there could be a major contracting exercise including "lead provider" contracts, which could result in private sector bidders taking over all or part of a range of services, especially in relation to the care of older people.

Given the poor track record of many of the more prominent private companies likely to be bidding for any contracts, this is unlikely to result in improved quality of reliability of services.

Nene CCG like others in East Midlands, also deepens the divide between commissioners and frontline providers by taking no account in its discussions of the potential impact of some of its proposals on the continued financial and clinical viability of NHS and Foundation Trusts.

Nottinghamshire (6 CCGs)

Mid Notts Better Together (NHS Mansfield and Ashfield and NHS Newark & Sherwood)

These two CCGs cover 312,000 people: Mansfield and Ashfield comprises 31 GP practices and has a budget of £325 million, while the smaller Newark & Sherwood has 15 GP practices and a budget of £147 million.

Their main hospital is the troubled King's Mill Hospital, the PFI-bloated costs of which are weighing down the Sherwood Forest Hospitals Trust.

There is also a small acute hospital in Newark with 56 beds and a 12-bed recuperation unit for elderly patients, and community hospitals in Mansfield and Ashfield which had 48 and 32 beds before a process of "decommisioning" scaled them back.

Mid Notts has set out hugely ambitious plans to switch patients away from hospital care, hoping to **cut A&E attendances by 15%, non-elective admissions by almost 20%, reduce the number of acute hospital bed days by a massive 30%, cut paediatric admissions by 20% and referrals to nursing homes by 25%** – all by 2019 on a frozen budget.

Of course there are no details on how this is supposed to work.

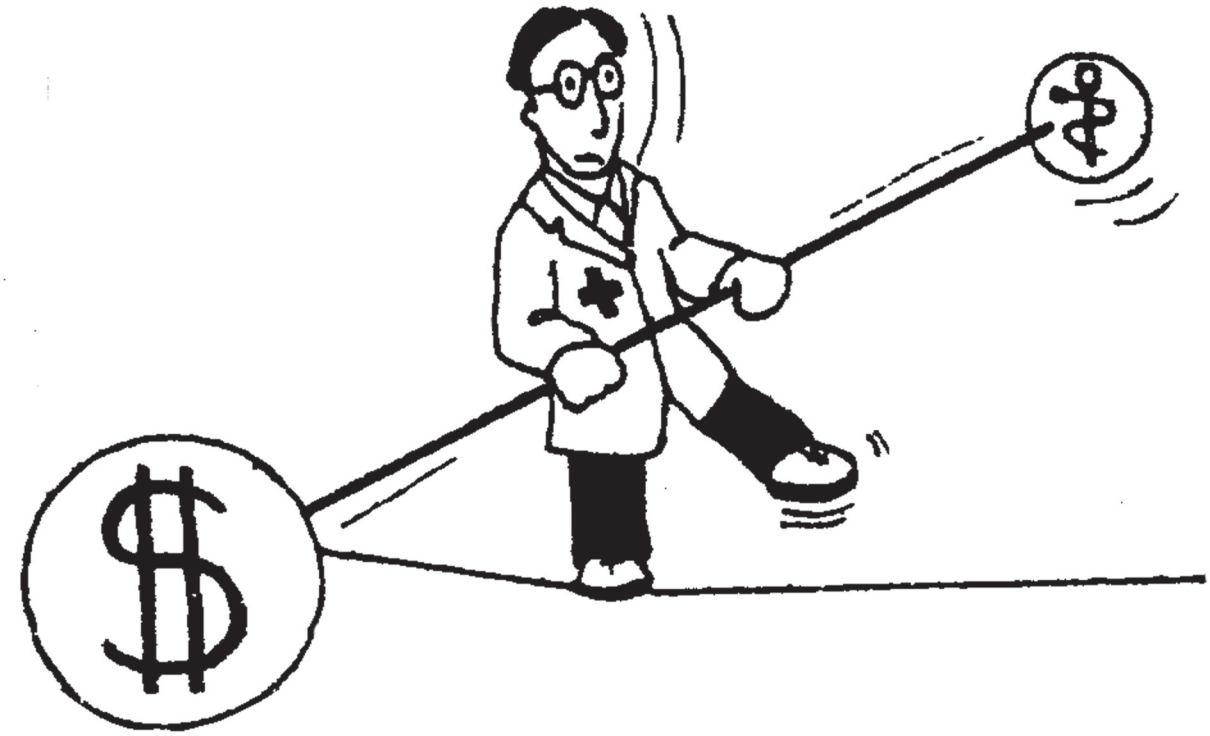
The proposals are uniformly vague and aspirational: nobody could object, but nobody has yet been shown any firm plans.

There is nothing wrong with establishing a "self care hub", improved access to primary care – especially if GPs are actually willing to deliver the additional effort required, and are on board for the scheme – **or with enhanced community services and intermediate care, and crisis response teams together with a "care navigator**" – whatever that may mean.

Everyone will welcome the idea of **more "integration" of acute and community urgent care services:** UNISON has called for this for years, only to watch as increasingly fragmented contracts are put into place in an increasingly competitive health care market.

But how would the new system be organised, staffed and paid for? Where's the working model to show it can deliver? Where's the evidence it is affordable in the tightening budgets from 2015? Where indeed are the serious costings: where's the cash?

The Better Together Strategy suggests all this could be done for recurrent operating costs of



£15m per year plus one-off transition costs of just £4.5 million.

This seems quite literally unbelievable, given the scale of the new services that would be required and the resources that would need to be in place. There are of course no details to explain how the figures have been calculated, or where the extra money would come from, given the need to make savings over the same period of at least £70 m.

Another question is what would be the impact on the already floundering Sherwood Forest Hospitals FT, if a major share of their patients, and therefore their income, is removed?

Both Mansfield and Ashfield (£5.1 million) and Newark and Sherwood CCGs (£4.4m) have been recording overspending on acute services at Sherwood Forest, which was £26 million in deficit last year. None of this seems to have been thought through.

Some of the centralisation of acute hospital care that is implied (and any savings it might have offered) has already been achieved.

It's not clear how much further the CCGs would wish to go in centralising more services, with all of the implications for reduced local access and increased pressure on the newly centralised service.

Given what has already been done, it is also unclear how much money – if any – might be saved by proceeding further along these lines: there is no sign of any developed or practical plan having been developed for alternative services.

South Notts (NHS Nottingham City, NHS Nottingham West, NHS Nottingham North & East and NHS Rushcliffe)

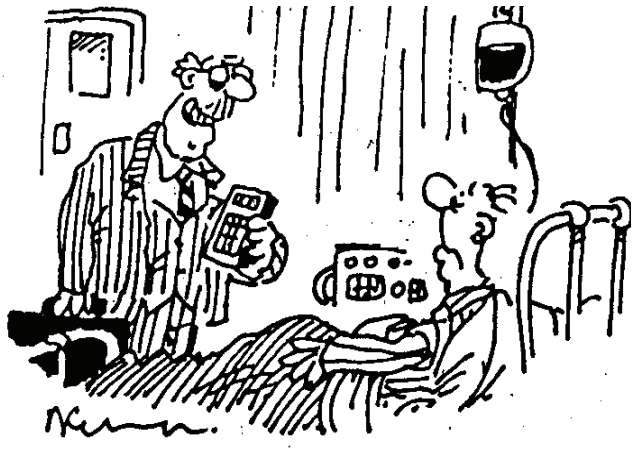
This group of four CCGs forms the South Notts "Unit of Planning", tasked with developing plans for the NHS to address the problems of increasingly constrained resources, and rising pressures on acute hospital and community services.

The Strategy Template has calculated that the "financial risk to the system" (i.e. savings target) locally is **£100-£140** million in the next five years, even after Trusts implement their own extensive Cost Improvement Programmes.

Mid Notts is hoping to cut A&E attendances by 15%, non-elective admissions by almost 20%, reduce the number of acute hospital bed days by a massive 30%, cut paediatric admissions by 20% and referrals to nursing homes by 25%

With current NHS spending in South Notts standing at just over £900 million, these savings would amount to between 11 and 15% of the existing NHS budget. This figure is "still being validated" even as the final draft of the Strategy has been completed for NHS England, and could be increased.

Following the same basic assumptions and unproven assertions that money could be saved by treating patients in non-hospital settings, the South Notts Strategy sets even more ambitious targets for this type of change than Mid Notts.



"I'm not Dr Jekyll – I'm Mr Hyde the accountant"

South Notts aims to cut adult A&E attendances by a massive 26%, non-elective admissions by the same amount, non-elective hospital length of stay by even more – almost a third (32%) – but also to cut adult referrals to outpatients and elective admissions by 10%.

Once again the possibility of achieving this is assumed rather than proved, since no details are given to show where the relevant alternative services would be put in place, how they would be organised, or indeed whether GPs are willing to take on the additional responsibilities their CCG boards have been signing up to on their behalf. It's another exercise in fantasy health care.

South Notts aims to cut adult A&E attendances by 26%, non-elective admissions by the same amount, non-elective hospital length of stay by even more – almost a third (32%) – but also to cut adult referrals to outpatients and elective admissions by 10%.

Indeed all of the financial assumptions underpinning the South Notts Strategy are admitted (pages 46-47) to be *estimates* based on projections elsewhere, or what are hoped to be informed guesses. They are also estimates based only on the vague "high level" plans, in which no details have yet been agreed – for staffing, training, premises, or any of the practical issues to make the plan a reality.

The summary figures on page 47, with no explanatory detail because they are simply estimates and guesses, look to generate misleadingly precise amounts of 'potential recurrent financial benefit' of £82.3-£123.5 million by 2018-19 (a variance of 50% between high and low estimates).

To achieve these benefits, the estimates are that the CCGs would have to spend between £48.6 and £60.8 million (a variance of 25%). This, we are told, might leave a net benefit by 2018-19 of anything from £21.6m to £74.9m (a variance of 250%, underlining how flaky and unreliable all of these figures really are): or, of course it may turn out very differently indeed.

All of these benefits are calculated purely from the CCGs' point of view: but many of their "savings" consist of passing problems on to the front-line providers, the trusts which actually deliver the health care. Nowhere does the Strategy discuss the impact of these changes on local NHS trusts, which would lose substantial income under the 'Payment by Results' system which pays them only for those patients they treat, while many of their *costs* would remain relatively inflexible, raising questions over the knock-on impact on the mix of services they currently provide.

This stands in contrast to the Strategy's commitment for South Notts CCGs to "support Nottingham University Hospitals NHS Trust and Nottinghamshire Healthcare NHS Trust "to become centres of excellence with respect to the delivery of specialist care" (p12).

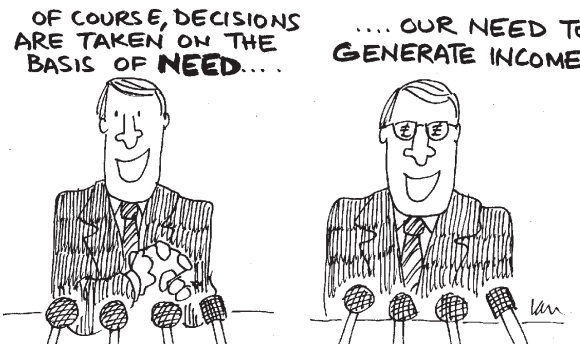
The Strategy is also interesting for its failure to follow through its strong statement on page 10 on the importance of improving mental health services. Although this is echoed with the analysis (p17) of the above average incidence of severe mental illness in Nottingham and the higher levels of dementia in Nottinghamshire than other East Midlands counties, mental health is largely ignored in the proposals, and the subsequent focus of the Strategy is almost exclusively on acute, community and primary care services.

It will also come as a surprise to many who may have gone along with the Strategy because they see it as replacing more hospital care with community-based care to find that the plan also involves a "reduction in community beds" (page 35). What is proposed is not really community care, but care as far as possible in people's own homes.

Of course once these changes have been made there would no longer be any choice in the matter,

and patients could find themselves being compelled to accept care at home if they receive any care at all – whether or not this suits them, their lifestyle or their families.

Indeed there may be little care delivered by the NHS at all. The Strategy spells out that



"care which does not need to be delivered in hospitals in South Nottinghamshire will develop options for the future delivery of these services using community, primary, *self-care* or other methods as appropriate." (p37)

With plans so vague, being discussed at such a level of abstraction, it's clear that there is a long way to go before any of these ideas are implemented, and any substantial changes are likely to require public consultation. But local people should also be concerned that the plans to generate the additional level of savings to bridge the £140m gap by 2018 have not even yet been discussed in abstract, and may offer even less palatable proposals.

Among the South Notts CCGs, **Nottingham West's** Operational Plan shows it is proposing to reduce spending not only on acute services, but also on mental health in 2015-16, with a standstill on community and continuing care budgets, and a minor increase in primary care.

South Notts CCGs are also facing chronically poor performance on its Patient Transport Services by the private contractor Arriva.

For the past year the company has been delivering as few as 63% of patients within 60 minutes prior to their appointment – against a target of 95%, and also failing lamentably to deliver on targets for collecting outpatients returning from treatment and discharged patients going home.

Summary and Conclusion

This report is a warning.

Health and social care services across the East Midlands are under threat as inexperienced commissioners, driven by impossible cash limits, seek to get around real problems by cutting and closing existing services and relying instead on largely imaginary and non-existent alternatives.

They are embarking on efforts to cut spending by more than £1 billion over the next five years, despite rising populations and even more rapidly growing numbers of older patients with greater health needs.

But the cost of sustaining services at current levels would be just £200 million this year – and £2 billion in England as a whole: such sums would be easily affordable, if the government was not intent upon reducing the share of national wealth spent on health and opening up the NHS for ever-increasing privatisation.

The decisions being taken by the 19 local Clinical Commissioning Groups in the East Midlands are in defiance of a total lack of evidence, and sometimes in defiance of simple common sense.

In **Leicestershire**, a massively indebted hospital Trust under pressure from CCGs to improve its performance in A&E, is borrowing money to open extra beds – while Leicestershire's CCGs draw up plans to ***close down*** hundreds more beds and scale down hospital services.

In sprawling **Lincolnshire**, with its awful road network, plans to save £105 million over five years are focused primarily on making huge savings from cuts in A&E, maternity and paediatrics by "centralising" on just one site – regardless of the journey times and problems this would pose patients, parents and their visitors. Health plans include the innovative idea that all of the beds in the homes of the county's 700,000 population should be viewed as "community" settings.

In **Nottinghamshire**, two separate plans are each proposing to force through massive cutbacks in hospital treatment, trying to slash not only numbers using A&E but also numbers of emergency admissions, acute hospital bed days – and even cut referrals to nursing homes by 25%.

But they also want to reduce community bed numbers as well: in the absence of any concrete plans for services to fill the gaps that would be opened up, the proposal is not for care in the community but for thousands of patients to look after themselves, unaided, at home.

In **Derbyshire,** again two separate plans have

been developed. In the north of the county, the **North Derbyshire CCG** wants to cut "avoidable emergency admissions" by 22% – but ignores the fact that the increase in emergency and elective caseload at nearby hospitals is because they are being sent there by GPs!

In **South Derbyshire**, where the £300m PFI-burdened Derby Hospitals Trust has been running at a deficit, the CCG proposes to solve part of its financial problem by redirecting patients from the hospital to "the community" – but has drawn up no concrete plans to establish the services patients would need. The result could be a bankrupt Trust and a glaring gap where there should be a service.

Northamptonshire is designated as a "challenged health economy" with proportionally the biggest "savings target" – of £276m in health and social care.

Nene CCG sees its answer to its own financial problems as imposing hefty financial penalities on the struggling Northampton General Hospital Trust for exceeding target numbers for emergency admissions – despite the fact that the high and rising numbers flow from the CCG's ***own failure*** to put any alternative services in place.

It all smacks of desperation with a dangerous admixture of wishful thinking and professional hubris on the part of the handfuls of GPs who sit on the boards of the CCGs, and present themselves as being in charge.

It's not clear how many of these plans have any degree of support from the local GPs who would be saddled with the extra workload and responsibility if patients really are to be steered in their thousands away from the hospitals that currently cope with demand, and go in search of alternative services.

Deeper divisions in the NHS

The combined pressure of the chaotic restructuring of the NHS by the Health & Social Care Act and the unprecedented scale and duration of the spending freeze on the NHS is deepening the conflicts of interest between the "commissioners" (CCGs) and the front-line providers who must deliver services with ever shrinking resources (NHS and Foundation Trusts).

For commissioners, the problems seem simple to resolve, by passing them down the line to the providers in the form of increasingly impossible and contradictory demands.

For providers, there is no escape, and nobody to pass the problems on to, other than the workforce – whether through privatisation of services as in Nottingham University Hospitals, or the moves towards diluting skill mix, downbanding and scaling down the workforce, as has been taking place elsewhere in the NHS.

Extra burden of PFI

For Derby Hospitals and Sherwood Forest Hospitals, an additional pressure is the constantly rising cost of their already hugely expensive PFI-funded hospitals, and the legally-binding requirement to pay the "unitary charge" for these buildings regardless of the consequences for patient services.

Trust/Foundation Trust	Deficit 2014-15 (£m)	Surplus/ deficit 2013-14 (£m)
Derby Hospitals FT	**20.2**	-9
Kettering General Hospital FT	**6.5**	-
University Hospitals of Leicester Trust	**40.75**	-39.8
United Hospitals Lincolnshire Trust	**25.4**	-26.3
Northampton General Hospital Trust	**7.8**	0.2
Nottingham University Hospitals Trust	**19.1**	0.7
Sherwood Forest Hospitals	**26.4**	-21.6
Totals	**146.15**	**-95.8**

Derby is shelling out 14% of its revenue, and Sherwood Forest an eye-watering 19% – yet still their CCGs look for ways of spending less money with these trusts and undermine any efforts to balance the books.

Competitive tenders

The system could get even more chaotic if some of the county-wide and cross-CCG plans go ahead and put large tracts of services out to tender, carving them up to encourage private sector bids, and leaving even less stability and viability in NHS and Foundation Trusts.

By publishing this survey, UNISON is sounding a warning: the toxic mix of "reform" and spending freeze is putting out whole NHS at risk.

It's high time the Health & Social Care Act was reversed, the spending freeze relaxed to fund services we all need, and pernicious PFI deals like some in East Midlands renegotiated on the basis of fair value to recoup some of the wasted millions and restore the viability of threatened Trusts.

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