

Cheshire & Merseyside STP

analysis by Keep Our NHS Public Merseyside

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Introduction

The Cheshire & Merseyside (C&M) Sustainability and Transformation Plan (STP) will determine the structure and budgets for the NHS from now until 2020/21. For the period 2016 – 2021, it envisages cuts totalling over £1.8bn to be offset by £352m from the Sustainability and Transformation Fund. The plan was submitted to NHS England on 21 Oct. The Health Service Journal, BBC, and Liverpool Echo obtained copies and on 4 Nov the [Echo reported on](#) and published [the plan](#). However, as the [BBC reported](#), NHS officials were already saying this was not the final version, and proposals for A&E downgrades in Macclesfield, Southport, Whiston and Warrington had now been dropped. Also on 4 Nov, a letter from Katherine Sheerin of Liverpool Clinical Commissioning Group (CCG) stated that the final plan would be published on 16 Nov, and she attached the North Mersey component.

The version published by the Echo did not include Appendices covering Technology, Estates, Workforce, Financial model highlights, Communications and Engagement Plan, and Cross cutting Clinical Programme PIDs (Project Initiation Documents). These were omitted when the CCG published the STP [“final version”](#) on 16 Nov and only appeared on [24 November](#).

In early October, a [draft submitted on 30 June](#) was leaked to Keep Our NHS Public. On 12 Sept the [Liverpool Echo reported](#) financial details not contained in the 30 June draft, nor in the version published on 4 Nov or the material circulated by Katherine Sheerin. No denial has been issued, and the Echo has not withdrawn the story.

The Liverpool Health & Wellbeing Board will discuss the final STP at a meeting on 1 Dec, to be addressed by Louise Shephard, Chief Executive of Alder Hey Hospital and nominated lead of the C&M footprint, a body with no legal status. As Sheerin's letter confirms:

“...accountable NHS organisations will remain responsible for ensuring their legal duties to involve are met during the design, delivery and implementation process of specific proposals. This includes ensuring that any reconfiguration proposals which represent a potential significant variation in service are subject to local authority overview and scrutiny.”

Throughout this shambles, the public and NHS staff have been bypassed completely by those formulating the plans, in line with NHSE guidance and pronouncements that the STP process is too important and [too urgent to be delayed by formal public consultation](#). As the 21 Oct leaked version

acknowledges, “In due course, it is likely that a number of the decisions required may face public resistance and political challenges”. However, contracts are due to be signed by 23 December, pre-empting any subsequent public consultation.

We have no idea which elected Councillors, local authority Chief Executives, Mayors, MPs, Directors or Chief Execs of NHS providers have been privy to the various versions or helped amend them. Elsewhere, at least 10 Councils have published their STPs despite guidance from NHSE to CCGs not to do so, and some have publicly rejected the plans. None of the local authorities within Cheshire & Merseyside published the STP.

However, on 16 Nov the Cheshire West & Chester Health and Wellbeing Board declined to endorse the plan, pending full consultations with the Local Authority, patients and the public. On 17 Nov Sefton Council voted 54-4-1 to deplore the plan, publicise its likely impact, and to notify the Merseyside and Cheshire NHS Sustainability and Transformation Programme lead and the Secretary of State for Health of its opposition to any programme of cutbacks or privatisation locally and nationally in the NHS created to meet underfunding by the Conservative Government.

Cheshire & Merseyside (C&M) is the 2nd largest of the 44 STP footprints, stretching from Macclesfield in the East, to Crewe in the South, the Wirral in the West, and from Liverpool to Southport in the North, while St Helens and Warrington are central to the region. It covers 2.5m people, 12 CCGs, 20 NHS provider organisations, and 2 proposed Devolution regions.

CCGs – Knowsley, South Sefton, Southport and Formby, Eastern Cheshire, Wirral, Liverpool, Halton, St Helens, South Cheshire, Vale Royal, West Cheshire, Warrington

Local Authorities: Knowsley, Sefton, Liverpool, Halton, St Helens, Cheshire East, Cheshire West and Chester, Warrington, Wirral

Providers: Liverpool Heart and Chest Hospital NHS Foundation Trust, Alder Hey Children’s NHS Foundation Trust, Royal Liverpool NHS Foundation Trust, Countess of Chester NHS Foundation Trust, St Helens and Knowsley Hospitals Trust, Walton Centre for Neurology and Neurosurgery, Bridgewater Community Healthcare NHS Foundation Trust, Wirral University Teaching Hospital NHS Foundation Trust, Mersey Care NHS Foundation Trust, East Cheshire NHS Trust, Cheshire and Wirral Partnership NHS Foundation Trust, Wirral Community NHS Foundation Trust, Liverpool Women’s Hospital NHS Foundation Trust, Warrington and Halton NHS Foundation Trust, 5-Boroughs Partnership NHS Foundation Trust, Mid-Cheshire Hospital NHS Foundation Trust, North West Ambulance Trust, Aintree University Hospitals NHS Foundation Trust, Clatterbridge Cancer Centre NHS Trust, Southport and Ormskirk Hospitals Trust, Liverpool Community Health Trust

Proposed Devolutions: Liverpool City Region, Cheshire & Warrington

At the outset, the STP aims to bridge a £1bn “affordability gap”, dubbed by the Echo a “black hole” in NHS finances across the C&M region. This is the projected difference in 2020/21 between an allocation of £5.8bn and a need, on current estimates of healthcare demand and cost, of £6.8bn. As the Echo reported on 4 Nov, the gap has fallen to £908m because of cuts which have already been implemented.

This gap is the C&M component of the £22bn cut which the Gov’t unilaterally imposed on the overall NHS budget as part of an Austerity programme which, at least for the NHS, has not been

scrapped. The C&M STP is not the source of that decision – it is a response to it, dictated centrally by NHS England. While the STP planners decided to accept these massive cuts and obey NHSE instructions, the public, clinicians, health unions and local authorities can reject them. The chorus of opposition is growing:

- **Julia Simon:** on 28 Sep the former head of NHSE commissioning policy told [GP Online](#) “...there is a lot of blue sky thinking and then you have a lot of lies in the system about the financial position, benefits that will be delivered - it’s just a construct, not a reality”. Describing the speed imposed by NHSE as “kind of mad”, Simon said “to do a statutory consultation - it’s three months. They don’t have three months.”
- **Chris Hopson:** On 11 October the chief of NHS Providers, told the Commons health select committee that England’s 44 STPs seemed unrealistic and vastly overambitious, even to their authors, and the plans were “[at risk of blowing up.](#)” Hopson’s earlier written evidence had warned of financial shortfalls and rising demand and costs, making even current service levels unsustainable.
- **BMJ:** On 19 Oct the British Medical Journal reported Hopson’s testimony and other dire warnings in a commentary entitled [Four riders of the NHS apocalypse.](#)
- **BMA:** In early Nov, a standing room only meeting of the British Medical Association in London unanimously resolved that the BMA should advise CCGs not to cooperate with STPs.
- **Unite:** On 26 Oct a [national press release](#) branded the STPs “Slash, Trash and Privatised” and warned “Another mega NHS shake-up, with a serious threat to patient services, is underway by stealth. The STPs herald yet another reconfiguration of the NHS which could see closures or relocations of local hospitals and A&E departments.”
- **Unison:** When the Liverpool Echo (12 Sept) revealed the £1bn “black hole” in C&M, the Liverpool NHS budget cuts and hospital merger plans, it quoted Unison [North West regional organiser Paul Summers.](#) “The government knows the level of funding that our NHS requires to meet public need but is deliberately choosing not to provide it. These are ideologically driven cuts by a government that wants to undermine and ultimately privatise the NHS.” The Echo quoted Unison in further STP-related stories on [26 Sept](#) and [18 Oct.](#)
- **Ealing and Hammersmith:** As the [Guardian reported on 26 Aug,](#) Ealing and Hammersmith councils refused to back the North-West London STP plan “amid fears two major London hospitals, Ealing and Charing Cross, are to be downgraded and will lose their A&E units and other acute services.”
- **Warrington:** On 5 July Warrington Borough Council Chief Exec Steve Broomhead described the plans as a [recipe for disaster.](#)

The NHS is affordable. In 2007 its budget was 8.4% of GDP, in line with other European countries, but the intention for 2020/21 is 6.9% of GDP, well below the European average and incompatible with a comprehensive, universal public health service free at the point of use. [Even at 8.8% it would be affordable in 2030,](#) and compatible with developed European countries and Japan, experts conclude. The underlying decision to cut £22bn – or £27.5bn given that the Gov’t contribution turns out to be [£4.5bn rather than £10bn as claimed](#) - is politically motivated and has little to do with an ageing population. For comparison, healthcare in the US accounts for [17.5% of GDP](#) (2014 data), and its [failures are notorious.](#)

However, the C&M STP does not merely concede the massive cuts. Like other STPs, it takes them as an opportunity to impose a range of structural changes to bring the local NHS in line with the US

healthcare industry, going beyond the privatisation of individual services through procurement exercises, to setting up Accountable Care Organisations to manage local health economies, and which could be partnered with the private sector or eventually sold off. Similar moves are taking place across England in line with the Five Year Forward View, dictated centrally and unilaterally by NHS England Chief Exec Simon Stevens, former advisor to Tony Blair and then head of European operations for the US healthcare giant UnitedHealth. Management consultants PwC (Price Waterhouse Cooper) were paid £300,000 to help write the C&M plan. What do we know about it?

23 Dec deadline

The timescale for irreversible decisions emerged very recently. It concerns two-year contracts to be signed between CCGs and provider organisations, whether NHS or other healthcare providers. The contracts will fix the NHS financial framework for 2017/18 and 2018/19. The deadline is not mentioned in Sheerin's letter, and there is only a brief indirect and partial allusion to it in the 16 Nov STP and none in the Appendices.

An [STP update](#) for Knowsley CCG on 6 October states:

6.2 A single NHSE/NHSI [*NHS England and NHS Improvement*] oversight process will seek to ensure effective alignment of CCG and provider plans. In addition the contracting timetable has been being brought forward with a target deadline of all 2017 - 19 contracts signed by 23 December 2016.

The deadline is also included in the overall timetable, which mentions consultation with providers over the national tariffs with results to be published in the week commencing 12 Dec., but no public consultation on any aspect of the plans.

Once contracts are signed, budgets and service specifications are set and any future consultation will be severely constrained if not entirely meaningless. There is a very short timescale to prevent this process from being irreversible and escaping democratic control.

The Knowsley report echoes [guidance from NHS England](#) as updated on 27 September

NHS Operational Planning and Contracting Guidance for 2017-19

...The 2017-19 operational planning and contracting round will be built out from STPs. Two-year contracts will reflect two-year activity, workforce and performance assumptions that are agreed and affordable within each local STP. We are issuing a two-year tariff for consultation and two-year CQUIN and CCG quality premium schemes... And, as requested by NHS leaders, the timetable is now being brought forward to provide certainty earlier – with a target deadline of all 2017-19 contracts signed by 23 December 2016... We expect all contracts to be signed by 23 December 2016. The earlier timetable for operational planning should give commissioners (CCGs and direct commissioners) and providers greater scope for constructive engagement over contracts. Access to formal arbitration must be a last resort.

In the STP 16 Nov “final version”, the only passing reference is a phrase in the North Mersey section on telehealth: “new contract enabling scale up to be implemented in December 2016 to March 2017”.

Frontloading the cuts

Any illusion that cuts will be stretched over 5 years or postponed to 2021 was dispelled when the

Countess of Chester Hospitals CEO briefed senior medical staff in early Sept. As reported to KONP, staff were told that “costs must be reduced by 10%, [otherwise] the deficit in Cheshire and Wirral would increase by £400 million a year. The savings must be made **in the next 6 months...**”.

Likewise, the NHS England guidance updated on 27 Sept (above) includes as “must do” priorities:

“Deliver individual CCG and NHS provider organisational control totals, and achieve local system financial control totals. At national level, the provider sector needs to be in financial balance in each of 2017/18 and 2018/19. At national level the CCG sector needs to be in financial balance in each of 2017/18 and 2018/19.”

and, later on

“As in 2016/17, release of the risk reserve to each local system will be dependent on delivery of its control total, subject to a satisfactory national risk profile.”

“Control total” is an accountancy concept whereby the overall budget for a system is fixed, though money may flow between its components, e.g. between hospitals or from hospitals to community services. However, it is unclear from the guidance whether “local system” refers to the whole footprint, or to Local Delivery Systems (LDS) through which the STP is to be implemented.

There are 3 LDS within C&M: Cheshire & Wirral, (Mid-Mersey) Alliance, and North Mersey.

The 16 Nov plan states “The North Mersey Leadership Group has agreed to explore the submission of an expression of interest for a North Mersey system control total, which would be submitted to NHSE by 31.10.2016 in line with the opportunity set out in the NHS Planning Guidance.”

The 16 Nov section on North Mersey contains no budgets or projected savings. When the financial appendix was finally published, it gave no information on the North Mersey component of the overall plan.

But on [12 Sept](#), the Liverpool Echo gave [details of the intended cuts](#) for Liverpool NHS providers, and the extent to which they would be offset by the Sustainability and Transformation Fund. Whilst the Echo reported these as cuts to be made by 2021, the timescale may be shorter.

Liverpool NHS financial crisis

Trust	Estimated funding shortfall by 2021	Cuts to be made by 2021	'Transformation funding' from Gov't	Difference
Aintree Hospital	£46.1m	£21.6m	£26m	+£1.5m
Alder Hey	£34.8m	£14.8m	£0	-£19.9m
Liverpool Community Health	£28m	£15.8m	£0	-£12.3m
Lpool Heart and Chest Hosp	£22.8m	£14.7m	£0	-£8m
Liverpool Women's	£23.9m	£6m	£18m	+£71
Mersey Care	£28.3m	£25.4m	£5.2m	+£2.3m
Royal Liverpool and Broadgreen	£66.4m	£42.8m	£26.m	+£2.4m
Walton Centre	£16.1m	£14.5m	£2.8m	+£1.1m
Clatterbridge Cancer Centre	£9.7m	£11.7m	£0	+£1.9m
TOTAL	£276.4m	£167.3m	£78m	-£31m

The Echo has not been challenged on these figures, and the story has not been withdrawn.

The 30 June draft shows that cuts are being frontloaded. In each LDS, the biggest single component of “savings” is “Provider efficiencies” - which includes cuts to staff numbers, downbanding (redefining staff roles at a lower pay band), deskilling (giving particular roles to staff with less training), or cuts to pay rates, terms & conditions. Nationally, [Trusts were instructed](#) earlier this year to cut staff, in direct contradiction to the moves towards Safe Staffing Levels after the Francis Inquiry into Mid-Staffordshire hospitals. The NHS is not over-staffed or overpaid, and such “efficiencies” actually mean cuts in services.

In the STP, “efficiencies” are referred to as “Business As Usual” or BAU, because every NHS organisation has been forced to seek such annual savings every year under the QIPP programme. Prior to the STP the target for 2016/17 was already [3% savings](#), up by 50% on the previous year.

For North Mersey, “Provider efficiencies” are projected (in the 30 June draft) at £171m annually in 2020/21. But 66% of these annual savings are to be achieved by 2018/19. For the Alliance, 75% of the projected £67m provider efficiencies in 2020/21 are to be achieved by 2018/19. For Cheshire & Wirral, provider efficiencies are projected at £131m in 2020/21 with 58% by 2018/19.

Whilst the 16 Nov version omits the corresponding figures, there is a clue in the section on Cheshire & Wirral. BAU savings of £26m appear as QIPP/BAU under the heading “Demand Management”, while a further £107m appears as Model Hospital/BAU under the heading Variation / Reconfiguration. Together, these form £133m of BAU efficiencies, just above the figure in the 30 June draft.

Such cuts cannot be achieved without jeopardising patient care. NHS Trust Directors know that any fat in the system has vanished after 6 years of continuous Cost Improvements, originally intended to save £20bn by 2015 in response to the bank failures of 2008.

These cuts will be imposed through the contracts covering 2017 – 19 to be signed by 23 December, intended to bring the NHS into financial balance, whatever the consequences.

Meanwhile, as the 30 June draft acknowledges, increasing shortfalls in local authority budgets for social care will place greater strains on the system: the annual social care deficit in 2020/21 reaching £49m for North Mersey, £57m for the Alliance, and £69m (including Public Health) for Cheshire & Wirral.

Other savings are projected through ambitious plans to merge hospitals, sell off land, move care into the community, encourage “self care”, use digital technology... In the 30 June draft, inputs from the Sustainability & Transformation Fund (STF) are only anticipated in the final year, when Cheshire & Wirral are projected to receive £79.9m, North Mersey £59m, with nothing at all for the Alliance. The 21 Oct version does not give comparable figures, but a chart shows the total expected from the STF at around £170m for the whole of C&M.

The Financial Appendix to the 16 Nov version anticipates contributions from the STF across the whole of C&M to be 0 in 2016/17, £81m in 2017/18 and 2018/19, 0 in 2019/20, and £190m in 2020/21.

Against this total of £352m of STF projected funding from 2017 – 2021, the plan envisages “solutions” - i.e. cuts – totalling over £1.8bn for the period 2016 – 2021.

Hospital Reconfigurations

As headlined by the Echo on 12 Sept., plans include the merger of the Royal Liverpool & Broadgreen, Aintree, and the Liverpool Women's Hospital. In the 30 June draft STP, this is projected to save £20m in 2018/19, £45m in 2019/20, and £70m in 2020/21. Opening the section on Hospital Reconfiguration, the 30 June North Mersey plan declared “We have too many providers”. Its first aim is “a centralised university teaching hospital campus with single service (35 acute services), system-wide delivery, along with reconfigured women’s and neonatal services, delivering clinical and financial sustainability.” The second aim is “Merger of the Royal Liverpool and Broadgreen University Hospitals, Aintree University Hospital and Liverpool Women’s Hospital as the first step to set the conditions for successful standardisation; single service pathways, delivered against high quality one-system clinical standards, one-system workforce, with single clinical leadership across all adult acute hospitals and sites.”

The 16 Nov plan echoes this without specifying the savings, and mentions “Site rationalisation across 4 to 5 hospital sites in the city” with a Full Business Case by 1 April 2018 and a “Single trust to deliver the majority of adult acute services in the city from April 2018” after final approval by the regulators.

Public consultation on the future of Liverpool Women's Hospital is to begin in Jan 2017, after the two-year contracts have been signed, with a final decision in May/June 2017. So far, there has been no formal consultation on any plan to move the Women's Hospital from its site in Toxteth.

Before the first draft STP was submitted, the Liverpool Women's Hospital Chair outlined his preferred option. The Royal is currently being rebuilt as a £335m PFI (Private Finance Initiative) scheme as part of a city centre 'health campus'. As the [Echo reported on 31 May 2016](#), "Robert Clarke, newly appointed chairman of the Women's Hospital, said his "preferred option" is for the Women's to become part of this new development... But Mr Clarke, a dairy farmer and former vice-chairman of Preston and Chorley hospitals, admitted finding cash to build a new hospital will be difficult." On 16 Nov, the [Echo quoted Katherine Sheerin](#) suggesting that local authorities could finance a new hospital as "Councils tend to be able to access borrowing at a very cheap rate."

The "Save Liverpool Women's Hospital" campaign has heard rumours that the move would allow the Toxteth site to be handed to Spire, a private hospital company. Spire has at least 4 Gynaecology consultants employed at LWH: [Nabil Aziz](#), [George Botros](#), [Andrew Drakeley](#), and [Ruben Trochez](#).

Naturally, there is no mention of Spire in the STP, and even the word "private", which did appear on 30 Jun, vanished from the 16 Nov version. However, the idea is still present (see Back Office and Clinical Support Services below).

The Cheshire & Wirral draft on 30 June envisaged developing an "Acute Hospital Chain" across the region, with Acute Hospital Reconfiguration to save £53m annually in 2020/21 without details. A "Road Map – Direction of Travel" diagram showed the current "Unsustainable acute provider landscape" with the Countess of Chester, Wirral Teaching Hospital, Mid-Cheshire Hospitals, and East Cheshire, to be transformed, through Clinical Alliances across providers, into a "Virtual Single Hospital (4 hospitals acting as one)" by year 4-5 (2020/21), shown as 4 linked ovals, each labelled "ACS" (Accountable Care System). In year 5+ this becomes a larger single oval labelled "Potential ACO" (Accountable Care Organisation), without explanation.

The diagram is missing from the 16 Nov version, but its section on Cheshire & Wirral Hospital Reconfiguration mentions "Accountable Care established in the 4 respective geographies that will determine the shape and form of health and social care delivery across Cheshire and Wirral" and "A provider collaborative, the shape and size to be determined".

The briefing to senior medical staff at the Countess of Chester in September was more explicit. As reported to KONP, "The direction of travel is towards hospital mergers and the CEO suggested that at some point in future Arrowe Park, Clatterbridge and the Countess of Chester would be replaced by a single hospital somewhere near Ellesmere Port. Similarly a merger between Crewe and Macclesfield was suggested."

When the [Echo \(26 Sep\) picked up the story](#) Margaret Greenwood MP and Justin Madders MP attacked the potential plan over accessibility and transport for patients and staff, and over secrecy. In response, NHS England stated: "We can confirm that there are no current plans to develop a single site hospital for Wirral and Cheshire, however, all options to achieve clinical and financial sustainability are being considered as part of the STP development process." So it's not ruled out, and is also mentioned in the [Arrowe Park] [Wirral University Teaching Hospital Annual Report](#) (p29): "The Trust will explore with CoCH [Countess of Chester Hospital] the potential for the development of a single Acute General Hospital covering Wirral and west Cheshire within the next 10-15 years".

However, the 16 Nov plan is explicit on other hospital reconfigurations.

"Explore an option to consolidate elective care between the Countess of Chester Hospital NHS

Foundation Trust and Wirral Teaching Hospital NHS Foundation Trust on the Clatterbridge Hospital site.”

A Defend Our NHS activist on the Wirral explains the implications.

Wirral has good transport links for those who have no transport of their own, even down to the Countess or Ellesmere Port, but I can't get to parts of Cheshire by public transport, nor can I get to Clatterbridge without over an hours travel and lots of walking and changes. I am far from the worst off – I live just 20 minutes from Clatterbridge by car. I am less than half an hour from Arrowe Park by car, but again it really isn't doable for a not so well person by public transport. There are never going to be enough volunteers to drive for hours to Clatterbridge and back, just for one patient, and as for using ambulances, where are they all coming from?

From even the villages near to Chester it's around two hours by public transport. 4 hours of travel to visit a relative or friend at Clatterbridge, so who will get visitors if they don't have cars? And that is best case – impossible for some. The Countess isn't 'handy' but at least it is doable. There are problems at the Countess, which could be resolved with a willing council. They were caused by decisions of the last council.

Likewise, the 16 Nov plan mentions:

“Explore the consolidation of Acute Care Alliance between Countess of Chester Hospital NHS Foundation Trust and Wirral University Teaching Hospital NHS Foundation Trust – creation of integrated low and high dependency units for women’s and children’s services.”

Where are the Impact Assessments for these plans?

Other explicit reconfigurations in the 21 Oct plan have been denied subsequently, as the BBC reported on 4 Nov. Both were described in that version as Agreed:

Remapping of ECT (East Cheshire Trust) elective and emergency care models. Agreed long term models for elective and emergency care in mid and south Cheshire based on strategic relationship with University Hospital of South Manchester and Stockport FT. Emerging clinical model (depending on savings generated): ED (Emergency Dept) downgraded to MIU (Minor Injuries and Illness Unit) staffed by GPs, elective care at MGH (presume Macclesfield District Hospital) provided by ECT (East Cheshire Trust) and UHSM (University Hospital of South Manchester) / Stockport, residual inpatient focus on care of older people; women’s and children’s services networked with south Manchester/ Stockport providers

Remapping of MCH (Mid Cheshire Hospitals) elective and emergency care models. Agreed long term models for elective and emergency care in mid and south Cheshire based on strategic relationship with University Hospital of North Midlands: MCH cannot see any robust clinical links with CoCH (Countess of Chester Hospital) or WUTH (Wirral University Trust Hospitals) being sustainable given travel times and population distribution.

Having cited travel times as a problem, the STP does not mention that University Hospital of North Midlands is in Stoke, while the existing A&E for Mid Cheshire Hospitals is provided by the Emergency Dept at Leighton Hospital in Crewe and Victoria Infirmary in Northwich. Travel time from Northwich to Stoke by car is 37 min (27.5 mi) via M6 and D Rd/A500. Also, the travel issue

was disregarded when assigning Clatterbridge as a potential South Mersey Elective Care Centre.

But are the East and Central Cheshire plans really dead? Not exactly. For Eastern Cheshire, the 16 Nov plan says:

Agreed long term models for elective and emergency care in Eastern Cheshire are being developed based on strategic hospital partnerships, building on existing relationships, including those with hospitals in Greater Manchester.

A number of emerging clinical models are being developed and will form the basis of an option appraisal. Clinical modelling covers emergency care (including options to retain the A&E department or the development of an urgent care centre) and elective care. The frailty pathways being developed will be explored to share best practice with other parts of Cheshire and Wirral.

For Central Cheshire, it states:

Agree long term models for elective and emergency care in Central Cheshire based on strategic relationship both within Cheshire and Wirral and surrounding localities so as to reflect patient flows.

The (mid-Mersey) Alliance LDS includes Southport Hospital, Ormskirk Hospital, Whiston Hospital, St Helens Hospital, Warrington Hospital, and Halton General Hospital. A&E services are provided at Southport, Whiston, and Warrington, and a Children's A&E at Ormskirk.

The 16 Nov plan considers 3 models of Urgent Care System: 1) 3 Trusts will have a Type I - 24hr A&E (Consultant led 24 hour service with full resuscitation facilities and designated accommodation for the reception of accident and emergency patients); 2) 3 Trusts will have a 24hr A&E . High acuity patients will be transferred to the Emergency centre; 3) 1 Trust will have a Type I - 24hr A&E, 2 trusts will re-profile opening hours with activity flowing to other 24/7 centres. This will lead to “Reductions in the consultant cover from 3 to 2 on call covering 3 sites” and “Activity transfer of 8,700-20,000 patients per year (one site). Increase in bed capacity of 80-150 beds required/freed up.”

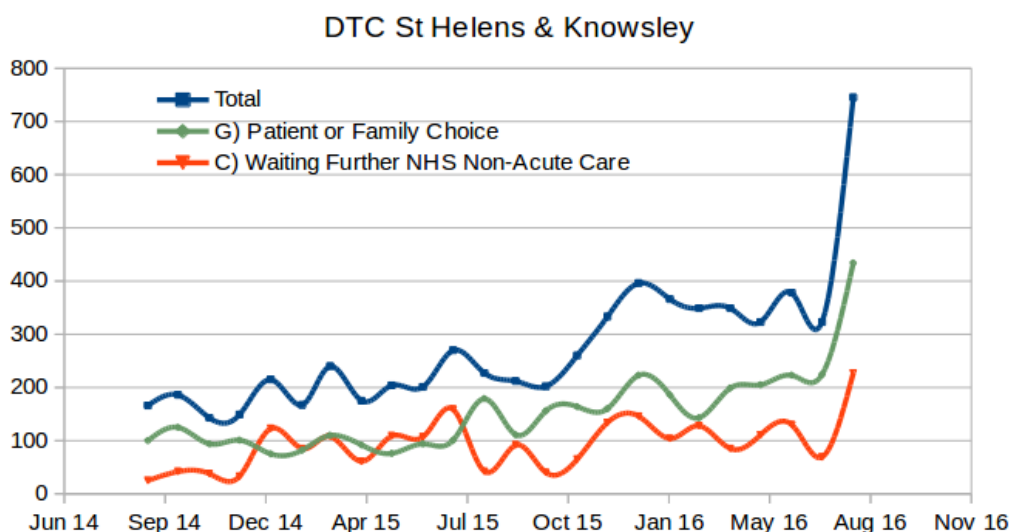
As part of Urgent Care redesign, the 30 June draft explained, “large scale system change is required, which will include co-location of services and changes to the payment system irrespective of service demand”.

This could mean private sector Urgent Care Centres with guaranteed funding regardless of demand. In July, [Virgin Care lost its contract](#) to run Croydon’s Urgent Care Centre 3 years after the CQC found patients were being streamed by untrained reception staff. 30-year-old Madhumita Mandal died of multiple organ failure and sepsis caused by a ruptured ovarian cyst after a receptionist at the urgent care centre failed to refer her to a medic.

A recent national survey of 99 CCG chairs and accountable officers, found that 31% said their STPs were likely to lead to the closing or downgrading of A&Es in the next 12-18 months. Almost half said they expected a reduction in beds, while 23% expected a reduction in full-time acute staff and 21% expected one or more hospitals would stop consultant-led maternity. The Royal College of Emergency Medicine described the [STP plans as catastrophic](#). The Royal College of Nursing and the Royal College of Midwives also attacked the plans.

Bed cuts were signalled for the Alliance in the 30 June draft as “with the large transformation in Primary and Community services and philosophy based on care closer to home, the shape and size of the hospital's bed base will need to be reconfigured to ensure the sustainability in the future.” For elective care, “Length of Stay reductions and reductions in Delayed Transfers of Care would enable greater efficiencies and rationalisation of inpatient bed capacity that would not be possible across a smaller foot-print.” The 16 Nov plan foresees “Ward reductions / closures based on reductions in Delayed Transfer of Care”.

Unfortunately, Delayed Transfers of Care are growing. For St Helens and Knowsley Hospitals NHS Trust, DTC grew from 166 patient-days in Sept 2014, to 396 in Jan 2016, reaching 745 in Aug 2016, the latest available data from NHSE.



data source

<https://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/>

definitions

<https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2015/10/mnth-Sitreps-def-dtoc-v1.09.pdf>

Nationally, there were 167,677 DTC days in April 2016, compared to 138,030 in April 2015, and 5,924 patients delayed at midnight on 28 April 2016, the highest number since monthly data was first collected in August 2010. Saffron Cordery, director of policy and practice at NHS Providers (the association for the NHS acute, ambulance, community and mental health services) blamed the figures on [funding pressures on the NHS](#).

Land and Buildings

The Alliance plan, as of 30 June, refers to “estates rationalisation” and aims to relocate GP services into multi-tenant centres provided by CHP (Community Health Partnerships) and NHSPS (NHS Property Services). Such centres are provided through [LIFT companies](#), which are “Locally based joint ventures between public and private sectors”. In the Halton, St Helens, Knowsley and Warrington area, the LIFT company is [Renova](#), owned by its private sector partner [Fulcrum](#), in turn owned by the investment group [Meridiam](#), “a global investor and asset manager specializing in public and community infrastructure”.

In Cheshire & Wirral, as of 30 June, plans for Acute Sector Reconfiguration will consider “Sustainability of current provision and estates”. In North Mersey, Hospital Service

Reconfiguration will result in “estates rationalisation”. Naturally, if sites such as Liverpool Women’s, Arrowe Park or Clatterbridge are “rationalised”, buildings can be leased to new owners and/or land sold for redevelopment.

The 16 Nov plan deals with Estates in an Appendix, and intends to “Review clinical service requirements and operational plans for future delivery analysing potential opportunities to rationalise the estate; reducing footprint and cost.” It also mentions “32 LIFT buildings across the Alliance and North Mersey LDS areas”.

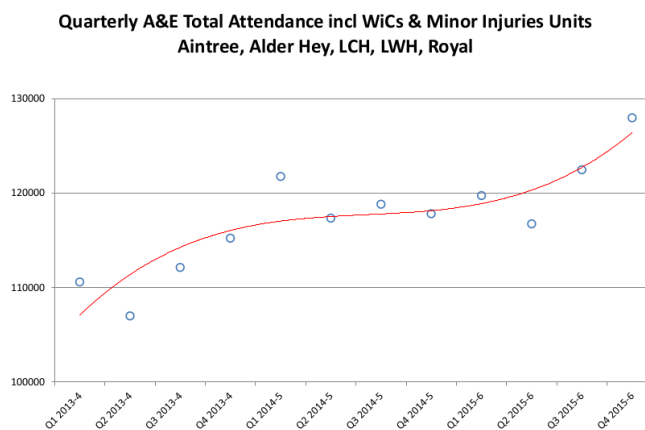
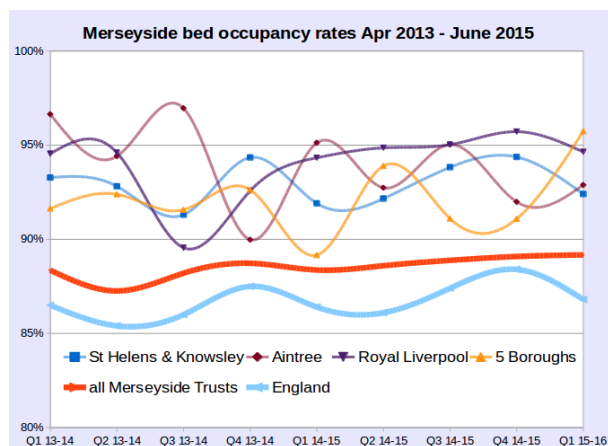
Nationally, the Department of Health is considering writing off NHS Trust debts by [accepting land disposal receipts](#) in place of money. In January 2016, its Finance Director told MPs on the Public Accounts Committee “We’ll look at their capacity to generate capital themselves through asset disposals... we’re looking to generate around £2bn of capital receipts across the period through estate disposals – partly to free up money for investment in transformation, and partly to play our part in supporting that public sector land sales for homes target as part of the wider government initiative.”

Selling off land and buildings will mean the reconfigurations are permanent, whatever problems of local access they cause.

Demand Management and New Models of Care

While the cuts and contracts are the immediate priority, the STP also aims to reduce demand for NHS healthcare. The 30 June plan asserts that in North Mersey “We already have ambitious schemes in place which are reducing demand for services”.

The actual data on bed occupancy and A&E attendance (from NHSE) show an escalating crisis.



Occupancy of overnight beds for Aintree Hospital reached 99.3% in Oct-Dec 2015, while in Apr-Jun 2016 (latest available) it was 94.1%, far above the national target and safe level of 85%.

The Demand Management proposals involve a shift from hospital to community care, and integration of health and social care. We should approach them with scepticism. Why?

First, the table published by the Liverpool Echo on 12 Sept shows massive cuts to Liverpool Community Health (which is to be replaced by a new provider) and to Mersey Care, the two main

organisations delivering community care (distinct from GP primary care) in Liverpool. In fact, most of the Sustainability & Transformation Fund inputs shown in the Echo table will go to hospital trusts. As above, the STP expects further cuts to local authority social care budgets, placing greater strain on the system.

Second, as [Julia Simon](#) put it “there is a lot of blue sky thinking and then you have a lot of lies in the system about the financial position, benefits that will be delivered - it’s just a construct, not a reality”.

Will Demand Management schemes actually reduce demand for acute care? The only way to find out is to put additional resources into the community, do pilot studies, publish peer-reviewed evaluations, and then seek a consensus – or at least a majority view - among clinicians and the public as to whether the demand has gone down or not. Only then could health planners safely consider to what extent resources can be shifted without damaging patient care and whether it is cost effective to do so. Proper care in the community also uses resources and staff – and digital apps won't suit many frail elderly patients, self-care can backfire etc.

Insofar as the Demand Management strategy is based on prevention / lifestyle changes, there will be a time lag – e.g. smoking cessation has major impacts several decades later. In the meantime, disease still needs treatment. The acute sector needs to be maintained even if community care is working, because demand could rise due to other factors – e.g. austerity or climate change.

Some of the existing research and reviews of evidence contradict claims that care in the community or pooling health and social care budgets reduces demand on the acute sector. See for example the section *Medical evidence for Integrated Care?* in the [Devo Briefing](#) produced by Keep Our NHS Public in April 2016.

In fact, reduction in demand does not necessarily imply reduction in need. When some patients stopped going to hospital at weekends because Jeremy Hunt wrongly claimed it was less safe, they still needed the care. If patients stop seeing a GP because they don't want to be a drain on the NHS, they may develop serious illness which could have been averted if they had sought treatment in time. What's needed is a professional consensus between NICE, the medical royal colleges, nursing and allied health professionals to ensure that no specialist services necessitating hospital care are inappropriately farmed out to the community in order to create inappropriately staffed but insurable care packages.

Although the draft STP is stuffed with words like “robust” and “evidence-based”, no actual evidence is included in the document, and no published studies are cited. The authors of the secret plan are taking a massive gamble for financial reasons. But if evaluating evidence is dumped in favour of directives from the Treasury, what's the point to medical school, nurse training, or medicine based on science?

In fact, the 16 Nov plan acknowledges that they cannot currently justify hospital reconfigurations. Instead:

There is a strong need for a service line by service line review of the current acute care model, in order to generate the evidence and data required to inform an explicit decision to be taken on the locations of acute provision based through analysis of future patient flows.

...

Work is underway with AQuA to identify from an international and national evidence base the

areas in which reduced variation would give the maximum potential in addressing the quadruple aims of the 5YFV across the whole of C&M.

In any case, in the 30 June plan the projected impact of Demand Management in the draft STP is rather small. By 2020/21, as part of the North Mersey plan to offset a deficit of £374.4m in 2020/21, Demand Management will contribute £18.9m, dwarfed by £171m from “provider efficiencies” and £70m from hospital mergers.

So, what does the STP propose? As of 30 June, the North Mersey plan would entail:

“A one-system model for proactive community care; the right care provided early, enabling people to live well, remain independent and avoid hospital. Integrated, neighbourhood services bringing together multi-disciplinary teams - primary and community services, children’s services, social care, mental health, intermediate care, care homes, education, housing and the voluntary sector.”

What does this mean? “Proactive” may refer to case management, a strategy of focusing resources on patients at high risk of hospitalisation. The Greater Manchester Strategic Plan (Dec 2015) says “Key features will be targeted case management of the population most in need delivered by upskilled multi-disciplinary teams, together with streamlined discharge planning in order to reduce the demand placed on acute hospitals.”

Research at the University of Manchester published in 2015 involved a systematic review and meta-analysis of case management for 'at-risk' patients in primary care. It concluded “ Current results do not support case management as an effective model, especially concerning reduction of secondary care use or total costs”. ([PLOS One 17 Jul 2015](#))

Wigan's [Integrated Neighbourhood Teams](#), introduced in 2013, are often cited as a good example of reducing A&E admissions through targeted case management. Nonetheless, by 2014/15 A&E admissions remained over 1% above the baseline rates in 2010/11.

Right Care

In connection with Demand Management, the 16 Nov plan mentions Right Care, projected to account for £42.5m worth of savings, with no details. The 30 June draft had slightly more detail:

The key element of pathway standardisation will be using the NHS Right Care improvement methodology to design/re-design optimal pathways of care. The same methodology will be applied to the design of each pathway:

1. Identify areas of biggest opportunity
2. Isolate what needs to change
3. Understand what good looks like and what needs to be done differently

Clinical leadership will be central to our approach and will include:

- Championing the NHS Right Care approach to others within commissioner and provider organisations and building a consensus within the teams of those organisations.

So what is Right Care? NHS England has produced “Commissioning for Value” packs for each CCG, claiming to identify savings which could be achieved in each major clinical area. The underlying assumption is that each CCG can be compared with 10 similar CCGs, chosen once and

for all independent of any particular clinical outcome. Then each CCG is urged to aim to achieve the average performance of the best 5 of the 10, where “best” is obtained, for each clinical outcome, by comparing the performance for that outcome. The savings for each outcome are the difference between its current performance, and the average of the best 5 for that outcome.

It's absurd. The relevant [“Where to Look”](#) pack says Liverpool CCG should be compared, for all outcomes, with:

- Salford CCG
- Sunderland CCG
- Bristol CCG
- Newcastle Gateshead CCG
- Brighton and Hove CCG
- South Tees CCG
- Hull CCG
- Stoke on Trent CCG
- Sheffield CCG
- South Manchester CCG

Then, when it comes to cancer, it is claimed that 103 lives per year could be saved if Liverpool performed at the level of the Best 5 of these 10. Sure, if Liverpool were Brighton & Hove, Bristol, or Sheffield, fewer people per 100,000 would die of cancer. But it isn't. How does that give Liverpool CCG any guidance on how to commission cancer care for the city, as it really is?

The bogus comparison gives the impression that cancer care in Liverpool is dreadful, which must be the fault of the CCG. But actually, one year survival rates in Liverpool (2013 data, the latest available) are 69.5%, not significantly below the national value of 70.2%.

The supposed opportunity to save 103 lives / year from unnecessary cancer deaths is a clear example of what Julia Simon rightly called “a lot of lies in the system about the financial position, benefits that will be delivered - it's just a construct, not a reality”.

Back Office

This insulting term covers all the admin support services without which the NHS cannot function, clinicians cannot access all relevant patient information, staff are not recruited, meetings are not minuted, diaries are not planned, invoices and wages do not get paid, costs escalate because they are not being tracked, etc. Currently, such services are mainly provided by NHS staff on NHS terms & conditions. However, the STP drafts hint at other possibilities.

The 16 Nov plan aims to “deliver cost effective, efficient and commercially sustainable Back Office operations”. *Commercially* is an odd word to use for NHS services, and identical phrases are used later in relation to Clinical Support Services . The aim is Cost Reduction.

There is no commitment to keep these services within the NHS. Instead, “Where appropriate, Back Office services will be maintained within the NHS”. There are two approaches, to be run in parallel.

- economies of scale and best in class approaches and models across the patch
- Procurement at category level, then built up to a cluster approach at LDS and then STP level

This appears to mean compelling Trusts to adopt “best practice” for these services, whether or not

an approach which works in Macclesfield will work as well in Liverpool; or / and putting some services out to tender.

A table of “Immediate Next Steps” refers to an Options Appraisal including “Market Maturity Assessment” and “Identify Potential Providers”.

The 30 June draft was more explicit. For non-clinical support services, “Five options have been identified – in-sourcing to best placed C&M entities, consolidation of all the functions to a single location, setting up a C&M-owned Shared Services Centre, setting a joint venture with a private sector partner and outsourcing to the private sector.” These options appear to be: a) handing specific support tasks for the whole of C&M to one Trust; b) handing over all such tasks for C&M to one site in one Trust; c) setting up a new service centre owned by C&M (even though the footprint has no legal status); d) a joint venture with the private sector; e) privatisation.

It is especially ironic that d) or e) should be under consideration, after the [debacle with Capita](#) led Liverpool NHS Trusts to take HR services back in house.

The aim was also explicit on 30 June: “Economies of scale: beginning with the consolidation of highly transactional services to reduce headcount”. In plain English, this means getting fewer support staff to cover more Trusts in a wider geographical area. This assumes, wrongly, that there are surplus staff with not enough work, and that it is possible to carry out support functions at a distance. Effective support requires specific knowledge of the services staff are supporting, far more than transferable skills like Office programmes. How would a secretary in Liverpool resolve admin queries in Northwich and Southport, without the level of local knowledge s/he uses daily?

In seeking to reduce spending on agency staff, rather than creating permanent NHS posts on NHS pay, terms & conditions, the 30 June draft envisages

setting up a jointly owned agency, starting with high impact staff groups and expanding over time. By 2021, we want to have built a large staff base by offering competitive rates and other non-financial benefits... used to enter into joint negotiations with external agencies to achieve lower rates. Along with a cultural shift in framework compliance, a shortlist of preferred agencies will be chosen and rates fixed...

It's unclear from this how C&M can jointly own anything, as it is not a legal entity, and the other owners are not identified.

Clinical Support Services

Likewise, the 16 Nov plan aims to “to deliver cost effective, efficient and commercially sustainable Clinical Support Services”, starting with Pathology, Radiology and Pharmacy. For Pathology the plan mentions an STP wide C&M single managed service with plans to “Evaluate the potential for novation of contracts over time”. This appears to mean the potential to transfer Path staff from their existing NHS contracts to some other form of employment covering the whole of C&M.

For Pharmacy, the plan for Medicines Information concludes “establish and transfer services”; for Aseptic Services it refers to a “potential transfer of services”; for Community Pharmacy it mentions “tender arrangements to secure preferred partner... legal documentation to support the proposed commercial partnership... new commercial vehicle(s) with proposed community pharmacy partner”.

These are plans for whole or part privatisation of Pathology and Pharmacy, at least.

The plan also states “Therefore, there are a range of future collaborative models which we are considering across the different support services in C&M, ranging from, for instance, setting up a single wholly owned subsidiary organisation for manufacturing and dispensing medicines, to outsourcing dialysis services to a satellite dialysis provider.”

Accountable Care Organisation

The STP privatisation agenda goes far beyond individual plans for specific services. In fact, the underlying organisational form which the STP aims to create is the preferred model for the US healthcare industry – Accountable Care Organisations, or ACOs.

The plan says the STP will “Create a framework for the development and implementation for Accountable Care approaches (ACOs)”.

For the Cheshire & Wirral LDS, one core aim by 2020/21 is to “Establish an approach to deliver Accountable Care Organisations across Cheshire and Wirral.” In that regard, the LDS will establish “Accountable Care Partnerships/Orgs across CW” which will entail:

- Introduction of 4 ACO/Systems across Cheshire and Wirral
- Budget Alignment on population outcomes
- Risk Sharing Arrangements across commissioning and delivery of services as per ACO.
- Delivery of new contract mechanism.
- Clear operating model

The 4 ACO/Systems echo the chart in the 30 June version as mentioned above re Hospital Reconfigurations, which showed 4 ACS for a “Virtual Single Hospital (4 hospitals acting as one)”

In the 30 June plan, the Cheshire & Wirral section on Accountable Care mentions “Outcome base capitated budgets with new contract mechanism”

North Mersey will “Explore options for the development of an Accountable Care System to support the radical step change required to manage demand and improve health outcomes”, and in connection with that, “explore the submission of an expression of interest for a North Mersey system control total, which would be submitted to NHSE by 31.10.2016 in line with the opportunity set out in the NHS Planning Guidance.” That is, the LDS control total is linked to the establishment of an ACO. Perhaps it would function as the overall budget for the North Mersey ACO.

The STP never explains what ACOs are or why they are being promoted or their origins in the US, where costs skyrocket but health outcomes are worse. The 30 June draft says:

Across the STP footprint, there is an appetite for hospital reconfigurations to reduce unwarranted variation. This follows from the concept of a new model of population health to better manage demand such as an Accountable Care System, whereby the system is held accountable for achieving a set of pre-agreed quality outcomes within a given budget or expenditure target.

...the system as a whole agrees to be accountable for the quality, cost, and overall care of a defined population with the objective of decreasing the total cost of care for the population compared to a spending benchmark.

...The NHS five year strategy sets out the ambition for 50% of the country to be covered by ACOs by 2018.

Obvious questions: Held accountable by whom? Quality outcomes as measured by whom? What happens when demand increases beyond the planned levels reflected in the budget?

The real story of ACOs and their origin in the US healthcare industry was explained by public policy analyst Stewart Player writing for OurNHS in March 2016

'Accountable Care'

- the American import that's the last thing England's NHS needs

Some excerpts:

ACO's appear to be part of an overall strategy to frustrate the introduction of national health insurance in the US, and quite possibly to destroy it in England.

Initially developed to improve performance in the federally run Medicare programmes, the ACO concept has since expanded significantly and is now regarded as a cornerstone of the US healthcare reform agenda.

The basic concept of an ACO is that a group of healthcare firms agrees to take responsibility for providing care for a given population for a defined period of time under a contractual arrangement with a commissioner. ACO's use a variety of market-based mechanisms to lower costs whilst achieving a set of pre-agreed quality outcomes. This is mainly accomplished by 'aligning incentives' between providers and commissioners, or in other words, sharing any budget savings between hospitals, doctors and the commissioning Medicare programme itself. For those ACOs contracting with private insurers any savings will be shared between the two organisations.

...the two models most frequently cited from the Forward View, the Primary and Acute Systems (PACS) model, and the Multispecialty Community Providers (MCPs), closely correlate with the US ACO 'integrated delivery systems' and 'multi-specialty group practices'.

Such models are currently in development via a range of vanguard sites throughout England, similar in fact to the Medicare pilot programme in the US, although other variants, including prime and alliance contracting are already in place.

And, as in the US, provider consolidation will become more commonplace and similarly detached from public ownership. Hospitals, for example, are being encouraged to form brand chains as [Stevens unveiled the plans to the Confederation of British Industry in November last year](#), and GPs and specialists are being encouraged to regroup into more business-like networks, federations and super-partnerships capable of contracting with a wider range of other healthcare firms and NHS fundholders.

Player explains the “capitated” budgets mentioned above for Cheshire & Wirral.

...‘capitated’ or ‘global’ payments, which are fixed payment to providers for all or most of the care that their patients may require over a contract period, such as a year, adjusted for severity of illness, and regardless of how many services are offered. The size of an ACO will on the whole dictate which payment option will be adopted: larger ones will have the scale and financial capability of adopting capitated payments which, although they mean offering more or less comprehensive care, involve greater financial reward.

Do ACOs save money?

Far from saving money the various Medicare ACO programmes have seen increased costs, largely through the use of shared saving bonuses and subsidies for providers. None of the projected \$320 million savings were achieved between 2011-2014 – in fact the ACO programme actually COST Medicare an additional \$3 million, according to a Kaiser Health Foundation report. The report also highlights how only a small (and shrinking) percentage of the ACOs really ‘share risk’ with Medicare – the vast majority, 334 out of 353, are eligible for bonuses but face no penalties for losses.

Who benefits?

Of perhaps more concern, especially for the NHS, is the extent to which ACOs, far from being transformative, are simply a faddish rebranding of existing for-profit structures – effectively, just Health Maintenance Organisations in drag... HMOs are often seen as the most objectionable aspect of the US ‘system’, and certainly a primary cause of repeated clamour for reform.

HMOs can be considered as the key institutional expression of what’s known as ‘managed care’, deemed a corporate compromise between insurers and large employers to contain costs whilst also ensuring profits and disciplining the workforce.

As leading critics of the model, Drs Himmelstein and Woolhandler, point out however the history of HMOs isn’t exactly edifying, and includes routine denial of patients’ access to medically necessary treatment, fighting claims, screening out the sick, paying exorbitant CEO salaries, and undertaking systemic fraud. And all while offering what is effectively low rent medical care with considerable hidden costs in the forms of top-ups and deductibles.

Whilst HMOs are primarily dominated by large corporate insurers, ACOs are put forward as being led by providers – and by friendly local healthcare providers, at that.

[However] consultants Booz & Co (now part of PwC) reported that “virtually every major payor (insurer) is either involved in, planning, or seriously considering ACOs. Many health plans are actively helping providers, especially integrated systems and primary care physician (PCP) groups, to form ACOs... some of these projects are more ambitious, while others are simple re-brandings of existing constructs”.

Is it a coincidence that PwC was paid £300,000 to draft the C&M STP? But back to Player:

Booz describe differing ACOs and how the insurance industry – companies like Aetna, UnitedHealth, Humana and Blue Cross - are taking a leading role in developing the model.

Such activities include offering shared savings to clinicians, to analysing data and assessing how risky patients are before they're accepted as eligible for that ACO's plan. They also offer ACOs disease management programmes and an already established customer base. By 2013 UnitedHealth, for example, were able to report that accountable care currently accounts for more than \$20 billion of the company's reimbursements to providers, and the insurer says it expects that number to more than double to \$50 billion by 2017 as it contracts with additional ACOs.

So where is it all going? The ACO model is favoured by US healthcare and insurance firms, and PwC drafted the C&M STP plan, so presumably those same firms will be happy with it over here. We can speculate that while no-one is big enough to buy the NHS, plenty of health giants, such as Simon Stevens' former employer UnitedHealth, are big enough to buy an ACO the size of one of the three LDS within Cheshire & Merseyside. All the systems will be in place if they wish to do so.