

Delivery costs extra: can STPs survive without the funding they need?



Contents

Executive summary.....	2
Introduction.....	2
What is the BMA view?	3
Survey results.....	5
Key themes summary.....	7
Theme 1: Public health and prevention.....	9
Theme 2: Primary and community care.....	11
Theme 3: Secondary care reconfiguration, consolidation and collaboration.....	14
Theme 4: New care models – accountable care, MCPs and PACS.....	16
Theme 5: Mental health.....	18
Theme 6: Urgent care.....	20
Theme 7: Funding.....	22
Theme 8: Workforce	26
Theme 9: Commissioning.....	28
Theme 10: Consultation and engagement.....	30
Appendix 1: List of closures.....	32
Appendix 2: Savings.....	35
Appendix 3: Consultations.....	36

Executive summary

England's health service is under increasing strain. For too long the Government has been underfunding the NHS, resulting in a predicted £30 billion funding gap each year by 2020/21. This is exacerbated by both the cuts facing social care and a lack of adequate investment in public health across the UK, which will inevitably make the situation worse in the future.

This is all in the context of an ageing population, with greater numbers of people living longer with more disability and often with two or more long term conditions. Difficulties with recruiting and retaining staff are another major challenge. BMA members report rota gaps and vacancies, an increasing number of GPs about to retire and potential additional challenges to securing staff in the aftermath of the UK's decision to leave the European Union.

Increasing demand, tight funding and workforce challenges all mean that across England the state of the health system is precarious. The future of general practice is under threat, with unprecedented increases in workload, shortages in GPs, and historic and continued underinvestment. The situation is equally challenging in secondary care, with significant reductions in bed numbers in recent years and trusts struggling with huge deficits.¹

This is the background in which STPs (Sustainability and Transformation Plans) have been introduced and gives some idea of the level of the challenge they face to resolve the crisis in our NHS. This paper follows up on some of the BMA's public facing work on STPs over the last six months (see below for more information). It considers objectively what STPs are trying to achieve locally and evaluates both the direction of travel and chance of success. This should give members the necessary information to consider their own STP in a more informed way and hold their leads to account. The BMA is committed to monitoring the content and progress of STPs.

Introduction

STPs are five year plans detailing how local areas will work together to modernise health and care and achieve financial balance by 2020.

In March 2016, England was divided into 44 STP geographic 'footprints' made up of NHS providers, CCGs, local authorities and other health and care services. These organisations were asked to work together to create a plan based on local health needs. Senior figures from organisations within the footprint were appointed to lead, with almost all from a health background.

Plans were submitted to NHS England and NHS Improvement in October 2016 and have since all been published. These plans are still in development and areas will simultaneously start to implement the sections of the plan furthest ahead whilst continuing to work on other sections.

[Click here for links to all the plans and a list of all the current STP leads.](#)

NHS England's '[Next steps for the Five Year Forward View](#)', published in April 2017, changes the language around STPs – referring to them as Sustainability and Transformation **Partnerships**.

It also gives details about ACSs (Accountable Care Systems), which go a step further by having collective responsibility for the resources and health of the identified population. In return, ACSs will be given additional responsibilities from the national bodies. Successful vanguards, 'devolution' areas and STPs working towards the ACS goal are likely to be candidates for ACS status, including Greater Manchester, Northumberland, Dorset and West Berkshire.²

1 At the end of Q3, NHS providers were £886 million in deficit (NHS Improvement, Quarterly performance of the NHS provider sector: quarter 3 2016/17).

2 For the full list of proposed candidates see '[Next steps for the Five Year Forward View](#)'.

What is the BMA view?

Since the plans were introduced, STPs have caused significant concerns across the health and social care landscape.³ The BMA asked for assurance related to the overall process and to each specific plan on the following five key asks:

1. The plans need to be made public as soon as possible.
2. All proposals within the plans need to be realistic and evidence based.
3. There needs to be a commitment to full consultation with clinicians, patients and the public on any proposed changes as soon as possible.
4. The plans need to be properly funded.
5. Patient care, and not savings, needs to be the priority of each and every plan.

We have been vocal in condemning any cuts to funding through the STP process, in particular the focus of the plans on generating 'savings' rather than delivering better patient care.

Following a series of freedom of information enquiries, investigations and analysis the BMA News team found that the 44 STPs will have to make at least £26 billion in cuts to keep inside the public funding constraints set by the Government.⁴ This was followed by an investigation showing that the plans require at least £9.5 billion of capital funding but NHS leaders are unlikely to have anything like the capital required to deliver the projects.⁵

Given this background, we do not believe that many areas would successfully meet our five asks, although progress has been made in some areas. Six months on from the plans being published this is how we think STPs are performing against our five asks:

1. The October submissions of all 44 plans have now been published. However, the lack of either data or clarity in the detail of the plans would need to be improved to constitute genuine transparency and to ensure that the public are being kept informed. **Progress level = Yellow**

2. There is a serious risk that the rushed timelines and the scale of the financial challenge means that plans are being implemented without the appropriate evidence. **Progress level = Yellow.**

3. Engagement with clinicians, patients and the public has not been good enough. **Risk level = Red.**

4. The upfront funding needed for transformation has not been provided. **Progress level = Red.**

5. Most plans do consider how to provide a more seamless, integrated experience for patients, with more care delivered closer to home. However, the fact that 'savings' of £26 billion need to be made within the next five years is extremely worrying in terms of the effect on patients. **Progress level = Yellow.**

- 3 The following resolution was passed at the BMA's ARM (Annual Representative Meeting) 2016: That this meeting deplores the projected future reorganisation of the NHS into 44 Sustainability and Transformation areas (Transformation Footprints) linked to Local Authorities which:
 - i) will require each area to have a Five Year Plan in place by September 2016;
 - ii) will develop new models of health care policy without reliable supporting evidence and;
 - iii) must achieve financial balance with the threat of large penalties for failure and calls on the BMA to condemn this massive "top-down" reorganisation.
- 4 <https://www.bma.org.uk/news/2017/january/hospitals-and-social-care-face-budget-cuts-of-twenty-six-billion-pounds>
- 5 <https://www.bma.org.uk/news/2017/february/nhs-needs-9-5-to-transform>

Forming local place-based plans could have offered a much-needed opportunity to bring about improvements to the NHS. We support the aim to integrate services across health and social care and create a long term strategic plan for NHS services locally. However, the risks to patient care implicit in the implications of STPs are too high for the BMA to be able to support the plans in their current form. Unless the concerns outlined above are addressed, and in particular the lack of resources available to both sustain and transform the NHS, then the BMA does not believe that these plans will be able to deliver a sustainable NHS for the future, and are even at risk of adding additional pressures to the system.

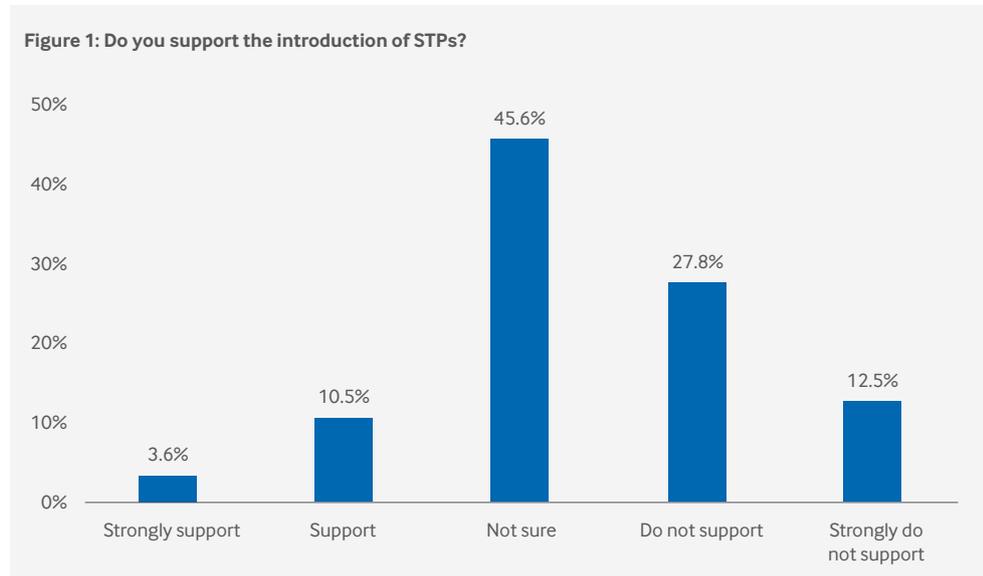
In addition, STPs are presented as key to the future of the NHS so it is alarming that they are being taken forward without a statutory or legal basis. Not only do they sit outside of the statutory framework but they seem to contradict current legislation, which still encourages competition and mandates for a competitive tendering process. The BMA calls on the government to clarify their intentions for the statutory basis of STPs and, in particular, for any more formal delivery structures that might be developed over the next few years (eg accountable care systems).

The BMA has been clear in its policy that sections of the Health and Social Care Act 2012 should be repealed,⁶ and in particular that CCGs should have the autonomy to choose the most appropriate procurement process/processes for the services that they wish to put in place for their patient populations. While NHS England are proceeding with collaboration regardless of the Act, the Government appear to have washed their hands of developing a proper governance framework for the NHS. Effective oversight by the Government and a fully worked through governance framework is even more crucial if local areas are taking on responsibility including the planning and management of services, and given that Parliamentary and Government time and effort are necessarily focused on Brexit.⁷ This must be resolved as soon as possible.

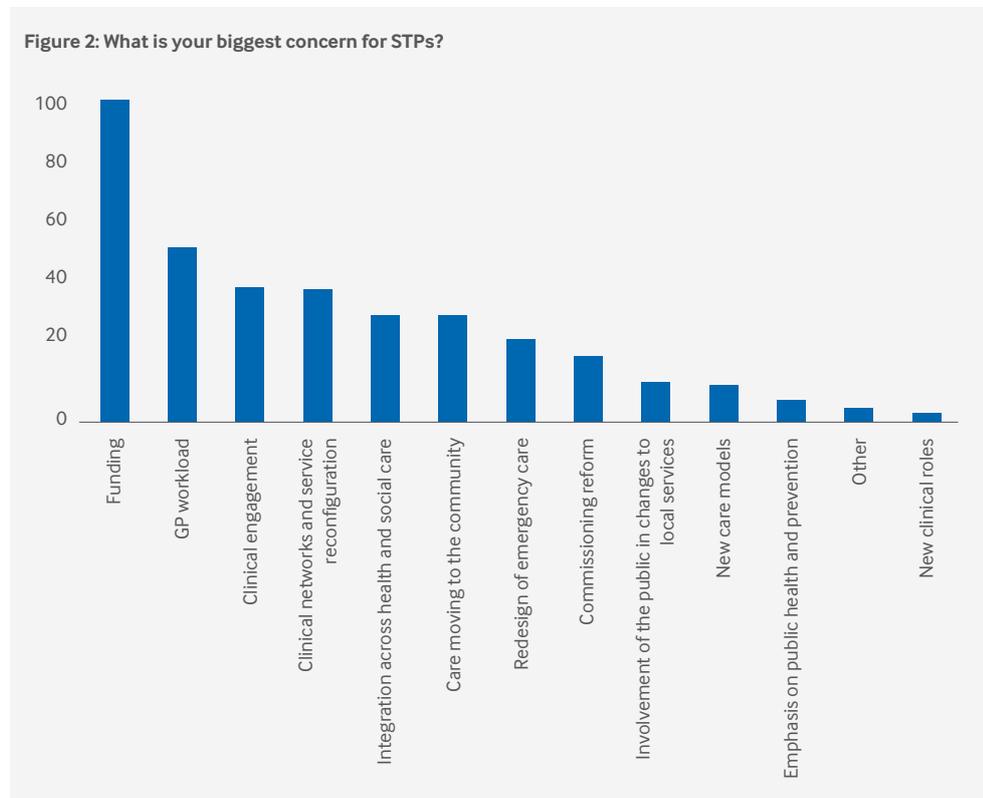
- 6 Section 1 should be amended to restore the statutory responsibilities of the health secretary to secure and provide universal healthcare, albeit with that function delegated to NHS England and CCGs.
 - b. Section 3 should be amended to remove Monitor's duty to prevent anti-competitive behaviour as should the concurrent duty of the CMA. Monitor's priority should be its duty to enable 'health care services... to be provided in an integrated way'.
 - c. Section 3 and The NHS (Procurement, Patient Choice and Competition) Regulations 2013 should be amended to give CCGs the autonomy to choose the most appropriate procurement process/processes for the services that they wish to put in place for their patient populations. This includes appointing a specific provider or group of providers without competition (Single Tender Action).
- 7 We have identified a number of priorities for health which need to be considered in the negotiations, including: the retention and recruitment of EU staff, mutual recognition of professional qualifications, science and research, health and safety legislation and public health protection and procurement. For more detail go to <https://www.bma.org.uk/collective-voice/influence/europe/brexit>.

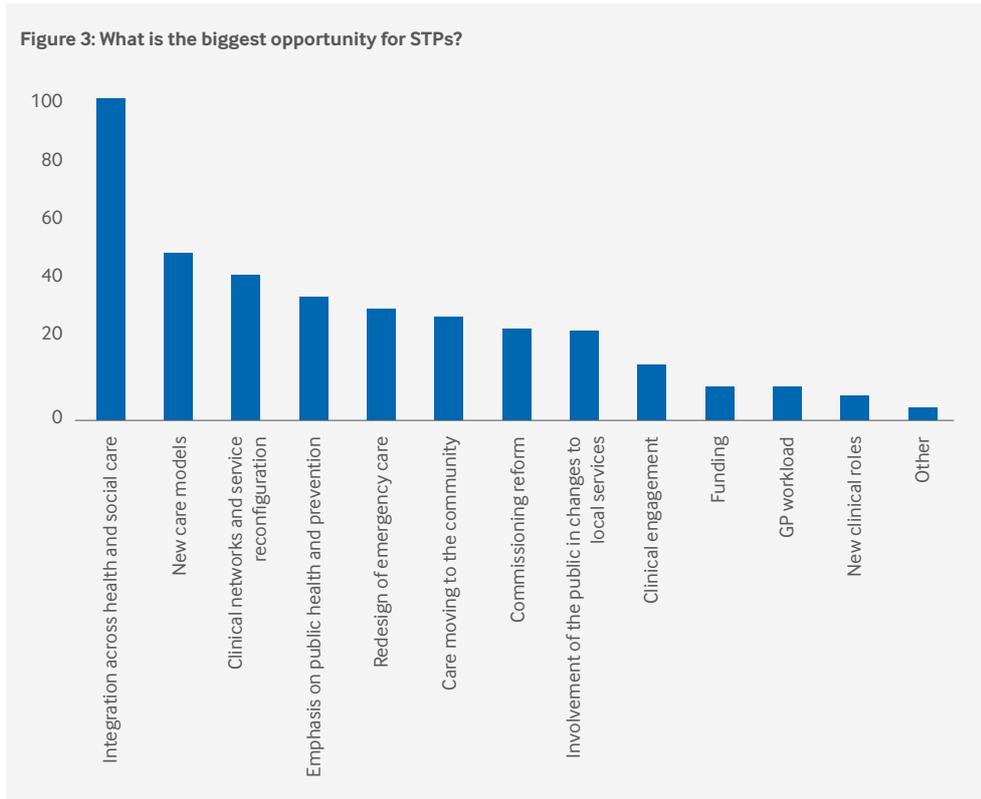
Survey results

However, feedback from doctors on the ground suggests that they have not yet formed a firm opinion of STPs. Our latest survey of BMA members on their opinions on STPs found that views are still mixed. The biggest majority (45.6%) are still unsure whether they support the introduction of STPs (see figure 1).



The main reason why doctors are concerned about STPs is because of the funding implications, followed by GP workload (see figure 2), whereas they see the main opportunity as the potential to integrate services across health and social care, followed by new care models (see figure 3).





For all the results from the survey please see the [BMA website](#).

Key themes summary

This paper identifies 10 key themes common to all 44 plans. Whilst there is generally a similar direction of travel in most plans there is significant variety in the level of detail included in the October submissions. This reflects the fact that different areas are at very different stages in terms of collaborative working and how much thought and/or money they have invested in transformation. The key messages from these 10 themes are:

Prevention (Theme 1)

- All STPs recognise the importance of prevention for improving the health of their local population, although the scale of action does not match what the BMA believes is required to support substantive improvements in population health.
- Several plans highlight the cost savings they estimate achieving as a result of improved public health/prevention. However, they rarely recognise that future cost-savings as a result of improved public health are unlikely to occur within their five year time frame.

Primary and community care (Theme 2)

- All STPs talk about moving care from hospitals into the community, giving patients the option to see a number of health and care professionals working in multi-disciplinary teams. Most plans propose a corresponding increase in investment, although with limited detail about where the funding would come from or the risks if savings elsewhere are not made.
- The need for immediate stability in primary care is generally recognised and working at scale is a consistent aim across all plans.
- Many plans predict moving care into the community will save money, but there is little to no evidence that this is the case to date or in the plans themselves.

Secondary care reconfiguration, consolidation and collaboration (Theme 3)

- Most plans look to centralise or consolidate services across acute and community hospitals. In many areas, these changes are associated with planned cuts to bed numbers and in some cases reductions in the number of hospital sites. There is little acknowledgement of the investment that reconfiguring acute care involves.
- Similarly, several plans contain optimistic assumptions for reducing demand on hospitals. The BMA is very concerned about how realistic these assumptions are and what the risks will be if these targets are not met. Unless appropriate capacity is developed in community settings before hospital capacity is reduced, the planned reductions in activity levels will simply not be achievable.
- The plans are clear that clinical reviews and/or consultations will take place before any changes are made.
- See [Appendix 1](#) for a list of all proposed hospital, A&E or bed closures.

New care models (Theme 4)

- Many STPs are planning to develop one or more new care models delivering population or place-based care. These are expected to increase integration between primary and community care. Some STPs are planning to improve integration more widely.
- Many plans lack both detail and credible funding for these new models of care, with the result that the savings the plans forecast from implementing new care models seem somewhat unrealistic.

Mental health (Theme 5)

- There is broad recognition across all STPs of the need to improve mental health care, including achieving parity between physical and mental health and recognising the link between mental health and social determinants of health.
- The plans often seem aspirational rather than clearly demonstrating how outcomes will be achieved, how care models will be implemented or whether funding for mental health will be ring-fenced.

Urgent care (Theme 6)

- Across all STPs there is a move towards more integrated urgent care, bringing together NHS 111 and other services. NHS 111 remains the primary point of access for patients, but a number of STPs are planning to establish a clinical assessment service or hub to provide clinical advice for patients contacting NHS 111.
- A number of STPs propose downgrading emergency departments to urgent care centres.
- Currently there is little consideration given in the plans as to the impact on the GP workforce if GPs are needed to staff clinical advice services/hubs or have GP-led triage services at A&Es.

Funding (Theme 7)

- Across all 44 STPs, £26 billion needs to be cut from budgets by 2020/21.
- Some of the biggest savings are predicted to come from 'business as usual' or provider/commissioner efficiencies, which, given the history in the NHS of missing overly-optimistic efficiency targets, is unlikely to be achieved.
- The plans calculate they need at least £9.5 billion of capital funding to make these changes, compared to the Budget announcement of an additional £325 million for capital proposals in STPs over the next three years.
- See [Appendix 2](#) for more detail on the savings proposed in individual plans.

Workforce (Theme 8)

- STPs are aiming for a workforce that increases the skill mix, reduces spending on agency staff, and introduces new professional roles to deliver care across the system.
- They are undertaking baseline mapping of workforce trends and gaps locally, including recognising the dire state of recruitment and retention across services.
- The plans provide few details on how they plan to improve morale and address serious issues such as burnout.

Commissioning (Theme 9)

- There is a move towards more integrated, collaborative commissioning across current organisational boundaries, including integrating health and social care commissioning. This is generally accompanied by a move to commissioning based on a capitated budget with a focus on outcomes rather than outputs. This is despite the fact that current legislation still encourages competition and mandates for a competitive tendering process.
- Several STPs suggest taking different approaches to prescribing or referral thresholds and predict significant savings from these.

Consultation and engagement (Theme 10)

- The BMA has been very clear that clinical and public engagement in the plans has not been good enough. Any successful transformation needs to be clinically led and involve full consultation with the relevant stakeholders in both primary and secondary care.
- It is encouraging to see that plans are recognising that they haven't got this right so far, and that there is still opportunity to change the content of the plans based on further engagement.
- Very few STPs contain plans for engagement with staff side representatives.
- The BMA has been calling for more transparency in the development of the plans, including more honesty around what is realistic in terms of timelines as well as demand reduction.
- See [Appendix 3](#) for a list of all current consultations.

Theme 1: Public health and prevention

Prevention is a priority of most STPs

All STPs recognise to some extent the importance of prevention for improving the health of their local population, and it is commonly described as a 'priority' in STPs. The plans, in general, are fairly good at setting out the challenge they face with regards to the burden of preventable illness in their footprint area. For almost all STPs prevention and public health are presented as an opportunity to make savings through reducing demand for health services.

But details of how STPs are planning to make this a reality are limited

Most plans only set out broad 'high-level' ambitions for what they hope to achieve through a focus on prevention/population health and it is not necessarily clear from the materials provided to STPs – including [NHS England's aide-memoire on prevention](#) – the level of detail they are expected to go into. Relatively few plans set out specific targeted interventions or detailed strategies for how they will improve public health. The South East London STP, for example, have provided an overview of the current provision and future plans for a range of prevention priorities. A number of plans reference the development of future prevention or public health 'strategies', without themselves providing any specific details of the action they plan to take to improve population health.

Assessing the evidence base for many of the plans is difficult as they often set out broad 'high-level' ambitions, rather than specific detail. Where more detail is provided, the specified actions are commonly evidence-based public health measures (such as the provision of smoking cessation services, or alcohol brief interventions), even if the supporting evidence is not highlighted in the STPs themselves. Certain plans, for example West Yorkshire and Harrogate, have linked their ambition for improving population health to specific outcome measures (eg reducing alcohol related hospital admissions by 500 people a year).

Few plans allocate funding, albeit they expect savings from better public health

The vast majority of plans have not allocated funding to public health/prevention. The Nottinghamshire and Cambridgeshire & Peterborough STPs are exceptions to this, having allocated specific budgets for these activities (£14.5 million and £20.8 million respectively). Whilst it is generally recognised that there needs to be funding to support prevention, the funding source is often unclear in the plans, and some plans appear reliant on nationally funded prevention programmes – for example the national diabetes prevention programme – to support their ambitions.

Despite not allocating specific funding, most plans have highlighted the cost savings they estimate to achieve as a result of improved public health/prevention. The basis on which these savings are calculated is often not clear. There are some limited examples of good practice, where estimated savings are linked to specific improvements in health outcomes. The Lincolnshire STP, for example, clearly sets out specific benefits and costs of activity to support a range of public health interventions.

What is the BMA view?

The BMA is clear that action to improve population health and reduce health inequalities is needed. However, the scale of action on public health set out in most STPs does not match the level of action the BMA feels is required to support substantive improvements in population health.

Many STPs set out ambitions, which we would support, but fail to provide specific detail on the interventions or action that will ensure these ambitions are achieved. This is particularly concerning, given the lack of action on population health despite the commitments in the NHS Five Year Forward View.

Measures to support improvements in public health are often highly cost-effective, and improved population health is vital for reducing future demand on health services. Nevertheless, these measures frequently take time to deliver benefits, and future cost-savings as a result of improved public health are likely to occur over the medium-long term. This has important implications for STPs' financial projections, as it may not be realistic to expect them to start realising significant financial savings as a result of public health interventions within the relatively short time period of the plans.

Theme 2: Primary and community care

A central theme in all STPs is moving care from hospitals into the community, giving patients the option to see a number of health and care professionals working in multi-disciplinary teams and focusing on preventative care.

Most STPs' vision for primary care is quality, at-scale provision based on the registered list

Primary care, and specifically the GP registered list, is seen as the centre of these models, with additional services (social care, community care and mental health) wrapped around it. Some STPs are more prescriptive than others in what they envisage the final model will look like. For example, Shropshire and Telford & Wrekin talk about working towards a MCP model led by the local authority, whereas Lincolnshire talk about the vision being consolidation and joint working across a network of practices working together as federations or super practices. And Primary Care Home is the preferred model for Wolverhampton.

There is acknowledgement in some plans (eg The Black Country) of the need to incorporate learning from the new care models, especially the vanguards within the footprint. Some areas, like Cambridgeshire and Peterborough, recognise that it will take time to decide which organisational form is most suited and how to appropriately contract for it.

Developing primary care at scale is an aim across all plans but there is variation in the suggested population size, with plans often talking about "natural" communities. For example, Staffordshire & Stoke on Trent mention populations of between 30,000 and 70,000, which is in line with the most common proposals, and yet Shropshire sees them potentially being as small as 17,000 and Herefordshire and Worcestershire as big as 150,000. It is generally assumed that efficiencies will be found from working at scale, specifically from the rationalisation of back office functions.

The need to standardise the quality and consistency of primary care across an area is put forward in a number of plans. Some areas have developed STP-wide primary care standards that all networks would be held to (eg Greater Manchester) and others are proposing a Universal Offer for Enhanced General Medical Practice (Birmingham and Solihull). North Central London have set up Quality Improvement Support Teams to provide "hands-on support for GP practices" and are planning to establish a single LCS (locally commissioned services) framework for the whole STP footprint. In general, all London STPs refer to the London Strategic Commissioning Framework for primary care as a consistent vision for primary care.

Stabilising primary care and implementing the GPFV locally is a priority

The fact that primary care needs to be stabilised before these changes can take place is generally recognised in the plans, and the actions proposed in the GPFV (General Practice Forward View) are seen as the way to do it. However, there is variation in the level of detail in plans about this. Lincolnshire specifically refer to supporting programmes at scale for struggling and vulnerable practices and Herefordshire and Worcestershire go into detail about what they see as the fundamental challenges to primary care sustainability (clinical indemnity, information governance and clinical liability).

There are a number of suggestions for how to manage demand in primary care; from triage methods to using more modern technologies and digital platforms to facilitate patient consultation from home. There is an expectation that this will "release time for clinical work" (Hertfordshire and West Essex). Most plans mention improving access to GPs, generally delivered through GP networks/hubs. For example in Manchester they have a number of primary care hubs offering 7-day additional access to care and in Leicestershire they suggest offering services at GP 'hubs' for appointments outside of standard times.

This includes future proofing GP through increasing skills mix and improved estates

Most plans reference the fact that there are serious workforce concerns in primary care, but there is variation in how they suggest mitigating it. Durham, Darlington, Tees, Hambleton, Richmondshire & Whitby and Northamptonshire discuss plans to attract more GPs to the area and expand the workforce but most areas pay more attention to the role that a wider primary care team can play in reducing the demand on GPs.

What is referred to as the wider primary care team varies between plans but includes community pharmacists, social workers, hospital doctors, community nurses, therapists, mental health nurses, healthcare assistants, care navigators, paramedics and physiotherapists. Within the wider team the GP is seen as the senior decision maker, working “at the top of their licence” and focusing on the more complex patients. Several plans propose working more closely with hospital consultants. For example, allowing GPs to access consultant advice without referral (Cambridge and Peterborough) or having integrated consultant roles working in the community (Norfolk and Waveney). See *the section on workforce for more information about new clinical roles*.

There is recognition that some form of infrastructure integration needs to take place and that GP practices are generally not fit for either working at scale or these new models of care. Suffolk and North East Essex refer to “innovative” estates solutions to address this and South East London talk about the possibility of using proceeds from disposals elsewhere. However it isn't always clear whether these solutions are realistic or whether the capital funding will be available to enable this transformation.

STPs commit to greater investment into GP, albeit sometimes relying on savings elsewhere

Almost all plans are clear that there needs to be an increase in investment in both general practice and primary and community care overall, with varying levels of detail. For example, Lincolnshire propose a 10% increase in investment in primary care by 2020/21. However, the investment in some plans (eg Derbyshire) is secured from savings proposed in other areas so it is unclear what the impact will be if these savings are not realised. See the section on funding for more information on resourcing for primary and community care.

What is the BMA view?

There does appear to be a genuine intention to improve care for patients by bringing care closer to home and making sure that patients with more complex or long-term conditions are seen by an integrated team. It is encouraging to see that in some areas there is variation in the care model proposed and recognition of the need to adapt to local circumstances.

However, accompanying this work stream are some pretty optimistic assumptions about the effect that these changes will have on reducing demand for acute attendances. These seem somewhat unrealistic given the increasing demand the NHS will continue to face in the next five years.

Similarly, the plans generally view care in the community as a cheaper alternative to acute care (eg Suffolk and North East Essex see alternatives to hospital as 20% cheaper). There is little to no evidence that shifting care to the community saves money⁸ – “many underestimate the potential that community based schemes may have for revealing unmet need and fuelling underlying demand”. Given this risk, it is important that these initiatives do not increase pressure on already overstretched primary care staff. Community and primary care services will not be able to take on any additional care without a corresponding increase in resources. Addressing the current crisis in general practice at the moment therefore has to be the priority.

⁸ The Nuffield Trust (2017). *Shifting the balance of care: Great Expectations*. London: Nuffield Trust.

Overall, this is an area that is probably further ahead than other areas in STPs in terms of the level of detail because primary care working at scale has already started to happen in most areas of the country. However, it is essential that the capital and transformation funding that most plans consider necessary to enable their vision is made available to them.

Theme 3: Secondary care reconfiguration, consolidation and collaboration

The majority of STPs are looking to change the provision of services within acute and community hospitals.

In secondary care STPs propose centralising services, consolidations and greater collaboration

Changes are centred on centralising or consolidating services, particularly specialist services, reconfiguring how and where they are delivered. For example, Cambridgeshire and Peterborough is planning to centralise specialised orthopaedic trauma services at two of the five acute trusts in the area (Cambridge University Hospitals Foundation Trust and Peterborough and Stamford Hospitals Foundation Trust).

A number of STPs are planning clinical reviews of all services (eg Cheshire and Merseyside, and Northumberland, Tyne and Wear), whereas some have already identified particular pathways for redesign. For example, Somerset has prioritised paediatrics, maternity, dermatology, oral maxillofacial surgery, urology and oncology for redesign this year). Given the number of clinical service reviews planned, there should be a good opportunity for clinical input if the reviews are conducted and used appropriately.

Numerous STPs are looking to consolidate emergency care, often by downgrading or closing one or more emergency departments. In many areas, such as Staffordshire, and Shropshire, Telford and Wrekin, the closure of one emergency department is proposed but the details are yet to be decided upon. Some emergency departments will be replaced by urgent care centres.

Maternity services are also highlighted as an area to be consolidated. For example, Lincolnshire is proposing to centralise services and may only keep consultant-led units on two hospital sites and Dorset is planning to remove consultant-led services from Poole and downgrade the services at Dorset County Hospital. Some services will be replaced with midwife-led units.

In order to consolidate services, a large number of STPs are planning some form of collaborative arrangement between local hospitals. This may simply be greater partnership working, to create shared services or pathways across providers, such as in Hertfordshire and West Essex, or a more formal arrangement such as the one proposed in Milton Keynes, Bedfordshire and Luton, where the three local hospitals have agreed to unify leadership, management and delivery of acute services.

Some areas are looking to establish clinical networks within or beyond their STP. For example, both Birmingham and Solihull, and West, North and East Cumbria are planning networks in children's services. At the trust level, some are planning to become formal partners, whereas a few are looking to merge (as in Manchester and Cambridgeshire) or join a hospital group (West Hertfordshire hospitals have an agreement in principle to be part of the Royal Free hospital group).

Changes are often accompanied by reductions in bed numbers or hospital sites

In many areas, these changes are associated with planned cuts to bed numbers in acute and community hospitals. In some cases reductions in the number of hospital sites are planned too. For example, North West London wants to reduce the number of acute sites from nine to five, Derbyshire is planning to cut 400 acute beds and 58 community beds by 2020/21, while Devon is proposing “a significant reduction in the number of acute and community beds” and has already held consultations on closing community hospitals and beds. These proposals are part of wider plans to move more care into the community (as described in the previous section).

In many cases the need for consolidation is based on evidence that particular services or sites are unsustainable. This is generally evidenced through (high-level) financial, demographic or workforce data. Most plans do not detail the evidence behind the solutions that are proposed and do not explain in detail how the planned savings will be achieved. In many cases it is planned that clinical reviews and/or consultations will take place before any changes are made, providing an opportunity to establish whether or not the evidence supports a given proposal.

There is a failure to acknowledge the investment required

Few plans acknowledge that reconfiguration of acute care will require investment and even fewer identify the specific funding required. Shropshire, Telford and Wrekin are one of the few that do – they state that reconfiguration of two hospitals and a closure of one of the emergency departments requires £311 million. The majority of STPs highlight the reconfiguration of hospital services as an area that will deliver significant savings, which appears to be the main driver for these changes. Connected to this, many detail expected reductions in activity levels (eg North Central London estimates up to 150,000 fewer emergency department attendances, 63,000 fewer non-elective admissions and 35,000 fewer outpatient attendances). Some STPs do outline additional rationales for change, including reducing variation (often citing Right Care data) and, in the case of midwife-led maternity units, increased patient choice.

What is the BMA view?

The BMA does not have policy on how particular clinical pathways should look, or how hospitals should work together to provide services. However, we are clear that the focus should be on forming inter-organisational partnerships, rather than mergers. Mergers do not guarantee savings, are disruptive and unlikely to achieve greater collaboration between staff or coordination of care for patients.

We believe that all proposals for change should be realistic, evidenced-based and clinically led. They should prioritise patient care and not savings. Many of the STP proposals for reconfiguring secondary care are therefore concerning, given their focus is on savings and evidence suggests that shifting care into the community does not save money.⁹

Moreover, unless appropriate capacity is developed in community settings, the planned reductions in activity levels will simply not be achievable. It is imperative that this capacity is developed before existing hospital capacity is reduced, which will inevitably mean some double-running costs to allow new services in the community to reach a safe level. It does not seem like this has been built into the financial plans of most STPs.

See [Appendix 1](#) for a more comprehensive list of all proposals to close hospitals or services or reduce bed numbers.

9 Nuffield Trust (2017) *Shifting the balance of care – great expectations*. London: Nuffield Trust.

Theme 4: New care models – accountable care, MCPs and PACS

Many STPs are planning to develop one or more new care models, drawing on the MCP (multispecialty community provider) and PACS (primary and acute care systems) models described in the 5YFV (Five Year Forward View) and currently being piloted by 50 vanguard sites.

Most STPs are planning to implement new models of care, building on the MCP model

The direction of travel in the STPs is strongly aligned with national policy on new care models. This is perhaps unsurprising, as one of the purposes of STPs was to set out how local areas were going to implement the 5YFV, of which the new care models were a significant part. The lack of detail in the plans makes it hard to judge how areas will implement the models (eg whether the new providers will take on responsibility for the whole health budget for their population).

STPs that contain existing vanguards are looking to build on progress made so far and, in areas such as The Black Country, roll the models out across the STP's whole population. These STPs often have more advanced plans for new models of care. For example Leicester, Leicestershire and Rutland set out in detail how they will build on their MCP vanguard, describing a model of primary care underpinned by integrated teams, with lists of 'concrete actions' and supporting data analysis. Some have even specified how models will be implemented differently across the localities within their STP. Others are far less detailed, with intentions to develop STP-wide and locality plans over the coming year.

Across all STPs there is a range of terminology used. Some of those, such as Worcestershire and Herefordshire, refer explicitly to developing an MCP model; others, such as Suffolk and North East Essex, discuss establishing accountable care organisations or systems. Others talk of accountable alliances, integrated care organisations or communities. These labels sometimes mask a lack of clarity, and it is likely that STPs have different interpretations or intentions when using particular terminology (eg in terms of contractual and budgetary arrangements). For example, Hertfordshire and Essex cites an 'accountable care partnership' which 'includes elements of both the MCP and PACS models of care and will inform the future ambition of an Accountable Care Organisation (ACO)'. It is unclear what exactly this will mean in practice.

While the labels vary, there is similarity in much of the thinking around new care models. A common theme is delivering population or place-based care. Most plans describe the different communities of care that their STP covers, often in terms of hubs, neighbourhoods or localities. This community based care will in most cases be built around general practice, linking very strongly with proposals for more at-scale provision and extended primary care teams (see the section on primary and community care).

Plans for integrating care are focused on care delivered in the community

One of the aims is to increase integration between primary and community care; with some also planning to improve integration more widely, for example with social care and mental health, but this is often a longer-term aim. Beyond existing PACS sites, there are no plans at present to fully integrate secondary care with primary and community services. However, almost all STPs do seek to shift care from hospitals into the community (in line with the planned closure of hospital beds, described in the previous section).

Some plans are proposing to move a significant volume of care into the community: for example Derbyshire plans to deliver an additional £247 million worth of care in the community by 2020/21. However, this is more frequently described in terms of planned reductions to hospital care (eg Dorset). Others, such as Somerset, simply state an intention to move more care into the community, without quantifying the scale of ambition.

Lack of funding cast doubts over whether new care models will deliver what is promised

Given the volume of care STPs are intending to move out of hospitals, the amount of savings predicted and the level of transformation funding required, it is very unlikely that STPs will be able to deliver on their proposals. Especially as the context is one of increasing demand for hospital services and funding shortages. And, as recent [research](#) has found, the evidence does not suggest that shifting care into the community generates savings (in contrast Sussex and East Surrey suggest £296.4 million will be saved).

It is too early for the impact of vanguards to have been fully evaluated, and while these sites can share their learning across STPs, it must be remembered that they received generous levels of investment. Most plans acknowledge the funding situation within their 'key risks', and some are explicit that their plans rely on the early release of transformation funding (eg Frimley Health has asked for £20 million in addition to previously agreed sustainability and transformation funding). This again calls into serious question how realistic the proposals are given that this funding is unlikely to be made available.

What is the BMA view?

The BMA has been calling for greater integration and collaboration between different parts of the health service, and health and social care for a number of years. We believe plans for new models of care should: be consulted on fully, be clinically-led and evidence-based; ensure collaboration between different sectors; create inter-organisational partnerships, rather than mergers; and focus on delivering services in a given area, rather than competing with providers outside of the locality.

Our general concerns with STPs apply equally to new care models: there has been insufficient clinical engagement, the plans lack detail and credible funding, and the intended savings are unrealistic and should not be prioritised over patient care. With the new care models there is also a risk that the focus on structures detracts from efforts to deliver more integrated care for patients. In addition, the limited involvement of local authorities in developing the plans does not suggest a genuine intention to collaborate with all sectors of the health and care system.

Theme 5: Mental health

On mental health STPs make the right noises but are largely aspirational

There is broad recognition across all STPs of the need to improve mental health care and the experiences of patients using mental health services. In particular, addressing high levels of unmet need; achieving parity between physical and mental health; improving the way services link up to meet the holistic needs of patients; and shifting towards appropriate care in the community.

Some STPs consider mental health throughout their plan (eg Bath and North East Somerset, Swindon and Wiltshire), whereas others have action on mental health as a specific priority area in itself (eg North West London, West Yorkshire and Harrogate.)

Most of the commitments on mental health in STPs match the Mental Health Five Year Forward View, so are appropriate, evidenced-based actions, such as commissioning for prevention and providing good quality for all seven days a week. It is difficult to assess how realistic the high-level commitments (eg around integrating services) are in the absence of detailed plans. Some STPs talk about specific models of care (such as Bath and North East Somerset, Swindon and Wiltshire and Kent and Medway) but these seem aspirational. Plans do not clearly demonstrate how better mental health outcomes will be achieved or how the model of care proposed will be implemented.

In addition, the plans do not consistently acknowledge specific commitments around crisis care and severe mental illness, provision of perinatal services, development of liaison services, and access to psychological therapies (IAPT).

The level of detail on mental health improvements varies between plans

Overall the level of detail about what mental health transformation will look like varies between STPs. Some provide very limited detail, whereas others set out more specific commitments and timelines. For example, North West London want to implement a 'tier-free' approach to children's mental health, ensuring an additional 2,600 children receive support by 2020/21; Birmingham and Solihull want to eliminate out-of-area placements by 2018/19; and Hereford and Worcestershire want to increase access and availability of psychological therapy to 25% by 2020/21.

Hampshire and the Isle of Wight have a specific initiative to have a 'Mental Health Alliance' across their four mental health trusts, commissioners, local authorities, third sector and service users, working together to deliver a shared model of care with standardised pathways. There is a commitment to commission services on an Alliance-wide basis by the end of 2016/17, initially focussing on out-of-area placements and crisis response. In 2017/18, they aim to develop a local recovery-based solution replacing high cost out-of-area residential long-term rehabilitation.

Very few commit to ring-fencing funding for mental health

The majority of plans do not discuss any funding being ring-fenced for mental health, although there are some exceptions. The Black Country and South West London highlight capital funding commitments; Hereford and Worcestershire highlight a 23% increase in investment for mental health and learning disability services; Cambridgeshire and Peterborough refer to a £21.3 million investment to deliver a mental health taskforce; although it is not always clear where this funding will come from.

A few of the plans mention specific savings related to the changes to mental health services. Hampshire and the Isle of Wight discuss savings of £28 million by 2020/21; whereas Kent and Medway estimate £20 million savings by 2020/21.

What is the BMA view?

The BMA have been calling for parity of esteem between physical and mental health for a long time, and welcomed the Mental Health Five Year Forward View when it was published. Therefore we were pleased to see that the STP commitments are in line with our objectives. We have expressed concerns previously around how national commitments are being delivered (eg whether new funding for mental health is reaching the frontline) and the lack of detail in the STPs offers little reassurance. We would expect more detail on exactly how the STP commitments on mental health will be delivered locally.

Another positive is that some of the STPs recognise the link between mental health and social determinants of health (such as housing and employment). This could be more consistently acknowledged and considered across all the plans. A good example is that one of Norfolk and Waveney's priority projects is implementing 'community hubs' for referral pathways to housing and welfare advice, mental health, healthy lifestyles, alcohol intake, falls prevention, financial and benefits advice, physical activity and befriending. The idea is that these will support outcomes for children and young people, working age adults and older people.

Theme 6: Urgent care

Across all STPs there is a move towards more integrated urgent care, bringing together NHS 111 and other services, with improved triage, clearer access for patients and increased clinical input.

NHS 111 will remain at the heart of urgent care, but there are moves to increase clinical input

NHS 111 remains the primary (and in some STPs, such as Birmingham and Solihull, the single) point of access for patients. However, a number of STPs are also planning to establish a clinical assessment service or hub, or have recently done so and are looking to build on this work across the footprint. For example, Lincolnshire set up a clinical assessment service in 2016, and their plan outlines how it will be developed over the next two years, with a shared IT portal and direct appointment booking (see below). These services will provide clinical advice to patients contacting NHS 111 (and potentially 999), and clinical support to other clinicians (eg paramedics). The West Midlands (crossing multiple STP boundaries) was the first to commission such a service in 2016; NHS England are currently gathering evidence on the impact to date of this, and other early sites.

Tentative steps towards greater integration of urgent care services are being made

Some STPs are clear about their intention to connect up the full breadth of urgent care services and establish data sharing. For example, North East London intends to implement a 24/7 integrated 111 urgent care service that also incorporates dental and pharmacy hubs and CAMHS (child and adolescent mental health services). Most plans do not detail the extent of integration with out-of-hours general practice services. Some have a high-level intention, eg Mid and South Essex will establish a 'clinical hub with a combined 111 and OOH service'. While others, such as Surrey Heartlands, highlight that both NHS 111 and OOH services will be re-procured in the coming year. The more developed STPs set out plans for NHS 111 to directly book GP out-of-hours appointments (eg Milton Keynes) and in some cases also in-hours appointments (eg Lincolnshire).

Urgent care centres are playing a more central role, although it is not always clear how they fit into the wider system

As described earlier a number of STPs propose downgrading emergency departments to urgent care or treatment centres. Some STPs (eg Birmingham and Solihull) describe the role of the centres as providing urgent primary care, diagnostics, pharmacy and/or minor procedures. It is often not explained how these centres fit into the wider urgent care system; however NHS England's recent document, Next Steps on the 5YFV, stated that it expects 150 standardised urgent treatment centres to be opened by Spring 2018. These centres will open 12 hours a day, seven days a week, with diagnostic facilities and integration into local urgent care services, including bookable appointments through NHS 111 and GP referral. Many are also planning to introduce streaming, often using GPs, into emergency departments, something which NHS England now requires all hospitals to do by winter 2017.

As in other areas, there is often a lack of detail in most plans and workforce concerns remain

The level of detail varies between STPs, with some clearly aligned with national policy on urgent care. The plans with the most detail tend to be areas that have already begun developing integrated urgent care systems and that are already working closely with NHS England through its integrated urgent care or urgent and emergency care work stream. Other areas only set out very high-level intentions, and in some cases state that work will be undertaken in the coming months to review urgent and emergency care or develop an operating model. Most plans are not detailed enough to assess how realistic they are (for example, how will the clinical advice service be staffed given workforce shortages?).

What is the BMA view?

The BMA is highly critical of NHS 111 in its current form, and remains concerned that it leads to increased pressure on GP and A&E services. We are therefore supportive of attempts to improve the system for the benefit of patients and clinicians alike. We support clinically informed and led triage systems, and welcome attempts to introduce more clinical input into NHS 111 at earlier opportunities. However, consideration does need to be given to the impact on the GP workforce, particularly in OOH services if GPs are needed to staff clinical advice services/hubs. Many OOH providers deliver high quality services and they must be involved in discussions as areas begin to plan and implement the changes discussed above. Similarly, we have some concerns about GP-led triage in A&E departments, given the ongoing pressures and workforce shortages within general practice.

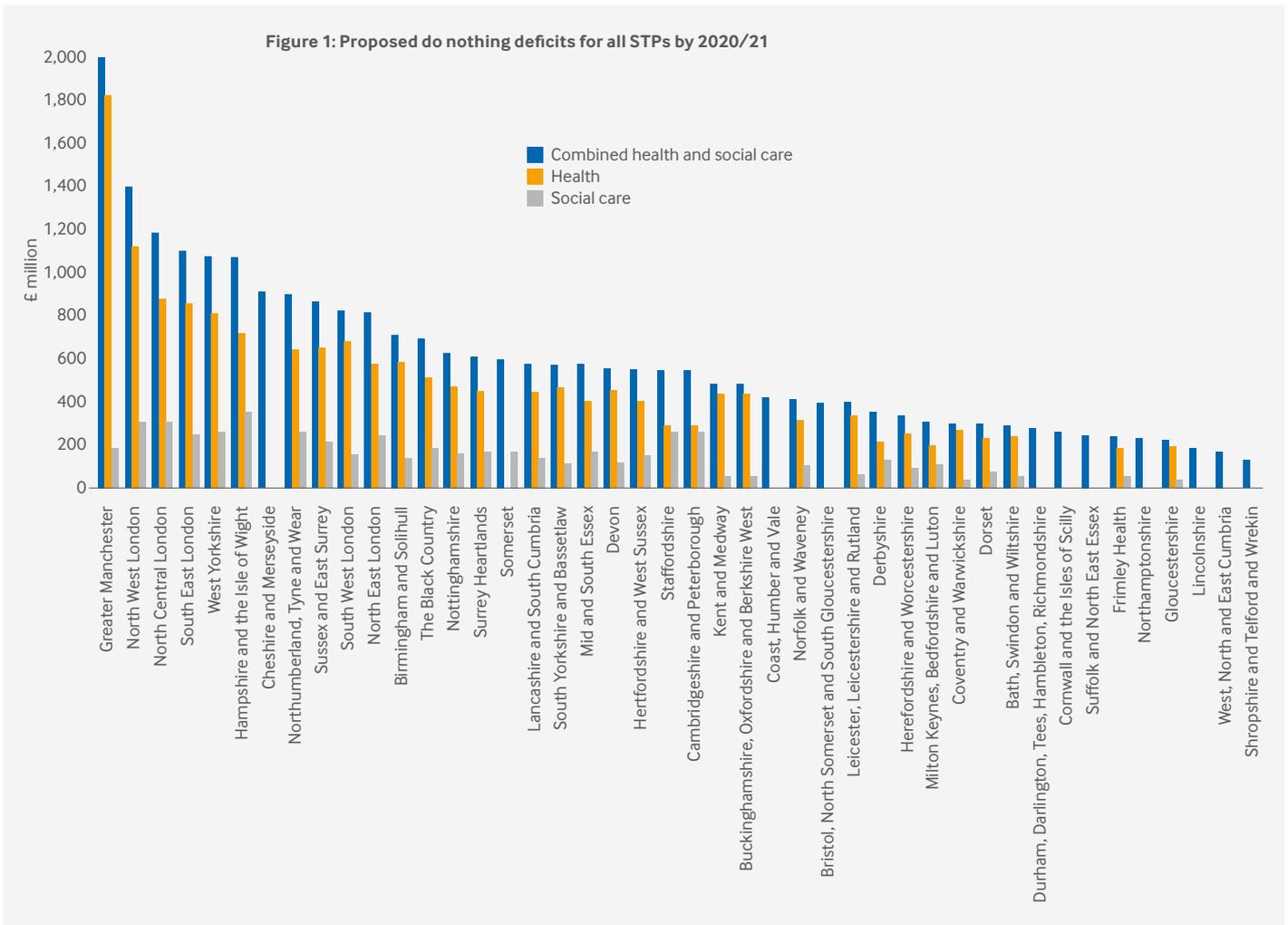
Theme 7: Funding

The majority of STPs have sizable 'do nothing deficits'

All STP footprint areas were told to detail the funding they thought they would need by 2020/21 compared to how much they will have, setting out the amount of overspend if they do not put any changes in place ('do nothing deficits'). Combining health and social care, across all 44 STPs these deficits add up to £26 billion – ranging from £131 million for Shropshire, Telford and Wrekin STP to as much as £2 billion for Greater Manchester. STPs in London have also reported high deficits: North West London – £1.4 billion; North Central London – £1.18 billion; and South East London – £1.1 billion.

In the majority of cases healthcare forms a large part of these deficits. However, there are some cases where the social care deficits are equally concerning. For example, Staffordshire STP reports a healthcare deficit of £286 million and a social care deficit of £256 million. Similarly, Derbyshire STP reports a healthcare deficit of £219 million and a social care deficit of £136 million. STPs are primarily focussed on resolving issues within the NHS, however, this will be almost impossible to do in areas where there are also significant gaps in social care funding.

This can be seen in Greater Manchester, which is more advanced than most other STP areas. The Greater Manchester Health and Social Care Partnership wrote to the Government and NHS England to highlight the fact that challenges around social care funding will 'gnaw away' at their ability to develop their sustainable funding platform over the next five years. They were clear that the predicted social care funding gap of £176 million over the next five years could impact their vision of integrating social care with mental health and physical health care.¹⁰



10 <http://www.nationalhealthexecutive.com/Integrated-Care-Social-Care/social-care-cuts-will-gnaw-away-at-gm-integration-plans>

Savings proposed are unrealistic at best

The majority of the footprint areas include some details about the savings they propose. How these savings are made varies and it is not always clear how they will be achieved. Some of the biggest savings are just reported as 'business as usual' or provider/ commissioner efficiencies. For example, South West London STP reports savings of £371 million through business as usual, Northumberland, Tyne and Wear STP report savings of £241 million through provider efficiencies and £105 million through commissioner efficiencies and Bristol, North Somerset and South Gloucestershire report £104.4 million as simply 'unidentified savings' (see appendix 2).

Given the NHS's history of missing overly-optimistic efficiency targets it is unlikely that these predicted savings will be achieved. For example, trusts delivered annual savings of 1.4% on average between 2008/9 and 2013/14. This was against an unrealistic target of 4%.¹¹

Another area where several plans are predicting to make savings is from moving care out of hospital and into the community. Together the plans that have explicitly given this level of detail suggest that at least £464 million will be saved by 2020/21 by moving care out of hospital and into the community. However, as discussed earlier, there is little evidence to show that moving care into the community actually makes savings.¹² Moreover, community and primary care services, which are both already under intense pressure, will not be able to take on additional care without equivalent additional resourcing.

Other common areas where savings are predicted to be made are through preventative care (at least £423 million) and through NHS RightCare (at least £409 million) (see appendix 2).

More investment than is available needed to implement plans

In order to put changes in place and deliver projects within the plans funding is required. More than half of the STP footprint areas have reported that they will need more than £100 million of upfront funding to make the changes, with some including Greater Manchester, Cambridgeshire, and Peterborough and West Yorkshire reportedly needing more than £500 million.

BMA News acquired the figures for the projected capital needs of 36 of the 44 footprint areas, which totalled £9.5 billion.¹³ Capital requirements ranged from £800 million for Cambridgeshire and Peterborough and £755 million for Cheshire and Merseyside, to £20 million for Staffordshire and Suffolk. However, it is very unlikely that this money will be available. In the Spending Review the Department of Health was given an annual capital allocation of just £4.8 billion from 2016/17 to 2020/21 and the majority of this money is expected to go towards filling large provider deficits. Since the Spending Review, the Spring Budget announced an additional £325 million for capital proposals in STPs over the next three years, but seeing as Shropshire, Telford and Wrekin alone state that the reconfiguration of two hospitals and a closure of one of their emergency departments requires £311 million this is unlikely to go very far.

A number of STPs include their share of the STF (Sustainability and Transformation Fund) in their plans to fill their financial gaps. For example, Northumberland, Tyne and Wear STP report using 48% of their STF on sustainability and only 10.8% on transformation. The remaining 41.1% will be invested in services. This is concerning, as if the STF is being used mainly for sustainability purposes and plugging deficits, less funding will be available for transformation. It is vital that upfront transformation funding is provided to enable services to address long term challenges or to have any chance of realising the visions put forward in the STPs.

11 NHS Providers (2016) *The state of the provider sector*.

12 The Health Foundation (2011) *Getting out of hospital? The evidence for shifting acute inpatient and day case services from hospitals into the community*.

13 <https://www.bma.org.uk/news/2017/february/nhs-needs-9-5-to-transform>

Several STPs consider how they could use their estates more effectively to release money for reinvestment in the service. The Naylor Review, published in April 2017, identified £2.7 billion in capital receipts from inefficiently used land but specified that it does not think these will be achieved without incentives for providers.¹⁴ The report is also very clear that the money from these sales must stay within the local area.

There is a real risk, acknowledged in several STPs, that the NHS will end up going to the private sector to get the necessary funding. In April 2017, it was reported that the NHS was in talks with hedge funds about borrowing up to £10 billion. There is little detail about this as yet but given the destructive impact of PFI (private finance initiatives) loans and the fact that the NHS is still paying £2 billion a year under these deals, it is extremely concerning.¹⁵

Few STPs commit to investing specific amounts into GP

General practice funding should be a key feature in all 44 STPs. For example, Coast, Humber and Vale STP stated that:

“GPs are the cornerstone of our health and care system and we are delighted that a significant amount of additional investment will be allocated to our local practices in line with the GP Forward View. This takes the total expenditure in primary care to 10% of the overall STP resource.”

However, some plans lack commitment to investment in general practice. For example, the GPFV (General Practice Forward View) is not mentioned at all in five STPs, namely Bedfordshire, Luton and Milton Keynes; Cornwall and Scilly; North Central London; Shropshire and Telford and Wrekin; and West North and East Cumbria. Those STPs that have stipulated specific funding for the delivery of the GPFV include:¹⁶

STP	GPFV investment
Suffolk and North East Essex	£72.6 million for the GPFV and extended GP access, with money released each year
Sussex and East Surrey	£51 million to deliver the GPFV
Cambridgeshire and Peterborough	£37.9 million for the GPFV and extended GP access, with money released each year
Surrey Heartlands	£34 million non-recurrent investment in the GPFV and delivering the out-of-hospital strategy.
North West London	£30 million for the GPFV and extended GP access, with money released each year
Buckinghamshire, Oxfordshire and Berkshire West	£28.9 million for the GPFV and extended GP access, with money released each year
Leicester, Leicestershire and Rutland	£18 million for the GPFV and extended GP access, with money released each year
Hereford and Worcestershire	£7.5 million a year in 2020/21 from Sustainability and Transformation Funding, and smaller (but undefined) figures in the three preceding years.

If the projected savings are not made each year funding for general practice may be even more at risk, as historically funding intended for general practice has been used to bail out struggling hospitals when funding is tight.

14 An independent report by Sir Robert Naylor for the Secretary of State for Health (2017). *NHS Property and Estates. Why the estate matters for patients.*

15 Chris Smyth, The Times (2017). *NHS seeks £10bn cash boost from hedge funds.*

16 Royal College of General Practitioners (2017). *GP Forward View Interim Assessment.*

In addition, some national guidance and recommendations for general practice are either not referenced in some of the plans or it is not clear how they will address them. For example, the GPFV stated that CCGs should spend £3 per head in 2017/18 and 2018/19 from their existing allocations for practice transformational support. However, many of the STPs do not include this in their plans; Northumberland, Tyne and Wear STP even state that this funding has 'yet to be secured'. Similarly, NHS England recommended that 15-20% of the Sustainability and Transformation Fund should go to general practice. This is rarely mentioned in the plans and very few STPs go into any details to explain how they will use this funding to improve general practice services.

What is the BMA's view?

Overall, the financial aspect of STPs is one of the most concerning. The sheer scale of the 'do nothing deficits' in certain areas shows how big the challenge is for some STPs. Our concern is that this immense pressure on budgets will simply end up with a reduction in services available for patients.

The lack of detail and variability in how savings will be made is also concerning. The fact that often the largest amount is predicted to come from 'business as usual' or 'provider/commissioner efficiencies' is questionable given the NHS's unreliable record of meeting unrealistic efficiency targets. Moreover, there is little evidence to show that moving care into the community actually makes savings¹⁷ and, even if it did, community and primary care services will not be able to take on this additional care without equivalent additional resourcing and time to set up services safely.

Moreover, it doesn't appear that the upfront funding necessary to transform services is available. The references in STPs to the STF imply that it will be used mainly for sustainability purposes and plugging deficits, meaning less money is available for transformation. It is vital that upfront transformation funding is provided to enable services to address long term challenges or to have any chance of realising the visions put forward in the STPs. There is a similar picture for capital funding despite the fact that together the 44 STPs have asked for over £9.5 billion in capital funding to make the necessary changes.

The short time-scale that savings are expected to be achieved in and the lack of funding available to make transformation happen make the overall success of STPs highly unlikely. See [Appendix 2](#) for more details about the savings proposed in individual plans.

17 The Health Foundation (2011) *Getting out of hospital? The evidence for shifting acute inpatient and day case services from hospitals into the community.*

Theme 8: Workforce

STPs present a broad overview of the workforce priorities that they believe will enable system transformation within each footprint. In general, they lay out a vision for an integrated, multidisciplinary and sustainable workforce. STPs are aiming for a workforce that increases the skills mix, reduces spending on agency staff, and introduces new professional roles to deliver care across the whole health system.

While there is variation in the level of detail across the plans, most appear to track national policy in the area of workforce planning and development to support system transformation. Some, but not all STPs, include funding estimates for workforce initiatives.

STPs are undertaking workforce planning for their footprint

Most STP areas are gathering data to establish baseline workforce across their footprint and are developing both short and long-term workforce strategies. Most STPs provide high level objectives while others describe more detailed activities which may reflect how far along they are. For example, Lincolnshire has adopted the Strategic Workforce Integrated Planning and Evaluation (SWiPe)¹⁸ framework for strategic workforce planning. It is perhaps the most advanced STP area in its use of the tool and the STP submission reflects this with its inclusion of baseline workforce data and modelling of future workforce requirements.

Workforce shortages are often identified by STPs as a major challenge, particularly in psychiatry, emergency medicine and general practice. Many plans also identify pharmacy, community services and social care as problematic. While many STPs envisage increasing certain sectors of the workforce, some STPs envisage a reduction in the overall workforce by removing current vacancies. For example, Northumberland, Tyne and Wear plan to see an overall reduction of 1,671 whole time equivalent staff.

Challenges around an ageing workforce are also highlighted in some STPs where a significant proportion of the workforce is aged 55 and over, such as in The Black Country where an ageing workforce exists across the whole system (15% of staff in healthcare, 17% in social care and 11% in primary care are aged 55+).

Improving recruitment and retention is an aim of most STPs

Most, if not all STPs cite major challenges with recruitment and retention across services. To address these challenges, some STPs recommend solutions while others are still developing short and long-term strategies. Buckinghamshire, Oxfordshire and Berkshire West, for example, seek to “improve [the] workforce offer and increase staff retention by working with trusts and Health Education England to improve recruitment, standardise terms and conditions and offer employees interesting rotational opportunities.” Others highlight the need to reduce workload in general practice as a necessary strategy for improving recruitment and retention.

New professional roles are seen as a way of increasing workforce skills mix

The introduction of new clinical roles features in most plans as a way to encourage a more diverse skill mix, reduce workload, address the shortage of skills within the existing workforce and underpin new models of care. New roles being developed include Physician Associates, Nursing Associates and Advanced Clinical Practitioners.

Increasing apprenticeships also features in many of the STPs. In Cambridgeshire, providers are working with HEE to develop roles that begin at apprenticeship level and take individuals all the way through to registrant or advanced practitioner level.

18 The SWiPe framework, developed by the Whole Systems Partnership, is a strategic planning tool, being adopted in a number of locations that provides “models that help local partners to explore workforce transformation priorities for recruitment, development or the shift between hospital and community.” For more information, visit: <http://www.thewholesystem.co.uk/workforce-modelling/>

There is generally little mentioned about funding needed to develop these roles, however the government have introduced an apprenticeship levy¹⁹ which will apply in many cases. Some STPs are further along than others in their development of new roles, as some are at the stage of working with HEE to develop career pathways. Plans generally align with national policy on the development of the new clinical roles and to increase apprenticeships across the public sector. However, the BMA has concerns about the introduction of some roles, including physician associates, as they are not professionally regulated.

Focus on improving staff health and wellbeing

STPs focus on prevention, self-care and the health and wellbeing of the population and the workforce. There is a running theme throughout most plans, that the workforce must be upskilled to provide health coaching and promote healthy living at every opportunity. There is particular focus on changing workforce culture to promote prevention and self-care and in turn improve workplace health and reduce staff sickness. Greater Manchester is working with HEE to upskill and train the workforce in these key areas.

Improved digital infrastructure aims to improve workforce productivity

Most plans include objectives around creating a digitally enabled health and care system with access to electronic health records, a paper free system and investment into the current infrastructure to encourage a technologically enabled workforce.

Plans align with national policy and most incorporate their local digital roadmap (LDR). Plans state that resources are required to deliver the digital change set out, however there are few who mention how much will be needed and where the funding will come from.

What is the BMA's view?

The BMA has long argued that effective workforce planning must be carried out at a national level based on good quality data. While we are encouraged that STPs are undertaking baseline mapping of workforce trends and gaps locally, we are concerned that complete devolution of planning will further exacerbate variations in care and access to services across the country. Workforce planning and development must take into account changing patient demographics and needs. We are encouraged that some STPs have recognised the implications of an ageing workforce.

We are pleased that STPs recognise the dire state of recruitment and retention across services as a major challenge for the NHS. Current staffing levels and the number of new doctors coming into the profession and moving through training are not sufficient to meet rising demand. Steps need to be taken to address shortfalls and improve conditions so that medicine remains an attractive career and the NHS is able to attract and retain talent. We welcome that some STPs seek to address workload and support innovation, but overall STPs provide few details on how they plan to improve morale, recruitment and retention.

¹⁹ For employers with an annual pay bill of over £3 million each year, an apprenticeship levy of 0.5% of the employer's annual wage bill is applied. For more information, visit: <https://www.gov.uk/government/publications/apprenticeship-levy-how-it-will-work/apprenticeship-levy-how-it-will-work>

Theme 9: Commissioning

Overall, there is a move towards more integrated, collaborative commissioning across current organisational boundaries.

As care delivery is becoming more integrated, so is commissioning

Some STPs (eg Greater Manchester, Birmingham and Solihull) are already on the path to merge several CCGs and have one commissioning body across the area. Greater Manchester is also intending to form a single commissioning organisation with Manchester City Council, although they recognise the governance and legislative barriers for this at the current time.

Most STPs are not at this stage, but some have put in place joint management teams (eg North Central London, South West London) and others are looking at using collaborative commissioning boards or joint committees to make decisions across an area (eg Lancashire and South Cumbria, West Yorkshire). There is generally a balance to be struck between planning some services at scale to ensure consistent quality, and others at a local level to meet the needs of the community.

Some areas recognise that they can learn from other areas that are further ahead or are still producing options appraisals for potential future models. South East London is clear that there will not be a single commissioning model, but that the plan will enable CCGs to adopt what suits their population. Where co-commissioning is not already happening there are intentions to move towards this, as well as delegated specialised services commissioning.

Integration in commissioning is generally seen as corresponding to more integrated delivery structures, and so will be accompanied by a move to commissioning based on capitated budgets with a focus on outcomes rather than outputs including a risk/gain share model. Some areas see this as a move towards a full ACO. This is also expected to reduce the transactional activity necessary at individual provider and commissioner level and, subsequently, will require a review of the skills and capabilities needed from staff at CCGs. There is an expectation that some functions previously managed by CCGs will be contracted out to providers.

With the increasing use of clinical networks for specialised services across an area, there are similar intentions to develop STP-wide commissioning for acute and some specialised services. For example, The Black Country have set out a timeline to procure a single acute and single mental health contract across the footprint as part of plans to establish a STP-wide ACO. There is a general intention to work closely with NHS England on specialised commissioning as well as with the regulators on reducing the burden of service assurance.

Integration between health and social care commissioning is a longer term ambition

Integrating health and social care commissioning is seen as a goal for several STPs, with varying levels of commitment. Some plans talk about pooling health and care budgets (eg West, North and East Cumbria; Greater Manchester have committed to pool £2.7 billion), or moving to a single commissioning arrangement between CCGs and local authorities (West Yorkshire). Some areas are clear however that they only want to integrate commissioning functions where it makes sense to do so (eg Durham, Darlington, Tees, Hambleton, Richmondshire and Whitby).

Funding pressures impact STP commissioning plans

Most STPs reference using Right Care data as a way to make savings, with the assumption being that it will mean some form of referral or medicines management. This is likely to include decisions to disinvest in procedures of “low clinical value” (eg Lincolnshire, Birmingham and Solihull). There are also plans to ensure that thresholds for withholding treatment are consistent across an area (eg Hertfordshire and West Essex). Given the savings proposed from these plans this is likely to mean a raise in thresholds in areas where they are lower.

What is the BMA view?

The BMA welcomes the principle of greater integration and collaboration between health and care services. This needs to happen through a genuine partnership approach and we believe can be successfully achieved without large scale structural integration or expensive reorganisations or mergers of health systems. The BMA has been clear that the integration of health and social care must not mean health spend being diverted to cover shortfalls in other areas.

We have always opposed the commercialisation of the NHS and centrality of the internal market. Therefore, we support the move towards more collaborative ways of commissioning as described in most STPs. However, it is unclear how these proposals fit with current legislation, such as the Health and Social Care Act 2012, which still encourages competition and mandates for a competitive tender process. Effective oversight by national regulatory bodies will, if anything, become more important if providers take on responsibilities for the planning and management of services.

The BMA has been and remains clear that the current payment system in England (the national tariff) is not fit for purpose and does not support integrated working around the needs of patients. Payment reforms focused on capitation may help to achieve closer working between different parts of the health service.

The effects of funding pressures on commissioning are equally concerning, for example CCGs or STPs taking different approaches to prescribing or implementing referring restrictions. This can lead to confusion and irritation for patients and potentially dangerous pressure to repeatedly change branded generics and implement varying restrictions on particular procedures. Rather than tinkering with the system there needs to be a fundamental review so that all patients are treated fairly, no matter where they live. Decisions on patient care should be based on individual clinical need and following royal college or other evidence-based standards.

Similarly, the development of care plans that are tailored to the needs of an area must not lead to a move away from the concept of a national health service.

Theme 10: Consultation and engagement

A lot of the publicity around STPs has been focused on their lack of engagement with both the general public and NHS staff members. Most plans recognise this and are very clear that these are only draft plans (eg Milton Keynes, Bedfordshire and Luton accept that to date clinical engagement has been “relatively light touch”).

After a rocky start most STPs now recognise the need for engagement on their plans

All STPs set out detailed plans for how they intend to increase their engagement going forward and some are explicit that no decisions will be made until thorough engagement has taken place. Where there was an earlier transformation programme the plans often refer to the engagement that took place for that as relevant to the STP (eg Lincolnshire through their Lincolnshire Health and Care programme, or The Black Country on Midland Metropolitan Hospital).

Almost all STPs have an email address on their webpage for feedback on their plan. There is generally discussion in the plans about holding engagement events with the public, local councils, workforce and volunteer organisations. The details about these events are on the STP’s relevant website. Healthwatch is often mentioned as a partner for engagement and several plans have representatives from Healthwatch on their board. Herefordshire and Worcestershire include the views of both Healthwatch organisations in their area within their plan, for example. Similarly, some plans mention the fact that Health and Wellbeing Boards are considering their STP through their scrutiny process (Birmingham and Solihull).

Engagement with local authorities seems to have been mixed. In some areas (eg Norfolk and Waveney, Greater Manchester, Birmingham and Solihull) the local authority chair is leading the plan, whereas in others, councils have raised concerns about the transparency of the process and how much the local authority had been involved (eg Durham, Darlington, Tees, Hambleton, Richmondshire & Whitby).

Clinical leadership is on the up, but greater staff engagement on workforce issues is needed

All plans emphasise the importance of clinical engagement and the fact that clinical views are at the heart of the plans. Work streams are generally given clinical leads and a significant majority of plans have some form of clinical engagement or reference group who can give advice to the board, as well as clinical representatives who sit on the board. However, there seems to have been a lack of wider clinical engagement and this is something that will need to improve if plans are going to have a chance of success.

There is sometimes an expectation on each partner to lead the engagement within their organisation, which does not appear to have happened in most areas. Greater Manchester are further ahead than most areas on this and have set up provider advisory boards for both primary and secondary care to make sure that clinical input is central to the plans. Several STPs plan to include LMCs or local GP federations in their list of organisations to engage with, which is encouraging. However it is important that this happens consistently across the country. It is also crucial that clinical engagement is cross branch of practice, and given the focus on developing primary and community care, GPs need to be central to the development of plans.

Some STPs mention that engagement on workforce issues will be through LWABs (local workforce action boards). It is not yet clear how LWABs will engage with staff side representatives but it is important LWABs, STPs and NHS trade unions are communicating with each other to ensure better engagement on workforce issues. Very few plans specifically mention engaging with unions, although Cambridgeshire and Peterborough state that the route for this is through the regional SPF (social partnership group).

Service changes will be formally consulted on, but it is unclear how disagreements will be solved

All plans are clear that any significant service change, such as acute reconfiguration, will require a formal consultation process. In some plans there are timelines for when they expect these to take place, but these have often been missed. Some areas have started consulting already. For example, in Herefordshire and Worcestershire consultations are open on proposals for reducing the availability of prescriptions and assisted contraception treatment, on the future of acute hospital services in Worcestershire and the delivery of high quality GP services in Hereford City. See Appendix 3 for all past or current consultations.

There is a lack of clarity around what happens if organisations involved with the plans disagree. It is not clear whether all STPs will take the approach of Birmingham and Solihull STP where all organisations retain sovereignty over decisions.

What is the BMA view?

The BMA has been clear for some time that clinical and public engagement in the plans has not been good enough. The plans could have offered a much-needed opportunity to transform care and deliver services more suited to their local area. However, any successful transformation needs to be clinically led and involve full consultation with the relevant stakeholders in both primary and secondary care. The lack of engagement in the development of the plans thus means many STPs are now facing an almost impossible task.

It is therefore encouraging to see that plans are recognising that they have not got this right so far, and that there is still opportunity to change the content of the plans based on further engagement. Yet the unrealistic timelines in which STPs are supposed to have started seeing results undermines these statements. More transparency in the development of the plans is needed, including more honesty around what is realistic in terms of timelines.

Engagement on workforce issues is extremely important, and has been lacking so far in some areas. STPs need to be engaging with staff side representatives through both existing structures (eg regional SPFs, LNCs (local negotiating committees) and any new structures set up (eg LWABs).

See [Appendix 3](#) for a list of all current consultations.

Appendix 1: List of closures

This appendix lists any potential closures of hospitals, A&E units or bed reductions proposed in STPs.

Closing hospitals

- **Birmingham & Solihull:** merger of the Heart of England Trust with University Hospitals Birmingham announced in September 2016, potential savings have been included in the plan.
- **Buckinghamshire, Oxfordshire and Berkshire West:** there will be a review of Berkshire West community hospital provision.
- **Cheshire & Merseyside:** merger of Royal Liverpool, Aintree and Liverpool Women’s Hospitals (predates the STP).
- **Cornwall & the Isles of Scilly:** likely that some community hospitals will close: “The number and condition of our community hospital estate is not sustainable. The small scale of some sites is not economically viable going forwards.”
- **Coventry & Warwickshire:** plans to consolidate services with one hyper acute stroke unit and additional rehabilitation beds across the other providers; land and site utilisation for University Hospitals Coventry and Warwickshire Foundation Trust, South Warwickshire Foundation Trust and George Eliot Hospital NHS Trust will be reviewed for potential reconfiguration.
- **Dorset:** currently have 13 community hospitals – proposing moving to 12 sites: seven community hubs with beds and five without beds.
- **Kent and the Medway:** East Kent have developed a number of options for how to reconfigure acute services, which are currently delivered over three hospital sites. Options include closing one site, and moving to a single site only option.
- **Leicester, Leicestershire & Rutland:** consolidating care on two hospital sites (the Leicester Royal Infirmary and the Glenfield) from three current sites.
- **North West London:** reducing the number of acute sites from nine to five.
- **Nottinghamshire:** there is a proposed merger of Nottingham University Trust and Sherwood Forest Trust, which has been delayed until later this year.
- **South West London:** modelling proposes reducing five acute sites to four.
- **Staffordshire:** community hospitals at Bradwell and Cheadle to be closed to new patients. Consultation will also open on the closure of Longton Cottage Hospital and Leek Moorlands Community Hospital.
- **The Black Country:** a consultation is taking place regarding the proposed closure of one learning disability assessment and treatment hospital.
- **West, North & East Cumbria:** number of inpatient sites with community beds will be reduced from nine to six.

A&E closures/downgrades

- **Cheshire & Merseyside:** three models for A&E delivery are being considered across the three trusts (Southport and Ormskirk Hospital Trust; St Helens & Knowsley Teaching Hospitals Trust; and Warrington and Halton Hospitals FT) which are set out below. HSJ report that Southport and Warrington are the ones most at risk of being downgraded.
 1. Three trusts will have a Type I – 24hr A&E, but with new models of staff rotas and working patterns
 2. Three trusts will have a 24hr A&E, but high acuity patients will be transferred to one central emergency centre
 3. One trust will have a Type I – 24hr A&E, two trusts will re-profile opening hours with activity flowing to other 24/7 centres

The STP suggests that downgrading the emergency department at Macclesfield is an option; however, local healthcare leaders have subsequently [denied](#) this is the case.

- **Coventry & Warwickshire:** possible A&E reconfiguration. The STP sets out plans to “right sizing urgent and emergency care capacity” and looks at how to address the “*current national shortages in the U&EC workforce*”. It also says it will “*review sustainability of the current urgent and emergency care system, including the review of access points at George Eliot Hospital (GEH) and University Hospital Coventry and Warwickshire Trust*”. The STP said no plans for a single A&E across patch had been discussed, and no decision had been made on the future of GEH A&E.
- **Devon:** urgent and emergency services have been prioritised for review, focusing particularly on the acute hospital provision of accident and emergency and co-dependent services.
- **Dorset:** proposals to reorganise acute hospital services by establishing one major emergency hospital and one major planned care hospital, either at Poole or Bournemouth. The site chosen as the planned care hospital will have its A&E downgraded to an urgent care centre. The third hospital in the area (Dorset County) will remain a planned and emergency hospital.
- **Durham, Darlington, Tees, Hambleton and Whitby:** consolidating acute emergency care services into two hospitals for the region: James Cook University Hospital in Middlesbrough and either the Darlington Memorial Hospital or University Hospital of North Tees in Stockton on Tees. The hospitals will provide A&E – with James Cook offering a 24 hour consultant service and the other a 16 hour consultant service. The hospital not chosen is likely to have their A&E closed and will provide day case and outpatient elective care, urgent care services, a frail assessments unit, short stay paediatrics, specialist elective care.
- **Herefordshire & Worcestershire:** plans to reduce physical access points to emergency care, but retain three A&E sites. Alexandra Hospital in Redditch is being downgraded to an adult-only A&E with a new GP urgent care centre.
- **Kent & Medway:** East Kent is considering moving to one emergency hospital centre with specialist services and a trauma unit. This site will be supported by a further emergency hospital centre and a planned care hospital, supported by rehabilitation services and a primary care led urgent care centre. The area currently has three hospitals providing emergency care (with two A&Es).
- **Lincolnshire:** proposing the closure of Grantham A&E; overnight closure of Grantham A&E has been trialled, and has continued beyond the initial trial period due to a lack of staff. The Secretary of State for Health has ordered a review.
- **Mid & South Essex:** five different options are outlined for emergency care across the three acute hospitals in the STP. Options will be consulted on, but it is likely to result in A&Es at Mid Essex and Southend being downgraded.
- **North East London:** previously planned closure of King George Hospital emergency department in 2019/20, to become an urgent care centre.
- **North West London:** it has been proposed that Ealing Hospital and Charing Cross Hospital would become urgent care centres without 24/7 accident and emergency departments. Chelsea and Westminster Hospital, Hillingdon Hospital, Northwick Park Hospital, St Mary’s Hospital and West Middlesex Hospitals would retain full A&Es. However, the STP states that: “*There will be no substantial changes to A&E in Ealing or Hammersmith & Fulham, until such time as any reduced acute capacity has been adequately replaced by out of hospital provision to enable patient demand to be met.*”
- **Oxfordshire:** the emergency department at Horton Hospital, Banbury is under review, and will be consulted on, as it not considered sustainable.
- **Shropshire, Telford & Wrekin:** closure of emergency department at Telford or Shrewsbury Hospital following a reconfiguration of the two hospitals which make up the trust. Expected to consult on plans to move emergency services to Shrewsbury, with an urgent care centre at Telford.
- **Somerset:** review of the emergency care services provided within Somerset in the South West Emergency Care Network.
- **South West London:** proposes cutting five sites down to three or four. St George’s will not be downgraded, given that it is a major trauma centre, nor will Croydon. Epsom, St Helier and Kingston are therefore the three sites at risk of being downgraded.

- **Staffordshire:** proposes closure of one of the three emergency departments in the County (County Hospital, Royal Stoke or Burton Queens) and replace it with a 24 hour urgent care centre. No formal decision has been made.
- **The Black Country, Birmingham and Solihull:** the new Midland Metropolitan Hospital opens in October 2018. This new emergency department will replace the A&E services at Sandwell (where there will still be an urgent care centre) and City hospital. This will operate across The Black Country and Birmingham and Solihull STP.

Acute bed reductions

- **Bath, Swindon & Wiltshire:** will model the number of beds required across the footprint to understand whether they require a similar or reduced number of hospital beds in the future.
- **Buckinghamshire, Oxfordshire and Berkshire West:** likely that there will be reductions in acute beds within Oxford University Hospitals Foundation Trust.
- **Cornwall & the Isles of Scilly:** review of acute medicine beds to examine its overall requirement and distribution.
- **Derbyshire:** will lose 400 beds by 2020/21.
- **Devon:** plans a significant reduction in the number of acute beds.
- **Dorset:** reduction in the number of hospital beds from 1,810 in 2013/14 to 1,570 in 2020/21.
- **Hampshire & Isle of Wight:** plans to generate 9% efficiency in its acute bed stock (around 300 beds).
- **Herefordshire & Worcestershire:** modelling suggests Herefordshire needs a 15% increase in acute beds, but has the potential for a 62% reduction in community beds. In Worcestershire, there is the potential for a 44% reduction in community beds and a small reduction in acute beds, but with redistribution required from Redditch to Worcester.
- **Hertfordshire & West Essex:** through reducing the volume of referrals into secondary care, the STP plans to support colleagues working to transform acute service to release capacity and 'right size' their overall bed base to the changing demands of its population.
- **Kent & Medway:** the plan discusses releasing capacity that is surplus to needs through a reduction in beds. Modelling suggests they will need 10% fewer acute beds in 2020/21 compared to today.
- **Leicester, Leicestershire & Rutland:** acute beds down 243 from 1,940 to 1,697 by 2020/21.
- **Northamptonshire:** a transformation objective is to reduce the number of intermediate care beds.
- **Staffordshire:** there will be a decrease in the number of hospital beds, although that number is not specified.

Community bed reductions

- **Cambridgeshire & Peterborough:** aim to reduce current total community bed stock by 2018.
- **Cornwall & the Isles of Scilly:** compared to most other health and social care economies, the area has significantly more community beds per population. The STP plans to use these resources more effectively across the local system.
- **Derbyshire:** will lose 85 beds by 2020/21.
- **Herefordshire & Worcestershire:** a reduction in the number of community beds will be considered as part of the plan – 202 beds could be cut.
- **Leicester, Leicestershire & Rutland:** community hospital beds down 38 from 233 to 195 by 2020/21; reconfiguration would reduce number of sites with inpatients from eight to six.
- **Shropshire, Telford & Wrekin:** full review of all community beds is proposed.
- **Somerset:** significant reduction in the Community Hospital bed base.
- **Staffordshire:** reduction in 105 community hospital beds.
- **West, North & East Cumbria:** through consolidating the number of community sites there would be a total bed base of 104 (compared to 133 now).

Appendix 2: Savings

This appendix gives some examples of some of the common savings themes proposed in STPs. These are not exhaustive and do not include all savings proposed.

Common savings themes:

STP	Out of hospital care	Prevention	NHS RightCare	Efficiency savings ²⁰	QIPP ²¹
Birmingham and Solihull			£18 million		
Buckinghamshire, Oxfordshire and Berkshire West		£3 million		£276 million	
Coast, Humber and Vale	£32 million	£11 million		£100 million	£50 million
Cornwall and the Isles of Scilly	£24 million				
Coventry and Warwickshire		£34.7 million			
Derbyshire		£5 million			
Dorset			£28 million	£100 million	
Durham, Darlington, Tees, Hambleton, Richmondshire and Whitby	£15.4 million	£9.6 million		£42.8 million	
Frimley Heath		£4.8 million		£97.4 million	
Greater Manchester		£70 million			
Hampshire and the Isle of Wight	£27 million				
Herefordshire and Worcestershire		£2.7 million		£106.6 million	
Lancashire and South Cumbria		£108 million	£118 million		
Lincolnshire			£16.2 million		
Mid and South Essex	£14.4 million			£129.3 million	
Milton Keynes, Bedfordshire and Luton				£104 million	
Norfolk and Waveney			£48 million		
North Central London	£114 million	£10 million			
Northamptonshire		£5 million			
Northumberland, Tyne and Wear	£89 million	£18 million		£346 million ²²	
Shropshire and Telford and Wrekin	£8.7 million			£45.2 million	
Somerset	£12 million	£100 million			
South East London				£262 million	
South West London				£371 million	
South Yorkshire & Bassetlaw				£10 million	
Staffordshire	£4 million		£27 million		
Suffolk				£88 million	
Surrey Heartlands		£15.2 million	£11 million	£251.6 million	
The Black Country	£81 million				
West, North and East Cumbria	£42 million			£86 million	
West Yorkshire		£31 million	£143 million	£532 million ²³	

20 Including CIP (cost improvement programmes) and business as usual.

21 Quality, innovation, productivity and prevention.

22 £241 million through provider efficiencies; £105 million through commissioner efficiencies.

23 £430 million through provider efficiencies; £102 million through CCG efficiencies.

Appendix 3: Consultations

This appendix lists any current or recently closed consultations related to the STPs. This list is not exhaustive. We suggest you contact your STP lead or BMA regional coordinator to find out more about how to input into consultations in your area. There are also several other engagement activities going on in addition to the formal consultations listed below.

- **Buckinghamshire, Oxfordshire & Berkshire West:** A 12 week consultation period on proposed changes to services closed on the 9th April. A full consultation report is likely to be considered by Oxfordshire CCG Board in May 2017 after which decisions will be made on the implementation of the proposed changes. Survey and consultation documents are available [here](#).
- **Coast, Humber & Vale:** A formal public consultation on the question of improving urgent care took place between October 2016 and January 2017. Analysis of the feedback can be found [here](#), and a final decision from the governing body was made on 21 March, and can be read [here](#).
- **Devon:** An engagement period for the acute services review took place in February and March. The feedback received will be presented to the clinicians in the workstreams “to ensure that the views of wider staff, stakeholder and public are incorporated into planning and thinking at the earliest stages.” Briefing is [here](#). Next update was due in April.
- **Dorset:** Consultation on proposed changes to community and acute services ran until February. Suggested changes can be read about [here](#). Over the coming months ORS (Opinion Research Services) will analyse the views and information gathered during the public consultation to produce a report, which is expected to be published by summer 2017. Consultation on [proposed changes](#) to the mental health model of care ran until March. Over the coming months the Market Research Group at Bournemouth University will analyse the views and information gathered during the public consultation to produce a report, which is expected to be published by summer 2017.
- **Herefordshire and Worcestershire:** [Consultation](#) on delivery of high quality GP services in Hereford City launched on 2 March and ended on 24th April. This included drop-in events. Consultation on acute services ran until 30th March, all consultation material can be found [here](#). No date for publication of findings as yet.
- **Milton Keynes, Bedfordshire & Luton:** Patients and staff were encouraged to feedback on a [discussion paper](#) by 31 March. All the views gathered will be collated into a “*What we’ve heard so far...*” document that will inform a ‘Case for Change’ published in May 2017.
- **North West London:** [Review](#) currently open about changes already made to children’s services at Ealing Hospital (which involved the closure of the children’s overnight ward and children’s A&E). Feedback is being sought about the communications issued around the change.
- **West, North & East Cumbria:** An independent analysis [report](#) on consultation feedback received was recently published. It includes qualitative and quantitative analysis of the responses about the potential restructure of services. The Cumbria CCG governing body met in the second week of March to make a number of [key decisions](#) based on the findings in the report.
- **West Yorkshire & Harrogate:** Initial engagement on West Yorkshire and Harrogate stroke services closed on 15 March. Papers from the meeting in January of the West Yorkshire Joint Health and Overview Scrutiny Committee are available [here](#). The findings will be published [here](#) in May, with any final decision made by CCGs in 2018.
- **South Yorkshire & Bassetlaw:** Consultations on [critical care for stroke patients](#) and [children’s surgery and anaesthesia services](#) took place between October 2016 and February 2017. Decisions on both are expected in May.
- **Sussex & East Surrey:** A review of stroke services in Sussex which began in 2014 now includes a number of recommendations from clinicians, including the centralisation of emergency stroke services at Royal Sussex Hospital in Brighton, which would mean that the Princess Royal Hospital would no longer provide this service. A feedback report was recently published. Approval from NHS England was expected to be received by April. Assuming the changes are formally signed off by the CCG and Brighton and Sussex University Hospital NHS Trust boards, implementation could begin by the end of April.
- **The Black Country:** List of ongoing and closed consultations [here](#). Views are currently being sought on proposals for improvements in [mental health day services](#). The consultation is running until 26/05/17.

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