UNISON

Ipswich Hospital and Colchester Hospital
Special report on merger plan

Spring 2018

Is merger plan setting the scene for cuts?

A review of the 'Outline Business Case' (OBC) for the 'Partnership between Colchester Hospital University NHS Foundation Trust and The Ipswich Hospital NHS Trust', drafted for UNISON health branches by Dr John Lister

The Outline Business Case (OBC) is a 132-page document, backed up by 60 pages of Appendices: but it is manifestly incomplete in many ways. As a result UNISON fears it is not fit for purpose as a clear statement of the long term planned system of services to be provided if the merger goes ahead.

After more than 100 mergers of NHS trusts have yielded few benefits and almost uniformly failed to meet expectations, this document clearly represents a triumph of hope over experience.

And while it is presented as a Business Case, it does not conform to the general notion of a business case, since it doesn't even come close to securing a sustainable financial situation.

If the trusts are, as we fear, over-optimistic in their expectations of securing NHS England support for ongoing deficits, the result will be that merger would be preceded or swiftly followed by cuts to slash spending and balance the books. This issue is not addressed at all.

Too many major questions like this have been ducked or deferred to the FBC, which will not appear until early 2018. Even a report on likely travel issues arising from the merger is not expected till February, despite the fact that it could be a major obstacle.

UNISON is not opposed in principle to merger, and is keen to see efficient, effective, accessible and safe services delivered through collaboration and partnership.

However the OBC as submitted does not convince us that a clear and credible plan exists to deliver a sustainable merger – not least because of the continued, chronic under-funding of the NHS as a whole since 2010 and the local health economy in particular.

We will continue to press for answers to the questions we have raised in this document and for a solution that ensures that our members in both trusts are treated with respect and enabled to deliver high quality, safe and efficient service for patients.

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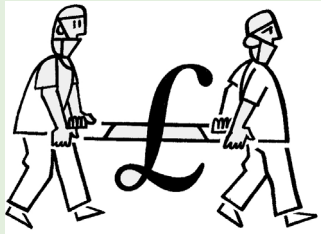

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When is a merger NOT a merger?

"There's been a big bank merger, sir, so you now have a joint checking account with a Mr. Slavomir Bezparyadok of Zagreb."

The Outline Business Case sets out the case for a "partnership" between the two Trusts which is largely indistinguishable from a merger. Indeed the terms are used inconsistently and interchangeably in the extended Frequently Asked Questions (FAQs) document issued by the two trusts.

While the notion of Partnership implies a minimum of two distinct, cooperating partners, on page 2 the FAQs refer to the Partnership resulting in just one trust:

"On 24 August 2017, the boards of Colchester and Ipswich Hospitals approved an outline business case. It recommended that the partnership works to form a single organisation with full integration of clinical services."

"If the new trust wanted to move a service from one hospital to the other and it meant that significant numbers of patients would have further to travel then staff, patients and the public would be consulted in advance of any decisions being made."

On page 4 the question is raised again:

Q: "The Ipswich Hospital NHS Trust is not a Foundation Trust, so how will it be merged with Colchester Hospital University NHS Foundation Trust?

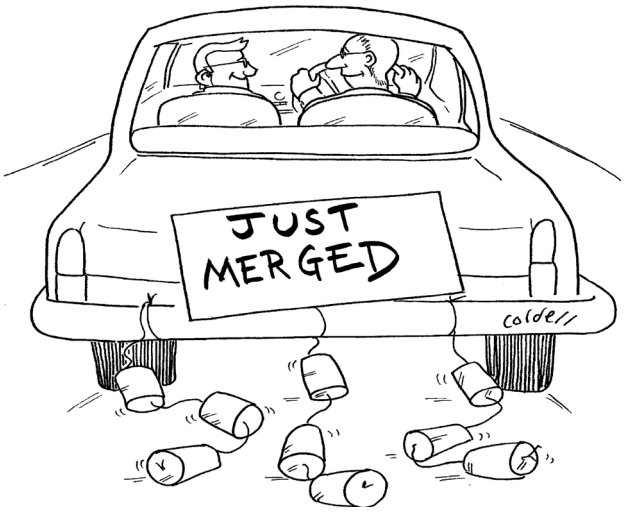
A: "We are currently seeking legal advice about how this could happen. NHS Improvement is involved in these discussions. The Partnership is committed to viewing each trust as equals and any arrangement entered into would be with the full agreement of both boards."

It's not clear why the word 'partnership' should have been chosen, although some explanations do suggest themselves.

Maybe it is to avoid the comparison with the sorry record of hospital mergers in the UK over many years. Research by pro-business management consultants McKinsey (referenced in the two trusts' Strategic Outline Case in January 2017), notes that in a study of over 100 hospital mergers:

"none enhanced care quality; at most of the hospitals clinical productivity remained unchanged and financial performance deteriorated."

Meanwhile to add to the confusion the management side is promising "soon" to open a consultation on what the name should be for "the new trust"!



'Unsustainable' – but unresolved

The Case for Change (1.2.2) refers to an "expected 4% annual growth in demand" – however the OBC sets out little if any suggestion of how or where resources might be developed to match this rising demand.

NHS England figures show the two Trusts have between them 38 fewer general and acute beds than they had in 2010, but average occupancy across the two trusts has risen from 89.2% to 94.6%, with Ipswich averaging more than 97% occupied.

There is little discussion of the profile of the two hospitals' caseload, or the extent to which the projected rising demand could be diverted to alternative services. 41% of Colchester's 99,000 admissions last year were emergency admissions, and 57% of admissions were from patients aged 65-plus.

By contrast just 35% of Ipswich's 100,000 admissions were as emergencies, even though the 65-plus age group accounted for 61% of all admissions.

"Give it to us straight. How long have we got?"

Ipswich faces the larger number of beds affected by Delayed Transfers of Care (32 compared with 27 in Colchester): unlike most STPs and merger plans elsewhere, this OBC includes little discussion of this issue or the drastic under-funding of social care in Essex and Suffolk, which is key to relieving these problems.

It seems at least from this brief overview that without substantial expansion of services to improve the health of older people, coupled where necessary with expanded services in hospital, both hospitals face a potentially unmanageable caseload in the near future, and will struggle to cope with the increased demand predicted this coming winter.

The summary also points out that both trusts face staffing problems, and warns that "the workforce will be unsustainable" – but the OBC itself has few tangible proposals to address the issue.

74% of deficit ignored

Section 1.4.4 (Financial evaluation) shows how small a proportion of the projected "do nothing" deficit by 2021-22 would be addressed by the OBC proposals, which would reduce the shortfall from £44.5m to £32.7m, leaving 74% of the deficit unresolved (Table 1-2). Section 1.5 sets out a clinical case that includes various potential troublesome issues for staff including "24/7 Resilience" which relies on 7-day working, staff "cross cover" and shared rotas across two hospitals 19 miles apart.

It's not at all clear that NHS staff, especially as they suffer an 8th year of below inflation pay increases and the consequences of significant under-staffing, will view these ideas as in any way positive or helpful.

When is a business case NOT a business case?

Even if it is presented as a Business Case, the joint document does not conform to the general notion of a business case, since it doesn't even come close to securing a sustainable financial situation.

As such it is less a strategy, and much more an interim, short term plan, setting out only part of the actions that would be necessary to bring the two trusts, which are currently estimated to be £39.9m in the red and facing a projected do nothing deficit of £133m by 2021 , into financial balance, let alone any surplus.

The plan, as set out in the OBC, would even after five years, and assuming all goes exactly according to plan, leave the "partnership" with a best-case scenario of £32.7m per year recurring deficit (p11), described in optimistic fashion as showing "greater progress towards achieving a break-even position for the Trust" (p54).

It seems most unlikely that this could be the end of attempts to balance the books.

The OBC makes no attempt to explain why it assumes that NHS Improvement and NHS England might be happy to accept a major trust/partnership running such a hefty long term annual deficit for years to come, with no further plans to reduce it.

Misguided optimism

The relentlessly optimistic tone of the document is maintained in section 3, which refers to the Suffolk & NE Essex Sustainability & Transformation Plan (STP) as if it is almost accomplished already, and guaranteed to address the problems of a rising population and a rising tide of ill-health.

The OBC insists that

"The plan [STP] will deliver against three priorities for creating a sustainable healthcare system in Suffolk and North East Essex".

However for anyone who has managed to read the evasive STP document, it is by no means clear what the STP is proposing in relation to Colchester or Ipswich trusts and acute services in NE Essex and East Suffolk.

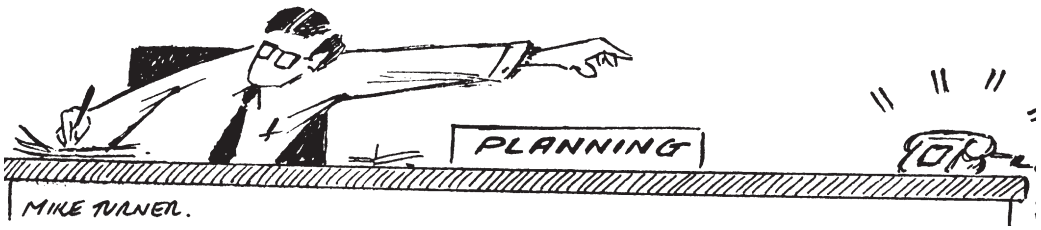
The STP discusses intention of 'centralising' and 'specialising' services at Colchester and Ipswich hospitals, as touched upon fleetingly by the OBC

(p30). There is an implied plan for the acute sector to be scaled down, on the assumption that primary and community care would take a greater role:

"A reordering of expenditure across care settings is likely by 2020/21 as care moves closer to the person and providers become 'right sized' [i.e. acute trust services reduced, and out of hospital services expanded] to manage the changes in demand.

"The aim is that the solutions will deliver a balanced in year position by 2020/21 however a cash solution will still be required to address the historic deficit". (STP p12),

However, no specific acute sites, bed numbers or A&Es are mentioned: and it's clear that the OBC comes nowhere near the aim of delivering a balanced in-year position by 2020/21.



Wanted: £70m capital for business case

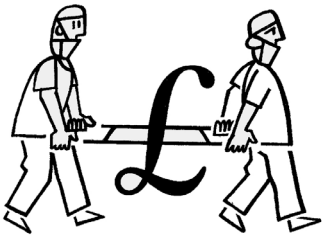
In order even to get down to a £32.7m deficit the OBC also makes clear the "partner" trusts would require access to £70m of capital, for which no ready source has been identified, although it is expected (p86) to come as public sector "Public Dividend Capital." PDC funds may not need to be repaid, but carry a continuing interest charge.

According to the Kings Fund's Ben Collins, access to this type of relatively soft borrowing was one of the main reasons for trusts developing merger plans from 2010 onwards.

There have been continued warnings from NHS England during 2016 and 2017 that after repeated raids on available capital to prop up revenue budgets there is precious little chance of securing public sector capital.

The OBC does not explain why – in this context – the Colchester-Ipswich partnership might assume it would get preferential access to such a large share of the limited amount available.

The situation is much more likely, in reality, to be one in which the "partnership"/merger brings the two trusts together, but with much lower, if any, capital investment, its availability linked to achieving further savings to balance the books.



This means the merger would be swiftly followed (as has happened in so many other hospital trust mergers over the last 20 years) by a further plan for reconfiguration and rationalisation of services in further efforts to put the new organisation into balance.

At that point the current guarantees that the existing services in both hospitals would in almost every case simply be bolted together into an even bigger service, with two full A&E departments and two full consultant-led maternity departments, would inevitably be discarded as having served their purpose in easing through the merger.

To save £32.7m from a £584m combined budget of a newly-merged trust in which acute services and bed numbers are already running close to capacity and struggling to cope would mean very substantial cutbacks would be required.

The savings target is equivalent to the full salaries of around 1,000 nurses or health professionals, or 4,000 hip replacements: such large sums can't be "saved" without putting the quality and quantity of health care at risk.

OBC faces two ways on future staffing

The OBC dream is that the new merged larger trust becomes a magnet for recruitment and retention of staff – although Colchester and Ipswich are by no means the only trusts pegging their hopes on the same notions. We are told:

"The combined organisation will become an increasingly attractive employer operating at a scale to provide excellent professional and personal development opportunities for staff.

[…]

"By making the combined organisation a highly attractive place to work and getting the right mix of skill development and roles for permanent staff, significant savings on agency spend are anticipated." (p65)

The OBC studiously avoids any explicit discussion of job losses even while it discusses corporate savings and efficiencies.

However Figure 7.4 coyly refers to staff being **"released from transactional activities"** and "outsourcing" (p81) without explaining where the surplus staff would be "released" to, or how many jobs might be affected.

Also on page 81 we see the weasel words:

"Services will be unified and integrated across the combined organisation. For example, in Estates and Facilities, critical risk and compliance roles such as fire, emergency planning and local security management, will be combined.

"The elimination of duplicate roles and provision of a unified service will deliver workforce efficiencies, cost savings and increased consistency in delivery." (p81)

In other words the merger DOES pose a threat to what so many similar documents describe as "back office" jobs – with no alternative jobs apparently on offer to ensure staff could be redeployed.

Among the many optimistic assumptions in the OBC's financial modelling are extravagant hopes for savings from reduced spending on agency staff as recruits flock to the trust and are recruited to substantive posts:

"The financial modelling assumes that a third of current agency spend is saved over the period of the OBC (after allowing for the cost of appointing to the required new roles)."

"Then again, gentlemen, we're in complete agreement in the sense that nobody knows the answer to any of the questions that have been raised."

Drawing by Stan Hunt; © 1983 The New Yorker Magazine, Inc.

Wrongly-added figures add to OBC confusion on on workforce planning

Sadly the discussion of workforce issues is no more grounded or detailed than any of the preceding sections of the OBC.

Once again a key factor in whether or not a merger of the two trusts can be successfully carried through, a serious implementation plan, is put off until the Full Business Case – giving no hint of what might be proposed:

"Implementation planning for staff moving into the combined organisation will be developed in the FBC phase.

"These will ensure that disruption is minimised and that business continues as usual during the changes to the organisational form.

"Early opportunities to harmonise policies and procedures and terms and conditions will be identified in preparation for the combined organisation." (p98).(emphasis added)

But it gets worse on the next page, when the OBC reveals that its authors can't even add up their own numbers to give a correct total.

Table 9-1 (p99) shows a headcount total of 9,291 individuals working in the two trusts; but the OBC text tells us there are "over 8,000".

The whole time equivalent workforce is 7,672 – fewer than 8,000, so either way it's clear that they have the numbers wrong.

This gives reason for concern that the actual numbers for each trust might also be wrong: do these numbers include the very substantial proportion of vacancies referred to on page 32?

In other words are these actual individuals in post, or posts available?

Unsolved riddle

The lack of interest in the OBC for any detail of workforce planning is underlined by the fact that the Table is not accompanied by any explanation of why similar-sized trusts with similar-sized budgets should have such a different composition of workforce.

CHUFT, which has almost 8% more whole time equivalent staff overall, has 510 Scientific and Professional staff, while Ipswich has just 222. Ipswich has slightly more consultants, doctors and nursing staff: Colchester has twice as many described as "other staff groups".

Vanishing beds … at a time of mounting pressures

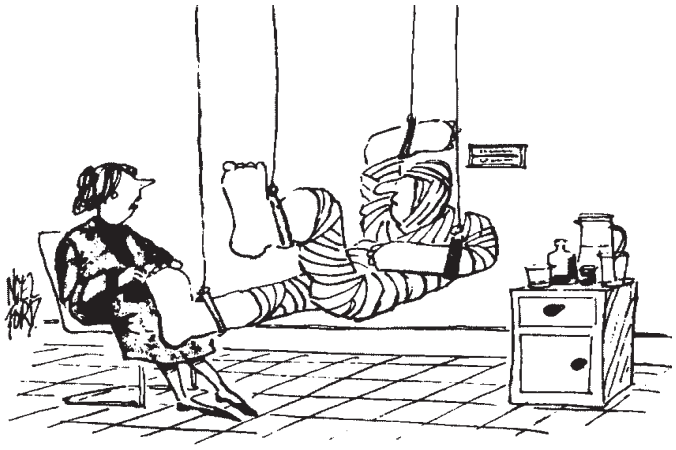
The OBC contains some worrying figures. In particular, the summary in Table 3-1 (p27) cites a reduced number of general and acute beds currently available, compared with the latest official figures. The OBC cites 1,101, compared with NHS England's figure of 1,179 in January-March 2017 – a difference of over 6%.

If this is an actual reduction it is likely to cause severe problems this coming winter.

Colchester Hospital which became national news in 2014 for declaring a 'major incident' because it was struggling to cope with the level of demand for emergency care and levels of staff shortages.

It hit news headlines again in January 2017 by declaring pressure alerts for lack of beds for six days in a row to January 8.

Ipswich was also on a long list of hospitals urging patients who did not have life-threatening emergency needs to stay away from A&E last winter.



'I never dreamed the bed shortage was so acute.'

In September Colchester Hospital University chief executive Nick Hulme told the BBC the past few months had been "as challenging as any I can remember - there has been no let-up.

"Our major concern going into this winter is staff - we are 50 junior doctors short on our rotas across the hospital. Every day is a constant struggle."

Table 3-3 on performance against some of the key targets (OBC p29) shows CHUFT lagging behind IHT on a number of targets (Cancer 2-week, 31 and 62 day standards, elective treatment incomplete).

The CHUFT shortfall on the 62 day standard for cancer treatment (69.5% compared with an 85% target) is especially worrying.

CHUFT also achieved only 54% of its planned savings in 2016/17, compared with IHT's remarkable 97% (p30).

On staff shortages, too, the situation in CHUFT is clearly worse for every group of staff than the still worrying situation in IHT: the problem is the greatest in consultant vacancies (12.7% CHUFT), junior doctors (14% CHUFT) registered nurses (a massive 19% shortage in CHUFT) and unregistered nursing (11% CHUFT). (p32)

This makes it even more surprising that the OBC remains at such a level of abstraction and evasion on how the trusts plan to address these weaknesses.

The national NHS bed shortage – the breakdown

(From Health campaigns Together #9, October 2017)

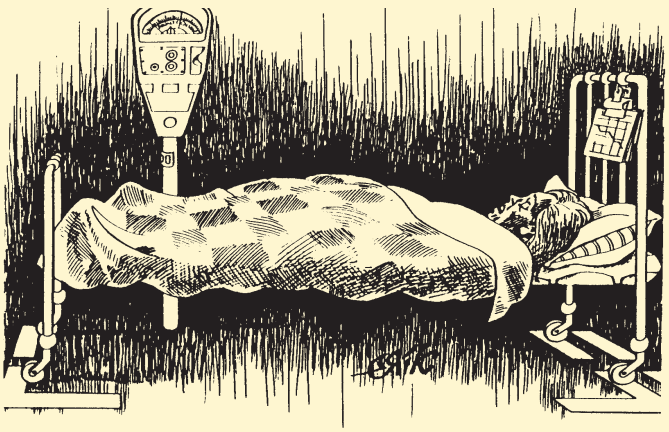
Numbers of NHS beds have more than halved in the UK in the last 30 years – making it "undesirable" to pursue any further plans for closures according to a recent King's Fund report.

This is a significant change of stance from the King's Fund which has until recently been an enthusiast for further reductions in beds and hospital services.

But the latest NHS England figures show that England in particular now has far fewer beds per head than any other country in the EU, with just 2.3 per 1,000 – less than two thirds of the EU average of 3.7.

Overall bed numbers have fallen by 157,000 since 1987. However the latest official bed numbers show that much more worrying than these global totals are the reductions in the last seven years, with a loss of 10% of beds in England.

The biggest proportional (57%) reduction has been in learning disability as a result of the large-scale transfer of these services out of the NHS into the heavily cut and privatised social care sector.



More than one in five mental health beds (5,066 – equivalent to 21%) have also closed since 2010, with a consequent rising pressure on services.

Meanwhile the headlines tend to focus on the growing crisis in acute services and elderly care, where almost 8,000 beds (7.2% of the 2010 total) have been axed as the spending freeze has taken its toll. Occupancy rates in both acute and mental health beds have soared above 89% as the numbers have declined.

STOP PRESS

As this newsletter goes to press average January 2018 bed occupancy has risen to 98.7% in Colchester and 98.3% in Ipswich.

What's wrong with existing NHS values?

It is also concerning that among the many vague and evasive statements in the OBC, the section on Workforce ends with a commitment to establish "a new set of values" (p102:

"A new set of values and expected behaviours will be developed for the combined organisation. These will be an enabler for embedding the desired culture. They will describe how all staff will work together to ensure that the combined organisation delivers high quality, patient-focused, efficient and consistent service."

Such a statement, once again giving no idea of what issues the OBC is seeking to address or what the new values statement might look like, poses a whole series of questions such as:

• What is wrong with the current set of values?

• How will the new values differ from the current professional codes of conduct for medical, nursing and other professional staff?

• Who will decide which new values to include – or exclude?

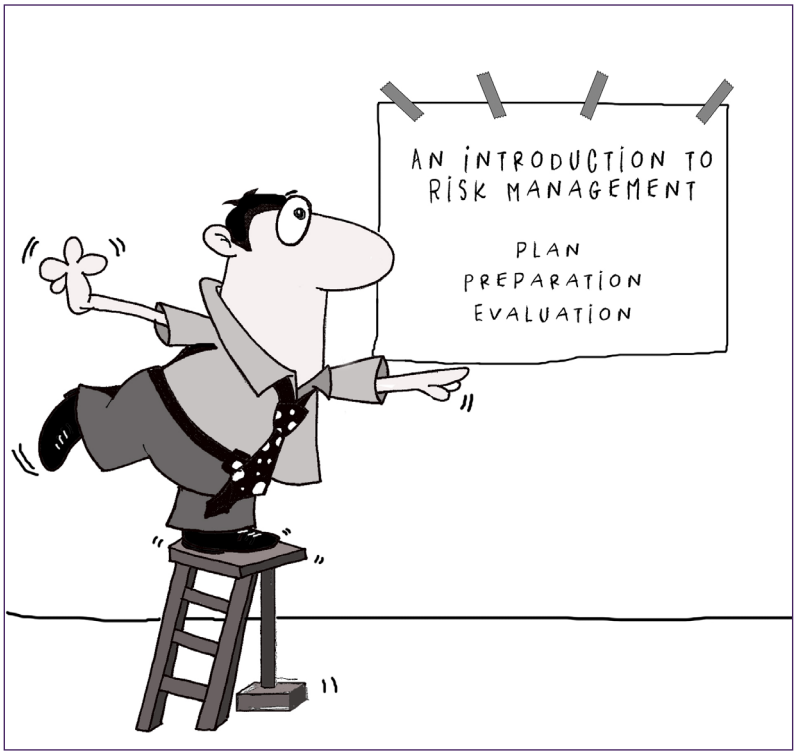
• Who will be consulted on these new values? Will all staff and their trade unions and professional bodies have a say? What about the public and patient groups?

• Who will take responsibility for upholding these values?

• What will happen if managers in pressurised and under-staffed departments fail to live up to the new values?

• What will happen if staff complain they are not able to work to the new values?

Risky business



The OBC is once again evasive when it comes to discussing what might go wrong.

They expect us all to take their word for it that risks which have been barely, if at all, discussed in the document are in fact all under control:

"The OBC phase, including the development of the draft clinical strategy and corporate TOM, has been underpinned by robust programme governance with the identification and management of risks, and developed plans for future phases of work. (p104) (emphasis added).

So apparently we need not worry about the gaps in the OBC. Everything is being taken care of: the two boards have it all sussed:

"Risks to delivering the Partnership vision and objectives have been identified, controlled and mitigated within the agreed governance structure. Risk management and control will continue to be maintained throughout the FBC phase"

(p104) (emphasis added).

So that's all sorted, then.

Except for the fact that the OBC does not offer a proper or evaluated risk register, as any genuine business case would.

If only … OBC's rosy-tinted future view

In other trusts and STPs the alleged need to centralise specialist services is often used time and time again to force the merger and downgrade or reconfiguration of services.

But the OBC reports that the conclusion of the clinical review on the possibility of centralising key services has come out with an opposite conclusion to these other reconfiguration plans:

"For the second approach, a desktop review of evidence, guidance and local considerations was undertaken.

"The review did not find strong evidence that services would be significantly improved by centralisation." (p61).

Whether the clinicians who have upheld this view in Colchester and Ipswich might sooner or later be pressed to rethink their position, to pave the way for a reversal of this approach and efforts to centralise key specialist services is something we will only discover in due course.

It is also notable that the OBC assumes that the existing workforce in each trust will simply be bolted together to form an even larger one covering both hospitals.

It seems more than likely however – especially if they are being asked to foot the bill for a long term deficit in the merged trust – that NHS England will demand indications of where productivity is to be improved – and numbers cut, even if only through 'natural wastage' and non-replacement of retiring staff.

However in the magical OBC world (where everything always goes just right, and apparently money is not a problem), the combined organisation would have

- "nearly thirty orthopaedic surgeons" (p65);
- the endoscopy service will be "twice as large" (p66);
- there would be "a stronger rationale for buying a new scanner" (p67);
- and oncologists would be working in a larger team in which "more than one oncologist specialises in the same types of cancer" and therefore there are no delays or problems if one is off sick or on holiday (p69).

If only the whole NHS could just expand in this fashion to meet demand, there would be little need for campaigners or protest.

Many reading this will fail to be convinced by this cock-eyed optimism.

List of risks that have been ignored

Some selected risks, vaguely defined, are listed in pages 115-118, but the full list and the full ratings of the severity and likelihood of each risk is not published even as an Appendix:

- There is no discussion of the risk that the trusts before and after merger are unable to recruit and retain sufficient staff to maintain services.
- There is no discussion of the risk that the two trusts have taken insufficient note of the implications of growing population and health needs in their planned provision of services.
- There is no discussion of the risk that social care continues to lack the resources needed to complement community health services and reduce the numbers of delayed transfers of care.

The nearest to discussing the risk that the finances won't turn out as expected is the concern that maybe not enough money is allocated for management consultants to draw up the FBC itself:

"Failure to recognise and provide for the cost of the work to reach a completed FBC will result in an insufficiently prepared case for change resulting in failure to reach approval ". (Table 10-3 p115)

The same table for the first time discusses the risk that it fails adequately to engage with stakeholders including staff and the public or ensure they are "able to influence the development of the partnership". This, it admits, could mean that the business case fails to secure stakeholder support, or worse:

"creates potential hostility to the proposed partnership arrangement, and the potential for legal challenge, resulting in a failure to obtain regulatory approval to proceed."

We might conclude that if this risk had been taken more seriously the OBC would have been drafted as a more open and complete proposal, and more effort would have been made to explain the likely longer-term plans for services to staff and the local communities of Suffolk and Essex.

The OBC made clear that regardless of the many hurdles they have yet to surmount, and despite the fact that the FBC is not yet even published, and was not expected until January, the two trusts had not discarded hopes of concluding and implementing the Full Business Case by April 2018. (p111).

But a report from a joint reference group meeting on November 27 makes clear that this has now been quietly pushed back – with "merger in the summer". The FBC is not expected before March at the earliest.

We recommend you don't hold your breath waiting: it could be a while yet!

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