Sustainability and transformation plans for reforming the NHS in England: what do they say and what happens next?

Plans for the future of health and care services in England hold promise but need time, investment and a dose of realism

Planning guidance[1] produced by national NHS bodies in December 2015 asked NHS organisations to work together to make plans for the future of health and care services in their area. The plans—called sustainability and transformation plans (STPs)—needed to cover all areas of NHS spending up to 2021, as well as how NHS services work with social care and other local authority services. NHS organisations were asked to describe how improvements would be made in three areas: population health and wellbeing; quality of services; and health care efficiency.

Forty-four parts of the country were identified as the 'footprints' on which the plans are based, with an average population size of 1.2 million people (range: 300,000 to 2.8 million).[2] STPs are intended to be the local plans for delivering the Five Year Forward View.[3] This is the strategy for transforming NHS services closely associated with NHS England's chief executive, Simon Stevens.

STPs are based on the idea that collective action is needed to improve care and manage resources. This represents a major shift in the approach taken to NHS reform in England, embracing collaboration rather than competition as a means for driving health service improvement.[4] This shift is taking place without changes to legislation. There is therefore a tension between the statutory framework for the NHS, created by the Health and Social Care Act 2012, and the direction being set by STPs.

The process of developing the plans[5] was criticised for taking place behind closed doors and not involving relevant stakeholders such as patients and the public, NHS staff and local authorities. Despite these difficulties, all 44 STPs have now been published and work has begun on implementing their proposals. Here we describe their content and the challenges they present.

The content of the plans

We reviewed the 44 plans and identified eight major themes.

[Box] Major themes in STPs

- Redesigning primary care and community services
- Changing the role of acute and community hospitals
- Strengthening prevention and early intervention
- Improving care in priority service areas, such as mental health
- Improving productivity and tackling variations in care
- Supporting and developing the workforce
- Improving IT, estates and other 'enablers'
- Organisational changes to support STPs

[box ends]

All STPs set out how they intend to redesign primary care and community services. The plans describe ambitions for closer coordination of health and social care services and for staff to work together in multidisciplinary teams. In West, North and East Cumbria,[6] for example, 'integrated care communities' are being developed to manage care for geographically defined populations, bringing together staff from general practice, social care, mental health, public health and community services, as well as some specialists based in hospitals.

The plans often involve GPs working together at greater scale through networks of practices. New roles are being proposed to manage care in the community, such as health coaches and care coordinators, alongside new care processes, such as care planning. Target populations for these new care models include older people and people with chronic conditions. Some areas are seeking to extend the range of services delivered in the community. It is expected that these new ways of working will reduce demand for acute hospital care.

STPs also aim to change the role of acute and community hospitals. Proposals include concentrating some services—such as stroke, maternity and orthopaedics—in fewer hospitals to address workforce shortages and concerns about quality of care and the financial sustainability of services. Some plans also propose reducing the number of acute hospitals. South West London's STP,[7] for example, makes the case for reducing the number of acute hospitals from five to four.

Reductions in the number of acute hospital beds are proposed in some of the plans. In Dorset,[8] ambitions to provide more integrated care in the community and redesign hospital services are expected to lead to a reduction in hospital beds from 1,810 in 2013/14 to 1,570 in 2020/21. They are also expected to reduce unplanned medical admissions by 25% and unplanned surgical admissions by 20%. A number of plans propose to cut the number of beds in community hospitals and in some cases to reduce the number of these hospitals.

All STPs aim to strengthen prevention and early intervention. Proposals include ambitions to promote healthy lifestyles, work more closely with local authorities to address non-medical determinants of health, and support people to manage their own health. Targeted prevention programmes are proposed for people with chronic conditions. Some plans also describe how they will draw on assets in their community to improve people's health—for example, by introducing 'social prescribing' schemes to refer patients to support in the community.

STPs outline commitments to improve care in priority service areas, which vary depending on local context. They include improvements in specific services—such as mental health—as well as for defined population groups—such as older people. In north central London,[9] for example, approaches are identified to increase mental health support—including improving access to primary care mental health services, developing a female psychiatric intensive care unit, investing in mental health liaison services, and introducing eating disorder teams.

Improving productivity and tackling unwarranted variations in care is a priority in all STPs. Data[10] have been used to identify areas for action—such as variations in elective referrals. Many areas are seeking to standardise clinical processes. Others aim to engage patients in decisions about their care. Non-clinical services—such as procurement of equipment—are also identified as areas to improve efficiency. These and other proposals are intended to

bridge the financial gap projected by 2020/21 if NHS organisations 'do nothing' to change how care is delivered.

Many STPs set out system-wide approaches to recruiting and retaining staff, as well as measures to reduce agency costs. They also describe the skills and roles that need to be developed to support implementation of new care models—such as training for staff in health coaching and quality improvement methods. Some STPs set out expected changes in staff numbers resulting from their proposals. Nottingham and Nottinghamshire's plan[11] suggests a 12% cut to band 5 nurses and similar roles and a 24% increase in community and primary care staff.

Changes to organisational arrangements and infrastructure are outlined to help deliver these ambitions. They include improvements to IT and digital services—such as developing electronic health records and introducing apps to support people to manage their conditions—as well as changes to the NHS estate—such as disposing of assets and developing new facilities. Proposed changes to NHS structures and incentives include plans for more integrated approaches to commissioning, new contracting models and payment systems, and collaboration between NHS and social care providers.

Familiar and wide-reaching

STPs echo proposals made in a succession of NHS policy documents dating back a number of years.[12 13 14] They are broad in scope—covering prevention through to specialised services, and incorporating nearly everything in between. The level of detail about how these proposals will be delivered varies widely between the 44 plans—dependent in large part on the history of collaboration between organisations in each STP area.[5] Detail is particularly lacking in plans to give priority to prevention and early intervention. The plans also vary in quality and completeness, with more work needed in some STPs to describe how service changes will be made and how they will improve the quality of care.

Testing the assumptions

Key assumptions in the plans need to be tested. The most obvious is the ambition in some STPs to reduce capacity in acute hospitals. The NHS already has one of the lowest number of hospital beds per capita compared with other OECD countries.[15] A&E attendances and emergency admissions to hospital are on a rising trend.[16] Delayed transfers of care are at record levels.[16] Bed occupancy rates are above 85%.[17] And services outside hospitals are struggling to cope—with growing pressures in general practice,[18] district nursing,[19] mental health,[20] and adult social care.[21]

Against this backdrop, any sort of moderation in demand for acute hospital services—let alone bed reductions—will only be possible if significant investment is made in care outside hospitals first. This investment has not been made: additional funding for the NHS is being used primarily to reduce hospital deficits, leaving little scope to develop new care models.[22] Cuts to social care and public health budgets also make these ambitions harder to achieve.[21 23]

There are, of course, opportunities to manage care more effectively in the community.[24 25] Areas involved in NHS England's vanguard programme are seeking to do this by more

closely integrating primary, community, mental health and social care services, as well as working with care homes and acute hospitals. These new care models offer promise but they are still in development and are not a short-term fix. The time it takes to implement large-scale change in the NHS is often underestimated, while the expected impact of new care models is overestimated.[26 27] Greater realism is needed to allow new care models time to produce evidence of impact.

Proposals to reconfigure acute and specialist services also warrant stress-testing. While some proposals to reconfigure care by concentrating services in fewer hospitals may be both necessary and desirable, others will require close scrutiny. Evidence on the impact of major reconfigurations on quality of care is mixed, and is strongest in relation to specialist services such as trauma and stroke care.[28] Evidence that reconfigurations produce financial savings is almost entirely lacking.

The financial backdrop for STPs is important. Local leaders were asked to show how their plans will address current and projected financial deficits in the NHS. A survey of 172 NHS trust chairs and CEOs carried out in September and October 2016 found that achieving financial balance by 2020/21 was seen by these leaders as the most important issue in STPs.[29] Previous analysis[30 31] suggests that bridging these gaps in NHS finances will be challenging, at best—and more likely impossible—even with the ambitious plans outlined in STPs.

Implementation challenges

STPs face a number of barriers to implementation.[5 32] The limited time available to write the plans made it difficult to meaningfully involve clinicians and frontline staff in their development. The involvement of local authorities varied widely, and patients and the public were largely absent from the process. While the plans have now been published, their mixture of jargon and technical language limit their accessibility. Without broader and deeper engagement in STPs—with staff, local people, and politicians—the support needed for implementation will be lacking.

Another barrier is the wide-ranging nature of STPs. The priority in every area should now be to identify a small number of service changes that offer the greatest potential to improve care. Dedicated teams must then be put in place to support the implementation of the plans across organisations. Governance arrangements should be developed to enable NHS organisations to make collective decisions while recognising the accountability of individual boards. This is an example of the tension between the current statutory framework and the process by which STPs have been developed and will be implemented.

STPs have no legal basis or decision-making authority. Improvements to services can still be made through organisations and teams working together, but the emphasis on competition in the Health and Social Care Act 2012 does not make this easy. The complex and fragmented organisational arrangements in the NHS also create challenges. Legislative changes are likely to be needed to regularise the major shift in approach to NHS reform that is occurring through STPs.

Where next?

Despite these issues and the challenges they have encountered, STPs offer an important opportunity to transform health and care services in England. Proposals to more closely integrate health and social care services and invest in preventing ill-health should be given high priority in all parts of the country. Plans to reconfigure hospital services should be supported where the case for change has been made. Gaps in the plans in relation to general practice[33] and other services that have not received sufficient attention need to be filled. Additional funding for social care and the NHS will be required to support the changes.

A more realistic timescale should be adopted for implementation, while recognising the need to take forward changes with urgency where the clinical case for change has been made. The government must be willing to support proposals in STPs where they will bring benefits for patients, even in the face of opposition from some stakeholders. If they do not, serious questions will have to be asked about the future of the Five Year Forward View and the government's commitment to the direction Simon Stevens and others have set.

[box] Key messages

- STPs are wide-ranging and propose changes to all aspects of health care in England. Key assumptions in the plans need to be tested for realism, including proposals to reduce capacity in acute hospitals and deliver large efficiency savings
- Plans to develop new models of community-based care will require investment and take time to implement
- Deeper engagement in the STPs is needed and their leadership and governance must be strengthened
- National and local politicians should support the plans where the clinical case for change has been made

[box ends]

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