Delivering sustainability and transformation plans in the NHS: from ambitious proposals to credible plans

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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, embracing collaboration rather than competition as a means for driving improvement and transforming how care is delivered.[4] Despite a series of challenges with the process of developing the plans,[5] all 44 STPs have now been published. Here we describe the content of the plans and the opportunities and issues 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—for example, by providing more outpatient appointments. It is often 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 centralising some acute hospital services—such as stroke, maternity and orthopaedics—and delivering care through networks of hospitals. 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. Quality issues and workforce constraints are commonly cited as drivers for hospital reconfiguration. The financial sustainability of services is also identified as a factor. A number of plans also propose to cut the number of beds in community hospitals and in some cases to reduce the number of these hospitals.

Some plans project a reduction in the number of acute hospital beds as a result of the changes they propose. 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%.

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. This includes 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 and a specialist community perinatal mental health team.

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

STPs include proposals to support and develop the health and care workforce. Many STPs set out system-wide approaches to recruiting and retaining staff, as well as measures to reduce agency costs. The plans also describe the skills and roles that need to be developed to support the 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 also outlined to help deliver these ambitions. This includes 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. Changes to NHS structures and incentives are also proposed. This includes plans for more integrated approaches to commissioning, new contracting models and payment systems focused on care outcomes, 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. Despite their familiarity, 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] The detail is particularly lacking in plans to give priority to prevention and early intervention.

Testing the assumptions

How realistic are STPs? Some key assumptions in the plans need to be tested. The most obvious example is ambitions 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 of 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 of 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 invest in new care models.[22] Cuts to social care and public health budgets also run counter to these ambitions.[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 dramatically underestimated.[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. Evidence on the impact of major reconfigurations on quality of care is mixed, and is strongest in relation to specialist services such as trauma, vascular services and stroke care.[28] Evidence that reconfigurations produce financial savings is almost entirely lacking, and—whatever their impact—reconfigurations represent a major organisational distraction. While some proposals to reconfigure services may be both necessary and desirable, others will require close scrutiny.

The financial backdrop for STPs is important. A survey of 172 NHS trust chairs and CEOs carried out in September and October 2016 found that achieving financial balance was seen as the most important issue in STPs.[29] But will this be possible? Publicly available information about the financial assumptions in STPs is limited. But previous analysis[30 31] suggests that meeting such ambitious financial targets will be challenging. NHS leaders must be realistic about what can be achieved within the levels of funding and timescales available, rather than setting STPs up to fail by overpromising on what will be delivered.

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 identified to support the implementation of the plans across organisations. More formal governance arrangements are needed to enable organisations to make collective decisions while recognising the accountability of individual boards.

The plans have also been developed within a legal framework that was not designed to support collaboration between organisations. STPs have no legal basis or decision-making authority. Some proposals in STPs may also bump up against aspects of the Health and Social Care Act relating to market regulation and competition—for example, when changes to the acute hospitals are proposed or when commissioners want to develop new care models. Legislative changes are likely to be needed to regularise the shift in approach to NHS reform that is taking place and to formalise the workaround that STPs represent.

Where next?

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 prevention 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.

Much hinges on the willingness of the government to back NHS England and other national bodies in taking forward the work STPs have started. This includes being willing to support changes in the delivery of health and social care where this will bring benefits, even if some proposals generate opposition from the public and politicians. In the absence of this support, 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 right across the NHS. Key aspects of 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 should be supported but will require investment and take time to implement
- Deeper engagement in the STPs is needed and their governance must be strengthened
- Politicians must lend their support to the plans where they will improve care

[box ends]

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