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The Sustainability and Transformation Plans: a critical assessment

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About the author

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John achieved a PhD in health policy in 2004, and has since authored books on global health policy and England's NHS, and participated in research on health systems, and engaged in campaigning with a variety of international organisations and individuals. He is a co-founder of Health Campaigns Together.

Introduction

Many members of the public, and even some politicians, are only just becoming aware of Sustainability and Transformation Plans, which were imposed in a policy directive from NHS England just 3 days before Christmas in 2015 as part of a major shake-up of the NHS. [1]

The dramatic reorganisation of England's NHS into 44 'footprint' areas, and the requirement for all NHS bodies to collaborate with local government social service agencies on these new 5-year plans, seemed like NHS England's best hope of balancing its budgets by 2020-21. But the variegated and inconsistent series of 44 documents that have been published since the end of October have clearly fallen far short of NHS England chief executive Simon Stevens' hopes a year ago.

The STPs are behind schedule, and lack any significant popular public support. And looking at the plans as published it does not take long to see that they will not deliver the promised results: most offer no viable or sustainable plans for staffing or management of the 'innovative' proposals to divert services away from hospitals, so the services proposed are not sustainable; there's virtually no capital available from NHS England to finance any serious transformation; in many of them the numbers plainly don't add up, and there is little or no evidence that some of their key proposals can work in practice. Many lack any financial detail, and almost none of them have any worked-through practical plan for implementation.

A year ago these plans were seen as blueprints of the future, and as recently as early January this year Simon Stevens was reported as describing them as 'the only game in town'. But he also acknowledged that they needed further engagement with the

public, and further work to turn them into proper plans. It remains to be seen what finally emerges from these processes.

Herts and West Essex

Drafts of all 44 STPs covering England have now been published, in varying stages of completion; [2] the latest are facing particular problems. The Hertfordshire and West Essex STP, one of the last three to appear, and clearly little more than a very incomplete summary, reveals that despite heroic assumptions and implausible figures of expected savings on health and social care spending, the area is (in common with others) unable to meet the 'control totals' (cash limits) that have been set for next year and 2018-19. The *Health Service Journal* reported that two drafts of the STP had been rejected by NHS England.[3]

The acute trusts in Herts and West Essex are mired in deficits, and the STP admits that no less than £328m of capital backlog is needed to patch up the crumbling Watford General and Princess Alexandra Hospitals, to keep them going for up to 10 more years, and to postpone consideration of a new £450m hospital to replace them.[4]

Indeed the 32-page Herts and West Essex STP contains almost no financial detail, and no serious attempt to explain how any of the hoped-for savings are to be achieved. How, for example, do they expect to save almost £60m through 'demand management', which includes not only the now routine aspiration to save millions of pounds by reducing illness in an implausibly short space of time through as yet unproven measures of 'prevention', but also save more than £42m of savings from the provision of primary and community health services?

The STP does not explain how a reduction of 186,000 A&E attendances within 3 years, and 456,000 over the five year period, is to be achieved, or how hospital in-patient treatment is expected to reduce by 16,025 cases within 3 years, and 36,000 over 5 years, equivalent to 24,534 and 51,874 bed days. Moreover, if the STP is to be believed, all of Herts and West Essex's plans to remodel, improve and integrate services – insofar as there are any actual plans – are free of any requirement for additional revenue cost, any increase in staff costs, or any expansion of primary care services or investment in facilities. There is just one mention of this type of investment, and none of the financial tables includes any mention of investing to save.

The planners also hope that the significant reductions in hospital use that are planned will also cut costs (and therefore spending) per patient by 2020-21, as well as enable 'colleagues working to transform acute services to reduce capacity and 'right size' their overall bed base'.

This could mean that long-running fears for the future of Princess Alexandra Hospital in Harlow – the struggling Essex outlier excluded from the 'success regime' spanning three trusts in the south of the county – will prove justified.

The STP also does not say how many jobs, and in which categories, would be lost to generate the hoped-for £109m worth of savings from 'other provider productivity/staff changes.' Most STPs are similar to Herts & West Essex's in offering no convincing detail on how they plan to 'reduce demand' other than the familiar proposal to stop providing services defined as having 'limited clinical value' – or finding other arguments for rationing care, or for excluding certain categories of patient. The Staffordshire & Stoke on Trent STP, for example, while making clear the aim to close an A&E department and downgrade one of three acute hospitals, also aims to make undisclosed savings from 'harsher' implementation of

restrictions on what they describe as 'procedures of limited/no benefit' (p51).*

No STP demonstrates any evidence for the central assumptions it makes, or its 'innovative' solutions. In the only STP which appears to offer serious bibliographic references to support its claims, North West London, many of the references turn out on closer examination to be inappropriate, incomplete, or references to the planners' own unpublished work.

Some STPs – unlike Herts & West Essex – do contain appendices or extended financial sections, and at least some detail on workforce and other essential issues. But many don't. In Cambridgeshire & Peterborough, for example, FOI requests for such details have been rejected: they are still under wraps.

Lack of public involvement

All STPs have one thing in common: just weeks before they were scheduled to begin to be implemented (the expectation was that CCGs would sign contracts implementing them by December 23, 2016), none of them had been subject to any serious public engagement or consultation. Few of the plans have been the subject of any real consultation, as opposed to limited exchanges with informal assemblies of selected councillors and council officers, along with a handful of clinicians, public health staff, NHS and social care managers and unrepresentative spokespeople for 'patients' and the 'voluntary sector'.

* A swift search has shown similar proposals described as the basis for varying levels of savings in STPs in Cheshire & Merseyside, Derbyshire, Hereford & Worcestershire, Lancashire & S. Cumbria, Lincolnshire, South West London and West Yorkshire.

Indeed some of the first plans to appear in the public domain were only published by irritated council leaders, who had been presented as 'partners' in making STPs but who lost patience with the secretive process decreed by NHS England. Liverpool's Mayor Joe Anderson, speaking to a motion calling on Liverpool's Health and Wellbeing Board to reject the Cheshire & Merseyside STP, summed up the frustration:

> 'As a city, we all support the principles of joined up working between the Council, health services and others, including residents themselves, for better integrated services, particularly in adult social care. However, there has been no, I repeat no, consultation or engagement with the city and any other city region local authorities over this STP, and for any plan to be sustainable the input from the relevant local authorities is critical.'[5]

Most of the later drafts have some approval from NHS England, but while we know that Hertfordshire's first two drafts were rejected, it's not clear why this plan, and some of the other vague and least convincing plans have got through. Yet it's clear that contracts in many areas will be signed on the basis of these deeply flawed documents and proposals.

STPs – a would-be response to underfunding

The key to all the STPs is that they are supposed to square the circle of frozen NHS funding while population, local needs and costs continue to rise inexorably. While real terms budgets are barely higher than they were in 2010 when George Osborne embarked on his ideologically-driven drive to reduce public spending as a share of GDP, the significant rise in overall

population, and within that the increased numbers of older people in particular, have driven costs upwards, along with general health service inflation, PFI costs and other factors.[6]

The Nuffield Trust's financial analyst Sally Gainsbury demonstrated in a powerful blog in October how the claimed 'extra' £10 billion the government claims to have given to the NHS is in fact a sleight of hand, while the real value of the 'extra' money is less than one tenth of that (just £800 million). Meanwhile after six years of freeze, trusts are sitting on underlying deficits of £3.7 billion:

> 'How did providers get into such a mess? The answer is pretty simple. Every year between 2010-11 and 2015-16 the amount hospitals were paid for each treatment they provided was cut, year after year. That meant that by 2015-16, a hospital was paid the equivalent of £820 to treat a patient they would have been paid £1,000 to care for in 2010-11. Hospitals tried to balance their books by cutting their costs by around 13 per cent over the same period. But the amount they were paid was cut even faster – by around 18 per cent, resulting in the expenditure-over-income deficit we see today.'[7]

NHS England board papers in December 2016 confirm the scale of the problem: demand has grown faster than resources.[8] A&E attendances – despite all the plans to reduce or contain them – have risen another 4.5% in 12 months, leaving acute trusts on average delivering the target performance in just 89% of cases instead of the required 95% in October 2016 – and leaving 220,000 people waiting longer than 4 hours to be admitted or discharged in that month. Stories of trolley-waits reminiscent of the bad old Thatcher days of the late 1980s are appearing once again. And there has been a similar increase in pressure on diagnostic tests (numbers up 4.7% in 12 months).

Numbers of emergency calls for ambulances also increased by almost 5% in 12 months. Under-funded ambulance services – impeded by delayed hand- overs of patients to A&E departments in hospitals with no free beds – have not been as able to cope, falling short of the target calling for 75% of ambulances to arrive within 8 minutes of a Category A (most urgent) call. In October 2016 the average of the ambulance services which reported figures was just 67%.

Numbers of calls to the NHS 111 service also increased, by a massive 14% over the 12 months to 1.2 million in October. Emergency admissions too were up almost 3% on 12 months ago. But even as more patients come in to hospital it's harder to discharge those who need any form of continuing care, since the promised developments in primary care, community care and social care have not occurred.

The NHS England report reveals that in October 2016 there was an overall 25% increase over last year's figure for delayed 'transfers of care' – totalling the equivalent of 200,000 bed days that month. The increase in delays was the highest in acute care, which saw a 29% increase from 104,000 in 2015 to 134,000 (the other delays were mainly in mental health). Meanwhile increases in the minimum wage and tightly constrained fees offered by local councils help to squeeze profit margins in the chaotic private market for nursing homes and domiciliary care – guaranteeing a rotten quality of care for those forced into reliance on it.

But it's not just emergency services and social care that are under strain. NHS England's own board paper admits:

> 'demand for elective care services continues to increase more than the capacity to treat patients, and it will not be possible to recover RTT (Referral To Treatment) performance in the short term'.

Under-funded hospitals are indeed failing to meet their targets. More than 10% of elective patients (364,000) are waiting over 18 weeks to start treatment, missing the time limit supposedly guaranteed under the NHS Constitution.*

We also know from news reports that mental health services are under pressure:[9] district nursing is desperately under-staffed, and community health services are facing cuts in staff, beds and resources in many STPs, especially in rural areas such as Devon or Cumbria. The system as a whole is struggling to cope. Since the New Year the pressure on hospital services has pushed the funding crisis to the top of the political agenda, with the Prime Minister's position being openly criticised by the Conservative chair of the Commons Health Committee. She and her ministers are have struggled to deal with daily local and national press headlines and refute the united opinion of the medical professions and the unprecedented intervention of the Red Cross in calling the situation in England's hospitals a 'humanitarian crisis'.[10]

The response of NHS England (and therefore of many STPs) has been to seek ways to cut services to fit the budget available by 'reducing demand' and by 'innovative models of managing demand'. The Board paper referred to above shows that teams of doctors and nurses are to be sent in by NHS England into the most pressurised hospitals to vet all those seeking help in A&E; or as NHS England put it, to 'accelerate plans to stand up streaming services at the front door'. It does not say where these teams are to be recruited from, or to whom they will be accountable.

Campaigners and the public have been understandably suspicious and hostile to the idea of STPs, especially where there is a pre-history of plans to 'rationalise', 'centralise', or in today's jargon

* There appears to be no reporting of the extent to which people are kept waiting once it is longer than 18 weeks, other than to record the very small numbers of patients who have been waiting over a year.

'consolidate' services on fewer sites, meaning that patients, including some with the most serious needs, will have to travel further to access treatment.

Even more suspicion is generated by largely evidence-free notion that large investments in 'digital' solutions can generate savings, on the assumption that frail older people with multiple long term health issues will become expert at using them. There are also hollow laughs over the futility of trying some of these systems in the many rural areas and 'dead' spots with little or no access to high speed broadband or mobile phone signal, or of trying to do serious business using the wonky connections offered by Skype. And who can take seriously plans for 'virtual teams' and 'virtual wards' when there are no physical staff or beds?

The majority of those who hear about the STPs have been unconvinced by the wishful thinking and positive 'vision' that characterises most STPs, and have shown themselves well aware of the way with which unwelcome details have been packaged in the plans.

As a result, and partly through lobbying by determined activists, local councillors, who are perhaps potentially the most politically vulnerable to public anger, have emerged in some areas as unexpectedly vocal challengers to the plans. This is in marked contrast with the last few decades during which – with a few noteworthy exceptions – councils have mostly shown scant interest in NHS policy and resource issues

Misleading language, or spin.

The reaction of politicians and even some health unions has been delayed and muted by confusion over the contradictory content of STPs, which talk abstractly about positive objectives, and about

getting commissioners and providers collaborating together while developing concrete and questionable plans to save money at the expense of service cuts on a large scale.

To this end every STP, following the *Five Year Forward View,*[11] uses words to describe its aims for which nobody would consciously choose the opposite. One example is the repeated call for better 'integration' of under-funded, fragmented and largely privatised 'social care' with under-funded, fragmented NHS hospital, community and primary care services. Who would be against a genuine integration – if the result was a coherent and coordinated public service, funded from taxation and free at point of use? Who doesn't want more effective preventive and public health measures to keep people from needing the NHS in the first place? Who would reject action to address the 'social determinants' driving ill-health? Who would say no to new resources to support and enhance primary care, and give easier access to GPs – and to offer care nearby or even in your own home, rather than having to trek miles to queue for attention in overwhelmed hospital services?

But abstractions like 'integration' and 'self care', to be found in every STP, distract attention from unpopular changes, and ignore facts on the ground. Public health programmes are actually being cut back across the country as a result of cuts in local government funding, so there is no money for the new prevention schemes that would be required to reduce the need for care, or for projects to tackle seriously the social determinants of health – which in any case would take years to show any measurable reduction in pressure on the NHS. Yet many if not all STPs rely on public health action to significantly reduce the 'demand' for services.

And primary care is already floundering: with more and more practices unable to cope with ever-increasing pressure, many GPs are leaving and are increasingly hard to replace, while Jeremy Hunt's promise to recruit 5,000 more GPs plainly lacks credibility.[12]

Many STPs seek to paper over the cracks, proposing that other, less qualified – and yet to be recruited –staff will take over a lot of the work now done by GPs.

As for community health services, some rural STPs involve closing community hospitals, with Cumbria and Devon expecting patients to travel up to 50 miles on sometimes hazardous roads when they need hospital care. None of the STPs addresses travel issues for elderly, less mobile patients, or single parents.

Even where community and home-based health or care services have been shown to be effective in enhancing patient care, they don't save money, but cost more[13,14,15,16] . Yet STPs are required to *save money*, to enable the NHS to deliver more services to more people and absorb more cost inflation and cost pressures over the next four years, and wipe out existing deficits.

Many questions also hang over the proposals, more developed in some STPs than others, for the development of new forms of organisation of health care through US-style Accountable Care Organisations or Partnerships, as outlined by Simon Stevens in the Five Year Forward View. Many of these schemes are for the medium or longer term, and none of the proposals explain how they are supposed to improve services while at the same time saving money. Indeed far from being cheaper to run, ACOs in the USA receive and require far higher spending per head than any British equivalent could even dream of, with allocations[17] between 3 and 5 times higher than the average £2057 spent per patient per year in England's NHS[18] – a figure which many STPs explicitly seek to further reduce.

Nor do STPs address the consequences for existing NHS and Foundation Trusts of establishing new contracts and provider organisations, or the proposed reductions in caseload and funding for existing providers which are central to the expected cost 'savings'. Since acute trusts are largely paid only for the patient

care they deliver ('payment by results'), a reduction in caseload in one service can trigger the collapse of viability of related services and pull the financial rug from already indebted trusts.

Conclusion

At the end of the day, when the innovations in STPs don't deliver savings for the NHS, NHS England will again resort to cuts and rationing. Indeed many knowledgeable people see the STPs as a smokescreen to divert attention from cuts at trust level, whittling away staffing levels, imposing smaller-scale service reorganisations, and preparing to push through controversial closures on 'safety' grounds (as has happened in Grantham and Chorley and is increasingly on the cards in Ealing).

Up to half of most STPs' planned savings are in any case to be squeezed out of the hospital sector, through ever more relentless 'efficiency savings' and reductions in staffing levels, along with closures of beds, services and even whole hospitals.

With no alternative services in place, and no capital available to build new or extend existing hospitals,[19] and with even community hospital beds and staff facing cuts, it is a recipe for a chronically under-resourced, chaotic and scandal-prone NHS.

Promoting STPs may seem an easier course of action for NHS England than to warn Mrs May that if the cash freeze begun in 2010 is extended to 2020/21, many services will collapse. We know that Simon Stevens' effort to do this after she became Prime Minister was met with a frosty reception[20]. But STPs cannot solve the problem of inadequate funding. Ministers will have to fund the NHS properly or take political responsibility for its collapse.

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