

STPs –Phoney War? Or the lull before the storm?

Former NHS finance director Roger Steer of Healthcare Audit Consultants Ltd compares some of the more prominent reports analysing STPs

Basking in the summer heat it is easy to forget the Sustainability & Development Plans (STPs) and the threat that they pose to healthcare in England.

It seems a long time ago since STPs appeared, but still most people are only dimly aware of them. There was little fanfare and mostly their intentions were wrapped in obfuscation and rhetoric¹. Their overall thrust is clear enough in the title “Sustainability and Transformation Plans (STP)” but the threat is more insidious.

For readers distracted by other things the Institute of Public Policy research (IPPR) provide a crisp description of STPs and where they have come from

“The NHS is facing one of the most challenging periods in its history. A toxic combination of ever rising demand and stagnant funding growth means that the service is facing a funding gap of more than £22 billion over the coming years.

“Meanwhile, the pressure on the social care system is even more acute, with many councils raising eligibility thresholds and making cuts to social care budgets. Sustainability and Transformation Plans (STPs) – which are local health and care reform plans, authored jointly by NHS and local government leaders to improve outcomes and drive greater efficiency in their local area – are one of the government’s main responses to this problem”.

They were published at the end of 2016, all 44 of them, each corresponding to newly-defined strategic ‘footprint’ areas encompassing healthcare and social care services for local populations across England. They comprised of hundreds if not thousands of pages of complex text almost impossible for the average citizen to comprehend.

They claim that the NHS faces an existential threat unless radical action is taken to introduce new models of care and another reorganisation of care, promising to reduce the demand for healthcare and thus enable better care to be delivered by fewer staff and fewer facilities than currently, despite the steadily increasing demographic pressures.

It is not surprising therefore that researchers and interested parties have taken the time to digest and present their analyses of these plans. The subject matter is important (literally life and death), political (it resulted in the delay of two of the reports listed below until after the election) and contentious (despite efforts to build an all-party consensus and clinical support).

As matters stand the roll out of these plans could either determine the result of the next election or prompt its timing².

The reader can select from a range of reports that relate directly or indirectly to STPs or the wider integration of health and social care process:

- 1. Kings Fund**

https://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/STPs_proposals_to_plans_Kings_Fund_Feb_2017_0.pdf

- 2. Nuffield Trust**

<https://www.nuffieldtrust.org.uk/files/2017-02/shifting-the-balance-of-care-report-web-final.pdf>

3. **Institute of Public Policy Research (IPPR)**
http://www.ippr.org/files/publications/pdf/STPs_devo_health_June2017.pdf?noredirect=1
4. **British Medical Association**
<https://www.bma.org.uk/news/2017/may/the-burning-issue-stps>
5. **National Audit Office**
<https://www.nao.org.uk/report/health-and-social-care-integration/>
6. **Reform**
<http://www.reform.uk/wp-content/uploads/2017/02/Saving-STPs.pdf>
7. **South Bank University.**
http://www.lsbu.ac.uk/_data/assets/pdf_file/0019/114409/sustainability-and-transformation-plans-critical-review.pdf

Here we must declare an interest as the authors of the report for the South Bank University but the purpose of this article is to draw together and contrast the themes that emerge from these separate analyses as well as from the STPs themselves. We identify the following themes and discuss them below:

- A. **Plans reflect a diverse English landscape with radically different contexts, problems and enthusiasm to pursue the direction charted by NHS England chief executive Simon Stevens in his “Five Year Forward View” published in 2014³. Published plans are however not regarded as good enough:**

The Kings Fund for example call for “Proposals set out in the 44 STPs submitted in October 2016 ... to be developed into coherent plans, with clarity about the most important priorities in each footprint” (p2). This is a polite way of saying existing plans are incoherent and unclear.

The Kings Fund further state “ Proposals to reduce capacity in hospitals will only be credible if there are robust plans to provide alternatives in the community before the number of beds is cut” (p2). This is a polite way of saying plans to cut beds are incredible and the plans to provide services in the community are not robust.

IPPR summarise as “there are a range of challenges that stand in the way of STPs realising their vision for improved health outcomes and greater efficiency. In particular, they:

- face a deficiency in leadership, especially at the national level, which means that the public is either unaware of the reform plans or is misinformed about them, leading to unnecessary opposition
- risk getting engulfed by the funding pressures on the service, with much of the existing funding being channelled into maintaining existing ways of working or filling in deficits, rather than enabling the reform agenda
- have no statutory powers with which to deliver their reform agendas, with the fragmentation created by 2012 Health and Social Care Act retained – making STPs a workaround – rather than addressed directly” (p3).

This is a polite way of saying the leadership of the plans is not good enough, there is no money to realise the plans and the existing legislation doesn't support the changes proposed or the plans being drawn up.

The South Bank University report concluded more bluntly “We have not identified one STP that is as yet capable of demonstrating readiness for implementation” (p9).

B. The evidence base supporting the claims that prevention and new models of care, including the bringing together of health and social care in partnership, can reduce the quantity of acute care significantly does not exist, but there is a curious reluctance from industry insiders to be explicit about this.

For example the Kings Fund state “Proposals to reconfigure hospitals *could* (our emphasis) improve the quality and safety of care, and need to be considered on their merits to ensure that a convincing case for change has been made” (p2).

This is a polite way of saying that the business case and the convincing case for change have yet to be written for reconfiguration proposals.

The Nuffield Trust summarise:

“in the context of long-term trends of rising demand, our analysis suggests that the falls in hospital activity projected in many STPs will be extremely difficult to realise. A significant shift in care will require additional supporting facilities in the community, appropriate workforce and strong analytical capacity. These are frequently lacking and rely heavily on additional investment, which is not available.

“We argue that NHS bodies frequently overstate the economic benefits of initiatives intended to shift the balance of care. For example, they may use prices to calculate savings rather than actual costs and can therefore wrongly assume that overhead or fixed costs can be fully taken out. Similarly, many underestimate the potential that community based schemes may have for revealing unmet need and fuelling underlying demand” (p5).

This is a scarcely polite way of saying plans are unachievable, unrealistic, unaffordable and based on false assumptions.

The NAO concluded: “The Departments have not yet established a robust evidence base to show that integration leads to better outcomes for patients”(p7) and “There is no compelling evidence to show that integration in England leads to sustainable financial savings or reduced hospital activity”(p7).

Our own report for the South Bank University attempted to summarise in its appendix1 all the evidence supporting STPs main assumptions. We recommended

“We suggest that there is a need for the evidence base supporting the case for change to be substantiated through independent academic review, before launching into plans for widespread ‘transformation’(p10).

This was our way of politely saying the evidence doesn’t exist – and if you don’t believe us, then commission some other serious academics to tell you so.

C. The size of the changes planned is very large and the risks of failure are very high.

A key message from the Nuffield Trust was:

“Our analysis suggests that some STPs are targeting up to 30 per cent reductions in some areas of hospital activity, including outpatient care, A&E attendances and emergency

inpatient care over the next four years. Yet this is being planned in the face of steady growth in all areas of hospital activity – for example a doubling of elective care over the last 30 years”(p4).

IPPR concluded “Given the barriers to progress set out above, STPs will not deliver the degree of change needed to improve the NHS and to meet the financial targets on which the Five Year Forward View depends.” (p6)

South Bank concluded

“None of the STPs provide a complete risk analysis. Most were wholly inadequate, some non-existent at this stage and those that did provide an analysis were a testament to the extent of risks, uncertainty and the attendant difficulties attached to the STP process and content. Overall, the risk is of poor investment decisions with STPs adding to the burden of the NHS rather than releasing capacity”(p9).

The Nuffield Trust report details the reductions in activity planned:

- 15.5 per cent fewer outpatient attendances (range 7–30 per cent)
- 9.6 per cent less elective inpatient activity (range 1.4–16 per cent)
- 17 per cent fewer A&E attendances (range 6–30 per cent)
- 15.6 per cent fewer non-elective inpatient admissions (range 3–30 per cent).”

South Bank warns:

“Examples exist of what happens when capacity was reduced prematurely in NW London as A&E departments close based on assumptions that demand can be reduced and existing capacity can cope: performance deteriorates and extra capacity has to be hurriedly commissioned⁴.

D. The vested interests standing to gain from this process are difficult to discern and are not made explicit.

It is possible to identify those vested interests that stand to gain substantially from presenting and implementing these ambitious and risky plans.

Primary and community care: The expectation is that these services will expand and take on more responsibility/income provided out of enhanced premises and facilities. Given that these are owned by GPs themselves they therefore have a direct fiduciary interest in the main thrust of STP plans.

Major Acute Hospitals: Acute services will be centralised reinforcing the position of clinicians and managers working within the major acute centres. Given that private earnings correlate to the volumes of work centralised senior consultants have a direct pecuniary interest in plans to centralise acute services. Managers’ salaries are also related to the size and scope of responsibilities and therefore they are well disposed to centralising initiatives.

Senior managers within the NHS and Department of Health. Despite the lack of an evidence base or comparable international examples supporting STPs the international interest in learning from or supporting the NHS in these plans is significant. Any direct experience is likely to have a value and command significant fees and salaries in any subsequent career.

It is well known that senior NHS figures are promoting opportunities for private sector involvement in the NHS which could represent a significant reward in future years.

Advisors and commercial interests – providing management consultancy, data analysis, financial planning, project management, change management services, communication services and management training – all stand to gain substantially from the changes being promoted.

Such organisations include the Kings Fund, Nuffield Trust and organisations such as IPPR and Reform which are sponsored by commercial interests as well as the large management consultancy firms such as McKinseys and PWC.

In the absence of published information for many STPs the South Bank report estimated costs of a minimum of c£0.5m per STP footprint per annum for the STP process (p26). A substantial proportion of this would be spent on senior management and management consultancy support.

In no other report is the existence of vested interests cited as a problem or declared in any of the STPs published despite this being an ever present issue. In the NHS it is regarded as impolite to refer to such conflicts of interest. In the case of organisations in receipt of substantial funds from commercial interests it may not be well received.

E. Lack of clear legal authority is an obstacle

It is only a little more than five years since the Health and Social care Act was passed enshrining choice, competition and localism into the delivery and commissioning of health and social care and yet it is clear that the STPs represent an explicit repudiation of the law of the land and instead intend to replace it with regional/area planning, collaboration and integrated approaches to both commissioning and delivery. Planning radical change in the teeth of the law heralds complications to say the least.

This reservation is expressed by the Kings Fund “Changes to the law are needed to amend aspects of the Health and Social Care Act 2012 that are not aligned with the Forward View, particularly those relating to market regulation” (p4).

IPPR point out:

“STPs have no statutory powers with which to deliver their reform agendas, with the fragmentation created by 2012 Health and Social Care Act retained – making STPs a workaround – rather than addressed directly” (p3).

Despite this the BMA have pointed out: “national health bodies, including NHS England, are stretching the Health and Social Care Act 2012 beyond reason by creating new health bodies, called ‘accountable care systems’, which have no mention in the act and no official accountability or governance”(p1).

Reform identify in their report of discussions with stakeholders of STPs “Interviewees consistently argued that it is difficult for STPs to draw up plans across their areas because they have no executive authority. STPs are also uncertain whether they are allowed to integrate local services, given the need to maintain competition under current legislation. The NHS payment systems are fragmented with separate budgets for primary, secondary and social care. They do not support organisations to plan and deliver care co-operatively” (p5).

Having a basis in legislation is the first thing that they teach you in public administration otherwise you run the risk of acting “ultra vires”.

F. Cost shifting onto local authorities and family budgets faces obstacles

Shifting care from acute hospitals into the community and back onto individuals and their carers constitute cost shifting onto individuals and their families. Help for those individuals and families from local authorities is being rapidly reduced as government funding reduces.

The expectation from local government is that significant extra resources to support social care can come from NHS budgets. But that can only happen if acute services can be safely reduced. As matters stand they cannot be. As the election campaign showed there is a marked reluctance of families to fund social care themselves except as a last resort.

The Kings fund found “Cuts in social care and public health and a lack of earmarked funds to support transformation will affect the ability of NHS organisations and their partners to implement their plans”(p2).

The Nuffield Trust found “Many initiatives we examine place additional responsibilities upon primary and community care, at a time when they are struggling with rising vacancies in both medical and nursing staff, and an increasing number of GP practices are closing. Addressing these issues is a necessary precursor to success”(p5).

The NAO found

“NHS England has not assessed how pressures on adult social care may impact on the NHS. NHS England has noted that the widening gap between the availability of, and need for, adult social care will lead to increases in delayed discharges and extra pressure on hospitals. However, we did not see any estimate of the impact on NHS bodies of pressures on social care spending”(p10).

The South Bank report drew attention to the highly critical report from the House of Commons Committee of Public Accounts, Adult Social Care in England, in July 2014. Having taken evidence from the Department of Health and the Department for Communities and Local Government, the Committee noted,

“The Departments do not know whether the care system can become more efficient and spend less while continuing to absorb the increasing need for care. [...] Local authorities’ cost savings have been achieved by paying lower fees to providers, which has led to very low pay for the care workforce, low skill levels within the workforce, and inevitably poorer levels of service to users. [...]

“We are concerned that the Departments have not fully addressed the long term sustainability of the adult social care system, and that its policies to drive change (the Care Act and the Better Care Fund) are not supported with new money and do not acknowledge the scale of the problem. [...] The Departments acknowledge that they do not know how local authorities will achieve the required efficiencies, but still believe the ambitious objectives of implementing the Care Act and integrating services are achievable” (p6).

None of these problems were reported to have been resolved (see appendix 1 pps 61-76).

G. Partnerships with local authorities remain faltering

Changes in local government organisation toward creating more combined authorities may be a distraction rather than a help for STPs as the capacity of local government is shrinking just as more is being expected of them. Despite the public show of partnership working plans do not reflect this and separate reports indicate that there is much more to be done in this area.

The Kings Fund state clearly

“Cuts in social care and public health and a lack of earmarked funds to support transformation will affect the ability of NHS organisations and their partners to implement their plans” (p2).

The Nuffield Trust are also clear “What is clear is that to avoid hospital admissions and accelerate discharges, there must be sufficient capacity and funding of alternative forms of care in the community. Without this investment, analysis suggests that the NHS will need to expand, not contract, its bed capacity”(p14).

IPPR draw attention to “There is an imbalance between NHS and local authority involvement, with just four out of the 44 STPs led by local authority chief executives, and membership on STPs being largely favourable to the NHS. Furthermore, engagement varies significantly, with one local authority chief executive, on the day of STP submission, quoted as saying: ‘I mean, I don’t even know what the STP looks like’ (Alderwick et al 2016)”(p18).

The NAO in their February report say “Without full local authority engagement in the joint sustainability and transformation planning process, there is a risk that integration will become sidelined in the pursuit of NHS financial sustainability”.

In a very recent report on combined authorities they draw attention to “The lack of geographical coherence between most combined authorities and other providers of public services could make it problematic to devolve more public services in the future” (p8)⁵ and “The capacity of most combined authorities is currently limited, and still being developed” and “There is a risk that local councillors will have limited capacity for the overview and scrutiny of combined authorities”(p8).

The South Bank University report looked for evidence of joint working between local authority and health partners but concluded that there was a need for greater clarification of arrangements and could find little evidence of jointly addressing financial problems in social care (p8).

Conclusions

Unsurprisingly there is a wide area of agreement in the analysis but a marked difference in the lessons drawn.

This seems to be based on a split between those organisations pre-disposed to support the direction of travel and realists who take a pragmatic attitude to evidence, risks and the quality of the business cases presented.

Thus we find the Kings Fund continuing to assert “Sustainability and transformation plans (STPs) offer the best hope for the NHS and its partners to sustain and transform the delivery of health and care”(p2).

Rather than displaying caution they call for

“The government should reiterate its commitment to STPs as the means for implementing the Forward View; it should support proposals to improve services where the case for change has been made, and recognise the need for additional resources for the NHS and social care”.

IPPR offer to save STPs by proposing strengthening leadership, increasing funding and giving more powers to STPs.

Reform offer to save STPs by proposing more competition (!), pooled budgets and simplified leadership arrangements.

Others are more realistic (Nuffield Trust, BMA, South Bank University) predicting lack of resources, and problems associated with unrealistic plans hitting a brick wall of reduced budgets, lack of staff and insufficient impact from measures to reduce demand and shift care out of hospitals safely. Continued constraints on local government will add pressures to acute services rather than acute services see declining demand.

What seems to be happening is that a select few front runners have been chosen to be the vanguard for the “United Healthcare of America” approach of establishing Accountable Care Organisations in STP footprints in some parts of the country, although with serious and growing restrictions on the funding available, while progress on STPs in general is likely to be slower elsewhere as plans continue to be worked on and clarified.

My own experience of such initiatives is that the ‘Hawthorn effect’ [in which the performance of a group of workers being studied was seen to improve as a result of being studied] can lift performance temporarily, especially if accompanied by more resources and incentives. But ACOs look a lot like old style health authorities before the purchaser–provider split, while lacking even the rudimentary democratic accountability that existed back then.

In the absence of sufficient funding, even on the most positive possible reading that is not a solution to rising demand and reducing resources but a recipe for the return to waiting lists and face off with the Treasury.

The realists are more likely to be correct. Expect the phoney war to be over soon as the frontline moves to those implementing ACOs and taking early steps along the implementation route for STPs. Expect casualties as plans face reality.

Our own view is that the evidence supporting the STP approach doesn’t exist and the limited success achieved is insufficient so far to justify the resources being committed to trying to make STPs work.

A more targeted approach to resolving supply side issues is likely to be more successful and we support the Labour Party call for a full review of the STP policy direction, with a halt to any half-baked cuts and closures of services in any of the 44 footprints until a viable plan and a plan for its implementation has secured local support.

¹ See (£) <https://www.hsj.co.uk/comment/-dont-be-deceived-by-the-rhetoric-of-reconfiguration/5061642.article>

This comment piece in the HSJ was written to warn against the use and abuse of rhetoric to win arguments.

² This is not an idle claim as recent election results in constituencies in NW London and Canterbury were arguably swung on the basis of opposition to changes embedded in local STPs. Pressing ahead with radical reconfiguration plans will only magnify the numbers of constituencies affected, largely in rural areas which stand to lose access to A&E, maternity and children’s services.

³ <https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>

⁴ <http://www.bpv.org.uk/the-independent-healthcare-commission/>

See in particular http://www.bpv.org.uk/wp-content/uploads/2015/04/150326-NWLHC-Interim-Report-final-version_tcm21-194963.pdf section 2 Patient access

⁵ <https://www.nao.org.uk/wp-content/uploads/2017/07/Progress-in-setting-up-combined-authorities.pdf>