



**London  
South Bank  
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**School of  
Health and  
Social Care**

# **Sustainability and Transformation Plans**

How serious are the  
proposals? A critical review

**May 2017**

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## Foreword

The Health and Social Care Act 2012 removed the NHS's intermediate tier, placing commissioning responsibility with Clinical Commissioning Groups in which many of the clinical leaders were new to this level of management and leadership; and giving NHS England responsibility for Specialist Commissioning and Primary Care. Expecting CCGs to work together as peers, with little experience of developing systems; with new Commissioning Support Units providing to varying degrees a wider intelligence function and planning capability; at the same time as the NHS was facing a significant increase in demand and pressure on its cost base, was a significant risk (one which was identified by the Health Select Committee at the time).

The NHS Five Year Forward View was cognisant of lessons from international health systems, with its population focus, development of locally relevant collaborations, and in 2016, the replacement of the intermediate tier for the significant issues that required a sub-regional planning footprint. There is no doubt that this is the right direction, however the intent has been opaque and the process has been hard to navigate for the NHS and for Local Government.

We commissioned this report as a reality check on the Sustainability and Transformation Plan process as a whole; to provide an opportunity for review; and to reconvene around the issues that need a sub-regional approach.

This report is a significant contribution to the myths and realities of the Sustainability and Transformation Plans and the process of their development. By starting from the actual situation in each STP footprint, this report grounds the plans in the reality of the local context, and provides a firm basis for any collective decision-making. Many of the STPs (the documents) are not clear about the full extent of the current situation (the baseline from which they are making their plans), which makes the collective STP leadership task extremely difficult.

When reading this report we noticed the lack of emphasis on reducing demand. The NHS has been beset by instructions to increase access. Whilst of course sick people do need to be able to access health care when they need it, there also has to be a focus on how best to enable people to look after themselves, to reduce failure demand, and to work with local assets to find community-based solutions to support mental and physical health. Primary care does feature in the plans, but has not been developed to an extent that we would have expected to stem the ever-increasing demand on health services.

This report brings to the fore the challenge of NHS and Local Government collaboration. With local government democratically accountable to its local population, working to meet local needs; and with the NHS accountable through NHS England and NHS Improvement; planning together over a wider footprint in terms of population, with completely different accountabilities, means the starting point for STP-level collective decision-making and planning is a challenge. Layer on top of this the fact that the STP process is an NHS policy (not provided in partnership with the Department for Communities and Local Government), which is being translated by NHS leaders in STP footprints as a policy requirement for collective working and joint decisions with local government, where

some of these decisions are likely to be challenged by local populations (and where local government clearly has to consult and represent local people's views), and you have the recipe for a poor starting place for collaboration. Finally the lack of clarity about the relationship between populations (local and STP footprint) makes this a messy process without clear boundaries.

Add to this that this ethos of collaboration is to take place within a legislative framework built for the market, with competition the driving force for change, it is no wonder STP leaders are struggling to achieve the scale of change that is required in the time-frame.

There is no doubt that there is work to do at STP footprint scale, particularly on NHS service configuration and wider workforce planning. There is also the key function of bringing business intelligence to bear on local decisions (by which we mean local place – Health and Wellbeing Board level) and evidence-based scrutiny of local decisions. Many of the STP documents are light on the evidence that underpins the proposals and this needs addressing. Of course health and social care should and can work better together, and whilst the evidence from integrated care does not show dramatic results, citizens do need a more integrated person-centred approach. The STPs would do well to learn the lessons from high performing health systems which is to keep change as local as possible, provide data-based business intelligence, support professional decision-making with evidence and scrutiny, develop collaborative relationships through dedicated time to learn together, work with citizens as part of the solution, have robust primary care teams at the heart of the delivery system, and develop skills for quality.

We commend this significant report to any leaders in health and social care working through the difficulties of collaborating across health and social care, and thank the authors for this detailed and important review.

**Prof Becky Malby, Prof Warren Turner**  
London South Bank University

<sup>1</sup>Baker, GR., Denis, JL. (2011). *A Comparative Study of Three Transformative Healthcare Systems: Lessons for Canada*. Canadian Foundation for Healthcare Improvement.

## Summary

In late 2016, 44 geographic areas of England published Sustainability and Transformation Plans setting out how health and care will be delivered within their local areas in the period to 2020/21. These plans are intended to bring about a radical transformation of the health care system in England. This report reviews all 44 STPs based on a detailed examination of the content of each one, and provides a critique of both the process and content of those STPs.

The STPs result from NHS England's Five Year Forward View and the subsequent NHS England directive that tasked all NHS organisations to form coherent geographic areas for the purpose of coming together to achieve three aims:

- to implement the Five Year Forward View;
- to restore and maintain financial balance; and,
- to deliver core access and quality standards for patients.

The acronym STP is now used interchangeably to mean the Plan itself, the people implementing it (the Programme Board), or as a generic term to embrace the various proposals within the Plans.

Individual STPs varied in size, depth, presentation and content. Each was subjected to an analysis aimed at establishing answers to the same set of questions. These questions addressed both 'process' and 'content' of the reports; the full analysis for each STP area is available on the London South Bank University Website<sup>2</sup>.

## Process

**Public participation and accountability:** there is a lack of clarity around the authority of STPs, their partnership arrangements, and their own role. This leads to a further lack of clarity about the public's role in the plans. Some STPs rely on public engagement and consultation on parts of their plans, others have developed their plans with some representation from the public. But overall it is unclear, given STP partners' own accountability to their local populations, how the STPs themselves are to be held accountable to their 'footprint' population, and there is a danger of a distance emerging between the decision-makers and the public.

**Openness:** there is considerable variation in the attention each STP pays to openness: to explaining the process to local people and ensuring they are informed about the plans. While the need for 'communication and engagement' with 'local stakeholders' features in each STP, there has been a disturbing level of secrecy about what was actually being produced. The details of each STP were hidden from public view for many months, and in many cases not even shared with 'local authority partners'. Even now, in many areas, key information is contained in appendices that are not publicly available.

<sup>2</sup> <http://www.lsbu.ac.uk/business/expertise/health-wellbeing-institute/health-systems-innovation-lab>

**Collaboration:** STPs rarely contained specific reference to stakeholders formally signing up to the document, although often it was implied (if only by omission) that there was unanimous support across the area. This is true even where there has been significant local authority opposition to the content and/or the process of the STP, for example in North West and South West London, Bristol, Coventry, Telford and Wrekin, Liverpool, Sefton, Wirral, Cheshire West, Chester, Stoke-on-Trent, and county councils including Shropshire, Warwickshire, Lincolnshire, and Oxfordshire.

Often opposition takes the form of local pressure groups representing the interests of local people; in some cases local politicians and some local clinicians are also vocal opponents.

**Role and Governance:** it is hard to determine from the STP documentation how the STP Board operates and where accountability and responsibility actually lie:

- Who makes the decisions, and how?
- What level of delegation is there when individuals are acting for an organisation?
- To what extent is it possible for the decisions of an STP to override those of constituent bodies?

Most STP documents provide lists of STP Board members although very often these are not named individuals: organisation names are used as proxies for individual names. Some attempt is generally made to show the governance structure for the STP often in the form of a graphic.

A minority of STPs operate, or intend to operate under a Memorandum of Understanding (MoU) – 10 out of 44. However, very few spell out in any detail how this works, and none are included with the main STP document although some can be found elsewhere as appendices to the main document or on the websites of local organisations.

**Partnerships:** a majority of STPs are aiming for radical changes in how the health and care system will operate, and most often this involves some form of ‘accountable care organisations’ (ACOs), or ‘accountable care partnerships’ (ACP), where one organisation or a group of organisations come together to take responsibility for delivering care to a given population – determined in this case by geographic location – operating within a limited budget.

**Footprint for change:** it is difficult to understand the relationship between ‘local’ and ‘system’ in many of the STPs: system-wide decisions should involve system-wide consultations. But it is virtually impossible to glean from any of the STPs how such system-wide decisions will be made: if democratically, for what population; if managerially, under what organisational umbrella and governance arrangements. The precise legal status of the STPs remains unclear.

Moreover there is little in the STPs to identify at what scale within the STP it is appropriate for the work to be undertaken – what can only be done at whole STP ‘footprint’ level, what at sub-levels and what at borough or at NHS CCG levels.

A minority of STPs are moving in the direction of devolution of powers, sometimes to local government, with an intention of shifting responsibility for health and care to the local level.

**Cost of the process:** there are almost no examples in the STP documentation where the costs of the STP process itself are set out. Exceptions to this are North Central London and Surrey Heartlands. But in most other STPs it is clear there will be costs involved. If the two that do provide figures are typical then we might expect at least £5m per year to be spent per STP amounting to a total annual sum of at least a quarter of a billion pounds. It is not unreasonable to expect some significant return on an investment of this size.

## Content

There is a wide variation in the level of detail and information in the STPs from one area to another.

**Needs analysis:** thirty-one of the 44 STPs offer no proper needs analysis above a few selected statistics, and fail to show that their proposals take account of the size, state of health and locations of the population. Eleven make partial reference to needs analysis, refer to local Joint Strategic Needs Assessments (JSNAs), or mention other documents as the source of their local planning. Only two (Nottinghamshire and North East London) appear to take serious account of such information.

**Impact on equality:** only five STPs mention the issue of the potential impact of their plans on equality, and the extent to which the proposals may impact on vulnerable groups. The absence of any concern to identify and act upon local health inequalities is compounded in many STPs by a failure to take account of the impact of the expanded geographical area that is covered by the Plan – ignoring the difficult issues of access to services and transport problems if services are relocated.

**Social care:** finally, in terms of local context it is significant that none of the 44 STPs carries any detailed discussion of proposals to address what in most areas are very significant projected 'gaps' in the funding of social care by 2020/21.

## Finance

Finance has been one of the key catalysts for the development of STPs: the requirement to deal with what was identified by NHS England as a massive emerging financial gap that would make the NHS 'unsustainable' by 2020/21. Without exception all of the STP documents refer to this.

**The size of the problem:** in each STP we find five-year 'Do-Nothing' scenarios that extrapolate large deficits based on the assumption that there will be a large and increasing gap between the need for additional resources and the funds that the government is planning to make available. We have tabulated these and the projected deficit comes to over £23bn.



At a national level, and this has been followed by each STP, the gap has been calculated by projecting the upward cost pressures (population increase, ageing, technology, staff, capital), at over 4% per year in real terms to 2020/21, by when the NHS in England would need to spend nationally £137bn, rather than the £107bn projected.

The quantity of savings required deliberately excludes any of the annual efficiency savings that trusts have been delivering year on year since the mid-1980s, and fails to acknowledge the positive track record of NHS financial managers in delivering recent financial balance with the exception of 2015/16 when the overall deficit was 0.1% or £149m. That the 'Do Nothing' scenario excludes provider and commissioner efficiency savings seems particularly misleading when in most cases these are simply added back in as BAU/CIP\* savings, as if this were part of the STP.

There is wide variation in the size of the financial problems faced by STPs. Our analysis based on STP-projected deficits by 2020/21 shows that these vary from £1.4bn in North West London to £131m in Shropshire. Given that population varies markedly between STP areas we have looked at the total STP-projected deficit per head by 2020/21 finding a range of £769 (Surrey Heartlands) at the top to a low of £216 (Durham, Darlington, Teesside, Hambleton, Richmondshire & Whitby).

**Providing a business case:** approval mechanisms for STPs should be as stringent as for any other large-scale business case. Our financial evaluation looked at Economic Case, Affordability, Deliverability and Risk Analysis and revealed particular systemic weaknesses. We have not identified one STP that is as yet capable of demonstrating readiness for implementation.

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.

## Activity and resources

**Workforce:** Two thirds of the STPs (30/44) have no detailed Workforce Plan to ensure an adequate workforce will be in place to implement the policies and new services outlined within them. As they stand, there appear to be contradictions in the plans between requirements for changed services and the workforce to deliver these, and radical plans to downsize or redistribute the workforce, or to do both.

**Reconfiguration of acute services:** in many cases the STPs have built on previously proposed rationalisation and reconfiguration of acute hospital services in their areas, often extended so as to speed up the process of seeking cash savings, with the resultant reduction in local access to health care.

\*BIU = Business as Usual / CIP = Cost Improvement Programme

Reductions in acute bed numbers and numbers of A&E departments are present in over 50% of published STPs.

Derbyshire STP has the greatest level of explicit bed closures with plans to close 530 by 2020/21. Kent and Medway STP proposes to reduce beds from the current capacity of 2,896 to 2,600 in 2020/21, based on optimistic assumptions about reduced activity, reduced LOS, and sustainable occupancy. Hampshire and the Isle of Wight aims to cut 300 beds, Nottinghamshire 200 and Herefordshire and Worcestershire STP wants to close 202 community beds.

Given the tightening financial pressures on the NHS and social care; the lack of capital to fund investment in new facilities, hubs and equipment; the sparseness of financial plans; the weakness or absence of serious workforce plans; the failure to provide analysis of the specific health needs of the growing populations within the 44 STP areas; and the lack of specific intelligence on the impact of any proposed new models of care within the STPs: there is little reason to believe that these ambitious reductions in demand and pressure on acute services will be achieved in the timescale proposed.

## Recommendations

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'. In this way it may be possible to create a wider base of support for the proposed changes.

Similarly before implementation of STPs is sanctioned there needs to be a much firmer legal authority and more clarity around the STP process. We suggest STPs should be clear whether their role is to act as the legal authority or to act as the enabler of a more complicated decision-making process. If the former, it is likely that changes in legislation will be required, and if the latter then the process needs clarification.

We suggest STPs should identify for each planned area of work:

- The appropriate framework for that work in terms of geographic area and what parts of the health and care system should be involved;
- The stakeholders for that area of work, the partnership agreements required and the accountability to, and relationship with, the population affected by any changes that are envisaged; and,
- The change process required and where authority for that lies.

We suggest STPs should also be clear for each planned area of work whether their role is to:

- Act as a scrutiny and intelligence function: providing the best intelligence to inform local change; scrutinising local plans and providing challenge; and, providing modelling intelligence for system-wide issues. Ideally this process would result in the co-production of a compelling business case for change as a basis for local agreement.

- Secure agreements across all partners by convening the difficult conversations that need to take place prior to decision-making, thereby enabling plans to be implemented.
- Commission collaboratively across all partners, where this is delegated by local organisations.
- Advocate and manage upwards: securing funding, and policy changes as appropriate; negotiating variations in contractual conditions; and, generating enablers so that sub-regional and local work can be more effective.

We suggest that, while some of the experiments with new models of care may eventually publish evaluated research that provides evidence that they offer improved services and value for money, more widespread attempts to generalise from specific projects should take place only where a viable business case has been established and sufficient staffing and adequate capital are available both to establish new services and to prove their effectiveness, before existing services are reduced.

# 1. Introduction

In the aftermath of the Chancellor's Autumn Statement in 2015 which underlined the tightening financial squeeze on the NHS, with funding rising substantially less each year than the estimated 4% annual real terms increase in cost pressures up to 2020, and further reductions in central government funding to local authorities (with severe implications for already constricted social care services), it was clear that NHS England faced a tough task in delivering the projected £22 billion of cost savings to enable the NHS to balance its books by 2020/21.

In this context, on 22 December 2015, NHS England<sup>3</sup> sent out planning guidance, *Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21* (NHS England, 2015a), to every NHS provider and commissioning body setting out proposals for a rapid, substantial change in the way the NHS was to work.

Less than three years after the complete reorganisation of the NHS as a result of the Health and Social Care Act 2012, it called for a fresh reorganisation, from planning in the smaller geographical areas defined by 209 Clinical Commissioning Groups established by the Act, to a more strategic 'place-based' system, in which commissioners in each 'local footprint' were intended to collaborate not only with local government, but also with local NHS providers, who in turn were expected to collaborate rather than compete with their fellow providers,

*“Planning by individual institutions will increasingly be supplemented with planning by place for local populations. For many years now, the NHS has emphasised an organisational separation and autonomy that doesn't make sense to staff or the patients and communities they serve” (p4).*

NHS England set a very swift and demanding timetable,

*“local NHS systems will only become sustainable if they accelerate their work on prevention and care redesign. We don't have the luxury of waiting until perfect plans are completed. So we ask local systems, early in the New Year, to go faster on transformation in a few priority areas, as a way of building momentum.*

*We are asking every health and care system to come together, to create its own ambitious local blueprint for accelerating its implementation of the Forward View. STPs will cover the period between October 2016 and March 2021, and will be subject to formal assessment in July 2016 following submission in June 2016” (pp 3-4).*

These proposals effectively attempted to sidestep existing legislation, and establish new structures capable of developing and driving forward new initiatives in line with NHS England's 2014 Five Year Forward View (FYFV) (NHS England, 2014). NHS England chief executive Simon Stevens later made clear his aspiration that the STPs should lay the basis for 'combined authorities', giving the possibility of overcoming the 'veto power' of

<sup>3</sup> The Planning Guidance was sent out jointly by NHS England, NHS Improvement (Monitor and the NHS Trust Development Authority), Care Quality Commission (CQC), Health Education England (HEE), National Institute of Health and Care Excellence (NICE), and Public Health England (PHE).

local organisations which has frequently obstructed the implementation of controversial reconfigurations of hospital services (Gray, 2016; West, 2016).

Each local area was left to organise urgent discussions to establish the areas that would be covered in the Plans, their own ‘footprint’, to be approved by NHS England, and the December 2015 guidance indicated each needed to secure the support of local government,

*“The first critical task is for local health and care systems to consider their transformation footprint – the geographic scope of their STP. They must make proposals to us by Friday 29 January 2016, for national agreement. **Local authorities should be engaged with these proposals**” (p6, our emphasis).*

The result of this process was NHS England endorsement of proposals dividing England into 44 ‘footprints’ in March 2016 (NHS England, 2016a), each of which then embarked on the process of creating a local leadership team and drawing up Sustainability and Transformation Plans (STPs). This has created a certain degree of ambiguity in the language, since the acronym STP is now used interchangeably to mean the Plan itself, the people implementing it (the Programme Board), or as a generic term to embrace the various proposals within the Plans.

Most of the Plans themselves failed to appear promptly to the prescribed rapid schedule (an initial deadline of June 2016). Prior to their official publication from the end of October 2016, almost all of them had only been discussed in closed meetings of the key participating organisations, with a few exceptions that opted to engage with their local Healthwatch or Health and Wellbeing Boards, for example West Yorkshire and Harrogate STP. The last few were not published until December<sup>4</sup>.

Even after failing to meet the June deadline, it is clear, as we illustrate, many STPs are still a work in progress rather than a finished plan: few have published the detailed financial appendices, workforce plans and implementation plans that are required to make any useful assessment of how realistic and viable the proposals may be. Many have developed their own distinctive jargon and their own interpretation of the ‘new models of care’ and the approach laid out in the FYFV, to deal with what are referred to there (p7) as three “gaps”: “health and wellbeing”; “care and quality”; and, “funding and efficiency”. Almost all also refer to the ‘triple aim’ as set out in Delivering the Forward View (p3): “to implement the FYFV”; “to restore and maintain financial balance”; and, “to deliver core access and quality standards for patients”.

The secrecy and obscure language have contributed to widespread public ignorance over STPs and what they represent<sup>5</sup>, while the documents themselves appear incomplete and unconvincing. However this does not mean the Plans are unimportant: they may potentially represent a landmark moment in the development of the NHS in England.

<sup>4</sup> All are now available at <https://www.england.nhs.uk/stps/view-stps/>

<sup>5</sup> An IPSOS MORI poll in January 2017 found just one person in seven had even heard of STPs (Clover, 2017).

For this reason it is important to make a critical assessment of the quality of the STPs themselves, how serious, developed and practical the actual plans appear to be, and what the potential implications are for providers, primary care and local authorities. It is also important to assess the extent to which these new bodies, which lack any legal basis or democratic accountability, and exist alongside (and in large measure in contradiction to) the provisions of the Health and Social Care Act 2012, have secured the consent and involvement of local government and local NHS organisations, and sought any genuine consultation with staff or local communities.

It is conspicuous in this respect that the December 2015 Planning Guidance was initially only addressed to NHS bodies, despite the fact that STPs are intended to work with local government as partners. It was two months later before a letter included local authorities and directors of Local Education and Training Boards (LETBs) in a joint communication to ‘system leaders’<sup>6</sup>. So STPs appear to have started as predominantly an NHS project; the extent to which joint working with local authorities emerged from this inauspicious beginning is examined in this report.

We note also the statement in the initial December 2015 Planning Guidance on the content and character of the Plans where NHS England insisted system leadership is required,

***“Producing a STP is not just about writing a document, nor is it a job that can be outsourced or delegated. Instead it involves five things:***

- (i) local leaders coming together as a team;*
- (ii) developing a shared vision with the local community, which also involves local government as appropriate;*
- (iii) programming a coherent set of activities to make it happen;*
- (iv) execution against plan; and*
- (v) learning and adapting” (p4, our emphasis).*

At this point, NHS England seems to suggest there may be times when it is not ‘appropriate’ for the STP to involve local government – though further clarification is not provided, thus begging the question of when it is or is not appropriate to include local government. This suggests a lack of coherence in the original intention: if NHS services, and services provided through local government, are to be viewed as part of one system<sup>7</sup> then surely it is always appropriate to include local government in any attempt at a system-wide response; if a shared vision is to be developed with the local community, then this may be possible without involving local government but it is hardly encouraging of a collaborative approach across the system, and moreover, seems to fall foul of existing legislation that places local government at the heart of democratic accountability for the health and care system through the roles of Health and Wellbeing Boards and Scrutiny Committees.

<sup>6</sup> The letter was from the Care Quality Commission along with NHS England and NHS Improvement (Monitor and the NHS Trust Development Authority), Health Education England (HEE), National Institute of Health and Care Excellence (NICE), and Public Health England (PHE), and is available at: <https://www.england.nhs.uk/wp-content/uploads/2016/02/sustainability-transformation-plan-letter-160216.pdf>

<sup>7</sup> Which we believe is wholly appropriate.

## Method

This report aims to provide an assessment of the 44 STPs in terms of how they stand as serious, coherent and achievable plans. Despite the variation in the size, depth, presentation and content of the 44 STPs, we have attempted to subject each to an analysis aimed at establishing the answer to the same set of questions. Our reviews of the full set of 44 reports are provided on the London South Bank University website<sup>8</sup>, along with the series of questions we have focused upon.

We treat each STP to the same rigorous appraisal as we would any set of NHS planning documents whose aim is to bring about major changes to care delivery systems through a programme of investment in services, facilities and staff. The fact that these Plans cover a wider area both in geographic terms and in terms of the whole health and care system should mean more care is taken by each STP to provide the detail that stands behind the proposals.

We expect to see expert evidence laid out in each STP (or pointed to as publicly available in appendices) to support the models of care that underlie the Plans. We require a clear exposition of how the needs of individual populations are matched with demand for care, and hence with demands on services, and hence use of resources: this would include a clear indication of key assumptions underlying the overall model as well as some examination of the robustness of system outcomes to these assumptions.

We also examine the approach of each STP to local governance and accountability, an area of particular importance given the potential changes that are heralded by the STPs. If an STP is a system-wide body then we argue there must be a clear form of system-wide governance, as well as system-wide accountability to local populations. How local accountability operates across a whole system of care is bound to be problematic.

To contain the scope of this report, we have aimed to focus first and foremost on the STPs themselves and the information they contain, with limited reference to additional supporting information. This approach, and the time and resource constraints in producing this report, meant we decided not to seek additional interviews with key stakeholders and not to request additional information not already clearly included in the STP itself. However, where evidence is readily available in the public domain that bears on the issues we examine, then we have included this.

For the same reasons of scope and time we have not concentrated in detail on particular aspects of the STPs that often are not clearly reflected in the overall presentation of projected savings. Thus we do not provide a critique of the 44 largely similar proposals for improved access to mental health and learning disability services – although many of them run into the same questions of practicality in terms of genuine priority, staffing and affordability that afflict many of the other proposals within the STPs.

Similarly we have not repeated the listing of the (generally similar) range of major threats to health and causes of premature mortality, or focus on the various proposals – some ambitious – to take action on wider social determinants of health such as housing, employment and social isolation, although we would question any assumption that a definite cash saving could be generated from such initiatives in the 5-year lifetime of any STP.

In addition we have not aspired to provide a comprehensive account of how the STPs have responded to ‘integration’ or ‘new models of care’ or ‘digital technology’ or ‘prevention’ other than to reflect on these where there are definite claims with the STP to yield savings to the system. These are all covered in our reviews of individual STPs referred to above as available on the London South Bank University website.

Having drawn out the information on the process and content of all the STPs, this report seeks to discuss some more general lessons from the 44 individual plans and offers some concluding remarks on their implications for the future of the NHS in England. The report is divided into two sections, with one section on ‘process’ (how the documents were prepared, including the extent to which plans have secured clear commitments of support from NHS bodies and local government, the governance arrangements proposed, and the establishment of a clear, accountable structure and transparent process including a commitment to consult with staff and local publics), and the other section concentrating on the content of the STPs. It is in the latter section that we assess the extent to which the plans appear to be coherent, realistic and evidence-based in their proposals, are matched with financial and workforce resources, and are likely to meet their financial imperatives.

We also provide an assessment of the numbers of A&E units, acute beds and community hospitals that could be closed as a result of the plans, as well as of increased provision in community settings. In addition we look at the way in which the plans propose to change services, how far the potential knock-on impact on local care providers has been taken into account, the scale of any proposed changes in workforce and the extent to which any coherent workforce strategy is evident in the STPs. Moreover we seek evidence that social care is genuinely integrated into the STPs and the extent to which the actions of local authorities seeking to balance their books and deal with any additional funding ‘gap’ are taken into account in the STPs.



## 2. The STP process

In this chapter we consider whether the 44 STP areas reflect good governance and process in the delivery of their plans. This is important as STPs should be ‘public-facing’ documents<sup>9</sup> and as such we would expect it to be easy for people to understand what they are looking at, and to be given a clear explanation of what is happening, how this affects them, and how they can influence it. In our view the principle adopted should be ‘is this written in a way that is clear to people living in our area who may be service users now or in the future’.

In addition, we would expect each STP to emphasise the importance of checking with local people and local politicians when determining future service provision in their area. Most STPs at least acknowledge the importance of this. The point is emphasised by NHS England in *Engaging local people A guide for local areas developing Sustainability and Transformation Plans*, published in September 2016 (NHS England, 2016b),

*“The legal requirement to involve patients and the public in planning and proposals for change still stands if there is only one proposal, or a preferred option. Service change must be evidence-based, and this evidence should be publicly available during the consultation and decision-making stages. It is important that the consultation is approached in a way that is genuinely open to influence” (p12).*

### Status of STP documents and consultation

Three issues emerge when we consider these Plans and how they are being used: how to assess them in terms of the need for formal consultation or just ‘engagement’; whether they should be viewed as sets of local documents or as a whole-system document or some combination; and whether as new bodies (albeit with unknown legal status) engagement or consultation carried out prior to their STP status may be considered adequate for STP purposes.

As noted above in *Engaging local people*, there are legal requirements for consultation that are laid out in legislation; these primarily relate to significant service change. Beyond this, there are clear policy statements that require the NHS to involve the public and patients in matters relating to services,

*“It is essential that the STP partners in every area have an ongoing dialogue with patients, volunteers, carers, clinicians and other staff, citizens, the local voluntary and community sector, local government officers and local politicians, including those representing health and wellbeing boards and scrutiny committees and MPs” (p7).*

Whether consultation should be a local activity or go across the whole system is a thorny issue, and one that seems to have elicited different approaches across the 44 STPs. Where changes clearly affect the whole of the area then it might seem appropriate to consult

<sup>9</sup> Thus, *Engaging local people A guide for local areas developing Sustainability and Transformation Plans* states “Using jargon free and accessible language that is appropriate to the audience will be essential to ensuring that people can participate meaningfully” (p12; NHS England, 2016b).

across that whole system. But when would this not be the case when part of the rationale behind STPs is that they draw together organisations and populations within natural boundaries for looking at service change? If there were not knock-on effects between organisations and within areas then the point of forming an STP would seem to be negated.

Many STP documents refer to engagement or consultation carried out prior to the existence of the STP. The question then is whether this is sufficient to fulfil any legal obligations that STPs may eventually have; this is particularly relevant for consultations where it is possible that the spectrum through which the consultation questions are now viewed may have changed.

We often find a lack of clarity on the status of the STP documentation, and what will be done with it. In many cases it is clear that there is no intention to consult on the STP itself, even though it is presented as a system-wide exercise, and therefore it would seem natural to expect a system-wide consultation on its content. Instead the best the public seem able to hope for is 'engagement', and sometimes this seems to be just a matter of 'letting them know what is going to happen'.

We do find many references to separate localities within the STP that are consulting on what often amount to acute service closures, or reconfigurations in the parlance common to NHS documents. For example, the Black Country STP has no plans for consultation on the whole STP: the document argues aspects of the plan have already been subject to consultation and now, instead,

*"This plan, itself informed by the ongoing public and patient involvement by partner organisations, is now at the point at which coordinated engagement across the Black Country and West Birmingham can be initiated, enabling the public to see (and to be able to contribute further to) how local plans relate to each other and how the benefits of working in partnership at scale can enhance the outcomes, experience and sustainability of Black Country and West Birmingham health services" (pp10-11).*

The West Yorkshire and Harrogate STP does not mention formal consultation on the overall plan. Where consultations are mentioned they tend to be at a locality level, e.g. in Calderdale (p31) or Kirklees (p37), or on acute reconfiguration as at Calderdale and Huddersfield FT (p59).

The local flavour is maintained. Thus the STP states,

*"Local plans have been developed and approved by local Health and Wellbeing Boards (or equivalent structures). Healthwatch is a key partner in our STP and provide leadership, assurance and challenge acting as the voice of the patient. We will always fulfil our legal duties to consult and we are already consulting formally with our populations on some of our proposals e.g. reconfiguration of hospital and community services in Calderdale and Huddersfield" (p69).*

On the other hand, the Humber, Coast and Vale STP is clear that, as part of what it calls its 'communications and engagement plan', there will be feedback on the STP through

democratic engagement in January 2017, followed by formal consultation on the STP in February 2017; and this consultation will inform the strategic plan for the STP footprint in May 2017, and there will be consultation around specific interventions from summer 2017.

The STP continues,

*“At programme level, we are working with The Consultation Institute to ensure that our consultation activities are appropriate, timely, legal and cost-effective” (p35).*

Durham, Darlington, Teesside, Hambleton, Richmondshire and Whitby STP refers to stakeholder forum events carried out under the Better Health Programme with Local Authorities, the Voluntary Sector, Healthwatch, CCG patient participation groups, a Joint Overview and Scrutiny Committee, and Health and Wellbeing Boards. It claims to have engaged the local community and provided them with information so they can influence decision-making on ‘Fit 4 the future’ proposals. The Plan states,

*“Engagement work so far has taken place across the footprint on local plans, the Better Health Programme and Fit 4 the future - transforming our communities. These programmes have undertaken wide-reaching and informative engagement using a variety of inclusive mechanisms and channels where we have aimed to engage with people across the DDTHRW area” (p43).*

But it could be argued that, unless the public were aware of the context and objectives of the STP, this work was not part of the STP process itself<sup>10</sup>. This work should of course be used to inform the development of the STP, but the work of the STP on engagement and consultation must start afresh.

It can be difficult to understand the relationship between ‘local’ and ‘system’ in many of these documents: if the rhetoric of the STP means anything, then much of what happens should be determined by system-wide decisions involving system-wide consultations. But it is virtually impossible to glean from any of the STPs how such system-wide decisions will be made: if democratically, for what population; if managerially, under what organisational umbrella and governance arrangements.

We find there is considerable variation in the attention that each STP pays to explaining the process. There would appear to be some commonality in the way that the documents are presented but the level of detail varies widely from area to area.

In contrast to many of the statements reported above, it has been claimed that the actual details of each STP were deliberately hidden from public view for many months, and in many cases not even shared with ‘local authority partners’. There were reports on ITV and reports from the King’s Fund in November 2016 stating that NHS England had given specific guidance to local STP leaders saying the plans should be secret (ITV News, 2016; p23, Alderwick et al., 2016).

<sup>10</sup> Did the DDTHRW area exist in the minds of the public or service providers prior to the formation of the STP in March 2016?

We find the Guardian reporting in November 2016 (Vize, 2016),

*“At least five councils have now published the STP, despite NHS England asking local areas to keep them hidden until the central bodies have given their verdict”.*

*“This pointless subterfuge has put local politicians in an invidious position; if they do as they are told they run the risk of being accused of conniving in a cover-up of plans to shut services”.*

All STPs are now available on the NHS England website (NHS England, 2016c) although often without access to important appendices even though the main STP documents suggest that is where more detail on issues like financial planning and workforce planning resides. Most STPs do not have a dedicated website (only 7 of 44 by our estimate) but have relied mainly on dissemination through the websites of constituent NHS organisations. This may be due to one organisation taking the lead in this activity. When local authorities were given access to STP documents, these have tended to be made available on their websites, although not always immediately obvious.

## Stakeholder sign-up

We were interested in whether the STP contains specific reference to stakeholders formally signing up to the document as we saw this as a way of gauging clear support for the Plan. We found this was rarely the case. In North West London all stakeholders have signed up to the STP (with certain provisos in the case of the six councils who signed), apart from Hammersmith and Fulham Council and Ealing Council who disagree with the plans for acute services (London Borough of Hammersmith and Fulham, 2016a). No official confirmation of this is provided in the STP however. Northamptonshire STP (p1) does list 11 organisations that have signed up to the STP including Northamptonshire County Council. In the case of Cambridgeshire and Peterborough STP (p5), there is also a clear indication that all NHS organisations have signed up to the STP although local councils are not listed as having done so. With respect to local government representation, the STP states,

*“The councils participate in the programme through their officer representatives, recognising that their policy and financial decisions are subject to the constitutional arrangements within their respective authorities.... The councils also have a particular requirement to scrutinise proposals for NHS service changes, as elected representatives of their communities, and must ensure the independence and integrity of those arrangements” (p5).*

Even where there has been significant local authority opposition to the content and/or the process of the STP, this is not reflected in documents that were only finalised near the end of 2016. Examples of publicly-voiced discontent include councils in North West and South West London, Bristol, Coventry, Telford and Wrekin, Liverpool, Sefton, Wirral, Cheshire West, Chester, Stoke-on-Trent, and county councils including Shropshire, Warwickshire, Lincolnshire, and Oxfordshire.

Instead we find the use of language like ‘partners’ and ‘stakeholders’, but the extent to which these partners have really been involved in constructing the STP is unclear. For example, the Humber, Coast and Vale STP in its ‘Building Strong Governance and Programme Structures’ section reveals,

*“Strategic Partnership Board (SPB) is the group where all key recommendations made about the STP are discussed. A senior leader of each partner organisation sits on the board. The board includes representatives from organisations that span the public sector including health, local government, GPs and the voluntary sector” (p33).*

But we find no reference in that STP document to formal statements of stakeholder sign-up.

In the South Yorkshire and Bassetlaw STP we find,

*“The communications and engagement team within the programme management office of the STP will continue to provide strategic oversight and support for all communications and engagement as our plans are put into action and by building on relationships with the voluntary sector and Healthwatch organisations, will engage with the public, as key partners, on our plans and future proposals. We will take account of their views and feed these back into our plans before any further work takes place” (p44).*

But engagement with voluntary organisations and Healthwatch is not sufficient for public consultation purposes. The same STP is clear that the Plan has been developed in consultation with chief executives or accountable officers from a list of organisations, including local authority officers. But local authority officers should not be viewed as representatives of the public in the way that local authority politicians might be. Moreover, no evidence is provided in the document that these organisations have signed up to the STP itself in any formal sense, nor are we told if they were asked to.

The since-departed Chief Executive of Birmingham City Council Mark Rogers expressed frustration at what he called the marginalisation of local government from the process, despite the fact that he was the designated lead of Birmingham and Solihull STP (Vize, 2016), and in May 2016 a survey by Public Health Executive magazine found two thirds of local government ‘partners’ felt they had been “shut out” of decisions on who was to lead local STPs (Public Sector Executive, 2016).

Moreover, while people living in the area, arguably those most affected, are often referred to as partners, co-producers etc, we find no evidence that they have ‘signed up’ to these documents, or been asked to do so in any direct way. On the other hand, West Yorkshire and Harrogate STP provides an interesting example where the local Healthwatch organisations have been included as part of the STP planning process. Thus the STP states,

*Healthwatch is a key partner in our STP and provide [sic] leadership, assurance and challenge acting as the voice of the patient. We will always fulfil our legal duties to consult and we are already consulting formally with our populations on some of our proposals e.g. reconfiguration of hospital and community services in Calderdale and Huddersfield” (p69).*

It is clearly desirable that the voice of the patient is heard in producing the STPs, and the involvement of Healthwatch is one way of doing this; however, as the STP recognises in the quote above, this is not a substitute for formal consultation where this is required.

We have not examined sources outside of the STP documents on a systematic basis to assess the level of local support for STPs, but there are several areas of the country where highly vocal opposition exists<sup>11</sup>. Often these are indicated in our individual STP reviews (these are provided on-line). In some cases while the STP documentation claims to have their support, we find this not to be the case; this is especially true of local government partners.

For example, the Coventry and Warwickshire STP does not indicate any disagreement. However, in mid-December Warwickshire Council in a full council meeting voted not to sign up to the STP unless a series of conditions were met.

Likewise, Coventry City Council made clear that<sup>12</sup>,

*“Whilst the Council recognised and endorsed the aim of health and social care organisations working closer together to improve services for local people, it did not support the approach taken in developing the STP, specifically in relation to transparency and involvement of both the public and local authority members. The Council’s involvement to date does not constitute it signing up to the Coventry & Warwickshire STP. Although a number of transformation work streams exist under the STP ... the detail and implications of these are not developed, and therefore the City Council will not be in a position to make decisions regarding progressing the implementation of any work stream until more detail is developed and this has been considered through the appropriate decision making processes”.*

Often this type of opposition takes the form of local pressure groups representing the interests of local people; in some cases local politicians and some local clinicians are also drawn in and become vocal opponents. For example there has been a vigorous campaign in North West London opposing the plans there. In this case some local politicians have also come out strongly against the STP.

We find Hammersmith and Fulham Council very clear in its opposition to the North West London STP (London Borough of Hammersmith and Fulham, 2016b),

*“NHS bosses have re-launched their flawed plan in a new report – the “North West London STP” – and still have the demolition of Charing Cross Hospital, and the sale of much of its site, as a key part of their scheme. H&F Council has totally rejected this plan – and needs your help to fight it all the way”.*

Something similar is happening in South West London where the Leader of Sutton Council, Ruth Dombey, is concerned about the process (London Borough of Sutton, 2016),

<sup>11</sup> Perhaps this is because opposition to the Plans is more newsworthy than expressions of support. Nevertheless we have not seen accounts of mass patient support for the STPs. A review of the reactions of patient bodies and local health pressure groups across the country is a task for another day.

<sup>12</sup> In Cabinet papers dated 3 January 2017, and in papers from a full council meeting on 24 January 2017.

*“As boroughs, we have been pleased that the NHS in South West London has been keen to engage us in the development of their thinking, but frustrated by a national process that has prevented, up to now, the public consultation and engagement we would need to be able to be properly involved. We now look forward to a full public debate and engagement on the issues set out in the STP and the opportunity to discuss the future of the health services in our area with our residents”.*

And,

*“We are concerned about the lack of certainty about the future of the hospital estate and services across our boroughs and the lack of clarity about the number of hospital beds that are needed now and in the future. A robust evidence base and widespread public engagement must now underpin the development of plans that will secure accessible, high quality, sustainable services for our residents.”*

Malcolm Pate, leader of Shropshire Council, where the STP includes the reconfiguration of A&E in Shrewsbury and Telford, closing the A&E at one hospital to create a new hospital specialising in emergency care, allowing another to specialise in routine surgery, told National Health Executive magazine (National Health Executive, 2016a),

*“NHS England have instigated a ‘launch’ of the STP, which suggests the plans have been fully worked through and agreed by all parties. Unfortunately this is not the case, as it is the opinion of both Shropshire Council and Telford and Wrekin Council that some elements of the document need developing”.*

In yet another example, Lincolnshire County Council unanimously passed a motion condemning plans to downgrade the A&E at Grantham Hospital at a meeting in December 2016. The council’s motion stated that the proposals were “completely unacceptable” and would “have a serious and detrimental effect on the health and wellbeing of residents”, and condemned plans to develop a single maternity team across Lincoln and Boston Pilgrim hospitals, closing maternity services in Boston (National Health Executive, 2016b).

The above observations suggest there may be a serious disconnection in some areas between STP plans and what local people and politicians see as key issues for local services. Possibly this has been exacerbated by an initial failure to work directly with local government, or a view that the inclusion of local government officers around the table is equivalent to that of politicians. The degree of secrecy around the plans, at least early on, has not helped. Some STPs seem to have worked more effectively with local patient bodies than others, and perhaps in those cases plans have emerged that will gain substantial local support. That remains to be seen for STPs as a whole. There is a history in the NHS of attempts at reconfiguration foundering on the rock of public support for the local hospital; efforts to avoid due process in the past have generated legal challenges, and references to the Independent Reconfiguration Panel and the Secretary of State, often resulting both in significant delay and substantially modified plans.

## STP governance

Most STP documents provide lists of STP Board members although often these are not named individuals; sometimes organisation names are used as proxies for individual names. Some attempt is usually made to show the governance structure for the STP often in the form of a graphic that, in our view, does not always convey key information about how the structure actually works. On the other hand there are STPs that provide some written detail on how the whole thing is meant to work.

West Yorkshire and Harrogate STP for example,

*“Local plans have been developed and approved by local Health and Wellbeing Boards (or equivalent structures). Healthwatch is a key partner in our STP and provide [sic] leadership, assurance and challenge acting as the voice of the patient. We will always fulfil our legal duties to consult and we are already consulting formally with our populations on some of our proposals e.g. reconfiguration of hospital and community services in Calderdale and Huddersfield” (p69).*

The STP goes on,

*“Local place-based plans have been designed and approved by all local Health and Wellbeing Boards (HWB) or equivalent and are in the public domain. Council leaders and Chairs of the HWB meet on a regional level. We are fully committed to sharing all proposals with our population and will publish our plan and public summary during the week commencing 31 October 2016” (p69).*

Northamptonshire STP provides one of the clearer accounts (and graphics) of governance arrangements,

*“The focus for the delivery of the STP will be the STP Board supported by a Memorandum of Understanding signed by all organisations and will work with the Health and Wellbeing Board to ensure alignment for strategies and support democratic engagement with the STP. The STP will operate within a clear system control total which will have a collective responsibility to support delivery of their plans based on the plans agreed through the STP” (pp58-59).*

Even where this degree of detail is given it can be difficult to form a clear view of how the STP Board actually operates; where accountability and responsibility actually lie,

- Who makes the decisions, and how?
- What level of delegation is there when individuals are acting for an organisation?
- To what extent is it possible for the decisions of an STP to override those of constituent bodies?

Some STPs operate or have stated an intention to operate under a Memorandum of Understanding (MoU) – 10 out of 44. However, very few spell out in any detail how this works, and no MoU is included with the main STP document although some can be found elsewhere as appendices to the main document or on the websites of local organisations.



Northamptonshire STP states,

*“The statutory bodies (CCGs, Providers and Local Authorities) will work within an agreed MoU for STP related business through the Northamptonshire STP Board” (p58).*

However, while the Plan clearly aspires to establishing a county-wide structure, it seems the required agreement has not yet been established. Thus,

*“The STP Board provide[s] the forum for bringing the system together and **will** have an agreed Memorandum of Understanding to manage processes and system/organisational conflicts” (p4, our emphasis).*

Cambridgeshire and Peterborough STP has a working MoU in place described thus,

*“Our MOU describes our approach to working together as a system. This has been signed by the CCG, CUHFT, PSHFT, CCS, HHCT, PFT, Peterborough City Council (MOU appendix 1 only) and Cambridgeshire County Council (MOU appendix 1 only). In future we anticipate that others will join or become more formally affiliated with the partnership embodied in the MOU including EEAST, GP federations, practices, or third sector organisations” (p37).*

Gloucestershire STP is also in the process of developing an MoU that will be ready by 2017,

*“By 2017 we will have ... agreed a Memorandum of Understanding (MOU) that supports the new STP collaboration approach and through this ensure a joined up approach to managing resources, risks and engagement across our STP priorities” (p28).*

But equally there are many (34 out of 44) where no MoU is reported to exist, and many where there is no discussion of the actual powers of STP Boards, nor a statement that this detail is under development. The latter may seem surprising given that all STPs were expected to be well-developed by this stage, but perhaps not given the difficulty that all have had in keeping to the original NHS England timetable. Developing partnerships and creating collective agreements is proving to be a more difficult task than perhaps NHS England anticipated. The fact that some areas have made more progress than others may reflect the degree of partnership working already present.

## Costs of the STP process

There are almost no examples in the STP documentation where the costs of the STP process itself are set out. Exceptions to this are North Central London and Surrey Heartlands. In most other STPs there may be some references to the process that clearly imply there are costs involved or at the very least the use of existing resources (or management consultancy) but no effort is made to explain how much is involved, what has already been spent and what will be spent in the future.

Kent and Medway STP for example has relied heavily on the work of management consultants, and so while no figures are given for past or projected future costs, it is safe to assume that these are not insignificant.

In another example Somerset STP does not mention the costs of the process nor staff involved. However in an Appendix to the main document we find,

*“Immediate need is project design team resources to develop business case”*,

*“Mobilisation of the project and completion of the planning stages of the project is dependent on external funding” (p55).*

The Appendix goes on,

*“Musgrove Hospital – Urgent Care: STP needs to be confirmed. Funding is required to provide resources to develop the business case” (p56).*

Detailed information on this seems critical to delivery of the STP plans and yet this reference to it appears here in an Appendix at the end of the main document; and no detail is actually provided.

In a similar vein, Birmingham and Solihull are clear that the process is to be,

*“Led by system wide Programme Director with appropriate support to ensure appropriate support and consistency across the major programmes and change projects” (p69).*

This was summed up,

*“A strong programme office capable of linking strategy, investment, delivery and change agenda will enable individual organisations, new joint bodies and the system as a whole to deliver better outcomes through improved services and better use of resources” (p68).*

However no details are given on how many staff may be required for this to work effectively, nor is there any overall costing for running the STP.

If the two STPs that do provide figures are typical then we might expect at least £5m per year per STP to be spent amounting to upwards of a quarter of a billion pounds for the country as a whole. It is not unreasonable to expect some significant return on an investment of this size.

## **Impact of STPs on system governance arrangements**

The NHS Planning Guidance in December 2015 talked about (p4) “local leaders coming together as a team”. In our introduction we referred to NHS England chief executive Simon Stevens making clear his desire that the STPs should lay the basis for ‘combined authorities’. So it is natural to ask to what extent the STPs can be viewed as introducing different governance and management arrangements into the health and care system.

What we find is considerable variation from area to area both in how the STP is currently working but also in what is apparently intended. In many cases the STP comes over as an exercise in limited joint planning but very much reflecting ‘Business as Usual’ with localities responsible for their own decisions for their own local areas. Others have

pursued a system-wide view and in some cases are planning for major organisational change. We discuss various examples below.

The ambition to devolve health and social care to one local body (in this case an elected local government) in Manchester has been much discussed<sup>13</sup>. But we find many other examples in the STPs we have reviewed. In Cornwall and the Isles of Scilly, there is what appears a firm move in the direction of devolution of powers to the county,

*“In addition to satisfying the NHS policy framework, the STP also provides a response to Cornwall’s Devolution Deal which was signed in 2015. One of the key strands of the deal was the progression of health and care integration and the STP is the mechanism through which this area of the Devolution offer will be developed” (p6).*

In Surrey Heartlands there is a similar move envisaged. Thus,

*“Since June we have achieved commitment to take forward a number of well defined, practical programmes of joint working to fulfil our ambition. This is supported by a strong track record of collaborative delivery on the ground ... Devolution ... will enable full integration with Surrey County Council, integrating health and care delivery with the wider determinants of health in our population and realising the benefits to health of contributing to the macro-economics of the local landscape to deliver maximum public value” (p2).*

These are exceptions rather than the rule, but a majority of STPs while not aiming for total geographic integration do propose radical changes in how the health and care system will operate. This most often involves ‘accountable care organisations’ (ACOs), or ‘accountable care partnerships’ (ACP), where one organisation or a group of organisations come together to take responsibility for delivering care to a given population – determined in this case by geographic location – operating within a fixed budget.

Our review reveals that 32 of the STPs mention some form of ACO or ACP. These take different forms and are at different stages of development across the country. Perhaps the most significant distinction between them is whether they deal with the whole STP population or the intention is to divide the STP population by locality between ACOs. The latter is most often the case.

For example, Humber, Coast and Vale STP promotes the development of Accountable Care Partnerships and ACO commissioning as part of place-based care (p27), and signals an intention between April and June 2018 to commission new locality ACOs (p28). In the ‘North Lincolnshire and North East Lincolnshire’ locality we find,

*“Through Healthy Lives, Healthy Futures (HLHF) we are developing locality approaches from March 2017 that will operate within our Accountable Care Partnerships (ACP)” (p29),*

<sup>13</sup> See <http://www.gmhsc.org.uk/>

and in the 'Vale of York' locality,

*“Organisations in the Vale of York will work together in a new way (called an Accountable Care System – ACS) and develop locality teams to provide a new approach to service delivery from April 2017” (p29).*

Lancashire and South Cumbria STP in its executive summary states,

*“This STP sets out ambitious plans to develop a sustainable services platform in respect of developing local accountable care systems” (p9).*

We find this STP's intention is 'to establish 5 Accountable Care Systems/Organisations' (p34) across the whole area through Local Development Plans.

On the other hand Cambridgeshire and Peterborough is an example of a much more ambitious plan for the entire STP area to begin to “behave like an ACO” and to work across organisational boundaries to a single “control total” budget. Thus the document states,

*“As a local health economy, we are attracted to the beneficial concepts of an Accountable Care Organisation (ACO), with one set of leadership, one set of financial incentives, and one set of clinical motivations.*

*Our ambition for the Cambridgeshire and Peterborough health and care system is to develop the beneficial behaviours of an ACO on the way to becoming a value-based system which is jointly accountable for improving our population's health and wellbeing, outcomes, and experiences, within a defined financial envelope” (p11).*

Although most STPs express an intention to develop some form of accountable care organisation, the Plans fail to clarify the extent to which the ACO concept represents an abolition of the purchaser/provider split or even a redistribution of such responsibilities. There is no explanation in any of the STPs of how they can credibly plan for social care to become part of an NHS Accountable Care arrangement, given that they have no powers in respect of local authority functions, and in many places have not fully engaged local government in the process.

## Conclusion on the STP process

We introduced this report by saying that we would treat each STP to the same rigorous appraisal as we would any set of NHS planning documents. In this section we have looked at how successful the STPs have been in involving local people in their development, as well as in having clear governance arrangements in place across the health and care system, and we find the great majority wanting in this respect. Most do not provide a comprehensible account of what is intended over the next five years, it is difficult to discern how most STPs will work as a system, and very few indicate any intention to consult on the overall plans across the whole of the STP.

In the next section we go on to look at the content of the STP documents and subject them to the same rigorous assessment of their Plans.

## 3. The STP Content

### Introduction

In this section of the report we look at what the STPs are actually about. They are purportedly plans to take the health and care system forward in specific geographic areas over the five years from 2016/17 to 2020/21 (although ‘the four years from 2017/18’ may be more logically consistent given the plans were only being written six or seven months into 2016/17): but what do they contain, and what is likely to be the impact on local populations and their access to health services?

In seeking to develop a consistent analysis of the 44 STPs, we have been faced with the problem of the wide variation in the level of detail and information in the STPs from one area to another. Many STPs are incomplete and inadequate drafts lacking much of the content they should contain, and replete with proposals that are almost entirely abstract and little more than vague aspirations rather than grounded and evidence-based plans.

Some plans are more than double the length of others, with the documents published from October ranging in size from just 32 pages (Hertfordshire and West Essex) to 121 (Lincolnshire). Mid and South Essex has a 31-page ‘update’ that refers back to and needs to be read with the June Draft and annexes that combine to produce 202 pages in total<sup>14</sup>. The largest document is produced by one of the 17 STPs covering a population of less than 1 million, while those with the largest populations (Greater Manchester 2.8m, West Yorkshire and Harrogate 2.5m, and Cheshire and Merseyside 2.4m) have STPs ranging from 57-84 pages (NHS England, 2016a).

There is an even wider variation in the level of detail included. For example only a small minority (3 out of 44) supply any detailed financial projections, while six offer only limited financial details, and eight more either claim such projections exist while not providing them, or publishing them elsewhere. By contrast 27 STPs include little or no financial detail, raising more serious questions over the coherence and viability of their proposals. Remarkably few STPs are explicit in their proposals on A&E departments, or identifying which units might be closed, even though studies have shown that up to 24 A&Es in England face possible downgrade or closure as a result of STPs and other plans (Illman, 2017). Some STPs discuss the closure of acute beds as well as community beds and hospitals, but many seem to evade this issue by not providing clear statements on their plans. Since some plans propose opening community hospital beds while others propose closing them it is difficult to identify any common basis of evidence that might inform both policies; this is not helped by the fact that the STPs themselves provide little more than the most generalised reference to any evidence.

We have not attempted to undertake a systematic review of the evidence that might support STP plans not least because the STPs themselves have failed to present evidence supporting their own plans. However we have provided a review of some of the key

<sup>14</sup> Four of the October versions of the STPs are above 100 pages, 4 are between 30-40 pages, while 13 are 40-50 pages long and the remainder 60-100. Documents available (NHS England, 2016c).

evidence in an appendix to this report. Also, the excellent recent report from the Nuffield Trust (Imison et al., 2017) is relevant in this respect and shows that changes to services must be approached with caution<sup>15</sup>.

There is little explicit discussion of how local providers are expected to generate 2% per year or more 'Cost Improvement Plans', with some much higher targets<sup>16</sup> – and very few STPs have anything consequential to say about social care and resolving the funding gaps identified by local government<sup>17</sup>. Similarly there is almost no detail supplied on how considerably more than £1bn of savings from specialist commissioning are to be realised.

Few of the STPs appear to have taken any account of the financial impact on existing local providers (many of which are already in deficit) if a growing share of their existing caseload (together with the funding for this treatment) is diverted into primary or community health services, leaving the fixed overhead costs of hospital buildings and staff substantially unchanged. Fewer still have explained how a limited pool of GPs can be expected to cover an ever-expanding agenda of tasks, delivering increasingly intensive and personalised packages of care to people in their own homes. There are indications of how this could be possible in some of the new models of care that are developing nationally, but the evidence does not feature in the STPs, and there is no evidence of doing this at scale.

There is also a great variation in the extent to which the STPs spell out an explicit timetable for completing the plan and implementing their proposals: while 15 of the 44 STPs do offer some form of timetable, many of these are very unclear, already out-dated, or relate to implementing proposals that have yet to be proven to be viable or affordable.

This chapter of our report will address the sections of our inquiry that examine the content of STPs, divided into four main sub-sections: the local context; finance; workforce; and the impact on services.

## Local context

Any serious plan to reshape services, and particularly to develop new, pro-active services focused on patients' health and care needs, should start by assessing the size and nature of the task i.e. what those needs actually are, as well as what their main determinants are. This requires an up-to-date and detailed picture of the size and spread of the population within each STP, together with an up-to-date needs assessment to identify the character and scale of the main health and care challenges in any designated population area. Of course the needs analysis is just the first step: needs must be coherently linked to demand for care and hence to activity and services, and finally resource use.

<sup>15</sup> The latest work from the Nuffield Trust was summarised by Nigel Edwards in the BMJ of 29 March 2017. In this he draws attention to some key features of the evidence that bears on STP plans (see Note 1).

<sup>16</sup> Herefordshire and Worcestershire's STP makes clear that for the two acute providers these programmes "equated to circa 15.0% and 9.3% of income respectively" (p16).

<sup>17</sup> The charity Hft has warned that increases in the minimum wage are set to raise pay costs by a third by 2020, while there has been no corresponding increase in fees payable for social care, and has launched the 'It doesn't add up' campaign (Cebr, 2016).

For CCGs and local authorities, and therefore logically STP Boards, there is a statutory requirement that they should develop a Joint Strategic Needs Assessment (JSNA) to describe the future health, care and wellbeing needs of the local populations and to identify the strategic direction of service delivery to meet those needs. A JSNA is the established way to define where inequalities exist, provide information on local community views and evidence of effectiveness of existing interventions which will help to shape future plans for services, and highlight key findings based on the information and evidence collected.<sup>8</sup>

However this is one element that is missing completely or seriously under-developed in almost all STPs: 31 of the 44 offer no proper needs analysis above a few selected statistics, and fail to show that their proposals take account of the size, state of health and locations of the population, which in some geographically large, sparsely populated areas (Cumbria, Devon, Lincolnshire, parts of Herefordshire and Worcestershire) may be widely spread and connected by poor roads and few transport links.

Eleven make partial reference to needs analysis, refer to local JSNAs, or mention other documents as the source of their local planning. Only two (Nottinghamshire and North East London) appear to take serious account of such information, although drawing some questionable conclusions from it, and presuming that services can be rapidly changed. Nottinghamshire hopes to achieve a 15.1% reduction in A&E attendances, and a 20-40% reduction in non-elective admissions, leading to a 30.5% reduction in non-elective acute bed days (p68). In North East London the STP does relate to delivery plans, equality reviews and a public health assessment in a conscientious attempt to inform the STP planning process from a public health point of view, but this has little obvious influence on the STP's proposals for action.

Most STPs do not provide a clear context-setting view of recent financial performance in their area demonstrating an awareness of the challenges faced by the system. For example, 29 of the 44 give little if any useful information to answer our question on 'details of local stakeholders and details of historical, current and projected financial deficits and any long-standing issues'<sup>9</sup>. The remaining 15 may give some of the information needed to assess the financial state of play in the STP, but none provide a full picture.

Cambridgeshire and Peterborough STP is unusual in making reference to a local history of chronic and increasing deficits,

*"We are more financially challenged than any other footprint. Our organisations have a combined deficit of 11% of turnover, with our CCG and three general acute trusts all facing severe financial problems. While Cambridgeshire and Peterborough received approximately £1.7bn to spend in 2015/16, our collective deficit was more than £160m" (p8).*

<sup>18</sup> Our summary is based on <http://cambridgeshireinsight.org.uk/jsna>

<sup>19</sup> See Question 10 in Appendix 3.



The deficits of the three acute trusts in the STP are not treated separately in this passage, but are subsequently examined in the context of specific issues. However the STP goes on from this to revert to projections of a generalised hypothetical ‘Do Nothing’ deficit, and the specific pressures on individual trusts are largely disregarded.

There is a similar acknowledgement in the North East London STP of the £83m deficit in Barts Health. Norfolk and Waveney, Staffordshire and Stoke-on-Trent, Bedfordshire, Luton and Milton Keynes, Herefordshire and Worcestershire, Hertfordshire and West Essex, and Suffolk and North East Essex, all refer to ‘historical deficits’: but most STPs lack this detail.

In Mid and South Essex the STP contains no detailed figures and it is necessary to refer to Trust Board papers to discover that all three acute trusts are chronically in the red, and facing an almost £80m deficit for 2016/17 (Mid Essex Hospitals £35.5m, Basildon and Thurrock £27.8m, Southend £16.2m) although these deficits as in many other areas will be partly offset by payments from the Sustainability and Transformation Fund, thereby reducing any amount available for investment in improved services.

Many STPs fail to make any financial assessment of local stakeholder trusts, or fail to separate out the financial situation of the various providers, calculating just an aggregate ‘all providers’ figure. This gives a false impression that the STP process has already advanced to override the Health and Social Care Act and the competitive market it reinforced in 2012, and that trusts (and foundation trusts, whose cherished autonomy appears for the most part to have now been almost completely set aside) have already been effectively amalgamated into a common ‘provider’ rather than each being still required by NHS Improvement to deliver their assigned ‘control total’ – in other words to stay within budget.

In most of these cases rather than address the specifics of current financial issues, STPs claim projected ‘Do Nothing’ deficits that in our view seem artificially inflated by excluding any of the expected ‘Business As Usual’ efficiency savings, which are then added back in as a major component of the STP ‘bridge’ from deficit to balance (or closer to balance in some cases).

Derbyshire is unusual in recognising the financial pressures arising from new hospitals funded through the Private Finance Initiative (PFI),

*“Specifically the underlying deficit at Royal Derby Hospitals driven by the PFI arrangements (as identified in the Monitor ‘Drivers of the Deficit’ report)” (p13).*

Many other STPs ignore this issue altogether – or assume, for example in the case of Cambridgeshire and Peterborough<sup>20</sup>, there will inevitably be some form of central subsidy to help defray the inflated overhead costs. Mid and South Essex flags up the costs of an ‘expensive PFI’ in the Mid Essex Hospital Trust’s new hospital in Chelmsford (STP June Annex p67). Cambridgeshire and Peterborough note the increased cost of Peterborough’s City Hospital, and Nottinghamshire’s STP is premised on receiving £20m a year towards the excess cost of Sherwood Forest Hospital: but Staffordshire and Stoke-on-Trent,

<sup>20</sup> On p9 of the STP.

Herefordshire and Worcestershire, Coventry and Warwickshire and many others fail even to mention the costly legacy of PFI.

These are not the only substantial issues that are missed or underplayed in many STPs. Only five STPs for example<sup>21</sup> even mention the issue of the potential impact of their plans on equality, and the extent to which the proposals may impact on vulnerable groups. Even these STPs are yet to do anything about the issue of equality, but they are the only ones to mention the future prospect of an Equality Impact Assessment: indeed many other STPs fail even to use the word ‘equality’ and do not demonstrate in any way that they have had regard to the need to reduce inequalities. For example, there seems to be a disregard of the implications of reducing ‘specialist commissioning’ budgets by over £1bn (our estimate). None of the STPs have identified where these savings are to be found – for example North West London ‘assumes’ a gap of £186m will be closed (p51). However such unresolved gaps leave the possibility that patients suffering rare and expensive disorders will find it more difficult to access appropriate care.

The Public Sector Equality Duty (PSED), flowing from the Equality Act 2010, stipulates that Public Authorities have a legal responsibility to assess their activities, and to set out how they will protect people from discrimination on the basis of the following ‘protected characteristics’: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation (Equality and Human Rights Commission, 2011).

While some of these may seem peripheral to the planning of local health care provision at the level of detail described in the STPs, a number stand out as significant, especially in areas where the proposed reconfiguration and centralisation of services potentially mean substantial and difficult additional travelling, with all the related cost and discomfort for patients and people who may be expected to travel with them or visit them, and who may be in disadvantaged circumstances: in particular the issues of age, disability, and pregnancy and maternity stand out. None of the STPs proposing centralisation or reconfiguration mentions any arrangement to ensure transport access for patients whose local services are to be downgraded, and none of them includes any equality impact assessment of the proposals in terms of travel for various sectors of the population.

NHS England reminded CCGs of these obligations in December 2015, in a briefing: Guidance for NHS commissioners on equality and health inequalities legal duties, just a week before embarking on the reorganisation into STP Footprints (NHS England, 2015b). This briefing recommended the use of Equalities Impact Analysis (EIA), although it is not a legal duty to carry out an EIA. Thus, referring to providing ‘evidence of having due regard’, the briefing states,

*“In order to demonstrate compliance with equalities legislation and, specifically, the PSED, you will need to provide any evidence you have that demonstrates the impact or potential impact your work may have on people sharing protected characteristics.”*

<sup>21</sup> Hampshire and the Isle of Wight, Lincolnshire, Somerset, North East London and North Central London.

*This evidence could be in the form of policy papers, project documentation or background research that takes into account what you know about the equality implications of your work. **The important thing is that any conclusions arising from your equality analysis are able to influence your work and the material produced*** (p9, our emphasis).

The NHS England briefing goes on,

*“CCGs have a duty to have regard to the need to reduce inequalities between patients in access to services that they commission. This involves,*

- Knowing the local population and local needs, commissioning through the use of joint strategic needs assessments (JSNAs) and additional supporting data and evidence, such as local health profiles and qualitative sources.*
- Identifying the local health inequalities and commissioning for all of the population in the area, **not just relying on General Practice registrations*** (para 5.3.6, p16, our emphasis).

The final point emphasised above seems to have been widely breached by STPs, which in a number of cases have based their limited population data on GP lists from component CCGs. This is of particular importance as it may lead to underestimates of future demand for services in areas where the population is highly transient with many individuals not registering with GPs, for example parts of London – with newly-arrived individuals and families, refugees and asylum seekers: these are also more likely to resort first to A&E and urgent care rather than primary care in the event of illness.

The absence of any apparent concern to identify and act upon local health inequalities is compounded in many STPs by a failure to take account of the impact of the expanded geographical area that is covered by the Plan – failing to address the difficult issues of access to services and transport problems if services are relocated. This is an issue in many areas for patients and potential patients, who may be older, of limited mobility, lacking access to a car, on low incomes and with no family members close by. The problems are most obvious in rural areas where STPs and other plans to centralise or consolidate services result in potential journeys of up to 50 miles on poor country roads to access hospital care: but there can also be problems for patients required to traverse laborious, unreliable and uncoordinated transport links across big cities and even smaller ones, especially for single parents with more than one child and those on the lowest incomes.

Transport and access can also be an issue for retaining staff, who also potentially face extended journeys to work, which in turn prolong the overall length of their working day, reduce their work-life balance, and carry financial costs as well as threatening potential disruption and stress to existing family commitments and impacting on employee health. Only one of the STPs recognises these issues: Lincolnshire, which reveals itself uniquely sensitive to the objective situation, and somewhat at variance with the drive towards reconfiguration, notes,

*“Impact of the Geographical characteristics of Lincolnshire, i.e. large geographical area covered within the county and a road network consisting of many single lane carriageways which are speed restricted, resulting in travel times between towns and villages being relatively high” (p103).*

As a result, the STP states that “The Transport Enabler Group will be re-launched in November”, and that, “...All Site reconfiguration scenarios will be modelled in terms of understanding the impact on emergency transport, patient transport, voluntary and private transport...” (p103).

Elsewhere, there is no such connection made. In Herefordshire and Worcestershire, the Plan begins with what seems an acknowledgement of the scale of the problem,

*“Our STP footprint has some unusual challenges compared to many of the other footprints. Our footprint is one of the largest in terms of geography – covering 1,500 sq miles, but one of the smallest in terms of population – covering about 780,000 people. By way of example the distance between Hereford County Hospital and Worcestershire Royal Hospital is more than 30 miles and typically takes more than an hour to drive on single carriageway roads” (p3).*

However despite this opening statement, the proposals in the body of the STP itself take no account of the distances or logistical issues of travelling between different parts of the ‘footprint’.

The failure of STPs to draw logical conclusions from local factors and the needs of potentially vulnerable and less mobile patients connects with another factor that goes to the heart of the new structure of STPs themselves: by extending the geographical spread in many cases from CCG level to much wider areas and populations, and by their lack of any basis in legislation, CCGs may become detached from any genuine local accountability, or sense of local responsibility. In some areas CCGs are planning mergers that would cover large and diverse communities, highlighting the issue of how effective existing local mechanisms would be in raising their concerns. Local authorities may retain powers of oversight and scrutiny on changes in NHS services, and Health and Wellbeing Boards may have some potential influence over public health issues; however, there is a danger that as the size of geographic spread expands, NHS commissioners will become less accountable to the needs and wishes of specific local communities.

This seems to coincide with what Simon Stevens wanted to achieve in establishing STPs: to overcome ‘veto power’. But it is also one of the reasons that plans such as Staffordshire and Stoke-on-Trent, Devon, and Lincolnshire, that appear to the communities who face losing local access to services as riding roughshod over local needs and views, have become controversial as soon as they have reached the public arena.

Finally, in terms of local context it is significant that none of the 44 STPs provides any detailed discussion of proposals to address what in most areas are very significant projected ‘gaps’ in the funding of social care by 2020/21, or the annual ‘gaps’ that would lead up to that total, which in practice would need to be addressed each year by local

government – since councils are legally barred from carrying forward a deficit from one year to the next<sup>22</sup>.

In short STPs are already showing themselves in practice to be far from the friendly, strategic, common-sense ‘place-based’ plans that they are purported to be, and their potential as extra-legal bodies to override the voices and views of local communities, statutory NHS bodies and even elected local district councils is a predictable basis for controversy.

## Finance

Finance has been one of the key drivers in the development of STPs: the requirement to deal with what was identified by NHS England as a massive emerging financial gap that would make the NHS ‘unsustainable’ by 2020/21. Without exception all of the STP documents refer to this.

In each STP we find five-year ‘Do Nothing’ scenarios that extrapolate large deficits using the assumption that there will be a large and increasing gap between the need for additional resources and the funds that the government is planning to make available. We have tabulated these and the projected deficit comes to over £23bn. Coincidentally this is close to the difference between £30bn (the projected financial requirement) and the £8bn the government offered to the NHS before the election in 2015 (Gainsbury and Dayan, 2016). Part of that £23bn refers to projected local authority deficits that, according to our calculations, although we can only provide rough estimates as the information in the STPs is incomplete, come to just over £4bn.

At a national level, and this has been followed by each STP, the gap has been calculated by projecting the upward cost pressures (population increase, ageing, technology, staff, capital), of around 4% per year in real terms to 2020/21 (Roberts, 2015), by when NHS spending nationally would be £137bn in England, rather than the £107bn projected; hence the £30bn gap of which £8bn is supposedly covered by ‘extra’ government spending and £22bn is savings that has to be found. This projection is based on virtually zero increases in real-term expenditure.

While this is realistic on one level, the quantity of savings required deliberately excludes any of the annual efficiency savings that trusts have been delivering year on year since the mid-1980s, and fails to acknowledge the positive track record of NHS financial managers in delivering recent financial balance with the exception of 2015/16 when the deficit was 0.1% or £149m. This may be fine at the national level where government is merely acknowledging the overall size of the task, but at a local level it is somewhat dubious to identify a ‘Do Nothing’ scenario that excludes provider and commissioner efficiency savings. This seems particularly misleading when in most cases these are simply added back in as BAU/CIP<sup>23</sup> savings, as if this were part of the STP<sup>24</sup>.

<sup>22</sup> See Note 2.

<sup>23</sup> BAU is ‘Business as Usual’; CIP is ‘Cost Improvement Programme’.

<sup>24</sup> However, it should be acknowledged that an unprecedented scale of savings is being attempted cumulatively. The HSI reported (Dunhill, 2017) that 60 Trusts (about 25%) have rejected their savings targets which now average 6.4% for them, and for some the targets are higher still. It is clear therefore that ‘Business as Usual’ savings are reaching unusual levels; past success may not translate into future success.

The standard of reporting of these BAU savings in the STPs is so variable that we have not attempted to provide an overall figure; however the following examples are indicative of the issue.

Frimley Health and Care STP representing a well-managed provider-led structure has some 63% of the overall savings target tied up in BAU savings with a target of just 17% of total savings from transformational changes. Northumberland, Tyne and Wear and North Durham STP has identified 61% of overall target savings from BAU savings; and Buckinghamshire, Oxfordshire and Berkshire West 70%. The real issue then becomes whether the NHS can continue to meet its efficiency targets and also deliver transformational change. The attention has been on transformational change but it may be that it is the BAU savings that represent the bigger challenge.

The threat of imminent financial disaster is constantly invoked as a means of overcoming resistance to what otherwise would seem to be counterintuitive policy directions: reducing acute capacity when the existing capacity cannot cope, embracing new models of care before they have been proven to work in practice in the UK; and destabilising the workforce when there are shortages throughout the NHS.

There is wide variation in the size of the financial problems faced by STPs. Our analysis based on STP-projected 'Do Nothing' deficits by 2020/21 shows that these vary from £1.4bn in North West London to £131m in Shropshire and Telford & Wrekin. Given that population varies markedly between STP footprints we have looked at the total STP-projected deficit per head by 2020/21 finding a range of £769 (Surrey Heartlands) at the top to a low of £216 (Durham, Darlington, Teesside, Hambleton, Richmondshire and Whitby). These figures need to be viewed with caution as STPs may not always have been consistent in reporting social care deficits but nonetheless it conveys the size of the issue STPs are confronting. Similarly, savings planned in 'specialist commissioning' vary from £262 per capita in South East London to £15 per capita in Cornwall and the Isles of Scilly.

## **Do STPs make the case for investment?**

We suggested in the introduction that approval mechanisms for STPs should be at least as stringent as for any other large-scale business case. Large sums of money are at stake and the onus should be placed on those making proposals for change to justify their plans. Widespread implementation should only occur once evidence exists that plans are sound and deliverable and thus replicable across STPs.

We examined the financial aspects of the STPs to draw out whether the plans are clearly expressed, rooted in a thorough financial analysis of the current local health economy, and present sound, coherent plans for the future to which local government partners and other stakeholders could readily sign up, fully cognisant of the risks involved.

We have adopted four headings common to business cases (NHS England, 2013) – Economic Case, Affordability, Deliverability and Risk Analysis – to draw out particular systemic weaknesses and to draw attention to the areas that will require future attention.

While the vast majority of STPs (the exception being Cornwall and the Isles of Scilly where the STP was presented as a draft Outline Business Case) make no claim to be presented

as rational economic appraisals or to adopt a business case format, we believe it is fair to analyse them in this way. These after all represent plans for large-scale change across the whole of England, and therefore deserve to be assessed as any other NHS plan would be. We recognise that perhaps this was not the intention of the authors, but nevertheless, where large-scale investment is potentially involved as well as disruptive change to existing services, then this must be the criterion by which they are held to account.

### **Economic Case**

An Economic Case requires an options appraisal of potential benefits relative to costs that demonstrates that value for money will be optimised. In the vast majority of the STPs we reviewed there were very limited attempts to present investment objectives based on a thorough understanding of the needs of the local community, options for delivering them, or to demonstrate positive returns for the investments proposed for the plan as a whole<sup>25</sup>. In several cases STPs were re-workings of previous plans (North West London, South West London, Leicester, Leicestershire and Rutland), and often this is referred to as though it excuses the STP from the duty of presenting these plans again, or to look again at investment objectives, options for meeting these objectives, and to conduct a sober assessment of the costs and benefits after quantifying the risks involved. As matters stand, in our view there are no STPs that are yet compliant with the Treasury Green Book, the guidance issued by HM Treasury on Investment Appraisals (HM Treasury, 2003).

The STPs themselves often admit that they have not yet attained the status of a plan, and often carry sub-titles underlining their provisional nature; for example, West, North and East Cumbria STP refers to its plan as an 'Integrated health and wellbeing system and clinical service strategy'; North East London STP refers to its as a 'draft policy in development'; and Bath and North East Somerset, Swindon and Wiltshire refers to an 'Emergent Plan'; seven others use the words 'draft' or 'work in progress'.

### **Affordability**

Affordability is an assessment of whether the financial means are available for the Plan to be executed. Given that very many Trusts have large underlying financial deficits and have to comply with individual financial duties which could limit spending, capital investment and organisational autonomy, this seriously undermines the ability of such bodies to cooperate in these well-intentioned but as yet poorly thought-through projects. The immediate effect of prevention strategies and pro-active care strategies is likely to be a short- to medium-term (at least) increase in costs as care and intervention is shifted to an earlier point in the care cycle. This makes it even more difficult for STPs to show that their plans are affordable.

The STPs seems to be based on an assumption that savings will be achieved. But we note that the National Audit Office (NAO) has already cast doubt on savings plans associated with health and social care integration and its likelihood to reduce hospital activity (National Audit Office, 2017). The NAO could not put it more starkly,

<sup>25</sup> This is true even though it is clear that in several STP areas there may have been years of efforts to launch wide-scale transformation that has failed to get off the ground but has been given a new lease of life with the opportunity to promote an STP. Examples include North West London, South West London, Leicester, Leicestershire and Rutland, and Cambridgeshire and Peterborough.

“There is no compelling evidence to show that integration in England leads to sustainable financial savings or reduced hospital activity” (pp7-8).

We have already referred to recent evidence from the Nuffield Trust questioning the potential for savings (Imison et al., 2017). The Kings Fund and the Health Foundation have both pointed to the difficulties in meeting targets without further injections of money. A report from the Healthcare Financial Management Association (HFMA) also found widespread scepticism of plans presented (Healthcare Financial Management Association, 2016), as the HFMA Director of Policy, Paul Briddock, indicates in an article in Public Finance (Briddock, 2017),

“...although most finance directors see STPs as a cornerstone of reducing the current deficit, an overwhelming majority are also concerned about the way they are set up, with nearly three quarters (72%) troubled about their governance. Finance directors have limited confidence in the simultaneous delivery of both STP and organisational financial objectives, with only 6% of trust finance directors and 17% of CCG chief finance officers (CFOs) believing that they are both deliverable”.

### **Deliverability**

Deliverability relates to whether management has demonstrated that the proposals can be delivered successfully.

As noted earlier, the STPs often rely on the availability of large sums of capital, something that is likely to be in very short supply as the Chancellor continues to limit public expenditure<sup>26</sup>. None of the STPs seems to have an alternative in the event that capital is not available. In the risk analysis, these risks are often noted without it being clear what the action would be if capital was not forthcoming. For example the total capital required in North West London, taking account of existing capital plans and new STP proposals, would total £1.4bn; West Yorkshire and Harrogate, and Greater Manchester, both require in excess of £1bn each. In North West London the risk of lack of capital funding is identified but the mitigating option of seeking funding through the One Public Estate route is not clarified; in Greater Manchester the risk analysis is not shared; and, in West Yorkshire and Harrogate the STP does not provide any risk analysis.

On the other hand some 20 STPs have not identified their capital requirements at all. It is unlikely that transformation on the scale they envisage can be delivered without capital investment.

Turning to the actual delivery plans contained in the STP documents only a minority have presented ‘Delivery Plans’: Lincolnshire, Hampshire and the Isle of Wight, North West London and South West London. But most of these are unconvincing. For example in Lincolnshire our analysis revealed that the savings targets appear to rely on extensive use of a top-down modelling approach based on national indicators and benchmarking with little reference to local intelligence. Although some of the assumptions are shared in the STP, it fails to point out possible shortcomings in the methodology and the risks if targets are not achieved.

<sup>26</sup> The Chancellor announced £325m for STPs in his March 2017 Budget (for the next three years). This is less than the amount requested and will still require business cases demonstrating affordability and value for money.



In Hampshire and the Isle of Wight, local CCG Delivery Plans rely on unrealistic assumptions. For example we found in our analysis that only minimal changes to staffing will be made despite the STP highlighting expected savings of £500m. In South West London there is a 150-page set of appendices discussing delivery but these mainly cover the approach being taken rather than focussing on actual plans to achieve timetabled delivery.

While it is true that most STPs intend to use a dedicated Project Management Office, with budgets for extensive 'support' from outside contractors, this reflects a view that the key problem is implementation skills for the plan rather than the coherence and deliverability of the plan itself.

Finally, workforce is another key element of delivery. However workforce plans (and their absence) are of particular concern – see the next section of this report for more discussion of workforce planning issues.

### **Risks**

We assessed the risk analysis accompanying STPs. A risk analysis for a business case would be expected to calculate the financial consequences of risk events occurring, to identify the probability of such events, and to demonstrate how mitigation would reduce or deal with the consequences.

In our judgement, none of the STPs provides a complete risk analysis. Most were wholly inadequate, some non-existent at this stage (around 15%), but 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.

For example, in the Nottinghamshire STP a good assessment of risks is made that identifies as a high risk,

*“Short term pressures both at organisation and system level conflict with the strategic direction set in this document” (pp74-75).*

As mitigation, the STP proposes,

*“Maintain open and trust based relationship with the regulator”, and,*

*“Maintain strategic alignment and co-ordination across the system through enhanced system governance arrangement” (pp74-75).*

It is not clear what might happen should that fail.

In Gloucestershire a risk assessment provides high warning levels for the following,

*“There are considerable resource requirements associated with delivering such large transformational change. Organisational capacity across county will have key impact on likelihood of success. Clinical leadership and change capabilities will determine likelihood of improvements being sustainable in long term” (p44).*

Proposed mitigation is,

*“Complete review of capacity aligned to key programmes and ensure this is reviewed at delivery board, discussion on commitment of resources with CEOs” (p44).*

But it is clear that this had not happened before the STP was actually submitted. In Northumberland, Tyne and Wear and North Durham there is a candid admission of the following financial risks,

*“Financial Risks*

- Underachievement of the savings planned;*
- Under realisation of the savings from reduced national tariffs;*
- Unplanned increases in the amount of non-elective hospital activity;*
- Unplanned increases in either volume or price of the prescribing;*
- LA funding reductions and the potential for additional cost pressures for the Health Economy” (pp53-55).*

But no effort is made to quantify or to mitigate for these risks and just to underline matters the STP lists among others the following limitations to the methodology used,

*“The plan has been developed for the footprint undertaking a top down approach using national indicators, benchmarking and pre application of local intelligence.*

*Local Authority funding pressures and the potential for additional costs across the health and social care economy with respect to such issues as increases in DTOC have not been modelled in the financial plan.*

*Simple rules and/or assumptions have been used to define the benchmarks*

*The benchmarking undertaken has not been adjusted to take into account differences in delivery models or case mix further than what is controlled for by the retention of the peer group.*

*The models use indicative values based on local intelligence, top-down literature and benchmarking and as such ranges for both costs and delivery may need to be considered further.*

*A simple rules based approach to SF (semi-fixed) costs has been taken, in line with the functionality in the top-down Solution Model. This does not account for a detailed analysis of SF costs elasticities linked to rota efficiencies, however assumptions drawn from the local system are used instead” (pp53-55).*

## **Concluding remarks on finance**

We have not identified one STP that is as yet capable of demonstrating readiness for implementation. According to the initial Planning Guidance issued in December 2015, all STP plans were to be submitted by June 2016 with the intention of being approved for implementation, with the most compelling and credible STPs securing the earliest

additional funding from April 2017 onwards<sup>27</sup>. We would expect to see better evidence that individual STP approaches are yielding results, that they can be delivered quickly and at scale, with some degree of certainty and with the effect predicted. No such evidence exists in our view. Much better plans are required before final decisions to proceed with implementation can safely be made.

To proceed in anything other than a controlled and experimental manner at this stage would represent too high a risk at too high a likely price. The risks are of poor value for money, uneconomic investments, more not less pressure on NHS budgets and further distraction for managers in delivering day-to-day services. Ultimately all these impact on the quantity and quality of patient care.

Simon Stevens in a letter of 12 December 2016<sup>28</sup>, Next Steps on STPs and the 2017-2019 NHS Planning Round, seems to have shifted his ground from the initial planning guidance issued in December 2015 that asked for two separate but connected plans. He now states,

*“The first phase of STPs has been to develop **proposals for discussion**. All 44 STP proposals will have been published within the next fortnight. Despite constrained funding growth, they all include important commitments on prevention, improving cancer outcomes, expanding access to mental health services, strengthening general practice and developing more integrated urgent care services, amongst other goals. They provide strategic direction for the tactical decisions you will collectively be taking in the few weeks [sic] about the 2017/18-18/19 commissioning round” (pp1-2, our emphasis).*

However, the initial expectation was set for immediate implementation, and so we believe that the STPs should be regarded and tested in that way, and in this respect they fall short. The NHS and the Treasury have developed clear rules for evaluating investment proposals and for assessing the robustness of plans. These rules should be applied to STPs.

## Workforce planning

Two-thirds of the STPs (30/44) have no detailed workforce plan to ensure an adequate workforce will be in place to implement the policies and new services they outline. Three STPs claim that a plan exists, but they have not published it. Four STPs at least offer some data on local workforce issues, but this falls well short of offering any coherent or practical plan.

Another seven STPs, far from focusing on investment in a sustainable workforce as a vital ‘enabler’ for any strategy, are seeking to make substantial savings from workforce budgets, and/or reduce the numbers of staff employed, the largest target for which comes from the North West London area – which in figures not disclosed in the STP document itself

<sup>27</sup> See p5 of Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21 (NHS England, 2015a).

<sup>28</sup> This was a joint letter to STP Chairs or Convenors, Chief Executives of NHS provider trusts, and CCG Accountable Officers, from Simon Stevens, Chief Executive of NHS England, and Jim Mackey, Chief Executive of NHS Improvement, laying out ‘Next Steps on STPs and the 2017-2019 NHS Planning Round’. It was copied to Chief Executives of Upper Tier Local Authorities (NHS Rotherham CCG Governing Body, 2016).

and only partly revealed in the Delivery Plan obtained through Freedom of Information requests, suggests plans to cut 8,000 staff by 2020/21<sup>29</sup>.

No one mentions the looming threat of Brexit, which is already beginning to impede recruitment of professional staff from within the EU, and will intensify in impact now that the government has refused to guarantee that the estimated 55,000 professional staff and doctors from throughout Europe will be able to remain in the UK after it leaves the EU<sup>30</sup>.

Even more disruptive is the prospect of a reducing inflow of trained staff as the abolition of bursaries impacts on the recruitment of students for university courses and professional qualifications in nursing, and allied health professions including radiography. Applications for nursing and midwifery courses at British universities for September 2017 intakes have fallen by at least 23% since the announcement of the abolition of student bursaries. Janet Davies, the General Secretary of the Royal College of Nursing is reported to have said (Adams, 2017),

*“The outlook is bleak: fewer EU nurses are coming to work in the UK following the Brexit vote, and by 2020 nearly half the workforce will be eligible for retirement. With 24,000 nursing vacancies in the UK, the government needs to take immediate action to encourage more applicants by reinstating student funding and investing in student education. The future of nursing, and the NHS, is in jeopardy.”*

The absence of any urgent discussion on this – and the potential implications for specific providers in acute care, mental health care, primary care, community health and social care – confirms the lack of sufficiently coherent or concrete approaches to the development of a workforce plan in any of the STPs.

Plans aiming at budget savings include several in the Midlands and East region. Nottinghamshire’s Workforce Plan, not in the main STP, makes clear that it wants to achieve savings by cutting 1,500 staff across Urgent Care, Planned Care and the diagnostic workforce, while recruiting 954 staff – 644 in ‘Community/pro-active care’, and 310 in Primary Care (Annex to STP<sup>31</sup>, web link added as footnote, Figure 9). The overall reduction in jobs is just 2.7% over five years, but it is clear that there will be disruption and uncertainty, especially in the absence of a workforce strategy that sets out clear proposals on how to secure the new staff that are required from an increasingly limited pool of qualified professionals.

In Leicester, Leicestershire and Rutland 1,500 provider jobs will be cut by 2020/21, while 234 extra primary care staff will be sought<sup>32</sup>. Lincolnshire is looking to cut 805 jobs, 201 from ‘pro-active care’ – well out of line with the proposals in many other STPs, for which pro-active care is an area where they hope to expand – 488 from planned care, and 116 from

<sup>29</sup> This refers to a response to a Freedom Of Information request to North West London Collaboration of CCGs, CCG/6979, dated 4 January 2017, Appendix A-1.

<sup>30</sup> 10% of doctors in England and 4% of nurses are from other EU Countries. See <https://fullfact.org/immigration/immigration-and-nhs-staff/>

<sup>31</sup> See <http://www.stpnotts.org.uk/media/116403/workforceplan.pdf>

<sup>32</sup> See the STP p5.

urgent care: it seeks to recruit 160 more to work in mental health and learning disability, and 96 for primary care – a net loss of 549 if all goes to plan.

Shropshire and Telford & Wrekin STP also proposes to cut a larger number from existing jobs and recruit fewer: cutting 350-363 WTE from the acute sector (p54), while 190 posts will be created ‘in the community’. There seems little to guarantee such changes will succeed in ensuring an adequate workforce will be in place.

Dorset STP is seeking ways of rewriting contracts and changing agreements to enable it to,

*“join our workforce across Dorset into a single network working together to support the delivery of more 24/7 services across our hospitals and the Integrated Community Service programme, as well as enhance skills acquisition and career and personal development opportunities “ (p29).*

This is a complex business, potentially eroding the national Agenda for Change agreement which guarantees terms and conditions, and creating problems for staff recruited to one trust and then potentially required to work anywhere in the county at the behest of another, regardless of the impact on domestic arrangements and the logistics of travelling across a county with little public transport.

It is perhaps understandable that the STP is seeking extra funding to assist with the potential legal costs given the right of STPs – which have no legal status – to interfere with the contracts and conditions of staff may be challenged by trade unions and professional bodies,

*“As part of our Acute Vanguard programme, we would like legal expertise to help determine the format and structure of the ‘vehicle’ that will be established to deliver our single clinical network and workforce” (p42).*

In Devon, too, where, “There will be challenges in recruitment in several areas such as domiciliary workers, social workers, health care assistants, primary care and senior medical staff in small specialties” (p44), the plan is similar, at least in primary care,

*“The priorities are first to support practices to work at scale, to work together and plan change together, working as part of a transformed multi-disciplinary fully integrated workforce. The CCG is working to overcome contractual and infrastructure barriers to better enable this” (p32).*

Meanwhile, to reduce costs, Herefordshire and Worcestershire is not the only STP looking at the possibility of effectively diluting the skill mix and relying more on less qualified staff,

*“As the recruitment pool becomes more shallow and as workforce challenges threaten clinical viability, Herefordshire and Worcestershire need to be in the vanguard of the introduction of new clinical roles. In Herefordshire a “vacancy harvesting” process will be used to trigger plans to review the lines of demarcation and introduce new clinical roles. In Worcestershire, there is, for example, a well advanced programme for the introduction of Physician’s Associates into key aspects of hospital delivery” (p72).*

The Durham, Darlington, Teesside, Hambleton, Richmondshire and Whitby STP is another looking at the same idea, while Buckinghamshire, Oxfordshire and Berkshire West is exploring the use of 'generic support', as is Birmingham and Solihull.

Just under half the STPs identify plans to make savings from so-called 'Back Office' services, a term used to describe the wide range of health workers in clinical and non-clinical roles that keep the 'front line' running, whether this be medical secretaries and records clerks, procurement, payroll, or in some cases diagnostics and pathology services. Some diagnostics and pathology services have already been merged into larger units, privatised or run as businesses, often with less than stellar results, according to the Royal College of Pathologists, who have warned NHS Improvement against pushing for short-term savings that may have long-term costs (Royal College of Pathologists, 2016).

In Herefordshire and Worcestershire for example, the following changes are intended in Diagnostics and Clinical Support,

*“Workforce and processing of pathology samples will be centralised across a much wider footprint releasing costs, creating economies of scale and increasing purchasing power. These savings will offset pressures in other front line service areas”(p31).*

These plans are also likely to run into the same issues of contracts, terms and conditions, and problems retaining the existing workforce that affect the so-called 'front line' workforce. Many staff who have been some years in post are highly experienced and have skills that are not easy to replace: the potential loss of organisational 'memory' and acquired expertise could prove equally as costly and dislocating as the process of recruiting and training new staff in a new 'culture' to which many of the remaining incumbents may not themselves subscribe.

A serious workforce strategy for the future has to begin by valuing the skills and dedication of the staff in post and understanding the many, often complex factors that have brought them to live and settle where they are, and the obstacles that some are likely to encounter in any substantial change. For this reason a strategy must not eventually seek consultation with trade unions and professional bodies, but begin with engagement and consultation, within each workplace and with the designated representatives of the staff.

## The impact on services

In this section of the report we focus on the likely impact of the STPs on service provision; in many cases this impact is not always made clear in the STPs.

The primary focus of our analysis has not been on the commitments to enhanced primary care or on improvements in provision in the community though these are common to many STPs, if often without detail on the resource implications. We accept there is a need throughout the country for improved primary and community services, improved and expanded public health programmes, and for intensified efforts to prevent unhealthy diet and lifestyles and thus eventually reduce demand on health care. However, we are not

convinced, and no evidence was provided in the STPs themselves, that these services can result in substantial savings in the short or even medium term.

In many cases the STPs have built on previously proposed rationalisation and reconfiguration of acute hospital services in their areas, often extended so as to speed up the process of seeking cash savings, with the resultant reduction in local access to health care. In some plans (for example Devon, West, North and East Cumbria, and even Bedfordshire, Luton and Milton Keynes) the definition of 'local' now extends as far as 50-60 miles from existing local care.

There are several examples where proposed rationalisation has appeared in leaked or published early versions of STPs but these have been subsequently toned down, notably in Devon STP, and Cheshire and Merseyside STP. Perhaps that is why it is remarkably hard to draw up a comprehensive list from the STPs themselves of how the plans will impact on service provision. Our review shows there are proposed reductions in acute bed numbers and numbers of A&E departments in over 50% of published STPs.

Many of the STPs do spell out plans that remain deeply controversial and have been challenged by local politicians in many areas, including leaders and elected councillors from some of the councils whose support the STPs needed to enlist. Half of the STPs (22/44) are abstract and vague, offering no clear or specific proposals, or have taken the easy option of deferring long-expected proposals or consultations until a later date, or running in parallel with the STP (for example the Oxfordshire Transformation Plan, a subset of the Buckinghamshire, Oxfordshire and Berkshire West STP was published in January, after the STP was published).

In several more areas, the NHS had already embarked on reconfiguration prior to the launch of STPs – for example West Yorkshire and Harrogate (where reconfiguration is currently downgrading services at Dewsbury, and at Huddersfield Royal Infirmary), Devon (where a number of community hospital closures are already happening), North East London (where the frequently delayed downgrading of the A&E at King George Hospital in Ilford dates back to 2009/10), and North West London (where the closures of A&E services at Central Middlesex and Hammersmith Hospitals in 2014, and the proposals to close A&E and acute services at Ealing and Charing Cross Hospitals, and sell off much of both sites go back to at least 2012). Such plans are still – subject to availability of capital and revenue resources – being promoted vigorously in parallel with the STPs, not least in areas where the STPs have not made explicit proposals on reconfiguration.

Other STPs are now considering more or less substantial additional downgrades of A&E: for example Durham, Darlington, Teesside, Hambleton, Richmondshire and Whitby STP (reducing from four acute hospitals with A&E to two), and potentially Cambridgeshire and Peterborough (reducing from three A&Es to two Emergency Departments and a lesser unit at Hinchingsbrooke Hospital), with Mid and South Essex, and Herefordshire and Worcestershire, each potentially reducing from three emergency departments to just one specialist unit with two downgraded lesser units.

Leicester, Leicestershire and Rutland STP, also following on from a previous reconfiguration plan, wants to reduce from three to two acute hospital sites, closing 243 acute beds at Leicester General to focus services at Glenfield and Leicester General Infirmary at a capital cost of £280m; the STP also proposes to remove beds from two of the eight community hospitals, closing 38, a total bed reduction of 13%.

West, North and East Cumbria STP, while not specific, implies West Cumberland Hospital Whitehaven A&E will be downgraded to 'minor trauma', leaving Cumberland Infirmary Carlisle as the only A&E and maternity unit, some 50 miles from much of the STP catchment population.

Dorset STP also makes clear there is a plan to reduce one of three acute hospital sites to a planned care site, with A&E services on two sites only. There are also plans (without capital) to build a new paediatric and maternity unit in east Dorset. As a result of the reconfiguration, either Poole Hospital or Royal Bournemouth Hospital would be established as the Major Emergency Hospital, to provide more specialist emergency services for the whole of Dorset, with hyper-acute specialist services provided at the region's tertiary centre, University Hospital Southampton.

This would leave either Poole or Royal Bournemouth to provide higher-quality elective services and a downgraded 24/7 Urgent Care Centre, while planned and emergency services in the west would continue at Dorset County Hospital. The STP projects a reduction of bed capacity in Dorset by 360 (20%) to just 1,570 beds.

Other STPs are less clear on exactly what changes they intend to make. The Staffordshire and Stoke-on-Trent STP is to "Reduce total bed capacity, estates and management overheads to take out fixed costs" (p49), with cuts in beds for acute as well as community hospitals, and a target saving of £22m from estates. By 2021 this is intended to result in "Realisation of cost savings from major estate closures post reconfiguration activities" (p31). However the details of the rationalisation of estates are not yet finalised (p51). The STP is explicit in revealing that one of the current three Emergency Departments is to be downgraded to an Urgent Care Centre (p51), but it does not reveal whether this should be Burton, Stafford or the new PFI-funded Royal Stoke Hospital. Nonetheless it is implicit that the downgrade will almost certainly occur at Stafford.

In Sussex and East Surrey STP the old rivalry between hospitals in Eastbourne and Hastings is implicitly revived and made more complex through suggestions of a wider 'reconfiguration' including the much larger Brighton and Sussex University Hospitals Trust – again with no clarity in the STP.

The long-running and repeatedly postponed process of reconfiguration in Bedfordshire, Luton and Milton Keynes, where either Bedford or Milton Keynes Hospital – or possibly both – face the prospect of a downgrading of A&E and acute services, with Luton, upwards of 17 miles away, as the major emergency centre, has also been revived by the STP: however this STP is another that does not provide any clear proposals but pushes the decision into other channels, further delaying any clear proposals until a later review and consultation process.



Some other STPs make clear the numbers of beds they want to close. Devon removed this detail from their (published) June draft in which they declared the ambition to close 590 beds in total: the October draft has no such details. As a result, Derbyshire now has the greatest level of explicit bed closures with plans to close 530 by 2020/21.

Kent and Medway STP proposes to reduce beds from the current capacity of 2,896 to 2,600 in 2020/21, based on optimistic assumptions about reduced activity, reduced LOS, and sustainable occupancy. Hampshire and the Isle of Wight aims to cut 300 beds, Nottinghamshire 200 and Herefordshire and Worcestershire wants to close 202 community beds along with an undisclosed number of the STP's scattered Minor Injury Units.

Lincolnshire STP proposes to reduce non-elective admissions by 29,377 (equivalent to 10%) and close 118 acute beds. This is based on an assumption that five Urgent Care Centres alongside pro-active care services will divert 244,063 potential cases from A&E by 2021. Meanwhile without further explanation the STP also proposes a reduction of around 750 WTE staff by 2021.

Norfolk and Waveney STP plans by 2020/21 to cut the non-elective caseload by 25% and avoid/prevent 10,080 A&E attendances through 'Out of Hospital Services', 13,528 more through 'individualised medical care planning' and 6,391 through prevention. Along with other measures, in total the Plan envisages a cut to the A&E caseload of 64,571 – 50% more than the expected growth in demand for A&E services on current trends. This would represent a very large shift of workload into primary and community services – but no equivalent precise plans are in place to ensure these services are equipped to deal with the extra workload.

The precise service implications for the acute trusts of the projected reductions in admissions and bed days in Hertfordshire and West Essex are not discussed, other than stating the need to “support colleagues working to transform acute service to release capacity and ‘right size’ their overall bed base” (p20). However it is clear that these planned reductions are substantial, and even the likelihood of achieving them is open to doubt.

This STP also hopes to reduce admissions of frail patients by 11,231 within three years and 24,451 in five years, requiring 28,222 fewer bed days. Plans also involve reducing admissions for Respiratory, CVD, Diabetes, Musculoskeletal and elective treatment, cutting a total of 16,000 in three years and 36,000 in five years resulting in almost 52,000 fewer bed days. In addition the STP proposes to cut activity among 'well adults' and reduce outpatient appointments by hundreds of thousands (186,000 in three years and 456,000 in five years). However, this the shortest of the 44 STPs does not spell out exactly how any of these changes are to be achieved, or how the staff required will be recruited, trained, resourced and managed.

Given the tightening financial pressures on the NHS and social care, the lack of capital to fund investment in new facilities, hubs and equipment, the sparseness of financial plans, the weakness or absence of serious workforce plans, and the widespread failure to address

the specific and growing populations and health needs of the 44 STP footprints, there is little reason to believe that the hugely ambitious reductions in demand and pressure on acute services will be achieved.

When we examined the evidence base behind the claims made for various models of care, or changes in mode or location of provision, that underlie STP plans we found this to be virtually non-existent in all STPs. Moreover, not one STP has made its financial, workforce or activity models available as part of the STP package of documentation, and very few even provide the set of assumptions underlying their projected figures for activity, workforce and costs. Where these have been provided often the STP itself has recognised the significant uncertainty surrounding them. It is concerning that most STPs do not acknowledge the lack of substantial evidence to support many of their proposals, and are developing no alternative plans to ensure a continuity of services in the event of the desired efficiencies not being forthcoming.

## 4. Conclusion

Having looked in detail across all 44 STPs it is impossible not to conclude that the whole exercise so far has failed to meet the initial vision and requirements of NHS England, which wanted decisive bodies taking a lead across health and social care and pushing historical local obstacles and rivalries aside as they drove through ‘at pace’ implementing plans for simultaneous transformation of services, introducing new models of care and new digital technology, improving the quality and responsiveness of local services, and making them financially sustainable.

Of course it is valid to ask whether changes on this scale, many of which require access to capital, and revenue investment to cover double-running and expansion of community and primary care staff, were ever possible within the limits of the unprecedented ten-year financial constraint on NHS spending from 2010, and the equally unprecedented year-on-year cuts imposed on local government (and thus social care) by successive governments. There is also a question over the extent to which NHS organisations, after more than 25 years of competition between providers, and between purchasers and providers in ‘internal’ markets and over ten years of increasingly open markets, which since the 2012 Act have been regulated by the Competition and Markets Authority, could within just six months have been fully drawn into a new and deep collaboration not only with each other, but also with local government which is funded on a completely different basis, and accountable to elected local councillors. Those areas with existing close relationships may have had a better chance to do so.

NHS England has attempted to drive this process through top-down pressure, but in our view anything more than a casual examination of the 44 STPs would show this has not succeeded. The result seems to have been a relaxation of the original timetable<sup>33</sup> as well as a change of language as STPs are now described as ‘proposals for discussion’; although as far as we are aware the financial and service issues that drove the original process remain unresolved. The whole process is already seriously behind the ambitious schedule. The series of confidential discussions and meetings that excluded the public and staff representatives from any information or participation in the development of the plans has left the minority of the public who are aware of the STPs seriously suspicious of the process and the plans themselves. There is a danger that time and the possibility of any public trust have been lost.

Lateness, incompleteness and a desire to catch up on an unrealistic timetable are not valid excuses to ignore the legal framework and the elements of due process built up over time in order to safeguard the public from misuse of public resources. It may have been more sensible for NHS England to have sought a change in the law so as to facilitate the more integrated system that it is hoped will emerge. Insofar as this would overturn the ‘purchaser/provider split’ that has developed since the 1989/90 NHS reforms and deepened since the Health and Social Care Act 2012, there may well be some public support and enthusiasm for change, as long as local accountability and democratic controls are not removed.

<sup>33</sup> See an earlier reference to a statement from Simon Stevens (NHS Rotherham CCG Governing Body, 2016).

Instead there still seems to be a blindness to the obvious legal and governance issues that arise from promoting new centralised structures for delivering health care when the Health and Social Care Act 2012 embodied competition and localism within the law. In addition there are onerous requirements for local authority scrutiny, public consultation and consent, employee consultation and equality protection also embodied within statute. Beyond that, further Treasury tests of demonstrating value for money and compliance with guidance seem to have been obscured from view. It is as if decision-making is being hustled along as a sense of impending doom is generated if deficits are not tackled. But even at this difficult time proper attention must be paid to due process and the rule book on evaluating business cases and plans, before steps are taken to 'transform' the NHS.

We also see in these plans evidence of opportunism in the way that previous large-scale reconfiguration proposals are being introduced through the back door with minimal if any further consultation, through the mechanism of STPs. For example, proposals in North West London, South West London, Leicester, Leicestershire and Rutland, and Cambridgeshire and Peterborough, among others, that have failed to present credible business cases and win public support in the past have been resurrected as part of STPs with little opportunity for proper scrutiny of the plans, many of which have substantially changed since the original proposals were first made public.

STPs have also been urged to draw up plans based on stronger and more ambitious public health programmes to encourage people to change from unhealthy behaviour, along with the use of expanded and pro-active multi-disciplinary teams which would not simply support people on discharge from hospital, but also intervene to support frail older people and where possible deliver treatment and care at home to reduce the need for emergency admission to hospital.

It would be hard to argue that such ideas are anything other than desirable in themselves, but again the question is whether with current funding constraints it could be possible to build up the necessary community teams, or indeed sustain any provision of care for people who fall short of the extreme levels of severity of condition that they now require to display before being assessed as eligible for social care or continuing health care. And little if any evidence has been produced to show that public health interventions, which historically have been through long-term population-level action on social determinants of health, can deliver results 'at pace' in the form of measurable numbers of hospital admissions prevented, especially if they are also expected to yield significant cash savings.

In the 2015 Autumn Statement, public health budgets, now controlled by local government, were specifically cut every year to 2020. NHS commissioners and providers are preoccupied by the need to tackle or avoid major deficits and meet increasingly onerous cash savings beginning in 2016/17 and increasing each year. The result is that there is no significant spare pot of money for the necessary investment to get any of these new, positive ideas rolling.

STPs may have been initiated in the quest for new ways of doing things, but the scale of the financial problems has increasingly driven commissioners and providers back to old-style methods of dealing with deficits – seeking to downgrade or downsize hospitals

through centralising services, cutting bed numbers, cutting staff numbers, diluting skill mix, and passing a much greater burden of care onto GPs and primary care teams and untested community-level initiatives which are perceived (quite probably in error) as cheaper and in themselves more desirable. None of these proposed changes is likely to win support easily from the local public, health workers or even the local authorities that are part of the STP Boards.

NHS England has now urged STPs to submit more realistic and achievable plans for immediate action: on recent form, they are likely to be disappointed once more. And with local elections putting more pressure on council leaders, and local MPs coming under pressure from constituents, some MPs even more aware now with the announcement of a general election in June that their seats could be in danger, the period of evasion and uncertainty could drag on for many months more.

NHS England has made clear its wish to strengthen the powers of STP Boards to drive through their plans, but the Boards remain extra-legal bodies, standing alongside the existing system that was embedded in new and controversial legislation as recently as 2012. The power of STPs to override the constitutional rights of local communities, the contracts and national pay and conditions of health workers, the legal duty of CCGs and Trusts to consult on major changes, and the provisions of the Public Sector Equality Duty has yet to be tested. Moreover, it is also possible that the private sector will challenge the de facto abolition of the purchaser/provider split, in as much as it effectively denies private providers an opportunity to bid for specific elective, primary care and community health services. The willingness of Virgin Care for example to initiate legal action after losing a contract for children's services in Surrey suggests that private firms may well not give up quietly on potential income streams (Plimmer, 2017).

Unfortunately, the increased association of the idea of reducing demand for care and improving public health with the drive for cutting budgets has if anything set back the movement for these approaches in terms of public awareness, increased suspicion, and made it more difficult for councillors to advocate plans which are seen as leading towards closure, or even privatisation of provision of more NHS services.

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'. In this way it may be possible to create a wider base of support for the proposed changes.

Similarly before implementation of STPs is sanctioned there needs to be a much firmer legal authority and more clarity around the STP process. We suggest STPs should be clear whether their role is to act as the legal authority or to act as the enabler of a more complicated decision-making process. If the former, it is likely that changes in legislation will be required, and if the latter then the process needs clarification.

We suggest STPs should identify for each planned area of work:

- The appropriate framework for that work in terms of geographic area and what parts of the health and care system should be involved;
- The stakeholders for that area of work, the partnership agreements required and the accountability to, and relationship with, the population affected by any changes that are envisaged; and,
- The change process required and where authority for that lies.

We suggest STPs should also be clear for each planned area of work whether their role is to:

- Act as a scrutiny and intelligence function: providing the best intelligence to inform local change; scrutinising local plans and providing challenge; and, providing modelling intelligence for system-wide issues. Ideally this process would result in the co-production of a compelling business case for change as a basis for local agreement.
- Secure agreements across all partners by convening the difficult conversations that need to take place prior to decision-making, thereby enabling plans to be implemented.
- Commission collaboratively across all partners, where this is delegated by local organisations.
- Advocate and manage upwards: securing funding, and policy changes as appropriate; negotiating variations in contractual conditions; and, generating enablers so that sub-regional and local work can be more effective.

Finally, while some of the experiments with new models of care may eventually publish evaluated research that provides evidence that they offer improved services and value for money, more widespread attempts to generalise from specific projects should take place only where a viable business case has been established and sufficient staffing and adequate capital are available both to establish new services and to prove their effectiveness, before existing services are reduced.

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## Notes

### Note 1

The latest work from the Nuffield Trust was summarised by Nigel Edwards in the BMJ of 29 March 2017. In this he draws attention to some key features of the evidence that bears on STP plans:

*“Our recent analysis of studies on 27 common schemes (to transfer care out of hospitals) found that seven had been proved to save money, including extra clinical support in nursing homes and better care outside hospital at the end of life. But six actually had a track record of increasing costs. The more successful initiatives tended to be those that improved access to specialists outside hospital, involved patients in their own care, and targeted specific groups of patients.*

*One reason savings are so elusive is that expanding care outside hospital can mean uncovering previously unmet need or providing extra services that patients effectively use on top of what already exists. For example, we have raised the concern for some time that longer opening hours in general practice may encourage more people on the margin of a decision to seek care to come forward, while diluting the time GPs have to spend with patients with more complex care needs.*

*Meanwhile, on the hospital side of the ledger there is a tendency to assume that preventing an admission means that all the associated costs can be chalked up as savings. In reality, reducing the number of bed days by 5% does not mean it will be possible to neatly reduce doctors and beds themselves by 5%, let alone overheads such as administration. Costs in hospital come in large chunks, and when activity is taken out many costs remain. Taking them out is often complex and risky.*

*Staff shortages also present a major obstacle. They are at their most severe in precisely those services that need to expand. There are too few GPs to fill the roles we already demand of them. In England, 21% of posts for district nurses stand vacant.*

*Lastly, there is a need to recognise the sheer complexity of these changes and of the care needs of the patients with which they deal. Many initiatives deal with a single, long term condition, but patients with the highest hospital use often have several. Understanding the impact of a change across the system, with data often not fully linked, is very difficult. As is identifying which patients could benefit most. It is all too easy to mistake regression to the mean—whereby the patients with the most admissions in one year naturally have fewer the next—for real progress”.*

### Note 2

This problem is not resolved by the Chancellor’s Spring 2017 Budget announcement of an ‘extra’ £2 billion of funding for social care from 2017-2020. This has been widely criticised as falling short of redressing the cuts inflicted in previous years, and inadequate as a way of securing services. See for example the Nuffield Trust response, “The £2 billion announced for social care over the next three years is welcome and desperately needed – but the £1 billion share of that cash promised for next year will plug only half of the

funding gap we've identified for that year. £1 billion is also only the sum that's already been cut from local councils' adult social care budgets over the last five years. More and more vulnerable people are therefore going to be denied the help they need in the next year" (Nuffield Trust, 2017).

## Appendix 1: STPs – an evidence review

In the main report we claim that the evidence provided in the STP documents supporting their key proposals is generally weak and in many cases non-existent. The purpose of this appendix is to draw attention to evidence that could be used to evaluate the likely impact of STP plans.

In doing this we were able to draw extensively on an excellent review recently published by the Nuffield Trust, *Shifting the Balance of Care*, that claimed its aim was to “inform the development of STPs to ensure that they are drawing on the best available evidence”, and that, “It also seeks to dispel some widely held myths about the ‘magic bullet’ of shifting care into the community” (Imison et al., 2017).

The Nuffield Trust report is an extensive review of the available published evidence on the effectiveness of shifting the balance of care from hospital to community – noting that the NHS is seeking to achieve this at a time of rising demand and the most stringent financial constraints in its 69-year history. The report notes,

*“There is widespread hope – both within the NHS and amongst national policy-makers – that moving care out of hospital will deliver the ‘triple aim’ of improving population health and the quality of patient care, while reducing costs. This has long been a goal for health policy in England, and is a key element of many of the Sustainability and Transformation Plans (STPs) currently being developed across the country” (p4).*

The report states 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, but questions whether these are realistic objectives, since, “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” (p5).

Many initiatives, warn the authors, place additional responsibilities upon primary and community care, at a time when these services “are struggling with rising vacancies in both medical and nursing staff, and an increasing number of GP practices are closing”.

The report offers a valuable, extensive bibliography of studies, and a detailed examination of the work that has been reported. It is not a purely negative critique, taking pains to identify those initiatives and policies that show the “most positive evidence” or “emerging positive evidence,” in which potential quality improvements in the care experienced by patients are included alongside financial evaluations, while highlighting primarily cost issues where it detects “mixed evidence” and “evidence of potential to increase costs”. It concludes, “Many of the initiatives outlined in this report have the potential to improve outcomes and patient experience. However, only a minority were able to demonstrate overall cost savings, many delivered no net savings and some were likely to increase overall costs” (p103), and goes on, “If STPs work towards undeliverable expectations there is a significant risk to staff morale, schemes may be stopped before they have had a chance to demonstrate success, and benefits in other outcome measures such as patient experience may be lost” (p103-4).

More directly still, the Conclusion warns,

*“Shifting the balance of care from the hospital to the community has many advantages for patients, but is unlikely to be cheaper, certainly in the short to medium term. Any shift will also require the appropriate analytical capacity, workforce and supporting facilities in the community. Currently these are lacking. The wider problem remains: more patient-centred, efficient and appropriate models of care require more investment than is likely to be possible given the current funding envelope” (p105).*

We begin our review by providing some context for our arguments in terms of the objectives of the STP process. We then examine the evidence in several key areas, and whether it supports contentions common to most of the STPs that we have reviewed. We end with some concluding remarks.

## Objectives of the STP process

The main objectives of the STP process as laid out in the planning guidance of 2015/16 (NHS England, 2015) announcing the STP process were,

- To implement the NHS Five Year Forward View (NHS England, 2014)
- To restore financial balance
- To deliver core access and quality standards.

The FYFV is itself summarised as follows (NHS England, 2017),

*“The NHS Five Year Forward View crystallised a consensus about why and how the NHS should change. It described three improvement opportunities: a health gap, a quality gap, and a financial sustainability gap. It proposed a series of measures to bring about the ‘triple integration’ of primary and specialist hospital care, of physical and mental health services, and of health and social care. And it argued that while much of this lay within the power of the NHS itself to bring about, it was also dependent on well-functioning social care, extra capital investment, transformation funding to support double running costs, and activism on prevention and public health” (p9).*

Key to plans that emerged from the STP process was a desire to save money while maintaining or improving the quality of care delivered to a population growing in size, with an ageing demographic, putting further pressure on limited resources. This is not new; it is common to most proposals for change that have emerged over the last 30 years in the UK, and in 30 years time we may well be having the same discussion.

We are aware that there are significant issues around the very viability of a service that is under-funded and under-resourced, both in historical terms, and when compared to other similar developed countries. The NHS has seen the lowest growth in real terms since it began (King’s Fund, 2017); there are shortages of key staff that are only likely to worsen, as Brexit progresses. At the same time, the UK as a whole spends significantly less on health care than similar countries, and has less doctors and acute beds (Appleby, 2016). Of equal

importance are the cuts to local authority budgets that have taken place over the last seven years making the delivery of social care extremely difficult<sup>34</sup>. But these issues are not the primary concern of this review. We focus on the direction of change proposed in the STPs, what this is expected to achieve, and what the evidence is supporting, or not, these aspirations<sup>35</sup>.

## Core propositions of the STP process

We consider the evidence in a number of key areas while acknowledging that often there is overlap between these.

1. Integration of care delivery
2. Long-term condition management –pro-active care
3. Shifting care from acute to community-based settings
4. Other

### Integration of care delivery

A common theme throughout the STPs is that NHS and local government must find ways of working together to provide care for an ageing population: that ‘integration’ of services will ensure better quality while allowing substantial cost savings. Although this often involves the NHS working with local government, it can also refer to better integration across NHS services that are provided by separate organisations.

#### What does the evidence show?

Integration of delivery is by no means a simple proposition. Nevertheless we find time after time individual STPs project substantial savings as a result of ‘integration’.

The lack of any coherent or convincing national-level plan for integrated care, to take account of the levels of need of older people and support them in their own homes was highlighted by a highly critical report from the House of Commons Committee of Public Accounts, Adult social care in England, in July 2014 (House of Commons Committee of Public Accounts, 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*

<sup>34</sup> See Note 1.

<sup>35</sup> See Note 2.

*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).*

The Committee continued,

*“The Department of Health acknowledges that it does not know whether some preventative services and lower level interventions are making a difference” (p7), and, “The Department for Communities and Local Government told us that they did not know how local authorities would be able to maintain spending on care for adults and improve outcomes in a situation where needs were increasing but overall public funding was falling” (p12).*

The Committee goes on to report that,

*“The Department of Health recognised the need for greater research in these areas, and it acknowledged that the lack of evidence on what works and how changes should be implemented was a barrier to integration of health and social care” (p13).*

In other words it seems the integration of health and social care, and the further integration of primary and community services – that runs as a common thread through almost all policy statements from the NHS – have been advocated and adopted as policy despite a lack of working examples and evidence.

The Public Accounts Committee was reporting three years ago; but in a more recent report, Health and Social Care Integration, in February 2017, the NAO found (National Audit Office, 2017),

*“The Departments have not yet established a robust evidence base to ... show that integration leads to better outcomes for patients. The Departments have not tested integration at scale and are unable to show whether any success is both sustainable and attributable to integration. International examples of successful integration provide valuable learning but their success takes place in a context of different statutory, cultural and organisational environments” (paragraphs 1.11 to 1.13, 2.13, 2.15, 2.18 and 2.19).*

The NAO continues,

*“Rising demand for services, combined with restricted or reduced funding, is putting pressure on local health and social care systems. Between 2011-12 and 2015-16, spending by NHS trusts and NHS foundation trusts increased by 11%, while local authority spending on adult social care has reduced by 10% since 2009-10. However, the number of people aged 65 and over in England is increasing at more than twice the rate of increase of the population as a whole. This number is projected to increase by 21% between 2015 and 2025. Key measures of the performance of health and social care sectors are worsening. For example, between November 2014 and November 2016, delays in discharging patients from hospital increased by 37%. The two main reported reasons for this increase were patients waiting for a care package in their own home and patients waiting for a nursing*



*home placement. These trends indicate that an ageing population is putting pressure on hospitals and social services” (paragraphs 1.5 and 1.6).*

So according to the NAO, the facts on the ground point do not bear out the proposition that there will be savings and improved performance as a result of integration of services. On the other hand, the report does acknowledge that many years of initiatives have still failed to provide truly joined-up services, going on to say,

*“Nearly 20 years of initiatives to join up health and social care by successive governments has not led to system-wide integrated services. Since the Health Act 1999 allowed local authorities and the NHS to pool budgets and merge care services, the Departments have supported local bodies to collaborate and trial various approaches to integrating care. However, shifts in policy emphasis and reorganisations which promote competition within the NHS, such as the move from primary care trusts to clinical commissioning groups in 2013 and the Health and Social Care Act 2012 have complicated the path to integration.” (paragraphs 1.10 to 1.12).*

Nevertheless, the NAO concludes,

*“There is no compelling evidence to show that integration in England leads to sustainable financial savings or reduced hospital activity. While there are some positive examples of integration at the local level, evaluations of initiatives to date have found no evidence of systematic, sustainable reductions in the cost of care arising from integration. Evaluations have been inhibited by a lack of comparable cost data across different care settings, and the difficulty of tracking patients through different care settings. As we stated in our November 2014 report Planning for the Better Care Fund, providers of health and social care have fixed costs. Therefore reductions in activity do not necessarily translate into sizeable savings unless whole wards or units can be decommissioned.” (paragraphs 1.11, 1.12, 2.5, 2.18 and 3.23).*

In our view these findings are decisive in undermining general claims in support of the financial savings associated with integration. The Nuffield Trust has carried out appraisals of experiments in integrated care undertaken in North West London, and reported (Wistow et al., 2015),

*“The costs of the programme to date are not insignificant: £24.9m over the three years 2013/14 to 2015/16, of which £7.9m was spent during the first two years on management consultancy to provide specialist expertise and support. Unsurprisingly in the current financial climate, the evaluation reported findings that questioned the value of such levels of investment in both management consultancy and the programme team, as well as evidence that their support had been positively appreciated. It is likely that the programme will need to account more explicitly for the cost-effectiveness of its current and past spending, especially in the absence of evidence, to date, that it has secured significant levels of service change on the ground” (p4).*

A report in April 2016<sup>36</sup> from the Policy Innovation Research Unit (Erens et al., 2015) evaluating the integrated care and support pioneers programme concluded,

*“Embedding large-scale cultural change is not a short-term process. So far, as we have seen, the extent to which the Pioneers have delivered actual changes to service patterns and service delivery is modest. We do not have the data to quantify this precisely, and would face the usual difficulties of attributing causation even if we did” (p120), and continued,*

*“In addition to the inherent difficulties of large-scale transformative change, the environment in which the Pioneers are operating is getting harsher and, in many respects, increasingly unsupportive of whole systems transformation” (p121).*

Overall, the evidence points to a number of considerations:

1. Integration is a long-term aim: short-term savings are unlikely to be realised;
2. The process of integration has been hindered by changes in policy and performance regimes;
3. The costs of integration have been significant;
4. The context in which integration is taking place is changing; and,
5. Although individual schemes have shown some improvements in quality, the impact that integration can deliver is largely uncertain.

### **Shared care**

One aspect of integration is ‘shared care’ defined as primary and secondary care professionals taking joint responsibility for the management of a patient. The Nuffield Trust (Imison et al., 2017) concluded that the evidence base on whether shared care can reduce hospital use is mixed. On quality improvements it reported,

*“One study of a COPD management programme found a reduction in length of stay (Rea and others, 2004). However, other studies found no evidence of impact on hospital admissions, length of stay or outpatient attendance (Schraeder and others, 2001; Warner and others, 2000). The context in which shared care is delivered may have a significant impact on its success. A Cochrane review found it may be more effective at reducing hospital admissions for older patients, those with depression and other serious chronic mental health illness, and those with higher levels of baseline morbidity (Smith et al., 2007)” (p36),*

And on costs,

*“Evidence on cost savings is also inconclusive. One RCT examining the management of patients with rheumatoid arthritis found that the mean cost per patient was slightly higher for those receiving shared care, but a small gain in quality of life meant that it was likely to be cost effective at £2,000 per quality-adjusted life years (QALYs) (Davies and others, 2007). Other work has found that cost effectiveness can depend on the degree of shared care offered, with complex patients who received higher levels of shared care*

<sup>36</sup> Although the report is dated September 2015, the PIRU website states that it was released for publication in April 2016.

*proving more costly (McCrone and others, 2004). That said, shared care can result in cost savings for patients (Winpenny and others, 2016). Generally speaking though, studies on cost effectiveness are scarce and more robust evidence is needed”(p36).*

## **Long-term condition management – pro-active care**

Another key theme appearing in the STPs is the potential impact of long-term condition management (‘pro-active care’) as a way of improving quality of care and reducing costs.

### **What does the evidence show?**

A recent impact assessment (Price, 2016) suggests the Government’s flagship diabetes prevention programme will only start to save the NHS money by around 2030. Other work looking at long-term care management shows mixed results as this extract from a report for the North West London system shows (Fearn and Scott, 2016),

*“Evidence on the impact of case management is promising but mixed. It is usually difficult to attribute any system changes explicitly to case management as there are often multiple factors at play, and as case management isn’t a standard intervention - it can be implemented in a variety of different ways. Case management works best when it is part of a wider programme where the cumulative impact of multiple strategies can be successful in improving patient experiences and outcomes.*

*In the US, when compared with a control group, older people enrolled in the PACE programme (case management) showed a 50% reduction in hospital use and were 20% less likely to be admitted to a nursing home. They did, however, use more ambulatory care services. Evaluations of Guided Care have found similar results.*

*Evercare was trialled in the UK after success in the US, but unfortunately only showed negligible results. In Wales, an evaluation of case management showed a reduction in non-elective admissions of 9.1% compared to a control group (and preintervention years) and a reduction in length of stay of 10.41%. Despite mixed evidence on the impact of case management on capacity in the system, there is strong evidence that case management results in an increase in patient satisfaction” (p21).*

The evidence for cost savings from developing GP and community out-of-hospital initiatives is also quite limited. Research published in 2012 surveying all out-of-hospital initiatives failed to demonstrate savings (Purdy et al., 2012).

Similar findings were highlighted by the Commission on Hospital Care for Frail Older People, set up by the Health Service Journal and conducted by a group of experts led by University Hospital Birmingham Chief Executive Dame Julie Moore. After surveying the evidence, the Commission concluded it was a “myth” that measures such as the “integration” of health and social care, and improved services in the community would reduce the need for hospitals or bring cash savings for the hospital sector. While better community services were desirable, the report argues that this would only delay rather than avoid the need for hospital stays; thus it states (Commission on Hospital Care for Frail Older People, 2014),

*“The commonly made assertion that better community and social care will lead to less need for acute hospital beds is probably wrong” (p1).*

Another Nuffield Trust report (Georghiou and Steventon, 2014), designed to show that better integration of social care and hospital care would reduce demand for acute care, concluded,

*“We were not able to detect lower use of hospitals for the Red Cross group compared with a matched control group over the longer term. In fact, the evidence suggested that emergency admissions may have been slightly higher in the Red Cross group”, and continued,*

*“The results reinforce the challenges around reducing rates of emergency hospital admission. This is a common concern across health services, and one that has proved difficult to convincingly address. In the absence of well accepted, evidence-based solutions to reducing emergency admissions, there is a need to subject promising new interventions and models of service provision of this type to thorough evaluation” (p7).*

A 2012 analytical paper in the BMJ (Roland and Abel, 2012) questioned the received wisdom that hospital admissions could be reduced and costs cut by improving primary care interventions, especially aimed at those of high risk (whose chronic health problems has led some to term them ‘frequent flyers’).

This study dispels the myth that high-risk patients account for most admissions, or that case management of such patients could save money, saying,

*“most admissions come from low risk patients, and the greatest effect on admissions will be made by reducing risk factors in the whole population. [...] even with the high risk group, the numbers start to cause a problem for any form of case management intervention – 5% of an average general practitioner’s list is 85 patients. To manage this caseload would require 1 to 1.5 case managers per GP. This would require a huge investment of NHS resources in an intervention for which there is no strong evidence that it reduces emergency admissions.”*

Roland also points out the difficulties of assessing the effectiveness of those interventions that have taken place because of fluctuations in numbers of admissions even among those at high risk. Some of the interventions that have been piloted, providing case management for high-risk groups of patients, have proved not only ineffective, but to result in increased numbers of emergency admissions – possibly because the increased level of care resulted in additional problems being identified. Indeed three trials of interventions have had to be abandoned because of increased deaths among the patients involved. Roland warns that an additional unintended negative consequence could result from GPs feeling under ‘excessive’ pressure not to refer sick patients to hospital. He criticises the failure of many plans aimed at reducing hospital admissions to consider the role of secondary care, and improved collaboration between GPs and hospital colleagues.

Subsequent research involving Roland (Wallace et al., 2016) raised even more questions over the value of case management as a means to deliver cost savings or reduce emergency admissions,

*“Evidence shows that case management improves patient satisfaction with care, promoting high levels of professional satisfaction and reducing caregiver strain, but its impact on reducing future emergency admissions has not been demonstrated in systematic reviews of randomised controlled trials (RCTs). [...] Current evidence does not support case management as an effective intervention for reducing emergency admissions, despite the effort it requires from the primary care team”.*

The Nuffield Trust in its excellent report *Shifting the Balance of Care* (Imison et al., 2017) looked at the success of various initiatives designed to manage better ‘at risk patients’. It concluded,

*“A large number of diverse initiatives over the last two decades have aimed to better manage ‘at risk’ populations, but while services are highly valued by patients, very few have successfully reduced hospital activity. The strongest evidence relates to those initiatives that target well-defined groups; that is, those in nursing and residential homes, and those at the end of life. There is growing evidence for initiatives that monitor people at home, particularly for some conditions such as heart failure. The extensivist model, which provides holistic care for those at greatest risk, has promising evidence from its use in the US, but its benefits have yet to be formally demonstrated in England. The initiatives which have the greatest challenge in demonstrating impact on hospital activity, but have other positive benefits for patients and their experience, are more general attempts to case manage those deemed to be at highest risk of admission, including the use of virtual wards” (pp88-9).*

The report pointed to the obvious reason for system cost savings not being apparent: that such initiatives will often increase the use of care by those who may not otherwise have done so. In addition the costs of care coordination are not insubstantial. This suggests a lesson that STP leaders might well want to listen to, “The lesson from the evidence is that significant attention needs to be paid to the accurate targeting of initiatives, while moderating expectations of their capacity to reduce overall cost”.

The following table is included in the 2017 Nuffield Trust report (p88) and attempts to show the level of evidence for various initiatives.

Initiative	Relative strength of evidence of reduction in activity and whole-system costs
Additional clinical support to people in nursing and care homes	Most positive evidence
Improved end-of-life care in the community	
Remote monitoring of people with certain long-term conditions	
Extensivist model of care for high risk patients	Emerging positive evidence
Case management and care coordination Virtual ward	Mixed evidence, particularly on overall cost reduction
Virtual ward	

### Shifting care from acute to community-based settings

NHS England proposed in Next Steps on the NHS Five Year Forward View (NHS England, 2017) that “Working closely with community services and councils, hospitals need to be able to free up 2,000-3,000 hospital beds” (p4). As we point out in our main report, over 50% of STPs are explicit in their intention to reduce the number of acute beds; in many cases the proposed downgrade of A&E is mentioned, and more rarely the closure of a whole acute hospital – although the hospital site may still be used for another health-care-related purpose. The UK starts from a base of one of the most centralised hospital structures in Europe with lower numbers of beds, doctors and clinical interventions than other similar countries. Bed numbers have been decreasing steadily in recent years. What is the evidence that further rationalisation will be cost saving, and what is the likely impact on the quality of care?

#### What does the evidence show?

First looking at quality of care, in the case of emergency care, centralisation may have a negative impact with mortality increasing the greater distances that have to be travelled. Thus Harrison (2012) has found,

*“Even if gains in outcomes are achieved by centralization, the longer journey times that it entails for some patients may offset them to some extent. One study of stroke care found that the clinical risks of longer journeys outweighed the benefits of centralization. Nicholl et al. found that for every mile a seriously injured person had to travel to hospital, the risk of death increased by one per cent. Other work has found that the longer journeys discouraged use of health-care services” (p4).*

A more recent report, Future Fit, for the West Midlands Clinical Senate (Shropshire, Telford and Wrekin Defend Our NHS, 2016) confirms this, pointing out that Nicholl’s study in 2007

(Nicholl et al., 2007) is one of the more important pieces of UK research on the relationship between journey length and mortality. This looked at survival rates for patients with life-threatening conditions, relating this to the distance between home and hospital. For patients travelling up to 10 km, the overall mortality rate was 5.8%; for those travelling 11-20 km, 7.7% died; and for those travelling 21 km or more, 8.8% died. Overall, people who travelled more than 20 km to access treatment were 50% more likely to die than those living close to the hospital. Those with acute respiratory conditions fared even worse, and were around twice as likely to die if they had to travel the longer distance to access A&E.

Future Fit reports,

*“More recent research confirms the pattern. A 2013 Japanese study looked at distance to hospital for patients with acute heart attacks, strokes and pneumonia – a sub-set of the conditions examined by the Sheffield study. The study found a strong correlation between transport distance and mortality for acute heart attack and for ischaemic stroke; and a moderate correlation between distance and mortality for pneumonia and for subarachnoid haemorrhage” (p16).*

And goes on to draw attention to a 2014 York University analysis of Swedish data that,

*“... compared survival rates from myocardial infarction for people having to travel different distances to emergency care. The author concluded ‘The results show a clear and gradually declining probability of surviving an acute myocardial infarction as residential distance from an emergency room increases’. People travelling 50 to 60 km to emergency care were 15% less likely to survive than those living close to the hospital. Most of the excess deaths were of people dying on the way to hospital. The author noted an inherent bias in much medical research, as studies typically look only at outcomes for people who arrive alive at hospital. Those who die on the way are excluded. Most research also takes place in urban areas, with little research on the impact on survival of rurality and/or long journey distance. The few studies that do exist strongly support the case that longer journeys to A&E result in higher rates of mortality”.*

Finally Future Fit refers to,

*“... evidence from the USA of Emergency Department closure having a strong ‘ripple effect’, with mortality increasing by 5% for patients at neighbouring Emergency Departments that remained open. Existing facilities can easily be overwhelmed by increased demand. A strong and growing body of anecdotal UK evidence is of severe pressure on A&Es that remain following the closure of a neighbouring unit”.*

Candace Imison’s report from the King’s Fund makes similar points (Imison et al., 2014),

*“There have been very few studies to assess the impact of centralising A&E services. The limited evidence available suggests that if services are centralised, there are risks to the quality of care where the centralised service does not have the necessary A&E capacity and acute medical support for the additional workload. A proportion of A&E attenders can safely be seen in community settings, but there is little evidence that developing these services in addition to A&E will reduce demand”.*

Her report concludes,

*“The reconfiguration of clinical services represents a significant organisational distraction and carries with it both clinical and financial risk. Yet those who are taking forward major clinical service reconfiguration do so in the absence of a clear evidence base or robust methodology with which to plan and make judgements about service change.”*

### **Demand management**

The 2017 Nuffield Trust report (Imison et al., 2017) quantified the overall reductions in demand assumed in STPs as follows,

*“Currently the STPs include widely differing assumptions about the impact that their local strategy will have on hospital activity and their underlying assumptions are often far from clear. With this caveat, our interpretation of the material in the public domain is that in 2020/21 the STPs are predicting activity to be less than forecast (based on current trends) by the following amounts:*

- 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).” (p9)

These are large reductions especially against a background of projections of steadily increasing demand.

A Nuffield Trust seminar in 2015 reviewed the evidence on Out-of-Hospital services and other demand management tools and confirmed that there was some evidence that facilitating rapid discharge from hospital would enable reductions in acute capacity. But it also found that the success of all other demand management experiments was very limited, with experiments proving small scale, and not reproducing significant impacts or significant savings.

Referring to more recent evidence the Nuffield Trust suggests (Imison et al., 2017),

*“Of the evidence reviewed, the initiatives with the most positive outcomes are those for condition-specific rehabilitation. Pulmonary and cardiac rehabilitation improve quality of life and reduce hospital admissions, and have been shown to be cost effective. There is emerging positive evidence for rapid access clinics and senior decision-makers in A&E, but further research is needed, particularly around their economic impact” (p13).*

It continues,

*“Evaluation of rapid response teams and the use of intermediate care beds show much more mixed results, suggesting that local implementation and context play a large part in their success. Clear referral criteria and good integrated working across health and social care appear to be important.*



*Hospital at Home schemes successfully provide a safe alternative to hospital, but there is little evidence that they deliver net savings” (p14).*

Finally while acknowledging that, “Absence of evidence is not necessarily a sign that a particular initiative would not work if introduced in an appropriate context”, the report is very clear in its judgement 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.”*

The Nuffield Trust report provides another helpful table (p13) showing the relative strength of evidence on various initiatives.

<b>Initiative</b>	<b>Relative strength of evidence of reduction in activity and whole-system costs</b>
Condition-specific rehabilitation	Most positive evidence
Senior assessment in A&E	Emerging positive evidence
Rapid access clinics for urgent specialist assessment	
Intermediate care: rapid response services	Mixed evidence, particularly on overall cost reduction
Intermediate care: bed-based services	
Hospital at Home	

## **Other**

We consider here several other areas where STPs have projected savings and improvements in quality of care,

- Self-care
- Digital technology
- ‘Unwarranted’ variation in provision of care

### **Self-care**

Most STPs make reference to the importance of self-care both as a way of improving quality of life, but also with the potential to reduce costs. Self-care refers to individuals in the first instance taking responsibility for their own care needs and determining when and how they should involve the formal, professional care system. How people respond will depend on how they perceive the risks they face, the costs, and the information available to them about the options available (Boyle et al., 1996).

Imison et al. report (2017) an estimate from the Department of Health that up to 80 per cent of people living with a long-term condition can be supported to manage their own condition (p90). They go on to claim,

*“Evidence suggests that self-care can have a positive impact, although it is often not clear which component makes it effective (Purdy, 2010; Taylor and others, 2014). Self-care in long-term conditions has been shown to reduce A&E attendances, in particular for adults with COPD and asthma, and possibly heart failure (National Audit Office, 2013; NHS England, 2015b; Purdy and others, 2012; Purdy, 2010). It can also improve adherence to treatment and medication.”(Challis, 2010).*

*A systematic review found self-management support was associated with reductions in cost, a small significant improvement in quality of life and significant reductions in health care utilisation, with evidence being strongest for respiratory and cardiovascular disorders. This covered a number of conditions, such as respiratory, cardiovascular, mental health, arthritis and other pain conditions (Panagioti and others, 2014). Furthermore, utilising IT in the form of wearable technology and apps can have a positive impact in helping patients manage their own conditions and improve their diet, exercise and medication adherence (Castle-Clarke and Imison, 2016). More research is needed, however, to establish what works in which contexts” (p91).*

### **Digital technology**

Each STP was required to develop its own ‘Digital Road Map’ and strategy to make use of new technology to enhance efficiency in the delivery of health care and open up new possibilities for patients to take control of aspects of their own health. However, little evidence was offered on the cost-effectiveness of such technology; this remains largely untested in the NHS. Moreover, some of the heaviest users of health care, notably those in long-term poverty, and the frail elderly, are often excluded by digital initiatives.

Castle-Clarke and Imison at the end of 2016 (Castle-Clarke and Imison 2016) echo the concerns of many critics of the drive for digital health care, while at the same time endorsing proposed developments. They report,

*“Over 12 million people in the UK lack basic digital skills (Commons Select Committee, 2015). This group is made up of people vulnerable to social exclusion: 60 per cent have no qualifications, 57 per cent are over 65 years old and 49 per cent are disabled (Tinder Foundation, 2015b). Recent figures show that almost two-thirds of people aged over 75 and a third of 65- to 74-year-olds say they do not use the internet at all, compared with 17 per cent of 55- to 64-year-olds and 5 per cent or less of people aged under 55 (Ofcom, 2016). There is also a relatively high ‘drop-out rate’ of internet use among the older population (West, 2015). Reasons for older people’s disengagement from internet use include:*

- *a lack of skills and knowledge of the internet*
- *a feeling that the internet is not useful to them*
- *cost*
- *disability*
- *social isolation*
- *a concern that the internet could take away social interactions” (p49).*

Nonetheless the authors argue that, “concern over widening inequalities should not act as a barrier to developing and promoting patient-facing digital tools in general.”

Digital technology is seen as having a vital role to play in enabling self-care. The 2017 Nuffield Trust report (Imison et al., 2017) agrees,

*“Where sufficiently supported and funded across the system, IT can be a useful tool in engaging patients and encouraging them to adopt more positive health behaviours (Castle-Clarke and Imison, 2016). Evidence shows that self-care initiatives, particularly those that rely on e-health or digital tools, are more successful when they are supported by professionals (Blackstock and others, 2015; In ’t Veen and others, 2014)”.*

However, the report goes on,

*“Patients’ level of health and digital literacy are also key factors in the success of self-care. Over 60 per cent of England’s working-age population find health materials containing both text and numbers too complex (Rowlands and others, 2014). Over 12 million people in the UK lack basic digital skills (Tinder Foundation, 2016)”.*

One aspect that may give pause for thought among those seeking cost savings through the use of digital technology is the finding of a 2012 US study (Palen et al., 2012) that “having online access to medical records and clinicians was associated with increased use of clinical services compared with group members who did not have access”.

### **‘Unwarranted’ variation in provision of care**

Benchmarking performance against other providers or commissioners has been common practice in the NHS for many years. The term ‘unwarranted variation in provision’ is often used when a provider trust for example is not in the top 10% on some performance measure. It may have longer lengths of stay than elsewhere, for example. Achieving the top 10% is then seen as a way of reducing costs and sometimes improving quality. We found most STPs refer to some form of benchmarking as a way of achieving short-term cost reductions.

However such policies can be over-simplistic, especially where they fail to take account of the widely differing history, geography, investment and other aspects of the local context for performance. Removing ‘unwarranted’ poor performance is desirable but identifying the reason for differences in performance is crucial. For example the case-mix for individual doctors and hospitals can vary widely as can the context in which care is delivered. An STP purports to be a plan across a whole system of care. It should not therefore adopt an approach that fails to take into account the complex interactions that take place within different systems, and how these may impact on performance as measured by single simple benchmarks. It is not that simple.

## Concluding remarks

Our brief review indicates that while much remains to be done in evaluating new – and not so new – ways of providing care there are still lessons to be learnt from examining the existing literature. STPs would do well to target their initiatives bearing in mind evidence relevant to their own special circumstances: there is no one fix for all systems.

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## Notes

**Note 1:** In England the financial situation for social care remains extremely challenging, with planned savings for adult social care in 2016/17 of £941 million (7% of net adult social care budgets). Funding for public provision for adult social care fell by over 10% in cash terms between 2010/11 and 2014/15 from £14.9 billion to £13.3 billion; in real terms it fell by an average of 2.2% per year between 2009/10 and 2014/15, leading to a 25% reduction in the number of people receiving publicly-funded social care. This is leading to increases in bed days lost caused by delayed discharges because social care was not available (Association of Directors of Adult Social Services, 2016).

**Note 2:** A House of Lords Committee report in April 2017, *The Long term Sustainability of the NHS and Adult Social Care* (House of Lords Select Committee on the Long-term Sustainability of the NHS, 2017), concluded, “We are clear that a tax-funded, free-at-the-point-of-use NHS should remain in place as the most appropriate model for the delivery of sustainable health services. In coming years this will require a shift in government priorities or increases in taxation. We are also clear that health spending beyond 2020 needs to increase at least in line with growth in GDP in real-terms. We heard that publicly-funded adult social care is in crisis. The additional funding for social care announced in the 2017 Budget is welcome and means funding for social care will increase by more than 2% a year for the next three years. This is more than the increase for NHS funding. However it is clearly insufficient to make up for many years of underfunding and the rapid rise in pressures on the system. The Government needs to provide further funding between now and 2020. Beyond 2020 a key principle of the long-term settlement for social care should be that funding increases reflect changing need and are, as a minimum, aligned with the rate of increase for NHS funding” (pp3-4).



## Appendix 2: STP Tables based on our analysis

STP name	Population millions	Number CCGs	Number local govt bodies
1 Northumberland, Tyne and Wear	1.4	5	7
2 West, North and East Cumbria	0.3	1	1
3 Durham, Darlington, Tees, Hambleton, Richmondshire and Whitby	1.3	6	7
4 Lancashire and South Cumbria	1.6	9	19
5 West Yorkshire	2.6	11	8
6 Coast, Humber and Vale	1.4	6	6
7 Greater Manchester	2.8	12	10
8 Cheshire and Merseyside	2.4	12	10
9 South Yorkshire and Bassetlaw	1.5	5	5
10 Staffordshire	1.1	6	2
11 Shropshire and Telford & Wrekin	0.5	2	2
12 Derbyshire	1	4	2
13 Lincolnshire	0.7	4	8
14 Nottinghamshire	1	6	9
15 Leicester, Leicestershire and Rutland	1	3	3
16 The Black Country	1.3	4	5
17 Birmingham and Solihull	1.1	3	2
18 Coventry and Warwickshire	0.9	3	2
19 Herefordshire and Worcestershire	0.8	4	8
20 Northamptonshire	0.7	2	1
21 Cambridgeshire and Peterborough	0.9	1	2
22 Norfolk and Waveney	1	5	9
23 Suffolk and North East Essex	0.9	3	9
24 Milton Keynes, Bedfordshire and Luton	0.9	3	4
25 Hertfordshire and West Essex	1.4	3	2
26 Mid and South Essex	1.2	5	2
27 North West London	2	8	8
28 North Central London	1.4	5	5
29 North East London	1.9	7	8
30 South East London	1.7	6	6
31 South West London	1.5	6	6
32 Kent and Medway	1.8	8	2
33 Sussex and East Surrey	1.8	8	5
34 Frimley Health	0.7	5	10
35 Surrey Heartlands	0.8	3	1
36 Cornwall and the Isles of Scilly	0.5	1	2
37 Devon	1.2	2	3
38 Somerset	0.5	1	1
39 Bristol, North Somerset and South Gloucestershire	0.9	3	3
40 Bath and North East Somerset, Swindon and Wiltshire	0.9	3	3
41 Dorset	0.8	1	2
42 Hampshire and the Isle of Wight	1.8	7	4
43 Gloucestershire	0.6	1	1
44 Buckinghamshire, Oxfordshire and Berkshire West	1.7	7	3
<b>Total</b>	<b>54.2</b>	<b>210</b>	<b>218</b>

STP name	Total health economy budget	2020/21 'Do Nothing' deficit £m	% Deficit that is NHS	Specialist commissioning deficit £m	Capital funding bid £m
1 Northumberland, Tyne and Wear	n/a	£904	61	n/a	£77
2 West, North and East Cumbria	n/a	£168	100	n/a	N/a
3 Durham, Darlington, Tees, Hambleton, Richmondshire and Whitby	n/a	£281	100	n/a	£115
4 Lancashire and South Cumbria	n/a	£572	78	n/a	£264
5 West Yorkshire	c£5bn	£1,065	76	n/a	0
6 Coast, Humber and Vale	n/a	£420	100	n/a	n/a
7 Greater Manchester	c£6bn	£1,100	80	£97.0	£1,600
8 Cheshire and Merseyside	n/a	£909	100	n/a	£1,680
9 South Yorkshire and Bassetlaw	£3.9bn	£574	81	£44.0	0
10 Staffordshire	n/a	£542	53	n/a	£20
11 Shropshire and Telford & Wrekin	n/a	£131	100	n/a	£311
12 Derbyshire	n/a	£355	62	n/a	0
13 Lincolnshire	n/a	£182	100	£24.0	£200
14 Nottinghamshire	n/a	£628	75	n/a	0
15 Leicester, Leicestershire and Rutland	£2.4bn	£399	86	£27.3	£280
16 The Black Country	£2.0bn	£700	73	£36.3	£101
17 Birmingham and Solihull	n/a	£712	82	£45.0	0
18 Coventry and Warwickshire	n/a	£300	89	n/a	0
19 Herefordshire and Worcestershire	£1.2bn	£336	75	n/a	0
20 Northamptonshire	n/a	£261	88	n/a	0
21 Cambridgeshire and Peterborough	£1.7bn	£504	100	£21.6	£800
22 Norfolk and Waveney	n/a	£415	100	£25.0	0
23 Suffolk and North East Essex	£1.8bn	£248	100	£25.1	0
24 Milton Keynes, Bedfordshire and Luton	£2.5bn	£311	73	£15.0	0
25 Hertfordshire and West Essex	£2.8m	£548	72	£39.5	£328
26 Mid and South Essex	n/a	£531	77	£63.3	0
27 North West London	n/a	£1,410	78	£189.0	£1,820
28 North Central London	£2.5bn	£876	100	£137.0	£1,742
29 North East London	n/a	£578	59	£49.0	£600
30 South East London	n/a	£854	100	£262.0	£1,137
31 South West London	n/a	£828	84	£99.0	£1,320
32 Kent and Medway	n/a	£486	89	£51.0	0
33 Sussex and East Surrey	n/a	£865	65	£56.0	£942
34 Frimley Health	n/a	£209	89	£30.0	£286
35 Surrey Heartlands	n/a	£615	73	£69.0	0
36 Cornwall and the Isles of Scilly	£1.2bn	£264	84	£15.0	0
37 Devon	n/a	£557	100	n/a	0
38 Somerset	n/a	£175	100	n/a	0
39 Bristol, North Somerset and South Gloucestershire	n/a	£305	100	n/a	£60
40 Bath and North East Somerset, Swindon and Wiltshire	£1.4bn	£298	83	n/a	0
41 Dorset	n/a	£299	77	£20.0	£189
42 Hampshire and the Isle of Wight	n/a	£769	75	£55.0	£195
43 Gloucestershire	n/a	£226	84	£20.0	£131
44 Buckinghamshire, Oxfordshire and Berkshire West	n/a	£479	100	£60.0	£150
<b>Total</b>		<b>£23,189</b>	<b>82</b>	<b>£1,301.5</b>	<b>£14,348</b>

STP name	Plan to close acute beds	Plan to close A&Es	ACO solution promoted
1 Northumberland, Tyne and Wear	yes	yes	yes
2 West, North and East Cumbria	yes	yes	yes
3 Durham, Darlington, Tees, Hambleton, Richmondshire and Whitby	yes	yes	no
4 Lancashire and South Cumbria	no	no	yes
5 West Yorkshire	yes	no	yes
6 Coast, Humber and Vale	no	no	yes
7 Greater Manchester	no	no	yes
8 Cheshire and Merseyside	no	no	yes
9 South Yorkshire and Bassetlaw	no	no	yes
10 Staffordshire	yes	yes	yes
11 Shropshire and Telford & Wrekin	yes	yes	no
12 Derbyshire	yes	yes	no
13 Lincolnshire	yes	yes	MCPs
14 Nottinghamshire	yes	no	yes
15 Leicester, Leicestershire and Rutland	yes	yes	yes
16 The Black Country	yes	yes	yes
17 Birmingham and Solihull	yes	yes	yes
18 Coventry and Warwickshire	yes	no	yes
19 Herefordshire and Worcestershire	yes	yes	yes
20 Northamptonshire		no	no
21 Cambridgeshire and Peterborough	yes	yes	yes
22 Norfolk and Waveney	no	no	no
23 Suffolk and North East Essex	no	no	yes
24 Milton Keynes, Bedfordshire and Luton	?	?	yes
25 Hertfordshire and West Essex	yes	yes	yes
26 Mid and South Essex	yes	yes	yes
27 North West London	yes	yes	yes
28 North Central London	no	no	no
29 North East London	no	yes	yes
30 South East London	no	no	LCNs
31 South West London	yes	yes	no
32 Kent and Medway	yes	no	yes
33 Sussex and East Surrey	no	no	yes
34 Frimley Health	no	no	yes
35 Surrey Heartlands	no	no	yes
36 Cornwall and the Isles of Scilly	yes	no	yes
37 Devon	yes	no	no
38 Somerset	no	no	yes
39 Bristol, North Somerset and South Gloucestershire	no	no	no
40 Bath and North East Somerset, Swindon and Wiltshire	no	no	yes
41 Dorset	yes	yes	yes
42 Hampshire and the Isle of Wight	no	no	yes
43 Gloucestershire	no	no	no
44 Buckinghamshire, Oxfordshire and Berkshire West	no	no	yes
<b>Total</b>	<b>23</b>	<b>18</b>	<b>32</b>

## Appendix 3: Questions used for analysis of STPs

### The STP Process

#### **Q1. Version Control:**

date of first publication;  
subsequent publication of versions;  
date of final/latest version;  
official consultation launched/closed.

#### **Q2. Stakeholder sign up:**

Who has agreed it?  
Who has not agreed it?  
Dates of agreement could be affixed to all named stakeholders.

#### **Q3. Does the STP seem to be introducing new governance arrangements that will delegate authority to new organisations?**

Will decisions still be made locally?  
Are there proposals to create ACOs?  
Does the plan include integration with local government or an additional tier?

#### **Q4. Is there an explicit timetable:**

for delivery of the STP?  
for obtaining agreement to it?  
for delivery of the changes that the STP proposes?  
List any short-term deliverables in 2016/17.  
Is there start and end date? If so, what are they?

#### **Q5. Is there reference to an STP Board and its Chair/Leader? List who these are.**

#### **Q6. Are the future costs of the STP process made clear? Are there projections for:**

budgets?  
personnel?

### The STP Content

#### **Q7. Is the start point for the STP clear in terms of population at 2016?**

Is there a needs analysis in STP (or reference to Health & Wellbeing Board needs analysis) for STP catchment area?

#### **Q8. Does the plan reflect the national template ie:**

Expansion of primary care? If so, are proposals concrete, costed and timetabled?

New models of care and proposals for more self-care? If so, how much do plans rely on new digital technology?

Preventative measures as way of reducing demand on acute services, and reducing deficits? If so is there an estimated timescale and value put on savings?

**Q9. Overall, are the objectives of the STP clearly expressed in SMART terms (specific, measurable, assignable, realistic and time-related)?**

**Q10. Clarity of plan: local context**

Provide any details of local stakeholders and details of historical, current and projected financial deficits and any long-standing issues, as available from STP.

**Q11. Clarity of plan: finances**

Are full financial projections included, or financial appendices published?

Are important details still to be published or withheld?

Are savings targets broken down by service and provider?

Are revenue implications for providers made clear?

Are capital requirements made clear?

**Q12. Clarity of plan: services**

Are the service implications clear?

Which services are cut back?

Which expanded?

List any acute services cut, sites closed.

List any A&E departments closed.

What staff posts are reduced?

Community services cut/ sites closed, or opened

Primary care services expanded

Other out-of-hospital services expanded

Staffing and service implications in terms of posts created, downgraded, or lost.

**Q13. Clarity of plan: workforce**

Is there a detailed plan to ensure an adequate workforce will be in place?

**Q14. Is social care included? What assumptions are made?**

**Q15. Is there a model that describes the plan?**

Has the model been made available?

Are assumptions made clear?

Do they appear realistic?

**Q16. Is there any reference to evidence supporting the plan?**

Is this robust and credible?

**Q17. Is there a risk analysis?**

If so, are risks quantified and probability attached?

What are top three risks cited?