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# Sustainability and Transformation Plans: what we know so far

*Discussion paper*

Nigel Edwards

September 2016

# About this report

In early 2016 NHS England published a map of 44 Sustainability and Transformation 'footprints' – geographical areas under which local health and social care organisations are expected to come together to draw up regionally specific plans to improve services and finances in an efficient and co-ordinated way over the coming five years. STPs are taking shape and programmes of action are being defined very quickly. With this in mind, the Nuffield Trust and the Healthcare Financial Management Association recently held a workshop for STP leaders that was designed to help those involved in STP footprints to develop their plans. We have drawn together insights from the workshop, from members of our learning networks for hospital CEOs and CCG accountable officers, and from a series of conversations with other STP leads. We have also reviewed a number of draft plans. This discussion paper reflects the work in progress from one third of STP areas, as captured in July and August 2016. It points to some important trends, ideas to be explored, issues that need to be resolved and steps that will need to be taken to ensure success.

## Suggested citation

Edwards N (2016) *Sustainability and Transformation Plans: what we know so far*. Discussion paper, Nuffield Trust.

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# Introduction

In early 2016 NHS England published a map of 44 Sustainability and Transformation 'footprints' – geographical areas under which local health and social care organisations are expected to come together to draw up regionally specific plans to improve services and finances in an efficient and co-ordinated way over the coming five years.

The leaders of each Sustainability and Transformation Plan (STP) footprint were appointed by NHS England from senior roles in clinical commissioning groups (CCGs), NHS trusts and local authorities. These people are responsible for convening the STP process in their geographical area and for overseeing the development of plans that meet the specific needs of the local population.

Final versions of these STPs are due in October 2016, but it is likely that further work to refine them will be required, after which the dauntingly large task of implementing the plans will begin in earnest. In spite of this short timetable, STPs are taking shape and programmes of action are being defined very quickly. With this in mind, the Nuffield Trust and the Healthcare Financial Management Association (HFMA) recently held a workshop for STP leaders. The workshop was designed to help the leaders develop their STP footprints through an interactive exchange of ideas, peer support and external challenge. Participants had the opportunity to share progress on STP plans, test ideas, and learn from other STP areas. We have drawn together insights from the workshop, from members of our learning networks for hospital CEOs and CCG accountable officers, and from a series of conversations with other STP leads. We have also reviewed a number of draft plans.

This discussion paper therefore reflects work in progress from one third of STP areas, as captured in July and August 2016. It points to some important trends, ideas to be explored, issues that need to be resolved and steps that will need to be taken to ensure success.

First, we look at the main changes in services that are being planned, which have significant implications for some institutions and can be characterised by 'doing more with less'. These service changes are likely to affect primary care, community hospitals and hospital services in particular. We then examine the proposals for efficiency improvement, financial management, demand reduction and management, prevention and the enabling areas of workforce, technology and estates. In the final sections we consider issues relating to the process and the challenges of implementation that are already emerging.

# Major service changes

A number of STPs are looking at pathways, specific conditions, groups of patients or cross-system issues such as improving flow, reducing admission and early detection. These problems are often complex and require change across multiple organisations. Many of the ideas are familiar, but we are interested in the combined impact of these and the extent to which these will lead to major service changes. Some STPs address this issue directly and there are some proposals for large-scale changes.

## Hospital services

Many STP areas are planning major service changes in hospitals. These include a number of radical and potentially contentious proposals, although many of these have often been under discussion for some years. The most significant proposals for changes to the shape of hospital provision seem to be driven by workforce factors rather than the need for savings. In fact, workshop participants were very cautious about assuming that major savings could be achieved through reconfiguration. Common ideas being discussed include the following:

- **Significant changes to the role of community hospitals** – ranging from closure of some, or all, inpatient beds to possible complete closure or repurposing. A number already have temporary service closures due to staffing problems.
- **Significant shifts of outpatient services**, including major redesign of these services. This is more about improving patient experience, productivity and site utilisation than delivering cash savings. Ideas include changing the approach to follow-ups, pathway redesign, new delivery models and changing referral routes, including direct access for some services or having hospital specialists support primary care.
- **The downgrading of some A&E departments**, hospital sites and the creation of more hot–cold splits (separating emergency from elective care). As noted previously, shortages in the medical workforce are a frequently cited reason for this.
- The most significant proposals are to make **major changes in where and how care is provided for the large number of patients in hospital who could be cared for in other settings**. In some cases this is likely to lead to major reductions in numbers of beds; in others the beds would be needed and retained in order to deal with anticipated growth in demand. Anticipated trends ranged from a flat number of beds over the five-year period, to a 20 per cent reduction. However. the cost implications of a more acute and short-staying inpatient service and ramped-up community services are not well understood. Previous work by Monitor[1] suggests that achieving large savings in this area very much depends on the starting point of the system and its ability to liberate large blocks of fixed and semi-variable cost. Workshop participants generally thought that better modelling was required here and were – in common with others we have talked to – aware that large savings from this type of change might be difficult to realise.

1 Monitor (2015) Moving healthcare closer to home. https://www.gov.uk/guidance/moving-healthcare-closer-to-home

## Specialist services

Specialist services are creating difficulties for many STP areas. They have been growing much faster than other commissioner budget lines and are set to continue to do so, albeit at a reduced rate.[2] In almost all cases they have a larger footprint than an individual STP. At the workshop we heard of one example in which NHS England planned to make a large-scale withdrawal of specialist services from one major hospital and progress in devolving commissioning in another STP area. However, with the exception of the mental health service changes described in the next paragraph, the approach to specialist services is yet to crystallise, and work is being undertaken nationally to help define it and to determine the level of appropriate devolution. STP leads were clear that this was an area that would require more attention and tight control. Similar approaches to other areas based on standardisation and reducing the number of services running very low volumes were thought to be a key part of this.

## Mental health services

Some STPs are looking at the rationalisation of inpatient sites and the large number of sites often operated by mental health services – sometimes for historical reasons. The repatriation of forensic services and attention to out-of -area placements offer opportunities for some savings as well as improvements for service users, and are being considered by some areas. A wide range of other service improvements are mentioned in plans, including the link between physical and mental health.

## Primary and community services

Workshop participants commented that, in some places, the STP has tended to be focused on acute care. However, it is clear that much of the strategy hinges on significant developments in primary care and improvements in the capability of community services and social care. There is general agreement that these services are in difficulty and that they are generally not equipped to deal with the scale of the challenge presented by the current environment or what is being planned. Common themes included the following:

- **Encouraging the development of at-scale general practice through support and incentives.** A focus on localities of 30,000–50,000 is a frequent element of plans. The use of neighbourhood teams and the development of some of the new models of care from the Vanguard programme were also perceived to be important. Participants were clear that the purpose of federation and larger-scale primary organisations was not just the General Medical Services (GMS) model at scale. The difficulty and potentially protracted timescale required for achieving this was recognised by workshop participants. Our analysis of the experience of a number of at-scale practices sheds light on this.
- In some cases, **change in primary care will mean unpopular decisions** such as not bailing out failing practices. In other areas, practices are not under so much pressure and are less likely to change. Some STP areas contained a mixture of

2 NHS England estimates that between 2009–10 and 2014–15, demand for health services increased by 2.7 per cent a year. Using this data, it expects demand for specialised services to increase by 4.4 per cent, and demand for other services to increase by 2.4 per cent, each year until 2020–21: www.nao.org.uk/wp-content/uploads/2016/04/The-commissioning-of-specialised-services-in-the-NHS.pdf

highly pressurised practices open to radical solutions, and those who saw rapid change as more threatening, making it difficult to agree initiatives across the whole inflow to particular secondary services.

- The main innovation in this area is an **emphasis on the development of new models of care**, moving towards various types of accountable care organisation.
- A number of areas are looking to **bring out-of-hours, 111, emergency, ambulance and sometimes other rapid response functions together** to reduce duplication and ensure accurate direction of patients. However, the value of general practice hubs as a method for diverting people from A&E is being questioned. There is national focus on seven-day services, although this is not thought to be a key priority locally.
- Particular attention was given by workshop participants to **support for nursing and care homes, in-hours visiting services** and other measures to support primary and urgent care.
- Enlisting the help of **secondary and community care providers to support new models in primary care**, including joint ventures, direct employment of GPs and other models were also mentioned as a way forward in some areas.
- Participants expressed concern that the problems in primary care of inadequate premises, recruitment and more fundamental changes in the model required **greater urgency than currently** seemed to be the case. Dealing with some difficult issues, such as practices with premises liabilities and dispensing, remains a major challenge. Some areas felt that relatively small investments in enabling GPs to overcome immediate problems of unfilled vacancies or a lack of premises investment could have relatively large pay-offs in stabilising the sector and gaining engagement and goodwill.
- There is more to do to **clarify the role of secondary care in supporting different types of accountable care organisation**.

# Demand management and prevention

STPs are required to develop plans for prevention and demand management. For many, the assumption that demand can be contained at the level dictated by demographic change is a key component of the plan.

## Demand management

While this term is commonly used, it has several different meanings, which include reducing activity or shifting it to lower-cost methods of delivery.

There was a lot of interest from workshop participants in developing more population health approaches using accountable care organisation-type models. However, some expressed a need for realism about the extent to which these approaches are able to make an impact or to develop quickly given the complexity of the task, the nature of the change and the need to develop strong local relationships and a high level of trust.

Risk stratification and targeting high users of services or those at risk of high use is seen by many as a promising approach. However, participants also noted that the evidence to support this, and the experience of some who have been trying it, suggest mixed results. There is some debate about whether dealing with the top 1 per cent of patients has enough of an effect, and whether these services need a greater reach – although this does reduce their potential effect. Without demand management, capacity reduction and other measures there is a suspicion that other patients will replace the high-risk patients whose admissions are prevented. This means that these methods need to be combined with other service redesign. Supporting self-care for patients with chronic conditions is seen as a priority to support this. Although technology did not feature very much in some initial submissions, the interventions here include new types of staff providing support and the use of technology and apps for patients to facilitate this. The process of learning how to use this technology is still in its early stages.

Some STPs are developing approaches to managing demand for planned care. Methods have already been developed successfully by some CCGs, but there is some concern that 44 or more different approaches to this will create risks and open the NHS to criticism.

The 'Right Care' and 'Getting it Right First Time' programmes were seen as offering some opportunities for improving decision-making and reducing variation. In some places this could reduce activity.

It is thought that there is potential to look at managing demand for other areas such as over-the-counter drugs, continuing nursing care, some specialist items such as gluten-free food and, more controversially, IVF.

## Prevention and health improvement

Participants expressed enthusiasm for the prevention and health improvement strand of work and provided a number of interesting proposals, including a focus on the NHS workforce. STP leaders had a wide range of ideas for improving health and reducing health inequalities in their areas. These included a range of interventions outside the traditional scope of the NHS – in particular an emphasis on obesity, exercise and early years. Social prescribing, identifying individuals at risk and some use of approaches such as asset-based community development are also being considered. Transport, education, employment and housing ideas also featured, as did opportunities to deal with benefits claimants with mental health and musculoskeletal conditions.

Several issues about this area were raised:

- A number of participants reported **very significant reductions in public health and prevention spending by local authorities**. The implications for sexual health services were a particular area of concern. There were reports of large-scale disinvestment in health visiting and school nursing, running counter to the recent national drive to increase health visitor recruitment. More generally, some felt that their local authorities were not going to be able to deliver their side of this work.
- While there is absolute agreement that investment in this area is the right thing to do, **demonstrating a positive return on investment is very challenging**. This is a particular issue in areas with high levels of population churn.
- There is thought to be **more immediate return from investment in secondary prevention**.

Overall, there is great amount of aspiration in this area, but a recognition that more needs to be done to make proposals concrete and to identify effective interventions that can demonstrate impact.

# Financial strategy and efficiency

The development of a common understanding of the financial challenge facing the NHS and social care is important. Some STPs have further work to do here, particularly in identifying the main drivers of problems – specifically the extent to which the driver is demand rather than rising costs or other sources. There is significant pressure to focus on closing the current year gap, which, while important, could detract from the need to look to the future:

> We have to focus on 16/17 or we start the Plan with a much bigger gap.
>
> STP finance lead

The underlying assumption still seems to be that a large part of the burden of closing the funding gap will be dealt with through efficiency improvements. However, the current tariff set a 2 per cent efficiency target: this is already greater than the historic rate. The reality is that a larger efficiency factor needs to be planned for, in addition to measures to reduce activity. STP leads considered that the 1 per cent efficiency target for commissioners translates into pressure on providers, either through a further reduction in costs or through reductions in activity. Since, in many cases, the marginal savings from activity reduction are relatively small, this means that providers have to find an even larger set of efficiencies. There are doubts about the credibility of these assumptions.

At present, a number of STP leaders have not managed to identify how their gap can be closed, and those that had done so commented that the plan only balanced "on paper". Indeed, there was a feeling among participants that some of the projections set centrally are simply unachievable. Nuffield Trust has carried out a detailed analysis of the factors that may be underlying this.

In a small number of places, there seems to be an implicit assumption that large-capacity reductions may lead to changes in admission thresholds, lengths of stay and referral behaviour and practice recalibration. Based on international experience of health systems that have experienced a sudden fiscal shock, there may be some truth in this. But the transition in these cases has been difficult and has done harm, so this seems to be a high-risk strategy. However, there may be few other options in some places, particularly where staffing problems could force capacity reductions.

Where efficiency savings lead to big reductions in bed use or outpatient visits, there is an unresolved issue in dealing with stranded capacity. This is discussed below, but the shortage of capital is clearly an obstacle. The fact that the bulk of the sustainability fund will be channelled into dealing with current financial problems compounds this.

The range of methods for improving efficiency is well understood. The Carter proposals – including those on pathology and back office functions – were not generally seen as controversial (apart from the pace proposed and the comment that rushing though

pathology reorganisation is a high-risk strategy). The actions and activity in this area require a large amount of rigorous and detailed work and a question remains regarding the capacity of many organisations to focus on this and other requirements of the plan. This is discussed in more detail below.

There is a great amount of emphasis on standardisation, reducing variation and on eliminating unnecessary testing, medicines optimisation and looking at treatment and referral thresholds. This creates difficulties for commissioners, who may need to agree common approaches to large providers that currently have to operate to multiple different types of specification. There is also a question about how far the standardisation needs to be supra-STP, since there are significant patient flows across their boundaries.

# Enablers: workforce, technology and estates

## Workforce

As noted above, the workforce is a major issue and is driving change independently of the needs of the STP footprints. Although it is acknowledged as crucial, it may not yet be receiving sufficient attention, and the level of innovation and imagination does not yet match the scale of the problems. However, workshop participants gave examples of a number of very innovative changes being considered, including:

- Acute trusts aligning terms and conditions to damp down pointless competition for staff and to create rotations and career development opportunities
- An ambulance service looking at how to get rotations for staff in other settings such as general practice to increase job variety and stop paramedics leaving
- Recruiting home care workers on NHS terms, allowing rotations in other settings and providing training and development for care home staff
- Other innovative area-wide approaches to recruitment
- Commissioning from care homes and insisting on pay above the living wage
- Setting up a locum bank across the STP
- Developing specialist nurses to deal with shortages in middle-grade posts.

STP leaders also identified a number of important issues that still need to be addressed, including the following:

- Housing costs and availability are a growing problem
- More strategic changes in the skills and deployment of existing staff, including extending the roles of existing staff and developing new roles. There is also a need to look at the medical workforce implications of the changes
- Health Education England (HEE) input. HEE's role in supporting these changes was highlighted by participants as a significant risk. In some places the local relationships are good and HEE is seen as helpful, but, in general, questions were asked about whether it is providing anything like the level of strategic and operational support that is needed. The general tenor of participant comments about HEE suggest that it needs to become much more responsive and proactive.

## Technology

There are 84 areas for creating local digital road maps and 44 STP footprints, which complicates matters to some extent. Participants expressed agreement that technology is a key enabler of many components of the plans to improve efficiency, reduce

variation, for case management and care coordination, and to improve access and manage demand.

Many participants saw creating single local records with read–write capability as the top priority in this area of interest. While an integrated health and care record is seen as essential, STP leaders were finding that NHS Improvement is risk averse regarding investment, and the return on investment here is difficult to demonstrate.

One important insight  is that integrated care records do not deliver value if the staff roles and workflow do not change and if staff are not clear how to use the information and interact with the system.

Databases, shared records and local systems also need to be brought together into business intelligence if the full benefits are to be realised. There is more to do in this area and the shortage of good analytics capability was mentioned by participants as an important rate-limiting step.

The memory of Connecting for Health[3] means that there is a strong bias towards organisational independence. This is not compatible with the requirements of the local digital landscape in future. One STP has set a rule to ensure that all new investment is compatible with the wider health system.

There is less emphasis on patient-facing technologies, although there is interest in redesigning access to services, for example via 111. There is interest in opportunities for web and telephone-first models of service, where patients use standardised entry routes for urgent or other types of care. These are being investigated and there is more work to be done in this area. While there is a lot of interest in self-care, beyond giving patients access to their records, workshop participants did not provide evidence of any large-scale plans to use technology to enable this.

## Estates

Some STP areas have been able to take a shared approach with their local authorities to the use of the public sector estate to improve space utilisation, make best use of empty space and private finance initiative/Local Improvement Finance Trust buildings and take the opportunity to co-locate services that need to work together.

In general, the preference from workshop participants seemed to be to turn spare assets into an income stream, for example by repurposing the building, developing a joint venture with a housing association or other development rather than selling assets and potentially losing the capital receipt.

The opportunity to work with local government and housing associations offers opportunities to fill the big gap in property development skills and capabilities in managing planning, commercial negotiation and other areas that are important to maximise the value of assets.

Participants raised a number of issues for which further work and thought are required:

- The role of Community Health Partnerships (CHP) and PropCo. These organisations are not seen as being aligned to the objectives of the wider system.

3 Connecting for Health was an ambitious national programme for IT in the NHS that ceased to exist in March 2013, prompting criticism over the limited benefits and large cost to the health service and the taxpayer.

This is particularly the case with PropCo, and some STPs would like to take the property back to manage as part of a more locally sensitive strategy.

- The shortage of capital to support strategic change in both asset use and service delivery is a problem. While Private Finance 2 (PF2) can be constructed as an off-balance-sheet transaction, it tends to favour new builds rather than refurbishment and is of no use for equipment, repurposing buildings or other enabling works. This makes it harder to deal with stranded assets.
- The state of many GP premises is an issue and is holding back ambitious plans for scaling up. Capital is seen as being very difficult to obtain, which appears difficult to understand given the availability of both NHS and commercial funding. Some practices are locked into complex financing deals, leading STP leads to consider buy-out options. The complexity of the sector and the large-scale loss of people with expertise in this area during the last reorganisation are holding back progress.
- There is a skills gap in property development, as referred to previously.

# The process

## Footprints

There has been some disquiet in STP areas where people have felt that they have been put together with others with whom they do not have natural patient flows or a history of working together. In these cases, there has been a lot more work to do to understand the issues and get to know new people:

> We have only met three times as a full leadership group, and one of those was before we met the top team to present our plan.
>
> STP leader

Participants felt that there was a risk that the STP would become the default unit for all change in the eyes of the centre.[4] It has been necessary to work out subsidiarity principles and to agree which issues should be addressed at STP level and which should remain at organisational or local-system level. Some areas have not yet done this. This is part of a wider challenge about governance that is discussed below.

The importance of coherent collective leadership is obvious, but participants noted that it has not been easy to establish. There are various levels of sign-up to the process, and some leads expressed concern that it is 'their STP' rather than a collective effort. Some footprints have acknowledged that there are system leaders with the relationships and legitimacy to influence and bring the system together. Those without these things are having more trouble.

## Speed

The speed at which the process takes place is an issue and has been a challenge for STP areas with large footprints, particularly those where there is not an established history of working together. The scale of the STPs and the number of different voices that need to be heard creates a logistical challenge. For some bodies that cut across more than one footprint (such as ambulance trusts and some county councils), there is a simple question about having enough people with time to participate.

## Stakeholder involvement

The level of stakeholder involvement and support for STPs appears to be very variable. In some cases, local authorities are active participants, but we also heard a number of examples of where local authorities regard the process as being too focused on the NHS or where they are not engaged at all. Local governments within an STP area may have very different demographic and political make-ups, and therefore potentially very different priorities. Situations where there are existing disputes and disagreements

4 Throughout this paper, where we refer to 'the centre', we mean the central organisational bodies of NHS England, NHS Improvement and, in some cases, the Department of Health.

between different tiers of local government can further complicate this. Workshop participants spoke of examples where local government is taking the lead and helping to move the process on; however, it seems that these efforts may not always be successful.

A similar picture emerged regarding local medical committees (LMCs), with some being very engaged and supporting fairly radical change, and others excluded from the process. The level of involvement of local GPs, health and wellbeing boards and other local stakeholders is, similarly, very variable. Workshop participants commented that, in some areas, GPs are focused on being part of federations, multi-speciality community providers or other at-scale organisations, and they may identify more strongly with these structures than with the STP. The role of clinical senates seems to be particularly confused, and their role in approving clinical change seems to be in need of further clarification.

Some attendees remained concerned that local authorities or CCGs might retract support for difficult decisions under pressure. The extent to which local MPs and other politicians not closely associated with the process are involved or aware of what is happening appears to be very limited.

More positively, a number of workshop participants thought that the process had been very helpful in bringing people together. The test of this will be in how it translates to action – something that has been an issue previously.

# Implementation

Participants pointed out that the NHS is better at writing plans than implementing them. The wide scope and high level of ambition of plans combined with the difficult financial situation and the need to continue with 'doing the day job' makes implementation challenging. Issues that will need to be addressed include governance, change management, and financial incentives and funding. Each of these is addressed in turn below.

## Governance

The STP leaders were aware that the governance of complex and contentious issues across organisations is known to be difficult and has been at the root of a number of previous failures to enact large-scale change. They recognised the need for strong governance, and some have developed decision processes that reduce the risk of defection from agreed positions and individual organisations having a veto. Further work is needed to develop these. The number of organisations with a stake in the process is often large, and this can make the process unwieldy. Some STPs are hoping to streamline this. There seems to be some variation in how far footprints have worked through the issues of subsidiarity and the scope of the STP's work in order to prevent it from becoming overloaded with central requirements and preoccupations.

There is a specific challenge for CCGs and foundation trusts because of their status as membership organisations. This is more of an issue for CCGs, because practices are more integrally involved in governance. In some cases this is leading to structural changes in CCGs across the area either being discussed or actually taking place.

## Managing the change

Participants expressed a number of serious concerns about the current state of understanding regarding the management of change. There is a feeling that the centre does not fully appreciate a number of important aspects of managing these sorts of changes. Some of the specific issues are listed below:

- The importance of developing long-term relationships and trust has been underestimated, and there is an assumption that the time taken to develop these can somehow be telescoped into a shorter period. As noted above, in some areas the relationships are still new.
- As noted elsewhere, the time required to implement has been underestimated and some systems lack the information required to make decisions – particularly those that have come together recently.
- It was felt that there is a lack of awareness in the centre of how nasty the process of major reconfiguration can get, with some examples being given of threats to people's families and personal attacks. There was limited confidence about whether the centre would support local areas if a situation becomes difficult, or whether they would simply disappear, potentially leaving areas to deal with local media interest and an outraged local population. STP leaders

have been told that they would be supported if they had the 'right' answer (that is, 'right' from the perspective of NHS England and NHS Improvement). On the positive side, there was a view from participants that GPs and CCGs are less troubled by local media and politics and are more able to weather the storms than primary care trusts were. This has not been fully tested.

- Participants were concerned about the extent to which other stakeholders, both locally and nationally, were ready for large-scale changes. There seemed to be very little evidence of public consultation or engagement. Foundation trust governors, among others, have expressed concern about this issue.
- Some STP leaders also felt that the approval process for change was confused. One area described a very complex choreography that seemed to be changed over time, giving the appearance of "being made up on the hoof". The local outposts of NHS Improvement and NHS England sometimes seem more risk averse and anxious to impose rules than the centre. Some areas reported that the two organisations had different ideas and priorities that were incompatible with one another. The criteria for upward referral of decisions are not very clear and seem to be variable. Interestingly, the approval rules seem to be put to one side during a success regime or other crisis intervention. The creation of a single area manager for NHS Improvement and NHS England was thought to be a partial solution to some of these (and other) issues. It was felt that the role of the Competition and Markets Authority would add a further, probably unavoidable, complexity.

## Financial incentives and funding

There exist some well-understood financial issues that have the potential to impede effective implementation of STPs.

Individual organisational accountability for financial performance means that acute trusts are reluctant to abandon the payment-by-results system. Previously, the Trust Development Authority had stopped one area from moving on to block contracts (as a way of moving from activity-based payment to outcomes-based commissioning). Non-payment-by-results approaches are not a panacea as they require total transparency over costs, which is often not available. Some workshop participants argued that regulators needed to "back off" if the STP was able balance its books across the area but individual institutions could not.

A key idea is that there is only one sum of money: mechanisms to maximise income or shift activity without a plan to reduce provider costs simply move the problems around the system. At best this is futile, and at worst it will undermine the success of the system. Several STP leaders suggested that there needed to be a shared financial framework – with transparency about costs and how the financial flows work – and that this needed to be agreed by all stakeholders.

As noted previously, access to capital is a serious obstacle to change and improvement, particularly in primary care. Some STPs are exploring whether they can secure capital via local authorities and housing associations that have different routes available for this. Opportunities to unlock this nationally exist, and these need to be accelerated. In primary care, some areas were rerouting money previously spent on local enhanced services, or from Vanguard grants into investment in wider out-of-hospital provision.

This included some that were not explicitly aimed at GP capacity, such as care home in-reach.

One area of interest that was not considered in detail at the workshop is the future of commissioning in future scenarios where many commissioning functions have been transferred to accountable care organisation/multi-speciality community provider/primary and acute care system-type organisations. This issue is the subject of further work the Nuffield Trust is currently carrying out alongside NHS England with a number of CCGs.

# Conclusion

The scale of the STP process is large and ambitious, and the speed with which plans are being pulled together is astonishing. So far, the plans are not sufficient to close the gap, but, if implemented well and combined with high-quality local efficiency improvement, they would go some way to doing so and would demonstrate the capability of the NHS and social care system to deliver.

Action is being taken on a wide range of fronts, and quite a lot of the plans will require not only a step up in day-to-day management and efficiency improvement, but also skilful implementation of a large number of complex, intra-organisational change management projects in areas that are likely to be controversial.

There are some significant risks embodied in what needs to be done. Some of the big-ticket items are areas that have long been recognised as important, but that have proved difficult to bring about real change. Others are still best described as plausible hypotheses with limited real-life evidence. The STP leaders were acutely aware of the dangers of optimism bias and even magical thinking, but there is a risk that the process itself may encourage this through an insistence on being radical. The STP leaders we spoke to were more inclined towards change models based on large numbers of smaller changes, and they were very clear that there is no magic bullet.

There is an even greater set of risks surrounding the implementation process – notably the absence of a clear mechanism for accountability for delivery, the limited managerial bandwidth available and the lack of involvement of many important stakeholders. Some of these stakeholders may find the proposals unpleasantly surprising, which will make the promises from the centre to support change even more crucial.

It is clear that actions to remove blockages, authorise decisions, provide capital, give support for major change and create headroom are needed at each level of the NHS to make this work. Some of these actions are technical and design issues that are challenging in themselves, but others are about changes in behaviour, mindsets and ways of working, which are perhaps even more challenging.

There is much more to be done to bring others into the process and to create a system that is capable of delivering change. We will be providing further opportunities for STP and other strategic planning leads to come together to explore these issues.

# About the author

**Nigel Edwards** is Chief Executive at the Nuffield Trust. Prior to becoming Chief Executive in 2014, Nigel was an expert advisor with KPMG's Global Centre of Excellence for Health and Life Sciences and a Senior Fellow at The King's Fund. Nigel was Policy Director of the NHS Confederation for 11 years and has a wealth of experience in health and social care. He joined the organisation from a role as Director of the London Health Economics Consortium at the London School of Hygiene and Tropical Medicine, where he remains an honorary visiting professor. Nigel has a strong interest in new models of service delivery and a practical focus on what is happening at the front line as well as a wealth of experience in wider health care policy in the UK and internationally. Nigel is a well-known media commentator and is often in the spotlight debating key policy issues.

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59 New Cavendish Street
London W1G 7LP
Telephone: 020 7631 8450
Facsimile: 020 7631 8451
Email: info@nuffieldtrust.org.uk

www.nuffieldtrust.org.uk

Published by the Nuffield Trust.