

Delivering sustainability and transformation plans

From ambitious proposals
to credible plans

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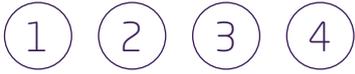
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Key messages

- The *NHS five year forward view* set a direction for the future of the NHS that has been widely supported.
- Sustainability and transformation plans (STPs) – the local plans for delivering the Forward View based on 44 geographical ‘footprints’ in England – offer the best hope for the NHS and its partners to sustain and transform the delivery of health and care.
- The context in which STPs have emerged is much more challenging than when the Forward View was published, with the NHS now facing huge financial and operational pressures.
- The changes outlined in STPs could help address these pressures, but there is a risk that work to sustain services will crowd out efforts to transform care.
- Proposals set out in the 44 STPs submitted in October 2016 need to be developed into coherent plans, with clarity about the most important priorities in each footprint.
- A high priority is to use existing services in the community more effectively to moderate demand for hospital care, which is a major cause of current NHS pressures.
- New care models being developed by the vanguards and in related initiatives demonstrate how services are being transformed, and need to be supported and spread to other areas.
- Proposals to reconfigure hospitals could improve the quality and safety of care, and need to be considered on their merits to ensure that a convincing case for change has been made.
- Proposals to reduce capacity in hospitals will only be credible if there are robust plans to provide alternatives in the community before the number of beds is cut.
- Cuts in social care and public health and a lack of earmarked funds to support transformation will affect the ability of NHS organisations and their partners to implement their plans.



- A more realistic timescale should be adopted for the implementation of STPs, given the time it takes for innovations in care to become established and deliver results.
- Changes to the law are needed to amend aspects of the Health and Social Care Act 2012 that are not aligned with the Forward View, particularly those relating to market regulation.
- The NHS should engage meaningfully with staff, patients and the public, local authorities and the third sector in discussing the proposals contained in STPs.
- The NHS should also strengthen the governance and leadership of STPs and put in place the capacity and capability required to support implementation.
- National bodies should work together in supporting the NHS and local authorities in the implementation of STPs and send out consistent messages on what they now expect.
- The government should reiterate its commitment to STPs as the means for implementing the Forward View; it should support proposals to improve services where the case for change has been made, and recognise the need for additional resources for the NHS and social care.



1 How NHS care has been transformed since 1948

Sustainability and transformation plans (STPs) are the latest in a long line of plans to transform the delivery of health and care services in England. Like their forerunners, STPs reflect changes in demography, clinical practice and policy-makers' thinking about the most appropriate way of meeting the population's health needs. More proximately, they set out how leaders in the NHS aim to implement the *NHS five year forward view*, in which NHS England and other national bodies set out their ambitions for the future of NHS services (NHS England *et al* 2014).

These ambitions centre on tackling gaps in health and wellbeing, care and quality, and funding and efficiency. The proposals in the Forward View seek to close these gaps by empowering patients, developing new care models, and using resources more effectively. They include a commitment to give greater priority to prevention, break down barriers in how care is provided, and bridge a funding gap of £30 billion by 2020/21.

The authors of the Forward View stated that these ambitions were all possible 'provided we take action on prevention, invest in new care models, sustain social care services, and over time see a bigger share of the efficiency coming from wider system improvements'. STPs have become the principal means for delivering this commitment. In a previous report, we analysed the process by which they were developed, noting challenges in relation to stakeholder involvement and other factors (Alderwick *et al* 2016). In this report, we focus on the content of the 44 plans submitted in October 2016 and the service changes they propose.

It is important at the outset to locate our analysis of STPs in the context of developments in the delivery of health and care since 1948. Although the NHS is sometimes perceived as an organisation that is resistant to change, the reality is quite different. There has been continuous adaptation of services throughout its history. Major examples of how NHS care has been transformed include the following.



- **General practices** have grown in size and are providing a much wider range of services to their patients than at the inception of the NHS. Primary care is now usually delivered by practices comprising groups of GPs instead of the single-handed and smaller practices that were the norm in 1948. GPs deliver care with the support of nurses and other members of the primary care team. Most practices today provide responsive care when patients present with medical needs, as well as much of the routine chronic disease management that previously would have been delivered in hospitals, and preventive services like vaccinations and immunisations. Some practices include GPs with special interests and undertake minor surgical procedures.
- **Acute hospitals** have fallen in number, and this has been associated with major reductions in the number of general and acute hospital beds – from around 160,000 in 1990/91 to 103,000 in 2015/16 – at a time when the population has been growing. These reductions have resulted from advances in medical practice (including the use of day surgery), less invasive surgical techniques, improvements in anaesthesia, developments in the treatment of medical patients that have reduced the length of time patients spend in hospital (treatment of patients following heart attacks being one example), and changes in the care of older people (*see below*). Some specialised services have been concentrated in fewer hospitals to improve the quality of care.
- **Care of older people** has moved out of acute hospitals following the closure of the ‘back wards’ that provided continuing care (rather than acute care) for older people from the 1980s onwards. Much of this care is now delivered in care homes and nursing homes, which expanded following changes enabling some of the costs of this care to be met from the social security budget. This shift represented a redrawing of the boundary between care provided and paid for by the NHS and care that is today the responsibility of local authorities and individuals and families, depending on the means of those receiving care. Care homes and nursing homes today have around four times the number of beds as acute hospitals.
- **Mental health and learning disability services** have moved away from care provided in hospitals to care delivered in the community and in people’s homes. The large asylums for people with psychiatric problems – often with more than 1,000 patients each – have been replaced with beds provided in small specialist units, care in acute hospitals and a range of services delivered by community mental health teams. Hospitals for people with learning disabilities have been



replaced with care in specialist homes and supported housing, with the aim of enabling these people to live ‘an ordinary life’. Advances in drug treatment lie behind changes in some of these services.

- **Care for people with tuberculosis** was transformed in the early years of the NHS by advances in drug treatment. Providing this care was a huge challenge for the NHS at its inception because few treatment options were available other than bed rest and there was insufficient capacity in the sanatoriums that provided this care. Plans were developed for a major building programme to expand capacity in the years after 1948, but these were rapidly abandoned following the discovery of streptomycin, which enabled most people with tuberculosis to be treated successfully. NHS sanatoriums were subsequently closed or used for other purposes, and the use of hospitals in Switzerland for the treatment of some NHS patients was no longer necessary.

These and other changes resulted from a combination of factors. Technological advances were responsible for many changes, including innovations in surgery, medicine and the diagnosis of illnesses. The discovery of new drugs was also important, helping in the development of more effective treatments and contributing to the reduction in the use of hospitals. Other factors included changes in the law (in the case of mental health services), shifting social attitudes (in relation to mental health and learning disability services) and changes to the funding of care for older people. Demographic pressures were also at work, especially the growing and ageing population, which resulted in the care of older people receiving more attention.

Government policies on health and care played a part too. This was evident in, for example: the new contract for GPs introduced in 1966, which helped stimulate improvements in the delivery of primary care; policies to provide more care in the community, which affected care of older people, mental health and learning disability services from the 1960s; and plans to develop acute hospitals dating from the Hospital Plan of 1962, which led to the rise of the district general hospital. More recent plans developed in the NHS lie behind the reduction in the number of hospital beds and the concentration of specialised services in fewer hospitals – for example, in a succession of reports on health services in London ([NHS London 2007](#); Tomlinson 1992).

Taken together, the changes outlined above have arguably transformed the delivery of health and care in ways that are possible to perceive only in retrospect. This is because of the time it takes to bring about many of these changes (30 years or more



in the case of mental health services, for example) and the fact that they result from the progressive implementation of a large number of small advances in care that cumulatively have a major impact. While the NHS has undoubtedly been slow in adopting some recent advances – the use of information technologies (IT) being an example – its record in adapting to changing population needs is arguably much better than sometimes perceived.

Returning to STPs, the NHS has been asked to develop these plans at a time of significant pressures on the health and care system, and with time and resources to bring about change both in short supply. The context in which STPs have been developed is much more challenging than the context in which the Forward View was written. This reinforces the need to transform care in the direction set by the Forward View but also makes the process of doing so more difficult. All the more important, therefore, that the proposals submitted in October 2016 are developed into coherent plans in each area of England.

Against this background, this report has two aims: first, to provide a descriptive overview of the proposals in the 44 STPs in England, organised under the main themes we identified in the plans submitted in October; and second, to discuss the challenges in implementing STPs and realising the opportunities they identify. In reading what follows, we would emphasise – as Simon Stevens and Jim Mackey did in a letter to NHS and local government leaders in December 2016 – that even the most advanced STPs are a ‘work in progress’ and are likely to change as they are developed further ([Stevens and Mackey 2016](#)). We discuss what this means in the final part of this report.



2 What are the main proposals in STPs?

We now describe the main proposals in STPs, based on our reading of the plans submitted in October. These plans are wide-ranging, and here we focus on the principal themes we have identified. Examples from individual STPs are used to illustrate the changes being proposed. We recognise that these plans may have changed or developed since they were first submitted in October.

Changing the role of acute and community hospitals

A number of STPs set out proposals for changing the role of acute and community hospitals. This includes plans to reduce the number of hospital sites and beds, centralise some acute services on fewer sites, and reconfigure the way that specialised services are delivered. It is hoped that these changes will improve quality of care and ensure safe staffing. All STPs also aim to tackle variation in the delivery of acute services, which is discussed on page 18. These changes are often closely linked to plans to redesign primary and community services and strengthen care delivered outside of hospitals (*see* page 12).

Reducing hospital capacity

STPs could lead to cuts in the number of acute hospitals in some areas, as well as reductions in the number of beds in acute and community hospitals. **South West London**, for example, makes the case for reducing the number of acute hospital sites from five to four. The aim is to ensure that patients receive care in the most appropriate setting, rather than ending up in acute hospital by default. The combination of changes being proposed in South West London seeks to bring about a 44 per cent reduction in acute inpatient bed days, a 20 per cent reduction in ‘unnecessary’ outpatient appointments and a 13 per cent reduction in elective surgical activity.

North West London also includes plans to reduce the number of acute hospitals in its area. These proposals are a continuation of major changes to health care services



that have been under development in North West London for a number of years as part of the Shaping a Healthier Future programme. They include proposals to reduce the number of major hospitals from nine to five. The STP makes clear that these proposals are not supported by Hammersmith and Fulham or Ealing councils.

In **Leicester, Leicestershire and Rutland**, the intention is to reduce the number of acute hospital sites from three to two. The number of acute beds will be reduced from 1,940 in 2016/17 to 1,697 in 2020/21. The plan includes proposals to cut the number of beds in community hospitals, with an overall reduction of 13 per cent. Community hospitals are also under review in other STP areas, such as **Buckinghamshire, Oxfordshire and Berkshire West**, and **Staffordshire and Stoke-on-Trent**. The latter may result in a reduction of 99 community hospital beds within two years (subject to formal consultation).

Like other areas, **Dorset** proposes to provide more integrated health and care services in the community and redesign how hospital services are provided. These changes are expected to lead to a reduction in the number of hospital beds from 1,810 in 2013/14 to 1,570 in 2020/21. The STP states that population changes will otherwise increase demand for hospital beds to 2,465. Dorset's proposals are expected to reduce unplanned medical admissions by 25 per cent and unplanned surgical admissions by 20 per cent.

Devon plans a 'significant reduction in the number of acute and community beds needed across wider Devon by 2021, where up to 600 people are being cared for inappropriately at present'. These plans reflect the view that care in Devon is too reliant on acute and community hospitals and that more appropriate alternatives should be developed. Consultation has started on the proposed closure of four community hospitals in South Devon and Torbay.

In **Nottingham and Nottinghamshire**, there are proposals to cut the number of beds in Nottingham University Hospitals NHS Trust by 200 and in Sherwood Forest Hospitals NHS Foundation Trust by 20. Bed reductions will be achieved by more timely discharge of patients from hospital. The STP also aims to reduce accident and emergency (A&E) attendances by 6 per cent. **Derbyshire** estimates that 400 fewer acute beds will be needed by 2020/21 by redesigning care in 21 geographically based community networks. In **Herefordshire and Worcestershire**, plans to implement more integrated services are expected to result in a 'significantly lower' number of beds being needed in future.



Not all STPs plan to reduce capacity in acute hospitals. In **Lancashire and South Cumbria**, for example, the aim is to prevent further growth in hospital activity by investing in prevention and out-of-hospital services. There are also plans to review where specialised services are provided and to centralise these services where appropriate. In **North East London**, where the population is growing rapidly, the priority is to use hospitals more efficiently to avoid having to build more hospital capacity, as well as to consolidate the provision of planned care and create surgical centres of excellence.

Reconfiguring acute services

Some STPs propose changes to where and how acute hospital services are delivered. In **Cambridgeshire and Peterborough**, for example, a number of services are being considered for centralisation, including orthopaedics, stroke, maternity and paediatrics. The proposals for stroke services include delivering all inpatient stroke and neurological rehabilitation care on a single hospital site instead of across multiple hospital sites. If implemented, the plans are expected to lead to improved outcomes for patients and financial savings for the NHS. The area's two hyper-acute stroke units, which provide immediate assessment and treatment, will be maintained.

In **Dorset**, there are proposals to reorganise acute hospital services by establishing one major emergency hospital and one major planned care hospital, either at Poole or Bournemouth. The site chosen as the planned care hospital will have its A&E downgraded to an urgent care centre. Acute hospitals in Dorset will deliver services as a network, including by working more closely with community-based services. Similar proposals are made in **Shropshire and Telford and Wrekin**, affecting Shrewsbury and Telford hospitals.

In **Durham, Darlington, Teesside, Hambleton, Richmondshire and Whitby**, there are plans for two hospitals to provide specialised emergency services, with four other hospitals to provide other acute services. The latter are described as 'local hospitals' that will deliver urgent care and, in most cases, midwifery-led maternity services. Local hospitals will also provide planned care and care for older people living with frailty. Challenges in recruiting consultants and other senior doctors to the area are a major factor driving these changes.



Staffordshire and Stoke-on-Trent sets out ambitions to reconfigure planned hospital care and simplify urgent and emergency care. It aims to reduce A&E attendances by 30 per cent and emergency admissions by 23 per cent, with delayed transfers of care falling to 2.5 per cent in 2020/21. The number of hospitals delivering planned care will be reviewed, with the aim of developing ‘highly efficient 7-day elective centres’ and separating urgent and planned care services where possible.

Cheshire and Merseyside states that its current configuration of acute services is unsustainable, particularly in Cheshire. The STP does not set out specific proposals to reconfigure services but commits to a review to assess how well the existing services are working. It also outlines an ambition to support district general hospitals through a network of specialist providers. **Northumberland, Tyne and Wear and North Durham** states its aim is to seek opportunities to rationalise services across the seven sites providing acute care. In both areas, the rationale is to ease workforce pressures and make better use of resources.

A number of other STPs recognise the need to reconfigure acute services but are not in a position to put forward specific proposals. **Devon** has embarked on a review of acute services with an initial focus on stroke services, maternity, paediatrics and neonatology, and urgent and emergency care. Likewise, **Bath and North East Somerset, Swindon and Wiltshire** has initiated a review of six specialties at the three acute hospitals in its area, where there are concerns about the sustainability of services. **Buckinghamshire, Oxfordshire and Berkshire West** plans to consult on service changes at the Horton Hospital in Banbury.

Reviewing the provision of specialised services

STPs in London place particular emphasis on the need for changes to the way specialised services are provided. The five London STPs describe a number of challenges to the current model of specialised services, including rising demand for care, fragmentation and duplication of services, inefficiencies and gaps in provision, and performance and quality issues. The London STPs intend to work together to plan specialised services where appropriate through a newly established London specialised commissioning board.

A review of specialised services in south London is being carried out with NHS England’s London regional team. The review will focus on a number of priority



areas, including specialist cancer, neurosurgery and adult secure mental health services. Its aim is to align services across south London's specialised providers to ensure that they are financially and clinically sustainable.

In **West Yorkshire and Harrogate**, a specialised services steering group has been established to develop more collaborative approaches to planning and transforming services across the footprint. The group's initial areas of focus include a review of Child and Adolescent Mental Health Services (CAMHS) tier 4 beds (with the aim of improving outcomes for patients and reducing out-of-area placements) and complex neuro-rehab services for adults with acquired brain injury. In **South Yorkshire and Bassetlaw**, children's surgery, anaesthesia, hyper-acute stroke care and the treatment of patients with acute gastrointestinal (GI) bleeds are identified as services to be reviewed.

Redesigning primary care and community services

All STPs set out proposals for redesigning primary care and community services and delivering more services outside of hospitals and in people's homes. These proposals invariably describe commitments to break down barriers between services and to develop care that is more integrated, including between the NHS and local authorities. General practices are typically at the heart of these new care models, with GPs and primary care staff working more closely with other community and social care services. It is often expected that these new ways of working will reduce demand for hospital care.

For example, **West, North and East Cumbria** describes how 'integrated care communities' are being developed to bring together general practice, social care, mental health, public health and community services, as well as some specialised services currently based in hospitals. Staff from these services will work together in multidisciplinary teams and manage care for their local population. Similarly, **Derbyshire** defines 21 'places' within its STP – ranging in population size from 30,000 to 100,000 – as the foundation for new models of integrated care. Groups of providers will be responsible for managing care for defined populations, and these 'place-based' teams will co-ordinate with specialised services provided across larger geographical areas.

GPs are being encouraged to work together at greater scale through networks and federations. In **South East London**, for example, 15 GP federations form the foundation of the area's plans for more integrated primary and community services, called



'local care networks'. In **South Yorkshire and Bassetlaw**, GPs are described as 'the senior decision maker in taking forward prevention, integration with social and voluntary sector partners and managing complex patients'. To achieve this, GPs will work together in groups and in multidisciplinary teams with other health and social care professionals.

Humber Coast and Vale sets out plans for implementing the *General practice forward view*. The aim is to improve access to general practice for residents, support practices to implement new ways of working (such as closer working with community health services) and look at new ways of managing demand. The plan also describes a longer-term ambition to increase the number of GPs working in the footprint.

In **Somerset**, there are proposals to widen the primary care team to include roles such as health coaches and pharmacists, as well as networking arrangements between practices to manage demand for same-day appointments and provide extended services seven days a week. Mergers and formal collaborations between practices are being considered to underpin these new arrangements. Another proposal is to take a shared approach to the primary care estate and other general practice functions (like telephone and booking arrangements).

Many areas are seeking to increase the volume and range of services provided in the community. **Dorset**, for example, intends to develop a network of 'community hubs', where mixed teams of health and care professionals will work together to provide services usually available only in hospitals – such as some outpatient appointments and diagnostic testing. Some hubs will also offer community beds, which will be used to provide rehabilitation after a stay in hospital and to support people at the end of their life. **Leicester, Leicestershire and Rutland** proposes to redesign 32 specialties and move more than 150,000 outpatients and 20,000 day-case procedures from acute to community settings.

Several areas – including **Somerset, The Black Country, Birmingham and Solihull**, and **Northumberland, Tyne and Wear and North Durham** – propose to spread the new care models being developed by NHS England's vanguard sites. One example can be found in **Frimley**, which includes one of NHS England's primary and acute care system (PACS) vanguard sites. It aims to create 14 'integrated hubs' to join up physical and mental health care, as well as social care and other services in the community. The hubs will provide a single point of access to services for residents. Prevention, early intervention and community support will be promoted.



General practices will be encouraged to work together at greater scale. Expected outcomes include an ‘incremental reduction in non-elective attendance towards 30 per cent for the patient cohort identified as frail and managed within integrated hubs’ and financial savings of £12.4 million over the STP period.

A range of service-level approaches are being developed in an attempt to manage and integrate care in the community – such as care planning, care co-ordination, and the use of telehealth and other digital technologies. A number of areas, such as **North West London** and **Greater Manchester**, are using risk stratification and population segmentation approaches to identify target populations for these new models of care (for example, older people and people with complex care needs). Emphasis is being placed on supporting people to manage their own health.

New forms of collaboration between health and social care commissioners and providers – such as accountable care organisations and accountable care systems – are being explored to support these new ways of delivering services. These are discussed further on page 24.

Strengthening prevention and early intervention

All STPs include ambitions to strengthen prevention and early intervention and help people to stay healthy for longer. Echoing the Forward View, plans talk about a ‘radical upgrade’ or ‘step change’ in prevention and public health, along with ambitions to embed prevention across the health and care system. **Lancashire and South Cumbria**, for example, expresses its ambition as developing ‘population health at scale’. Some areas (including **Nottingham and Nottinghamshire**, and **South Yorkshire and Bassetlaw**) make specific commitments to increase levels of investment in prevention.

Many areas focus on the drivers of health outcomes that sit beyond the scope of traditional health care services. Tackling these wider determinants of health involves considering factors such as the quality of housing, the ability to find and remain in employment, and access to education and training. These proposals often involve working closely with local authorities, the voluntary sector and other partners in a local area.

North West London, for example, includes a new Work and Health programme to provide employment support for people with learning disabilities and mental



health problems, as well as targeted services to support sustained employment. **Cornwall and the Isles of Scilly** aims to improve access to affordable, good-quality housing, to reduce fuel poverty through energy efficiency and housing improvement schemes, and to prevent homelessness. **South West London** sets out ambitions to collaborate with local authorities, for example, to influence alcohol licensing schemes, and to build on the principle of ‘making every contact count’. This includes work with the London Fire Brigade to explore how health-related advice and preventive measures might be incorporated alongside fire safety.

Tackling health inequalities is a common ambition. In some cases, plans include specific outcome measures to track the impact of proposals on health inequalities. **South Yorkshire and Bassetlaw’s** prevention programme, for example, aims to reduce the gap in healthy life expectancy by five years by the end of the STP period.

Other areas focus on early years support. **North East London**, for example, has ambitions to work with schools to promote healthy lifestyles and develop new models of care for children and young people. **South East London** also intends to establish a network to plan services for children and young people, with a particular focus on improving primary care services for this population group, as well as building parenting support services in the community.

Many areas describe ambitions to improve the health of their local populations through tackling unhealthy behaviours. **Hertfordshire and West Essex**, for instance, outlines a number of interventions being developed by public health teams, including working with employers to increase awareness of smoking cessation services, introducing Smokefree ‘toolkits’ and increasing the role of community pharmacies in efforts to tackle smoking. The aim is to deliver a 10 per cent reduction in the number of current smokers over the STP period. Similar initiatives are proposed for alcohol and weight management.

Targeted interventions for people with long-term conditions such as diabetes, chronic kidney disease and hypertension are described in many STPs, with the aim of helping people to live more independently. Proposals include early disease identification through programmes such as NHS Health Check, rollout of the NHS Diabetes Prevention Programme (and other similar local programmes), and other structured education and support programmes.



Many STPs include plans to promote mental wellbeing and prevent mental illness. These range from general ambitions to improve the local population's wellbeing to more specific plans and objectives. **North East London** focuses on building resilience and mental wellbeing through a variety of proposals relating to employment, leisure and green space. **Surrey Heartlands** plans to establish a 'wellbeing prescribing model', and place voluntary sector workers within primary and community care settings to act as 'wellbeing co-ordinators'.

Plans often focus on improving people's ability to manage their own health – including through self-care and self-management programmes, peer support, and 'patient activation' approaches. **Herefordshire and Worcestershire** plans to train the health and social care workforce to be able to coach patients to become more active in managing their own health and wellbeing. **Cheshire and Merseyside** aims to provide people with IT equipment to monitor their health conditions at home. The programme is expected to reduce acute emergency activity by 4 per cent and deliver estimated gross savings of £1.8 million by 2020/21.

Initiatives to create a healthy NHS and social care workforce also feature. **Staffordshire and Stoke-on-Trent**, for example, states one of its measures of success as the improvement of the health of the NHS and care workforce by 2021. To help achieve this ambition, the STP intends to add requirements to support workplace health to all acute trust contracts.

Improving mental health and other services

STPs describe ambitions to improve care in specific service areas – such as maternity, mental health, learning disabilities, and children and young people's services – depending on local needs and priorities. Some plans also include proposals on how adult social care services will be supported and improved.

North Central London outlines a range of proposals to increase mental health support for all age groups, with initiatives to improve community resilience, increase access to primary care mental health services, improve acute mental health services, develop a female psychiatric intensive care unit, and invest in mental health liaison and dementia-friendly services. There are also proposals to improve mental health services offered to children and young people, including



the introduction of eating disorder teams and a specialist community perinatal mental health team, as well as comprehensive support services (building on the ‘child house model’ established elsewhere) for abused children.

Northumberland, Tyne and Wear and North Durham’s learning disability transformation plan is focused around the idea that many patients in inpatient settings could be managed in the community. Its proposed model of care aims to reduce hospital admissions for this group by 51 per cent by 2018. In total, 77 beds are expected to be closed by the end of 2018/19. Any resources released as a result of these closures ‘will need to be reinvested in community provision’. Additional investment will be required.

Some plans focus on services for women and children. One example is **Lincolnshire**, which aspires to ‘have gone a long way to implementing the national maternity review recommendations’ in two years’ time. Initiatives to improve maternity services include implementing personalised care plans and community-based midwifery teams to improve continuity of care. Steps to improve paediatric services include establishing a ‘neighbourhood team’ for children and young people. The ambition is to commission an integrated child health programme, as well as ensuring that recommendations from the National Institute for Health and Care Excellence (NICE) are being delivered in key areas such as in care for people with autistic spectrum disorder.

Buckinghamshire, Oxfordshire and Berkshire West is planning an STP-wide paediatrics programme, one of the aims being to reduce unwarranted variation in admissions for this population group. This encompasses a range of actions across primary and secondary care, with a focus on ensuring that common clinical guidelines are adopted across the area.

Several plans give priority to adult social care. **Frimley**, for example, seeks to ‘transform the social care support market’, starting with an in-depth analysis of the current market and identification of alternative support options where appropriate. **Lancashire and South Cumbria** is another area in which social care – for adults and children – features prominently.



Improving productivity and tackling variations in care

A wide variety of measures to improve productivity and efficiency are included in the plans, covering providers and commissioners. They include implementing recommendations from Lord Carter's review of hospital efficiency, such as those focused on optimising non-clinical resources like procurement and back-office functions, as well as some clinical services like pathology, imaging and pharmacy.

West, North and East Cumbria's 'business as usual efficiency' programme, for example, has three components: provider efficiencies; efficiencies through shared organisational arrangements, including IT, human resources (HR) and estates; and clinical commissioning group (CCG) and specialised commissioning efficiencies. Taken together, expected savings across these areas total £86 million over the five years covered by the STP.

Kent and Medway sets out a programme to deliver productivity improvements, including work on consolidating corporate services (including IT, estates and facilities, finance, HR, procurement and legal services), with a target saving of £39 million by 2021. The area is also exploring similar opportunities with local authorities, and plans to undertake a larger programme looking at shared clinical support services and collaborative prescribing.

Opportunities to improve efficiency through collaboration between organisations are also being developed by providers in **North East London**, which it is estimated could save between £21 million and £56 million. The plan focuses on four priorities: collaborative procurement; common bank and agency approaches; pathology consolidation; and back-office functions. Potential areas for collaboration with respect to procurement include patient transport services and 'soft facilities management' (such as cleaning and waste management services). Different models for pathology are being explored, where it is thought that between 3 per cent and 7 per cent of costs could be saved through consolidating services and making better use of automation.

CCG efficiency programmes are also included. **Sussex and East Surrey's** plans for specialised commissioning Quality, Innovation, Productivity and Prevention (QIPP) schemes next year include a set of proposals relating to medicines optimisation (for example, switching to generic drugs and 'biosimilars' and optimising procurement opportunities), rollout of the national devices procurement scheme, and reviewing



shared care pathways (among others). In **Nottingham and Nottinghamshire**, all NHS commissioning organisations will reduce their running costs by between 0.5 per cent and 1 per cent each year, and local authorities will also deliver between 5.8 per cent and 9.5 per cent efficiency savings.

Reducing unwarranted variations in clinical care is a common theme in many STPs. Most plans make reference to NHS England's RightCare programme, using data sent by the programme to each footprint to help identify priority areas for action. Reducing variation in referrals for elective care is one area of focus.

Bedfordshire, Luton and Milton Keynes aims to standardise referrals by strengthening specialist expertise among primary care professionals and supporting GPs through mechanisms such as referral management services, RightCare and GP variation analysis. **Frimley** identifies five disease areas where variation could be reduced: respiratory, musculoskeletal (MSK), neurology, circulation, and genito-urinary services. This is expected to result in savings of £36.5 million over four years.

Many plans focus on services with high volume or high variability, where there is greatest opportunity to achieve impact, such as orthopaedic care, drawing on the 'getting it right first time' approach. Some areas are developing shared clinical protocols to be applied by providers. In **Birmingham and Solihull**, for instance, the aim is to standardise clinical practice 'with the adoption of single care pathways and a shared set of clinical protocols and quality standards that optimise clinical outcome [sic] across Birmingham'.

Herefordshire and Worcestershire proposes a programme to reduce variation in prescribing by making greater use of information and technology to support appropriate use of medicines. The same area proposes work to reduce the number of procedures performed where there is 'a limited clinical benefit or enhanced risk of harm' and to 'work with patients to improve their overall wellbeing by seeking lifestyle improvement as part of the elective pathway'. This is also an approach taken by **Leicester, Leicestershire and Rutland**, which proposes to increase its focus on the rigorous application of existing policies as well as to identify new procedures of limited clinical value.

Involving people in decisions about their care is described as a route to reduce unwarranted variations in practice. **Gloucestershire** commits to 'making shared



decision-making a reality’ based on evidence ‘that most people want to be more involved in their own health, and that when they are, decisions are better, health and health outcomes improve, and resources are allocated more efficiently’. Like others, Gloucestershire identifies medicines optimisation as a priority, to ensure that ‘the right patients get the right choice of medicine, at the right time’. It plans to achieve this by embracing the principles of the Choosing Wisely approach.

Workforce

Problems in relation to staff recruitment and retention feature heavily in STPs, with staff shortages linked to the quality and sustainability of services in some areas.

Surrey Heartlands explains that a ‘combination of workforce issues and the pressure of high demand and increasing complexity has impacted upon [women’s and children’s] services ability to maintain high quality and good outcomes’.

Proposals for tackling these problems include collaboration between organisations within STP footprints. **Hampshire and the Isle of Wight**, for example, makes a commitment to ‘working as one... with one workforce strategy’. **Bristol, North Somerset and South Gloucestershire** sets out ambitions to align staff terms and conditions, and to develop training ‘passports’ and define core skills to enable staff to work across organisations.

Some areas describe ambitions to mitigate recruitment and retention issues by reducing levels of staff sickness. Others look at ways to open up health and social care opportunities to younger people or to make the sector more attractive – for example, by taking advantage of the government’s new Apprenticeship Levy and developing apprenticeship schemes or, as in **Devon**, exploring opportunities for more flexible career pathways that enable staff to rotate between different organisations.

A number of STPs outline the impact of their proposals on staff numbers, cost and efficiency. **Hampshire and the Isle of Wight** plans to retain the health and care workforce at current levels while cutting the overall pay bill by 0.2 per cent by reducing reliance on agency workers (saving an estimated 10 per cent of current spend) and redesigning corporate functions (reducing costs by 15 per cent). **Nottingham and Nottinghamshire** proposes changes which suggest a 12 per cent cut to band 5 nurses and similar roles, while at the same time proposing a 24 per cent



increase in the community and primary care workforce over the next five years ([Nottingham and Nottinghamshire 2016](#)).

Many plans propose new roles, largely aimed at supporting the development of new care models and shifting care away from hospital and into the community. The role of care navigator is described by [Hampshire and Isle of Wight](#) as a way of 'shifting primary care activity to a non-clinical workforce'. Other plans refer to the need to develop nurse associates (for example, [Gloucestershire](#)) and physician assistants (for example, [Bristol, North Somerset and South Gloucestershire](#)) to support the introduction of new models of care.

[Lancashire and South Cumbria](#) discusses the need for the workforce to become more 'flexible and multi-skilled' to meet the needs of the population. [Norfolk and Waveney](#) describes creating a workforce that attracts and retains 'digital natives', and commits to supporting leadership and organisational development by co-ordinating local, regional and national leadership provision across the footprint. [Gloucestershire](#) calls for 'a system wide approach to quality and service improvement through the development of a countywide quality academy'.

Developing the enablers

Each STP describes a range of 'enablers' to support the service changes described in its plan. IT and estates are two of the main enablers.

IT

Health and care systems were asked to come together in 2015 to develop local digital roadmaps setting out how they would make better use of digital technology and become paper free by 2020. The geographical relationship between the 44 STP footprints and 73 local digital roadmap footprints is mostly one-to-one or one-to-many, although six digital roadmaps cross STP boundaries.

STP areas with a coterminous local digital roadmap (such as [Gloucestershire](#), and [Staffordshire and Stoke-on-Trent](#)) have used this as a starting point for their digital ambitions, demonstrating in their plans how they will implement the roadmap, as well as build on it to support some of their broader ambitions. STPs with one-to-many local digital roadmaps, or whose roadmaps cut across STP boundaries, differ in



their approach. Some (for example, [Suffolk and North East Essex](#), and [Herefordshire and Worcestershire](#)) have combined a number of these roadmaps to form a single digital roadmap, while others state an intention to plan and deliver the roadmaps at locality level (the [Cheshire and Merseyside](#) STP footprint, for example, maps onto three local digital roadmaps, and [West Yorkshire and Harrogate](#) maps onto six).

Many STPs propose some form of electronic patient record that can be shared across organisations. [Norfolk and Waveney](#) proposes a digital platform that allows all providers of out-of-hospital care access to the same records, as well as developing a shared electronic patient record system – ‘e-hospital’ – linking the three acute hospitals. [Dorset](#) proposes implementing the Dorset Care Record – a shared record of people’s interactions with different services – to enable information to be shared between health and social care practitioners across the STP. The Great North Care Record has similar ambitions on a larger scale, implementing shared care records across four STPs in the north east of England and north Cumbria region, covering 3.6 million people.

Expected benefits from sharing records in this way include improving integrated working, delivering more efficient and higher-quality care, and better patient safety and experience. Some STPs emphasise the ability of shared records to facilitate greater mobile working. This is particularly the case in STPs that cover rural areas – for example, [Bath and North East Somerset](#), [Swindon and Wiltshire](#).

Many STPs are clear that digital technology will be essential to progress plans for self-management and prevention. [Lincolnshire](#), for example, plans to give people the ability to view and contribute to their digital record. Plans for a new patient portal will also enable people to find information about local services.

Ambitions to enable patients to interact with health and care services digitally differ between STPs. While some hope to use digital technology to allow more people to book appointments online, others aim to deliver a proportion of their services using digital technology. For instance, [Lincolnshire](#) aspires to offer 95 per cent of primary care patients e-consultations and other digital services by 2019, while [Cambridgeshire and Peterborough](#) is planning to introduce a series of health apps to support people with long-term conditions to better understand their symptoms and manage their conditions.



Few STPs include much detail on revenue and capital requirements for their digital plans. Where they do, they are likely to be dependent on securing central funding. For example, **Frimley** states that to create a ‘truly digitally enabled economy’ it will cost £71 million. While it has already earmarked £38 million (£30 million of capital and £8 million of revenue) for investment, it will still require £33 million of new money.

Estates

Most STPs set out proposals to make better use of their estate, including disposing of assets deemed to be surplus to requirements. **Staffordshire and Stoke-on-Trent** identifies ‘too much’ estate and underutilised inpatient capacity as one of several drivers of its forecast ‘do-nothing’ deficit. The STP is considering various options to use its estate more effectively, with a view to delivering £22 million of savings by 2020/21.

Many areas set out proposals to work with local authorities and the wider public sector on an estates strategy. **Leicester, Leicestershire and Rutland** is planning work with local authorities, ambulance and fire services to identify opportunities for co-location of services, as well as rationalisation and consolidation of the estate. Similarly, **Bedfordshire, Luton and Milton Keynes** is proposing to build on work already being undertaken by councils under the One Public Estate initiative. The aim is to develop local centres accommodating health and social care staff alongside other local public services, such as housing.

Bristol, North Somerset and South Gloucestershire’s proposals for improving and developing the NHS estate include replacing buildings that are no longer fit for purpose with new facilities (where appropriate, to be funded by a reduction in the overall estate). **North West London** plans to improve the primary care estate through an investment fund of up to £100 million and ‘minor improvement grants’. **Cambridgeshire and Peterborough** identifies an opportunity to develop new primary and community facilities when GP practices’ leases expire. This would include creating ‘larger, modern, family and frailty friendly hubs’, bringing together GPs, social care and community staff as well as providing direct access to diagnostics and specialist advice.

STPs are light on financial detail relating to proposed changes to estates, although this may be because it is included in the financial template that each area submitted to NHS England (and which are generally not in the public domain).



Some detail, however, is given on the capital required to implement some of the estates strategies. [Lincolnshire](#), for instance, outlines a total capital requirement of around £200 million to fund projects including the estates requirements of new care models and service reconfigurations.

Recognising that ‘any national capital funding is likely to be limited’, Lincolnshire suggests that it is exploring other sources of capital (including third-party developers, public-private partnership (PPP) and county council funding). To help source funds for its estates strategy, [Coventry and Warwickshire](#) calls on the Department of Health to revisit its overarching policy on capital receipts, allowing local areas to retain them for reinvestment rather than returning them to central government.

Developing organisational arrangements to support STPs

Various changes are proposed to current organisational arrangements to support the implementation of STPs. These can be grouped under three related headings: collaborative commissioning; new approaches to contracting and payment; and provider collaboration. Proposals are also put forward for strengthening the governance and leadership of STPs themselves.

Collaborative commissioning

Greater collaboration between CCGs ranges from informal collaboration to full mergers. In [Birmingham and Solihull](#), three CCGs are ‘setting out a path’ to merging organisations with a view to reducing duplication of roles and functions. The ambition is to reshape commissioning so that it works at the STP level and supports the commissioning of new models of care – in the process reducing costs by more than £5 million.

More integrated approaches to commissioning are proposed between the NHS and local government, ranging from greater alignment between commissioners to full integration and single commissioning agreements. [Somerset](#), for example, sets out plans for a ‘strategic commissioning’ function where NHS and social care commissioners work together under a single agreement to ‘secure outcomes and pool budgets’.

[Hertfordshire and West Essex’s](#) ‘collaborative commissioning workstream’ involves the three CCGs and two county councils working together to provide ‘a single standard



for commissioning integrated services' across the STP. This includes work to produce a common set of commissioning intentions based on STP priorities, as well as common specifications, thresholds and exclusions, and moving to joint teams and committees. It also has a cost saving attached.

Mid and South Essex also proposes changes to its commissioning arrangements, including more integrated commissioning between the NHS and local government, new CCG joint decision-making arrangements (partly to try to address the complexity of the current commissioning landscape, which comprises more than 300 contracts with more than 100 providers), and development of a single acute commissioning team across the footprint.

New approaches to contracting and payment

New approaches to contracting and payment arrangements reflect these changes. Proposals include introducing alliance and prime provider contracts, capitated budgets and other payment mechanisms, as well as local alternatives to national incentives like the Quality and Outcomes Framework (QOF). The ambition for many of these proposals is to share risk between organisations, focus on outcomes of care, ensure that contracting enhances rather than hinders collaboration, provide greater flexibility, and align incentives between providers. Often these proposals are still developing and being explored, rather than set out as concrete delivery plans.

Greater Manchester is carrying out work to identify contracting and payment mechanisms that align with the new models of care being developed and implemented – in particular, the local care organisations being developed in all 10 localities in Greater Manchester. A number of approaches are in place and being explored and developed across the footprint. In one locality, Bolton, a new contract between the CCG and foundation trust 'combines activity and cost reduction incentives, with cost risk share and an agreed fixed income'. In another locality, Stockport, a capitation-based contract linked to defined outcomes is being developed, which will facilitate a multispecialty community provider (MCP) to be commissioned as the key integrated provider of services in the area.

Northamptonshire proposes to create a single commissioning framework across the STP, with a view to developing an integrated commissioning and contracting process that is 'significantly less transactional' than existing arrangements and



focuses on outcomes of care. Other plans in this area include using risk/gain share contracting models, using prime provider and alliance-type models, and in the longer term looking to learn from others and move to a form of capitated budgets (but recognising that this will require 'significant' work).

Provider collaboration

New models of provider collaboration include both vertical and horizontal models. Vertical models have emerged out of the PACS and MCPs and are most advanced in areas such as Northumbria, Morecambe Bay, Salford and Somerset. In these and some other areas such as [Bedfordshire, Luton and Milton Keynes](#), [Cheshire and Merseyside](#), [Suffolk and North East Essex](#) and [South Yorkshire and Bassetlaw](#), there is growing interest in the development of accountable care organisations (ACOs) and systems that would take responsibility for a budget for the delivery of services to a defined population.

Emerging thinking on ACOs is challenging the current separation of responsibility for commissioning and provision. This is because ACOs are usually seen as alliances of providers set up to deliver a wide range of services and undertake some commissioning functions – for example, when they subcontract with other providers. Where this is happening, CCGs and local authorities are likely to become strategic commissioners, often working across bigger footprints and with a focus on holding ACOs to account for delivering agreed outcomes.

Horizontal models can be found in both primary care and acute hospitals. The emergence of GP federations, networks and 'super partnerships' in the MCPs and elsewhere exemplifies what is happening in general practice. The acute care collaboration (ACC) vanguards are taking forward plans to develop hospital chains in areas including [North Central London](#), [Greater Manchester](#), and [South Yorkshire and Bassetlaw](#), and partnerships of specialist providers in other areas. Some of the ACC vanguards span more than one STP.

Looking across the STPs, the convergence in thinking around new care models such as PACS and MCPs is striking. As an example, [Northumberland, Tyne and Wear and North Durham](#) states that across the north east of England the expectation is that services will build on work going on to develop these models because their thinking and underpinning frameworks are absolutely in line with the STPs.



STP governance

Many STPs are underpinned by some form of shared governance arrangements to take forward the changes described and in an attempt to support joint decision-making and accountability. **Greater Manchester's** governance has been developed to oversee the region's health and care devolution plans, and brings together 37 local authority and NHS organisations from across the footprint. The Greater Manchester Health and Social Care Strategic Partnership Board sets the vision, strategy and direction, and is supported by an executive. There is also a joint commissioning board, an NHS provider trust federation board, and an overarching provider forum. Primary care is represented on the partnership board and executive and has also set up a primary care advisory group. Other organisations are involved as appropriate, including representatives of national bodies and the voluntary sector.

South Yorkshire and Bassetlaw has an executive group comprising chief executives of local authorities and NHS trusts, and accountable officers of CCGs. The executive group is supported by an STP co-ordinating group and a programme office. The plan for this area also describes an 'STP guiding coalition' playing a part in debating and shaping proposals in two system-wide events. A review will take place in 2017 to develop the right governance to take forward the proposals in the STP. Options being considered include developing 'an overarching provider forum', including both health and social care providers, and more formal joint commissioning arrangements. This consciously draws on areas that are further ahead in the development of their governance, such as **Greater Manchester**.

Several areas emphasise that plans have been developed across the footprint as well as for areas within the STP. In **Greater Manchester**, these areas have been defined as localities led by local authorities and partner CCGs, while in **Cheshire and Merseyside**, three local delivery systems have been identified for planning purposes. Similarly, **Northumberland, Tyne and Wear and North Durham** sets out proposals for three local health economies. **Lancashire and South Cumbria** identifies five local delivery plan footprints.



3 What are the opportunities and challenges in implementing the plans?

The themes we have identified in the 44 STPs reflect a succession of policy documents extending back a decade or more on why and how the delivery of health and care must adapt to meet the population's changing needs ([Department of Health 2008, 2006, 2004](#)). They are the latest attempt to translate a broad consensus on the need for new care models into improved services. Many of the issues identified in them are therefore very familiar. Their scope is wide, encompassing prevention through primary care, community services, mental health services and acute hospital services.

Links between the NHS and local government are a recurring theme, particularly in relation to social care and public health, although they are more prominent in some plans than others. While much of the content of STPs is about how health and care services will change to address the three care gaps described in the Forward View, they also outline the financial challenges that lie ahead. This includes quantifying the funding gap that might exist if the organisations involved in preparing STPs 'do nothing', and how they plan to close this gap by 2020/21.

A priority in all STPs is to achieve greater integration of care by building on innovations already under way, such as the work by vanguards involved in the new care models programme. This is linked to an ambition to develop services in the community. STPs also set out proposals to reduce reliance on hospitals and to give greater priority to prevention. Through investment in community services and the development of new care models, the plans seek to moderate demand for hospital care and deliver more care in people's homes.

A survey of 172 NHS trust chairs and chief executives carried out in September and October 2016 found that achieving financial balance was seen as the most important issue in STPs ([NHS Providers 2016c](#)). The next most important issues were moving



care into the community and reconfiguring acute services, while the least important was investing in preventive services. The survey's findings confirm our previous analysis, which found that bringing the NHS into financial balance had become much more salient in the process of developing STPs, alongside plans to improve services (Alderwick *et al* 2016).

It is clear, from our work and that of others (NHS Providers, personal communication 2016), that there are variations in the readiness of different areas to implement planned changes in health and care. Areas that are furthest ahead are, not surprisingly, those that are able to draw on work already completed or under way when the decision to set up STPs was announced. These include areas where the future of acute hospital services was under review and where plans to reconfigure these services were well advanced, with specific options for change having been identified. Areas involved in the vanguard programme also tend to be well advanced in their thinking.

Areas where work of this kind has not been initiated have produced STPs setting out proposals for improving care in much more general terms and are stronger in explaining why change is needed than what it will mean in practice. In some cases, there is explicit acknowledgement that more needs to be done to turn these proposals into actionable plans. NHS England and NHS Improvement have recognised the need for further work in strengthening the proposals submitted in October 2016 into fully developed plans. In some areas – Cheshire, for example – the thinking has already moved on (Dunhill and Rodwell 2016).

Many STPs are clearer on the changes they want to see than on how these changes will be implemented. As an example, plans for the 'radical upgrade in prevention' mentioned in the Forward View list a large number of opportunities, including actions to reduce cigarette smoking, tackle overweight and obesity, and to narrow health inequalities. What is often missing is detail on the specific programmes that will be put in place to deliver these benefits and the evidence that lies behind them. Cuts to local government funding, including public health budgets, will make it difficult to sustain existing preventive services, let alone expand them.

The King's Fund has advocated for many of the changes outlined in STPs (Ham *et al* 2012), and we welcome the broad direction they set. The development of new models of integrated care has been at the forefront of this work, and we



have been supporting the vanguards as they try to make integrated care a reality. The ambition to reduce reliance on acute hospitals and provide more care in the community is both necessary and desirable. The aim in some places to develop accountable care systems echoes our own thinking, and that of others, on population health systems and place-based systems of care.

The big question is whether the direction set by STPs can be implemented at scale and pace in a context that is much more challenging, as we noted earlier, than when the Forward View was published. Hospitals are stretched to their limits as demand continues to rise at a faster pace than resources. Services provided in the community, including general practice and social care, are also feeling the strain. NHS finances have also deteriorated sharply since the Forward View was written, and additional funding intended to support transformation is being used mainly to reduce hospital deficits. The extent of political backing for some of the changes proposed in STPs and a willingness to support NHS leaders in making these changes is uncertain.

Our recent assessment of progress in implementing the Forward View argued that lack of funding to support transformation is the area of greatest concern (Ham *et al* 2016b). Without this funding, it simply may not be possible to put in place improved and expanded services in the community and accelerate and spread the development of new care models at the pace and scale needed to transform the delivery of care. Continuing staff shortages resulting from failures in workforce planning will also slow or stymie the ambitions contained in STPs to manage rising demand outside hospitals.

Equally important is the preoccupation of leaders and staff within the NHS with tackling financial and service pressures, and the risk that this will crowd out capacity and capability to transform care. Dealing with these pressures and transforming care are two sides of the same coin, and there needs to be more explicit recognition of the role of new care models in enabling the NHS and social care to deal with operational challenges. If this does not happen, the urgent will drive out the important and STPs will not receive the attention they need if they are to provide the sustainable solutions to the pressures facing the NHS and local authorities.



To make these points is to argue that STPs are the right thing to do but the devil, as always, is in the detail. The most important questions are:

- Is it possible to convince the public, local authorities and other stakeholders to lend support to STPs when controversy has accompanied their development to date?
- Is it realistic to plan reductions in the capacity of acute and community hospitals when many of these hospitals are currently operating at or above their limits?
- Where will the resources and staff be found to invest in services in the community, including social care, to deliver more care closer to home?
- Are plans to reconfigure acute and specialised services by concentrating some services in fewer hospitals necessary and desirable?
- Can these and other changes be implemented at sufficient scale and pace given the ambitions of STPs, the need to consult on plans, and other requirements?
- Will the legal framework in which STPs have been developed and the changes they propose act as a barrier to progress?
- Will the proposals included in STPs be sufficient to close the care gaps identified in the Forward View, or at least make substantial progress in so doing, and enable the NHS and local authorities to live within the funding available to them between now and 2020/21?

We now discuss each of these questions in turn.

Is it possible to convince the public, local authorities and other stakeholders to lend support to STPs when controversy has accompanied their development to date?

NHS organisations have worked hard with local authorities and other partners to develop STPs in less than a year, while also focusing on their own performance. They have done so in a context that was not designed to support collaboration between organisations. The deadline for submitting plans was demanding and national requirements have often been ambiguous and shifted over time. STP leaders and their teams deserve credit for progress made to date.



Having made this point, there have been several challenges in the process of developing STPs (Alderwick *et al* 2016). The limited time available made it difficult for local leaders to involve all parts of the health and care system meaningfully, including clinicians and other frontline staff, as well as patients and the public. Local government involvement varied widely and some council leaders were critical of the lack of transparency surrounding the development of STPs.

STPs use a mixture of jargon and technical language and make few concessions to lay readers or those who are less familiar with NHS planning and funding. The very term ‘sustainability and transformation plans’ symbolises this challenge, carrying little meaning other than for dedicated followers of health policy. There is no readily available narrative that explains, in plain English, the rationale for STPs and what they mean for the public, underlining the communications challenge going forward.

An urgent priority is to extend involvement in the development and implementation of STPs beyond the relatively small number of leaders within the NHS who have done much of the work to date. This means reaching out to staff, patients and the public as well as local authorities and the third sector. It will also require much more meaningful engagement with local and national politicians, whose understanding and support is essential if some of the more radical proposals in the plans are to be implemented.

Our view is that a huge effort is now required to make up lost ground, engage in genuine consultation on the content of STPs, and explain the case for change and the benefits that will be delivered. This will require the leadership and staffing of STPs to be strengthened to create the capacity and capability to implement proposals that in some cases are likely to generate opposition. STPs remain fragile and nascent additions to an already cluttered landscape, and their place in the governance of the NHS needs to be clarified to avoid unhelpful ambiguity and complexity.

Is it realistic to plan reductions in the capacity of acute and community hospitals when many of these hospitals are currently operating at or above their limits?

One of the issues that has attracted attention in STPs is planned reductions in the capacity of acute and community hospitals, which continues the long-term policy trend discussed in the first section of this report. Although not the main theme in STPs, in the previous section we noted some proposals to close community hospitals



in some areas, acute hospitals in other areas (South West London, North West London, and Leicester, Leicestershire and Rutland), as well as the downsizing of some acute hospitals. But how realistic are these proposals when hospitals are under so much pressure?

Analysis shows that the recent growth in hospital activity exceeds increases in funding ([Maguire et al 2016](#)). Acute hospitals are working at or beyond the limits of current capacity, and bed occupancy rates are well above the recommended level of 85 per cent ([Appleby 2016](#)). With delayed transfers of care also increasing – in part because of cuts in social care – many hospitals are having difficulty meeting the demands placed on them with the beds currently available. Variation in the efficiency with which beds are used in different areas suggests that improvements in NHS care ought to be possible, but even hospitals with a track record of good performance are now struggling to meet demand.

The demands facing acute hospitals could be met more appropriately in other settings in some cases – for example, by providing alternatives to hospital admission and to support early discharge after admission. Long-term reductions in the number of hospital beds has been achieved in part by developing these alternatives at a time when there is growing recognition that hospitals are not always the safest environment in which to care for patients. These reductions mean that the NHS now has one of the lowest numbers of hospital beds in relation to the population served of any OECD country ([OECD 2015](#)).

The last major inquiry into hospital beds in England ([Department of Health 2000](#)) was used by the government of the day to increase the provision of intermediate care rather than expand hospital capacity. Increases in intermediate care provision may have enabled the NHS to meet rising demands (particularly from an ageing population) when public funding was growing, but has come under scrutiny when social care budgets have been cut and NHS funding has been constrained. Even with these increases, the National Audit of Intermediate Care suggests that the NHS has only around half the beds and places needed ([National Audit of Intermediate Care 2015](#)).

All the more worrying therefore that a recent survey found that intermediate care and beds in the community have been cut in some areas, adding to the pressures on acute hospitals ([NHS Providers 2016a](#)). This may explain why the



long-term trend of declining lengths of stay in acute hospitals appears to have stalled (NHS Digital 2016). Some estimates suggest that the NHS may in fact need 17,000 more hospital beds in future in the absence of measures to moderate rising demand for care (Smith *et al* 2014), although how these would be funded and staffed is not clear.

Our view is that proposals to reduce capacity in acute and community hospitals will only be credible if there are coherent plans to provide alternatives for patients in the community prior to hospital capacity being reduced. This must involve collaboration between the NHS and local government to use existing health and social care services in the community more effectively and to fill gaps in provision. Mental health services were successfully transformed in this way, as we discuss below, and STPs should learn the lessons from this experience. Work under way to test the assumptions on which STPs are based should test rigorously any proposals to reduce hospital capacity – if necessary to destruction.

Where will the resources and staff be found to invest in services in the community, including social care, to deliver more care closer to home?

NHS funding is increasing, but almost all of the additional resources made available in the 2015 Spending Review are being used to reduce deficits. These are to be found mainly in acute hospitals, primarily because hospitals recruited extra staff in the wake of the Francis Inquiry into Mid Staffordshire NHS Foundation Trust, and chose to overspend their budgets rather than compromise patient safety. Since the general election, the government has made it clear that restoring financial balance is a priority for the NHS, and much less funding is available than planned to invest in services in the community.

Financial pressures go hand-in-hand with workforce shortages in all areas of care. Our recent research has described the impact of these shortages on district nursing and the growing challenges of recruitment and retention in general practice – two of the services in the community that need investment if more care is to be delivered closer to home (Baird *et al* 2016; Maybin *et al* 2016). Even if additional funding were made available, it might not be possible to recruit the staff needed to strengthen services in the community. Cuts to social care spending and services accentuate the pressures on NHS staff in hospitals and the community.



There are, of course, opportunities to use the staff and resources currently available in the community more effectively, and this is already happening in many places. The vanguards involved in the new care models programme are at the forefront of these developments and are working to achieve greater integration between general practices, district nurses and related staff, and mental health services, typically in localities serving populations of between 30,000 and 50,000. This includes supporting practices to work at scale through networks and federations, in some cases with much closer links with care homes and acute hospitals. Proposals to strengthen community services are seen by leaders of NHS trusts as the most important priority in STPs, after achieving financial balance.

STPs in a number of areas set out ambitions to extend the work of the vanguards through the development of accountable care organisations and systems in which services in the community are integrated with acute services. This includes meeting the needs of vulnerable people in the community and avoiding hospital admissions where appropriate. Some of the vanguards are going further to give greater priority to prevention as part of a wider ambition to evolve into population health systems involving local authorities as well as NHS organisations. Ambitions to redesign and expand community services reflect the consensus that has developed on the need to develop and implement new care models able to reduce reliance on acute hospitals.

Making more effective use of existing staff and resources in the community has become a necessity when resources to invest in additional community health services are constrained. Yet even if community services can be redesigned at scale, we doubt whether all of the ambitions of STPs can be delivered without more funding for social care, which has a critical contribution to make in achieving the aims of the Forward View and STPs. Protection of public health funding is also necessary. As we noted in the first section of this report, the plans set out in the Forward View assumed that both social care and prevention would be protected to support delivery of new care models.

Recognising these constraints, our view is that the vanguards offer the best prospect for the NHS to strengthen services in the community with the aim of moderating demand for hospital care. They should build on previous examples within the NHS where this has been done (*see Monitor 2015*), and on international experience in



places like Canterbury District Health Board in New Zealand and the Southcentral Foundation's Nuka system of care in Alaska (Collins 2015b; Timmins and Ham 2013). Earmarked funding is required to implement proposals to strengthen services in the community and to cover double running costs, given the central importance of these proposals in STPs.

Are plans to reconfigure acute and specialised services by concentrating some services in fewer hospitals necessary and desirable?

Proposals in STPs to reconfigure acute and specialised services continue a series of changes in the provision of hospital services that have been under way for many years. In the previous section of this report we showed that these changes affect specialised care such as trauma care, stroke care, cancer care and neurosurgery, as well as services such as A&E, maternity and orthopaedic surgery, which are usually available in district general hospitals. These proposals are likely to attract most attention in view of the importance the public attaches to acute hospitals and experiences in areas like Kidderminster, where the local MP was unseated in 2001 by a campaigner seeking to defend a hospital whose services were under threat.

Various rationales are advanced in STPs for specialised service reconfigurations, including opportunities to improve the quality of care, reduce duplication between neighbouring hospitals, make better use of the workforce, and reduce the costs of care, thereby contributing to closing the funding gap facing the NHS. A major review undertaken by The King's Fund found that evidence on the impact on quality is much stronger in relation to specialised services such as trauma, vascular services and stroke care than in other areas of care (Imison *et al* 2014). The review also found that evidence on the impact of senior medical and clinical input on quality was strong, especially for high-risk patients.

Workforce shortages in the NHS have become a more important consideration in proposed reconfigurations in recent years. In some cases, these shortages have led to access to some services like A&E being restricted to times when senior medical staffing can be provided; in others, they have resulted in services being led by non-medical staff, as in the case of midwifery-led maternity units. In these and other areas of care, specialist networks have been used to raise standards across participating hospitals, sometimes with the support of remote monitoring and other technologies.



Reconfigurations are sometimes undertaken with a view to producing financial savings, but The King's Fund's review found that evidence that they deliver savings is almost entirely lacking ([Imison et al 2014](#)). Trust mergers are one way of enabling reconfigurations to take place by removing organisational barriers to changes in services. A review of six mergers commissioned by Monitor reported that savings were realised both from back-office functions and from changes in the provision of clinical care ([Aldwych Partners 2016](#)). However, these savings have to be considered alongside the additional costs of trust mergers, and these were not analysed as part of Monitor's review.

A parallel study of 20 mergers between 2010 and 2015 by The King's Fund found that the Department of Health allocated close to £2 billion to support 12 of these mergers for which data was readily available. This funding was used for various purposes, including to pay off legacy debt, tackle underlying deficits, and invest in new buildings and upgraded facilities to enable clinical services to be reconfigured ([Collins 2015a](#)). It is not clear if these mergers produced commensurate financial benefits through changes to clinical care or through cutting back on management costs.

STPs whose reconfiguration plans require access to capital expenditure face particular challenges as funding for capital projects is likely to be in short supply for the foreseeable future (West 2016). This may turn out to be as big a brake on the ambitions of STPs to reconfigure services as lack of revenue funding is for new care models. A possible solution is to embark on joint ventures with commercial developers, but this is only likely to be an option in areas such as London where land values are high. The ongoing review of the NHS estate may offer other options for the rest of England.

Even if reconfigurations may not deliver savings, the need to explore ways of improving clinical care by changing where specialised services are provided is well understood in many parts of the NHS. The argument that quality of care may be improved by concentrating specialised services on fewer sites, especially when there are shortages of clinical staff, needs to be articulated more clearly and consistently. Failure to do so means that patients will not always receive the best possible care. Making the case for change is never easy and is particularly challenging in areas where reconfiguration is seen – often wrongly – as a response to 'cuts' rather than a means of raising standards. Early engagement with local authorities is essential.



Our view is that some reconfiguration proposals will be both necessary and desirable whereas others will require detailed review to ensure that they stand up to scrutiny. All will have to handle the inevitable trade-offs between access, quality and cost, and each case needs to be considered on its merits. Experience from areas that have reconfigured services successfully – for example, London and Manchester in the case of stroke care – should be used to inform this work (Turner *et al* 2016). Reconfigurations stand little chance of being implemented without support from the government and a willingness to back NHS leaders where the case for change has been made.

Can these and other changes be implemented at sufficient scale and pace given the ambition of STPs, the need to consult on plans, and other requirements?

Major service changes have to go through established processes of consultation before they can be implemented. This means that STPs are the beginning of a conversation with the public, staff, local authorities and other stakeholders, rather than the last word. The more ambitious the changes they propose, the longer and more challenging this process is likely to be, unless those affected have been involved from the outset and have a well-developed understanding of the rationale behind what is being proposed.

There is a parallel here with the transformation of mental health services referred to in the first section of this report. The progressive shift away from the former asylums to mental health care in the community did not occur through a ‘big bang’ but rather a succession of clinical and policy changes implemented over 30 years or more. Our assessment of this process shows how mental health services were transformed through a lengthy process of trial and error, which had to confront unpredictable developments and unintended consequences (Gilbert *et al* 2014). These developments were facilitated by social movements and voices for change, growing therapeutic optimism, and changing professional roles and cultures.

There are many lessons for the transformation of other services, not least on the management of change. Large-scale de-institutionalisation in mental health was underpinned by investment in double running costs and the release of resources from land sales. New services were created before the asylums closed, creating confidence that appropriate alternatives were in place. The commitment to reinvest savings helped overcome professional resistance to change. Regional health authorities and their forerunners took on a critical role in planning and leading change. Politicians also lent their support.



The parallel we have drawn is not exact because mental health services and physical health services have as many differences as they do similarities. Nevertheless, there are important implications for how change is managed and funded and the potential for STPs to fill the planning vacuum left by the abolition of strategic health authorities (SHAs). Securing the support of local and national politicians for planned changes will also be crucial. Perhaps most important of all is to recognise the time it takes to implement large-scale change. The rundown of the asylums started in the late 1960s, gathered pace in the 1970s and 1980s, and continued into the 1990s and beyond.

Our view is that the timescale associated with the Forward View is much too optimistic in relation to its most ambitious goals. Recent examples of service changes in the acute sector that have led to improvements in care have taken at least two to three years to negotiate and implement (examples include stroke care in London, the acquisition of Trafford Healthcare NHS Trust by Central Manchester University Hospitals NHS Foundation Trust, and the relocation of cancer and cardiac services between University College London (UCL) Hospitals NHS Foundation Trust and Barts (St Bartholomew's Hospital)). Other service changes have taken much longer. A realistic expectation would be for those STPs that include major reconfigurations (and are most advanced in their planning) to be in the process of being implemented by the end of the period covered by the Forward View.

Will the legal framework in which STPs have been developed and the changes they propose act as a barrier to progress?

STPs are a conscious 'workaround' by national bodies of the complex and fragmented organisational arrangements that are the legacy of the Health and Social Care Act 2012. They rely on the willingness of NHS leaders at a local level to collaborate with their peers in the best interests of the populations they serve. STPs have no basis in statute, and their proposals need to be endorsed and supported by the boards of the NHS organisations involved as they move from planning to implementation.

There is an ever-present risk that these proposals will be challenged by those who oppose them through judicial review and other means. Were this to happen, it would introduce further delays to the implementation of planned changes. All the more important therefore that their governance and decision-making processes



are formalised to align the ambition to collaborate in STPs with the sovereignty, accountability and legal duties of the boards of NHS organisations and local authorities (Alderwick *et al* 2016).

Proposals that involve the reconfiguration of acute services may have to navigate the requirements of the 2012 Act relating to patient choice and competition. These requirements include referral to the Competition and Markets Authority (CMA) when service changes restrict choice and competition. The CMA has previously been involved in adjudicating on the proposed merger and associated change of services at Bournemouth and Poole hospitals, which is again under discussion as part of the Dorset STP. Were this to be referred to the CMA – a distinct possibility given its previous involvement – then one of the most advanced proposals for reconfiguration in any of the STPs could be delayed and potentially derailed.

Our view is that there is a need to revisit the 2012 Act in the very different circumstances that exist today. The aim of doing so would be to amend those aspects of the Act that are not aligned with the direction now being taken by the Forward View and STPs. The sections of the Act relating to market regulation would particularly benefit from review, both in relation to the role of the CMA and requirements on commissioners to use competitive processes in procuring new care models. There is also a need to recognise more formally the role that STPs are expected to play alongside the boards of NHS organisations and local authorities.

Will the proposals included in STPs be sufficient to close the care gaps identified in the Forward View, or at least make substantial progress in so doing, and enable the NHS and local authorities to live within the funding available to them between now and 2020/21?

All STPs list the ways in which they plan to close funding gaps if they ‘do nothing’ between now and 2020/21. These include provider-based cost improvement programmes, efficiency savings assumed by commissioners, and system-wide opportunities of the kind identified in the Carter review (for example, sharing of back-office functions and rationalisation of pathology services). For the largest STPs, the sums involved are in the order of £1 billion, although caution is needed in interpreting these estimates, which are based on working back from a worst-case scenario rather than projecting forward from work already under way.



The difficulty in closing the funding gaps through provider-based cost improvement programmes is one of the factors behind proposals to reduce hospital capacity and explore system-wide opportunities such as the rationalisation of pathology services and centralising back-office functions. Earlier, we questioned the realism behind some of these proposals. If they do not go ahead, then some of the potential efficiencies banked in the financial plans underpinning STPs will not be realised and other ways of closing the funding gaps will need to be found.

We have not made an assessment of the financial plans underpinning STPs because the information available to do so is too limited. However, three observations are in order.

First, the NHS faces well-known challenges in realising efficiencies of this scale against the backdrop of seven years of austerity and the time needed to deliver some of the required efficiencies. Second, surveys by NHS Providers and the Healthcare Financial Management Association (HFMA) have found that leaders within the NHS were not always confident themselves that transformation was happening quickly enough to deliver financial balance ([HFMA 2016](#); [NHS Providers 2016b](#)). Third, local authorities are under even greater pressure than the NHS. Some STPs – for example, in Nottingham and Nottinghamshire – are explicit in stating that their plans include a gap in the funding of adult and children’s social care and public health that needs to be bridged.

As the STPs submitted in October 2016 are reviewed and strengthened, it will be essential to stress-test the financial as well as clinical assumptions on which they are based. Leaders of the NHS nationally and locally are under intense pressure to demonstrate that they are able to sustain existing services and begin the process of transforming care outlined in the Forward View. Their desire to set out ambitious aims for the future is understandable, but ambition needs to be leavened with realism about what can be achieved and over what timescale. Over-promising and under-delivering would not be helpful at a time of heightened media and political interest in the NHS.



Our view is that with exceptional leadership and commitment at all levels, STPs should provide evidence by 2020/21 that the NHS and its partners have embarked on a process that over a longer timescale holds out the prospect of closing the care gaps identified in the Forward View. They may also provide comfort that in transforming care, they are enabling the NHS to achieve financial stability. As we have argued, the capacity and capability of those working on STPs will need to be strengthened for this to happen, and there must be absolute alignment between NHS England and NHS Improvement, both nationally and regionally, in their approaches to the performance management of organisations and of the local systems of which those organisations are a part.



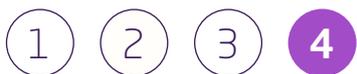
4 What now needs to be done?

The proposals outlined in the STPs submitted in October 2016 indicate the scale of ambition of NHS organisations and their partners, and the opportunities they offer to transform health and social care. In this report we have highlighted some of the challenges in implementing STPs, and the need to test the assumptions on which they are based. While it is too early to predict the outcome, there are already signs – both from national leaders (West 2017) and from developments at a local level – that some proposals will not be taken forward.

The main task now is to develop STPs into coherent plans and, in so doing, to be clear on the top priorities in each area of the country. The plans cover an extremely wide range of issues, in varying levels of detail. The next iterations of STPs should focus on those proposals that offer most potential for improving care while also helping to bridge the financial gap in the NHS and social care. These proposals must be capable of being taken forward within the known constraints of funding (capital as well as revenue) and workforce.

The most contentious proposals in STPs are likely to be those affecting hospitals. Some of these proposals will be inherently difficult to execute when they entail reconfiguring services or closing hospitals or sites. Plans to cut hospital capacity will require particular scrutiny for the reasons we articulated in the previous section of this report. Priority should be given to proposed reconfigurations that are most advanced in their planning and where the case for change has already been made. Difficult decisions will be needed on how to use the limited funds available for capital investment to support planned changes in the role of hospitals, and not all will be able to proceed.

Our assessment of STPs and our work with the new care models programme suggest that proposals to transform services provided in the community should be a high priority in all areas. In the context of cuts to local government budgets and pressures on NHS spending, this means using existing resources more effectively because funds for additional investment are in very short supply. Proposals to reinvent care outside hospitals through greater integration of community services in populations of between 30,000 and 50,000, and with general practices at the heart of these services, should be the starting point to provide the alternatives to hospitals that are so urgently needed.



Proposals to increase the focus on prevention should also be a priority. Exactly how to do this is something that needs more attention – an example of where the missing detail in STPs needs to be addressed. Some areas are using community assets in imaginative ways, as in the Morecambe Bay vanguard, which has engaged schools in programmes to encourage pupils and staff to exercise regularly. These and similar initiatives are relatively low-cost interventions that draw on a much wider range of resources than in many mainstream preventive programmes. The ability to work in novel ways in ‘fully engaging’ communities is particularly important in the current context.

We have emphasised the importance of prevention and the need to transform services in the community because they hold the key to moderating demand for hospital care – arguably the biggest challenge facing the NHS today. Unless demand is moderated, acute hospitals will continue to experience huge pressures, and resources that might be spent on alternative forms of care in the community will be used to help hospitals meet this demand. The NHS will be caught in a downward spiral in which time and resources are used to deal with operational pressures, with little left over to invest in new models of care to better meet changing population needs.

Additional investment and earmarked funds are required to support transformation and to cover the double running costs of large-scale transformation. The most urgent priority is to recognise the claims of social care, which is already in crisis and is adding to the significant pressures on the NHS. The claims of the NHS will also require a response given the infinitesimal growth in its budget planned for 2018/19 and 2019/20. It is no longer credible for the government to argue that it has provided ‘the funding needed to deliver the NHS’s own plan’ when most of the additional funding identified in the 2015 Spending Review is being used to keep services afloat rather than to transform care, which was the proposal at the heart of the Forward View.

Making a successful case for additional funding for social care and the NHS will be more convincing if the NHS can provide evidence of progress in implementing the Forward View, including through the new care models that have been in development for two years at the time of writing. Our work shows that these models are making a positive difference in many parts of England in line with the direction set out in the Forward View. The challenge now is to demonstrate their impact with



data – for example, in moderating demand for hospital care. Producing evidence of impact has to recognise the time it takes for service transformation to begin to deliver measurable improvements in care.

The update on the Forward View expected to be published in March 2017 will provide an early opportunity to assess the thinking of NHS England, NHS Improvement and national bodies on the state of STPs and what needs to be done to ensure delivery and spread of new care models. The government must be willing to support the NHS and its leaders by providing the resources and time required to implement planned changes where the case for change has been made. The NHS and the government, with partners in local authorities and the third sector, need to make a long-term commitment to seeing through the implementation of the Forward View that is capable of surviving changes among national leaders. Leaders at all levels need to engage with their communities and communicate why services are being transformed.

STPs need strengthening if they are to deliver what is expected of them. We would reiterate that they are fragile and nascent additions to the NHS landscape and have no formal powers to take and implement decisions – something that remains the responsibility of NHS boards. They also depend on the ability and willingness of partner organisations to release staff to work on the development of plans and to follow these through into implementation. STPs need to increase their capacity and capability to take forward the proposals in the October 2016 plans, including in quality improvement methods, which are in short supply in the NHS ([Ham et al 2016a](#)). Their place in the governance of the NHS needs to be clarified too.

There is also a need to take stock of whether the ‘workaround’ represented by STPs is sustainable in the longer term. Current organisational arrangements in the NHS are complex and fragmented and do not make it easy for NHS organisations to collaborate in the development of STPs and engage other organisations. Incremental changes of the kind under way in many areas – where CCGs are collaborating, providers are working in partnership, and accountable care organisations and systems are under development – are to be preferred to a further top-down reorganisation.



Having made this point, the costs and complexity of the workaround are high, both financially and in the demands placed on NHS leaders. Finding a way of reducing these costs without distracting leaders from their core responsibility of improving health and care is becoming more urgent. Aligning the organisation of the NHS and social care with the direction set by the Forward View and STPs will ultimately require these issues to be addressed across England if the noise of organisational fragmentation and complexity is not to drown out the signal of service transformation.



Appendix: List of STP footprints

STP footprint	Link to STP
Bath and North East Somerset, Swindon and Wiltshire	www.bathandnortheastsomersetccg.nhs.uk/get-involved/project/sustainability-and-transformation-plan
Bedfordshire, Luton and Milton Keynes	www.blmkstp.co.uk/
Birmingham and Solihull	www.birmingham.gov.uk/stp
Bristol, North Somerset and South Gloucestershire	www.bristolccg.nhs.uk/about-us/sustainability-and-transformation-plan/
Buckinghamshire, Oxfordshire and Berkshire West	www.oxonhealthcaretransformation.nhs.uk/about-us/buckinghamshire-oxfordshire-berkshire-sustainability-and-transformation-plan
Cambridgeshire and Peterborough	www.fitforfuture.org.uk/what-were-doing/publications/
Cheshire and Merseyside	www.liverpoolcommunityhealth.nhs.uk/news/sustainability-and-transformation-plan-stp-for-cheshire-and-merseyside/20829
Cornwall and the Isles of Scilly	www.cornwall.gov.uk/health-and-social-care/shaping-the-future-of-health-and-social-care-services/
Coventry and Warwickshire	www.uhcw.nhs.uk/about-us/stp
Derbyshire	www.southernderbyshireccg.nhs.uk/publications/joinedupcarederbyshire/
Devon	www.newdevonccg.nhs.uk/about-us/sustainability-and-transformation-plan-stp/102099
Dorset	www.dorsethealthcare.nhs.uk/trust/sustainability-and-transformation-plan.htm
Durham, Darlington, Teesside, Hambleton, Richmondshire and Whitby	www.hartlepool.gov.uk/downloads/file/2420/durham_darlington_teesside_hambleton_richmondshire_and_whitby_sustainability_transformation_plan
Frimley	www.surreyheathccg.nhs.uk/about/frimley-health-care-stp
Gloucestershire	www.gloucestershireccg.nhs.uk/gloucestershire-stp/
Greater Manchester	www.gmhsc.org.uk/delivering-the-plan/
Hampshire and the Isle of Wight	www.westhampshireccg.nhs.uk/stp
Herefordshire and Worcestershire	www.hacw.nhs.uk/yourconversation/
Hertfordshire and West Essex	www.healthierfuture.org.uk/
Humber, Coast and Vale	http://humbercoastandvale.org.uk/index.php/publications/



STP footprint	Link to STP
Kent and Medway	www.kmpt.nhs.uk/information-and-advice/stp.htm
Lancashire and South Cumbria	www.lancshiresouthcumbria.org.uk/sustainability-and-transformation-plan
Leicester, Leicestershire and Rutland	www.bettercareleicester.nhs.uk/
Lincolnshire	http://lincolnshirehealthandcare.org/en/stp/
Mid and South Essex	www.succesregimeessex.co.uk/
Norfolk and Waveney	www.southnorfolkccg.nhs.uk/about-us/sustainability-and-transformation-plan
North Central London	www.candi.nhs.uk/about-us/north-central-london-sustainability-and-transformation-plan
North East London	www.nelstp.org.uk/
North West London	www.healthiernorthwestlondon.nhs.uk/documents/sustainability-and-transformation-plans-stps
Northamptonshire	www.neneccg.nhs.uk/northamptonshire-s-sustainability-and-transformation-plan-2016-2021/
Northumberland, Tyne and Wear and North Durham	www.northumberlandccg.nhs.uk/get-involved/stp/
Nottingham and Nottinghamshire	www.nottinghamcitycare.nhs.uk/stakeholders/stp.html
Shropshire and Telford and Wrekin	www.sath.nhs.uk/news/healthier-future-stp/
Somerset	www.tsft.nhs.uk/about-your-hospital/somerset-sustainability-and-transformation-plan/
South East London	www.ourhealthiersel.nhs.uk/about-us/
South West London	www.swlccgs.nhs.uk/category/questions-and-answers/stpfaq/
South Yorkshire and Bassetlaw	www.smybndccgs.nhs.uk/what-we-do/stp
Staffordshire and Stoke-on-Trent	www.twbstaffsandstoke.org.uk/index.php
Suffolk and North East Essex	www.westsuffolkccg.nhs.uk/health-care-working-together-differently/
Surrey Heartlands	www.nwsurreyccg.nhs.uk/surreyheartlands/Pages/default.aspx
Sussex and East Surrey	www.hastingsandrotherccg.nhs.uk/news/sussex-and-east-surrey-sustainability-and-transformation-plan/#.WEA-Dk9dHIU
The Black Country	http://sandwellandwestbhamccg.nhs.uk/better-health-and-care
West Yorkshire and Harrogate	www.southwestyorkshire.nhs.uk/west-yorkshire-harrogate-sustainability-transformation-plan/
West, North and East Cumbria	www.cumbriaccg.nhs.uk/news/2016/November/sustainability-and-transformation-plan-for-west-north-and-east-cumbria-published.aspx



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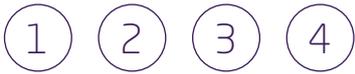
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About the authors

Chris Ham leads The King's Fund's work. He rejoined the Fund in 2010, having previously worked here between 1986 and 1992. He has held posts at the universities of Birmingham, Bristol and Leeds and is currently emeritus professor at the University of Birmingham. He is an honorary fellow of the Royal College of Physicians of London and the Royal College of General Practitioners.

Chris was director of the strategy unit in the Department of Health between 2000 and 2004, has advised the World Health Organization (WHO) and the World Bank, and has acted as a consultant to a number of governments. He has been a non-executive director of the Heart of England NHS Foundation Trust, and a governor of the Health Foundation and the Canadian Health Services Research Foundation.

Chris researches and writes on all aspects of health reform and is a sought-after speaker. He was awarded a CBE in 2004 for his services to the NHS and an honorary doctorate by the University of Kent in 2012.

Hugh Alderwick is senior policy adviser to Chris Ham. Since joining the Fund in 2014, Hugh has published work on NHS reform, integrated care and population health, and opportunities for the NHS to improve value for money.

Before he joined the Fund, Hugh worked as a management consultant in the PricewaterhouseCoopers (PwC) health team, providing research, analysis and support to a range of local and national organisations on projects focusing on strategy and policy.

Hugh was also seconded from PwC to work on Sir John Oldham's Independent Commission on Whole Person Care, which reported to the Labour Party at the beginning of 2014. The Commission looked at how health and care services can be more closely aligned to deliver integrated services meeting the whole of people's needs.

Phoebe Dunn is a researcher in the policy team, primarily working to help the wider team stay on top of the changing policy environment, as well as contributing to a range of health and care research projects.



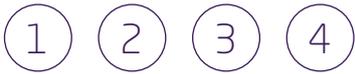
Before joining the Fund, Phoebe worked for a marketing and strategy agency on projects for small and large organisations from across the health and care sector. These included the launch report for the Point of Care Foundation, digital strategy for a large health charity, and a myth-busting campaign around outcomes-based approaches to health care.

Helen McKenna is a senior policy adviser at The King's Fund and, as a generalist, her role spans the Fund's policy and communications functions and involves identifying, analysing and communicating emerging policy issues as well as advising on their implications.

Before joining the Fund, Helen was principal policy adviser on health and social care at Which?, where her work included campaigns to improve the transparency of dental charges and to make it easier for people to complain about public services.

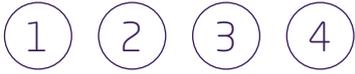
Helen also worked at the Department of Health as a fast-stream trainee and then as a manager. Her roles at the Department included working on the Health and Social Care Act reforms, leading a review of the NHS Constitution and developing a programme of collaboration on health matters between China and the UK.

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Sustainability and transformation plans (STPs) have been developed in 44 footprints across England, with the aim of transforming care in line with the *NHS five year forward view*. But can the proposals in STPs be delivered?

Delivering sustainability and transformation plans: from ambitious proposals to credible plans looks in detail at the content of the 44 STPs and the opportunities and challenges for implementation.

The report finds that:

- STPs are wide-reaching and cover a number of themes - from prevention through to acute and specialised services
- a high priority for many STPs is to redesign services in the community to moderate demand for hospital care
- proposals in the 44 STPs need to be developed into coherent plans, with clarity about the most important priorities in each area.

The authors argue that STPs offer the best hope to sustain and transform the delivery of health and care services. Key aspects of the plans require stress-testing and a more realistic timetable should be adopted for implementation. Earmarked funding will also be needed to support transformation. But the government should reiterate its commitment to STPs where the case for change has been made.

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