Royal College of Physicians

Sustainability and Transformation Plans (STPs)

What do they mean for physicians?

Summary

- STPs are variable in detail and transparency, but overall the plans are very similar in their main themes.
- The STPs as published should be seen as works in progress by both the authors and those affected by them. There are still opportunities for secondary care clinicians to engage with the development of their local plan, and the RCP strongly encourages all of our members to get involved in order to shape the future of healthcare delivery.
- All plans support the principles described in the RCP's report *Future hospital: Caring for medical patients*. These include making public health and prevention a priority, moving care closer to the patient, reducing variation in hospital healthcare, and ensuring close links between social care, primary care and secondary care.
- The financial efficiency savings planned will be challenging. The median financial gap for healthcare is £320 per person in the STP's population (range £215–608) and the median financial gap for social care in the 29 STPs that have assessed this is £102 per person (range £28–233).
- Reliance on Sustainability and Transformation Fund (STF) monies in financial plans is high, with a median proportion of 19% of the financial gap for 2020/21.
- Shortages in all areas of the health and social care workforce will need to be addressed. Most plans rely on expansion of GP-led services to reduce acute sector demand and manage care closer to home. Engagement with GPs and improvement of GP workforce issues are therefore critical to STP success, and there is variable evidence in the plans for this.
- There is lack of evidence for meaningful engagement with the social care challenge in some STPs, which is concerning for those plans.
- Planned reductions in urgent and emergency care (UEC) measures, when given, are very optimistic. Accident and emergency (A&E) attendance reductions of 2–36%, non-elective admission reductions of 7–30% and bed reductions of 9–37% are proposed. Such reductions, while laudable, seem highly aspirational and should be viewed with scepticism.
- Evidence of secondary clinician engagement within the plans is very patchy. This will make implementation much more difficult than needed. The RCP is happy to help to improve engagement through its communications and networks. STPs also need to engage effectively with patients and the public.

The origin of STPs

Sustainability and Transformation Plans (STPs) were announced as part of NHS England's NHS planning guidance 2016/17 – 2020/21. Along with the government's mandate to NHS England for 2016–17, these documents created a new funding environment for NHS providers that aims to achieve collaboration rather than competition. To receive funding, providers have to demonstrate that they have worked with each other, commissioners, the public and local authorities to create plans that will address the three gaps identified in the NHS *Five year forward view* (5YFV):

- health and wellbeing
- care and quality
- finance and efficiency.

As a result, over the past year 44 STPs have been produced across England, covering populations from 330,000 to 2.8 million.

STPs were published in draft form in June 2016, and in a more final form in November 2016. However, all STPs are still required to go through a process of assessment, engagement and further development.

The nine 'must-dos' of 2016/17

As part of operational planning for 2016/17 (and to receive funding), providers and commissioners had to demonstrate success in the following nine 'must-dos', and these are thus integral to the STPs.

- Develop and agree an STP.
- Achieve financial balance using efficiency improvements as described by the Carter review, reducing variations as demonstrated in NHS RightCare reports, and reduce agency and locum spends.
- Develop a local plan for general practice, including workforce.
- Achieve 95% standard for 4-hour A&E waits; improve ambulance and other UEC targets.
- Achieve 92% for 18-week rate for non-urgent referrals.
- Achieve 62-day targets for cancer referrals and improve 1-year survival rates.
- Achieve the two mental health access targets.
- Develop local plans for people with learning difficulties.
- Improve quality of care, especially with respect to avoidable mortality.

These nine 'must-dos' are therefore the new key performance indicators for local healthcare organisations and so are priorities for clinical commissioning groups (CCGs) and hospital managers.

Sustainability and Transformation Fund (STF)

NHS England has a pot of funds available to support STPs, called the Sustainability and Transformation Fund. The STF is significant, at around £3.8 billion for 2020/21 or around £50–100 million per STP. This is made up of a small amount of NHS England funding for transformation, and a much larger amount for sustainability. The funding for sustainability is controlled by the Treasury, Department of Health, NHS Improvement and NHS England. This is important, as funds will only be released to providers if they can demonstrate three key achievements:

- financial deficit reduction

- improvement in access targets, especially regarding UEC
- progress with developing the STP.

The STF is crucial for the successful implementation of STPs, for two reasons. Firstly, it provides a fund to support transformation above current funds (successful transformation requires initial investment). Secondly, it forms a significant part of almost all STP financial recovery plans: if the access targets are not met, STF monies will be withheld and the STP will probably fail. Plans where STF monies form a significant part of the solution are therefore at higher risk than those STPs where STF monies are seen as an enabler.

A more detailed explanation of the origin of STPs and the STF has been produced by the King's Fund.

Review of individual STPs

The STP documents for each footprint are publicly available. The NHS England STP page contains many out-of-date links, but links to the latest documents (October–November 2016) can be found on the RCP website.

Many STPs are clear that their published plans are part of ongoing programmes and will undergo further development. Almost all contain reasonably detailed financial plans, and many use the same methodology to assess need for change and propose similar solutions to achieve their aims.

Many themes arise from review of the 44 STPs, allowing some assessment of whether these plans are realistic.

Financial plans, social care funding and the STF

Financial efficiencies are a key driver for STPs; however, improvements in care quality and population health can only be made with a financially stable health and social care system. Any STP that looks unable to balance its books will not receive all of its STF monies and will be unable to deliver the services that it sets out to achieve.

The 44 plans do not make it easy to compare financial risk and mitigation. Many contain 'waterfall' and 'bridging' diagrams, showing the causes of the financial gap between income and spending and the proposed solutions to this. Most of these have actual figures attached to them, but some do not. Most describe the 'do-nothing gap', which is the financial deficit that will be accrued in 2020/21 if action is not taken. One important technical point that may be missed is that these plans are all very reliant on stable interest rates for their calculations. They are therefore dependent on the national economy remaining in its current state; this is a substantial risk, given international events over the past year.

The financial plans also vary between STPs, as some clearly include planning for a social care financial gap (adult but not always children's services) as well as looking at the current combined health and social care gap. This makes comparing plans extremely difficult, as they contain a 'health gap', a 'social gap' and a 'total gap' in varying combinations. Furthermore, the wide variation in population size means that comparing absolute amounts is meaningless.

Forty-three of the STPs give a 'health gap' and thus a gap per member of the population. Figures for populations are given in many plans, but not all. These figures often differ from the population figures given on the NHS England STP pages. The median value for this gap is £320 per person (range £215–608).

Twenty-nine of the STPs include a 'social gap' and the median value for this is £102 per person (range £28–233). One STP (Devon) only gives a total gap and has very little financial information in the plan.

The wider variation in the social care gap shows the difficulties in calculating this value, but also the importance of engagement with social care as part of the STP. Those STPs that have not specifically looked at social care may well fail, as the two systems are utterly dependent upon each other when it comes to planning acute and community services.

As stated, above use of STF monies is key to the success of the financial model of many of the plans. Not all plans give a clear figure for STF monies, but 36 out of 44 do. The median proportion of the health gap that the STF will make up is 19% (range 10–32%). It seems likely that those plans which place a heavy reliance on the STF are more likely to fail, as this is dependent upon the targets set (especially UEC targets). Those plans that do not give an STF value may be no better or worse than those that do. Omission may suggest that the plan does not rely on any STF monies, but this seems unlikely.

A summary of these financial measures for the different STPs is given in Table 1 below.

STP format

Most of the STPs are similar in their layout and proposed working. Typically, an STP will include the following information.

- An executive summary, including a 'plan on a page' diagram.
- The case for change or the need for change. This usually addresses the needs of the local population based on the three 5YFV gaps. Information given usually includes:
    - data on public health issues, early mortality, social care aspects (the health and wellbeing gap)
    - variation from national targets and standard for condition- and site-based metrics (the care and quality gap). NHS RightCare is often used as a data source and the standards by which success will be measured
    - financial modelling of the 'do-nothing' scenario.
- The priorities of the plan, usually including:
    - focus on care closer to home and community/primary care models
    - UEC models and acute services pathway reconfiguration
    - cancer services
    - mental health and learning disability
    - specialised commissioning.
- The enablers of the plan, including digitisation, workforce and estates.
- Engagement and communication plans.
- Governance structures.
- Appendices with further detail, particularly around financial planning.

Primary and community care

All the plans rely on an improved primary/community care model and many reference *General practice: Forward view*. Some plans acknowledge that expansion in the number of GPs is unlikely, given current recruitment problems, and consider other parts of the workforce that might meet the primary care workforce need. However, it seems that the success of most of the plans relies on GP-coordinated services to prevent admissions to higher levels of care. The GP workforce crisis represents the second biggest challenge to the success of the STP programme.

Models of care

The principles outlined in the STPs fit well with the recommendations of the RCP's Future Hospital Commission report and, as such, are fully supported by the RCP. Several STPs also have vanguard programmes already underway, either MCPs (multispecialty care providers) or PACS (primary and acute care systems). These are used as evidence of collaboration and success. However, it is important that the transformation of the current care models towards the vision of care described for the future is done in an achievable way. The financial modelling requires change 'at pace' and 'at scale'. It is difficult to see how monies required by the current system will be freed up to support the new systems without the current system collapsing.

Collaboration between STPs

Almost all of the STPs have aspects that are to be commended and are best practice. Some of these are novel and should be replicated in other STPs if successful. The STPs should therefore be seen as iterative, and it is crucial that learning is shared between STPs. Some STPs clearly state that they will work with neighbouring STPs to ensure success. However, some view themselves in isolation and will rely on patients and healthcare systems respecting boundaries that may only exist on the footprint map.

Urgent and emergency care (UEC) models and targets

UEC is a key theme of most STPs for the following reasons.

- The reliance on achieving UEC targets to obtain STF monies.
- Reduction in non-elective activity should result in reduced acute sector bed needs and thus reduce costs.
- UEC targets are easy to measure and thus a simple set of metrics for the 'success' of the STP.
- All STPs describe an increase in UEC activity over recent years and the pressures that this has placed on their local healthcare system.

Estimated reduction in A&E attendances in the plans varies from 2 to 36%, and reduction in non-elective admissions (NEL) from 7 to 30% (Table 2). Given the inexorable rise in both of these over the past 15 years (around 50%), some of these predictions seem rather optimistic and are unparalleled in the history of the NHS. Furthermore, the success of the plans relies on such reductions to reduce bed usage. The use of hospital beds is a recurrent theme, with some STPs stating that 25–50% of hospital beds are used by patients who do not need to be there.

Few of the plans give specific targets for reduction in beds. Those that do cite between 9% and 37%, based on current and future 'do nothing' bed usage/requirements. These will be achieved by reduction in NEL by prevention, better management of long-term conditions and improved care in the community. The historical reduction in NHS beds has been 25% over the past 15 years, so these targets seem very aspirational. It should be noted that some of those STPs that do not provide bed reduction predictions have more ambitious UEC targets than those that do.

It is appropriate to plan to reduce these UEC targets, but closing hospital beds to free up funding to support models of care not yet in place will be potentially disastrous. STPs need to have clear transition plans in place.

Engagement

All of the plans acknowledge the need for engagement with the public and the current system, although the evidence that clinicians in secondary care have been involved to this point is very thin. Most clinicians do not know what an STP is, and it is vital that STP leads engage with all parts of the healthcare workforce to produce locally created plans with buy-in. The RCP is happy to support this engagement with our members and fellows in any way that we can.

Conclusion

The need for wide-scale system change in the health and social care system is obvious and supported by the RCP. STPs present well-evidenced cases for change, and propose novel and appropriate methodologies for achieving this. However, the pace of change required and the financial expectations are extremely challenging. Some STPs are more likely to succeed than others, based on financial risk, engagement, UEC targets and the scale of change needed.

Dr Andrew Goddard
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Table 1: Financial descriptors for the 44 STPs

Figures are accurate as of 30 January 2017.

STP	Healthcare gap (£ per person)	Social care gap (£ per person)	STF as proportion of plan (%)
Cheshire and Merseyside	353		
Durham, Darlington, Teesside, Hambleton, Richmondshire and Whitby	258		15
Greater Manchester	320	63	19
Humber, Coast and Vale	300		
Lancashire and South Cumbria	336	76	
Northumberland, Tyne and Wear and North Durham	377	155	10
South Yorkshire and Bassetlaw	309	71	
West, North and East Cumbria	509		15
West Yorkshire and Harrogate	311	102	
Bedfordshire, Luton and Milton Keynes	368		19
Birmingham and Solihull	448	100	15
Cambridgeshire and Peterborough	560		11
Coventry and Warwickshire	297	37	24
Derbyshire	215	108	32
Hereford and Worcestershire	323	108	20
Hertfordshire and West Essex	284	108	25
Leicester, Leicestershire and Rutland	334	57	19
Lincolnshire	236		29
Mid and South Essex	358	167	18
Norfolk and Waveney	317	99	22
Northamptonshire	329		21
Nottinghamshire	455	149	15
Shropshire and Telford and Wrekin	279		10
Staffordshire	260	233	15
Suffolk and North East Essex	261		
The Black Country	366	134	19
North Central London	608		12
North East London	304	125	24
North West London	535	143	13
South East London	549	142	14
South West London	453	99	15
Bath and North East Somerset, Swindon and Wiltshire	270	54	26
Bristol, North Somerset and South Gloucestershire	315		20
Buckinghamshire, Oxfordshire and Berkshire West	266		22
Cornwall and the Isles of Scilly	446	82	17
Devon			
Dorset	305	49	23
Frimley Health	249	65	25
Gloucestershire	306	58	21
Hampshire and the Isle of Wight	321	107	21

STP	Healthcare gap (£ per person)	Social care gap (£ per person)	STF as proportion of plan (%)
Kent and Medway	242	28	23
Somerset	313		21
Surrey Heartlands	531	193	12
Sussex and East Surrey	384	125	
Median	**320**	**102**	**19**

Table 2: Urgent and emergency care, elective and outpatient reduction targets

Figures accurate as of 30 January 2017.

STP	Bed reduction (%)	A&E attendance reduction (%)	Non-elective admission reduction (%)	Outpatient reduction (%)
Cheshire and Merseyside				
Durham, Darlington, Teesside, Hambleton, Richmondshire and Whitby		23	23	20
Greater Manchester				
Humber, Coast and Vale				
Lancashire and South Cumbria				
Northumberland, Tyne and Wear and North Durham		17	15	10
South Yorkshire and Bassetlaw		15		
West, North and East Cumbria				
West Yorkshire and Harrogate		16		
Bedfordshire, Luton and Milton Keynes				
Birmingham and Solihull	15	25	17	
Cambridgeshire and Peterborough				
Coventry and Warwickshire		12	10	6
Derbyshire	37			
Hereford and Worcestershire	12			
Hertfordshire and West Essex				
Leicester, Leicestershire and Rutland	13	36		
Lincolnshire		10	28	21
Mid and South Essex		10	13	16
Norfolk and Waveney		20	20	
Northamptonshire		20		
Nottinghamshire			6	10
Shropshire and Telford and Wrekin		9		
Staffordshire		23	30	
Suffolk and North East Essex		11	7	
The Black Country				
North Central London		33	26	
North East London				20
North West London				

STP	Bed reduction (%)	A&E attendance reduction (%)	Non-elective admission reduction (%)	Outpatient reduction (%)
South East London				
South West London		10		
Bath and North East Somerset, Swindon and Wiltshire				3
Bristol, North Somerset and South Gloucestershire		30	30	15
Buckinghamshire, Oxfordshire and Berkshire West				
Cornwall and the Isles of Scilly				
Devon				
Dorset	36	25	20	
Frimley Health				
Gloucestershire				
Hampshire and the Isle of Wight	9	16	10	8
Kent and Medway	28	13	16	12
Somerset				
Surrey Heartlands		2		
Sussex and East Surrey		11	7	
Median	**15**	**16**	**16**	**12**