

Can Simon Stevens' Sustainability and Transformation Plans save the NHS?

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Introduction

Predictions that the NHS is facing disaster have been issued so often that people no longer pay much attention. This time there is unanimity. Even normally government-friendly experts are in agreement, and for good reasons.¹

Since 2010 the NHS budget has been almost static, while the UK population has increased by two and a half million and is predicted to grow by 440,000 a year over the next ten years, with a growing proportion living longer and having more long-term illnesses.² So it is no surprise that NHS hospitals in England look likely to have overspent their 2015-16 budgets by £2.5bn and that even so care quality is now seriously declining. There is also an acute shortage of GPs;³ CCGs are announcing cuts in the range of treatments they will pay for;⁴ waiting times for treatments, including for cancer, are rising;⁵ hospital wards are understaffed;⁶ beds are also unavailable because too many are occupied by patients who can't be discharged because of cuts to social care provision.⁷ And Monitor has told seriously overspent trusts to 'reduce their headcount'.⁸ The Kings Fund normally gives cautious support to government policy but on 7 April its Chief Executive, Chris Ham, finally broke with precedent and in effect told the government it was in denial in maintaining that services can be maintained and even improved when funding per patient is already too low and is planned to drop fairly rapidly over the next five years:

NHS leaders have never felt this target was credible and are now wondering when the emperor will be seen to have no clothes. Many feel as if they are living in a parallel universe in which they are striving to sustain existing services in conditions of adversity while politicians promise improvements in care that cannot be delivered with available resources.⁹

NHS England's response

In other words, without a major increase in funding the NHS as it presently operates cannot continue; but a major increase in funding is ruled out by the government's austerity strategy, and most of the practicable savings from salary freezes, delayed maintenance, etc, have already been made.¹⁰

In response the Chief Executive of the NHS in England, Simon Stevens, has proposed (a) major improvements in disease prevention (or health promotion) and (b) a radical transformation in the way health services are organised, in the belief that this can make services better as well as cheaper, improving productivity by as much as 3% a year by 2020-21. His 2014 paper, *A Five Year Forward View (FYFV)*,¹¹ estimated that

to maintain services of the same quality as in the past, by 2020-21 the NHS in England would need £30bn a year more than the government was planning to give it. (The basis of the predicted gap has been questioned, but not in a way that suggests it has been overestimated – it could even be greater.)¹² In November last year Stevens got Mr Osborne to agree to provide £8bn of the £30bn a year needed by 2020-21, with some of the increase coming early enough to cover the cost of adopting the ‘new models of care’ on which the hoped-for productivity improvements depend, and which are currently being trialled at 50 ‘vanguard’ sites around England.¹³ The remaining £22bn per annum gap predicted for 2020-2 was to be closed largely by these improvements.

Until the experiments have had time to be tested and evaluated we can’t know whether they are really capable of improving (or even maintaining) care quality while also saving major sums of money, let alone within five years. To judge from Chris Ham’s intervention, even sympathetic experts don’t think they are. ‘There is now no prospect’, he writes, ‘that efficiencies on this scale can be achieved by 2020/21.’ He thinks that much of the ‘front loaded’ £8bn new money extracted from Mr Osborne and intended by Simon Stevens to pay for costs of shifting to new models of care will be swallowed up in paying off deficits. Moreover it is not clear that the ‘vanguards’ which are trying out new forms of integration between primary, secondary and community health care – and in some cases also social care – are being independently evaluated. And there is no prospect that new measures to prevent ill-health could have a significant impact in reducing the need for health care by 2021, even if the government were to adopt them as a matter of urgency, which it so far shows little sign of doing.

Sustainability and Transformation Plans

But since, without a radical change in the government’s austerity policy, services are threatened with collapse, it is easy to see why most people in the health policy-making circuit initially supported Stevens’ strategy. Now, however, they are being asked to put their money where their mouths are and implement his central idea, in an extraordinary exercise in collaboration outside and across the unreformed but discredited apparatus created by the 2012 Health and Social Care Act. NHS England’s document, *Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21*, published just before Christmas last year, calls on ‘local health systems’, consisting of ‘clinicians, patients, carers, citizens, and local community partners including the independent and voluntary sectors, and local government through health and wellbeing boards’, to ‘work together to develop robust plans to transform the way that health and care is planned and delivered for their populations’.¹⁴

For this purpose England has been divided into 44 ‘local health systems’, each of whose ‘footprints’ covers, on average, 1.2 million people, three or four local councils and some 5 CCGs.¹⁵ Each of these ‘local health systems’ is called on to produce, by

the end of June this year, a Sustainability and Transformation Plan (STP) covering the next five years.

The first requirement is that CCGs and providers must – somehow – cut their expenditure and stay within their budgets in 2016-17; and then, by keeping all providers' books balanced for the following four years, and by making satisfactory responses to a long set of questions set out in the guidance, local health systems can earn access to centrally-controlled 'transformation' funding which will allow them to make changes to service delivery while 'maintaining and improving' patient safety and quality over the years 2017-21. The incentive to comply is that local health systems whose STPs fail to secure an overall financial balance in 2016-17, or which fail to meet enough of the other requirements spelled out for them, will not get any transformation funding – which will from now on be the only additional funds available.

What this has meant for many trusts, according to one hospital trust finance director, is pressure to manipulate their accounts to appear to be in financial balance, or at least facing a lower deficit than they really are, because Sustainability & Transformation funding would be given only to those trusts that agreed to meet the control total and other conditions including access targets. In evidence given to the Public Accounts Committee in February he or she stated that

My own organisation has been working hard on its draft 2016/17 plan since October 2015 and we predict a sizeable deficit for 2016/17. But, the regulator's control total is for a deficit some £5-10million lower than what the Board currently considers it can realistically and, more importantly, safely achieve... The regulators have provided no explanation as to how they arrived at their control total for my Trust... I have already been in contact with the FDs of almost a dozen other acute trusts, all of whom have "control total" gaps in their draft 2016/17 plans of between £5m and £20m. My real concern is that Boards are being pressurised into accepting a 2016/17 control total that they do not yet have plans to achieve.¹⁶

As for the questions STPs have to answer, they come in a form that makes it clear that not doing what they call for is not an option. Not all of the measures look like an improvement in care so much as ceasing to offer it (for example: 'How will you achieve a step-change in patient activation and self-care? How will this help you moderate demand and achieve financial balance?') or transferring work to unpaid family carers ('How will your area ensure that people with learning disabilities are, wherever possible, supported at home rather than in hospital? How far are you closing out-moded inpatient beds and reinvesting in continuing learning disability support?'). But many of the new service models look sensible, indeed obvious, and especially those that envisage a future that, in the words of the *Five Year Forward View*,

dissolves the classic divide, set almost in stone since 1948, between family doctors and hospitals, between physical and mental health, between health and social care, between prevention and treatment. One that no longer sees... services fragmented, patients having to visit multiple professionals for multiple appointments... organised to support people with multiple health conditions, not just single diseases. A future that sees far more care delivered locally but with some services in specialist centres where that clearly produces better results (*FYFV* p. 7)

But how far these aims can be achieved by new models of service delivery that also reduce expenditure is open to serious question. The guidance makes it clear that saving money is now primary – as the King’s Fund puts it, the post-Francis era of concern for quality and safety is over. But STPs must also contain proposals for improving care; yet even the King’s Fund says that ‘It is inconceivable that the NHS will be able to achieve both financial sustainability and large-scale transformation within these financial constraints’.¹⁷ The demands made also sometimes seem absurd, given the limited powers and resources available at local level and the lack of a correspondingly serious policy at the national level (e.g. ‘What action will you take to address obesity, including childhood obesity?’). There are in all 60 such questions (including sub-questions).

Moreover the idea that the diverse collection of local organisations and people who make up a ‘local health system’ can together produce – by the end of June – practicable plans that offer meaningful answers to even half of these questions seems so unrealistic as to almost make one wonder whether it is seriously meant. After all, ‘local health systems’ are not in fact systems. No legal or other structures link the organisations and individuals involved, there are no procedures for determining how disagreements are to be resolved, they largely lack planning expertise, and all the people who are expected to collaborate in producing STPs already have heavy workloads. And while the six organisations that have jointly issued the guidance (NHS England, NHS Improvement [Monitor and the NHS Trust Development Authority], Health Education England, NICE, Public Health England, and the CQC) presumably have the power between them to require the local NHS bodies concerned to do all the things asked of them, this does not apply to local councils, which are responsible for social care and are also included in the ‘local health systems’. Councils can no doubt be leant on by the Department for Communities and Local Government, but the whole process has a markedly extra-legal character.

The fact that ‘local health systems’ are now being given ‘guidance’ (which was code for ‘instruction’ inside the pre-2000 NHS) also signifies what was already clear from the *FYFV*, that improvement is no longer expected to result from competition between providers in a market (competition is not mentioned), but from CCGs, providers and local authorities responding to orders from the centre. The same point is clear from the fact that all NHS foundation trusts as well as trusts are now to be subject to ‘financial control totals’ managed by the DH and the Treasury as a condition of having access to any additional funding – definitively abandoning the

idea, which has been central to government thinking since 2003, that they are independent businesses.

Rather than acknowledging that that idea has failed comprehensively, and amending the law, the government has chosen to leave the Act's dysfunctional structures unchanged and give 'localities' the task of dealing with the contradiction between its rhetoric of improvement and the increasingly inadequate NHS budget. This means that the resulting decision-making is governed by no statutory rules: it is not clear who will be accountable for the results in terms of service provision, or the accompanying redeployments of public funds, or the conflicts of interest and opportunities for fraud which the process is liable to generate. As a minimum the process needs to be made open and accessible in a way that doesn't so far seem to be provided for in the STP arrangements. Who is participating in each 'local health system', who they represent, how they are reporting back, where a record can be found of the meetings held and decisions reached - this information at least should surely be systematised and made public if the process is to be considered in any way democratic. Independent published evaluations are also needed of what the various new models of care have achieved in practice, in terms of both patient care and productivity gains.

Conclusion

Of course we are where we are, and perhaps sceptics will have a pleasant surprise, with the NHS emerging in 2020-21 transformed and improved, however unlikely it seems. But where we are is the result of political choices. One of these choices is to spend some two and a half percentage points less of our GDP on health than comparable European countries— 8.5%, compared with France's 10.9%, Germany's 11.0%, the Netherland's 11.1%, and so on.¹⁸ This is a huge difference. Matching these countries' present commitment to their health services would already mean an additional £40bn a year for the NHS¹⁹. As Chris Ham points out, we are now almost back to the level of spending we were at before Tony Blair's 2000 commitment to catch up with the European average.

The first aim of the new planning process is 'sustainability', but what is truly unsustainable in the long run is providing a first-class health service on a third class budget. And the decision, on top of this, to be spending only £8bn a year more on the NHS in England five years from now, in the interest of shrinking the state, is another political choice, which has less and less support even among mainstream economists.

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- ¹⁰ NHS England nonetheless expects a significant part of the savings needed by 2021 to come from further 'pay restraint' (http://www.hsj.co.uk/newsletter/topics/finance-and-efficiency/nhs-england-reveals-breakdown-of-22bn-savings-plan/7004629.article?WT.tsrc=email&WT.mc_id=Newsletter308). Whether this is compatible with maintaining safety and quality standards may be doubted.
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