

# Sustainability and Transformation Plans: Five key questions for planners

Vivek Kotecha

*Staff?*

*Social care?  
Public health?*

*Beds?*

*Quality of care?*

*Elective care?*



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## About the author

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He previously worked as a manager in Monitor and NHS Improvement analysing and reporting on the operational and financial performance of the provider sector. Prior to that he worked as a management consultant at Deloitte for 4 years. Vivek holds a BSc Economics (Hons) from the LSE and is a chartered accountant. He is currently studying for a MSc Economics at the University of London.

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## Introduction

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1. Across England 44 Sustainability and Transformation Partnerships have been tasked with transforming the provision of NHS services in their local areas, as part of the plans for closing the NHS's unprecedented 'funding gap'.<sup>1</sup>
2. Each Partnership is charged with producing a 'Sustainability and Transformation Plan' (STP) for an average population of about 1.25 million.
3. There is no legal basis for the joint planning between the different organisations in the NHS and local government that are involved in the planning process. In reality it has been centrally-driven and heavily reliant on expertise provided by outside consultants.
4. The plans have been produced under extreme time pressure. NHS England first called for them in December 2015, to be submitted by the end of June 2016.
5. By 2016 the degree of NHS underfunding had become even greater than originally foreseen. The Department of Health (DH) tightened its control of NHS finances, obliging both providers and CCGs to eliminate their overall sector deficits by 2017-18 and stay within their budgets every year thereafter. This means that if STPs do not prove realistic and feasible patients will face declining or even failing services.
6. Most STPs involve reducing the growth in hospital bed numbers, or even closing beds, and increasing the number of staff working in non-hospital or community settings; changing the numbers and skill sets of NHS staff; changing the way non-emergency care is accessed; and relying on prevention and self-care to reduce the need for hospital beds.
7. For each STP, five key questions need to be asked:
  1. Will there be enough staff with the right skills?
  2. Will there be enough beds?
  3. Will there be good access to non-emergency (elective) care?
  4. Will NHS care still be good quality care?
  5. Will NHS care be effectively complemented by social care and public health measures?

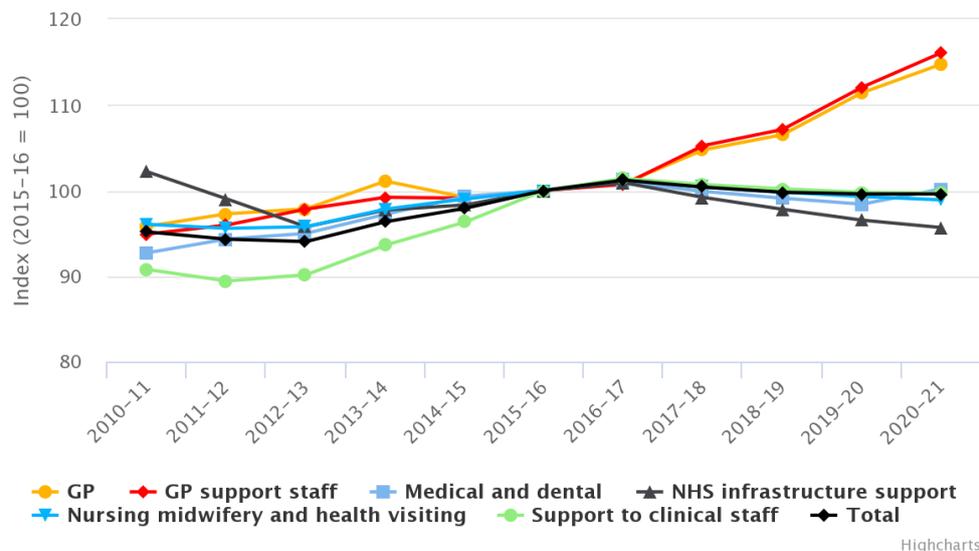
<sup>1</sup> The funding gap is currently taken to be the difference between the amount of money the NHS is projected to need each year up till 2020/21 and how much the government is planning to provide it with. This annual gap rises year on year, reaching £22bn by 2020/21. For a detailed analysis see *The Five Year Forward View: do the numbers add up?* at <https://chpi.org.uk/wp/wp-content/uploads/2017/05/CHPI-5YFV-May17.pdf>

# 1. Will there be enough staff with the right skills?

## The right number

8. With staff costs making up around a third of total health spending (and two-thirds of hospital expenditure) there is pressure on STPs to at least curb their growth, and if possible cut them.<sup>1 2</sup> An analysis by the *Health Service Journal* (HSJ) of the workforce plans that were available in January 2017 for eleven of the 44 STPs showed a planned reduction of 1.6% in total staff, with a 2.3% fall in ‘nursing, midwifery and health visiting staff’.<sup>2</sup> The sample included more than one plan from each of the NHS’s four regions, and a mix of urban and rural areas. If the pattern in these eleven STPs was repeated in the other 33 it would mean a reduction of 17,300 staff across England, and 7,300 in nursing, midwifery and health visiting. On the other hand, in accordance with NHS 5YFV’s aim of shifting health care from hospitals into the community, these STPs envisaged a 13.8% increase in the number of GPs, and a 15.3% increase in GP support staff (see Figure 1).<sup>3</sup> This implies a shift in the demand for healthcare workers over the coming years. A number of STPs also plan to cut the number of registered nurses and replace them with more GPs, GP support workers, and Advanced Nurse Practitioners.<sup>4 5</sup>

Figure 1. Projected change in staff needs in eleven STPs.<sup>2</sup>



Source: Health Services Journal

9. Despite the apparent aim of cutting nursing posts in hospitals there is uncertainty over whether this will happen in practice. NHS Improvement’s director of nursing, Ruth May, has called workforce planning the weakest part of the plans because they don’t demonstrate that there will be sufficient staff to maintain patient care and

<sup>2</sup> All measured in Full Time Equivalentents (FTE)

deliver the new healthcare structure.<sup>6</sup> STPs are acknowledged to be still in formation rather than finalised, but it is clear that staffing will be an issue, whether it is maintaining, or even cutting, existing numbers, especially of nurses, or increasing the number of GPs and GP support staff. All of the plans must also reckon with the government's commitment to 7 day NHS services, which will need more staff to deliver.

### **Nurses**

10. In 2015 there were 30,818 vacancies (an 8.9% vacancy rate) for nursing and midwifery staff in England, and 7,497 vacancies (an 8.9% vacancy rate) for allied health professionals (e.g. paramedics, dieticians, occupational therapists).<sup>7</sup> These vacancies are likely to persist over the coming years. The adoption of stricter minimum income thresholds for visas for workers from outside the European Economic Area has reduced the number of nurses recruited from outside the EEA from 12-15,000 a year in the 2000s to just 665 in 2014/15,<sup>8</sup> whilst nurses from within the EEA can't be relied upon as a long-term solution: the *Nursing Times* found that that 28% of overseas nurses recruited in 2012/13 left within two years.<sup>9</sup> More worryingly there has been a drop of 96% in the number of nurses from the EU registering to practice in the UK from July 2016 to May 2017.<sup>10</sup> Meanwhile the number of nurses leaving the profession overall has been rising each year, with the majority attributed to turnover and not retirement.<sup>7</sup>

11. To help meet the predicted rising demand for nurses and midwives (up 4.9% to 363,965 by 2020) Health Education England (HEE), which leads and coordinates health education and training nationally, is planning to increase the number of nursing places ('commissions') over the coming years, a reversal of the cuts in the numbers trained from 2010 to 2013.<sup>7</sup> But as it takes three years to train a nurse, while rising numbers are leaving the profession, it seems more likely than not that the numbers needed to meet the needs set out in the STPs will not be there. Recognising this, HEE has created a new 'Nursing Associate' (NA) role to support nurses and healthcare assistants by taking on less complex tasks. The expectation is that 1,000 NAs will begin a two-year training in 2017.<sup>11</sup> In theory, their role will be to support nurses, but there have been some fears that they will end up taking on nursing responsibilities that they have not trained for if the staff shortage continues.<sup>12</sup>

### **Doctors**

12. An estimated 13,500 consultants and GPs will retire in the 5 years to 2019, which is expected to create a shortage of GPs in particular.<sup>13</sup> Part of this shortage has been caused by bad planning: in 2012 the government decided to reduce medical training places by 2% a year for fear of an oversupply.<sup>14</sup>

13. Until now much of the growing demand for doctors in England has been filled by doctors trained abroad. Thirty-three per cent of registration applications in 2015 were made by doctors from overseas.<sup>15</sup> This may not continue after Britain leaves the EU if immigration restrictions tighten or the UK becomes less desirable a place to work. The government announced last year that it would fund an additional 1,500 medical school places, but these doctors won't graduate until 2023/24, whilst shortages exist

now.<sup>16</sup> Furthermore, only 52% of last year's medical graduates chose to stay in the health service - the lowest proportion ever recorded.<sup>17</sup>

14. To help increase the NHS's ability to provide care outside hospitals the government has committed to providing an additional net 5,000 GPs by 2020 (a 15% increase on the 2015 workforce)<sup>3</sup> and an additional minimum of 5,000 other primary care staff to support them, such as mental health therapists, clinical pharmacists, physician associates and general practice nurses.<sup>18 19</sup> But the NHS is already facing difficulties in recruitment, with 10% (975) of GP training roles unfilled from 2014/15 to 2016/17, 5.3% of GPs permanently leaving the profession each year, and a preference for part-time work by the increasingly female and salaried GP trainee workforce.<sup>20</sup>

15. Given the uncertainty over the supply of doctors, plans such as those in the eleven STPs analysed by the HSJ, to increase the number of GPs by 13.8%, seem optimistic. This has been recognized and the number of 'Physician Associates' will be expanded, with 200 being recruited from the US for hospital trusts in London, and others being trained by UK universities.<sup>21</sup> Physician Associates receive 2 years of postgraduate training to take medical histories, diagnose illnesses, carry out examinations, analyse test results and develop management plans. Whether sufficient Physician Associates can be recruited and trained to provide the projected 15.3% increase in the number of 'GP support staff' (see Fig. 1 above) is questionable.

### *The right skills*

16. Concerns have been raised about patient safety in relation to the new roles of Nursing and Physician Associates. Nursing Associates will be professionally regulated by the Nursing and Midwifery Council (NMC), while Physician Associates remain an as yet unregulated profession.<sup>22</sup> The concern is that unless rigorous professional standards are laid down and enforced, staff shortages will lead to these new kinds of staff increasingly substituting for the work of registered nurses and doctors, rather than complementing them, as envisaged in the plans. This would pose risks to patient safety. A 2016 study covering hospitals in England and five other European countries has found that 'substituting one nurse assistant for a professional nurse for every 25 patients is associated with a 21% increase in the odds of dying',<sup>23</sup> and highlights the risk of substituting less highly skilled staff for more skilled staff without first testing the change in small and long-term pilots, which the STPs cannot afford to do given the limited time left until 2021.

17. Moreover the time period for the existing NHS workforce to adjust to the envisaged new roles is short. NHS staff are already overworked and stressed, with staff sickness rates 27% higher than in any other public sector organizations, and 39% of cases citing stress and overwork as the causes.<sup>24</sup> It is hard to see how existing nursing and medical staff will have time to train Nursing and Physician

<sup>3</sup> Full time equivalent (FTE) workforce excluding locums

Associates whilst also caring for patients and supervising trainee doctors and nurses. And in January-March 2016 the sickness absence rates for Healthcare Assistants and Other Support Staff (a similar band to the new Associates) were the highest of all staff categories, with an average of 6.5 per cent.<sup>24 25</sup>

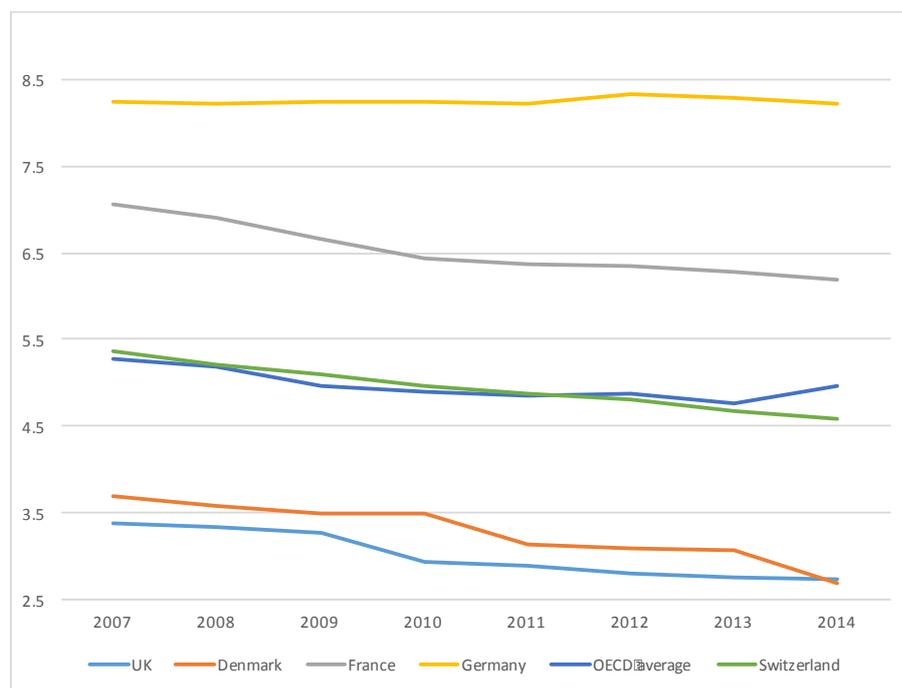
## 2. Will there be enough beds?

18. The projections of savings from reductions in the required number of beds are generally based on the assumption that the current number of beds is sufficient to meet current needs, and that there will be little or no further growth in the need for beds due to more care being provided outside hospitals. Eight STPs have gone further and proposed an actual reduction in existing bed numbers, for a combined loss of 2,000 beds. But where closing existing beds is not judged clinically or politically acceptable savings are sought from reducing the skill level of the staff responsible for them, most commonly by changing obstetrician (doctor)-led maternity wards to midwife-led wards; or by not building beds that would otherwise be needed due to population growth and ageing. The latter savings can be large: in East London the planners estimate that if no change is made in the way services are currently organized, 550 additional inpatient beds will be needed by 2025, which would cost £250m a year to provide, not counting the cost of building.<sup>26</sup>

### *Current bed numbers*

19. As in most comparable countries, hospital bed numbers per thousand population in the UK have fallen steadily over many years, but as Figure 2 shows, the UK ratio is amongst the lowest in the OECD.

Figure 2. Total hospital beds per 1000 population



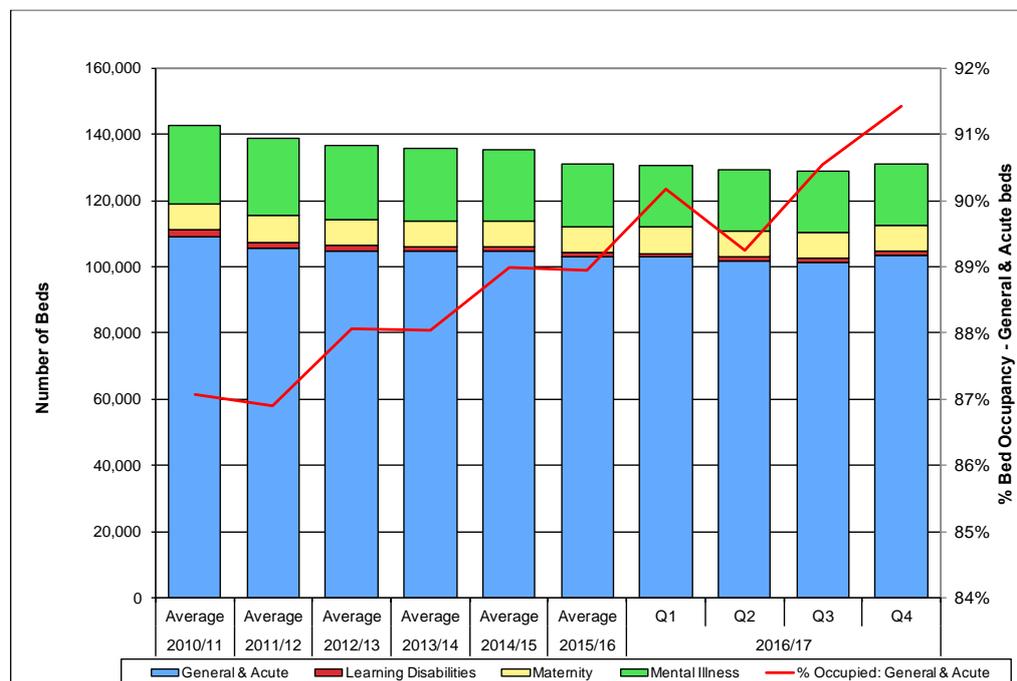
Source: OECD Health Statistics 2016.<sup>4</sup>

20. Under pressure to find ever tighter annual ‘cost-efficiencies’ hospital trusts cut the total number of available overnight beds in England from 144,455 in early 2010 to 131,992 by March 2017, and the number of ‘general and acute’ hospital beds from 110,568 to 104,598. This has led to a shortage of available hospital beds and a record high England-wide occupancy rate of 91.4% (see Figure 3).<sup>5 27</sup>

<sup>4</sup> For Denmark, data for 2012 was not available so the average of 2011 and 2013 was taken.

<sup>5</sup> The overnight bed figures include estimates for two trusts which did not submit data for all quarters of 2016/17. For more information please see: <https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/04/KH03-Q4-2016-17-Statistical-Press-Notice.pdf>

Figure 3: Number of overnight beds (NHS England) and occupancy rate for 'general & acute' beds.



Source: NHS England Statistics. Note that in order to ensure the occupied percentages were comparable across years the figure does not include estimates for 2 trusts that did not submit data for all quarters of 2016/17

21. The medical consensus is that to avoid risking patient safety bed occupancy rates should not be above 85%, yet the NHS has been above this level since 2012, and the situation has been getting worse.<sup>28</sup> Recent news stories about avoidable deaths and long trolley waits for patients without a bed indicate that there are not enough beds in the NHS to meet current needs. Whether the planned shifts of work out of hospitals into community settings can be achieved without prejudice to patient safety or care quality is therefore a critical issue

### Future bed numbers

22. A key assumption of the 5YFV is that the rate of growth in the volume of treatments in hospitals will fall from 2.9% to 1.3% a year.<sup>29</sup> This would reduce the need for opening more hospital beds, although the savings will be partially offset by the need to provide more beds in the community. Reducing the growth in hospital activity to 1.3% a year will be tough, given that, as noted earlier, it is estimated that a minimum increase of 1.5% a year is needed just to meet the need arising from the changing age distribution and increasing size of the population.<sup>30</sup> NHS England believes that it can free up 2-3,000 hospital beds through quicker discharges of those awaiting social care, but this depends on adequate investment in social care and this is far from certain (see question 5 below).<sup>31</sup>

23. Detailed figures of the bed numbers which STPs propose to create in alternative non-hospital settings are not yet available: the new community care models sketched

in the 5YFV are based on mostly untested proposals which need to be implemented within a short time-frame and on a large scale. If they do not succeed in reducing the growth in the number of patients needing to be treated in hospitals, then not increasing the number of hospital beds will create a graver crisis than is already facing NHS hospitals in England.

### 3. Will there be good access to non-emergency (elective) care?

24. To meet the challenge of rising need but insufficient funding, one route to save money is to reduce the amount spent on non-emergency (i.e. 'elective') care. CCGs cannot generally control, in the short term, the amount that has to be spent on emergency treatments, so the majority of the savings have to be achieved through reduced spending on non-emergency (elective) care. And as some CCGs are in worse financial conditions than others this has led to large variations in the availability of treatments in the NHS, which have worsened in recent years.

25. As a result, in 2016 almost a third of all CCGs had implemented or proposed limitations to eligibility for NHS services.<sup>32</sup> The services affected included hearing aids, cataract surgery, physiotherapy and IVF treatments, and restrictions were sometimes also placed on the services offered to smokers or obese patients. Commissioners in Cheshire, for example, have put restrictions on obese patients receiving total hip or knee replacements, in apparent contradiction to national guidance, and the Royal College of Surgeons has criticised some of the proposed restrictions on knee and hip replacements as having 'no clinical justification'.<sup>33</sup>

26. But CCGs have a statutory duty not to overspend, and in 2016/17 NHS England is requiring CCGs, in aggregate, to end the year without a deficit. They are also required to set aside 1% of their income as a 'risk reserve'. But by February 2017 (eleven months into the 2016/17 financial year) CCGs were forecasting a combined year-end deficit of £550m (excluding the 1% set aside); so as the shortage of funds grows, restricting access to elective services is liable to become increasingly common, and the geographical variations are liable to become wider.<sup>34</sup> National standards are ceasing to be maintained in more and more cases.

## 4. Will NHS care still be good quality care?

27. The most obvious general effect of underfunding is a tendency for the quality of the treatment that is provided to decline, through reductions in the number or length of appointments or in follow-up appointments, or in the number of diagnostic tests, or in the ratio of nurses to hospital patients, and so on. With NHS hospitals (providers) and commissioners (CCGs) under increasing pressure to stay within the financial constraints imposed upon them a decline in the quality of care is a predictable result.

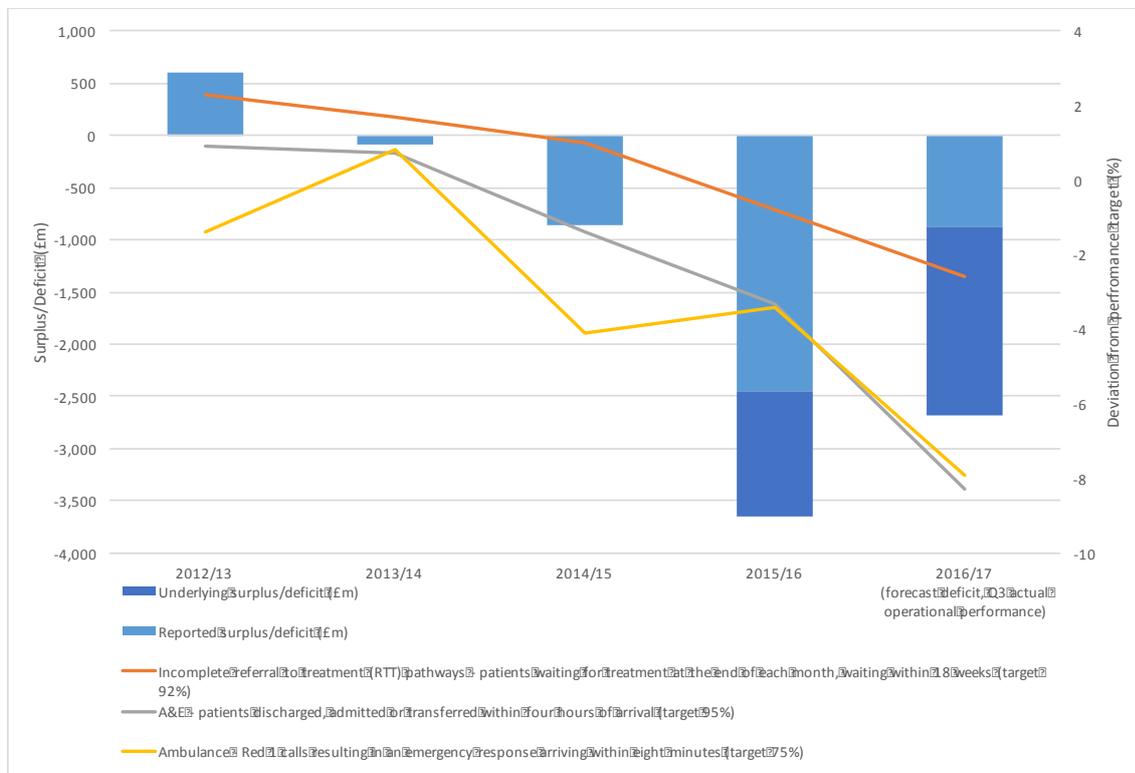
28. It is hard to measure declines in quality, but there are some indicators. In mental health services, for instance, between 2011/12 and 2012/13 the number of patients using the service went up by 5.1% whilst the amount of contact (i.e. the number of appointments) that each patient had with mental health services fell by 4.3%, suggesting that the quality of care was diluted.<sup>35</sup>

29. The Royal College of Nursing's 2015 employment survey of its members found that 37% of nurses had experienced an increase in patient or client caseload or number of beds to look after, and 34% had experienced recruitment freezes which left vacancies unfilled. This had led to 59% of nurses feeling too busy to provide the level of care that they would like to provide. Whilst the average number of patients per registered nurse on NHS wards fell overall from 7.9 in 2013 to 7.5 in 2015, in 'acute and urgent' wards there was an increase, from 4.7 to 7.3 patients per registered nurse; but this was partly offset by the presence of health care assistants and students. Mental health and elderly patients' wards were worst affected, with over 10 patients per registered nurse at night.<sup>36</sup>

30. Underfunding has also affected the speed of access to health services. The National Audit Office (NAO) has found a clear association between trusts' financial performances and their ratings for overall quality of care.<sup>29</sup>

31. In particular, Figure 4 shows that as hospitals' financial situations have worsened, speed of access to care has fallen. Hospitals' incomes have increased by less than the rate of inflation in their costs, and their ability to meet care targets has declined.

Figure 4. Financial position<sup>6</sup> of NHS trusts and deviation from key speed of access performance targets



Sources: National Audit Office, NHS Improvement

32. To sum up the previous four points: with expected workforce shortages, potential lack of beds, and financial challenges facing the NHS until 2020/21 there is a heightened risk that the quality of care (and hence patient safety) will decline.

<sup>6</sup> The 'reported financial position' shows the hospital trusts' surplus/deficit after taking into account additional sustainability and transformation funding and accounting adjustments. These acts to reduce the size of the reported deficit. The addition of underlying surplus/deficit shows the worse financial position before extra funding and accounting adjustments. It reflects the real scale of the financial difficulties faced.

## 5. Will NHS care be effectively complemented by social care and public health measures?

### *Social Care*

33. As Simon Stevens has pointed out, the strategy of the 5YFV assumed an appropriately funded social care system. However, between 2009/10 and 2014/15 the amount that local authorities were able to spend on adult social care fell in real terms by 10%, from £16.3bn to £14.6bn, leading to a fall of 26% (400,000 people) in the number of elderly people receiving local authority-funded care, even though the number of people aged 65 or over in England increased in the same period by some 27%.<sup>37 38 39</sup>

34. This occurred while the number of older people admitted to hospital was increasing, between 2010/11 and 2014/15, by 18%, compared to a 12% increase for all age groups. Elderly patients now account for 62% of all acute hospital bed days.<sup>40</sup>

35. Many of these patients are staying in hospital after they are medically fit to leave hospital and be cared for in a community setting; between 2013 and 2015 the number of patients waiting for a home care package doubled, and the number waiting for a place in a nursing home increased by 63%.<sup>39</sup> The National Audit Office has estimated that these 'delayed transfers of care' represent an annual cost to the NHS of £820m, versus a cost of an estimated £180m a year if the care was continued outside hospital.<sup>39</sup>

36. With hospital bed occupancy rates at record highs, delayed transfers of care have an impact on the quality of care that the NHS can provide, and a financial impact too, given the cost of looking after these patients and of having to cancel elective operations because of a shortage of beds. It also affects the elderly patients who are obliged to stay in hospital, with studies finding reductions in muscle strength of up to 5% a day, and 12% of over 70s experiencing a declining ability to undertake key activities (e.g. washing, dressing, eating) compared with their condition before they were admitted.<sup>41 42</sup>

37. But so far the impact of social care pressures on the NHS budget has not been fully estimated in the STPs, since they focus on the financial sustainability of the NHS and not of the social care system. This is liable to mean that plans for reducing local hospital provision will underestimate the need for hospital beds for people who really need social care but for whom none will be available. The likely outcome of this gap would be growing numbers of elderly people trapped in hospital beds as well as an increased burden on unpaid family carers at home.

38. The underfunding of social care is expected to persist over the coming years, reaching a shortfall of £3.5bn by 2020/21.<sup>40</sup> The 2017 spring budget announcement of an extra £2bn of social care funding in England, spread over the next three years (2017/18 to 2019/20), will only partly offset this. In 2017/18 alone the shortfall is estimated to be £2bn, double the additional £1bn to be made available for that year.

The rise in the National Living Wage will also add £900m to the cost of social care provision next year.<sup>43</sup> The ability of the NHS to reduce the need for more hospital beds seems likely to remain seriously limited by the lack of adequate social care provision.

### *Public Health*

39. Significant savings are expected to come from reductions in the need for health care through public health measures to prevent specific illnesses such as cancer and heart disease and through helping patients to take more responsibility for their own health ('self-care'). But £3bn of the £10bn additional real-terms funding being provided to the NHS by 2020/21 is coming from cuts to other areas of Department of Health spending, and one of these is the grant the Department makes to local authorities for public health.<sup>7</sup> Local authorities have warned that this will mean cuts to front-line health services such as smoking cessation groups, sexual health clinics and health visits.<sup>44</sup> These cuts to public health spending (cuts averaging 3.9% a year up till 2020/21) make it very unlikely that the costs to the NHS arising from obesity, smoking, drug abuse and similar causes will be significantly reduced.<sup>45</sup> The STPs' reliance on a reduction in the growth of need from improved public health seems incompatible with these public health spending cuts. Moreover even with sufficient funding the positive outcomes from public health interventions are likely to materialise many years later, not in the short time frames covered by the STPs.

<sup>7</sup> A breakdown of the additional government funding provided can be consulted on the CHPI website at: <https://chpi.org.uk/publications/analyses/stps-and-the-5yfv-appendix/>

## Conclusions

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40. As the chief executive of NHS Providers, Chris Hopson, has pointed out, healthcare funding per head in England is already significantly below that of comparable European countries and even with its existing funding the NHS as presently organised can no longer continue to provide adequate services.<sup>46</sup> Confronting this, the NHS hospital sector has delivered an impressive level of cost efficiencies, managing to absorb a real cut of 20% in what they were paid in 2015/16 compared with what they received for the same work in 2009/10.<sup>30</sup> To cope with these cuts in their income they would have needed to reduce their operating costs by 4% a year; this being impossible, since 2013/14 they have accumulated much-publicised financial deficits, while coming close to being unable to continue to meet the ever-rising need for services. CCGs are now under similar stress with a forecast £550m deficit driven by a need for average savings of 3% in 2016/17, up from 2.2% in 2015/16, in order to set aside 1% (£800m) for paying off the expected provider sector's deficit.<sup>34</sup>

41. But the response to this situation set out in the 5YFV is not well supported by evidence. The implementation needs to be rapid but NHS staff are already overloaded and tired. The resources needed for the transformation of services are being used to cover hospital deficits, leaving little for even with the additional funding from the Spring Budget 2017. As the CHPI's report, *The Five Year Forward View: do the numbers add up?*, has shown, the assumptions on which the STP programme rests are often unrealistic.<sup>47</sup> Meanwhile, the more severely underfunding presses down on commissioners and providers, the fact that legal or regulatory requirements on every trust and CCG oblige them to meet increasingly unrealistic financial targets makes collaboration with each other and with local councils increasingly difficult.

42. If the STPs fail, waiting times for the treatment of emergency conditions and for diagnosis and treatment of non-life-threatening conditions will continue to grow. There will be fewer hospital beds per population, fewer GPs and GP surgeries, more patients will be seen by less qualified staff, the availability of treatments non-emergency conditions will be more limited and the eligibility thresholds for others will be raised. Rationing non-emergency care, the withdrawal of services, and/or reducing cost by reducing quality will be the only options. There is a strong risk that NHS care will diminish in both availability and quality. The risks to patient safety from overcrowding and understaffing will get worse. The situation will be aggravated if the reorganisation of services is itself insufficiently funded or poorly implemented.

43. Following the June 2017 election there is a widespread recognition that the underfunding of both the NHS and social services cannot continue. Whether the scale of the response will be adequate depends, however, on whether the scale of the problem is fully understood. The main party manifestos did not suggest that it is. This was especially clear in relation to social care, as pointed out in the CHPI's election briefing note, *Social Care Funding: Understanding the reality behind the manifesto commitments*.<sup>48</sup> Those charged with attempting to implement STPs will

need to take an equally realistic look at the resources which will actually be made available to the NHS.

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