

# Sustainability and transformation plans

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## Introduction

The [NHS Shared Planning Guidance](#)<sup>1</sup> asked every health and care system to create a local place-based plan for “accelerating implementation of the Five Year Forward View (5YFV)”. These STPs (Sustainability and transformation plans) cover the period between October 2016 and March 2021.

In March 2016 [44 STP footprints](#)<sup>2</sup> were announced. Each footprint covers NHS providers, CCGs, local authorities and other health and care services, who are expected to work together to produce the STP. The footprints are not statutory boundaries and planning will still need to take place at different levels.

Senior figures from organisations within the footprint have been appointed to lead, with almost all from a health background (for a list of these see [NHS England’s webpage](#)<sup>3</sup>). A notable exception, one of only four STP leads from a local authority background, is Sir Howard Bernstein in Greater Manchester, Chief Executive of Manchester City Council.

The footprints submitted their initial STPs in April 2016 to the Strategic Programme Office for the Five Year Forward View. This is a team led by Jo Lenaghan that cuts across the 5YFV ALBs (arm’s length bodies): NHS England, Public Health England, NHS Improvement, the Care Quality Commission, Health Education England and the National Institute for Health and Care Excellence. This was followed by a series of conversations between footprint leaders and leaders from the ALBs.

The next version of plans were reviewed throughout July 2016 following the official deadline for submission at the end of June. However, the level of detail in the plans varies according to area and the submission is now being referred to as a “pipeline” process. The plans will not be published until they are agreed locally and nationally. We would expect this to happen between autumn and the end of the year.

## Content

Footprints were asked to diagnose the current and projected gaps in health and wellbeing, care and quality and finance and efficiency – the three gaps identified in the [Five Year Forward View](#)<sup>4</sup>. Local areas are expected to use this data to develop an understanding about the challenges in their area and to determine the priorities for their STP, including identifying 3-5 critical decisions to ‘really shift the dial’ to close the three gaps. They must also include how the footprint will achieve better integration with local authority services, including, but not limited to, public health services and social care. Plans are expected to set out their strategy for 2020/21 but also how they are going to start implementing it now.

In May 2016, the 5YFV ALBs published a series of ‘aide-mémoires’, available on NHS England’s [STP support](#)<sup>5</sup> webpage, to set out what success would look like in 2020 for areas where footprints had asked for further clarity. They also make suggestions for how areas could approach implementation in 2016/17.

More advanced plans are also expected to reflect on 10 key areas where there is general agreement that progress is needed across the health and care system – see the section on [10 priorities](#) for more information. Less advanced footprints are not expected to go into these in so much detail.

The King’s Fund are [tracking](#) the progress of developing STPs in four areas of the country and will be feeding back to the national bodies<sup>6</sup>.

## Funding

The footprints have been asked to consider how changes to services and shifts in investment can lead to efficiencies, and all STPs must be underpinned by actionable financial plans that show how they will close the local financial gap and achieve sustainable financial balance over the next five years. Footprints have been given a financial template to allow them to capture their financial, activity and workforce plans at a high level.

In order to support STP footprints to develop these plans NHS England published indicative [funding allocations](#)<sup>7</sup> for each STP area, comprising CCG allocations, primary care medical allocations and specialised services allocation. Any growth in CCG allocations for 2017/18 onwards is contingent on the development and sign-off of their local STP during 2016/17.

Similarly, STPs will become the single application and approval process for all transformation funding programmes from 2017/18. This would include the Sustainability and Transformation Fund, which is £2.9bn in 2017/18, as well as any additional funding earmarked for transformation such as funding for digital and IT development.

## Workforce and engagement

Workforce has been stressed as a key issue in almost every footprint. The template mentioned in the previous section also includes requirements to make an initial assessment of the workforce consequences of service proposals. More detailed workforce requirements are expected to emerge as consensus on service models is finalised, but this should be an initial assessment to form the basis for conversations with new Local Workforce Action Boards. These boards are expected to bring together senior representatives from organisations in the local area, supported by HEE (Health Education England) local teams, to develop a five-year workforce strategy and development plan. They will be co-chaired by HEE and a senior local STP representative but the exact form and function are yet to be agreed.

A [letter](#) that went out to local leaders in February 2016 is explicit that there should be “robust plans for genuine engagement as part of the decision making process”.<sup>8</sup> Areas are expected to use existing mechanisms such as Health and Wellbeing Boards and other existing local arrangements to do this. There is not expected to be any formal consultation until after plans have been agreed nationally.

Footprints are expected to use the ‘[six principles](#)’ developed by the People and Communities SYFV Board as the basis for engaging individuals, communities and staff going forward.<sup>9</sup> The six principles require that:

- Care and support is person-centred: personalised, coordinated, and empowering
- Services are created in partnership with citizens and communities
- Focus is on equality and narrowing inequalities
- Carers are identified, supported and involved
- Voluntary, community and social enterprise and housing sectors are involved as key partners and enablers
- Volunteering and social action are recognised as key enablers.

## 10 key priorities

The guidance sent out to STP footprints ahead of their April submission set out 10 key priorities for the more advanced footprints to focus on.

### 1. Prevention

NHS organisations are expected to work closely with local government and other local partners to build on existing local efforts and strengthen and implement preventative interventions. This should include providing targeted advice and integrated care to tackle excessive alcohol consumption and smoking, creating healthy environments to improve diets and keep people in work and supporting action to reverse trends in obesity. They will also be expected to consider how to improve patient pathways, including early intervention and improved condition management.

### 2. Engagement of patients, communities and NHS staff

STPs should bring about a step-change in patient activation and self-care. They are expected to set out how meaningful care planning can take place for people with long-term conditions or ongoing care needs. Patients should be offered support to improve confidence and capacity to manage their condition.

Expansion of integrated personal health budgets and choice is also expected, particularly in maternity, end-of-life and elective care. Plans should detail how the NHS will work with local authorities to support local populations to build community capacity and resilience, as well as consider how to improve the health of NHS employees and reduce sickness rates.

### 3. Primary Care

STPs are expected to translate the aims and key elements of the [GP Forward View](#)<sup>10</sup> into local plans. They should set out plans to make progress in: (i) supporting and growing the primary care workforce; (ii) improving access to general practice in and out of hours; (iii) transforming the way technology and infrastructure are used; and (iv) managing workload.

### 4. New Care Models

The strongest STPs are expected to be a blueprint for how areas expect to develop and spread new care models, making the greatest possible use of technology and a reshaped workforce. The new care models are only expected to cover specific communities at first, with wider spread thereafter, rather than the whole STP footprint.

### 5. Performance against core standards

STPs are expected to achieve and maintain performance against core standards including A&E and ambulance waits as well as referral-to-treatment times.

### 6. Clinical priorities

STPs are expected to meet national 2020 ambitions on key clinical priorities, including: the recommendations for the [independent cancer taskforce report](#),<sup>11</sup> [The Five Year Forward View for Mental Health](#),<sup>12</sup> the [Dementia Implementation Plan](#)<sup>13</sup> and the [National Maternity Review Report](#),<sup>14</sup> using the opportunity to think holistically across mental and physical health.

STP areas should support the work of [Transforming Care Partnerships](#)<sup>15</sup> to help consider the wider needs of people with a learning disability or with autism, with the aim of improving participation in society, improving health and wellbeing, decreasing avoidable hospital admissions and reducing premature mortality.

## 7. Quality and safety

A set of [10 clinical standards](#)<sup>16</sup> for seven day services have been developed by NHS England. STPs are expected to focus on a sub set of four priority standards to ensure patients admitted to hospital **in an emergency** receive the same quality of assessment, diagnosis, treatment and review throughout the week. The four priority clinical standards are:

1. Standard 2: Time to Consultant Review
2. Standard 5: Access to Diagnostics
3. Standard 6: Access to Consultant-directed Interventions
4. Standard 8: On-going Review

They are also expected to achieve a significant reduction in avoidable deaths, ensure most providers are rated outstanding or good in their CQC ratings and improve antimicrobial prescribing and resistance rates.

## 8. Technology

[Personalised Health and Care 2020](#)<sup>17</sup> sets an ambition that 'all patient and care records will be digital, interoperable and real-time by 2020'. STPs are expected to improve the digital capability of secondary care providers and enable more effective information sharing across care settings. They should also demonstrate how they will drive and implement LDRs ([Local Digital Roadmaps](#)),<sup>18</sup> despite the fact these cover different geographies.

## 9. Workforce

STPs are to include plans to reduce agency spend and develop, retrain and retain a workforce with the appropriate skills and values. This should involve having multidisciplinary teams to underpin new care models, including using new roles such as associate nurses, physician associates, community paramedics and pharmacists in general practice.

## 10. Financial balance

Plans must include a local financial sustainability plan, with credible plans for moderating activity growth by c.1% p.a. There should also be evidence of improved provider efficiency of at least 2% p.a. including through delivery of the [Carter Review](#)<sup>19</sup> recommendations.

# Implications for doctors

The footprint based nature of STPs means that the implications will vary depending on which area of the country you work in, as each footprint will have 3-5 priorities that they are focussing their time and resources on. STPs will bring together all previous transformation proposals under one umbrella and therefore should encourage more strategic planning across the footprint. Local areas will receive central support from the Strategic Programme Office for the Five Year Forward View and other ALBs to help make sure the strategic plans are achievable.

With these variables in mind, there are a number of opportunities for doctors from STPs:

- **More opportunities to work with colleagues across disciplines:** We would expect there to be an increase in multidisciplinary teams, managed clinical networks and more joined-up care pathways, which should give doctors the opportunity to work better with colleagues across different branches of practice and other providers/organisations.
- **Reduced workload pressures:** The developments in technology should not just make it easier for doctors to care for patients with multi-morbidity, they should also help reduce time spent on bureaucracy. In addition to this there is an emphasis on spending more time and money on prevention and enabling self-care, which would result in more care taking place in the community or at home. This should help to relieve some of the workload pressures that general practice, as well as some other specialties, are facing at the moment.
- **Better, evidence based decision making:** The footprints have been encouraged to spend time producing good quality data on their geographic area, which should help to make evidence based decisions on care. This in turn might be useful to highlight and resolve workforce challenges.

However, it is also possible that STPs will further complicate local decision making, particularly if the STP footprint doesn't match natural organisation/geographical alliances. STPs could result in decisions being made at different levels, making it unclear where ultimate accountability lies and the fact that different STPs will focus on different priorities could lead to increasing fragmentation. In addition, the accelerated timetable might mean decisions are made without a clear governance structure in place. In some cases, for example where STPs make changes to the way care in their area is delivered by introducing new models of care, STPs could also result in a shift in where you see and treat your patients or a change in which organisation employs you.

For these reasons it is critically important that doctors and other key stakeholders engage in and influence the plans as they develop. While there is national direction and oversight of STPs, they are being developed locally. Why not make contact with your [STP lead](#), [your LMC](#) (local medical committee), [your LNC](#) (local negotiating committee) or your industrial relations officer to find out the best way to get involved. See [Annex 1](#) for a list of key questions to ask leaders in your area.

Alternatively you could speak with a BMA regional coordinator who will be monitoring developments in your area.

- South West – [email Sean Cusack](#)
- South Central/South East Coast – [email Glyn Jones](#)
- London – [email Andrew Barton](#)
- East of England – [email Hugh Townsend](#)
- East Midlands – [email Jim Stringer](#)
- West Midlands – [email Alan Roberts](#)
- North West/North East/Yorkshire and Humber – [email Ursula Ross](#)

If you are looking for an overview of the key issues at a national level then please [contact the health policy team](#).

## BMA policy

The BMA supports the aim to integrate health and social care and encourage footprints to use this opportunity to adopt a 'health in all policies' approach, reflecting the importance of the social determinants of health.

However, it is important that greater coordination of policy across footprints does not result in health funding being diverted to cover shortfalls in other areas. Greater integration must not make the health funding crisis worse. Linked to this, the public must understand what they will be expected to pay for personal care now and in the future and STPs must not undermine the principles of a publicly funded and publicly provided NHS.

We have some concerns about the priority that financial balance has within STPs, and that this may result in policy being developed without supporting evidence. Whilst it is undoubtedly important for the NHS to be financially sustainable, this cannot be cost-cutting, achieved through further pressure on NHS staff pay and it must not come at the expense of good quality services. For any reconfiguration there must be a thorough impact assessment of any proposals, including an examination of safety issues.

Accountability to patients, doctors and their representative bodies needs to be clear from the start. If providers are taking on additional responsibilities beyond the planning and management of services then effective oversight needs to be in place. Local clinicians must be fully consulted and supported in any planned changes to workforce, which need to be considered fully locally but also in the context of the impact it may have to any national workforce planning and training programmes.

BMA policy on the 5YFV equally applies to STPs:

- Any plans should involve collaboration between primary, community and secondary care, without any group dominating another.
- The focus should be on supporting organisations to work together rather than creating a new single organisation that would employ all staff. In order to enable greater collaboration between services to develop we need some stability. Change must not be achieved through another structural reorganisation of the NHS.
- The process must involve consultation and engagement with all sectors and patient groups from the earliest possible stage. Any change should be clinically-led and based on good clinical evidence that care will be improved or at least not compromised.
- In addition, given the critical role of public health spending in delivering the ill-health prevention agenda and the focus on population based health, public health must be a priority.

## Annex 1

### Key questions for STP leaders

#### Governance structure

- What is the governance structure? Who has accountability?
- How will decisions be made and how will they be published?

#### Engagement

- Who has been involved in developing the plans? Has my LMC/trust been involved?
- How can I get involved in the decision making process?
- Where can I find out more information?
- When will I be consulted on the design and implementation?
- Has it been clinically led?

#### STP priorities

- What are the priorities of my local STP and why?
- What will the planned changes mean for local services? Why will it work better than what there is now?
- What is the evidence base that care will be improved or at least not compromised?
- How will funding change with the planned changes?
- How is public health incorporated into the plans?
- Which services will be affected? How will it affect my day-to-day work?
- How will it be clearly defined which services constitute healthcare, and are free at the point of delivery?

#### Timescales

- What is the timeline for implementation?
- When will I be able to see the effect of the changes?



## Further reading/references

- 1 NHS England (2015). *Delivering the Forward View: NHS planning guidance 2016/17 – 2020-21*.
- 2 NHS England (2016). *Sustainability and Transformation Plan footprints*.
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- 4 NHS England (2014). *The Five Year Forward View*.
- 5 NHS England. *Support for STP footprints*. <https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/stp/support/>
- 6 The King's Fund. *Tracking the development of sustainability and transformation plans in England*. <http://www.kingsfund.org.uk/projects/tracking-development-sustainability-transformation-plans>
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- 9 National voices (2015). *Six principles for engaging people and communities*. <http://www.nationalvoices.org.uk/node/1116>
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- 11 Independent Cancer Taskforce (2015). *Achieving world-class cancer outcomes. A strategy for England 2015-2020*.
- 12 Independent Mental Health Taskforce to the NHS in England (2016). *The Five Year Forward View for Mental Health*.
- 13 Department of Health (2016). *Prime Minister's Challenge on Dementia 2020. Implementation plan*.
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- 16 NHS England (2016). *Seven day services clinical standards*.
- 17 HM Government, NHS England (2014). *Personalised health and care 2020*.
- 18 NHS England. *Local digital roadmaps*. <https://www.england.nhs.uk/digitaltechnology/info-revolution/digital-roadmaps/>
- 19 Lord Carter of Coles (2016). *Operational productivity and performance in English NHS acute hospitals: Unwarranted variation*.

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