Editorials

Sustainability or transformation?

Without additional funding, STPs are unlikely to deliver both

Who now remembers the fanfare that greeted the *Five Year Forward View* (FYFV)?[1] It seems so long ago: a pre-Brexit age of innocence when politics was at least predictably unpredictable. Launched in October 2014, the 'FYFV' was billed as Simon Stevens's bid to reconfigure the NHS. It marked a shift away from competition as a means of health service improvement to a more collaborative approach. Sustainability and transformation plans (STPs) were the vehicle through which NHS organisations and their partners were to develop new models of care in their area. Over halfway through those 5 years, what has been achieved and what does the future portend for STPs?

PROGRESS THUS FAR

From the outset, the production of STPs was tightly controlled from the centre; 44 geographical areas ('footprints') were defined, covering the whole country. The King's Fund has described the production process based on detailed interviews in four sites.[2]

Much creditable work has been done generating innovative plans over a short period.[3] In time-honoured fashion, NHS England has pump-primed 50 'vanguard' sites as exemplars transmitting early experience. Of the proposed care models, most interest from the primary care perspective has focused on multispecialty community providers (MCPs) and primary and acute care systems (PACS), which feature in more than half the vanguards.

MCPs form extended primary care group practices through federations, networks, or single organisations to provide a wider range of care using a broader range of professionals. They may, for example, employ consultants or take them on as partners. PACS are a new variant of 'vertically integrated' care allowing single organisations to provide GP, hospital, community, and mental health services.

Compared with their 2014/2015 baseline, both PACS and MCP vanguards have seen a slower increase in emergency hospital admissions and emergency inpatient bed days than the rest of England.[4] However, sample sizes are small and no cost comparisons are yet available. Longer term, more comprehensive assessments often fail to sustain such early claims.

Many participants testify to a sense of common purpose but they face enormous, if mostly familiar, obstacles. Experience has been most positive in areas with a history of collaborative planning. Where pre-existing relationships were poor — often in the most socially challenging contexts — progress has been slowest.

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The pressured timetable has limited local leaders' capacity to involve all parts of the local health and social care economy. In some areas, local government has hardly contributed at all. As usual, the public voice has been neglected. Notably, primary care professionals have been largely disengaged from the process thus far. Twenty-one 'GP ambassadors' have been recruited in an attempt to address this.[5]

As economic prospects have worsened, the emphasis has increasingly been on financial sustainability via acute trust reconfiguration. The usual formula envisages upstream investment in the community to release spending on unnecessary secondary care with few practical suggestions about how to achieve this. Hospital closures may be a necessary prerequisite of innovative community-based initiatives but they are hard to sell to local politicians and the public.

FROM PLANS TO PARTNERSHIPS

Past experience of similar initiatives suggests that, while drawing up grand plans can be difficult, large-scale and swift implementation is harder still. In its mid-term review, NHS England lists an impressive array of attainments and aspirations.[4] There is no doubting the scale of endeavour but those claims that are related to primary care sit uneasily alongside the College's recent progress report.[6]

The *GP Forward View* (published in April 2016) aimed to end the crisis in general practice in England.[7] An additional £2.4 billion per year in general practice and fanciful pledges to increase the workforce by 5000 GPs and 5000 other members of the staff by 2020 were represented as a turning point for general practice.

The movement of care out of hospitals and into communities cannot succeed without strong general practice. Yet many of the STPs fail to reflect the *GP Forward View* in any detail. Driven by the need to tackle large acute sector deficits, many STPs seem to regard general practice simply as the solution to problems in secondary care without acknowledging the need to reinforce it. Federations are hardly tried and tested as agents of systemic change.

Claims to be addressing workforce shortfalls are undermined by uncertain estimates of current shortages and the numbers required to plug the gap.[8] GP Career Plus, the Time to Care Programme, and a panoply of other initiatives designed to improve working conditions look too much like sticking plasters. From the vantage point of practices coping with today's demands in the face of a continuing recruitment crisis, vows to extend out-of-hours and weekend access to general practice (*'to 100% by 2019'*) sound hollow.[4]

NHS England (NHSE) must therefore ensure that adherence to the *GP Forward View* and increasing investment in the general practice workforce are at the core of all STPs. Vertical integration must not suck funds one-way: downwards, to hospitals. Given the differential progress described above, an inverse care effect is all but inevitable. In a previous *BJGP* editorial, Ben Jackson and colleagues have proposed a 'sustainability imperative' whereby appropriate funds are channelled into addressing inequities in general practice provision.[9]

FIVE YEARS FORWARD

The future is already here in the form of 'accountable care systems' (ACS), the

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next stage in the evolution of STPs. In an ACS, local NHS organisations, often in conjunction with local authorities, work together as an integrated system. The ACS has collective responsibility for resources and population health, operating on both a horizontally and vertically integrated basis, in partnership with local GP hubs. In return, these systems will get more control over the health system in their area with any savings shared between providers. Significant obstacles remain, nevertheless.

NHSE notes the need for an implementation 'support chassis' but the 2012 Health and Social Care Act presents legal impediments in the form of provisions on competition and market access. NHSE is reluctant to be prescriptive but existing accountability arrangements focus on individual organisations and do not facilitate the kind of collective governance envisaged by STPs. Legislative change may be needed to establish new statutory bodies — axles and wheels — suitable for the next stages of reform.[10]

It is ever harder to ignore the need for a single system of funding to commission health and social care. Without tackling the disincentives that operate across the health and social care divide, significant progress will be elusive. Other learning from Greater Manchester, where the local authority has taken control of a devolved £6 billion health and social care budget ('Devo Manc'), thus far remains opaque.[11]

For all the talk of local control, NHSE's preferred direction of travel over the next few years is plain: successful vanguards, 'devolution' areas, and high-achieving STPs are expected ultimately to become 'accountable care organisations.' This is where commissioners contract with a single organisation for population health and the bulk of health and care services in the area.

DON'T HOLD YOUR BREATH

To grizzled veterans of NHS reform, these plans always looked like a triumph of managerial hype over expectation. Beyond the novelties, the most salient feature of the FYFV was a projected funding shortfall of £30 billion by 2020 of which £8 billion was to be tax-financed. The new plans therefore need to yield £22 billion in increased efficiency savings. As part of the euphemistic 'capped expenditure process', 14 STPs have already been told to make 'difficult choices' in search of further savings.[12] Some fear that the costs of 'transformation' will be outweighed by cuts to existing services.

Needless to say, few of the transformative plans are grounded in research on cost-effectiveness.[13] There remains little evidence that integrated care yields cost savings in the short term.

Where does that leave the rank-and-file? GP leaders have little choice but to maintain constructive involvement; STPs remain the only game in town but they are unlikely to survive a change of government in their present form. At the other extreme, the wearied and cynical can be forgiven for regarding the promise of financial salvation through STPs as a manipulative illusion. Without additional investment, STPs look about as sustainable as the current Cabinet.

The rest of us face a familiar dilemma. Past experience suggests that, without clinical engagement, STPs have little chance of success.[14] Thankfully, these reforms provide plenty of opportunities for visionary work at a local level — if, that is, we can find energy to spare from meeting the self-evident needs of patients today and from balancing our own books.

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