

STPs and Five Year Forward View – the case of the missing evidence

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The generally weak – and in many cases almost complete lack of – evidence to support some of the key proposals in the 44 STPs reflects their origins in the largely speculative *Five Year Forward View* policy adopted by NHS England in 2014¹, which has been updated in March 2017 in the document *Next Steps on the NHS Five Year Forward View*².

The Executive Summary of *Next Steps* gives an overview which presents a completely one-sided assessment of the current situation and short term future of the NHS, focused entirely on the “good news” and future aspirations. It largely ignores all of the concrete problems that have been highlighted in the actual developments in the last 12 months.

It explains that *Next Steps* sets out the main national service improvement priorities for the NHS over the next two years, “within the constraints of what is necessary to achieve financial balance across the health service” – but makes no serious mention of the unprecedented scale of the financial pressures that have followed since what the Health Foundation has designated the “Year of Plenty” (2015/16) ended with trusts in record deficits³.

Nor does NHS England offer any response to the powerful statement from NHS Providers in March 2017 explaining why, now the less onerous funding squeeze in 2016/17 has come to an end, the even tighter financial situation in the next two years makes the delivery of the NHS England agenda “Mission Impossible”⁴.

Winter crisis

The *Next Steps* document also brushes aside the scale of the widely reported and acknowledged winter crisis, and the evident shortage of hospital beds to deal with emergency admissions with the bland statement “There are difficulties in admitting sicker patients into hospital beds and discharging them promptly back home.”

In order to maintain this focus on the up-side, the fact that – despite the capacity shortages highlighted by last winter’s problems – a number of STPs and pre-existing plans for centralisation and reconfiguration of services involve further closures of large numbers of acute and community hospital beds is not explicitly addressed at all in *Next Steps*, although the contradiction has been clearly identified, and the wisdom of the policy challenged, by frontline professionals⁵.

At least one STP, Leicester, Leicestershire & Rutland, has taken some note of pressures on services and been prepared to amend its proposals. It has moved since the winter crisis to revise downwards its plans for large scale acute bed closures,⁶ reducing the bed numbers at risk from 243 to 61.

And in a section that is not mentioned in the summary, *Next Steps* also indicates a shift of position on this from NHS England:

“where significant hospital bed closures will result from proposed service reconfigurations, NHS England will in future require STPs to meet a ‘fifth’ new test in addition to the four existing ones put in place in 2010.

“From 1 April 2017, NHS organisations will also have to show that proposals for significant hospital bed closures, requiring formal public consultation, can meet one of three common sense conditions:

- That sufficient alternative provision, such as increased GP or community services, is being put in place alongside or ahead of bed closures, and that the new workforce will be there to deliver it; and/or
- That specific new treatments or therapies, such as new anti-coagulation drugs used to treat strokes, will reduce specific categories of admissions; and/or
- Where a hospital has been using beds less efficiently than the national average, that it has a credible plan to improve performance without affecting patient care (for example in line with the Getting it Right First Time programme).” (p35)

Social care

The practical steps that NHS England propose in *Next Steps* include “Working closely with community services and councils, hospitals need to be able to free up 2,000-3,000 hospital beds.” NHS England has indeed published target numbers of beds it would like to see ‘freed up’⁷ with the discharge of older patients to some form of social care.

This optimistically assumes local authorities will spend all or most of the additional social care funding given to them in the 2017 budget to relieve the pressure on the NHS, by increasing the provision of nursing home places and domiciliary care to support patients in their own homes.

However it’s clear from other analysts that given the mounting crisis in social care there are questions over whether anything like this level of relief can be delivered⁸.

The facts would indeed suggest otherwise. As NHS England completed *Next Steps*, new figures were emerging showing the extent of actual cuts in social care that have already been imposed by councils whose core funding has been cut by 37% since 2010, and faces further cuts each year to 2020. Overall spending fell by 11% to 2015, but one in ten councils made cuts of over 25%, according to the Institute for Fiscal Studies, while of course even more cuts have followed in 2016/17⁹.

A survey for *GPonline* magazine has found four out of five GPs reporting that social care cuts have been driving up the workload on their practices in the last year,¹⁰ including delays in social care assessments, problems finding respite care, and patients who could be supported at home having to be sent to hospital for lack of adequate social care alternatives.

The BBC has now reported a letter from the chairman of the UK Homecare Association to the Prime Minister warning that with a constantly changing and discontented, underpaid workforce, the adult social care system has “begun to collapse”¹¹. A Commons Communities and Local Government Committee report has also warned of the instability and pressures on under-funded and financially precarious care homes and services, raising serious doubts over their ability to play the role required of them by the NHS Five Year Forward View and the STPs. While some positive examples clearly do exist of nursing homes run, mainly by small businesses to deliver high standards of care¹², many

others clearly fail on a number of levels, not least in the lack of adequate nurse staffing and proper engagement with clinical support from GPs.

Staffing is a major issue. On latest figures 84,000 social care jobs were vacant, and the turnover of care staff is alarmingly high, with 48% leaving within a year of starting – and up to half of the care workforce on zero hours contracts, with pay levels averaging close to the minimum wage¹³ and around half the national median annual earnings.

These poor employment conditions make it even harder to recruit and retain staff, leaving the sector heavily dependent on an estimated 60,000 staff from other EU countries and overseas – with an IPPR report raising even more questions over the long term viability of social care services as Brexit looms¹⁴.

Indeed the threat of Brexit and its already visible impact on recruitment and retention of NHS staff including nurses and other professionals is a striking omission from the STPs and from NHS England's *Next Steps* document, with the word Brexit used just twice in passing in 75-pages, giving an even more surreal and falsely optimistic feeling to a document which is supposed to be forcing the pace of STPs and related changes. By contrast a recent leaked report by the Department of Health showed predictions that if the flow of EU-trained nurses was halted the estimated supply of qualified nurses and midwives would fall by 14,000-22,000 full-time equivalents by 2025-26.¹⁵

A similar failure to address the looming problems of recruiting and retaining professional and other staff can be seen in the generally abstract or non-existent workforce strategies of most STPs, after seven years in which the real terms value of NHS pay has fallen by more than 15%, workloads are rising, morale has fallen and more, even more drastic demands for “efficiency savings” and attempts to make savings from payroll are on the agenda until 2021. A House of Lords report on sustainability of the NHS has identified the lack of adequate workforce planning as a major threat to the viability of services¹⁶.

Primary Care

The surreal picture is further developed by the references to General Practice, with increased GP appointments suggested as one of the ways to divert thousands of patients from over-stretched A&E services, alongside promises that as well as swift access for urgent cases, routine patients will also be able to get “a convenient and timely appointment with a GP” when they need one:

“That means having enough GPs, backed up by the resources, support and other professionals required to enable them to deliver the quality of care they want to provide,”

says the *Next Steps* – and this is where NHS England again resorts to wishful thinking in the face of adverse facts.

Ignoring repeated complaints from the BMA that despite the warm words of last year's *General Practice Forward View*,¹⁷ resources and staffing in primary care are still inadequate to deal with rising demand and increased responsibilities allocated by NHS England¹⁸, the *Next Steps* states that

“We have begun to reverse the historic decline in funding for primary care, and over the next two years are on track to deliver 3,250 GP recruits, with an extra 1,300 clinical pharmacists and 1,500 more mental health therapists working alongside them.”

By contrast the *Daily Telegraph* reports *Pulse* magazine figures showing record numbers of GP practices closing¹⁹, with closures increased by numbers of GPs retiring ahead of new tax burdens on larger pension pots. Far from increasing, *Pulse* has found the total number of GPs fell by 400 in the last year.

There is also the question of what services GPs are being pressed to provide; the *Forward View* embraced the government’s obsession with the notion of a 7-day NHS, and NHS England has taken on the task of rolling out extended GP access including weekend appointments: but there is little evidence where this has been tried that it is money well spent. In Greater Manchester an extra £41m is being spent to roll out a new system along these lines, but after early results suggesting that maybe the desired reduction in A&E attendances had been achieved in the pilot scheme in Bury, more recent figures show A&E attendance have not only bounced back, but increased above the level before the scheme.

The *Health Service Journal* has highlighted a report from the GM Devolution Team that concedes the economic case for 7-day access to primary care is “unproven” and that the cost of delivering the service is greater than the savings achieved²⁰.

Debate over supersurgeries

Some of the practice closures are linked to the process of mergers into “supersurgeries” and “hubs” as part of the *Forward View*, with plans outlined in many STPs and minister David Mowat telling MPs the new model could reduce general practice in England from 7,500 practices to just 1,500, covering lists of 35-40,000 patients. This runs counter to the evidence that a majority of GPs are opposed to this concept of developing this new kind of “primary care at scale,” with 4 in 5 GPs in a *GPonline* survey voicing concerns that it would undermine general practice²¹ and just 5% saying it would improve GP services.

More than half of the respondents in the *GPonline* survey said they would not be willing to work in a superhub, rejecting a policy that also appears to fly in the face of evidence that primary care is most effective where continuity of care is established²². Regardless of this, NHS England has announced new initiatives in 2017 seeking to push smaller GP practices towards mergers, through a system of incentives to join local hubs serving up to 50,000 people,²³ along with possible financial penalties in the form of reduced funding for their smaller premises, for those who are resistant to do so²⁴.

There seems to be little clarity on what might be done in response to more than half of the 328 new GP federations and networks that have already been established, but which are significantly *larger* than the 30-50,000 target, and exceeding even the 70,000 top limit, with such large units raising even more serious questions on local accessibility of services and on continuity of care²⁵.

NHS England plans, following a winter of bed crises, for a GP-led ‘triage’ unit to be located next winter at the front door of every A&E unit have been vigorously challenged by Plymouth A&E consultant Ian Higginson, who describes the policy as “yet another top down, one size fits all approach,” noting that “it is uncertain whether there are enough GPs to man these services when

primary care itself appears to be in a state of distress.” NHS England, he notes, have allocated a small amount of capital to assist in establishing these new services, but no revenue funding, leaving the possibility that other budgets will need to be cut to pay for it. But more fundamentally he argues it will not solve the problem of A&E:

“The initiative will not address the problem of ED crowding, since this is not due to low acuity attendances. ED crowding is the result of increasing numbers of sick, elderly, complex patients attending understaffed departments, many of which are obsolete, and which suffer from exit block due to crowded hospitals.”²⁶

Other proposals on A&E in the *Next Steps* and in STPs are based on the assumption that large numbers of A&E attendances are from people who should not only not be there, but who might be persuaded to go elsewhere, concepts that have been raised for at least the last 25 years since the Tomlinson Report on London’s hospital services, and effectively critiqued over the years by many, not least in 2010 by Dr John Launer of the London Deanery²⁷.

Is integration the answer?

The *Next Steps* also goes on to address the issues of more closely integrating health services and health and social care, emphasising strongly the role and the lessons from some of the vanguard schemes that have been funded to experiment with new models of care in various parts of the country. None of the findings from such projects have yet been published in peer reviewed journals, indeed the recent data from as-yet relatively short-lived schemes has clearly not even been fully evaluated at local level, and there is some scepticism over their wider applicability²⁸.

However it’s clear that the findings from specific vanguard projects will need to be seen in the context of the enhanced levels of resources, top-level support and pressure to make them succeed, and the specifics of each local population before any wider relevance can be firmly established: the *Next Steps* document itself admits that “Given sample sizes and duration it is important not to over-interpret the data currently available.” (p30).

It’s important for NHS England to be able to deploy any new evidence, since some of the key assumptions of the *Forward View* and of many other current plans and initiatives – including STPs – lack any significant evidence that they can deliver the “triple aim” which NHS England and Simon Stevens have picked up from the work of Don Berwick and the Institute for Healthcare Improvement²⁹: the aims of improving health care, improving health, and saving money to enable the NHS to deliver within a budget that has been squeezed by seven years of real terms freeze.

Accountable Care Organisations and Systems

There is also a growing body of evidence questioning the wisdom of another key project from the Five Year Forward View, which has since been further promoted by Simon Stevens and in a number of STPs: Accountable Care Organisations (or “partnerships”).

These are stated in the *Forward View* to be modelled on US schemes, many of which grew under Obamacare, with commercial hospital providers and private insurers at their core. In theory an ACO provider accepts a contract based on a fixed capitation-based fee to cover all of the designated health care issues for a local population, and deliver an agreed range of outcomes³⁰.

The track record so far of similar large scale contracts in England has been less than successful. The ACO notion of a fixed capitated payment is complicated by the fact that in almost every instance in the NHS, commissioners have seen the new structures as a way to make substantial savings. However if there is insufficient money in the contract to deliver adequate care, yet providers remain accountable for delivery of specified outcomes, then even NHS providers will be unable to continue.

This is what happened in the ambitious £700m “lead provider” contract to take on the risks of providing the full range of services to the whole local population of older people on a fixed budget that was so low most of the private bids were withdrawn before the final stage of tendering, and which as a result was eventually tendered out by Cambridgeshire & Peterborough CCG to a consortium of two local foundation trusts. As predicted, the 5-year contract collapsed, sooner than some expected, within just 8 months – for lack of adequate funding³¹.

Now, after a prolonged hiatus, and many months of efforts to get it off the ground, a similar – even more controversial – lead provider contract to organise cancer services for much of Staffordshire has also been abandoned before the contract was even signed³². The CCGs concerned now say that the company they shortlisted and had named as preferred provider “couldn’t convince us they could deliver with the resources available. They couldn’t meet the required evaluation criteria.”

Affordability of the new system also seems to be an issue in Northumberland, where the full launch of the flagship ACO proposal, pioneered by NHS Improvement’s current chief executive Jim Mackey, and due to go live from April 2017³³ has now been shelved for an indefinite period because of major deficits (£31m) belatedly revealed in the budget of the main commissioning body, Northumberland CCG³⁴, and apparently partly covered up as a result of pressure from NHS England³⁵. As a ‘vanguard’ project, the Northumberland ACO had in any event received substantial additional funding from NHS England since 2015³⁶, and the *HSJ*’s Daily Insight column raised the obvious question:

“Its deteriorating financial position also raises important questions about whether there is enough money in the local system to set up an ACO which doesn’t fall over the instant it goes live³⁷.”

In similar fashion another showpiece of integration of health services and social care, the Torbay and South Devon Integrated Care Organisation was set up in October 2015, following participation in the NHS Kaiser Beacon Sites programme³⁸, and funded to test out new systems for focusing care. The plan was for the Integrated Care Organisation’s mission to pool health and social care budgets and run the services from under one roof – effectively the Multi Specialty Community provider (MCP) model as set out in the Five Year Forward View and many STPs.³⁹

However the scheme which was supposed to save millions of pounds by creating and testing the first combined health and social care trust now turns out to be running at a £12m deficit in its first year⁴⁰, and Torbay and South Devon NHS Foundation Trust has told the two councils involved in the ICO that it is withdrawing from a ‘risk-sharing’ agreement, which splits liabilities for unexpected costs.

Torbay Council has been warned that the organisation presents a ‘substantial financial risk’ to the local authority. So it seems the ACOs can only maintain any level of integration if funded significantly more generously than local commissioners believe they can afford.

It’s not just a British issue. ACOs in the US have proved to be far from free of problems or a guaranteed profit stream: the cost savings they were originally expected to deliver⁴¹ have not always come at all, and any savings have only come at a price. Harvard academic Ashish Jha, crunching the numbers published by the CMS (Centers for Medicare and Medicaid) in August 2016 for the first four years of ACOs involved in the Medicare Shared Service Program found just over half (203) of the 392 that reported delivered savings totalling \$1.5 billion, while 48% (189) showed losses totalling \$1.1 billion, leaving a total saving of \$429m⁴².

Even these ‘savings’ turn out to be largely illusory, since the CMS was forced to pay out a higher sum to the ACOs, which take a share of any savings, but do not carry any of the costs for losses – leaving Medicare and Medicaid with a net loss of \$216m. And it’s also revealing that only the first cohort of ACOs, dating back to 2012, delivered any savings at all, with projects launched in subsequent years delivering losses.

All this is on the basis of dramatically higher spending per person in the USA than in the UK. Even the loser ACOs received a generous \$9,601 (£7,700) per person covered per year, while those making profits secured an even larger \$10,580 (£8,500). These figures are respectively more than 3 and more than 4 times higher than the average £2223 spent per patient per year in England’s NHS⁴³ – a figure which Simon Stevens has warned is set to fall this year and next as a result of even tighter spending limits.

Different calculations show that with ACOs still covering less than a tenth of the US population, hundreds of ACOs have collectively invested more than \$1.5 billion so far – but recouped savings of only \$656m⁴⁴.

The lack of evidence for such new models of care has been noted over a number of years by academics, health professionals, management consultants such as EY⁴⁵, and more recently argued in a more concerted way in significant reports by the National Audit Office⁴⁶ and the Nuffield Trust⁴⁷.

The NAO Report

The NAO report *Health and social care integration* notes that the Departments^a “have not yet established a robust evidence base to show that integration leads to better outcomes for patients”: they have not yet tested integration “at scale”, and the NAO points out that international examples take place in a very different context of statutory, cultural and organisational environments. In addition

“There is no compelling evidence to show that integration in England leads to sustainable financial savings or reduced hospital activity”.

^a Department of Health and Department for Communities and Local Government

In particular the Better Care Fund, which had been seen as a way of getting NHS and local government-commissioned social care working together to reduce pressure on hospitals and save money, failed on both counts. It wound up costing £311m more than planned, while numbers of emergency admissions and delayed transfers of care increased, which the NAO points out confirmed that 2014 plans were based more on optimism than evidence.

Despite this it appears that lessons have not been learned and the Department of Health has not yet clarified how the Better Care Fund aligns with the new “sustainability and transformation planning process”. And the NAO is critical of the fact that “local government was not involved in the design and development of the NHS-led sustainability and transformation process,” which is “widely regarded as NHS-led and NHS-focused”. Nor has NHS England assessed how pressures on adult social care may impact on the NHS – a problem which we note is echoed in the STPs.

Even more worryingly for NHS England, the NAO goes on to warn in similar vein that hopes of saving £900 million through new care models by 2020-21 “may be optimistic:” “The new care models are as yet unproven and their impact is being evaluated.” The NAO tacitly notes that even though this evaluation will not be complete until the end of 2018, NHS England is pressing ahead with the rapid roll-out of the untested schemes which are a major feature of the *Forward View*.

Shifting the Balance of Care

The Nuffield Trust Report, by a team including well-known academics and researchers, is an extensive 140-page review of the available published evidence on the effectiveness of shifting the balance of care from hospital to community – noting that the NHS is seeking to achieve this at a time of rising demand and the most stringent financial constraints in its 69-year history.

“There is widespread hope – both within the NHS and amongst national policy-makers – that moving care out of hospital will deliver the ‘triple aim’ of improving population health and the quality of patient care, while reducing costs. This has long been a goal for health policy in England, and is a key element of many of the Sustainability and Transformation Plans (STPs) currently being developed across the country.”(p4)

The report states that some STPs are targeting up to 30 per cent reductions in some areas of hospital activity, including outpatient care, A&E attendances and emergency inpatient care over the next four years, but questions whether these are realistic objectives, since:

“A significant shift in care will require additional supporting facilities in the community, appropriate workforce and strong analytical capacity. These are frequently lacking and rely heavily on additional investment, which is not available.” (p5)

Many initiatives, warn the authors, place additional responsibilities upon primary and community care, at a time when these services “are struggling with rising vacancies in both medical and nursing staff, and an increasing number of GP practices are closing.”

The Nuffield Trust Report offers a valuable, extensive bibliography of studies going back to the 1990s, and a detailed examination of the work that has been reported. It is not a purely negative critique, taking pains to identify those initiatives and policies which show the “most positive evidence” or “emerging positive evidence,” in which potential quality improvements in the care

experienced by patients are included alongside financial evaluations, while highlighting primarily cost issues where it detects “mixed evidence” and “evidence of potential to increase costs”. It concludes:

“Many of the initiatives outlined in this report have the potential to improve outcomes and patient experience. However, only a minority were able to demonstrate overall cost savings, many delivered no net savings and some were likely to increase overall costs.” (p103)

It draws important conclusions for STPs:

“If STPs work towards undeliverable expectations there is a significant risk to staff morale, schemes may be stopped before they have had a chance to demonstrate success, and benefits in other outcome measures such as patient experience may be lost.” (p103-4)

More directly still, the Conclusion echoes some of the warnings from NHS Providers when it argues that:

“Shifting the balance of care from the hospital to the community has many advantages for patients, but is unlikely to be cheaper, certainly in the short to medium term. Any shift will also require the appropriate analytical capacity, workforce and supporting facilities in the community. Currently these are lacking. The wider problem remains: ***more patient-centred, efficient and appropriate models of care require more investment than is likely to be possible given the current funding envelope.***” (p105, emphasis added).

Other evidence on shifting care out of hospitals

The evidence for cost savings from developing GP and community out of hospital initiatives to replace hospital care is very limited. Research published in 2012⁴⁸ surveying all out of hospital initiatives failed to demonstrate savings. Also in 2012 an analytical paper in the BMJ by Professor Martin Roland and Gary Abel⁴⁹ questioned the received wisdom that hospital admissions could be reduced and costs cut by improving primary care interventions, especially if aimed at patients perceived to be at high risk as a result of chronic health problems. Among the bevy of myths dispelled by this study was the illusion that high risk patients account for most admissions, or that case management of such patients could save money:

“most admissions come from low risk patients, and the greatest effect on admissions will be made by reducing risk factors in the whole population. [...]

[...] even with the high risk group, the numbers start to cause a problem for any form of case management intervention – 5% of an average general practitioner’s list is 85 patients. To manage this caseload would require 1 to 1.5 case managers per GP. This would require a huge investment of NHS resources in an intervention for which there is no strong evidence that it reduces emergency admissions.”

Roland and Abel also pointed out the difficulties of assessing the effectiveness of those interventions that have taken place because of fluctuations in numbers of admissions even among those at high risk. Some of the interventions that have been piloted, providing case management for high risk groups of patients, have proved not only ineffective, but to result in increased numbers of

emergency admissions – possibly because the increased level of care resulted in additional problems being identified.

Roland and Abel note that in three extreme cases trials of interventions had to be abandoned because of increased deaths among the patients involved, and warns that an additional unintended negative consequence could result from GPs feeling under “excessive” pressure not to refer sick patients to hospital. The article criticises the failure of many plans aimed at reducing hospital admissions to consider the role of secondary care, and improved collaboration between GPs and hospital colleagues.

In 2014 the Commission on Hospital Care for Frail Older People, set up by the *Health Service Journal* and conducted by a group of experts led by the respected Birmingham hospital chief executive Dame Julie Moore surveyed the evidence, and concluded it was a “myth” that measures such as the “integration” of health and social care, and improved services in the community would reduce the need for hospitals or bring cash savings for the hospital sector.

While accepting that better community services were desirable, the report argues that this could only delay rather than avoid the need for hospital stays: “The commonly made assertion that better community and social care will lead to less need for acute hospital beds is probably wrong.”⁵⁰

Another report by Candace Imison, for the King’s Fund in 2014, titled *The Reconfiguration of Clinical Services: What is the Evidence?* also made similar points in the context of centralising A&E services, as some STPs now seek to achieve:

“There have been very few studies to assess the impact of centralising A&E services. The limited evidence available suggests that if services are centralised, there are risks to the quality of care where the centralised service does not have the necessary A&E capacity and acute medical support for the additional workload. A proportion of A&E attenders can safely be seen in community settings, but there is little evidence that developing these services in addition to A&E will reduce demand.”⁵¹

That report concluded:

“The reconfiguration of clinical services represents a significant organisational distraction and carries with it both clinical and financial risk. Yet those who are taking forward major clinical service reconfiguration do so in the absence of a clear evidence base or robust methodology with which to plan and make judgements about service change.”

In particular Imison found that evidence to show financial savings from large-scale reconfigurations of hospital services is almost entirely lacking; and evidence on the impact on quality is mixed, being much stronger in relation to specialist services than other areas of care.

A third 2014 study, from the Nuffield Trust, *The Effect of the British Red Cross ‘Support at Home Service’ on Hospital Utilisation*⁵², was designed to show that better integration of social care and hospital care would reduce demand for acute care. It concluded:

“In the absence of well-accepted, evidence-based solutions to reducing emergency admissions, there is a need to subject promising new interventions and models of service provision of this type to thorough evaluation.”

By contrast it appears that the well-evidenced value of investing in intermediate care beds to relieve pressure on more expensive hospital beds has not been taken on board, and as a result, according to the National Audit of Intermediate Care⁵³:

“the capacity of intermediate care remains stubbornly stuck, and almost certainly stuck at a level below the threshold for whole system impact. Each year the NAIC has posed the same question to commissioners: ‘What is your investment in intermediate care services?’ And each year the summarised answer has been remarkably similar. Calculations by the NHS Benchmarking Network suggest this level of spend is consistent with about a half of the intermediate care capacity required to meet demand. The gradually increasing waiting times for intermediate care access (bed based 3 days; home based 6.3 days; re-ablement 8.7 days) compared to previous audits is corroborative evidence of insufficient capacity.” (Page 4)

Other evidence used to support STPs

The most developed series of references cited in any STP are the 78 Endnotes in minute type at the back of the North West London STP. However on closer examination not one of these is a reference to a working example of any of the proposals being applied in practice. Some references lack sufficient detail to identify the source.

Many are to unpublished data and analysis kept confidential by the STP team, local NHS management and their management consultants, or to other material of doubtful relevance, while other references provide chapter and verse to uncontroversial statistics, without addressing concerns that the statistics themselves may be insufficiently up to date to facilitate adequate planning of capacity to match developing local needs.

In general STPs are notable for their lack of adequate references to show where information is taken from, and the basis of key assumptions. A number of STPs refer to the Rightcare database produced by NHS England, which aims to provide each CCG and STP with:

- a high-level overarching national case for change;
- priorities for improvement and key high impact interventions along a pathway
- underpinning guidance and evidence
- implementation resources to help make change on the ground; and
- practice examples that show the potential in population health approaches.⁵⁴

In each case STPs/CCGs are encouraged to aim to ensure that the services they commission are in the “best five of ten similar” services, how many lives might be saved, how many bed days might be saved, and by implication how much money might be saved. All of course is based on the premise that the services and comparators really are comparable, and the unlikely scenario that all of the Commissioners and Providers in 44 STPs could simultaneously secure the necessary human, financial and other resources to match the current performance of the top five of ten.

Digital technology

While each STP is required to develop its own “Digital Road Map” and strategy to make use of new technology to enhance efficiency in delivery of health care and open up new possibilities for patients

to take control of aspects of their own health, little evidence is offered on the cost-effectiveness of such technology, which has been only slowly rolled out even in the USA, and remains largely untested in the NHS.

A report on this by the Nuffield Trust at the end of 2016⁵⁵ echoes the concerns of many critics of the drive for digital health care, but also seems to endorse NHS England's disregard for some of the actual problems, not least that some of the heaviest users of health care, notably those in long term poverty, and the frail elderly, are often left out by digital initiatives:

"Over 12 million people in the UK lack basic digital skills (Commons Select Committee, 2015). This group is made up of people vulnerable to social exclusion: 60 per cent have no qualifications, 57 per cent are over 65 years old and 49 per cent are disabled (Tinder Foundation, 2015b). Recent figures show that almost two-thirds of people aged over 75 and a third of 65- to 74-year-olds say they do not use the internet at all, compared with 17 per cent of 55- to 64-year-olds and 5 per cent or less of people aged under 55 (Ofcom, 2016). There is also a relatively high 'drop-out rate' of internet use among the older population (West, 2015). Reasons for older people's disengagement from internet use include:

- a lack of skills and knowledge of the internet
- a feeling that the internet is not useful to them
- cost
- disability
- social isolation
- a concern that the internet could take away social interactions" (p49)

Some of the problems noted in this list are pretty major obstacles to significant groups of NHS patients accessing digital services (not least the cost of broadband connections for those on extremely low incomes). In addition the blog promoting the report concedes:

"Recent studies suggest 60 per cent of working-age people in the UK find health information containing both words and numbers too complex. Some people also struggle to identify trusted sources of online information. And millions of people in the UK are still offline or lack basic digital skills. Many of these are the people at most risk of social exclusion, such as those aged 65 and over, the unemployed and people with disabilities."⁵⁶

Nonetheless the Nuffield Trust report, in line with the impatient approach of NHS England in the Forward View and many of the STPs, argues that "**concern over widening inequalities should not act as a barrier** to developing and promoting patient-facing digital tools in general." (emphasis added)

With a positive spin it effectively glosses over many of the hardest points, stating: "In recent years, digital divides have narrowed, with a rise in internet access across the board, and this is likely to continue". (p50)

However one aspect which may give pause for thought among those seeking cost savings through the use of new technology is the finding of a 2012 US study that "having online access to medical records and clinicians was associated with increased use of clinical services compared with group members who did not have access".⁵⁷

Nor is there much indication of surging public demand for more digital links. In November 2016, HSI revealed that while 97 percent of patients were served by GP practices offering digital bookings, just 4% of GP appointments were booked online.⁵⁸

Like so many other aspects of the *Five Year Forward View* and the STPs, the case for investment into the digital roadmap lacks credible evidence and viable systems to deliver its claimed objectives.

So over and above the danger of cuts in beds, downgrading hospitals and ill-defined “efficiency savings”, the STPs and the Forward View appear to represent a major challenge to the future of local health services. Campaigners are right to challenge them.

¹ <https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>

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⁵ See for example David Oliver’s powerful BMJ blog Closing more hospital beds—the policy zombie they couldn’t kill (January 6 2017), at <http://blogs.bmj.com/bmj/2017/01/06/closing-more-hospital-beds-the-policy-zombie/>

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