Faculty of Public Health

of the Royal Colleges of Physicians of the United Kingdom

Working to improve the public's health

Sustainability and Transformation Plan Questionnaire Report

EXECUTIVE SUMMARY

Sustainability and transformation plans (STPs) are the platform on which the *Five Year Forward View* of NHS planning is being taken forward in England. The *Five Year Forward View* envisages a radical upgrade of prevention as a lever to reducing demand on NHS and social care services. Public health specialists are also involved in planning and analysis of the effectiveness of healthcare services. The UK Faculty of Public Health (FPH) undertook a survey of directors of public health (DPHs) to look at the public health aspects of STPs in England, early in 2017. An outline report was presented to the FPH Board in February 2017. This report presents more detailed findings.

Notable welcome findings include: 90% of respondents reported strategic-level input from a DPH; 100% of respondents reported that there was a clear population-health analysis of the major causes of mortality and morbidity; 83% reported use of clinically effective interventions and consideration of return-on-investment evidence; only 9% thought that service rationalisations were evidenced only by a drive to save money; 83% believed STPs were applying new models of care from young to old, well or unwell; only 17% believed application of new models was poor, but none believed them to be excellent; 100% thought their STPs demonstrated commitment to child and adult safeguarding; 90% of STPs reported performance relative to national Fingertips profiles on cardiovascular disease, cancer and mental health; 82% of respondents believed their STP considered waiting times for assessment, treatment and access to primary care; 80% reported inequalities in health by geography and by age.

Less than two thirds of STPs included children's outcome profiles, few considered accidents or housing (10%), and none referred to violence. Inequalities due to ethnicity were covered in only 60% of STPs. Inequalities were not covered in relation to sex by 60%, or by other Equality Act characteristics by 90%. Drugs and alcohol featured in only 30% of needs assessments in STPs; given the major impact on services, particularly of alcohol, the impact of drugs and alcohol, and the means to address these, really should be found consistently in all the plans.

Many of the areas for which the responses were split nearly 50/50 suggest considerably more action is needed to ensure consistency across the STPs. Only 57% of respondents reported their STPs to have described the social, environmental and economic assets of their communities and the strengths of their health and care systems. And only 54% thought these assessments were generating the priorities and key actions of their STPs. Only 33% thought their STPs encouraged education authorities to maintain investment in early years' services and only 33% thought their STPs recognised economic development issues and the role of the health and social care system in job creation and local procurement. Only 17% considered policies to reduce the NHS carbon footprint.

Only 58% of plans showed evidence of integration of planning of services across physical and mental health needs and only 50% showed evidence of integration of health and social care at age transitions.

Only 46% showed evidence of proposed rationalisation on grounds of improving clinical outcomes or safety (eg. stroke services)

Whilst the questions on consultation and collaboration were answered by only 35% of respondents, the findings confirm those reported elsewhere and should be of concern if the whole programme is to be successful. Only 29% believed there was genuine pooling of sovereignty and funds, sharing of staff and lead responsibilities identified across agencies. Only 57% reported support from all local authorities and integration across local authorities – although 71% believed there was consideration of complementary plans of partners.

The level of involvement and support from clinicians, patients, carers, and the public were all disappointingly low and, unless improved, will prevent success for the programmes. Only 43% believed there was clear evidence of clinical, public and stakeholder support and only 14% believed there was evidence of patient and carer support.

The use of tools for health needs analysis was variable. Fingertips profiles varied according to condition. ONS comparator family groups featured in 88% of responses and best performing hospitals or health economies in 63%. Return on investment featured in the majority. Use of Disability Adjusted Life Years appeared in only one third.

This survey suggests STPs are falling some way short of translating aspirations into achievable targets and commitments.

The level of strategic public health input is reported as very high but the impact of this on the STPs appears variable and, in some geographical and service areas, to be disappointingly poor eg. the level of evidence of effectiveness for proposed interventions, the extent and depth of collaborative working and integration and stakeholder support, and a lack of confidence that the interventions are realistic. Our findings would appear to confirm the fear of the King's Fund that cuts in social care and public health and a lack of earmarked funds to support transformation will affect the ability of NHS organisations and their partners to implement their plans (The King's Fund. *Delivering sustainability and transformation plans, from ambitious proposals to credible plans*. ISBN: 978 1 909029 71 2. The King's Fund, London 2017).

The ambition to strengthen intervention has also been limited by the year-on-year budget cuts to the public health budget. This is of concern in an environment where integrated working does not seem to be strong in some areas. This coupled with reducing numbers of public health trained staff, particularly specialists, who are perceived as an expensive resource, is compromising the ability of the system to deliver prevention.

Our survey has also found a failure to tackle the wider determinants of health with some of the more concerning signals about several specific determinants also identified by the King's Fund including quality of housing, employment, and access to education and training.

We have identified some very positive experiences including strategic level input from DPHs and use of population-based analyses and metrics such as ONS comparator families. However, it must be of concern that overall our findings appear to reflect the results of a survey of 172 NHS trust chairs and chief executives carried out in late 2016 which found that investing in preventative services was considered the *least* important issue in STPs (King's Fund 2017)). We agree with the King's Fund analysis that STPs have real potential to close the care gaps identified in the *Five Year Forward View* but that this is predicated by a focus on prevention as a priority. Evidence that this is being taken forward in STPs is currently lacking and must be addressed. Additional resources should be invested in prevention and protected from a diversion to reducing deficits.

Recommendations:

1. FPH believes these findings suggest that STPS currently are not sufficiently driven by local population-based needs assessment and an evidence-based approach linking with need to deliver effective outcomes.
2. The approaches taken both to preventing ill health, and to proposing health and care services which are evidence-based and likely to improve outcomes, are not consistent enough.
3. We recommend a much greater involvement of public health principles in the STPs and much greater engagement of public health expertise.
4. We recommend that existing tools for public health needs analysis are used to a much greater extent and local expertise is brought into play to interpret the data and inform priority setting. Public Health England (PHE) centres and regional directors should work with NHSE counterparts to ensure greater consistency of applications to 'level up' the quality of needs analysis and its impact on priority setting and outcome expectation.
5. We recommend that there is development of real costed investment plans for prevention of ill health in each STP. The PHE report *Local Health and Care Planning: Menu of preventative interventions* is a good starting point.
6. We note also that there is evidence of insufficient and inconsistent joint working, strategically between STP partners, in planning and in operational activity to integrate health and social care, physical and mental health services and in transition planning across age groups. There seems to be inadequate evidence of genuine pooling of sovereignty, joint planning and collaboration. There is certainly insufficient involvement of clinicians, patients, carers and the public. These weaknesses will undermine the potential for the success of these partnerships and plans.

Sustainability and Transformation Plan Questionnaire Report

INTRODUCTION/ BACKGROUND

Sustainability and Transformation Plans (STPs) are critical in delivering the widely welcomed public health and radical prevention aspirations of the NHS England *Five Year Forward View*. The reintegration of the NHS public health function with local authorities, key partners in the STP process in 2013 presented a real opportunity for a powerful and collaborative public health input to health and local authority services. Public health intelligence, practice and partnership-building could form a powerful bridge between health and local authorities, helping to create population-based, needs-driven public health, health and social care services. The expectation within the *Five Year Forward View*, for a radical upgrade to prevention of ill health should lead to both a cultural shift in health and care planning and actual evidence of commitment to investing in preventive services. However, concerns have been expressed by, and within the public health community, about some aspects of STP development, scale, commitment to prevention, funding, and ownership. The Faculty of Public Health (FPH) Board accordingly requested a survey of Directors of Public Health (DPHs) in England to gauge the level of involvement by key local public health staff in local authorities and the NHS. The online survey was conducted during December 2016 and January 2017 and an initial summary analysis of responses was reported to the FPH Board of 23 February 2017. This paper builds on that summary report and identifies the key public health influences, opportunities and challenges in ensuring the successful delivery of the objectives of the *Five Year Forward View*.

THE SURVEY

An online survey was developed by a small working group including a DPH to ascertain the effectiveness of the following public health and preventative elements of the STP:

- Appropriate level of input and influence
- Explicit commitment to a preventative approach
- Asset based approach
- Evidence base
- Priority setting based on population needs analysis and evidence based interventions
- Consideration of wider determinants
- Inequalities
- Alignment to deliver required outcomes
- Integration
- Funding/Rationalisation
- Effective consultation and collaboration

The survey included 26 questions together with a free text ‘comments’ section and an optional location identifier, the latter reflecting a sensitivity that some DPHs may have been reluctant to be critical. The survey is available on request.

RESULTS

Twenty responses were received. The response rate to the survey was 46% (20/44) and responses to each question ranged from 30-100% (mean 61%).

The responses were a mixed range, neither suggesting bias towards respondents with ‘axes to grind’ nor to respondents who were ‘flag waving’ for the process. We have therefore presented the findings without detailed sensitivity analysis. The responses are important more for the level of variability they suggest about the current set of the plans and suggest a need for more consistent inputs and action. Response rates by question and answers are shown in the following table and the free text comments received are provided in the appendix:

THEME	QUESTION	RESPONSE RATE%	YES %	NO %
Appropriate level of input and influence	Strategic level lead input from a director of public health?	100	90	10
Explicit commitment to a preventative approach	Evidence that preventive interventions of known effectiveness are being agreed for priority investment	80	62.5	37.5
	Jointly funded and commissioned	65	38	62
	Realistic and compliant with legislation	70	80	20
	Confidence that proposed interventions have strong evidence base	75	60	40
	Appropriate process for appraising evidence for proposed interventions	75	73	27
Asset based approach	Evidence of social audit and assessment of local strengths and assets (physical, capital, natural, human, social and environmental) in the services provided and in the community in general	70	57	43
	Evidence that these analyses are generating the priorities and the key actions of the STP	65	54	46
	Does this apply across the whole STP footprint	65	70	30
Evidence based	Does the STP include:	60		
	• clear population health analyses of the major causes of mortality and morbidity		100	0
	• analyses from primary care based morbidity information		67	33
	• use of clinically effective interventions		83	17
	• consideration of return on investment		83	17
Wider determinants	Does the STP:	30		

	• include analyses of social care and housing factors impacting on delayed discharges or reasons for admissions		67	33
	• encourage education authorities to maintain investment in early years		33	67
	• demonstrate contribution to children and adult safeguarding		100	0
	• demonstrate interaction with economic development to promote health and social care job creation and local procurement		33	67
	• demonstrate commitment to low carbon footprint; energy, water, transport and prescribing efficiency, because these will reduce costs		17	83
Inequalities	Are there analyses and/or evidence of inequalities in need by	50		
	Geography		80	20
	Age		80	20
	Sex		40	60
	Ethnicity		60	40
	other Equality Act characteristics		10	90
Aligned to deliver required outcomes	Does the STP include a description of the local STP position or performance relative to the national Fingertips health profiles	50		
	• CVD		90	10
	• Cancer		90	10
	• Children		60	40
	• Accidents		10	90

	• Violence		0	100
	• Housing		10	90
	• Mental health		90	10
	• Drugs and alcohol		30	70
	Does the STP include analysis of performance relative to	40		
	• the ONS comparator families or neighbours		88	12
	• the best performing hospitals or health economies		63	27
	Does the STP include analysis based on Right Care indicators	60	67	33
	Does the STP include consideration of waiting times for assessment and treatment and access to primary care	55	82	18
	Does the STP include care pathways reflecting sound preventive and rehabilitative content	85	67	33
	Does the STP include metrics to determine likelihood of success to improve outcomes in lives saved, DALYs etc	60	33	67
	To what extent are STPs applying new models of care proposed for elderly patients to children:	60		
	• Poor		17	83
	• Fair		67	33
	• Well		17	83
	• Excellent		0	100
Integration	Evidence of integration of planning for services across physical and mental health needs	60	58	42
	Evidence of integrated planning of health and social care services across age transitions	60	50	50
Funding/Rationalisation	Appropriate resources identified for the evaluation of any new interventions and models of care	60	25	75

	Evidence of investment commensurate with levels of need and to improve outcomes effectively	55	27	73
	Proposed rationalisations of services evidenced by:	55		
	• improving clinical outcomes or clinical safety (eg. stroke services)		46	54
	• clear efficiencies/economies of scale confirmed by risk assessments not to be detrimental		46	54
	• solely by saving money		9	91
	• not evidenced		36	64
	Based on return on investment	50	70	30
Effective consultation and collaboration across all LAs in STP footprint	Is the STP based on:	35		
	• genuine pooling of sovereignty and funds, sharing of staff, joint posts, and lead responsibilities across all agencies		29	71
	• support from all LAs		57	43
	• integration across all LAs		57	43
	• consideration of complementary plans of partners		71	29
	• consideration of public consultation on fluoridation if dental health is a problem		0	100
	• evidence of clear clinical support		43	57
	• public and stakeholder support		43	57
	• patient and career support		14	86
	• shared confidence in the delivery of outcomes		14	86

DISCUSSION

The overall response rate was 46% of STP footprints if it is assumed that all the responses were from different STP areas. However, this is unlikely and the real response rate is very probably less than 46%. We recognised that some DPHs may have been sensitive about being seen to criticise their local STPs so the question on location was broadly couched as 'region'. However, 50% of respondents still did not provide any geographical locus suggesting that this apprehension was valid and may have contributed to the modest overall response rate. We are also aware of the potential criticism of 'respondent bias' with negative experiences and opinions increasing the likelihood of response. However, several of the responses to specific questions were highly positive providing some reassurance and there was general agreement in the responses from the London footprint. While recognising that this survey cannot claim to be comprehensive and is subject to the limitations associated with all such qualitative assessments, we do consider the survey to be a useful and timely contribution to the consideration of the public health and preventative debate of STP development. This section discusses the results by the thematic structure of the questions:

There was a 100% response with a very encouraging 90% reporting strategic level lead input from a DPH reflecting an *Appropriate level of input and influence*.

Again, there was a strong response to *Explicit commitment to a preventative approach* section ranging from 65-80% across the five questions. There are concerning issues particularly around evidence with only 73% of respondents expressing confidence in the evidence appraisal process, 40% *not* confident about the underpinning evidence base for interventions, and 38% citing no evidence of prioritising investment in interventions of known effectiveness. In addition, 62% reported that proposals are *not* jointly funded or commissioned, and a disturbing 20% considering the interventions to be neither realistic nor compliant with legislation. This contrasts somewhat with the *Evidence based* section which, while attracting a lower response rate of 60%, showed a very strong commitment to population-based health analyses (100%), use of clinically effective interventions (83%) and primary-care-based morbidity data (67%).

There was a strong response to the *asset based approach* theme with an average response rate of 76%. Less than half reported social audit and assessment of local strengths and assets in the services provided and in the community in general (43%) or that these were generating the priorities and key actions of the STP. This is disappointing.

Only 17% identified a commitment to low carbon footprint, energy, water, transport and prescribing efficiency. This is a missed opportunity given the high public, professional and media concern around these issues and the recognised imperative to get the NHS carbon footprint down. Some caution is required in interpreting the outcomes of the *wider determinants* section given the low response rate of 30% but the 100% demonstration of a contribution to adult and children safeguarding is encouraging even if the other metrics are not; only 67% included analyses of social care and housing factors impacting on delayed discharges or reasons for admissions, and only a third addressed education investment in early years or economic development to promote health and social care job creation and local procurement.

The 50% response to the *inequalities* theme is especially disappointing given its fundamental impact on health and wellbeing, and the level of analyses by age and geography (80%) is reassuring. The level for sex (40%) and ethnicity (60%) is disappointing and, at 10%, 'other Equality Act characteristics' is very worrying. The *alignment to deliver required outcomes* had the same moderate response rate and similarly mixed reports. The local STP position or

performance relative to the national Fingertips health profiles was strong in terms of CVD, cancer and mental health at 90% but moderate for children (60%), poor for accidents and housing at 10%, and non-existent for violence. That a third did not base their analyses on the Right Care indicators is very disappointing given their credibility. Also disappointing is that a third did not use care pathways to reflect sound preventive and rehabilitative content or include metrics such as DALYS to determine likelihood of success in terms of lives saved. Only 17% considered that the STP process was effectively using new models of care from children to elderly patients. However, responses within this theme also demonstrated encouraging levels of inclusion of ONS comparator families (88%), waiting times for assessment and treatment and access to primary care (82%).

Effective integration is one of the corner stones of the STP, so it is especially concerning that half reported no integrated planning of health and social care services across age transitions and 42% no integration of planning for services across physical and mental health needs. The response rate to the *Effective consultation and collaboration across all LAs in STP footprint* theme was a very disappointing 35% and, while 71% considered complementary plans of partners, only 57% involved the support or integration of all the LAs and only 29% a genuine pooling of sovereignty, funds, staff, and lead responsibilities across all agencies. Fewer than half had clear clinical, public or stakeholder support (43%) and even fewer identified patient and carer support or, critically, shared confidence in delivery of outcomes (14%). None had considered public consultation on fluoridation where dental health was a problem. *Funding and rationalisation* is another cornerstone, and again the DPHs experience is concerning with a response rate of less than 60% and 75% of those considering the resources identified for the evaluation of any new interventions and models of care as inadequate and 73% that there was no evidence of investment commensurate with levels of need and improving outcomes effectively. Although 70% were satisfied that rationalisations of services were based on return on investment, more than a third reported that they were not evidenced at all and fewer than half identified the effective consideration of improvement in clinical outcomes or clinical safety or clear efficiencies/economies of scale confirmed as safe by risk assessments. Indeed 9% of respondents reported that the proposed rationalisations were predicated solely by saving money.

CONCLUSION

While the recent King's Fund report, *Delivering sustainability and transformation Plans: From ambitious proposals to credible plans*, reported that all STPs include ambitions to strengthen prevention and early intervention and help people to stay healthy for longer echoing the aspirations of the *Five Year Forward View*, this survey suggests STPs are falling some way short of translating aspirations into achievable targets and commitments.

The level of strategic public health input is reported as very high but the impact of this on the STPs appears variable and, in some geographical and service areas, to be disappointingly poor eg. the level of evidence of effectiveness for proposed interventions, the extent and depth of collaborative working and integration and stakeholder support, and a lack of confidence that the interventions are realistic. Our findings would appear to confirm the fear of the King's Fund that cuts in social care and public health and a lack of earmarked funds to support transformation will affect the ability of NHS organisations and their partners to implement their plans.

The ambition to strengthen intervention has also been limited by the year-on-year budget cuts to the public health budget. This is of concern in an environment where integrated working does not seem to be strong in some areas. This, coupled with reducing numbers of public health trained staff, particularly specialists, who are perceived as an expensive resource, is compromising the ability of the system to deliver prevention.

The apparent lack of successful engagement with staff, patients, the public and local authorities that we have found was also highlighted as a threat to STPs in the same report and in a recent *British Medical Journal (BMJ)* paper by Professor Kieran Walshe who was concerned that professional and public consultation and engagement have been largely neglected, leading to suspicion and opposition from the medical profession, the public and the media, and a default to suspicion and opposition, mostly focused on hospital cuts and closures (*BMJ* 2017; 356 doi: https://doi.org/10.1136/bmj.j1043).

Our survey has also found a failure to tackle the wider determinants of health with some of the more concerning signals about several specific determinants also identified by the King's Fund including quality of housing, employment, and access to education and training.

While we have identified some very positive experiences including strategic-level input from DPHs and use of population-based analyses and metrics, such as ONS comparator families, it must be of concern that overall our findings appear to reflect the results of a survey of 172 NHS trust chairs and chief executives carried out in late 2016 which found that investing in preventative services was considered the *least* important issue in STPs (NHS Providers 2016). We agree with the King's Fund analysis that STPs have real potential to close the care gaps identified in the *Five Year Forward View* but that this is predicated by a focus on prevention as a priority, the evidence for which is currently lacking and must be addressed. Additional resources should be invested in prevention and protected from a diversion to reduce deficits.

Appendix:

Free Text Comments

- 'The STP is currently secondary care driven. The radical prevention approach is not being incorporated into the paradigm. This is a weakness at CCG level as commissioning strengths lie with commissioning secondary care.

- 'The STP talks about whole systems approaches yet only mentions health and social care. Talks about 9 fold increases in smoking cessation whilst LAs are cutting PH funding. Has 'wants' such as reducing childhood obesity and increasing healthy eating but nothing on how this might be done. Talks about wider determinants and then MECC - MECC is about individual choice. Talks about helping people to be independent. I have no idea of what that means nor how it is going to be done. Talks about drinking less - apart from screening - how? Are we going to screen 1.45m people? In short, very little confidence that this will deliver.'

- 'Little opportunity to reflect LDPs within STP Plans.'

- '……is at the design stage for most programmes however, they have endorsed the public health programmes and we are currently looking to LDSs for how we will fund these. They are working with KPMG to design programmes and they will include ROI etc.'

- 'integrated working isn't strong is some areas. In London, the develop of STPs over multi-borough footprints has had the effect of diminishing the effectiveness of integrated working.

- 'By way of explanation – my borough is one of 7 London boroughs in the North-East London footprint. The 7 boroughs were chosen by NHSE, with no local decision making, although there was some lip service. This configuration of 7 is not one that would have arisen natural, nor it one in which the boroughs work together easily. Additionally, the governance structures of the STPs don't facilitate this joint working with local authorities, despite local authorities holding the reins on prevention.

- 'The above is also coupled with 2 devolution pilots in the STP. These pilots require, by their very nature, local individual innovative thinking.'