Royal College of Nursing response to the Health Select Committee Inquiry into Sustainability and Transformation Partnerships

Key messages

- We are supportive of the aims and underpinning objectives of the 'Sustainability and Transformation Partnerships' (STPs) process, on the basis that partnership working and regional planning for health and social care is desperately needed to improve health outcomes.

- However, the manner in which most STPs have been structured, and their implementation plans developed, has been opaque and exclusive. Intelligence from our members, which includes our recent survey results, indicates that meaningful engagement with staff, patients and the wider public has been limited. STP leadership and approaches are running the risk of implementing changes that have not been fully thought through and do not have the support of key stakeholder groups.

- We support the aim of reducing demand on acute services both by improving population health and by giving greater focus to delivering care in appropriate community based settings. But any such changes to service provision must be evidence-based, focused on the needs and safety of patients and once agreed, must be fully funded, including transformation costs.

- Our own analysis is that many STPs will result in significant changes to the employment terms and conditions of healthcare staff, including nurses and nursing staff, who will be required to work across different locations, sectors or even organisations. While these changes could offer positive opportunities for staff, such as new 'integrated' roles and more autonomous working, if they are made solely only the basis of saving money they run the risk of creating unsafe nurse staffing levels and skill mix.

- The RCN's position is that there can be no justification for any STP reducing overall nursing staffing levels, given the current national shortages. Further to this, any plans that propose changes to roles or responsibilities must be negotiated openly, and must be premised on sound evidence-based recommendations that maintain or improve patient outcomes and population health. They must also provide safeguards for the delivery of safe and effective patient care, including credible workforce strategy.

- To improve the STPs service planning process, we believe the following aspects must be addressed.

    - The STP 'Progress Dashboard'[i] currently measures a range of hospital and patient related performance targets. While these should be positively affected by successful STP progress the dashboard needs to include a range of focused measures around engagement, workforce planning and use of population and workforce data to drive service planning decisions.

    - The Government needs to ensure necessary funding is available to support effective implementation of any service redesign. This includes ensuring appropriate nurse staffing levels for safe and effective patient care, including support for improving the recruitment and retention of the nursing workforce.

    - We recommend that all STPs make explicit commitments about the allocation of funding and other resource to public health, as the original vision outlined in the Five Year Forward View, and supported by relevant evidence. This is vital to the successful realisation of the STP

vision and intention, as without any improvements being made at population level many of the challenges facing local health and care systems, such as increasing rates of diabetes, will continue and increase.

- NHS England should provide further guidance to establish the assurances that all STPs and Accountable Care Systems (ACSs) should be required to demonstrate in areas such as service and workforce planning driven by population needs, taking into account stakeholder expertise, governance and accountability. NHS England should also apply firmer controls on the money being spent by individual STPs on management consultancies in developing and taking forward their plans.

- The governance structures of STPs/ACSs need to be more transparent and demonstrate accountability, such as through publishing minutes of meetings and consulting affected parties ahead of decisions being made, so that all stakeholders can have confidence in the decision making process. We would like to see greater involvement of senior nurse leaders, both at the top on the STP boards, and across any programme bodies that the STPs establish for design and implementation. Nurse leaders, the RCN, and other representatives must have a meaningful voice in STP and ACS planning and decision making, enabling appropriate oversight and constructive challenge to take place, and ensuring decisions reflect relevant information.

Responses to specific questions

- The RCN is in the process of completing an audit of the experiences of RCN regional leads in relation to quality of engagement and information provided by STPs. We have so far received responses relating to 31 of the 44 STPs and have been able to feed in some early analysis in response to some of the questions below. Some questions used a five point rating scale: very good, good, acceptable, poor, very poor. We would be happy to share fuller analysis of the responses with the Committee once this work is completed, during February.

How effective have STPs been in joining up health and social care across their footprints, and in engaging parts of the system outside the acute healthcare sector, for example primary care, local authorities, public health, mental health and voluntary sector partners? How effectively are they engaging local communities and their representatives?

1.1 Our evidence shows that the consistency and quality of strategic stakeholder engagement is variable across the country. In our experience many STPs are dominated by leaders from NHS organisations within the acute care sector, who seem, so far, to have failed to fully engage local authorities and community care organisations in a partnership process[ii]. A key reason for this seems to be the tension between NHS organisations and local authorities over control and finances. Through our regional contacts we are aware that many senior staff in local government see the STP process as an "NHS imposed" solution, while understanding that the challenges the process is seeking to address are a shared problem. This view is supported by several reviews of STPs, such as those by the King's Fund[iii] and London South Bank University[iv], which found significant local authority opposition to their local STP. This suggests that without significant national upstream support and guidance, STP planning and innovation is unlikely to be successful in developing new approaches to delivering joined up, community based health and care provision, as envisaged by NHS England and other health Arms-Length Bodies as set out in the Five Year Forward View.

1.2 The creation of ACSs, along with additional devolution arrangements in Greater Manchester and elsewhere, does appear to support whole system integration much better than most STPs, but this has so far been achieved only in a few areas and has required a lot of effort by staff and civil society organisations to ensure their constituencies are adequately represented and involved.

How reliable are the ratings in the Sustainability and Transformation Partnerships Progress Dashboard, and what do they tell us about the state of the plans and the relationships that underpin them?

2.1 Many of the measures in the STP Progress Dashboard are general indicators covering hospital performance (such as referral and A&E waiting times) and patient outcomes (such as GP access and cancer diagnosis rates). Although STP progress should have a longer-term impact on these issues they are not a meaningful indicator of shorter-term progress in implementing the STP's plans, which needs to include assessments of practical progress being made to deliver necessary policy, organisational and governance changes.

2.2 The section in the progress dashboard on 'transformation', which looks at areas such as emergency admissions, delayed transfers of care (also known as DTOCs) and system wide leadership, seems more closely related to STP progress. However, the data currently used does not provide sufficient information about the quality of planning and effectiveness of implementation, and should be combined with a range of practical measures of progress. We suggest that the dashboard should include an assessment, perhaps through a RAG rating, of whether:

a. relevant parts of the health and care system, including local authorities and community based providers, are meaningfully engaged within the STP process in design and implementation,
b. a stakeholder engagement plan is available and active, including meaningful involvement for non-medical professional groups, such as nurse leaders, and robust public consultation processes have taken place,
c. a workforce plan is available and provides detailed information on future workforce needs, based on population needs and a clear evidence base, and how changes will be implemented,
d. evidence, and other data, is available to support the claims and assumptions made in STP plans,
e. an implementation timetable is available and progress against this is consistently publicly reported.

What do the available evidence, and experience so far, tell us about the deliverability of STP plans given the financial and workforce pressures across the NHS and local government? Are the demands being made of STP plans through the NHS Mandate and the NHS Shared Planning Guidance deliverable, and can STPs ensure the fulfilment of the requirements of the NHS Constitution?

3.1 The health and care system in England is under unprecedented pressure. There were around 40,000 registered nurse vacancies across health settings in December 2016 in the NHS in England alone. From May 2010 to September 2017 there were nearly 12,000 more nurses employed in acute hospitals. The decision to increase nurse staffing levels in hospitals was a direct response to the Francis report which highlighted poor nursing care contributed to the failings at Mid Staffordshire NHS Foundation Trust. However, over the same period, the nursing workforce in community services has shrunk by 15% (over 6,000 FTE posts)[v]. This is alongside cuts of 60% to funding for continuing professional development for nursing staff, including training for nurses to mentor and supervise nursing apprentices. This strain, coupled with rising patient demand for services and challenges such as A&E waiting times, is combined with STPs being asked to implement significant organisational and cultural changes to improve population health outcomes. There is a serious risk that the system, and the people working within it, are being asked to achieve more than the current capacity and resources that are in place to deliver. Although improvements in public health and a greater focus on community based provision

should lead to reductions in demand on acute services such benefits cannot be expected to be realised without investment in the workforce.

3.2 We do not therefore believe that, as currently financed and positioned, STPs will be able to deliver the totality of demands being placed upon them. While welcome, many of the cost-savings measures in the 'Next Steps' report are extrapolations of anticipated savings, the amounts actually saved are likely to be significantly less than this, a point supported by research undertaken on similar cost-savings measures, such as the 'Commissioning for Quality and Innovation' (CQUIN) programme[vi].

3.3 Many STPs have drawn-up plans which focus primarily on addressing the deficits of their constituent organisations and, as in consequence of that approach, on reducing or removing services or treatment options. We are also aware of some plans identifying planned reductions in overall nursing numbers, or proposing substitution of registered nurse posts with support staff roles, although we appreciate that these run counter to comments made by NHS England that "*The NHS will need more registered nurses in 2020 than today, as will the social care system. HEE forecasts growth of at least 6,000 extra nurses but this could be considerably higher…*"[viivviii]. Without a clear evidence base for decisions about changes and/or reductions in the numbers and types of staff, and a transparent impact assessment regarding patient safety and experience, health outcomes staff working conditions, this practice is totally unacceptable. The NHS Constitution requires all NHS funded organisations to "engage staff in decisions that affect them and the services they provide" but the extent of such engagement by STPs with nurse leaders to date has been generally poor. From our internal survey responses, two thirds of our regional leads rated the engagement with staff or representative organisations as either poor or very poor.

3.4 It is also crucial to consider the impact of cuts to local authority funding, which have reduced the monies available for social care and public health provision, with the consequence of driving up need for healthcare, particularly for acute services, and which run counter to the policy direction set out within the Five Year Forward View.

3.5 To address these challenges Government must invest in raising nurse staffing levels to ensure the right number of nursing staff with the right skills are in the right place at the right time, to help ensure delivery of safe and effective patient care in all health and care settings. Government must also ensure monies are directed to improving the supply of new entrants into the workforce, as well as retaining nursing staff currently in service. There is now sufficient evidence that safe nurse staffing levels are critical to delivering safe and effective services, across health and care settings, in terms of quality, experience, outcomes and mortality rates, as well as multi-disciplinary team productivity. For example, a recent Health Foundation report[ix] found that hospitals with a higher proportion of nurses have higher consultant productivity. Increasing the proportion of nurses in a hospital by 4% was associated with 1% more activity per consultant.

3.6 Focus and resources must also be given to public health, which has seen sizeable cuts to its funding over the past five years. This is necessary for the simple reason that without clear improvements to public health at population level many of the challenges facing health and care services will continue, and are likely to increase. Our analysis is that while many STPs reference public health to their objectives, very few have actually made any commitments to increasing spending in this area or building activity into their planned approaches to service design and delivery.

3.7 Finally, NHS England needs to apply firmer controls to the money being spent by individual STPs on management consultancies, especially but not only in developing and taking forward their plans. We believe that this expertise should be able to be delivered within the health and

care system itself. In addition to this point, and from our own analysis, all STPs plans should be firmly supported by robust and published evidence.

Looking across all STPs, are there any major areas where the content of the plans needs to be tested for credibility and realism? Are there any major gaps? For example, are proposals in some plans to reduce bed capacity credible?; are the NHS efficiency estimates in STPs robust?; is the workforce available to enable the implementation of STPs?; or is the timescale for the changes proposed in STPs realistic?

4.1 We are quite sure that existing gaps in the workforce, and especially around the nursing workforce, where we know many providers are finding it difficult to recruit, risk undermining successful delivery of the STP plans, and the provision of community based services to enable reduced bed capacity. This is true across all groups, but especially in primary and community, where we have evidence of both gaps and a looming large scale loss of staff due to retirement. A lack of sufficient numbers in these workforce will certainly impact upon the aim of moving more care provision from acute hospitals into community settings. It is particularly unfortunate therefore that workforce planning information is so limited. According to a London South Bank University report, "Two-thirds of the STPs (30/44) have no detailed workforce plan to ensure an adequate workforce will be in place to implement the policies and new services they outline"[x].

4.2 Even where workforce plans are available, they generally set out broad-based principles and provide little detail about expected future staffing requirements across grades and specialisms, how staff resources might be reallocated from acute to community based care, potential changes to roles and responsibilities, etc. Similarly, experience to date gives little confidence in nursing workforce planning data coming from the Local Workforce Advisory Boards (LWABs). This lack of robust planning has direct risk implications for patient safety, experience and outcomes, which should not only be a clear factor in planning, but should be the first fundamental consideration of any aspect of designing and delivering services in any health and care setting.

4.3 For example, plans to reduce bed places (which can be significant: e.g., 535 in Derbyshire[xi], 360 in Dorset[xii]) seem to be based on assumptions of an almost immediate impact from activities to reduce demand, with little or no supporting evidence provided. As such, we have serious doubts that the efficiencies/savings assumed by various STPs can be delivered to the timescale, quality and outcomes required.

4.4 One of our major concerns relating to almost every STP plan is the comparative lack of data-driven evidence to support their analysis, proposals, and recommendations. The plans set out efficiency/savings assumptions to close (usually fully) the expected funding gap by 2010-21. Many of these efficiencies fall under unspecified 'business as usual' savings, or are grouped into broad categories with little or no evidence provided to explain how they will be delivered. These 'assumptions' consistently include savings from reducing demand on acute hospital services, although there seems to be little consistency of approach and methodology between individual STP plans. For example, a Nuffield Trust report[xiii] noted that STPs expected 17% fewer A&E attendances (ranging from 6-30% reductions) and 15% fewer outpatient attendances (ranging from 7-30% reductions). We would expect to see investment in community based alternatives to hospital first, resulting in reduced bed capacity and therefore savings, not bed reduction as a start point. The STP plans provide no evidence of patient safety assessments having been made to ensure standards of care are maintained or improved.

4.5 Further to this, the impact of increased activities to improve public health (tackling obesity, reducing smoking, etc.) will take some time to work through into reducing demand on acute services; though the lack of data about underlying assumptions makes assessment of the plans difficult. However, many STP plans seem to assume savings almost immediately. 75% of our internal survey responses rated the STPs use of data as either poor or very poor.

How will the development of STPs into Accountable Care Systems (ACSs) change the delivery of care in an area?

5.1 It is our understanding that the models of ACS that are being proposed by NHS England seek to further integrate local health and social care organisations, working under shared management and governance structures and pooled budgets. Whilst we accept that such cooperation and shared priorities have potential benefits, the approach being taken to implement them raises a number of concerns.

5.2 Establishing the ACSs poses a number of legislative, technical and organisational challenges. These structures push at the boundaries of what is allowed under current legislation, as is evidenced by the judicial review, launched by the campaign group '999 call for the NHS', against NHS England; this is premised on the NHS England created contract for 'Accountable Care Organisations' (ACOs) breaching the Health and Social Care Act 2012. In support of this point, NHS leaders in Greater Manchester have had to scale back ambitions to hand new care model contracts to two new ACOs[xiv]; agreeing a large multispecialty community provider contract with a consortium of existing providers was not possible because legislation means the new provider could incur additional VAT charges. These developments demonstrate just how far beyond current and settled legislative boundaries ACOs/ACSs are taking the NHS in England, and raise serious concerns about how they will be resolved in a way that meets the needs of patients, staff, and the public.

5.3 These points accepted, any move towards creating more integrated organisation models for the delivery of health and care must ensure that all staff, as well as patients and the wider public, are fully involved throughout their development, and must at each stage of development fully and transparently address any concerns raised. It is more than likely that these new structures will necessitate staffing working across existing employment boundaries, taking on broader roles and working in new locations. Any such changes would raise issues around the role and conditions of service that must be dealt with properly and fairly. To ensure that they fully utilise the skills, knowledge and experience of the profession, nurses, the RCN, and other workforce representatives must be given an active role in the development of these organisations and structures, and once established, also in their management and oversight.

What governance, management and leadership arrangements need to be created to enable STP planning and implementation to be carried out effectively? Are additional, or different, arrangements required for areas which are developing ACSs?

6.1 We would like to see more transparency in the overall architecture of each STP. This need was acknowledged in the 'Next Steps'[xv] guidance published by NHS England. While the guidance notes that STPs are not new statutory bodies but supplement rather than replace existing accountabilities, it is vital that the tensions created by the different responsibilities, priorities, and accountabilities of organisations within the STP are recognised and addressed. Transparent structures and processes are therefore vital for the delivery and demonstration of suitable and robust governance.

6.2 One way of addressing this need would be by the creation of a formal governance arrangement that can operate alongside an STP board; to ensure decision makers are properly held to account. Such a structure would need to include representation from the full range of health and care professions, include patient organisations and members of the public. It could also be the arbiter of a standardised arbitration process (perhaps designed by NHS England), to be used in the event of any differences or disagreements between individual STP partner organisations. Such a governance structure could also be charged with ensuring that each STP meets its public sector equality duty obligations.

6.3 We welcome and play an active role where possible, in the involvement of staff-side and trade unions mechanisms within STP structures. However, such representation is varied, and in too many cases is either entirely absent or limited to areas such as LWABs where our members are absent from the key discussions around STP structures and development. We need an increase in involvement of senior nurse leaders, both at the top on the STP boards, and across any programme bodies that the STPs establish for design and delivery; this call is supported by the King's Fund[xvi]. We believe this is vital to ensure effective system change and workforce development which can achieve the level of aspiration set out in the Five Year Forward View.

6.4 The issues are similar for Accountable Care Systems, although the even greater levels of integration are likely to stretch existing organisational governance and accountability arrangements beyond the acceptable limits of current legislation. If this direction of travel is the desired option for Government, it will need to make appropriate legislative provision. The RCN will consider this further, as and when the Government makes further pronouncements on the matter.

What legislative, policy and/or other barriers are there to effective STP and ACS governance and implementation, and what needs to be done by national bodies and national leaders in the NHS to support the implementation of STPs and ACSs?

7.1 As already mentioned, and despite NHS England's guidance, the creation of overarching STPs or ACSs that incorporate a range of organisations with their own legislative status, responsibilities and accountabilities, creates potential conflicts. We have already begun to see these played out through some of the legal challenges taking place. The lack of an arbitration process is also a barrier, as it can lead to organisations removing themselves from the STP process if they feel unable to have their voices heard. The addition of social care to the responsibilities of the Secretary of State for Health and Social Care and the Department also provides an opportunity to address the comparative lack of involvement of local authorities in the STPs and to ensure social care issues are fully integrated into proposals.

7.2 We support the principle of local decision making and accountability across the health and care system in England. However, NHS England must provide further guidance that creates universal principles that all STPs/ACSs should work to, promoting good practices in engagement, ensuring necessary consistency in methodologies, and developing appropriate governance structures.

7.3 The lack of staff engagement in most STPs is also a clear barrier to effective implementation of any service design; since staff feeling excluded from the change processes being set in train by STP leaders are less likely to engage and accept them. Furthermore, a lack of staff input and insight about the challenges facing the health and care systems in which they work is highly likely to lead to misaligned aims and unrealistic objectives.

7.4 Finally, for STPs to be able to realise their ambition of integrated and co-ordinated care, they will have to create shared data arrangements, so that information can be safely and effectively shared across different providers involved in care pathways; this has already started to happen, but needs to be increased in pace and scale[xvii]. The King's Fund work on this, including its report on the Christchurch approach, provides a template for how this might be achieved universally and at scale[xviii].

What public engagement will be necessary to enable STPs/ACSs to succeed, and how should that engagement be undertaken?

8.1 Full, frank and inclusive public and staff engagement is vital to STP/ACS success. This means communicating the plans but also involving and engaging public and staff, listening to any issues and concerns that are raised, and ensuring relevant stakeholders are actively involved in the

decision-making process. Unfortunately all of the evidence to date is that such levels of engagement have been absent from the development of most STPs.

8.2 Public and staff alike are often sceptical of the aims behind many changes proposed by NHS organisations, and naturally focus on the efficiencies/savings being sought, rather than any potential benefits, intended or realised. If the planners developing individual STPs/ACSs are sincere in their attempts to make different parts of the health and care system work together more effectively to improve patient experience, care and outcomes, then they, supported by national leaders and politicians, need to do more to engage all stakeholders in honest and open discussions about the challenges and opportunities that their plans offer. Equally as importantly, they need to ensure that funding is available to deliver the changes.

8.3 STP/ACS plans will ultimately only work if the wider health and care system is able to recruit and retain staff; and equip them with the skills necessary for working in new and different ways. Evidence tells us that staff perform best in workplaces where they feel valued, are clear about their role, and are engaged and involved in decisions that affect them at work[xix]. High quality patient care requires workplaces that are positive, well-managed, and that support the health and wellbeing of their staff.

8.4 Current resource pressures in the health and social care system are impacting on the working lives of NHS staff with a knock-on effect on their wellbeing, workload and morale. This was amply demonstrated in a recent RCN report[xx] that analysed the results of over 30,000 returns by nurses about their last shift, and clearly described the impact that poor staffing has on both patient care and staff wellbeing. Organisations at all levels of the STP/ACS should engage with staff and their representative organisations about the decisions that impact them.

About the Royal College of Nursing

With a membership of around 435,000 registered nurses, midwives, health visitors, nursing students, health care assistants and nurse cadets, the RCN is the voice of nursing across the UK and the largest professional union of nursing staff in the world.

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