Sustainability and Transformation Partnerships: What are they and how do they affect dentistry?

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In brief

Discusses Sustainability and Transformation Partnerships or 'STPs' which bring together health and social care providers across 44 regions in England.

Outlines the development of STPs.

Suggests that dental services should be included in STPs early and possible ways to achieve this.

Sustainability and Transformation Partnerships or 'STPs' have been formed from NHS and social care providers, commissioners, and local councils in 44 areas covering the whole of England to improve the care they provide. Proposals, known as 'Sustainability and Transformation Plans' have been developed that address the needs of the whole population of each area, rather than the needs of each individual organisation. STPs are fundamental to how care will be delivered and commissioned in the future and have recently been portrayed in the media as the vehicle for cuts to NHS services. Here we explore how accurate this is, how STPs vary in different areas, and the opportunities they present for dentistry to become more integrated with other NHS services.

What is an STP?

STPs aim to produce place-based (rather than organisation-based) plans for everyone using health and care services in 44 areas across England.[1] Their grouping into geographical 'footprints' refers to the fact that most people use health and care services which are in some way connected within their local area; patients therefore often follow a certain pathway through services. It is these services which STPs aim to draw together. Not all patients have the same 'footprint', however, and the STP footprints don't always follow previous commissioning boundaries so there are continued challenges in providing and commissioning care in this way.

Membership of STPs can vary but they should ideally involve:

- NHS England
- Hospital trusts (acute and mental health)
- Clinical Commissioning Groups
- Local authorities
- Ambulance services
- GPs
- Patients
- Local private providers of community care, such as Virgin Care
- Local professional networks including dentistry.[2]

Where are we now?

Local health and social care leaders across England were asked to suggest potential STP boundaries by the end of January 2016. A report by The King's Fund suggests that local leaders' proposals were often rejected by national bodies who wanted larger STP footprints leading to the 44 current footprints.[3] A named individual from each footprint was then selected to lead each STP who was required to be 'a senior and credible leader who can command the trust and confidence of the system, such as a CCG chief officer, a provider chief executive or a local authority chief executive'.[4] In some areas, the partnerships are going even further to integrate services and funding to develop 'accountable care systems'. This is essentially a partnership (of local health and social care providers) who, when fully developed (into an 'accountable care organisation', or 'ACO') can become responsible for the budget allocated by the relevant commissioners to deliver agreed outcomes under the agreed budget.[5]

All this means that STPs vary in size and population and currently each STP is developing at a different pace to all the others. Add to this that the main role of the person leading each STP may be different and it is clear that an STP in one area might look very different even from neighbouring STPs. This more localised approach is in-keeping with the overall aims of future plans for the NHS. STPs were not envisaged as another 'top down' re-organisation, and the differing pace of change across each footprint, with STPs evolving according to local requirements, fits well with the original vision of STPS.

Why were they developed?

The *NHS Five Year Forward View*, published in October 2014, set out a vision for how the NHS would continue to improve the quality of care provided under the considerable financial challenges it faces.[6] It suggested increased collaboration both within the NHS and between

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health and social care providers. This was a move away from the emphasis on competition within the NHS as a way of improving quality and efficiency, which was a main aim of the Health and Social Care Act 2012. It is notable that STPs bring together both providers and commissioners which some see as a welcome departure from the purchaser-provider split which has prevailed in the NHS since the late 1980s. The 2014 *NHS Five Year Forward View* also had a strong focus on prevention as a way of reducing the burden on the NHS.[6]

The NHS Five Year Forward View underwent a refresh in March 2017. *Next Steps on the Five Year Forward View* focuses even more on collaboration between health and social care organisations and on improving primary care to reduce the strain on A&E departments.[7]

Next Steps suggests support for strengthening the current governance arrangements of STPs, with the promise of increased support for STPs from NHS England.[7] There is, however, no extra funding for STPs and *Next Steps* makes it clear that NHS England expects continuous cost-savings to ensure sustainability. The 'NHS' 10 Point Efficiency Plan'[7] clearly sets out where these 'efficiencies' are expected to be made. Examples include reductions in:

- Overall operating costs
- The number of hospital beds
- Temporary staffing costs
- Inefficiencies in prescribing costs
- 'Unwarranted variation' in care quality, efficiency and the provision of care seen as unnecessary.

Do they affect dentistry?

There is currently wide variation in the degree of involvement of local dental professionals with STPs. It is hard to say how things will evolve in the future, and as outlined above, each STP is likely to differ from the others. Input from dentistry at an early stage in STP development would be a seemingly important aim for the profession as a whole. Local Dental Networks (LDNs) have strong links between local dental professionals and NHS England and as such can influence and implement local dental commissioning decisions. It might be useful, therefore, for local dental network chairs to contact their local STP leaders initially to make them aware of how the LDNs operates. As always, ensuring oral health is on the agenda can be challenging, and the variation in how STPs are developing makes it hard to be prescriptive about how to do this. Reducing the pressure on A&E, GPs and other services where dental patients can present could be a useful focus. This should also emphasise the dental profession's involvement in improving oral health at the population level, both to reduce the burden of dental disease generally and because many of the patients who present at GPs and A&E are unlikely to be regular dental attenders. An example of where this is starting to happen is the 'Healthier Lancashire and South Cumbria' partnership. Dental services here are working with GPs to divert patients with dental problems to dentists away from GPs during the period from 8 am–8 pm. They have also ensured oral health is a priority for prevention and population health across the footprint by highlighting potential reductions in hospital admissions for dental general anaesthetics. Both approaches emphasise the need for dental services to highlight benefits to broader partners in health and care in trying to raise the profile of oral health within STPs.

If current trends continue it looks as though local collaborations of health and social care providers will increase the control they have over their own budgets. How long should we, as dentists, allow these groups to form in our absence?

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