

STPs AND ACCOUNTABLE CARE background briefing

As part of our new programme on sustainability and transformation partnerships (STPs) and accountable care, this briefing brings together an overview of how national policy has evolved to promote system-based collaboration, including the development of STPs, accountable care systems (ACSs) and accountable care organisations (ACOs). It includes:

- the national policy story so far, as plans evolved into partnerships
- definitions of key terms associated with STPs, accountable care, and new care models
- five conditions for success based on our conversations with trusts
- NHS Providers' position and information on the support trusts can access from us.

Key points

- NHS trusts support the principle of collaboration at the heart of the STP/ACS approach; it provides one solution to the challenges facing health and care by focusing on local system partnerships rather than isolated activity by any single organisation.
- Trusts are leading, and contributing to, the development of STPs/ACSs, and ACOs across the country and will continue to play a pivotal leadership role in many local areas.
- Key examples of the changes underway in some areas include the development of more strategic approaches to commissioning, through the merger of clinical commissioning groups (CCGs), integrating commissioning with local authorities and the emergence of ACOs, as well as the integration of services, horizontally and vertically, between providers.
- However, the pace of change varies considerably across the country largely dependent on whether areas have a history of strong relationships on which to build. We look forward to working with the national bodies to ensure that all STPs receive the support they need to develop, particularly those areas which are progressing more slowly.
- The national bodies must be clear about the core aims of STPs and ACSs and avoid overloading them, for example, with requests to monitor and deliver new policy aims.
- We need an honest conversation about how to develop governance and accountability mechanisms which support system-level partnerships and complement the statutory obligations of their component organisation – in the case of trusts, the unitary board. We also need to ensure public engagement and consultation on plans for change.
- We need to develop a shared understanding about the terms used in relation to accountable care, particularly the definition of an ACO, as set out by the Department of Health (DH) and NHS England. Local partners must be clear about the contractual and partnership models underpinning new and integrated approaches.

From plans to partnerships

Trusts will recall the genesis of STPs as sustainability and transformation plans which NHS and care organisations were asked to develop collaboratively in new footprints as part of the planning guidance¹ at the end of 2015. These plans were designed to address the core gaps set out in the *Five year forward view*² of improving health equity, closing the financial gap, and reducing unwarranted variation in quality.

Plans for the 44 STPs which now exist across England were published by December 2016 and involve trusts and foundation trusts, CCGs, specialised providers, primary care, local authorities including social care and public health, and sometimes private and voluntary sector provision.

In March 2017 NHS England published *Next steps on the Five year forward view (Next steps)*³ which made clear the expectation that STPs evolve as long-term partnerships rather than time limited plans, as well as an ambition for STP footprints to become ACSs and for some geographical areas to develop ACOs.

Trusts' experiences of developing, and contributing to, the development of their STP or ACS vary considerably depending on a range of factors. These include: the quality and history of local relationships; leadership capacity; the financial and operational challenges facing the health economy and its component organisations; the size and nature of the population; and the geographical challenges inherent in some of the footprints.

Those systems progressing at pace often benefit from a more manageable population size, coterminous boundaries between (some if not all) partners, fewer organisations in the footprint and a natural geographical boundary, consistent with how patients access services in that area. However, local leaders from STP and ACS areas where plans are more advanced uniformly point to a history of trusted partnership working as the foundation for their achievements and future aspirations. They often describe the STP/ACS process as adding momentum to existing plans. Other areas will require more time upfront to build trust, form relationships and move towards the collective agreement of aims and objectives.



STPs...are a pragmatic effort to ensure that the different organisations in a geography plan together and integrate services rather than each individual component – be it the hospital, the GPs, the mental health trusts and the social care – ploughing their own furrow and thinking that the net effect of that will be good things happening for patients...STPs are simply a convenient process for driving that kind of integrated population-oriented planning and care delivery.

Simon Stevens, chief executive, NHS England, in response to a question from Maggie Throup MP at the health select committee as to whether STPs were 'a silver bullet', 10 October 2017

1 <https://www.england.nhs.uk/wp-content/uploads/2015/12/planning-guid-16-17-20-21.pdf>

2 <https://www.england.nhs.uk/publication/nhs-five-year-forward-view/>

3 <https://www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf>

In July 2017, NHS England published a progress dashboard⁴ for STPs in which five were rated outstanding, 20 advanced, 14 making progress and five needs most improvement.⁵

There has been some turnover of STP leads during their short lifetime. However, at the time of writing there were 19 provider chief executive leads, 15 CCG leads, four local authority leads and six independent leads.⁶ Fulfilling the role of STP lead and contributing to an STP requires significant leadership time. Consequently some STP leads, including trust chief executives, are adopting the STP lead role full time.

Governance and the art of the possible

The move towards locally-based collaboration rather than competition as the key driver of improvement in the system marks a significant shift in national policy, not least given that much of the latter is underpinned legislatively by the Health and Social Care Act 2012. While the current legal frameworks certainly do not prevent partnership working and integration in different forms, this makes for a complex environment for trusts, and their partners, to navigate.

STPs have no legal status and derive their decision making powers from the statutory bodies which comprise them. Reconfiguring services in health and care is always controversial and despite the high-level parameters for public engagement within the *Next steps* document,⁷ this remains a challenge and a source of media and political attention locally and nationally. For example, although Labour has consistently supported devolution and the integration of health and care, they have concerns about the development of STPs and ACOs⁸ on the grounds they are not based in statute and, in their view, could open the NHS up to privatisation, an argument which is gaining ground.

The *Next steps* document also sets out some expectations with regard to governance. This includes the requirement that each STP forms “a board drawn from constituent organisations...including appropriate non-executive participation, partners from general practice, and in local government wherever appropriate”. In addition, “formal CCG committees in common or other appropriate decision making mechanisms [should be created] where needed for strategic decisions between NHS organisations”⁹

We know that developing the governance mechanisms to underpin local relationships and support the legal duties for decision making and accountability in the component partner

4 <https://www.england.nhs.uk/systemchange/sustainability-and-transformation-partnerships-progress-dashboard-baseline-view/> (accessed 11 Dec 2017)

5 <https://www.england.nhs.uk/publication/sustainability-and-transformation-partnerships-progress-dashboard-baseline-view/> (accessed 12 Dec 2017)

6 <https://www.england.nhs.uk/stps/view-stps/#mids>

7 <https://www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf> (p.34-5)

8 <https://labourlist.org/2017/12/jon-ashworth-toxic-privatisation-agenda-destroys-the-soul-of-our-nhs/> (accessed 11 Dec 2017)

9 <https://www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf> (p.34)

organisations remains a priority for trusts.¹⁰ Many trust boards have raised issues about how best to ensure non-executive and governor engagement in the STP process, as well as clinical engagement. In addition to recent publications such as *The art of the possible* with Hempsons, NHS Providers will share existing practice with regard to governance more widely this year as part of our STPs and accountable care programme.



In a challenged local health and care economy our partners are committed to the destination and the benefits for our population but we're discovering the best route to get there. We do need an honest conversation about governance and what is possible in the existing frameworks.

Sue Harris, Director of Strategy and Partnerships, Worcestershire Health and Care NHS Trust, and Communications and Engagement Lead, Herefordshire and Worcestershire STP

A vehicle for change?

There is no doubt that STPs, ACSs, and ACOs are seen nationally as the mechanism to deliver the aspirations of the *Five year forward view* including returning the system to financial balance. Our analysis from speaking with trusts is that STPs are being used locally as a catalyst to:

- plan and deliver the local reconfiguration of services
- helpfully support discussions on day-to-day operational collaboration for instance on winter planning
- as a means of driving and locally overseeing new models of integrated care.

However there is also concern from trusts that STPs are also being asked by the national bodies to act as:

- The default footprint to deliver national policy. Initiatives and increasingly funding are now passed down for delivery at STP footprints. Recent examples include the introduction of system control totals with the ability to apply to NHS Improvement and NHS England to adjust organisational control totals as long as the system target is met; the allocation of capital funding for 18/19 to the eight ACSs; and monitoring requests relating to workforce; and
- An additional layer of performance management with a strong encouragement for STPs to monitor and manage finance and performance at a system levels.

¹⁰ Research from the HFMA shows majority of CCG and provider finance managers have concerns about governance and this reflects feedback from our members: <https://www.hfma.org.uk/publications/details/nhs-financial-temperature-check-briefing-november-2017> (accessed 18 Dec 2017)

Our view is that there is considerable variation in different STPs' capacity to deliver on all of these expectations at pace.

In those areas with established partnerships, the renewed focus on collaboration is certainly fueling significant structural change, not least the development of a more strategic approach to commissioning. This includes mergers of CCGs,¹¹ or arrangements whereby several CCGs appoint a shared accountable officer¹² and the development of integrated commissioning arrangements with local authorities.¹³

In addition, there is a trend towards the consolidation of provider organisations through new alliances and groups, or proposed merger both to tackle financial challenges and to reduce unwarranted variation in quality standards. The extent to which an STP/ACS drives this degree of change will vary considerably but in some areas they are becoming a natural vehicle for conversations to tackle deep seated issues such as:

- developing a more preventative and population health-based approach
- moving care closer to home
- improving pathways for clinical services through horizontal and or vertical integration
- managing pressures on the ambulance service
- delivering efficiencies through integration of back office and clinical services across a number of providers (horizontal integration).

Clearly those STPs/ACs with more established relationships will rightly be keen to negotiate more freedoms and flexibilities in exchange for taking on collective responsibilities for finance and performance at a system level. However other STPs lack the relationships, mandate or infrastructure to deliver such a challenging range of priorities so quickly.

It is also important to remember that the NHS has always delivered across a number of footprints and will continue to do so. As such, the STP will play an important role but will not always be the optimum mechanism for delivery. For example, specialised and ambulance services operate to a wider population on regional and sub regional footprints which are larger than an STP; at the other end of the spectrum much of the frontline integration of health and social care is taking place on sub STP footprints in place-based or neighbourhood systems; and some initiatives will continue to be delivered by individual organisations.

11 <https://www.hsj.co.uk/commissioning/mapped-ccg-mergers-shared-leaders-and-link-ups-with-councils/7016646.article> (accessed Dec 19 2017)

12 <https://www.hsj.co.uk/nhs-bromley-ccg/new-leader-named-for-five-ccgs-and-stp/7021300.article> (accessed 19 Dec 2017)

13 <https://www.hsj.co.uk/workforce/council-chiefs-to-take-on-leadership-of-several-ccgs/7021284.article> (accessed 19 Dec 2017)

Are we speaking the same language?

It has become clear over recent months that the terminology and acronyms used to describe collaboration and accountable care approaches are not always fully understood or are being used interchangeably. Here we offer definitions and commentary on the most commonly used concepts to support a shared understanding and effective communication.

Population health

Given the focus on prevention at the heart of the *Five year forward view* approach it is natural that STPs/ACSs should be developed with the aspirations of population health in mind. In some local areas this will mean widening partnerships to address the wider determinants of health – housing, education, transport and access to services. The King's Fund defines population health as “addressing the health outcomes of a defined group of people, as well as the distribution of health outcomes within the group so that health equity – the avoidable differences in health between different parts of the population – is a core part of understanding population health.”¹⁴



[STPs are] clearly...not going to be something that solves every problem that we face in the NHS, but they are a very important part of our long-term strategy for the NHS, which is to move the centre of gravity in our healthcare system to one where prevention is taken as seriously as curing disease. That means tackling issues upstream in an out-of-hospital context, investment in mental health, general practice and other out of hospital services where it is much cheaper to address issues than if you wait until people need expensive hospital treatment.

Rt Hon Jeremy Hunt MP, Secretary of State for Health
(10 October 2017, oral evidence, health select committee)

How far STPs and ACSs are able to move to population health approaches in the short term will depend on shared understanding and analysis of the issues facing their population, and the ability to take stock and invest in new ways of working rather than be drawn into operational imperatives. As Chris O'Neill, Director of Humber Coast and Vale STP puts it, “We are trying to encourage providers and their partners to think ‘future state’ – with an increasing, collective focus on population health rather than organisational targets.”

Trusts also recognised the importance of wider partnership working in delivering a more outcome-focused, population-based approach. Many cited the importance of relationships with primary care and local government in particular. For instance, Jade Renville, Trust Secretary, Taunton and Somerset NHS Foundation Trust commented: “Our STP senior responsible officer is from local government and engagement with the council, social care and wider services has been a core benefit of the partnership to date.”

¹⁴ <https://www.kingsfund.org.uk/publications/what-does-improving-population-health-mean> (accessed 4 December 2017)

Accountable care systems (ACS)

The *Next steps* document describes an ACS as “an ‘evolved’ version of an STP that is ‘working as a locally integrated health system...in which NHS organisations (both commissioners and providers), often in partnership with local authorities, choose to take on clear collective responsibility for resources and population health”¹⁵ either on the STP footprint or, more likely, a smaller, sub STP footprint.

In return for increased responsibilities as a system, an ACS will have access to new freedoms and flexibilities. These include: the development of a system-level performance scorecard; a system-level control total; the potential for CCGs to have delegated decision rights in respect of primary care, mental health and specialised services; transformation funding; and support from NHS England and NHS Improvement to develop new ways of working. The national bodies are also working with ACSs to develop an approach to system-level oversight and a governance maturity tool to assess the level of freedoms an ACS should enjoy, in complement to existing, institutionally-focused regulation.

NHS England has identified the following eight areas to lead the development of ACSs. They have each developed a memorandum of understanding with the national bodies.

- 1 Frimley Health including Slough, Surrey Heath and Aldershot
- 2 South Yorkshire and Bassetlaw, covering Barnsley, Bassetlew, Doncaster, Rotherham and Sheffield
- 3 Nottinghamshire, with an early focus on Greater Nottingham and Rushcliffe
- 4 Blackpool and Fylde Coast with the potential to spread to other parts of the Lancashire and south Cumbria at a later stage
- 5 Dorset
- 6 Luton, with Milton Keynes and Bedfordshire
- 7 Berkshire West, covering Reading, Newbury and Wokingham
- 8 Buckinghamshire

In addition to the Manchester devolution arrangements,¹⁶ Surrey Heartlands will receive support to integrate health and care in a devolution agreement. Further ACSs are expected to be confirmed by NHS England and NHS Improvement in 2018.¹⁷

15 <https://www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf> (p.35-6)

16 <https://www.greatermanchester-ca.gov.uk/homepage/59/devolution>

17 <https://www.england.nhs.uk/accountable-care-systems/> (accessed 6 Dec 2017)

Accountable care organisations (ACOs)

The King's Fund sums up the emergence of accountable care as "relatively new", originating in the United States and representing "the most recent manifestation of well-known integrated systems, such as Kaiser Permanente." They identify three common characteristics of accountable care organisations: "firstly, that they involve a provider or an alliance of providers which collaborate to meet the needs of a defined population, secondly, that the providers take responsibility for a budget allocated by commissioner(s) and thirdly, that the ACO works under a contract that specifies the outcomes and objectives it is required to deliver within a given budget, often extending over a number of years."¹⁸

In the *Next steps* document, NHS England describes the potential for an ACS to evolve into an ACO. In practice, and depending on patient populations and local relationships, presumably an ACS could also develop more than one ACO within its footprint.

Given the varied connotations of the term accountable care organisation it is important to focus on what the development of an ACO means for health and care within the English NHS. NHS England states that an ACO occurs "where the commissioners in that area have a contract with a single organisation for the great majority of health and care services and for population health in the area."¹⁹ A recent DH consultation²⁰ on the development of the existing accountable care contract²¹ makes clear that the two vanguard models, multi-speciality community provider (MCP) and integrated primary and acute care systems (PACs) could also be considered as accountable care organisations.

Our understanding is therefore that the development of an ACO requires the creation of a strategic commissioning function procuring one organisation to take responsibility for delivering outcomes for a given population, within an agreed budget, over an agreed timeframe. Within this, the contracted organisation would adopt tactical commissioning responsibilities and deliver particular services with a range of different partners.

As the ACO contract can only be let to one provider, there is a clear opportunity for trusts to adopt a leadership role in collaboration with partners in this regard. Commentators recently suggested that existing trusts and foundation trusts, or a newly formed trust, could be the legal entity for developing an ACO.²² In addition, DH is seeking to make minor amendments to ten regulations by February 2018 to allow for the development of ACOs (for example to allow GPs to stay on their existing contracts within an ACO, and to set out how NHS pensions would apply for staff in an ACO).²³

18 <https://www.kingsfund.org.uk/publications/accountable-care-organisations-explained>

19 <https://www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf> (p.37)

20 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/643714/ACO-contract-reg-changes-consultation-1.pdf

21 <https://www.england.nhs.uk/new-business-models/publications/>

22 <https://www.hsj.co.uk/commissioning/new-form-of-nhs-organisation-planned-for-first-acos/7021292.article?> (accessed 18 Dec 2017)

23 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/643714/ACO-contract-reg-changes-consultation-1.pdf (p.4-5)

Given the complexity of these changes, the indications are that the national bodies do not envisage working with many ACOs in the short term. In fact NHS England acknowledges that only “a few areas are on the road to developing an ACO” (often where an MCP or PACs vanguard project has progressed successfully), that this process takes years and involves a complex procurement process and a different approach to risk management.²⁴ The national bodies have confirmed they are currently working closely with four local areas where a procurement process to establish an ACO is underway.

Despite the definitions above, trusts and their partners are understandably adopting the language of accountable care in different ways and pursuing similar outcomes and objectives through partnerships and alliances. While this makes sense where it helps to drive collaborative, patient-centred behaviours, it is important to ensure clarity is maintained on the legal, contractual and governance frameworks underpinning the approach.



In West, North and East Cumbria we are identifying and promoting the collaborative behaviours we know will support the development of accountable care, and we are doing it from existing resources. We are establishing a joint executive team and developing joint non-executive positions between the two major provider trusts in our ACS to support this endeavour.

Daniel Scheffer, Joint Company Secretary for Cumbria Partnership NHS Foundation Trust and North Cumbria University Hospitals NHS Trust

Vanguards and new care models

National funding and support for the new care models originally announced in the *Five year forward view* comes to an end at the end of this financial year. However, at local levels, work continues both within and outside of the official programme to develop more integrated models of care for patients. The achievements of many of the vanguards have been acknowledged, not least in reducing hospital admissions²⁵ and the learning from the programme should inform the development of STPs, ACSs and ACOs.

Moreover many of the STPs/ACSs seen to be progressing well include and involve new care models already in operation. In some areas this adds another level of complexity to STP and ACS plans but in many local areas it will make sense to develop or pilot integration at sub-STP levels.

The following provides a reminder of the main vanguard new care models:

²⁴ <https://www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf> (p.37)

²⁵ <https://www.hsj.co.uk/emergency-care/vanguard-areas-saw-lower-activity-growth-last-year-analysis-shows/7021004.article> (accessed 11 Dec 2017)

The multispecialty community provider model (MCP) focuses on moving specialist care out of hospitals and into the community. Groups of GP practices work together and collaborate with other health and social care professionals to provide a range of primary, community, outpatient, mental health and social care services. MCPs build on an understanding of population health needs and ultimately might take on contractual responsibility for the health budget for their whole population. As set out above, this model is considered to be a form of ACO.

Integrated primary and acute care systems (PACS) have a similar population health focus to MCPs, but they also join up hospitals with primary, community and mental health services to improve the coordination of care and move care out of hospital where it is appropriate to do so. Under the PACS model, a single entity – typically a lead provider – would take responsibility for the health needs of the whole population and the delivery of health care services. As set out above, this model is considered to be a form of ACO.

Acute care collaboration (ACC) vanguards link local acute hospital providers together to improve the clinical quality and financial sustainability of care services. The organisational form of these models ranges from collaborative to contractual and can include consolidation. The scope of their services includes hospital groups in which several providers work collaboratively under a single group structure and formal joint working arrangements; multi-service networks in which several providers work collaboratively to provide a range of clinical and non-clinical services; and single service networks in which networks of trusts and their clinical teams work on a specific service.

For example, Matt Graham, Programme Director, West Yorkshire Association of Acute Trusts, describes the approach in the West Yorkshire and Harrogate Health and Care Partnership: “The West Yorkshire Association of Acute Trusts (WYAAT) is an acute care collaboration between the six acute trusts in West Yorkshire and Harrogate and we have established a committee in common of chairs and chief executives to oversee the collaboration. Although WYAAT was created before the STP process, it has become a core part of the WYH Health and Care Partnership. The lead chief executive for WYAAT sits on the partnership’s leadership executive and other chief executives lead partnership workstreams. WYAAT provides a natural delivery mechanism for a number of system-wide programmes both to deliver efficiencies and improve the quality of services for patients. As part of the partnership, we are using WYAAT to build a bottom-up approach, based on eliminating unwarranted variation through strong clinical involvement, to tackle a range of issues, from back office efficiencies, through networked clinical support services, to transformation of clinical services”.

Enhanced health in care homes vanguards aim to improve older people’s quality of life and healthcare. NHS services work closely with care home providers, local authorities and the voluntary sector to join up health, care and rehabilitation services, optimising the health of elderly residents.

In order to deliver the five principles set out in the Keogh review, **urgent and emergency care vanguards** are also improving the coordination of services to reduce pressure on A&E departments.

Five keys to success

From our conversations with trusts involved in STPs at all levels of development, the common enablers we have identified can be summarised as follows:

- **The quality of relationships between all key players in the local system:** GPs, local authorities, CCGs, acute, mental health, ambulance and specialist providers – alongside consideration of the voluntary and private sectors.
- **The quality and capacity of local leaders** and their ability to engage and mobilise the wider workforce, including clinicians, and engage with the public. Many people mentioned how difficult it is to find the capacity and resource to drive change until it becomes ‘the day job’.
- **A collective commitment to prioritise the needs of patients and the system** at the expense of the individual institution, based on a shared understanding and analysis of local challenges.
- **A ruthless focus on a small number of practical priorities** and a drive for practical improvements on the ground in chosen priority areas, rather than just trying to build a grand plan.
- **A culture of pragmatism meets continuous improvement.** Trying new things, learning and making improvements if it doesn’t work.



In terms of enablers, the starting point for any collaboration is trust. Resources to invest in a change management process, and to explore flexibilities in how we make best use of our valued workforce at a system level would also be of benefit.

Jane Tomkinson, Chief Executive, Liverpool Heart and Chest NHS Foundation Trust and Senior Responsible Officer for the cardiovascular strand of the Cheshire and Merseyside STP

In West, North and East Cumbria, we are lucky to have a relatively simple, decluttered landscape with a manageable number of partners. We have one system-wide vision, which has improving population health at the heart of it. We have developed eight place-based, integrated care teams in our ACS as the focus for building our population health management system. We are also encouraging our staff to ‘think without walls’ and developing system-wide enabling strategies to support them in this such as organisational development, information management and technology, and a shared and consistent improvement methodology.

Ramona Duguid, Programme Director,
West, North and East Cumbria Integrated Health and Care System – ACS/ACO

NHS Providers' view

In summary, STPs are clearly developing at different paces across the country. Those involved in the ACS model or developing an ACO are progressing well. Other areas need additional time and resource to invest in relationship building to underpin new partnerships.

We fully support the principle of collaboration underpinning the STP process and the move to develop accountable care models which will improve and integrate services for local populations. We welcome the focus on population health approaches and a clear acknowledgement from government and the national bodies that the solutions to the challenges facing health and care services in England lie in system-based solutions rather than isolated activity by individual organisations. We also welcome the opportunities for local leadership generated by STPs/ACs and the emergence of ACOs in some parts of the country. We strongly support the national bodies' acceptance that depending on their starting point, different parts of the country will develop their approaches at different paces and in different ways.

It is clear that NHS trusts are, rightly, playing a key role in both leading and contributing to new partnerships to improve outcomes and address the challenges set out in the *Five year forward view* of improving health inequity, improving quality and reducing the financial gap.

However in order for trusts, their partners and the wider public to reap the rewards of the significant resource, leadership time and energy invested in the STP and ACS process, it is essential to remain realistic about the scale of the ask of STPs and their component organisations. We must ensure that both trusts and the STPs they contribute to are set a deliverable task within the available funding envelope. These new partnerships and approaches, however well intentioned, are developing within a legislative framework and a system architecture set up for different times and a competitive rather than collaborative approach which will create additional complexities to navigate – locally and nationally. As the recent legal challenge demonstrates, it is important that the national bodies have a convincing public narrative in support of the approach.

During the development of STPs, we have raised concerns about the pace of change expected and the multiple priorities asked of STPs by national bodies. While we welcome the investment and support that NHS England and NHS Improvement are offering to well-established partnerships, it is only fair to providers, their partners and taxpayers that support (and funding) is offered to STPs at all stages of development. It would be wrong to penalise those populations where STPs are developing at a slower pace, for a range of legitimate reasons.

We also have concerns about the increasing tendency for STPs to become the default footprint for delivering national policy initiatives when they do not have the mandate, statutory authority, or infrastructure to deliver. On the other hand, we accept that more established and progressive partnerships will benefit from negotiating additional freedoms and flexibilities with the national bodies.

While STPs and ACs are an understandable and pragmatic solution to the complex challenges facing the health and care system, it is important not to lose sight of the fact that

statutory responsibilities in the system still lie with individual organisations, notably trusts, and CCGs. We look forward to working with trusts and the national bodies to ensure that the governance arrangements at a system level complement the statutory accountabilities of provider boards and other organisations. We also recognise the importance of non-executive engagement, clinical engagement and public consultation on new proposals at organisational and system levels.

We look forward to working with trusts and their partners, the national bodies and partner organisations such as the NHS Confederation, the Local Government Association, NHS Clinical Commissioners and think-tanks to help capture and share the learning from the development of STPs/ACs, and ACOs. We hope our new programme of influence and support in this space will both support our trusts and help fuel debate about the next steps for system-level collaboration and accountable care.

Support for trusts

In the next six months we will be setting out a programme of support for members around STPs, ACSs and ACOs which will build on the learning from a shared programme of support (with NHS Confederation, NHS Clinical Commissioners and the Local Government Association) for the vanguard programme and include:

- briefings, blogs, articles and case study publications with a clear focus on sharing practice and understanding of the trust provider perspective
- publications such as our *Provider voices* series to capture the range of views on STPs, ACSs and accountable care and fuel debate
- the development of our work on governance mechanisms to support STPs, ACSs and ACOs
- maximising opportunities to use our existing networks, development offers and events to showcase case study examples and offer a safe space for providers to share achievements and concerns, include our board development programme, GovernWell, and executive and non-executive induction, annual conference, *Governor focus* conference and the governance conference
- in addition, we look forward to exploring how our existing partnership with the NHS Confederation, NHS Clinical Commissioners and the Local Government Association can develop new and more bespoke offers of peer-based support for those STP areas voluntarily seeking additional help.

Your feedback on this briefing and the development of our wider offer is very welcome – to share your learning so far or offer feedback on our approach, please contact head of strategy miriam.deakin@nhsproviders.org

For more information:

www.nhsproviders.org/stps-and-accountable-care

Suggested citation:

NHS Providers (December 2017), *STPs and accountable care: background briefing*