Health select committee: Sustainability and transformation partnerships inquiry

Submission by NHS Providers, January 2018

NHS Providers is the membership organisation and trade association for the NHS hospital, mental health, community and ambulance services that treat patients and service users in the NHS. We help those NHS foundation trusts and trusts to deliver high-quality, patient-focused care by enabling them to learn from each other, acting as their public voice and helping shape the system in which they operate. NHS Providers has 99% of all trusts in membership, collectively accounting for £74bn of annual expenditure and employing more than one million staff.

Key messages

- **Context:** In the face of significantly increasing levels of demand and acuity, with funding levels not keeping pace, the need for health and care services to transform is widely recognised both locally and nationally. Trust leaders support collaborative working, the idea of system-based planning and the vision outlined in the *Five year forward view* of new ways of providing care. As the NHS moves from a focus on individual NHS institutions to integrated local health and care systems, it is right that the most viable vehicles for achieving this – sustainability and transformation partnerships (STPs) and accountable care models – are properly scrutinised, locally and nationally.

- **Effective integration:** The NHS and social care are being asked to deliver a breadth and scale of transformation that many other international health systems have taken at least a decade to achieve. It remains early days in their development and, given the complexity of the task, it is understandable that the progress made by each footprint to date is variable. In our recent conversations with trusts, a number of key factors contributing to the progress of STPs have become clear. Above all, local leaders from STP areas where plans are more advanced uniformly point to a history of trusted partnership working as the foundation for their achievements and future aspirations.

- **Progress Dashboard:** The ratings give a useful broad indication of progress, but should be treated with a degree of caution, both in their interpretation and their application. In particular, the use of performance figures underlines the continuing tension between sustainability and transformation expectations, with no current measures looking directly at the degree of change against plan and integration achieved. The dashboard also highlights the issue of how the regulators balance oversight of health systems with individual institutions. Regardless of their rating, the national bodies should support all STPs, not just those that are advanced or behind, and avoid further polarisation of the performance of the system. We need to consider both how we support all STP footprints and how we manage the reality that it may be impossible for some areas to come to fruition and make sufficient progress to deliver the necessary change.

- **Deliverability of STP plans:** Despite the strength of the vision and the degree of agreement behind STPs, the NHS risks being pulled away from collaboration through pressure on financial and staffing resources. There is also a lack of consistent focus and priorities set out by the NHS national bodies, which is proving challenging, and a continuing tension over whether short-term financial sustainability or long-term strategic transformation is the priority for STPs in the eyes of the NHS national bodies. The considerable financial and operational investment is further under-acknowledged: local areas will need to ensure a managed transition (most likely through a period of double running) to ensure new models are proven. While STPs and improved care

configuration are likely to contribute to better performance standards, this will only be over the long-term. They are not a short-term route to meeting the NHS constitutional standards.

- **Credibility and realism of STP plans:** The changes in emphasis around sustainability versus transformation mean that the STP plans are similarly variable in whether they were predominantly based on either (1) on the expected funding envelope, and tailored to fit, or (2) the ambition for future health and care services first and foremost, and then adapted to the expected available funding. In reviewing STP plans, we would encourage consideration of issues including: how bed capacity is redistributed through the system, the investment required and efficiencies expected, the leadership and workforce implications, and the intended timescales.

- **Delivery of care by accountable care systems (ACSs):** Accountable care models – within the England health and care system – bring together a variety of provider organisations, including primary care, to plan for and meet the care needs for a defined population within a set budget to an agreed level of quality. While an ACS is not necessarily the same as an STP – not least as one STP footprint may ultimately encompass multiple ACSs – ACSs and STPs are pursuing similar objectives through similar means.

- **Governance, management and leadership:** Neither STPs nor ACSs are statutory bodies – they derive their legitimacy from their component organisations, and it is largely this fact that is driving the complexity around their development. As STPs and accountable care models move to becoming delivery vehicles, it will be important to ask: are internal governance arrangements suitably robust; are the structures in place for each STP legal; are accountability structures clear; and how will the oversight regime operate?

- **Legislative, policy and other barriers:** Competition as the key driver of improvement in the system is underpinned in legislation by the Health and Social Care Act 2012. The move towards locally-based collaboration is therefore a significant shift in national policy. While the current legal frameworks do not prevent partnership working and integration in different forms, this makes for a complex environment for trusts, and their partners, to navigate. There are also a number of policy areas which need to be addressed in taking STPs and accountable care models forward. First and foremost, there needs to be far greater clarity and discipline over what STPs are intended to deliver. Additional issues include ensuring support for all STPs, realistic expectations, regulatory and financial alignment, and clarity over data sharing.

- **Public engagement:** Reconfiguring services in health and care has historically been highly controversial. Despite the high-level parameters for public engagement within the *Next steps*, this has arguably not been robustly promoted by the arm's length bodies. Overcoming the concerns that have arisen as a result will take considerable time and effort, but it is crucial to do so – otherwise the progress made in improving patient care through better joined up services will be jeopardised.

A. Introduction

1. The 2015 planning guidance asked NHS and care organisations to collaborate in developing sustainability and transformation plans across 44 footprints.[1] The plans, published in December 2016, were designed to address the core gaps set out in the *Five year forward view* (5YFV) of

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

improving health equity, closing the financial gap, and reducing unwarranted variation in quality.[2]

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

3. In the face of significantly increasing levels of demand and acuity, with funding levels not keeping pace, the need for health and care services to transform is widely recognised both locally and nationally. In recent years, a series of initiatives – including the Better Care Fund and the Integration Pioneers – have been designed to accelerate closer working both within NHS services and between the NHS and social care. These have had mixed success, but STPs (along with the vanguard programme[4]) have experienced a level of investment of local leadership time, energy and resource beyond their predecessor initiatives.

4. However, the establishment of STPs has been controversial, with their introduction and subsequent levels of public support undermined by the national approach to and guidance on local engagement. STPs (and accountable care models), by encouraging collaboration over competition and by drawing together individual lines of accountability, are also testing the limits and application of the Health and Social Care Act 2012. These factors, combined with the nomenclature of "accountable care" which brings with it connotations of the US private healthcare system, have left the changes vulnerable to judicial review and there are currently two legal challenges to their progression.

5. Moreover, the difficulty of the task facing health and social care should not be underestimated: wide-ranging transformation is being undertaken against a backdrop of an increasingly unstable service and a widening financial gap, with complex new local system relationships being developed at a point when leadership and management capacity is already under pressure.

6. As the NHS moves from a focus on individual NHS institutions to integrated local health and care systems, it is right that the current and most viable vehicles for achieving this – STPs and accountable care models – are properly scrutinised, locally and nationally.

B. 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?

7. The NHS and social care are being asked to deliver a breadth and scale of transformation that many other international health systems have taken at least a decade to achieve. It remains

[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
[4] In January 2015 the NHS invited local health partnerships to apply for 'vanguard' status for the new care models programme, as an early step towards delivering the NHS Five year forward view and supporting service integration and improvement. Vanguard projects in 50 localities are now up and running. Each vanguard site is leading the development of a new care model and receives dedicated support and transformation funding from the new care models team, including help in overcoming barriers and building capability to enable change that can be replicated elsewhere. The models are intended to provide a blueprint that can be used to transform care delivery across the system and detailed frameworks are being developed to support this goal.

early days in their development and, given the complexity of the task, it is understandable that the progress made by each footprint to date is variable.

8. There are a number of core issues which STPs are seeking to address. In particular, STPs have become a natural vehicle for tackling deep-seated issues such as:

    a. **Whole population management,** with a focus on how to improve the health outcomes of the entire population serviced, not just those presenting at a hospital or GP surgery
    b. **Prevention and wellbeing,** investing more in ensuring the health and wellbeing of the population served and in preventing illness, rather than just focusing on those who become ill
    c. **Moving care closer to home,** ensuring that as much care as possible is delivered in a patient's home or community setting, as well as ensuring that hospital care is used only where necessary
    d. **Greater patient self-management and control,** enabling citizens – such as those with long-term conditions – to take greater responsibility and control of their own health and treatment
    e. **New care models,** joining up care across health and social care, physical and mental health, and primary and secondary care
    f. **Strategic commissioning,** ensuring commissioning focuses on whole population health outcomes and avoids being overly focused on tactical contract management
    g. **Information technology,** using information technology more effectively to support and enable the required changes
    h. **Building blocks to underpin and enable change required,** developing new contracting, funding, workforce and information governance models and organisational forms

9. As each footprint pursues these changes, partners will be responding to the needs of their populations and existing service patterns; facing specific local organisational, workforce and financial challenges; and seeking ways of overcoming shared barriers around governance, accountability and regulation.

10. In April 2017, NHS Providers surveyed NHS foundation trusts and trusts on their views of local transformation.[5] While there were signs of progress in a small number, survey respondents on the whole had little confidence that transformation activity in their local area would progress as well as it needed to over the coming six months to deliver long term plans. Almost two-thirds (62%) of leaders were worried that their local area was not transforming quickly enough and fewer than two in 10 (17%) were confident that this was happening.

11. In the first months of the STP process, there were also signs that while trusts, clinical commissioning groups (CCGs) and local authorities were engaged, primary care, patient groups and the third sector were less so.[6] This was worrying considering that all local stakeholders and partners need to be fully engaged if successful outcomes are to be achieved.

12. Since then (and as discussed in section C) NHS England has rated each STP through a progress dashboard. It is clear that STPs are developing at different paces across the country. A handful are making significant progress or significantly behind, with the clear majority in the middle of the spectrum. To date, NHS England and NHS Improvement have had a tendency to invest in those local areas seen to be progressing most swiftly, whereas it is only right – given the national

[5] 158 chairs and chief executives from 125 NHS trusts that responded, cover more than half (54%) of all trusts with all regions and trust types well represented.

[6] See for example our November 2016 report, http://nhsproviders.org/state-of-the-provider-sector-11-16/transformation

imperative to transform and systemic financial pressures – that the organisations within all STP areas, and the populations they serve, receive support.

13. In our recent conversations with trusts, a number of key factors contributing to the progress of STPs have become clear. Above all, local leaders from STP 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 already have a shared culture and commitment, often describing the STP process as adding momentum to existing plans. The common enablers to progress we have identified are:

    - **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.

14. Where such factors are absent or less developed, we would expect them to require more time upfront to build trust, form relationships and move towards the collective agreement of aims and objectives.

15. In addition to the quality of existing relationships, those STPs progressing at pace often feature a number of practical factors that better enable closer working:

    a. A more manageable population size
    b. Coterminous boundaries between (some if not all) partners
    c. Fewer organisations in the footprint
    d. A natural geographical boundary, consistent with patient flow

16. However, it is also important to note 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:

    a. Specialised and ambulance services operate to a wider population on regional and sub regional footprints which are larger than an STP
    b. Much of the frontline integration of health and social care is taking place on sub-STP footprints in place-based or neighbourhood systems
    c. Some initiatives will continue to be delivered by individual organisations

17. Our response to the effectiveness of local engagement is given in section I.

C. 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?

18. NHS England states that the sustainability and transformation partnerships (STP) progress dashboard is intended to give *"an initial baseline view of STPs' work, showing the starting point from which they will drive improvements in care. It tracks the combined achievements of local services through 17 performance indicators across nine priority areas, each falling into three core themes of hospital performance, patient-focused change and transformation"*. NHS England intends to update the dashboard annually to enable progress to be tracked. Its methodology may also evolve over time.[7]

19. In July 2017, NHS England rated each STP, with five rated as outstanding, 20 as advanced, 14 as making progress, and four as needs most improvement.[8] The ratings give a useful broad indication of progress, but should be treated with a degree of caution, both in their interpretation and their application.

20. While it is helpful that NHS England is working from existing data rather than creating an additional reporting burden, the measures currently included in the dashboard risk giving only a partial impression. For example, an indicator of providers in special measures is included, but not of CCGs in special measures. Moreover, the dashboard collects organisational performance measures rather than data intended to report against progress in STP implementation. The use of performance figures also underlines the continuing tension between sustainability and transformation expectations, with no current measures looking directly at the degree of change against plan and integration achieved.

21. The dashboard also highlights the issue of how the regulators balance oversight of health systems with individual institutions, particularly in terms of the consistency of their expectations (both between NHS Improvement and NHS England, and between systems and organisations). Given trusts are already held to account for their contribution to the wider system through the NHS Improvement's Single Oversight Framework, it is important that the national bodies remain consistent and that these new ratings do not result in different signals being sent to trusts and other STP partners about priorities to focus on.

22. Finally, the national bodies should support all STPs, not just those that are advanced or behind, and avoid further polarisation of the performance of the system. Successful local systems – those who are at the forefront of collaboration and delivery – have so far been rewarded with additional investment on an STP footprint basis. Often that progress reflects where STPs have benefited from, amongst other things, pre-existing relationships and coterminous geographies. Insufficient financial and practical support has been given to those – encompassing the majority of areas – tackling considerable barriers to integration and struggling to progress as quickly.

23. The nature of the preferential approach being taken is illustrated by the National Audit Office (NAO) in its January 2018 report, 'Sustainability and transformation in the NHS': *"The Department has allocated early capital funding to those partnerships rated as the most advanced. … NHS England and NHS Improvement are supporting partnerships and organisations in difficulty through other, non-financial ways. However, these partnerships and organisations*

[7] https://www.england.nhs.uk/systemchange/sustainability-and-transformation-partnerships-progress-dashboard-baseline-view/

[8] https://www.england.nhs.uk/publication/sustainability-and-transformation-partnerships-progress-dashboard-baseline-view/

face additional challenges. For example, to discourage trusts in financial special measures from seeking additional financial support, the Department imposes on them higher interest rates on loans (6% compared with 1.5% for most other trusts)."[9]

24. The NAO also notes, *"Local transformation of care is being hampered by a lack of resources and ongoing pressure to make increasingly tighter finances balance each year. Effective transformation takes time and resources. But the partnerships we visited told us they were struggling to find the resources to further develop and implement their plans. Partnerships' tight financial positions make it difficult to shift focus from short-term day-to-day pressures."*[10] The current approach to support makes it more likely that those STPs facing the greatest challenges will fall further behind. We need to consider both how we support all STP footprints and how we manage the reality that it may be impossible for some areas to come to fruition and make sufficient progress to deliver the necessary change.

D. 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?

Financial and workforce pressures in the NHS

25. Despite the strength of the vision and the degree of agreement behind STPs, the NHS risks being pulled away from collaboration through pressure on financial and staffing resources.

26. The NHS is struggling to maintain performance in the face of rising demand and constrained funding, with severe pressures apparent across every health sector and across social care. The service is currently unable to deliver three key acute care targets, with the 95% 4-hour A&E target last met in July 2015; the 92% 18-week RTT target last met in February 2016; and the 85% 62 day cancer referral to treatment target last met in December 2015.[11] The rate of delayed transfers of care (DTOCs) remains stubbornly above the 3.5% government target.[12] This has been despite the best efforts of staff and despite realising productivity gains much greater than the whole economy average.[13] Beyond the provider sector, mounting pressure can be seen in primary care as GPs struggle to maintain patient access and in adult social care, with the Care Quality Commission (CQC) warning in 2017 that it was *"approaching tipping point"*.[14]

27. Recovery of the four-hour A&E standard to the trajectory set out in *Next Steps on the Five Year Forward View* currently looks to be impossible. In March 2017, NHS Providers estimated that regaining the 18-week elective surgery standard alone would cost an estimated minimum of £2-2.5bn – an estimate made before decisions in the run up to and during winter 2017/18 to cancel elective operations. This amount is far more than the £1.6bn of additional revenue funding allocated across the service in the 2017 Budget.

[9] https://www.nao.org.uk/report/sustainability-and-transformation-in-the-nhs/
[10] https://www.nao.org.uk/report/sustainability-and-transformation-in-the-nhs/
[11] https://www.england.nhs.uk/statistics/statistical-work-areas/
[12] https://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/
[13] http://www.health.org.uk/sites/health/files/Election%20briefing%20NHS%20and%20social%20care%20funding.pdf
[14] https://www.england.nhs.uk/statistics/2017/07/06/gp-patient-survey-2017/; http://www.cqc.org.uk/publications/major-report/state-care

28. On capital funding, Sir Robert Naylor's review of NHS property and estates calculated that £10bn was required to fund and maintain an NHS estate that could continue to deliver safe, high-quality care for patients. While the Government announced an additional £10bn *"package of capital investment"* in the 2017 Budget, only £3.5bn additional funding from HM Treasury itself was announced.

29. Meanwhile, trust chairs and chief executives cite workforce as the most pressing challenge to delivering high-quality healthcare. There are significant shortfalls in the number of staff. In 2014, Health Education England (HEE) estimated a gap of 5.9% or 50,000 clinical staff. Its draft health and care workforce strategy for England (published in December 2017) estimates that the NHS will need to grow by 190,000 posts by 2027 to meet demand if no further action is taken to reduce demand.[15] The workforce gap has widened given increasing patient demand, acuity of need, regulatory expectations and staff leaving the system, and despite steps to increase domestic and international supply. This has resulted in the closure of some services (including A&E and children's services), restricted opening hours for others, and pressure on staff as they put in extra hours to try to maintain quality of care.[16]

30. Not only is the NHS unable to meet the standards of care required by the NHS Constitution within its current funding envelope, but the result of these financial and workforce pressures is that in some cases, patterns of NHS service delivery are moving away from the agreed direction of travel set out in the *5YFV*, with cuts made to preventative and community-based services. For example, an NHS Providers survey in late 2016 found that intermediate community service capacity – such as step up and step down beds – was being reduced rather than increased.[17] The King's Fund found in early 2017 that financial pressures were having the greatest impact on essential support and prevention services including genitourinary medicine and district nursing.[18] It also found instances where innovation was stifled because of the necessary funding, staff time or skillset being unavailable. The NAO's January 2018 report finds that *"While developing preventative services was a strong feature of all the plans we examined, most partnerships we visited noted that they had made insufficient progress so far. Their need to make short-term immediate savings meant they were often overlooking investment in preventative services."*[19]

Mixed messages from the NHS national bodies

31. There is also a further risk in STPs being regarded as the central health and care delivery mechanism. As explored in section G, STPs are not corporate bodies – their constituent organisations each remain individually accountable. Moreover, trusts report there are four different sources of power and authority in the NHS, each with its own set of priorities:

    - **NHS Improvement** wants providers to achieve financial balance, meet performance targets, maximise their CQC rating, realise efficiency savings and cut agency spending
    - **NHS England** wants providers to implement the *5YFV*, co-lead their local system towards new care models, help create local system sustainability and transformation plans, and implement the outcomes of the cancer and mental health taskforces and the maternity review

[15] https://www.hee.nhs.uk/news-blogs-events/hee-news/health-education-england-launches-plan-future-proof-nhs-care-workforce
[16] https://nhsproviders.org/a-better-future-for-the-nhs-workforce/introduction
[17] https://nhsproviders.org/resource-library/surveys/delivering-care-in-every-setting
[18] https://www.kingsfund.org.uk/publications/understanding-nhs-financial-pressures
[19] https://www.nao.org.uk/report/sustainability-and-transformation-in-the-nhs/

- **The CQC** wants providers to deliver the right quality of care and guarantee the right levels of staffing in every setting
- **The Department of Health and Social Care** wants providers to move to seven-day services, create a paperless NHS, and focus relentlessly on patient safety issues

32. Each of these individual priorities on their own are sensible and command provider support. Taken together though, they are far too large a collective set of priorities to deliver consistently and effectively. This lack of consistent focus and priorities is proving challenging for trusts, with a continuing tension over whether short-term financial sustainability or long-term strategic transformation is the priority for STPs in the eyes of the NHS national bodies.

33. As highlighted in section B, there also needs to be greater recognition from the national bodies that STPs will not always be the appropriate delivery mechanism for new initiatives – specialised and ambulance services, for example, work across boundaries, with other provision best delivered in smaller footprints or by individual organisations.

34. The considerable financial and operational investment required in integrating care is further under-acknowledged: local areas will need to ensure a managed transition (most likely through a period of double running) to ensure new models are proven before the previous service arrangements are decommissioned (for example, building up community-based provision before decommissioning acute beds).

35. While STPs and improved care configuration are likely to contribute to better performance standards, this will only be over the long-term. They are not a short-term route to meeting the NHS constitutional standards.

E. 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?

36. The changes in emphasis around sustainability versus transformation mean that the STP plans are similarly variable in whether they were predominantly based on either (1) on the expected funding envelope, and tailored to fit, or (2) the ambition for future health and care services first and foremost, and then adapted to the expected available funding.

37. In reviewing STP plans, the following points merit consideration:

    a. **Redistribution of bed capacity across the system:** Where reductions in acute bed capacity are made to fulfil the drive to move care out of hospitals, there needs to be a related and realistic level of investment in community and mental health beds. Those adjustments also need to take account of the challenges in primary care capacity. Likewise, ongoing cuts in social care mean significant capacity has been lost, which will take some years to rebuild. In the meantime, displaced demand will necessarily be absorbed by the NHS.
    b. **Acute capacity:** Plans need to be realistic about ongoing growth in population, demand and acuity, with a growing ageing population needing more care. The experience of winter 2017/18 lays this bare, and shows that acute bed capacity will always need inbuilt

flexibility to cope with spikes in demand and an increase in the absolute number of people for whom hospital will be the most appropriate setting. At the start of winter, general and acute bed occupancy was already at 94.5% (with 85% being the recommended safe level).[20] Bed occupancy levels remained high throughout the festive period despite several hundred additional beds being opened. The NAO's review of STP plans found that *"Most of the plans rely on transforming services to move more care out of hospital and into the community. Built into plans are significant reductions in hospital activity. For example, clinical commissioning groups' plans for 2017-18 and 2018-19 expect non-elective admissions to fall by an average of 0.2% a year, compared with actual growth between 2014-15 and 2016-17 of 2.2% a year."*[21]

c. **Investment required:** Investment – most likely alongside running existing services – is crucial to the delivery of new care models, yet the availability of additional funding for STPs is very limited. The significant NHS capital maintenance backlog – currently standing at £5.5bn – is also noteworthy in this respect.
d. **Efficiency estimates:** National efficiency expectations are often unrealistically high. At a local level, there will be variation in what further improvements can be made, but it will nevertheless be the case that increasing efficiency further, and especially given the cross-system working required, will need investment and acceptance that there may be an initial cost burden before savings are realised.
e. **Leadership bandwidth:** To speed up the pace of change, trusts need much enhanced leadership capacity at the frontline to deliver the required transformation alongside the task of providing outstanding day to day care in an increasingly unstable context where demand is rising rapidly. Given the lack of a statutory footing, there is also an over-reliance on relationships and goodwill amongst local leaders – this creates a risk as personnel will change over time and so progress may be lost, and as operational and strategic pressures are liable to erode goodwill and foster increased insularity.
f. **Workforce availability:** The most important enabler for transformation is the health and care workforce. Organisations will need to embrace new cultures and ensure their workforce has the right skills, values and behaviours to work effectively. The ability for individuals and multi-disciplinary teams to adapt to provide care in different settings, at different times and in different organisational and team structures will be essential. Complex employment law issues may also arise and will need to be managed carefully.
g. **Timescales:** There is concern that the STP process, which in many cases relies on creating new, cross-local system relationships, is being rushed. Based on current experience, consistently realising the benefits and improvements from new care models will be a 10 to 15 year, not a three to five year process.

38. The NAO view of these challenges is stark: *"The NHS will need to make difficult choices to stay within its resources. Most sustainability and transformation partnerships' plans are overly optimistic, relying on transforming services to move more care out of hospital and into the community. However, there is limited evidence to suggest that these changes will achieve the level of savings required. In addition, partnerships are at different stages in their development and some may take longer to achieve their plans than others. For 28 of 44 partnerships, planned savings in 2017-18 are in excess of savings achieved in 2016-17 for both the commissioner and trust sectors. Partnerships need to find effective ways of managing demand for services or delivering services at a lower cost, or both. Without these, the NHS will have to make difficult choices about which services it can and cannot afford."*[22]

[20] https://www.england.nhs.uk/statistics/statistical-work-areas/winter-daily-sitreps/winter-daily-sitrep-2017-18-data/
[21] https://www.nao.org.uk/report/sustainability-and-transformation-in-the-nhs/
[22] https://www.nao.org.uk/report/sustainability-and-transformation-in-the-nhs/

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

39. It is important to be clear about the definitions of STPs and accountable care systems (ACSs), as well as accountable care organisations (ACOs), especially given the ambition set out in *Next steps* for STPs to develop into ACSs.

40. NHS England gives the following definitions:

    a. **Sustainability and transformation partnerships:** *"[NHS England's] aim is to use the next several years to make the biggest national move to integrated care of any major western country. Why? As the CQC puts it: 'The NHS stands on a burning platform - the model of acute care that worked well when the NHS was established is no longer capable of delivering the care that today's population needs.' … This will take the form of Sustainability and Transformation Partnerships covering every area of England."*[23]
    b. **Accountable care systems:** *"ACSs will be an 'evolved' version of an STP that is working as a locally integrated health system. They are systems 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. They provide joined up, better coordinated care. In return they get far more control and freedom over the total operations of the health system in their area; and work closely with local government and other partners to keep people healthier for longer, and out of hospital."*[24]
    c. **Accountable care organisation:** *"In time some ACSs may lead to the establishment of an accountable care organisation. This is 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. A few areas (particularly some of the [Multispecialty Community Providers, MCPs] and [Primary and Acute Care Systems, PACS] vanguards) in England are on the road to establishing an ACO, but this takes several years. … they will not be the focus of activity in most areas over the next few years."*[25]

41. In other words, accountable care models – within the England health and care system – bring together a variety of provider organisations, including primary care, to plan for and meet the care needs for a defined population within a set budget to an agreed level of quality.

42. 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.

43. While an ACS is not necessarily the same as an STP – not least as one STP footprint may ultimately encompass multiple ACSs, with STPs likely therefore to have a broader remit and scale – ACSs and STPs are pursuing similar objectives through similar means. Neither STPs nor ACSs

[23] https://www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf
[24] https://www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf
[25] https://www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf

are statutory bodies – they derive their legitimacy from their component organisations, and it is largely this fact that is driving the complexity around their development.

44. Meanwhile, ACOs are a step removed from STPs and ACSs. In an ACS, organisationally separate partners work together to integrate care and develop collective responsibility for population health, whereas it is envisaged that ACOs will be single organisations holding single contracts which are responsible for the planning and delivery of the majority of health and care services in an area.[26] ACOs would be responsible for sub-contracting services as appropriate (in other words, for tactical commissioning), with CCGs developing a more strategic, population-focused, role. It seems likely that few ACOs will be established given the extent of required organisational change.

45. In the first instance, the change from an STP to an ACS should therefore have less direct effect on delivery – given that they are pursuing similar outcomes and objectives – than on the legal, contractual and governance frameworks underpinning the approach. Nevertheless, there may be delivery changes arising from those evolving corporate frameworks. For example, in each model, health and social care – with their differing funding sources – are likely to be coming together. While this is positive in terms of coordination and quality of care, attention will need to be paid as to whether the line between state-funded and self-funded care is moving as a result. In addition, as there may be multiple ACSs or ACOs within a single STPs, care will also need to be taken to ensure comprehensive coverage remains for the whole population in question.

G. 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?

46. *Next steps* sets out that all NHS organisations will form part of an STP, with the STP having a board and other "appropriate decision making mechanisms", a chair or leader and programme management support. NHS England and NHS Improvement highlight individual organisations' "duties of collaboration" and their ability to take action to ensure these are fulfilled, as well as their ability to ratify the STP chair/leader.[27]

47. Despite those expectations, it is important to note that STPs have no legal status in themselves, instead deriving their decision making powers from their constituent bodies corporate. Developing appropriate governance mechanisms to underpin local relationships and support the legal duties for decision making and accountability in the component partner organisations is therefore a priority for trusts.[28] On the face of it, it is possible to do so within the current legal framework, but there are significant attendant risks within the developing leadership and governance structures which would benefit from being formally addressed.

48. In those areas with established partnerships, there are instances of structural changes reflecting the drive towards further collaboration. This includes development of a more strategic

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[26] 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.

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

[28] 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

approach to commissioning with mergers of CCGs[29], or arrangements whereby several CCGs appoint a shared accountable officer[30] and the development of integrated commissioning arrangements with local authorities.[31] In addition, some provider organisations are consolidating through mergers or new alliances and groups.

49. Nevertheless, at the moment, STPs are likely to be comprised of several bodies corporate. Only bodies corporate have decision making powers, can properly be held to account and can be regulated, and so STP arrangements rely on delegations, to either executive directors or to committees.[32] In order to enable multiple partners to make decisions, STPs are exploring a variety of mechanisms including joint committees, committees-in-common and working groups.[33] Some STPs have seconded chief executives and other executive directors and are looking to recruit panels of existing CCG lay members to take on a quasi non-executive director (NED) role in order to facilitate coordinated decision-making.

50. There are risks in such approaches. Over-reliance on delegations can mean that decisions are not subjected to the rigorous challenge that is the standard way of working at board level and constitutes best practice. They may also begin to act as if they were entities with decision-making powers in their own right. In addition, some boards have agreed to fetter their own powers so that they will not veto a shared executive without a majority among the other partners, bringing significant risk in terms of holding executive directors to account.

51. The leadership of STPs therefore needs to take care to enable proper scrutiny, referring back to partner organisations and respecting the unique role of boards as well as the liabilities and duties of directors. As they are not board-led organisations with a NED majority or built in NED challenge, STP leaderships also need to consider how real challenge can be built into the way they operate and will also need to deal with challenge from partner organisations. In absence of legislative change to reflect and enable new NHS structures, NHS foundation trust and trust boards will need to assure themselves that decisions taken on their behalf are made lawfully, and that new and existing risks are identified and properly managed and mitigated.

52. Beyond governance structures, there are ongoing questions around stakeholder engagement and input, particularly of clinicians and foundation trust governors. There are also a number of practical issues where detailed local consideration and planning are vital, as well as support from the national bodies in guidance and sharing of best practice. For example, where new jointly owned vehicles are established, regulation, funding, information sharing, contracting, tax, VAT, workforce and pensions implications need careful investigation.

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[29] https://www.hsj.co.uk/commissioning/mapped-ccg-mergers-shared-leaders-and-link-ups-with-councils/7016646.article
[30] https://www.hsj.co.uk/nhs-bromley-ccg/new-leader-named-for-five-ccgs-and-stp/7021300.article
[31] https://www.hsj.co.uk/workforce/council-chiefs-to-take-on-leadership-of-several-ccgs/7021284.article
[32] Delegations are more restrictive for NHS foundation trusts than trusts, because foundation trusts can only delegate to executive directors or to committees of directors.
[33] In some limited circumstances, depending on the nature of the partners involved, a partnership board can be set up as a joint committee. A joint committee will be able to take decisions on behalf of its members. This option is not available to FTs except in some situations where they are integrating health and social care services. An alternative is to set up a partnership board as a committee-in-common, where each partner sets up a committee of its organisation which makes sovereign decisions at the same time and in the same place as other partners. In some circumstances, committees-in-common can have some or all of the same membership. The aim of a committee-on-common is to facilitate coordinated decision-making. In all other circumstances, a partnership board effectively operates as a working group and will only be able to make decisions which the members appointed to it have the delegated authority to take. An organisation cannot be bound by a decision which the member it appoints to the board does not agree with. So decisions can only be made by consensus.

53. Regulation also remains an issue for collaborations and partnerships and for those organisations that own or part-own subsidiaries that provide healthcare services. Greater clarity and more consistency is needed around whether the direction of travel is towards system regulation and how organisations will be held to account.[34]

54. In addition, the creation of ACSs and ACOs will result in the formation of some very large entities, presenting governance challenges. Existing large organisations are meeting these challenges by looking at group structures with a group board, but with each component part of the group having its own CEO and executive directors. Some trusts are considering appointing associate NEDs at this level to ensure that there is appropriate challenge and an independent perspective at all levels.

55. As STPs and accountable care models move to becoming delivery vehicles, it will be important to ask:

    a. **Are internal governance arrangements suitably robust?** For example, how would they behave under the pressure of performance issues within one partner jeopardising a system control total?
    b. **Are the structures in place for each STP legal?** Controversial decisions are vulnerable to legal challenge, and STPs need to have sufficient statutory underpinning to enable them to respond to this. The ability of STPs to make progress in improving patient care should not be wholly frustrated where there are questions over a particular aspect of service delivery.
    c. **Are accountability structures clear?** What is the STP accountable for and what are the individual institutions within it accountable for? For example, who is accountable when an STP control total fails because of one institution's performance?
    d. **How will the oversight regime operate?** Both NHS England's and NHS Improvement's current CCG and provider oversight regimes are based on individual institutional oversight. How will those complement an STP-focused oversight regime?

56. STPs and ACSs are a pragmatic solution to the complex challenges facing the health and care system, but 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. Governance arrangements at a system level need to complement the statutory accountabilities of provider boards and other organisations.

57. We also recognise the importance of non-executive engagement, clinical engagement and public consultation on new proposals at organisational and system levels. There has been a notable decrease in the level of public consultation undertaken across the Government and its arm's length bodies on major policy change, with the implementation of STPs and accountable care models a particularly high profile instance. We would urge greater national commitment to open consultation during the policy development process, to ensure robustness, uphold transparency and encourage trust.

H. 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

[34] For example, best practice in governance would lead to the regulation of those who have the legal power to make decisions. However, NHS Improvement recently consulted on regulating companies owned by trusts or in shared ownership of trusts as entities in their own right, rather than their owners, for their performance tends. ADD REF

and national leaders in the NHS to support the implementation of STPs and ACSs?

Legislative barriers

58. Competition as the key driver of improvement in the system is underpinned in legislation by the Health and Social Care Act 2012. The move towards locally-based collaboration is therefore a significant shift in national policy. While the current legal frameworks do not prevent partnership working and integration in different forms, this makes for a complex environment for trusts, and their partners, to navigate.

59. Competition and procurement rules continue to apply to the NHS. For example:

    a. Where a merger will create a new single organisation (ie, in this context, an ACO) or brings together two providers of the same services (or multiple GP practices), this may be subject to review by the Competition and Markets Authority (CMA).
    b. STPs and accountable care models will also need to avoid anticompetitive agreements, and take care not to deliberately or inadvertently restrict the ability of other providers to provide services in a way that cannot be justified in terms of ensuring the best possible service to patients.
    c. There is also the current risk that once an ACO is established, it may be regarded under competition law as having a dominant position in the services that it provides – this would imply additional obligations on the ACO when considering how it interacts with other healthcare providers and has the potential to constrain how it carries out tactical commissioning responsibilities.

60. Where a change in emphasis around collaboration over competition has been indicated, this is at the discretion of the relevant national bodies. We understand that it is currently the case that, where commissioners and providers are focused on delivering the best possible service to patients, and can show that their decisions have been taken with this in mind, they will minimise the risk of breaching competition rules. However, such an approach is clearly dependent on the direction given by the national bodies and is liable to change, and the NHS would benefit from greater statutory certainty in this area.

61. As described in section G, health and social care would also benefit from a statutory underpinning for STPs and regulatory alignment, and in the meantime, from leadership by the national bodies in sharing best practice on establishing appropriately risk managed governance arrangements.

Policy barriers

62. There needs to be far greater clarity and discipline over what STPs are intended to deliver. There is an increasing tendency for STPs to become the default footprint for delivering national policy initiatives, but they do not currently have the mandate, statutory authority, or infrastructure to deliver these. Neither are they necessarily the most appropriate delivery body. Beyond this, there are a number of policy areas which need to be addressed in taking STPs and accountable care models forward:

    a. **National vision:** If STPs and accountable care models are to be the main vehicle for transformation, there needs to be much greater clarity on their longer-term status, with a much stronger public narrative from NHS England and appropriate levels of public and

political engagement. Significant resource, leadership time and energy are being invested in STPs, and there needs to be a more forthright explanation of their role. Local and national politicians have a key role to play – their constructive challenge is valuable, but it is as important for them to play their part in communicating the benefits of changes and enable transformation.

b. **Support across STPs:** While we welcome the investment and support that NHS England and NHS Improvement are offering to well-established partnerships, support (and funding) should be 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. Moreover, we would urge the national bodies to build an evidence base for the impact of vanguard programmes before seeking to apply or scale up their approaches nationally.
c. **Delivery ask:** 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.
d. **Regulatory expectations and alignment:** Transformation at the scale required to meet the financial, quality, demand and workforce challenges the NHS is facing will take time, investment and support. It also needs system leaders to support the development of new governance and accountability structures and to ensure that the current, institutionally focused, regulatory structure develops into one focused on local systems. This implies a sea change, with the arm's length body model moving from an approach based on assurance and regulation to one that supports and enables change and transformation.
e. **Financial incentives:** Financial incentives in a number of areas are currently misaligned with the policy intent of STPs. For example, it is unclear where the line will be drawn between partly self-funded social care and state-funded healthcare, while the intent to move care closer to home is not supported by the payment system in the secondary care system which drives activity towards hospitals. Specific funding routes have also contained mixed messages. For example, of the £2.1bn NHS sustainability and transformation fund for 2016/17, £1.8bn was allocated to covering NHS deficits rather than driving transformation.
f. **Information sharing:** There is patient demand for online services, with 10.4m people registered for online services and 1.1m appointments managed online. There is also evidence of the considerable efficiencies and improvements in care quality that can be made through online services and data sharing. However, information sharing remains a substantial barrier to integration. Further national guidance and support is needed to facilitate data-sharing and governance, while maintaining patient confidentiality, across the health and care system.

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

63. Reconfiguring services in health and care has historically been highly controversial. Despite the high-level parameters for public engagement within the *Next steps*, this has arguably not been robustly promoted by the arm's length bodies.[35] The level of service change requires therefore remains a challenge and a source of media and political attention and contention locally and nationally.

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

64. STPs have received criticism for the way in which they were introduced, at pace and without sufficient transparency. Undervaluing meaningful engagement at the start of the process means that there are persistent suspicions of proposed changes. This is despite an increasing number of examples of welcome and extensive local engagement (including public events, online surveys, third sector and community group consultation and Healthwatch-led engagement). Overcoming the concerns that have arisen as a result will take considerable time and effort, but it is crucial to do so – otherwise the progress made in improving patient care through better joined up services will be jeopardised.

65. The importance of staff engagement should not be underestimated – NHS organisations are key parts of their communities, with staff acting as their ambassadors. It is crucial that STPs work to develop a united culture, with a shared vision and principles embodied by leaders and staff at all levels. As organisational changes are undertaken, engagement with health and care professionals, the wider workforce and trade unions must be meaningful and go beyond formal consultation processes both prior to and during the implementation of current and future proposals.

66. There needs to be an ongoing and responsive dialogue, with all partner organisations and local stakeholders – including the workforce, patients, the public, councillors, independent and voluntary sector providers, trust non-executive directors and CCG lay members – embedded in STP implementation. This must be encouraged and supported at, and by, all levels of the NHS in an open and transparent way. Assuming more realistic expectations around the timescales for change would support more thorough consultation and engagement. As health and social care come together, there is an opportunity for the NHS to learn from local government on its approaches to community involvement and personalisation.

67. As the King's Fund points out, there is also an issue around terminology undermining public trust which needs to be addressed: *"STPs use a mixture of jargon and technical language and make few concessions to lay readers or those who are less familiar with NHS planning and funding. The very term 'sustainability and transformation plans' symbolises this challenge, carrying little meaning other than for dedicated followers of health policy. There is no readily available narrative that explains, in plain English, the rationale for STPs and what they mean for the public, underlining the communications challenge going forward."*[36]

J. Conclusion

68. The existing fragmented NHS pattern of service delivery is no longer fit for purpose and trusts recognise the need for transformation. Trust leaders support collaborative working, the idea of system-based planning and the vision outlined in the *5YFV* of new ways of providing care. They see the integration of health and care as a potential means of addressing the challenges of rising demand, responding to the growing number of individuals with more complex health needs and improving health outcomes.

69. Yet there are a number of fundamental barriers to overcome, with realism, support, transparency and risk management central to progress. Against a backdrop of growing financial and workforce pressures across health and social care, it is also important to note that there is no compelling evidence that new care models will deliver long-term financial savings or reduced hospital activity.

[36] https://www.kingsfund.org.uk/publications/delivering-sustainability-and-transformation-plans