Harry Quilter-Pinner

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IPPR

STPs

SUSTAINABILITY AND TRANSFORMATION PLANS

WHAT, WHY & WHERE NEXT?

CONTENTS

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SUMMARY

The NHS is facing one of the most challenging periods in its history. A toxic combination of ever rising demand and stagnant funding growth means that the service is facing a funding gap of more than £22 billion over the coming years. Meanwhile, the pressure on the social care system is even more acute, with many councils raising eligibility thresholds and making cuts to social care budgets.

Sustainability and Transformation Plans (STPs) – which are local health and care reform plans, authored jointly by NHS and local government leaders to improve outcomes and drive greater efficiency in their local area – are one of the government's main responses to this problem. These plans rightly focus on decentralising power within the NHS, investing in leadership and relationships (over incentives or structural change) to drive improvements, and on local health and care organisations coming together to overcome the silos created by the 2012 Health and Care Act.

Although these plans vary in content, they have (by and large) correctly identified the most promising reform solutions, including the reconfiguration of the acute sector, the movement of care into the community, and the delivery of an upswing in prevention, with reform to commissioning, workforce, estates and local innovation infrastructure all considered key enablers.

However, going forward, there are a range of challenges that stand in the way of STPs realising their vision for improved health outcomes and greater efficiency.

In particular, they:

- face a deficiency in leadership, especially at the national level, which means that the public is either unaware of the reform plans or is misinformed about them, leading to unnecessary opposition
- risk getting engulfed by the funding pressures on the service, with much of the existing funding being channelled into maintaining existing ways of working or filling in deficits, rather than enabling the reform agenda
- have no statutory powers with which to deliver their reform agendas, with the fragmentation created by 2012 Health and Social Care Act retained – making STPs a workaround – rather than addressed directly.

POLICY RECOMMENDATIONS

Leadership

1. National leaders across all political parties – especially the prime minister and health secretary – should back the reform agenda and lead a high profile public engagement exercise to make the case for it, especially controversial and little understood hospital reconfigurations.
2. STP leads – who are currently voluntary and part time – should be appointed into formal paid positions and given a budget for a support

team and office staff. This would recognise their important role in the system and the huge amount of work involved in the process.

Funding

3. The government should create a new hypothecated 'NHS tax', by raising income tax and national insurance for the highest paid to provide a further £3.9 billion a year to tackle the funding crisis in the NHS, and reform pensions tax relief to deliver a £3 billion a year cash boost to social care. The former should be channelled through the transformation element of the Sustainability and Transformation Fund, in order to help close the remainder of the funding gap.

Power

4. The government should offer STPs powers akin to a devo-health deal, but within the STP framework. This would include appointing a new accountable chief officer with delegated powers over some specialised and primary care commissioning, as well as introducing a shared control total for the area alongside the local area's share of the Sustainability and Transformation Fund.
5. Existing national legislation should be amended – in particular Section 75 of the NHS Act 2006 – to better enable the pooling of budgets and commissioning functions locally. As reform progresses, the creation of new national legislation should be considered to give the regional (STP) level a formal role in the system, codify place-based health and care, soften emphasis on organisational silos, and move from competition to collaboration.

INTRODUCTION

The NHS is facing one of the most challenging periods in its history. Demand is growing, but the level of investment is not keeping up. As a result, waiting times are on the rise, there are downward pressures on quality and safety, and the service is starting to lag behind the scientific frontier. Meanwhile, the pressures on social care are even more acute: many councils are already having to raise eligibility thresholds and make large cuts to other parts of their budgets in order to cover the shortfall.

The last government's answer to this was Sustainability and Transformation Plans (STPs). These are local health and care reform plans, authored by system leaders up and down the country, designed to drive improvements in the efficiency and quality of care, as well as reduce inequalities in outcomes by 2021. As set out in this paper, these initiatives have many strengths, including a focus on the local ownership of the health and care system, and on joining up the NHS with local government.

However, they also exhibit some fundamental weaknesses. In particular, while STPs are not simply a cover for cuts, they will fail to deliver on their reform potential without adequate investment in the health and care system from the government. Moreover, it is becoming increasingly clear that they are struggling to drive real change in a system without a clear policy framework and dominated by the legislative legacy of Andrew Lansley and the Coalition government.

Many believed that these deficiencies would result in them failing to emerge from the election intact. These fears were fuelled by the Labour Party's decision to hold a 'moratorium' and 'a full-scale review' of the STPs if they won, and rumours that if Theresa May got the landslide she was looking for, she would move to replace both Jeremy Hunt and Simon Stevens. In the end neither of these outcomes occurred, leaving the STP agenda in place, but undoubtedly weakened.

As a result, regardless of the evolving political context, there is now an urgent need to rethink and refresh the STP, and wider health and care reform, agenda. This rethink must ensure that there is adequate national and local leadership to win support for reform amongst the population; that more funding is put into the system to ensure it is timely, effective, efficient and is 'keeping up with the science'; and that the legislation and policy framework gives local leaders the powers they need to propel the reform agenda forward at pace.

WHAT AND WHY?

WHAT ARE STPS?

In December 2015, Simon Stevens, chief executive of the NHS, asked local NHS and local government leaders to come together and jointly set out five year plans for the health and care of their local populations. These plans were (catchily) named Sustainability and Transformation Plans, or STPs for short.

Each STP is based around a locally-determined geographical footprint – of which 44 were agreed in March 2016 (see figure 1) – with leaders from all statutory organisations including GPs, hospitals, clinical commissioning groups, and local government involved in the process.

These leaders were tasked with analysing the challenges facing their local health and care system, and using this knowledge to set out a small number of key policy actions, to be used to drive improvements in the efficiency and quality of care as well as inequalities in outcomes by 2021.

STPs in numbers

- The average footprint of an STP covers 1.2 million people, but their size varies significantly: the smallest covers 300,000 people, and the largest covers 2.8 million.
- Each STP footprint spans an average of five clinical commissioning groups, with the smallest at just one and the largest at 12.
- Just four of the 44 STPs are led by local government chief executives rather than NHS leaders.

WHAT IS DRIVING THIS AGENDA?

In 2014, Simon Stevens, chief executive of the NHS, published a document setting out his reform plans for the NHS, entitled the Five Year Forward View. This document identified three main challenges facing the NHS.

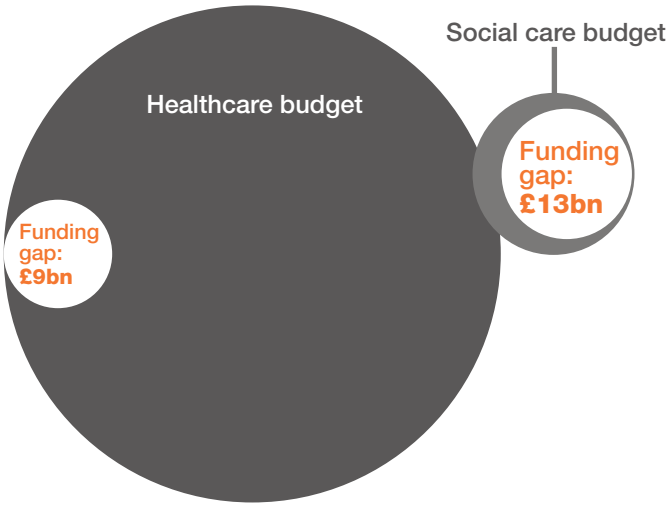
1. The health and wellbeing gap: the need to start prioritising prevention, in order to address health inequalities and reduce avoidable illness.
2. The care and quality gap: the need to reshape the delivery of care, in order to reduce variations in the quality and outcomes of care
3. The funding and efficiency gap: the need to close the NHS's funding gap by investing any additional funding for the NHS into driving increases in efficiency.

It then identified a range of measures that would narrow these gaps. These included greater integration within health and between health and social care, the movement of care from the acute sector into the community, and better prevention of ill health in order to deliver 'more for less'.

FIGURE 1

There are large funding gaps in both health and care

Healthcare and social care budget funding gaps, present–2030



Source: Roberts et al 2015

However, the challenge for Stevens – and for any politician or civil servant at the centre – is how to get local leaders to implement these reforms at the local level, especially at a time when resources are tight and day-to-day pressures high. STPs are NHS England's response to this dilemma (NHS 2017a). They aim to empower local leaders, and make them accountable for driving the vision set out in the Five Year Forward View in their local patch.

PROGRESS SO FAR

STPs have had a pretty bumpy ride so far (see figure 2). The deadline for submission for final STPs was repeatedly pushed back by NHS England as local NHS and local government leaders scrambled to build relationships and come up with viable plans.

STP leaders were originally instructed by NHS England not to publish draft plans, but many have leaked, as local leaders – particularly those with a democratic mandate – became increasingly nervous about the impact of some of the decisions being discussed.

As plans emerged, the media turned against STPs, highlighting fears – fuelled by campaigning groups such as 38 Degrees, as well as the Labour Party – that they were being used as cover for cuts and hospital closures.

FIGURE 2

There are 44 STPs across the country

Map of STPs

1. Northumberland, Tyne & Wear
2. West, North & East Cumbria
3. Durham, Darlington, Tees, Hambleton, Richmondshire & Whitby
4. Lancashire & South Cumbria
5. West Yorkshire
6. Coast, Humber & Vale
7. Greater Manchester
8. Cheshire & Merseyside
9. South Yorkshire & Bassetlaw
10. Staffordshire
11. Shropshire & Telford & Wrekin
12. Derbyshire
13. Lincolnshire
14. Nottinghamshire
15. Leicester, Leicestershire & Rutland
16. The Black Country
17. Birmingham & Solihull
18. Coventry & Warwickshire
19. Herefordshire & Worcestershire
20. Northamptonshire
21. Cambridgeshire & Peterborough
22. Norfolk & Waveney
23. Suffolk & North East Essex
24. Milton Keynes, Bedfordshire & Luton
25. Hertfordshire & West Essex
26. Mid & South Essex
27. North West London
28. North Central London
29. North East London
30. South East London
31. South West London
32. Kent & Medway
33. Sussex & East Surrey
34. Frimley Health
35. Surrey Heartlands
36. Cornwall & the Isles of Scilly
37. Devon
38. Somerset
39. Bristol, North Somerset & South Gloucestershire
40. Bath, Swindon & Wiltshire
41. Dorset
42. Hampshire & the Isle of Wight
43. Gloucestershire
44. Buckinghamshire, Oxfordshire & Berkshire West

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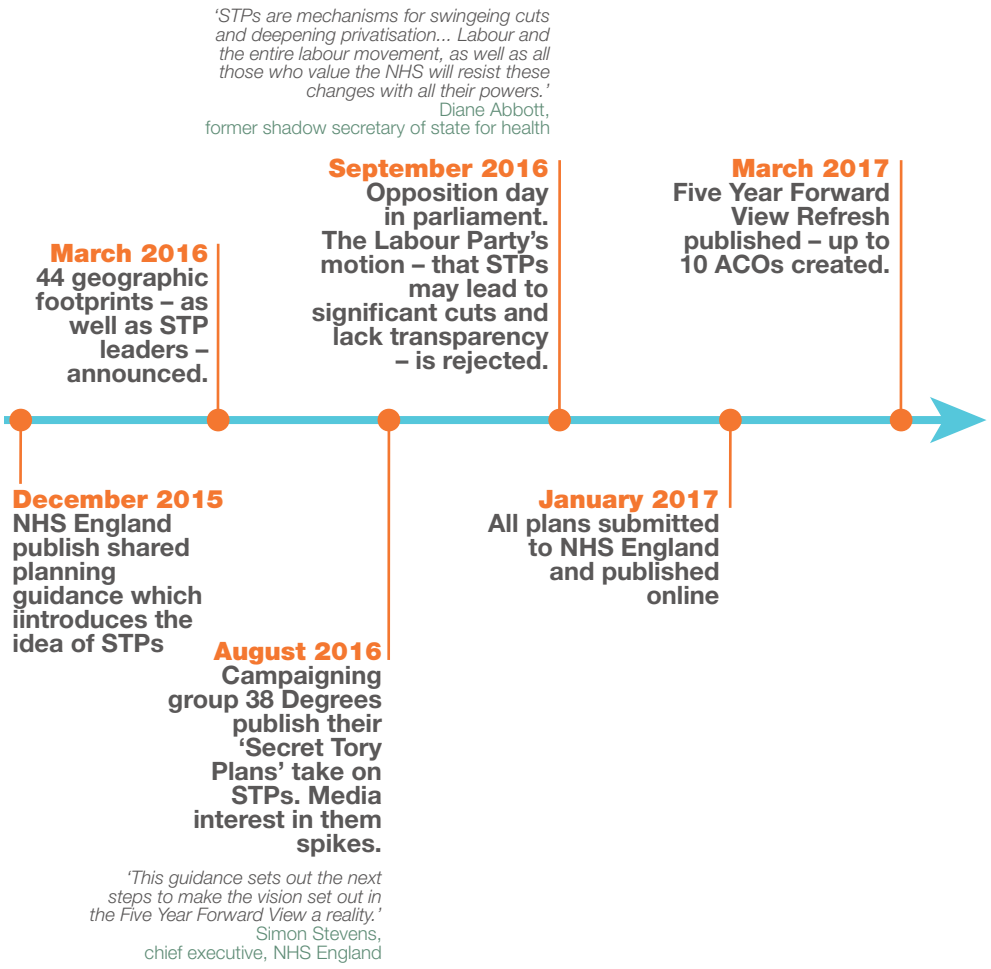
However, as we entered 2017, local areas were getting on top of the content of their plans, and consultation with the public had begun, with national health leaders taking to the airwaves to explain what STPs are and what they might mean for the public.

In March, two years since the Five Year Forward View was published, NHS England published its 'Next Steps' document. This set STPs the task of moving their plans from paper, into reality, offering STP leads more powers in exchange for progress on delivering change.

FIGURE 3

STPs have faced a bumpy ride so far with fears of cuts leading to opposition from campaigning groups

Timeline of the progress of STPs, December 2015 – present



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Fears that STPs would fail to emerge unscathed from the general election were fuelled by the Labour Party's decision to hold a 'moratorium' and 'a full scale review' of the STPs if they won, and rumours that if Theresa May got the landslide she was looking for, she would move to replace both Jeremy Hunt and Simon Stevens. In the end, neither of these outcomes occurred, leaving the STP agenda intact, but undoubtedly weakened. Regardless of the evolving political context in the coming months, it is now clear that there is an urgent need to rethink and refresh the STP – and wider health and care reform – agenda.

STPS: COMMON THEMES AND ENABLERS

'The Five Year Forward View is a vitally important plan. It's about the move... to prevention and not cure... Sustainability and transformation plans are the way that we implement the Five Year Forward View and it is vital we stick with them.'
Jeremy Hunt, Secretary of State for Health

STPs vary significantly in their content, level of detail and the quality of their propositions. However, a number of key themes reappear throughout.

RE-CONFIGURATION OF THE ACUTE SECTOR

Most, if not all, STPs set out proposals for reform of the acute sector in their area; this is unsurprising given that this is where NHS spend is concentrated. These proposals include plans to reduce the number of hospital sites and beds, as well as centralising some acute services on fewer sites. The aims of these changes are to improve the quality of care, reduce variation, maintain safer staffing levels, and move care into the community.

MOVING CARE INTO THE COMMUNITY

The flipside to acute re-configuration is the delivery of more services outside of hospitals, with a focus on social care, primary care and keeping people in their own home. Across the board, STPs focus on integrating health and social care – often via new accountable care organisations or systems (see below) – and reform to primary care, with new hubs bringing together GPs, social and mental health workers as well as housing and employment support.

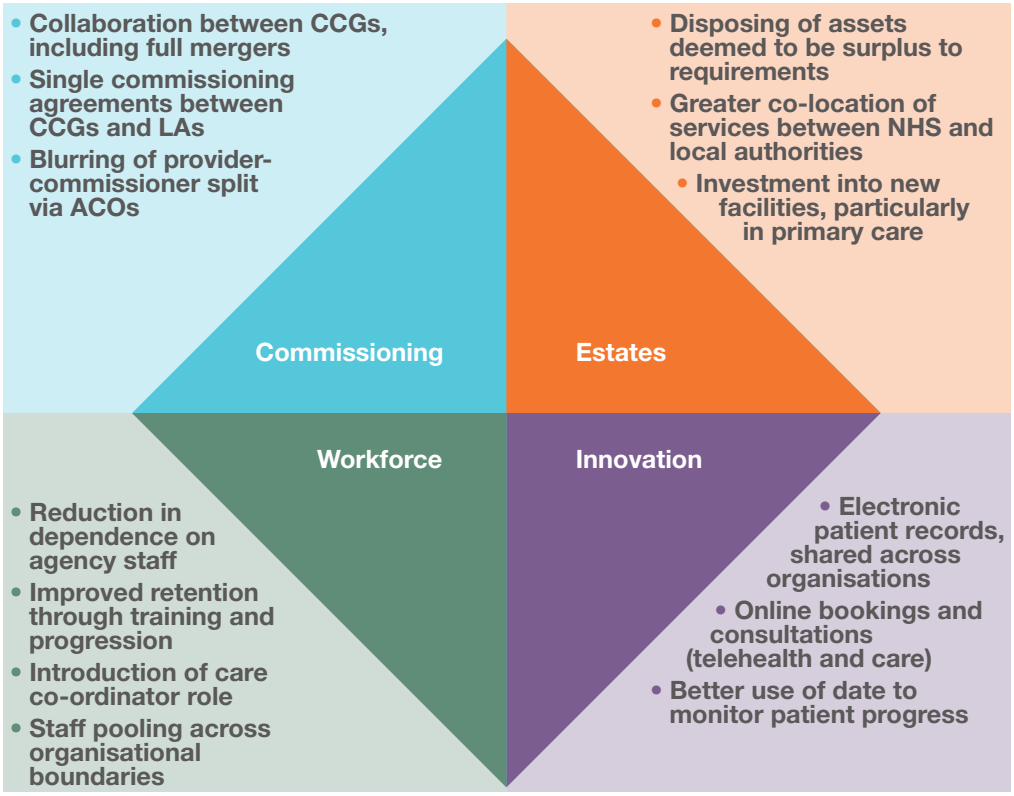
PREVENTION

All STPs aim to deliver a health system that helps people to stay healthy for longer. These plans either focus on the four main 'unhealthy behaviours' (smoking, excessive alcohol use, poor diet, and low levels of physical activity), or on working in partnership with local authorities to tackle the wider determinants of health through housing, transport, welfare, and education/skills policy.

Meanwhile, across most STPs, a small number of recurring enablers are also identified. These are shown in figure 5.

FIGURE 5

Four recurring enablers have been identified across most STPs



Source: IPPR, author's analysis

Deep dive: Could hospital closures be desirable?

At the heart of much of the controversy surrounding STPs are plans in some areas to re-configure or close hospitals. Our analysis of the 44 STPs confirms that hospital reconfigurations are afoot, with some 45 per cent of the plans making clear reference to centralising or changing the services available at particular hospitals, or outright closures of one or more hospitals in their area.

Furthermore, most of the other plans, while less clear, also make reference to upcoming reviews or attempts to shift care out of acute sector, which may ultimately translate into some reconfigurations. The public and campaign groups claim that this is the result of cuts to the NHS which risk the quality of, and access to, care for patients. However, there are some potential good reasons for hospital re-configurations or closures (see table 1 below).

For example, there is strong evidence that, for some services, particularly A&E and specialist surgery, concentrating care in fewer locations can save lives (Brooks and Farrington-Douglas 2007). This is partly because it allows people to access highly trained doctors and the best equipment, but also because with increased patient numbers comes increased experience, and therefore fewer mistakes among staff. Likewise, some treatments need immediate access to other services such as intensive care or orthopaedic trauma, which can only be provided in larger hospitals.

TABLE 1

Potential justifications of hospital reform

Reason	Explanation
Quality	In order to provide complex healthcare safely, professional teams need to see sufficient volumes of patients with a particular condition. Furthermore, there needs to be immediate access to intensive care, anaesthetics, acute medicine, general surgery and orthopaedic trauma. This may require larger, more specialised – and therefore probably fewer – hospitals.
Access	While some services need to be centralised, other services could be moved closer to home, into community hospitals or even GP surgeries, in order to allow people to receive treatment closer to home.
Efficiency	People should only be kept in hospital for the minimum time necessary for their treatment. However, at present, there are wide variations in length of stay, which cannot be explained by clinical factors. There is therefore potential to improve efficiency in the use of hospital beds, and allow patients to go home earlier.
Prevention	More people are now living with chronic conditions. Providing ongoing support in the community and at home would be more effective both for the NHS and the individual than waiting for acute flare-ups and regular emergency readmission. This requires shifting greater resources into primary and community, as well as prevention, and away from the acute sector.

Source: Adapted from Farrington-Douglas 2007

Stroke treatment in London

In London, it has been estimated that the recent reconfiguration of stroke services will save more than 400 lives a year (Morris et al 2014). This is through the establishment of stroke networks that have concentrated specialist stroke expertise and diagnostics in fewer units, while retaining local access to stroke rehabilitation services in local hospitals.

However, this argument will not necessarily apply to all the re-configurations proposed within England's STPs, with many areas of treatment showing no link between scale and outcomes (Imison 2011). Furthermore, the evidence in favour of re-configuration based on the other arguments set out above, and efficiency in particular (Imison 2015), is less robust, despite Monitor's modelling which suggests that reconfiguring services and integrating care more effectively across providers could yield productivity improvements in the region of £2.4 billion–£4 billion by 2021 (Monitor 2013).

STRENGTHS

> *'Their (STPs) success will largely depend on the extent to which local leaders and communities now come together to tackle deep-seated and longstanding challenges that require shared cross-organisational action.'*
>
> Simon Stevens, chief executive of the NHS

Based on our analysis of all 44 STPs – alongside conversations with STP leads up and down the country – we have identified three key strengths of the current reform agenda, in theory and (in most cases) in practice. In looking to rethink and refresh STPs following the election, these elements of the agenda should be protected and retained.

MOVING TOWARDS PLACE AND DECENTRALISATION

At the heart of the STP agenda is the concept of 'place-based health and care services'. This is a system in which leaders and organisations work together to improve health and care for the population they serve. It involves moving away from organisational silos and 'fortress mentalities', towards collaboration and integration at the local level to manage the 'common-pool resources' available to them (Ostrom 2010).

Central to such a system is the creation of pooled budgets and commissioning functions for health and care. as well as moving towards population health management by incorporating other health-related public services in these initiatives (Alderwick et al 2015). This, in turn, could drive more integrated, preventative and coordinated provision which could lead to better efficiency and health outcomes.

Furthermore, embedded within the concept of STPs is decentralisation. There are two elements to this decentralisation.

1. STPs are designed to put local leaders – from both the NHS and local government – in control of their local health economy. As part of this, STP leaders have been given greater access to senior leaders at national organisations such as NHS England and NHS Improvement in order to gain support for changes outside of their remit, such as regulation, re-configurations, and specialised and primary care commissioning.
2. For areas interested in more tangible forms of decentralisation – for example, a devo-health deal – NHS England has encouraged them to use the STP process to 'set out their plan for devolution, providing a clear understanding of the ask' (NHS 2016). There is evidence that a number of areas across the England indeed doing this, including Greater London and Greater Birmingham.

The focus on place-based management of care and decentralisation is welcome and necessary in order to deliver more integrated and joined up services at the local level. NHS England and other national bodies must

now ensure that the STP process lives up to these underlying principles in reality as well as in rhetoric.

FOCUS ON LEADERSHIP AND RELATIONSHIPS

STPs are also a recognition that changes of the scale set out in the Five Year Forward View require strong leadership and relationships across the health and care system. Focus on these two factors has often been overlooked in favour of more tangible policy levers, such as structural reform, performance targets, and payment systems and money. However, there is growing evidence that both leadership and strong local relationships are an important, and underutilised, driver of change in the NHS (Timmins 2015a).

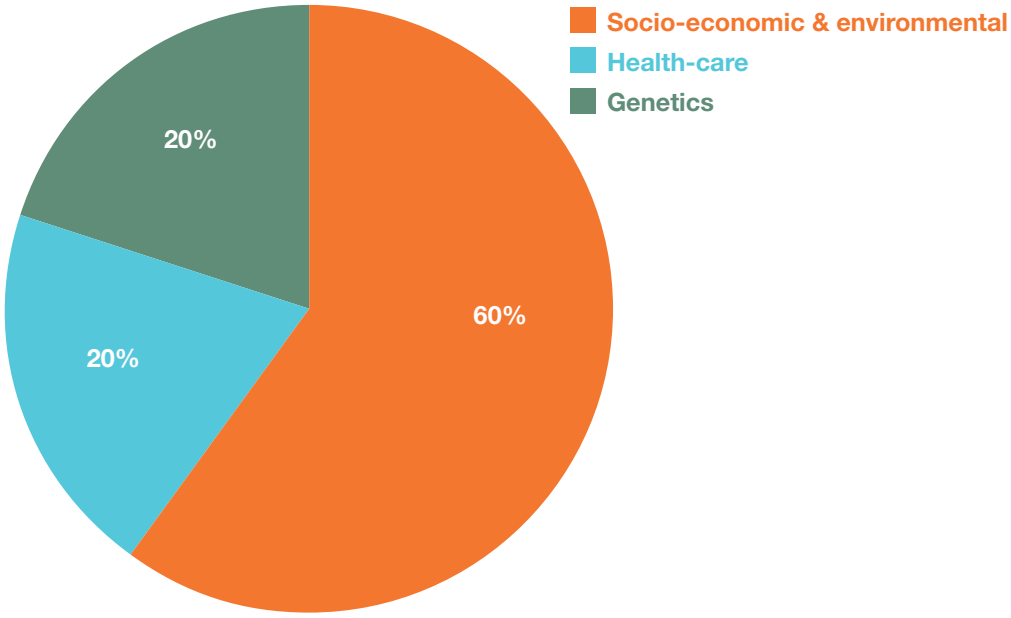
Strategic leadership at the regional level in particular has been lacking in the NHS since the abolition of strategic health authorities in 2013, with a perception on the ground that there is 'no one in charge'. While there are leaders that manage individual organisations at the local level, larger regions at the mezzanine levels, and, of course, at the national levels, no one is bringing together all of the elements of the system at the scale at which transformation is likely to take place. STPs, focussed as they are at the regional level, can help correct this by bringing together 'constellations of leaders' from across the health, care and public service sector at the local level (Ham and Alderwick 2015).

MOVING BEYOND THE NHS

FIGURE 4

Socio-economic and environmental factors are by far the greatest determiners of health outcomes

The proportional impact of different factors on the variation in health outcomes (%)



Source: Buck and Maguire (2015)

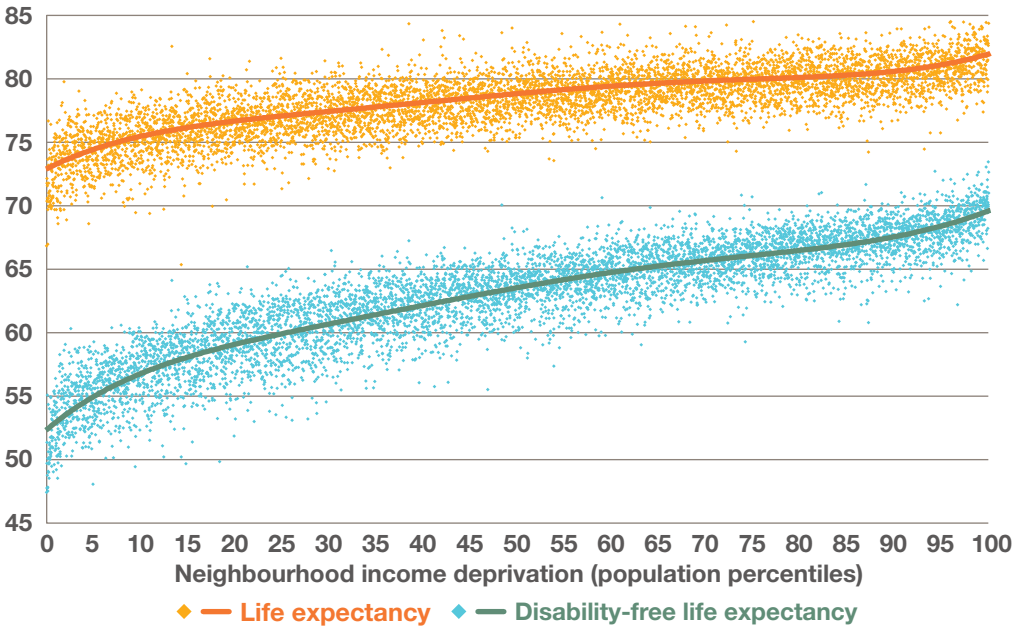
The STP process is explicitly aiming to encourage closer partnerships – and joined up policy – between local government and the NHS. This is important because there is strong evidence that traditional health policy – meaning healthcare systems like the NHS – only determines a small proportion of the variation in health outcomes (see figure 7).

Instead, it is clear that ill health stems from a whole host of factors; from the level of skills and education we have to the type of jobs we do, from the conditions in which we live to what we eat and how much exercise we do. This means that, in order to address large and growing health inequalities (see figure 8), action is needed across a much wider range of policy areas.

FIGURE 5

Life expectancy varies significantly across the country, with people from poorer areas living shorter lives.

Life expectancy and healthy life expectancy plotted against level of deprivation



Source: Buck and Maguire (2015)

Local government already has many powers that could help achieve better health including over social care; public health; housing and local economic planning. Furthermore, as part of ongoing devolution process local government is gaining even more powers with fiscal devolution; transport; criminal justice; employment and welfare all on the table.

It is clear going forward that one of the most significant opportunities for STPs is using local government powers alongside NHS reform to drive better health outcomes for local populations. This is motivated not just by a desire for social justice, but also a demand for greater efficiency: it often costs less to prevent illhealth before it happens than to wait it for it to occur and then respond to it.

RISKS

'A reorganisation so large, it can be seen from space
Sir David Nicholson, former chief executive of the NHS

'Never again must the NHS… be subjected to such a car crash of policy making.'
Nicholas Timmins, King's Fund

Based on our analysis of all 44 STPs – alongside conversations with STP leads up and down the country – we have identified three key weaknesses of the current reform agenda which are impacting on the ability of local leaders across the country to deliver to various degrees. As part of the post-election refresh, these elements of STPs need more thought and policy action to strengthen the reform agenda.

COVER FOR CUTS

The heath and care system in England faces significant cost pressures over the coming years. These pressures are driven by a number of factors, including a growing and ageing population, rising public expectations of the health and care systems as incomes grow, and large drug and treatment costs as new technologies come on stream.

In 2014, Simon Stevens came forward with new figures suggesting that these pressures would require the NHS to find an extra £30 billion between 2015 and 2020, either through increased efficiency or increased funding. The funding gap in social care is, if anything, even more challenging.

The previous and current government have made a choice not to fully meet these cost pressures, providing just an extra £8 billion over the five-year period for the NHS, thus requiring NHS England to fill the remaining £22 billion with efficiency savings. Even less leeway has been given to local government for social care.

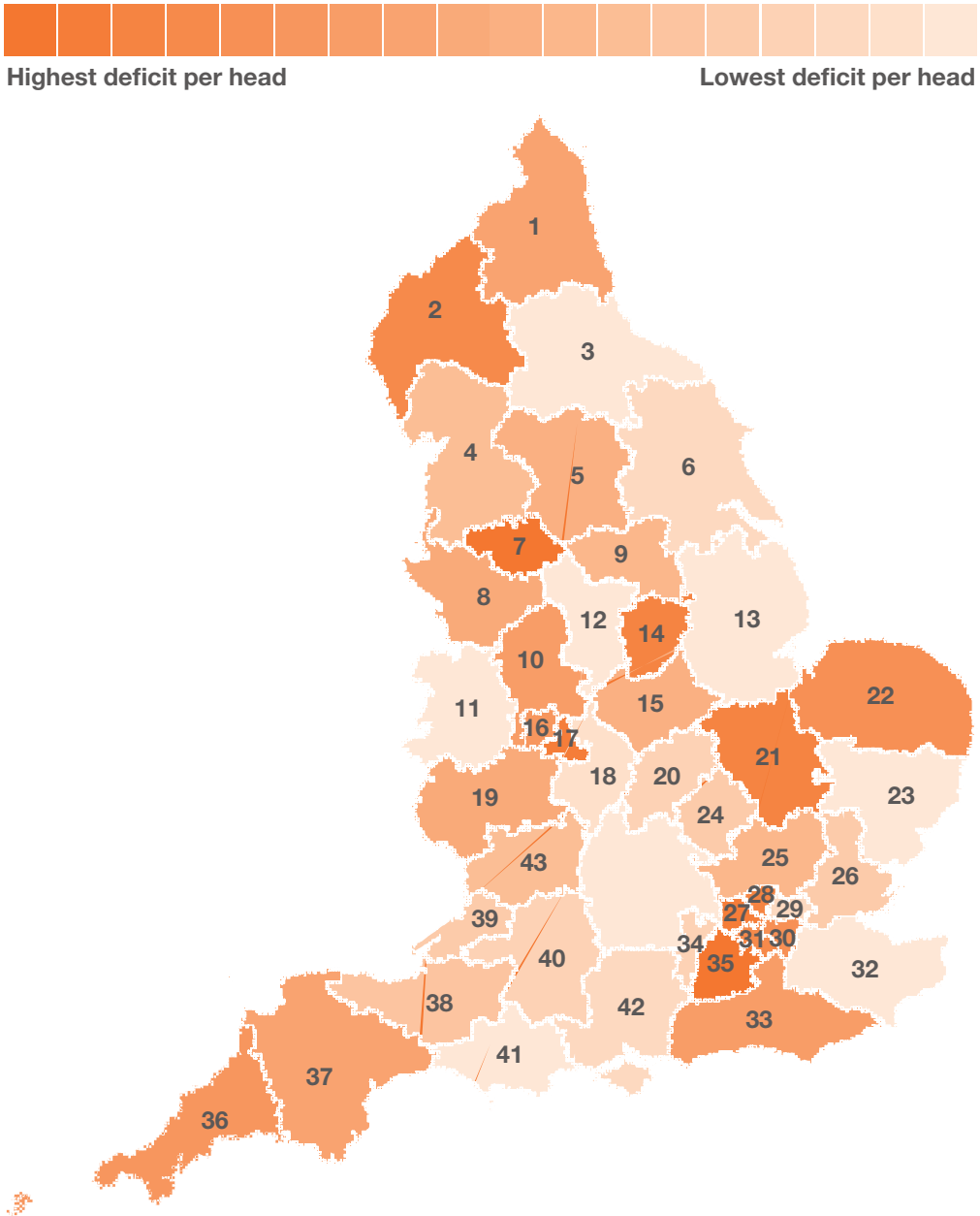
Subsequently, each STP footprint has estimated their local share of this funding gap (or 'efficiency target'), including both health and care (see figure 9). This analysis reveals that the funding gap is, in fact, even larger than originally thought, totalling £23.4 billion by 2020/21.

Moreover, while our analysis finds that there is significant variation across the country – with some regions such as Surrey and Greater Manchester facing a deficit 2.5 times the size of those of other places like Derbyshire and Durham – there is not a single area in the country that is forecasting a surplus by the end of the decade.

Going forward, STPs will be the main delivery mechanism for driving efficiencies across health and care. Proponents of STPs and the Five Year Forward View argue that this will be delivered by integrating health and care, moving care into the community, and driving better prevention.

FIGURE 6

STP Finder England



Source: IPPR 2017

However, although there is much evidence that the reforms set out in the Five Year Forward View will deliver better health outcomes, the evidence that they will deliver increased efficiencies is more sketchy (Imison et al 2017). Furthermore, there is increasing evidence that much of the 'low hanging fruit' in terms of efficiency has already been achieved, and that funding pressures are now impacting of quality and safety, with wait times for A&E, surgery, GP appointments, transfers between the NHS and social care, and ambulance responses all being missed.

In contrast to the line taken by campaigning groups such as 38 Degrees, this does not mean that STPs in and of themselves are to blame for the cuts, or that many of the reform initiatives set out in STPs – including some hospital closures (see above) – are undesirable. Reform to the NHS would be necessary regardless of the funding situation, and the underlying principles of STPs are a significant step in the right direction (such as a place-based approach, decentralisation, and focus on integration).

However, it now seems incontrovertible that, in order to succeed in their reform ambitions, local leaders will need a better funding settlement for both health and care. There is little doubt that one of the biggest risks facing the STP process is that they are being asked to 'deliver the undeliverable'.

BRINGING PEOPLE ON THE JOURNEY

There is growing evidence that key groups of people are not being adequately involved in the process of developing STPs and their recommendations. Three concerns in particular are worth raising.

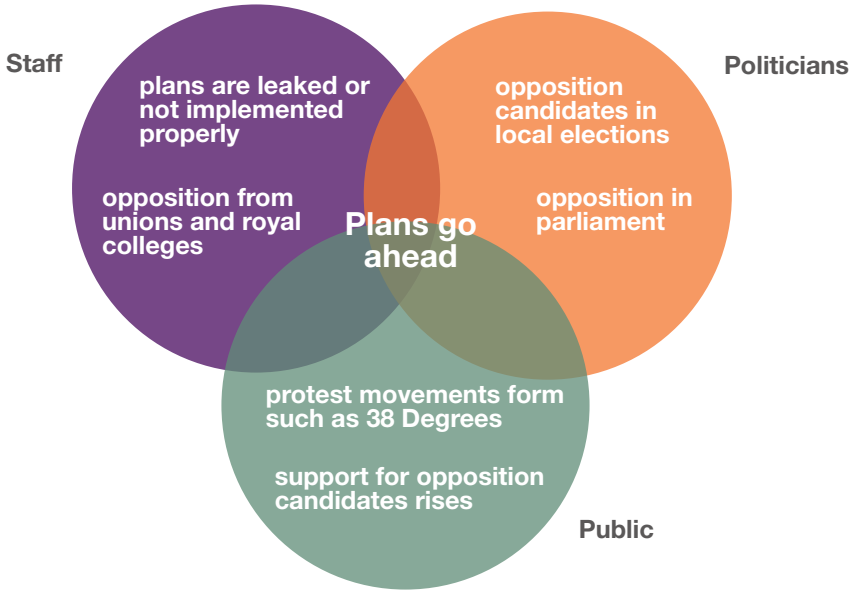
1. There has been a lack of transparency and consultation with the public, with STP leaders originally instructed to not discuss or publish draft plans before they had been signed off (Alderwick et al 2016). Over time, plans have leaked, but this vacuum in public discussion has allowed others – and in particular protest groups such as 38 Degrees – to dictate the narrative (see figure 7).
2. There is an imbalance between NHS and local authority involvement, with just four out of the 44 STPs led by local authority chief executives, and membership on STPs being largely favourable to the NHS. Furthermore, engagement varies significantly, with one local authority chief executive, on the day of STP submission, quoted as saying: 'I mean, I don't even know what the STP looks like' (Alderwick et al 2016).
3. Finally, the group of staff within the NHS engaged in the STP process is very small, with clinicians and practitioners particularly sidelined. Early polling in London found that more than 50 per cent of doctors knew nothing about their STP (BMA 2016). Meanwhile, the chief nursing officer at the NHS warned that nurses risked being locked out of the discussions (NHE 2016).

This is concerning, because history shows that reforms – and hospital closures or restructuring in particular – rarely go ahead properly unless all interested parties, including politicians, the public and professionals, are persuaded of the case for change and involved in the decision-making process (see figure 11 for risks).

FIGURE 7

NHS staff, the public and politicians all need to be supportive for reforms to succeed.

Potential implications if key groups are not supportive of reform plans



Source: Author's analysis

GOVERNANCE: LANSLEY'S LEGACY

The NHS is one of the largest and most complex organisations in the world. This complexity has increased significantly in recent years as a result of the 2012 Health and Care Act (Timmins 2012).

One of the most significant changes introduced has been the dissolution of primary care trusts, which commissioned the majority of health functions, including primary care, secondary care and community care. These were replaced by separate commissioners for the various services in health and care.

Another result has been the strengthening in the legislation of the provider/commissioner split and competition law, at a time when cost containment and integration is the dominant objective. These changes, although they are not the root causes of the NHS's problems, have not made reform easy.

As such, its it is an open secret that STPs are an attempt to circumvent the silos created by the Health and Social Care Act. Simon Stevens recently said that the creation of Accountable Care Organisations (see below) will 'effectively end the purchaser/provider split' (West and Thomas 2017).

Together, these trends suggest that the reform agenda being driven by STPs is in fact an attempt to undo the two most significant bits of NHS legislation since the 1970s. To adjust Nicholson's now famous quote, STPs are 'a workaround so large, they can be seen from space'.

This is no great travesty. There is plenty of evidence that the purchaser/provider split has been ineffective, with the best commissioners working in close partnership with providers (Timmins 2015b), and the worst wasting large amounts of money on poor care (Paton 2014). Likewise, no-one will mourn the death of Lansley's reforms, widely regarded as of the biggest barriers to integrated care.

However, attempting to do this without the use of legislation poses a number of problems.

1. It may make it harder for STPs to drive real change in the system, as they would have no statutory footing. This has been repeatedly highlighted in our research interviews and roundtable discussions: 'If I need something done I can only use my relationships with other people to make it happen. I have no formal power. When facing controversial decisions this is often not enough.'
2. It might prove a block on the integration of commissioning functions and provision. For example, local leaders in Greater Manchester attempting to create a single commissioning function said it had been 'difficult and convoluted', and 'could have been made much easier if the legislation was more conducive to place-based solutions'.
3. If local leaders can overcome these two barriers, the changes they deliver (albeit welcome in terms of the quality of care) will leave a significant gap between the system that the legislation describes, and the one that exists on the ground. This will make it nearly impossible for people on the outside to work out who is accountable and where decisions are taking place.

As such, there is now clearly both a significant short term challenge, how to allow STP leaders to get on with reform, as well as fundamental long term one, how to govern the system once it has been reformed. Therefore, it seems that, win or lose, STPs – and the NHS – face a significant deficit in clear and effective governance.

Deep dive: Greater Manchester, the first STP

One potential approach to the short-term governance issues faced by the STPs is provided by Greater Manchester's devo-health experiment: indeed, in many ways Greater Manchester was the 'prototype-STP'.

In 2014, the NHS and local authority leaders in Greater Manchester were asked to put together a five-year strategic plan for health and care in the region, and set out what powers they needed to take this forward (in essence, this is what STP leaders have been asked to do subsequently).

This plan, ultimately published under the heading Taking Charge (GMHSC 2015), set out an ambitious NHS (and wider public service) reform agenda, as well as a shared objectives and outcomes framework for the whole region.

On the back of this, in 2015 the chancellor announced a provisional deal to hand down to the regions £6 billion health and care budget alongside a range of other freedoms, a proposal which went live in April 2016 (see table 3).

To manage these powers, a number of non-statutory governance arrangements were put in place, including:

- a new chief accountable officer for Greater Manchester, with formally delegated responsibility for the majority of the decentralised powers
- a host of new 'committees in common' – joint boards between commissioners, providers and elected officials where joint decisions are made before being ratified by all constituent organisations (see figure 7).

TABLE 2

Commissioning decentralisation in Greater Manchester (£m) annually

Function	Budget	Decentralisation	
Acute, mental health & community	£3,861	-	CCG level
General practice co-commissioning	£388	⇩ Delegated under co-commissioning policy	To CCG level
Specialised commissioning (GM)	£904	⇩ Deconcentrated under 132B of the NHS Act	To chief officer GM
Primary care (dental, optometry, pharmacy)	£310	⇩ Deconcentrated under 132B of the NHS Act	To chief officer GM
Public health	£40	⇩ Devolved under Cities and Devolution Bill	To combined authority
Social care	£857	-	Local authority level
Other (including running costs)	£81	⇩ Deconcentrated under 132B of NHS Act	To chief officer GM

Source: Quilter-Pinner and Antink 2017: table 3.1

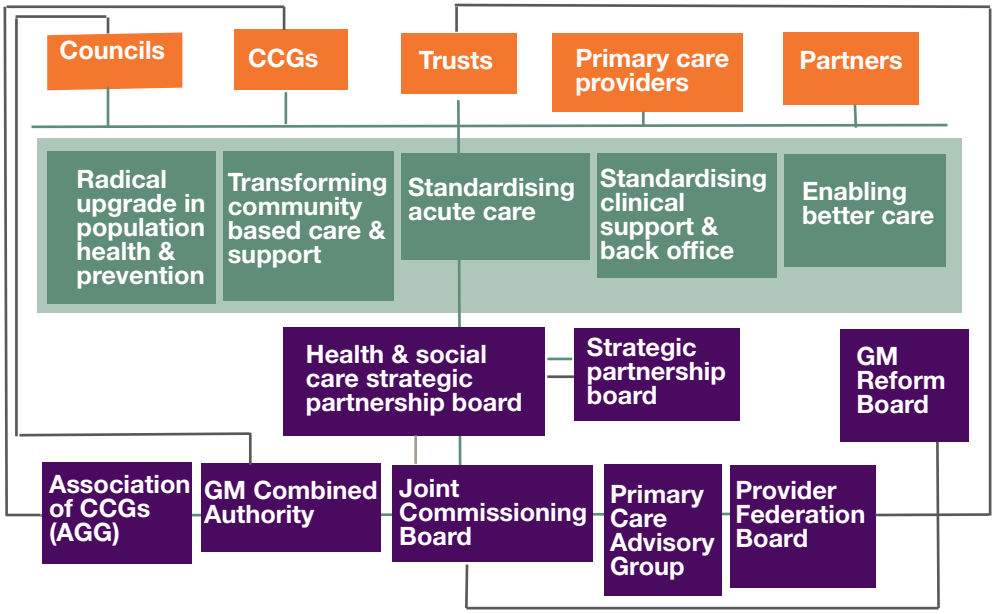
On top of these governance mechanisms, local leaders in Greater Manchester have also taken on (or are in the process of making the case for) a range of regulatory powers that give local leaders real power to drive forward change, including:

- the creation of joint appointments between NHS Improvement and NHS England at the local level, in order to better align regulatory functions
- a combined control total for providers – and between providers and commissioners – across a whole region, alongside the delegation of the regions' share of the sustainability and transformation fund.

As a result of this – alongside Greater Manchester's long standing history of partnership working – the region is making significant progress towards a more integrated and place based health and care system (Quilter-Pinner and Antink, 2017).

FIGURE 7

Governance arrangements in Greater Manchester are more evolved than other STPs



Source: author's analysis

Deep dive: Accountable care organisations and systems

Another approach to the governance problem being pursued by some areas is the creation of Accountable Care Organisations (ACOs). These are groups of providers across a region that formally take on responsibility for the whole population's care for a defined period of time under a contractual arrangement with a commissioner, who then takes on a more strategic role, providing funding and performance managing the new organisation.

Emerging from the US healthcare landscape over the last decade, and building on the well-known success of Kaiser Permanente (King's Fund 2017a) and Intermountain Healthcare (King's Fund 2017b), ACOs usually include GPs and at least one hospital, as well as other social care and wider social-determinant-focussed providers.

In England, we have already started developing similar organisations in the form of the new models of care, such as multi-specialty community providers, or primary and acute care systems. However, 'proper' ACOs are few and far between, as they require complex preparatory work and strong local relationships.

Northumberland ACO

Under the new arrangements, the clinical commissioning groups (CCGs) in Northumberland will transfer funding for most core NHS services to a new accountable care organisation, which will operate as a partnership between Northumbria Foundation Trust (which already has delegated

social care commissioning powers), Northumberland, Tyne and Wear NHS Foundation Trust, the mental health provider, and other providers.

Northumbria Foundation Trust will hold the formal contract, but it will be managed through a type of partnership arrangement with the other providers, with agreements signed on payment mechanisms, the pooling of funds (including any savings or overspends). All partners will sign up to a joint strategy and outcomes framework.

As part of NHS England's attempt to drive better governance and faster reform, they announced that they will work with between 'six to ten' of the more advanced STPs to start the journey towards creating an ACO (Collins 2017), by creating what they are calling an Accountable Care System (ACS).

This will involve passing down a number of new powers over commissioning to the local groups of commissioners and providers (similar to Greater Manchester), in order to begin the process of forming the relationships, governance and frameworks necessary to tender for and create an ACO.

NHS England have already tentatively suggested the following areas as candidates for this new initiative (NHS 2017b) (see figure 4.5):

- Frimley Health
- Greater Manchester
- South Yorkshire & Bassetlaw
- Northumberland
- Nottinghamshire, with an early focus on Greater Nottingham and the southern part of the STP
- Blackpool & Fylde Coast, with the potential to spread to other parts of the Lancashire and South Cumbria STP at a later stage
- Dorset
- Luton, with Milton Keynes and Bedfordshire
- West Berkshire.

However, while both devo-health arrangements and Accountable Care Organisations and Systems offer a short term fix, they can only go so far in addressing the deficit in power and governance within the system. This was implicitly recognised in the Conservative Party manifesto, which stated that: 'If the current legislative landscape is either slowing implementation or preventing clear national or local accountability, we will consult and make the necessary legislative changes.' The next step must be undertaking this review and then making the necessary changes to propel the reform agenda forward including new legislation and a clear policy framework in which health and care leaders can operate.

WHAT NEXT?

In conclusion, going forward, there are a range of challenges that stand in the way of STPs realising their vision for improved health outcomes and greater efficiency.

In particular, they:

- face a deficiency in **leadership**, especially at the national level, which means that the public is either unaware of the reform plans or is misinformed about them, leading to unnecessary opposition
- risk getting engulfed by the **funding** pressures on the service, with much of the existing funding being channelled into maintaining existing ways of working or filling in deficits, rather than enabling the reform agenda
- have no statutory **powers** with which to deliver their reform agendas, with the fragmentation created by 2012 Health and Social Care Act retained – making STPs a workaround – rather than addressed directly.

Policies must now be put in place to address the deficiencies in each of these three key areas.

LEADERSHIP

STPs, and their constituent reforms, are both complex and controversial. To ensure that both staff and the public engage with, understand and support these changes, supreme leadership will be needed both at the national and local levels. So far this has been limited; at the national level by the governments desire to absent itself from the NHS altogether, and at the local level by the lack of capacity for leadership.

We therefore recommend the following.

1. National leaders across all political parties – but especially the prime minister and health secretary – should back the reform agenda and lead a high profile public engagement exercise to make the case for it, especially controversial and little understood hospital reconfigurations.

2. STP leads – who are currently voluntary and part time – should be appointed into formal paid positions and given a budget for a support team and office staff. This will recognise there important role in the system and the huge amount of work involved in the process.

FUNDING

While it is untrue that STPs are simply a cover for cuts, it is also clear that both the NHS and social care are underfunded, and that without an injection of cash (if not a longer term funding solution) STPs will fail to deliver on their potential. This is both because of the immediate needs of the NHS (such as waiting times), but also because there is much evidence

that reform requires some degree of up-front investment (Health Foundation and King's Fund 2015).

3. The government should create a new hypothecated 'NHS tax', by raising income tax and national insurance for the highest paid to provide a further £3.9 billion a year to tackle the funding crisis in the NHS, and reform pensions tax relief to deliver a £3 billion a year cash boost to social care. The former should be channelled through the transformation element of the Sustainability and Transformation Fund, in order to help close the remainder of the funding gap.

POWER

Central government must also give STPs and STP leaders the tools to deliver on their reform plans, and then step back and let them get on with it. This must involve wrapping governance around STPs, both to give them real power within the system, but also to make them more accountable for how they use this power.

Government should:

4. Offer STPs powers akin to a devo-health deal but within the STP framework, to include a new accountable chief officer with delegated powers over specialised and primary care commissioning, and a shared control total for the area, alongside the local areas share of the Sustainability and Transformation Fund.

5. Amend existing national legislation – in particular Section 75 of the NHS Act 2006 – to better enable the pooling of budgets and commissioning functions locally. As reform continues at pace, government should consider the creation of new national legislation to give the regional (STP) level a formal role in the system, codify place-based health and care, soften emphasis on organisational silos, and move from competition to collaboration.

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ANNEX

RESEARCH METHODOLOGY

Our analysis in this report is based on:

- a comprehensive literature review of relevant research papers and policy documentation, including all 44 STPs and associated documents
- over 100 semi-structured interviews with local and national policy makers and experts in the field, including six STP leads, as well as the Department of Health, NHS England, HM Treasury, NHS Improvement and CQC
- four roundtable discussions with policy makers and experts.