STPs – early areas of action

Executive summary

The Sustainability and Transformation Plan (STP) process is one of the key mechanisms for making decisions about the future delivery of health and care in England. STP footprints have been tasked with delivering improvements in health outcomes and the quality of services, as well as achieving financial sustainability. They are responsible for bringing organisations together and making decisions about service delivery that cross the boundaries of statutory NHS organisations.

Despite this critical role, STP footprints have no statutory status and they are being asked to work at rapid pace, developing plans with significant implications for the future of NHS services in a matter of months.

The information available on the progress STP footprints have made in the development of their plans is patchy and the different STP footprints have taken different approaches to engagement and publishing information. This audit – which was commissioned by 38 Degrees – brings together the information available on STPs at the time of writing to identify key emerging themes. It should be stressed that most STPs are still at a relatively early stage and that available plans are in draft form, subject to amendment and sign-off from NHS England. Nonetheless, the audit provides a snapshot of the emerging thinking of a new tier of NHS leaders.

Addressing the NHS deficit is the overriding priority for STPs and it is clear that some STP footprints are considering significant changes, which are likely to prove to be controversial with politicians and the public. Examples of the cost-saving measures being propsed include:

- The closure or downgrading of some Accident and Emergency (A&E) units and other services deemed to be clinically and / or financially unsustainable
- Reductions in the number of hospital beds
- Supporting the NHS 'financial reset', including reducing growth in staffing costs and consolidating back office functions
- Reducing estate costs and disposing of surplus land

Although reducing costs is an important motivation, many STP footprints also argue that changes will enable improvements in quality, supporting service 'transformation.' Draft plans also set out ambitions for change on a series of national priorities, including on maternity services, cancer, mental health, diabetes, learning disability and the development of new models of care.

Many STP footprints recognise the controversial nature of some of their proposals and have requested "*air cover*" for service changes. To date, public engagement on these plans has been limited.

Although the STP process requires local NHS leaders to come together develop plans, the extent of 'coproduction' with patients and the public appears to have been limited, perhaps necessarily by the punishing timetable for the development of these plans.

Given this, it remains to be seen what reaction the proposals will elicit, or indeed what support will be provided for them by NHS England and national politicians. It is clear that further engagement with patients and the public will be required before changes can be introduced and the proposals can be expected to provoke significant discussion, debate and controversy. The extent to which local communities will support the plans – or to which NHS organisations will be able to push through changes in face of opposition – remains to be seen.

Introduction

STPs – the new place-based strategic plans intended to create financially sustainable health and care services across England – are expected to be significant and transformative vehicles in England's health landscape. While the concept was only announced publicly in December 2015, STPs have already become a primary focus for local commissioners, providers and health stakeholders looking towards the future.

In light of the significance of STPs, 38 Degrees asked Incisive Health to prepare an analysis of the likely early areas of action outlined in draft plans. This analysis was undertaken throughout July 2016 and the analysis presented in the report is accurate as of 28 July 2016, when the report was published. The analysis was conducted through:

- Intelligence from STP footprint first movers
- Interrogation of published STP documents

This short report sets out:

- A brief background to the STP process and how it aligns with current health policy
- The results of our analysis
- Conclusion and early thoughts on implications for local communities

It is important to stress that many STPs are still in the relatively early stages of their development and as such are still evolving. Many key documents for different STP footprints are not publicly available or easily accessible. STPs are also subject to revision and sign-off from NHS England. Nonetheless, this early analysis demonstrates the anticipated scale of impact as outlined in the different STPs, as well as some of the likely implications for patients, health services and local communities.

Background to STPs – the balance of sustainability and transformation

What are STPs for?

STPs were first announced in the December 2015 NHS Shared Planning Guidance[1] and are seen as a key mechanism for implementing the *Five Year Forward View* (FYFV). The Planning Guidance stated, "*we are asking every health and care system to come together, to create its own ambitious local blueprint for accelerating its implementation of the Forward View*"[2].

New, place-based, health system plans are to be drawn up to cover the period October 2016 to March 2021. The emphasis is placed on planning for local populations rather than individual institutions (such as a single hospital trust or sole provider).

To deliver this, the Planning Guidance calls on a wide range of stakeholders (commissioners, providers, local authorities) to come together to create a local blueprint describing how each area will work together to close three nationally identified gaps:

- The health and wellbeing gap
- The care and quality gap
- The finance and efficiency gap

It is important to stress that the STP footprints are not part of the existing NHS architecture and nor do they have a formal status in law, but are intended to provide a geographically coherent focus for health service planning.

STP footprint leads – appointed by NHS England – have responsibility for overseeing regional planning across the health and care system, including the reconciliation of different – often competing – interests of organisations to meet the needs of a local population. In this sense STP footprints bear a strong resemblance to the ten Strategic Health Authorities (SHAs) which were abolished by the Health and Social Care Act 2012.

Unlike SHAs, STP footprints do not have a statutory underpinning and thus, at least to date, are not subject to the same level of scrutiny that SHAs were. Moreover, although STP footprints are being asked to deliver many of the same functions as SHAs, STP footprints are also being asked to find and deliver financial savings in a way that SHAs never were.

How have STP footprint areas been identified?

Before developing their plans, local areas were tasked with agreeing the geographical area ('footprint') covered by their STP. After a degree of negotiation and horse-trading, this led to the emergence in March 2016 of 44 STP footprints[3] covering the whole of England. They range in size and population coverage, with the smallest – West, North and East Cumbria – covering 300,000 people and the largest – Greater Manchester – covering nearly three million people.

Clinical commissioning groups (CCG) were used as the primary defining boundaries and each STP footprint contains at least one CCG (the largest STP footprint consists of 12 CCGs). This means that many of the other health and care structures such as provider organisations and local authorities[4] may be covered by more than one STP footprint.

STP footprint boundaries often do not match up with the boundaries of other NHS England initiatives. For instance, it was recently revealed that NHS England is working to resolve the mismatch between the geographical areas covered by the STPs and the local digital roadmaps

(LDRs), which are responsible for developing strategies for how health localities will be paperless at the point of care by 2020[5].

Figure 1: Map of STP footprints[6]

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

20	Northamptonshire	42	Hampshire and the Isle of Wight
21	Cambridgeshire and Peterborough	43	Gloucestershire
22	Norfolk and Waveney	44	Buckinghamshire, Oxfordshire and Berkshire West

Each footprint has appointed a senior lead to drive the process. These leaders come from a range of backgrounds, including provider chief executives, CCG accountable officers, local authority leaders and clinicians[7].

NHS leaders have made a virtue of the fact that footprint areas will need to focus on different priorities dependent on local demographic demands. Simon Stevens described this as a 'horses for courses' approach[8], where all areas don't have to look the same as long as they focus on solutions.

What have STPs footprints been told to consider?

The Planning Guidance outlined a list of 'national challenges', framed around three overarching questions, that local systems are expected to answer as they go about creating an overall vision for health and care sustainability and transformation in their area. The three overarching questions are:

- How will you close the health and wellbeing gap?
- How will you drive transformation to close the care and quality gap?
- How will you close the financial and efficiency gap?

The Planning Guidance also outlined a list of 29 high level questions, covering core priorities of NHS England and the Department of Health, that areas must have regard to when developing their plans and give '*an early sense of what you [STP footprints] will need to address to gain sign-off and attract additional national investment*'[9].

The 29 questions span both specific disease areas (cancer, diabetes, learning disabilities, maternity and mental health and dementia) and overarching themes such as estates planning, digital strategy, governance and workforce planning.

Selection of core questions STP footprints are expected to address

- How will you assess and address your most important and highest cost preventable causes of ill health, to reduce healthcare demand and tackle health inequalities working closely with local government?
- How rapidly could you achieve full local implementation of the national Diabetes Prevention Programme?
- What is your plan for sustainable general practice and wider primary care?
- What is your plan for transforming urgent and emergency care in your area?
- How will you improve mental health services, in line with the forthcoming mental health taskforce report, to ensure measureable progress towards parity of esteem for mental health?
- How will you deliver the necessary per annum efficiency across the total NHS funding base in your local area by 2020/21?
- How will you reduce costs (as opposed to growing income) and how will you get the most out of your existing workforce?

- What actions will you take as a system to utilise NHS estate better, disposing of unneeded assets or monetising those that could create longer-term income streams?

Further guidance and support to the STP footprints have expanded on these first initial ideas as plans have been worked up. To that end, many local areas or individual healthcare organisations had already developed local plans or initiatives to address some of these issues. However, securing agreement on how best to tackle big, entrenched health challenges across organisations (who may not have a history of working together or agreeing to joint priorities) will have been, and remains, a challenge in many footprint areas.

Much of the early narrative surrounding the STP process focused on closing the health and wellbeing gap, and the care and quality gap. To that end, STP footprints have been encouraged to seek transformative change, be bold on the scale of ambition and drive towards a step change in patient empowerment.

Access to a £1.8 billion Sustainability and Transformation Fund (STF) – part of £8bn allocated to the NHS in the Spending Review – was promised to the best plans. The Planning Guidance states that:

> *"For the first time, the local NHS planning process will have significant central money attached. The STPs will become the single application and approval process for being accepted onto programmes with transformational funding for 2017/18 onwards."*

However, the third identified gap – addressing funding and efficiency challenges – is the core imperative for the STP process and as such much of the focus has pivoted to financial control.

This message has been reinforced by NHS leaders. Both Simon Stevens and Jim Mackey, Chief Executives of NHS England and NHS Improvement respectively, have stated that the STPs are 'not a bidding process', but a decision-making process[10]. Both have stressed the need to use the opportunity of the development of STPs to tackle the difficult decisions or longstanding 'elephants in the room.' The expectation is that this will be achieved through new approaches rather than additional resources.

This means that those developing the plans have had to attempt to balance two different core elements – sustainability and financial control on the one hand, and major system reform and transformation on the other. How far STP leaders – and the organisations within each footprint – are able to deliver either element to any significant degree remains to be seen.

What is the timetable for STP development?

After footprint areas were agreed in March, each area was required to submit a 'checkpoint submission', outlining the top line thinking to NHS England in April 2016. Many areas submitted these in the form of a slidedeck and 35 of these have been identified in the public domain.

The Planning Guidance stated that full STPs would be submitted by the end of June 2016 and assessment and review of the plans would be completed by the end of July 2016. However, given the scale of the task – agreeing footprint areas, bringing together all local stakeholders, engaging local populations, identifying plans and agreeing the best approach – the initial timeframes always looked ambitious.

NHS England has since relaxed the deadlines, calling on STP footprints to submit at least a basic version of their plan, if not a fully developed plan by the end of June. These drafts are being scrutinised and challenged by NHS England, NHS Improvement and the Department of Health, with an 'informal ranking' of the plans to be prepared in late July (these were not available at the time of writing). Seven footprint areas have published longer drafts online.

The details of how each of the STPs will be evaluated is yet to be confirmed, however the Planning Guidance stated that plans will be evaluated according to several factors:

- The quality and scale of the ambition of the plan
- Progress already made towards transformation
- The strength and unity of local system leadership within each footprint

The slipping of the submission deadline is also likely to reflect the variability in STP footprints' maturity and ability to agree to a joint strategy. As recently noted by Simon Stevens:

> *"The reality is that some places have been working together quite effectively for a period of time; they have a quite well-articulated view as to how they locally would implement the five year forward view, and are looking to fire the starting gun, which we expect to be able to do in October. At the other end of the spectrum, there are some people, frankly, for whom this is the first time they have shared their views together locally on how services need to change, so they have a further path to tread"*[11]

The majority of 'final' STPs are now expected to be submitted by October 2016. However, it remains unlikely that all footprint areas will comply with this deadline, or will submit plans that meet NHS England's expectations. As Simon Stevens tellingly remarked recently: "*The majority of the country will have well-designed service improvement and change plans that we [NHS England] will be able to back come October*" (our emphasis)[12].

The final plans submitted in October will form the basis for two-year, organisation level operating plans for 2017/18 and 2018/19. These will outline collaborative working across local health economies backed up by 'system control totals' or spending limits[13].

Appendix 1 shows a table of which of the 44 footprints have published full draft plans and / or checkpoint slide decks, and those for which there appears to be neither formal document. A number of these other areas do have some papers online, for example summary notes to brief local stakeholders, and engage the public.

Emerging themes in STPs

It is now possible to analyse some of the headline themes emerging from the draft STPs. Given the lack of detailed drafts from a significant number of footprint areas, our analysis has focused on those plans where information is available. It is also important to note that none of the plans have yet been signed off by NHS England, meaning that there could be major revisions to these drafts.

This section is divided into two parts:

1. Achieving sustainability
2. Delivering transformation

Achieving sustainability

STPs are being used by NHS national bodies as a key mechanism for regaining financial control over commissioners and providers. The STP plans are expected to play a major role in terms of identifying and then delivering savings across footprint areas. The financial 'reset' plan[14], published on 21 July 2016 by NHS England and NHS Improvement provided some more detail about priority areas for savings and the role of STPs in delivering them.

The financial reset outlines a carrot and stick approach

The financial reset also gives NHS Improvement and NHS England the power to place trusts and CCGs in 'special measures' if they are not meeting the *'financial discipline expected of them'*. Trusts put in special measures will have regulatory action determined by NHS Improvement. CCGs put in special measures will be intensively performance managed by NHS England, or could see themselves broken up, required to share joint management, or a range of other severe interventions. The five trusts and nine CCGs identified as the first cohort to enter the new regime are listed in Appendix 2.

This development has potential to create some complex command structures between CCGs, providers, NHS England and NHS Improvement. For example, Glenn Douglas, is the Chief Executive

of Maidstone and Tunbridge Wells NHS Foundation Trust – which has been placed in special measures – but he is also the footprint lead for Kent & Medway STP.

In terms of incentives (the carrot), the reset offers providers access to funding through the STF, but only if they meet their financial control targets (which must be agreed with NHS England and NHS Improvement) and meet national performance targets.

Despite trusts only being able to access the STF if they meet control totals, Appendix 3 shows that, at the time of writing, 23 trusts had not agreed their control totals with NHS England.

The vast bulk of the 2016/17 £1.8 billion STF – £1.6 billion – has been earmarked to fund the 'sustainability' side of STPs. This £1.6 billion will be made available to providers of acute emergency care services to help them reduce the combined provider deficits to £250 million in 2016/17. Only £200 million will be targeted at supporting providers to maximise efficiency (ie deliver transformation)[15].

The dominance of sustainability over transformation has led to concerns among stakeholders. The Health Select Committee's recent report into the impact of the 2015 Spending Review stated:

> *"At present the Sustainability and Transformation Fund is being used largely to 'sustain' in the form of plugging provider deficits rather than in transforming the system at scale and pace. If the financial situation of trusts is not resolved or, worse, deteriorates further, it is likely that the overwhelming majority of the Fund will continue to be used to correct short-term problems rather than to support long-term solutions"*[16].

Implementing the financial reset

The reset document calls on the NHS to deliver savings across a number of core areas. Some of the responsibility for finding these savings falls specifically on STPs, but – even where CCGs or providers are responsible – STP footprints will still have to take into account the savings being asked of their constituent parts and adjust accordingly.

- **Staffing**: the reset plan highlights 'excessive paybill growth', and targets 63 providers deemed to have unsustainable wage bills. Appendix 4 lists the top 15 trusts identified in the plan, demonstrating the scale of cuts expected. Alongside this will be a re-evaluation of national staffing ratios – a move that has been widely criticised, with suggestions that the NHS is forgetting the lessons of Mid-Staffordshire[17]
- **Consolidation of back office and pathology services:** STP leads were given eight days to identify 'quick wins' in two key areas identified in Lord Carter's review of efficiency savings[18]

- **Consolidation of 'unsustainable services':** STP leads are expected to rapidly identify any services that could be more efficiently delivered by nearby facilities, particularly those services reliant on expensive locum and agency staff
- **Controlling the use of agency staff:** a cap will be imposed on pay for temporary staff, with limits on how long they can be employed for

Examples of action to improve sustainability

Even before the publication of the financial reset, many of the organisations within each of the STP footprints were seeking to find efficiencies across the system in order to improve financial sustainability. To deliver on this, the vast majority of footprints with published materials identify "reconfiguration" or "rationalisation" – or, in plain English, the closure – of services as a required course of action.

Some of the plans set out a financial rationale for change, publishing estimates of the likely deficit if a 'do nothing' scenario is adopted. Not all of the footprints have been able to do this. Some have given a different deficit prediction, some have provided no estimate at all. Unless otherwise stated the number in the figure below represents the 2020/2021 'do-nothing' deficit for the Health and Social Care sectors combined. It is clear that this consideration is driving behaviour as STP footprints develop their plans.

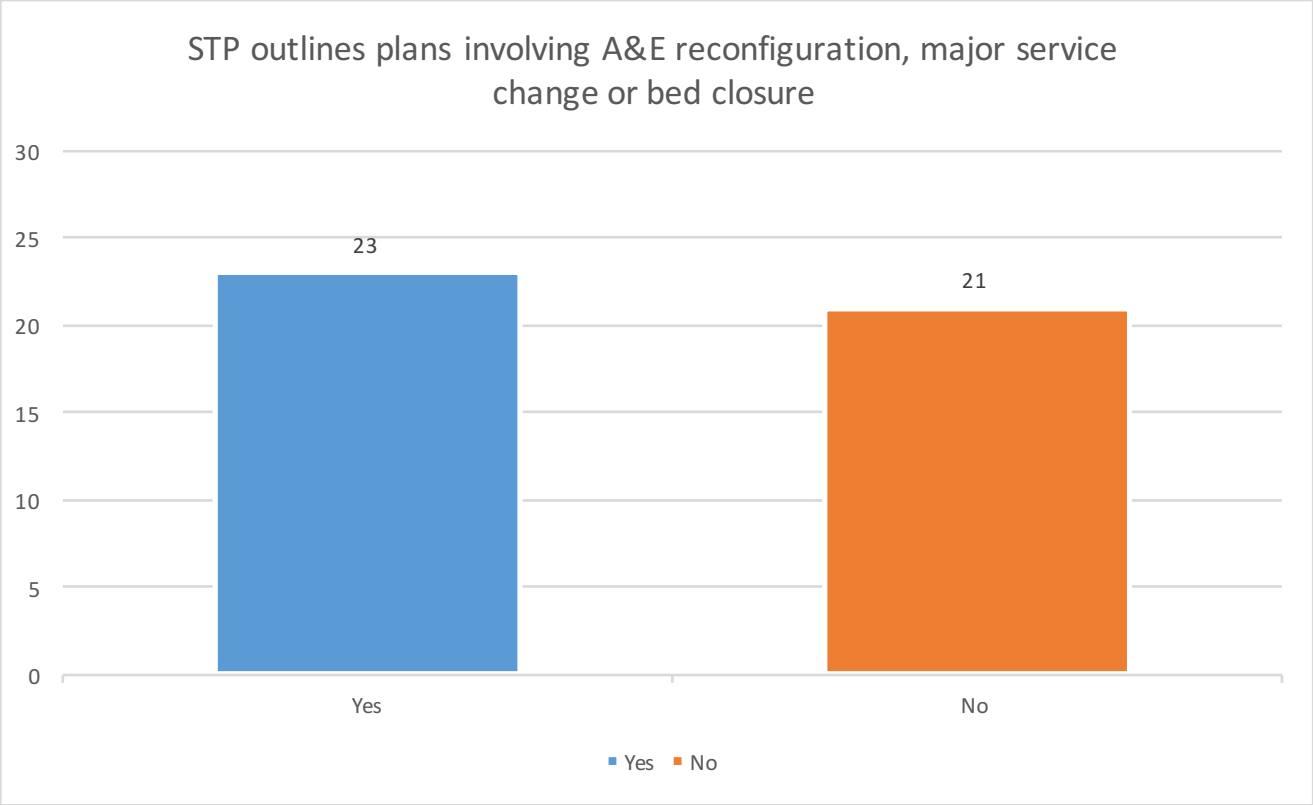
STP Footprint name	Predicted size of the deficit in 2021 for the health and social care sector
Bath, Swindon and Wiltshire	£490m
Birmingham and Solihull	Not found
Bristol, North Somerset, South Gloucestershire	Not found
Buckinghamshire, Oxfordshire & Berkshire West	£200 million
Cambridgeshire and Peterborough	£250 million
Cheshire and Merseyside	£150 million
Coast, Humber and Vale	Not found
Cornwall and the Isles of Scilly	Circa £50m in 2016/17
Coventry and Warwickshire	Not found
Derbyshire	Not found
Devon	£384 million
Dorset	£158 million
Durham, Darlington and Tees, Hambleton, Richmondshire and Whitby	£500 million
Frimley Health	£248 million
Gloucestershire	Not found

Greater Manchester	£2 billion
Hampshire and the Isle of Wight	£540-610 million
Herefordshire and Worcestershire	Not found
Hertfordshire and West Essex	£234 million by 2019/2200 (*Hertfordshire and West Essex combined)*
Kent and Medway	10-20% shortfall in revenue
Lancashire and South Cumbria	£805 million
Leicester, Leicestershire and Rutland	£700 million
Lincolnshire	Not found
Mid and South Essex (as the Mid and South Essex Success Regime)	£94m in 2015/16
Milton Keynes, Bedfordshire and Luton	Not found
Norfolk and Waveney	Not found
North Central London	£771 million
North East London	£511 million
North West London	£1.04 billion
Northamptonshire	£218.5 million
Northumberland, Tyne and Wear	£960 million
Nottinghamshire	£500 million
Shropshire and Telford and Wrekin	£140.5 million
Somerset	£212 million
South East London	£1.015 billion
South West London	£600 million
South Yorkshire and Bassetlaw	£500 million
Staffordshire	Not found
Suffolk and North East Essex	Not found
Surrey Heartlands	Not found
Sussex and East Surrey	£580 million
The Black Country	£476.6 million
West Yorkshire	Not found
West, North and East Cumbria	£163.8 million

It is clear that many STP footprints are exploring ways to reform acute services. For instance, Cheshire and Merseyside flags a major review, which is likely to include A&E closures:

> *"Secondary Care Services lines will be reviewed for both clinical and financial sustainability with an emphasis on "hot [meaning A&E], warm and cold sites". This will require services to be reconfigured so that they are clinically and financially sustainable, based on levels of demand and the appropriate level of geographic access"*[19]

Reference to reconfiguring A&Es is a theme covered in many of the STPs, as set out in the figure below:



Examples of acute service reconfiguration described in some of the plans include:

- North West London indicates that the "*integration of services*" includes plans to lose 500 acute beds[20]
- The Black Country includes plans for "*Horizontal Integration*" including consolidating "*a major A&E and acute function, and [merging] two District General Hospitals into one – with associated community infrastructure – by October 2018*"[21]
- Shropshire and Telford & Wrekin plans to establish a secondary care clinical model for the Shrewsbury and Telford hospital sites – in effect closing an A&E at either Shrewsbury or Telford[22]
- Leicester, Leicestershire and Rutland have plans to reduce their acute hospital footprint from three to two sites[23]
- Mid and South Essex Success Regime (a precursor to the STP) plans to "*reconfigure the acute hospitals to ensure delivery of core acute services at each site, yet greater concentration of more specialist care, and greater separation of non-elective and elective care to improve operations*"[24]
- Devon will "*ensure that acute and specialised services are 'right sized' to be safe, sustainable and accessible with fewer inpatient beds*"[25]

Service reconfigurations are often controversial[26]. At least two footprints have requested help from national organisations in providing media or political "*air cover*" for service changes[27,28]. In 2015 Simon Stevens made it clear that he was willing to publically support organisations trying to deliver radical change in just this way:

> "*We need to make the space for a new approach, vigour and vision to be sustained. One of my undelegatable personal responsibilities has to be to provide national 'air cover' for people doing exactly that*"[29]

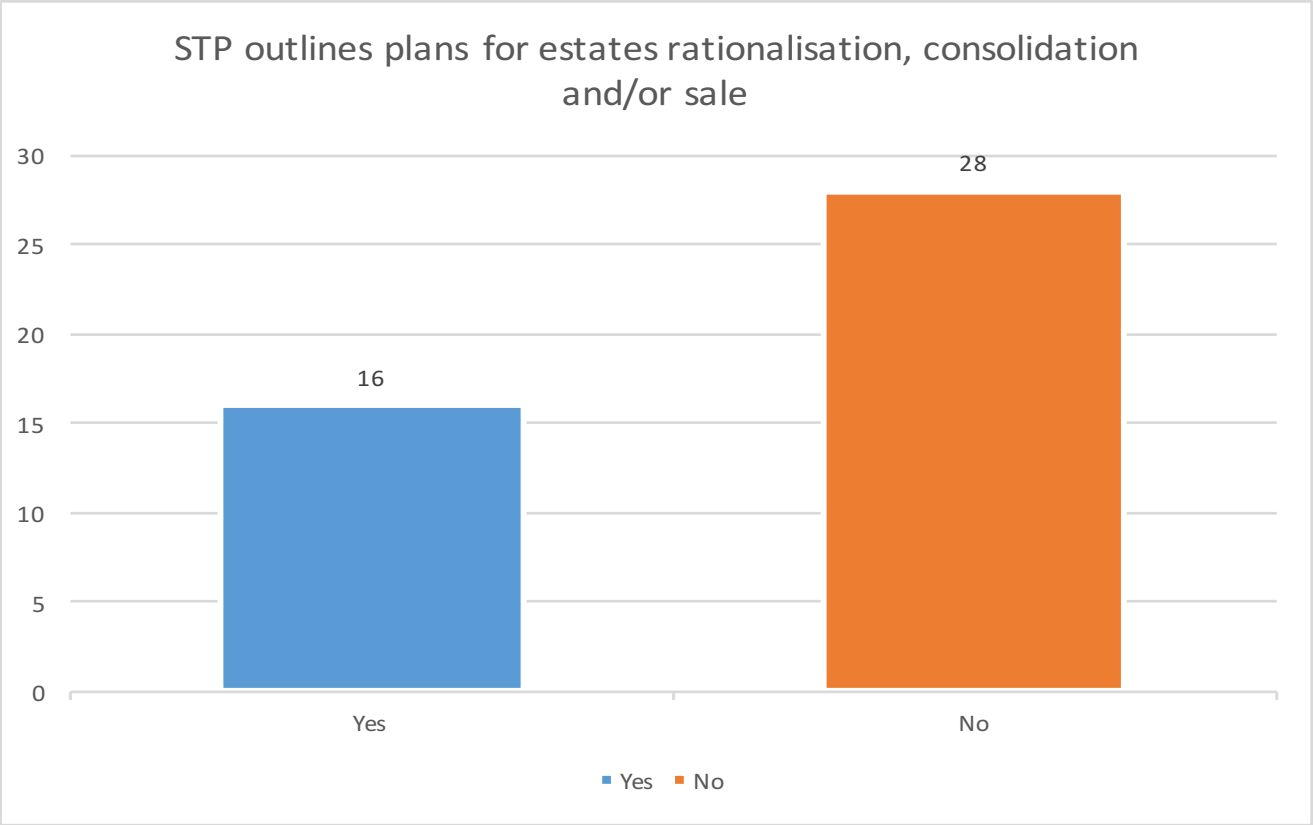
Many of the STPs emphasise the clinical benefits of reconfiguring services, arguing that such a move is necessary to affect their desire for better services and higher standards of care. For instance, Dorset envisages that:

> *"Our planned expanded integrated teams could deliver more and better services from a fewer number of sites than the 13 community hospitals with beds and 135 primary care sites that currently operate across Dorset"*[30]

As a result Dorset *"expect the bed capacity in Dorset to reduce to around 1,570 beds, from a level of 1,810 in 2013/14"*[31]. Similarly, Cheshire and Merseyside views reconfiguration and consolidation as the way to bring about higher standards:

> *"We expect every person in* Cheshire *and Merseyside to be able to access the highest standards of specialist and acute care 24 hours a day, 7 days per week. This will require our hospitals to be reconfigured, consolidated with less sites and clinicians and consultants working increasingly in new emerging networks"*[32]

How STP footprints intend to better manage and utilise their estates also features heavily in many draft plans.



Given the Government's aim to generate £2 billion from the sale of surplus public land and buildings – including across the NHS estate – it is unsurprising that many STPs talk of 'estate rationalisation' (ie reducing estate footprint or disposing of unused land). Typical examples include:

- Lancashire and South Cumbria who "*will look at estate utilisation across sectors and partners in the Lancashire and South Cumbria system to maximise support to delivery of new models of care; shifts of service provisions; and minimise spend on poor quality, under-used buildings*"[33]
- Frimley Health, which is "*considering how best to use our estate and resources across the system flexibly to support delivery of our new models of care*"[34]
- Bath, Swindon and Wiltshire, which is identifying "*opportunities for delivering lower cost services (workforce, estates)*"[35]
- North East London, which is undertaking "*joint work with local authorities on shared estates opportunities (also part of devolution) including disposals*"[36]

In Greater Manchester, the only footprint with a devolved budget, better use of the whole public sector estate is seen as a means to drive economic growth, as well as cut overheads:

> *"A rationalisation of our public sector estate will inevitably free up much needed space that is required to support our economic growth both through new housing and employment sites"*[37]

Several of the STPs also identify that productivity can be improved through the pooling of back office functions (in line with the Carter Review[38]):

- North East London and South East London argues that the productivity opportunity is significant through "*collaborative back office functions, and optimisation of estates and workforce*"[39,40]
- Buckinghamshire, Oxfordshire and Berkshire West sees "*shared back offices and estates*" as a key step to delivering sustainability[41]

Cornwall and the Isles of Scilly's STP captures the scale of the organisational realignment envisaged by other plans:

> *"Enablers being consolidated and aligned include a single estates strategy, shared digital roadmap, workforce development, legal and commercial, information sharing and business intelligence, communications and engagement, and commissioner integration"*[42]

Delivering transformation

Although the majority of financial resource allocated to the STP process is earmarked for achieving sustainability, the transformation element of the process is something that each STP footprint must also address if the aspirations of the FYFV are to be delivered. To that end, footprints have been encouraged to be ambitious in their approach to confronting some of the big health challenges in their area. To assist the 44 footprints NHS England have produced 14 'aide-memoires' on the big issues facing the health service. These are intended to be "*a description of the top-line objectives we collectively need to achieve by the end of the decade, both nationally and locally*"[43].

With respect to specific diseases or health issues, each of the 44 STP footprints were instructed to ensure their plan outlines their approach to: cancer, diabetes, learning disabilities, maternity, mental health and dementia. Examples of how – and why – areas are transforming cancer, diabetes and maternity are described below. It should be stressed that footprints' strategies for addressing these health areas often sit along side other objectives the STPs footprints are expected to address (ie prevention, patient experience, safety, new care models) so can be difficult to isolate.

Cancer

On cancer, each of the STP footprints is expected to outline how they will implement the recommendations of the cancer taskforce locally in order to improve outcomes across England. Examples of the approaches outlined by different footprints include:

- One of West Yorkshire's emerging priorities is "*identifying potential for collective working on other parts of the cancer pathway, eg focus on prevention*"[44]

- Greater Manchester is using its cancer vanguard to test out new models of care delivery across the entire cancer patient pathway. The aim of this is to *"bring significant improvements in outcomes and patient experience through a strengthened focus on early referral and rapid access to diagnostic services"*[45]
- Buckinghamshire, Oxfordshire and Berkshire West is aiming to reduce "*overlap and inefficiencies in access to diagnostics and supporting services along cancer pathways and specialist referral routes*"[46]

Given the fact that a cancer patient may need to use one or more services across a large geographical area, it's likely that planning for some cancer services – especially highly specialised services – will span more than one STP footprint.

Diabetes

STP footprints have been given a clear brief to reduce the variation in diabetes care and outcomes across England, and provide a more robust approach to prevention. As outlined below, STP footprints are adopting different approaches to address diabetes:

- Cornwall and the Isle of Scilly highlights that diabetes is a specific challenge in their area with a large undiagnosed population and poor disease management combining to put pressure on hospital admissions[47]
- Cheshire and Merseyside's proposals for diabetes emphasise the power of joint planning: "*it doesn't make sense for a hospital to develop isolated plans to improve diabetes care without working with local GPs and local authorities on how to help prevent people from having diabetes in the first place*"[48]
- Shropshire and Telford & Wrekin's proposal for diabetes includes "*reducing unwarranted variation across GP practice performance will contribute to reducing health inequalities*" for patients with diabetes[49]

Maternity

STP footprints were asked to set out a vision for maternity services. This was expected to be in line with the recommendations of the National Maternity Review, to provide care that is safer, more accommodating to women's choices and more joined up. Examples of how different STP footprints are approaching maternity services include:

- The Black Country aims "*to improve the maternity care, infant and child health outcomes… through the development of standardised pathways of care and quality improvement*"[50]
- Leicester, Leicestershire and Rutland has plans to reconfigure and consolidate maternity services[51]

- West and North East Cumbria intends to rebalance and reconfigure "*all of the services in line with the proposals being developed within the West and North East Cumbria Success Regime, maternity services and mental health services*"[52]

Mental health and dementia

In line with the Government's commitment to 'parity of esteem' for patients with mental health issues, the STP process is seen as an important driver for improving mental health services. Many footprints outline ambitious plans to achieve the FYFV goal of 'parity of esteem' by 2021:

- Durham, Darlington and Tees, Hambleton, Richmondshire and Whitby is looking to "*strengthen mental health services across the footprint with the intention of implementing the 'core 24' standards by 2020 to ensure mental health services are working alongside acute services with standardised delivery*"[53]
- Hampshire and the Isle of Wight is seeking to "*achieve and continuously improve performance against NHS constitution standards focusing on referral to treatment, accident and emergency, ambulance waits, cancer, mental health, mortality and dementia*"[54]
- Leicester, Leicestershire and Rutland has plans for "*improved mental health services for all, focusing on prevention, resilience and improving crisis services*"[55]
- Frimley Health recognises the importance of a holistic approach "*providing proactive management of frail complex patients, having multiple complex physical and mental health long term conditions, reducing crises and prolonged hospital stays*"[56]
- Milton Keynes, Bedfordshire and Luton aims for "*clearer integration of urgent primary and secondary physical and mental health care for seamless patient access*"[57]
- Kent and Medway is focusing on "*new approaches to contracting, supporting the development of more integrated pathways*" for people with mental health issues[58]

Learning Disabilities

STP footprints were mandated to consider both how to reduce the number of people with learning disabilities in specialist inpatient care and to consider the wider needs of people with a learning disability in their footprint. Plans include:

- Buckinghamshire, Oxfordshire and Berkshire West will review inequalities in the uptake of cancer screening by people with a learning disability and implement emerging improvements[59]
- North East and Cumbria referred to its Learning Disability Transformation Plan, which will "*deliver a 50% reduction in admissions to inpatient learning disability services by 2020*"[60]
- Leicester, Leicestershire and Rutland is improving "*support for people with Learning Disabilities to live in community settings and a reduction in inpatient beds over time*"[61]

New care models

New care models were first introduced in the FYFV as a way for the NHS to better integrate health and care services and deliver best value for the taxpayer. With that in mind, many STP footprints have outlined ways to develop and spread new care models, both as a way of ensuring efficient use of resources, and as a way of improving patients' experiences of their care. As highlighted by Simon Stevens:

> *"I think one of the very positive elements of how these conversations [around STPs] are developing is that local authorities and local government leaders are much more involved in the way that health and social care integration should look like in their area given the funding envelope"*[62]

A typical statement is one such as this from Cornwall and Isles of Scilly:

> *"We need to change from a traditional model of bed-based care to one which wraps multi-disciplinary teams around people in the community, and has the right configuration of beds and home based care to meet future demand with a model of care, based upon best clinical evidence"*[63]

This concept of a 'whole system' approach that brings different segments of the health and care systems together is emphasised in many plans:

- In Hampshire and the Isle of White "*improving the health of the local population will require integration with health, social care and third sector partners to deliver joined up services*"[64]
- Buckinghamshire, Oxfordshire and Berkshire West is "*developing a whole system integrated model to manage the ebbs and flows of urgent care demand across all providers, including virtual support from one unit to another*"[65]
- Cheshire and Merseyside highlights that silos between primary and secondary care as well as with local authorities prevent local people receiving the best care, and that "*planning by place – rather than by individual organisation*" will transform the care received for the local population as a whole[66]

STPs footprint's ambition to deliver service transformation is often seen as a necessary lever for delivering on efficiency targets. For instance:

- South East London estimates that "*cross-organisation productivity savings from joint working, consolidation and improved efficiency*" will save them a net £230 million[67]
- Buckinghamshire, Oxfordshire and Berkshire West argues that "*significantly reducing variation will drive efficiencies*"[68]

- Hampshire and the Isle of White recognises the productivity benefits of reducing "*unwarranted variation between benchmarked CCG referral rates to better manage demand*"[69]
- The West and North East Cumbria Success Regime (a precursor to the STP) will "*improve quality through reduced clinical variation*"[70]
- Staffordshire argues that "managing variation across the system will close the quality and reduce the financial gaps, giving a consistent service to patients"[71]

However, in the Financial Reset NHS England and NHS Improvement make clear that achieving financial sustainability takes precedence over service transformation:

> "*Providers in special measures will be required to focus firmly on their recovery actions and will therefore not be eligible to lead on transformation programmes (eg as New Care Model vanguards) or organisational transactions*"[72]

Supporting people to manage their own health, wellbeing and care

Along with a 'whole system approach' almost all STP drafts highlight how a culture of 'care closer to home', which supports people to manage their own health, wellbeing and care, will improve both finances and patient outcomes. For example:

- Dorset "*will extend health and care services far beyond doctor's surgeries and hospitals, into people's homes and our communities – the places where it is needed most*"[73]
- Buckinghamshire, Oxfordshire and Berkshire West is identifying "*opportunities to provide alternative services closer to home which would provide demonstrable financial and quality benefits*"[74]
- Bristol, North Somerset and South Gloucestershire "*have worked together to progress a system wide vision based on clinical consensus, of care closer to home and reduced reliance on acute services*"[75]
- North East London identifies "*shifting care closer to home, and less dependency on hospital system and beds*" as an overall priority in improving care and the quality of services[76]
- Durham, Darlington and Tees, Hambleton, Richmondshire and Whitby argues that "*most care should be provided out of hospital and close to the patients home*"[77]

Conclusion: implications for local communities

The introduction of the STP process is an ambitious attempt to impose financial discipline and drive innovation and transformation across the NHS in England. The plans produced by the 44 STP footprints and agreed with NHS England and NHS Improvement will be the driving force for local health planning and delivery, at least for the next two years.

STP footprints are required to work at rapid pace and have often developed plans with only limited public or patient involvement. As non-statutory bodies, their duties to engage are unclear and public or political accountability for their decisions is opaque.

Although STP footprints may have no formal position in the architecture of the NHS, it is clear that they could wield considerable power. The changes that STPs are contemplating in their draft plans have far-reaching implications for the delivery of health services and there will be legitimate public interest in the decisions that are made, as well as how they are arrived at.

To date public discussion of plans, or involvement in their development, has been limited. Given that many plans involve changes to popular local services, including A&Es and maternity units, public discussion and debate will occur sooner or later. When it does occur, it is likely to be controversial. As well as calling for support from NHS England, STP footprints will need to consider how they build public and political support for proposals. Lessons from previous service changes suggest that doing so without effective engagement and involvement will be challenging.

Appendix 1. Overview of the information available for each STP footprint

The STP footprints are currently under no obligation to publish or publicise their plans (although they are required to engage the public in the development of their plan). STP footprints were required to submit a 'checkpoint submission' to NHS England in April 2016 and we have found 33 of these are in the public domain. Some footprints have also chosen to publish longer written plans. In total we have either a written plan or checkpoint submission from 35 of the footprints (80%).

In compiling this list, we have sought to uncover the publicly available information relevant to STPs, but as this is often located in CCG board papers, reports to Health and Wellbeing Boards, or briefings to Local Authorities – it is not always easy to find.

STP Footprint name	Checkpoint submission (April 2016)	Full five-year plan submission (June 2016)
Bath, Swindon and Wiltshire	Yes	No
Birmingham and Solihull	No	No
Bristol, North Somerset, South Gloucestershire	Yes	No
Buckinghamshire, Oxfordshire & Berkshire West	Yes	No
Cambridgeshire and Peterborough	No	No
Cheshire and Merseyside	Yes	No
Coast, Humber and Vale	Yes	No
Cornwall and the Isles of Scilly	Yes	No
Coventry and Warwickshire	Yes	No
Derbyshire	No	No
Devon	Yes	No
Dorset	No	Yes
Durham, Darlington and Tees, Hambleton, Richmondshire and Whitby	Yes	Yes
Frimley Health	Yes	No
Gloucestershire	No	No
Greater Manchester	No	Yes
Hampshire and the Isle of Wight	Yes	Yes
Herefordshire and Worcestershire	Yes	Yes
Hertfordshire and West Essex	Yes	No
Kent and Medway	Yes	No
Lancashire and South Cumbria	Yes	No
Leicester, Leicestershire and Rutland	Yes	No
Lincolnshire	No	No
Mid and South Essex (as the Mid and South Essex Success Regime)	No	Yes

Milton Keynes, Bedfordshire and Luton	Yes	No
Norfolk and Waveney	Yes	No
North Central London	Yes	No
North East London	Yes	No
North West London	Yes	No
Northamptonshire	Yes	No
Northumberland, Tyne and Wear	Yes	No
Nottinghamshire	Yes	No
Shropshire and Telford and Wrekin	Yes	Yes
Somerset	Yes	No
South East London	Yes	No
South West London	Yes	No
South Yorkshire and Bassetlaw	Yes	No
Staffordshire	Yes	No
Suffolk and North East Essex	Yes	No
Surrey Heartlands	No	No
Sussex and East Surrey	Yes	No
The Black Country	Yes	No
West Yorkshire	Yes	No
West, North and East Cumbria	Yes	Yes

Appendix 2. List of the five trusts and nine CCGs that have been placed in special measures[9]

Barts Health NHS Trust
Croydon Health Services NHS Trust
Maidstone and Tunbridge Wells NHS Trust
Norfolk and Norwich University Hospitals NHS Foundation Trust
North Bristol NHS Trust
Coventry and Rugby CCG
Croydon CCG
East Surrey CCG
Enfield CCG
North Somerset CCG
North Tyneside CCG
South Gloucestershire CCG
Vale of York CCG
Walsall CCG

Appendix 3. List of those trusts that have failed to agree to control totals with NHS Improvement[9]

Barnet, Enfield and Haringey Mental Health NHS Trust
Croydon Health Services NHS Trust
Imperial College Healthcare NHS Trust
West London Mental Health NHS Trust
Cambridge University Hospitals NHS Foundation Trust
Cambridgeshire And Peterborough NHS Foundation Trust
East Midlands Ambulance Service NHS Trust
Norfolk and Norwich University Hospitals NHS Foundation Trust
Staffordshire and Stoke on Trent Partnership NHS Trust
Wye Valley NHS Trust
5 Boroughs Partnership NHS Foundation Trust
Alder Hey Children's NHS Foundation Trust
Greater Manchester West MH NHS Foundation Trust
The Newcastle Upon Tyne Hospitals NHS Foundation Trust
Pennine Care NHS Foundation Trust
University Hospital of South Manchester NHS Foundation Trust
Dorset County Hospital NHS Foundation Trust
Dorset Healthcare University NHS Foundation Trust
Maidstone and Tunbridge Wells NHS Trust
North Bristol NHS Trust
Plymouth Hospitals NHS Trust
Poole Hospital NHS Foundation Trust
South Western Ambulance Service NHS Foundation Trust

Appendix 4. List of the top 15 trusts identified for excess pay bill growth since 2014[9]

The amount that trusts are expected to cut from their pay bill is shown in column D.

Trust Name	A. Gross planned pay growth in 15/16 to 16/17 (ex inflation) (£k)	B. Gross planned pay growth 14/15 to 16/17 (ex inflation) (£k)	C. Potential pay growth opportunity (£k)	D. Part Year Effect from October 2016 (£k)
University Hospitals of Leicester NHS Trust	30,626	42,329	42,329	21,165
Royal Devon and Exeter NHS Foundation Trust	31,185	30,621	31,185	15,593
Barts Health NHS Trust	0	29,404	29,404	14,702
Imperial College Healthcare NHS Trust	8,913	29,231	29,231	14,616
Tameside Hospital NHS Foundation Trust	23,365	28,898	28,898	14,449
Norfolk and Norwich University Hospitals NHS Foundation Trust	5,221	23,065	23,065	11,533
Cambridge University Hospitals NHS Foundation Trust	8,432	22,375	22,375	11,188
Pennine Acute Hospitals NHS Trust	12,039	19,846	19,846	9,923
Nottingham University Hospitals NHS Trust	11,520	19,760	19,760	9,880
Ipswich Hospital NHS Trust	8,330	17,699	17,699	8,850
West Suffolk NHS Foundation Trust	6,092	17,226	17,226	8,613
Royal Brompton and Harefield NHS Foundation Trust	13,651	15,312	15,312	7,656
Milton Keynes University Hospital NHS Foundation Trust	6,377	15,170	15,170	7,585
Medway NHS Foundation Trust	3,190	14,867	14,867	7,434
Croydon Health Services NHS Trust	5,288	14,650	14,650	7,325

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