

Saving STPs

Achieving meaningful health
and social care reform

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Executive summary

1 Reforming the health and social care system

Current ambitions for NHS and social care reform rest on the success of Sustainability and Transformation Plans (STPs). The 44 STPs covering the whole of England are the main delivery vehicle for the *Five Year Forward View*, which aims to strengthen prevention and primary care, develop new care models that reduce the burden on acute hospitals and deliver much better value for money.¹ These changes are also needed to deliver the financial targets agreed by NHS England i.e. to achieve £22 billion in efficiency savings by 2020-21, thereby needing no additional financial support from the taxpayer.²

The idea of STPs is that local health economies, rather than individual NHS organisations, are best placed to decide together how to reform health and social care in their areas. STPs will encompass all health bodies – primary, secondary, tertiary, mental health providers and commissioners – and also local authorities, who are responsible for social care and public health provision.

STPs have been developed to enable these different organisations to look beyond a ‘fortress mentality’, in which each acts in its own self-interest rather than in the wider population interest. In particular, STPs should enable acute hospitals to consider the wider picture, and so allow resources to be transferred intelligently into the community, from secondary care to primary care and prevention. A number of areas have a history of integrated working that predates STPs and this paper highlights the following good practice examples:

- > The development of an embryonic Accountable Care Organisation (ACO) in Morecambe, based on a Memorandum of Understanding (MoU) between all local NHS providers, commissioners, and authorities. NHS Improvement has reported a fall in emergency occupied bed days in the Morecambe Bay area of 29 per cent between 2014-15 and 2015-16.³
- > The centralisation of emergency care in Greater Manchester from twelve existing hospitals to four high-acuity centres, reducing variation in care and improving quality.⁴

STPs build on the efforts of successive governments to improve the performance and productivity of the NHS, in particular by separating the purchasing of care from its provision (“commissioning”) and by encouraging choice and competition between providers where appropriate. The principles for successful health reform are: achievement of high quality; value for money; and competition and choice.

1 NHS England, *Five Year Forward View*, 2014.

2 Ibid.

3 NHS Improvement, *New Care Model Update: NHS Improvement's Role in Establishing and Overseeing Accountable Care Organisation*, 2016.

4 Dean Kirby, Manchester Evening News, ‘Healthier Together: Hospital Bosses Join Forces to Produce a “Plan B” for NHS Shake-Up’, Web Page, (2 October 2014).

2 Promise unfulfilled

Partial success in driving reform

Experts interviewed for this paper reported that STPs have achieved some positive progress. In particular they have brought leaders together from across the health and social care system to have conversations about integrated working that would not have happened otherwise. In areas where pre-existing plans were in place, the STP has bolstered work previously done.

Positive themes have emerged from the current proposals, including genuinely innovative ideas for integrated working, community care provision, reduction in unit costs, reduction in health inequalities and integration of technology. Areas that have moved from the planning phase to implementation typically have a history of working together on integrated care models prior to the introduction of STPs.

Insufficient engagement and support

These themes show the potential of STPs and indeed the opportunity to achieve the depth and breadth of change that the NHS needs. The balance of evidence, however, suggests that these examples will be the exception rather than the rule unless key barriers are addressed.

Interviewees report that, in some STPs, the involvement of local authorities has been minimal. They spoke of concerns from local authorities that they are not being treated as equal partners, partly due to their much smaller budgets. There is also concern that some STPs have all but ignored mental health provision.

Collaboration has been difficult partly because of the chosen footprints of STPs, described by one interviewee as “mad geography”. Some footprints cover as many as 12 Clinical Commissioning Groups (CCGs) or 10 local authorities.⁵ For bodies that are part of numerous STPs (such as county councils and ambulance trusts), finding people with enough time to participate has been a challenge.

The priority for STPs has been eliminating financial deficits in the short term rather than drawing up plans for the future.

Surveys reveal that a majority of clinicians have not heard of the plans, and citizens are yet to be involved. As a result, interviewees fear that local politicians may not support plans for significant redesign of services when they are presented.

An inconsistent vision

Interviewees reported that the messages from NHS England and NHS Improvement were inconsistent. NHS England are focused on the *Five Year Forward View* as a whole and NHS Improvement are more focused on achievement of financial balance in the short term. Interviewees also spoke of a disconnect between the formal and informal guidance.

Lack of executive authority

Interviewees consistently argued that it is difficult for STPs to draw up plans across their areas because they have no executive authority. STPs are also uncertain whether they are allowed to integrate local services, given the need to maintain competition under current legislation. The NHS payment systems are fragmented with separate budgets for primary, secondary and social care. They do not support organisations to plan and deliver care co-operatively.

⁵ NHS England, *Sustainability and Transformation Plan Footprints*, 2016; Greater Manchester Combined Authority, ‘About GMCA’, Web Page, (2017).

3 Saving STPs

Given the barriers to progress set out above, STPs will not deliver the degree of change needed to improve the NHS and to meet the financial targets on which the *Five Year Forward View* depends.⁶ The following recommendations would save not only STPs but also the current plans for NHS reform:

- 1 A single set of health outcomes for each STP area, based on population health measures relevant to each area.** Manchester has already drawn up population outcomes based on starting well, living well and ageing well.
- 2 Pooled budgets, commissioned by a single body in each STP area.** The creation of a single budget for health and social care, under a single commissioning body, will overcome the barriers to joint working which have stymied STPs.
- 3 Competition in order to hold providers accountable for performance.** As services become integrated, commissioners will need to ensure that competition is maintained. They can do this by: maintaining the purchaser-provider split; commissioning for outcomes; renewing contracts at regular intervals; allowing smaller providers to bid for parts of larger contracts; and decommissioning services that are not delivering outcomes.
- 4 New guidance clarifying how current legislation surrounding competition applies in the context of STPs.** There is currently confusion as to what is permitted under existing legislation regarding collaborative working.
- 5 Introducing a directly elected individual responsible for the STP budget, whether a metro mayor or a new Health Care Commissioner.** Such an appointment would provide legitimacy for the decisions that are needed to reform the NHS through engagement with voters.

⁶ NHS England, *Five Year Forward View*.

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Reforming the health and social care system

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Current ambitions for NHS and social care reform rest on the success of STPs. The plans will deliver the vision of the *Five Year Forward View* with radical change to the operation of the NHS in order to deliver much better value for money.

The NHS is the biggest public service by far. Its budget of £116 billion accounts for around one sixth of all public spending.⁷ It employs 1.2 million people.⁸ Its model of universal provision at the point of need is highly valued by the public. Successive governments have tried to improve the performance and productivity of the NHS, in particular by separating the purchasing of care from its provision (“commissioning”) and by encouraging choice and competition between providers where appropriate.

1.1 Background: bringing reform to the NHS

Since its establishment in 1948, the Secretary of State for Health has held overall responsibility for the NHS. The challenge has been to combine that responsibility with effective management and accountability for performance, throughout the service.⁹

In 1983, the Griffiths Report identified a disproportionately powerful clinical body with inefficient, unclear management functions.¹⁰ It led to the introduction of a supervisory board chaired by the Secretary of State where NHS budgets, objectives and strategy were decided.¹¹ Since then, reorganisations of the NHS have seen changes to its structure, but the basic principle of NHS management remains the same: central government outlines the priorities of the service and the method of delivery, whilst lower-tier bodies and regional offices are accountable for delivery.¹²

The most recent and largest reorganisation – the Health and Social Care Act 2012 – was designed to continue the trajectory of policy development across political parties since 1989.¹³ The “internal market” was initially introduced in 1991 by Ken Clarke, then Secretary of State for Health.¹⁴ He split the health authorities (which were to commission care on behalf of the population) from hospital trusts (which competed to provide care). General Practitioner (GP) fundholders were also introduced, meaning General Practices could purchase care on their patients’ behalf.

New Labour adopted the principles of competition and expanded the involvement of private sector organisations in the NHS.¹⁵ Waiting lists for outpatient appointments were too long and so secondary care providers were paid for activity to reduce them. In 2001, the Government introduced 303 Primary Care Trusts to commission services; in 2006 this was reduced to 152, the majority of which were coterminous with local authorities.¹⁶ Finally, New Labour introduced national guidelines and targets designed to reduce variation in the quality of care.¹⁷

The Health and Social Care Act sought to improve commissioning by giving a stronger voice to primary care physicians. It also created new commissioning roles for local authorities, via Health and Wellbeing Boards. The reforms became highly controversial due to confusion around the Act’s proposals and the scale of the change to commissioning organisations. Since 2012, Ministers have stated that “what won’t work is a return to top-down direction from the Department of Health”.¹⁸

7 NHS Choices, ‘The NHS in England’, Web Page, (13 April 2016).

8 NHS Digital, *NHS Workforce Statistics – September 2016, Provisional Statistics*, 2016.

9 Martin Gorsky, ‘Coalition Policy towards the NHS: Past Contexts and Current Trajectories’, Web Page, (3 January 2011).

10 Roy Griffiths, ‘NHS Management Inquiry: Griffiths Report’, *British Medical Journal* 287, no. 6402 (1983).

11 Ibid.

12 Harry Quilter-Pinner, *Devo-Health* (Institute for Public Policy Research, 2016).

13 Gorsky, ‘Coalition Policy towards the NHS: Past Contexts and Current Trajectories’.

14 Ibid.

15 Nicholas Mays and Anna Dixon, *Assessing and Explaining the Impact of New Labour’s Market Reforms* (The King’s Fund, 2011).

16 Department of Health, ‘Reorganisation of Ambulance Trusts, SHAs and PCTs’, Web Page, (13 October 2009).

17 Mays and Dixon, *Assessing and Explaining the Impact of New Labour’s Market Reforms*.

18 Jeremy Hunt, ‘New Deal for General Practice: Jeremy Hunt Speech in Full’, Speech, (19 June 2015).

1.2 The *Five Year Forward View* and STPs

Continued concern over the performance of the NHS, and its financial sustainability, led to a further wave of reform in 2014. The *Five Year Forward View* called for improved prevention and public health, reduced variability in the quality and safety of care, the introduction of new care models to reduce the burden on acute hospitals, and the restoration of financial balance to the NHS.¹⁹ It also sought to end the separation between health and social care.

The *Five Year Forward View* is being delivered by 44 STPs. The idea of STPs is that local health economies decide together how best to reform health and social care in their areas.²⁰ They encompass all health organisations – primary, secondary, tertiary, mental health providers and commissioners – as well as local authorities.²¹

The intention is that they enable these different organisations to look beyond a ‘fortress mentality’ in which each acts in its own self-interest rather than in the wider population interest.²² Acute hospitals are the major concern. Because acute providers are paid according to their activity, they have strong incentives to increase activity in order to improve their financial performance. The result, however, has been to divert resources away from community and primary care services; provision that is ultimately better placed to deliver services that meet patient need. If successful, STPs will enable acute hospitals to look beyond their own boundaries and allow resources to be transferred intelligently from secondary care to primary care and prevention.

Some areas are already delivering integrated community care. This has taken a variety of forms including ACO models and reconfigurations of acute care.

Accountable Care Organisations

An ACO is an arrangement in which all the bodies that commission and provide health and social care in an area come together into one organisation that is accountable for all care. This could be as a fully integrated system or a looser collaboration. An NHS Improvement briefing explained that ACOs represent a slight shift in boundary between commissioners and providers.²³

This integrated care system model was first developed by Kaiser Permanente and Intermountain Healthcare in the United States. It is being seen in various forms in England, both in the new models of care vanguards and the STPs.²⁴

One such example is in Morecambe Bay, where providers, commissioners, local authorities and General Practice Federations signed an MoU in March 2016 to agree common objectives for their local health population. The collective they created is called Bay Health Partners, which they are describing as a “shadow” ACO, recognising that a “full” ACO is not possible under the current legislative framework.²⁵ The MoU has no legal status: “It is seeking commitment and sign up from partner organisations to the next phase of work and how we work with each other over the next year, rather than a formal binding agreement.”²⁶

The move towards a new way of working in the Morecambe Bay area followed a vanguard programme set up to reduce variable quality of care and provider deficits.²⁷ A CCG board paper said that the ACO was a means to escape annual contracting cycles. It allowed for organisational, rather than systemic, regulation and payment models meaning the ACO can be incentivised to deliver desired outcomes.²⁸ According to NHS Improvement, there was a 29 per cent reduction in the number of emergency occupied bed days in Millom and Duddon Valley (the Morecambe Bay area) between 2014-15 and 2015-16.²⁹

19 NHS England, *Five Year Forward View*.

20 NHS England, ‘About Sustainability and Transformation Plans (STPs)’, Web Page, (2016).

21 NHS England, *Five Year Forward View*.

22 Chris Ham and Hugh Alderwick, *Place-Based Systems of Care A Way Forward for the NHS in England* (The King’s Fund, 2015).

23 Ibid.

24 The King’s Fund, ‘Accountable Care Organisations (ACOs) Explained’, Web Page, (22 March 2016).

25 Bay Health Partners, *Draft Memorandum of Understanding (MoU) for a Shadow Accountable Care System in the Bay Area*, 2016.

26 Ibid., 4.

27 Ibid.

28 NHS Lancashire North Clinical Commissioning Group, *Better Care Together – An Accountable Care System for Morecambe Bay*, 2015.

29 NHS Improvement, *New Care Model Update: NHS Improvement’s Role in Establishing and Overseeing Accountable Care Organisation*, 2–3.

Reorganising acute care

Some of the most controversial proposals being put forward in the STPs concern acute care reconfiguration. One interviewee explained that Greater Manchester is reorganising its acute care to reduce local variation and ensure everyone receives high quality care. It is establishing four high-acuity centres which will each cover the majority of emergency care (each centre cares for an area previously covered by three hospitals). For example, the high-acuity centre for Wigan, Bolton and Salford will be located at Salford.³⁰ Wigan and Bolton will retain their emergency centres but, if the ambulance crew believe a patient is acutely unwell, they will be taken to Salford. To balance the increased acute care activity at Salford, the other hospitals will increase their elective care.

Establishing a high-acuity centre across three hospitals means that the most unwell patients will be seen and treated by senior clinicians and emergency surgery will be carried out on one site. This intervention should reduce variation in care. Focusing resource in one location can also deliver better care.³¹ In communicating the plans to the public, local leaders have been very careful to emphasise that the guiding principle is to improve quality, not to close services.

1.3 Principles of NHS reform

The NHS should support people to remain healthy at home and, when they do need support, high quality care should be delivered in the most appropriate place by the most suitable people.

Collaborative working may go some way to delivering this vision. When designing STPs, it is vital that leaders remember important reforms of the past and follow key principles of successful service delivery.

1.3.1 Quality care

High quality healthcare has been a key priority for successive governments. The question, though, hangs around what high quality care is and how it should be measured. Various targets have been introduced over the last 20 years.³² In secondary care, these have been based on waiting times and rates of infection. These do not necessarily measure quality. As the Shadow Scottish National Party Westminster Group Leader for health, Philippa Whitford, put it, the four-hour A&E waiting target acts as “a thermometer to take the temperature of the acute service, and it does that really well, because it measures not just people coming in through the front door but how they are moving through the hospital and out the other end.”³³ The four-hour wait gives an indication of the pressures on acute care within a hospital but not the wellbeing of the local population. In primary care, the Quality and Outcomes Framework is sometimes used to evaluate General Practices. The system has been criticised, however, for rewarding process over outcomes.³⁴ Such targets are limited in their ability to measure what is important to patients.

The quality of the NHS has been compared to other health systems across the world.³⁵ Cancer survival rates are used as a proxy for healthcare performance, and, internationally, the UK does relatively poorly.³⁶ Similar results are seen for cardiovascular disease.³⁷ The NHS strives to achieve world-class care for such conditions and, whilst international comparisons are useful in initiating debate, caution should be exercised when drawing any conclusions because of differences in data collection, definitions and patient characteristics.³⁸ When considering what high quality care is, the focus should be on

30 Dean Kirby, Manchester Evening News, ‘Healthier Together: Hospital Bosses Join Forces to Produce a “Plan B” for NHS Shake-Up’.

31 Candace Imison et al., *The Reconfiguration of Clinical Services* (King’s Fund, 2014).

32 Mays and Dixon, *Assessing and Explaining the Impact of New Labour’s Market Reforms*.

33 Philippa Whitford, ‘NHS and Social Care Funding’, Web Page, (11 January 2017).

34 Carolyn A. Chew-Graham et al., ‘How QOF Is Shaping Primary Care Review Consultations: A Longitudinal Qualitative Study’, *BioMed Central Family Practice* 14, no. 103 (2013).

35 Kristian Niemietz, *What Are We Afraid Of?* (Institute of Economic Affairs, 2015).

36 Lucia Kossarova, Ian Blunt, and Martin Bardsley, *Focus on: International Comparisons of Healthcare Quality* (The Health Foundation, Nuffield Trust, 2015).

37 Ibid.

38 Ibid.

outcomes that are important to the public. Whilst individuals want to survive their cancer diagnosis, they would far sooner avoid the disease completely.

1.3.2 Value for money

Value for money links cost to outcomes, rather than just outputs.³⁹ There is a temptation to equate cost cutting with greater productivity, but this in itself is not helpful.⁴⁰ For example, delivering knee replacements more cheaply may not deliver better value for money than an exercise programme that aims to improve health and prevent degenerative joint disease. A better framework considers spending and outcomes at every stage of the decision-making process. Since the NHS was created, broadly speaking, funding has increased but improvements in value for money have been variable.⁴¹ Ministers tend to emphasise the importance of increasing inputs, both workforce numbers and spending, rather than efficiency and effectiveness.⁴²

More positively, recent work has looked at how to deliver care whilst spending taxpayers' money wisely. The Carter review highlighted £5 billion of efficiency savings by centralising back office functions and improving approaches to absenteeism, procurement, estates and prescribing.⁴³ The Academy of Medical Royal Colleges found that an estimated £2 billion is wasted on unnecessary intervention.⁴⁴ For example, wasted medication costs £300 million each year.⁴⁵ Moving care away from the relatively expensive acute sector and into the community has delivered savings in health systems in other countries.⁴⁶ By focusing on prevention and primary care, Kaiser Permanente have a model of delivering healthcare that is 16 per cent more cost effective than the other approaches in the markets they serve.⁴⁷

1.3.3 Competition and choice

Competition works to drive down costs, spur innovation and increase the focus on consumer need.⁴⁸ Public service markets are subject to the limitations of a quasi-market: policy makers are driven by factors other than efficiency, such as outcome equality, and generally consumers do not pay directly for services.⁴⁹ However, competition can be used to avoid monopolisation of healthcare and ensure that services are designed to suit users rather than those delivering them.⁵⁰

The theoretical benefits of competition in healthcare are clear. Evidence from the Organisation for Economic Co-operation and Development, International Monetary Fund and others, suggests that competition can be used "effectively to create a system that's responsive and to incentivise high quality and efficient care".⁵¹ However, competition within the NHS is negligible. For instance, in August 2016, 1.3 per cent of contracts within general practice had been tendered or retendered in the preceding 12 months.⁵² This is

39 For a full discussion of the opportunities and difficulties in doing this, see Elizabeth Crowhurst, Amy Finch, and Eleonora Harwich, *Towards a More Productive State* (Reform, 2015); Harwich, Hitchcock, and Fischer, *Faulty by Design. The State of Public-Service Commissioning*.

40 Crowhurst, Finch, and Harwich, *Towards a More Productive State*.

41 Rachael Harker, *NHS Funding and Expenditure* (House of Commons Library, 2012); Dale Bassett et al., *2012 Reform Scorecard* (Reform, 2012).

42 Harker, *NHS Funding and Expenditure*; Bassett et al., *2012 Reform Scorecard*.

43 Lord Carter of Coles, *Securing the Future: Proposals for the Efficient and Sustainable Use of Custody in England and Wales*, 2007.

44 Academy of Medical Royal Colleges, *Protecting Resources, Promoting Value: A Doctor's Guide to Cutting Waste in Clinical Care*, 2014.

45 Paul Preofessor Trueman et al., *Evaluation of the Scale, Causes and Costs of Waste Medicines* (York Health Economics Consortium and The School of Pharmacy University of London, 2010).

46 USA Today, 'Kaiser Permanente CEO on Saving Lives, Money', Web Page, (23 October 2012).

47 Ibid.

48 Frontier Economics, *Choice and Competition in Public Services: A Guide for Policy Makers* (Office of Fair Trading, 2010).

49 Ibid.

50 Ibid.

51 Isabelle Joumard, Christophe Andre, and Chantal Nicq, 'Health Care Systems: Efficiency and Institutions' (OECD, 2010); Carlo Cottarelli, 'Macro-Fiscal Implications of Health Care Reform in Advanced and Emerging Economies' (International Monetary Fund, 2010); Will Hazell, 'Monitor: Role for Competition in New Provider Landscape', *Health Service Journal*, 2014.

52 Alexander Hitchcock, 'Contradictory NHS Policy Will Undermine Improvements in Care', *The Reformer Blog*, 5 January 2017.

because almost all contracts are open ended and renewed without retendering. This prevents new models of care expanding across the country, although some, such as the two vanguards Modality in the West Midlands and Lakeside in Northamptonshire, have expressed interest and demonstrated success as primary care providers.⁵³

Choice and competition are closely related. Choice by individuals, or by commissioners on behalf of individuals, is a lever for creating successful markets.⁵⁴ Choice can have a positive impact on the provision of care by driving providers to adapt services to users' needs.⁵⁵ Although patients can choose their General Practice and secondary care provider, engagement with such decisions is currently limited. Patients rarely change their General Practice, and GPs largely choose secondary care providers on behalf of their patients.⁵⁶ That being said, it is surely a fundamental principle of a healthy healthcare system that patients have choice over where and how they are treated.

53 Nick Renaud-Komiya, 'Exclusive: Vanguard GP "super Partnership" in Talks to Expand across England', *Health Service Journal*, 1 February 2016; Robert Professor Harris, 'Leading from the Front in Primary Care', *The Reformer Blog*, 12 April 2016.

54 Frontier Economics, *Choice and Competition in Public Services: A Guide for Policy Makers*.

55 Cathy Corrie and Leo Ewbank, *How to Run a Country: Health and Social Care* (Reform, 2015).

56 Monitor, *Improving GP Services: Commissioners and Patient Choice*, 2015; Anna Dixon, *Patient Choice* (The King's Fund, 2010).

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Promise unfulfilled

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2.1 Partial success in driving reform

Interviewees for this paper agreed that the vision of the *Five Year Forward View* is the right approach to healthcare reform. They believed that STPs are starting to put in place the building blocks required to deliver on that vision.

The STP proposals lay out some genuinely innovative ideas for integrated working and they have brought leaders together from across the health and social care system to have conversations about integrated working that otherwise would never have happened. In areas where pre-existing plans were in place, STPs have bolstered work previously done.

Positive themes that have emerged from the plans include: innovative ideas for integrated working; community care provision; reduction in costs; reduction in health inequalities; and integration of technology. Areas that have moved from the planning phase to implementation generally have a history of working together on integrated care models prior to the introduction of STPs.

The partial success stories show the potential of STPs to achieve the depth and breadth of change that the NHS needs, but they have proved to be the exception rather than the rule. Interviewees identified three main problems that were stalling the progress of STPs: insufficient engagement and support; an inconsistent vision within and between national bodies; and lack of executive authority within the STP.

2.2 Insufficient engagement and support

To succeed, STPs have to bring together all NHS bodies within their area to enable joined-up thinking. This has to include local authorities. Working together, they must produce plans for coherent redesign of local services. This is not happening across all STPs. Nor are they achieving the buy-in from politicians, NHS employees and citizens needed to make lasting change possible.

2.2.1 The “mad geography” of STP footprints

Some STP participants cited the geographical footprint as an initial stumbling block to collaboration, with one interviewee describing it as “mad geography”. There is a feeling that the footprint boundaries do not marry with historical relationships, patient pathways, or the boundaries of existing authorities. Where authorities (such as county councils and ambulance trusts) are in more than one footprint, finding sufficient time to participate is a challenge.⁵⁷ Some felt the national agenda to have larger footprints was being imposed from above while local leaders wanted smaller footprints.⁵⁸ Some footprints have as many as 12 CCGs⁵⁹ or 10 local authorities⁶⁰, while others have only one CCG.

Although there may be some scope to readjust the boundaries where they are found not to be working, local leaders need to accept their footprints and establish new relationships. The footprints were drawn up following extensive research by Monitor (now part of NHS Improvement) on health economies.⁶¹ Historical relationships may not be so valuable where they are not delivering consistent high quality care. Furthermore, in previous research, *Reform* has recognised that some CCGs are too small and providers are outgrowing them.⁶²

57 Nigel Edwards, *Sustainability and Transformation Plans: What We Know so Far* (Nuffield Trust, 2016).

58 Hugh Alderwick et al., *Sustainability and Transformation Plans in the NHS: How Are They Being Developed in Practice?* (The King's Fund, 2016).

59 NHS England, *Sustainability and Transformation Plan Footprints*, 2016.

60 Greater Manchester Combined Authority, 'About GMCA'.

61 Monitor, *Considerations for Determining Local Health and Care Economies*, 2015.

62 Leo Ewbank, Alexander Hitchcock, and Thomas Sasse, *Who Cares? The Future of General Practice* (Reform, 2016).

2.2.2 Insufficient involvement of local authorities

In some STPs, involvement of local authorities has been minimal. Interviewees spoke of concerns from local authorities that they are not being treated as equal partners, partly due to their much smaller budgets.

Without the engagement of local authorities, STPs cannot generate ideas that work with social care or public health. More generally, the NHS will not benefit from local authorities' wider perspective on local areas. As one health and social care manager has said:

[Local authorities see] the wider picture – what really is driving demand, why people really turn up to A&E – because they spend their lives talking to local people and have a much broader insight into the possibilities for tackling those issues. They will offer solutions that are different to the usual NHS solutions.⁶³

There is potential for the NHS to learn from local authorities' experience of delivering services within a fiscal envelope and of delivering efficiency savings. Local authorities have achieved this using approaches ranging from management reorganisations and recruitment freezes, through to major transformational programmes and service redesign.⁶⁴ The Wiltshire 'Help to Live at Home' service, for example, has replaced traditional community care services for older people with an integrated system of care and support. The service reconciles three competing aims of social care reform: personalisation, recovery and prevention. Assessments for the service are person centred and focus on outcomes that leave customers better able to have a better quality of life with less care. Outcomes from the service have exceeded expectations and efficiency savings now total £11.6 million.⁶⁵

As yet, attempts to integrate the work of local authorities and the NHS have not been successful. In February 2017, the National Audit Office reported that the Better Care Fund delivered neither expected financial savings nor reductions in hospital admissions.⁶⁶

2.2.3 Insufficient involvement of mental health

Interviewees doubted whether STPs would succeed in involving mental health providers alongside their primary, secondary and tertiary colleagues. Mental health was not mentioned in many of the first drafts of STPs, and NHS England's National Director of Mental Health said it had initially been neglected.⁶⁷ Mental health is rightly a key priority of the current government.⁶⁸ One in four adults suffer with a mental illness and poor mental and physical health are linked. If mental health is to achieve parity of esteem it must be a pillar of STPs.

2.2.4 STP Boards: sustainability rather than transformation

According to interviewees, the priority for STP Boards has been eliminating financial deficits in the short term. Pressure to balance the books has led some STPs to focus on structural reconfiguration of the acute sector rather than comprehensive and proactive change to minimise and manage demand, taking into account primary, community, social and end-of-life care.⁶⁹ As GP Helen Stokes-Lampard said, "STPs ... are being distracted by shoring up the acute sector deficit, which is a real distraction from what they really need to be doing, which is fulfilling the aims of planning for the future."⁷⁰

63 Institute of Healthcare Management, *Swimming Together or Sinking Alone: Health, Care and the Art of Systems Leadership*, 2016, 9.

64 Department for Communities and Local Government, *Good Practice in Local Government Savings*, 2014.

65 Local Government Association, *LGA Adult Social Care Efficiency Programme*, 2014.

66 National Audit Office, *Health and Social Care Integration*, 2017.

67 Simon Wessely, 'NHS England Should Learn a Lesson from Ofsted and Get Tough over STPs', *Health Service Journal*, 24 January 2017.

68 Theresa May, 'Mental Health Problems Are Everyone's Problem', Speech, (9 January 2017).

69 Hempsons and NHS Providers, *Governing for Transformation: STPs and Governance*, 2016.

70 Helen Stokes-Lampard, 'The Long-Term Sustainability of the NHS: Oral Evidence' (House of Lords Select Committee on the Long-Term Sustainability of the NHS, 22 November 2016).

It is likely that the requirement to promise immediate financial improvement will leave some STPs unable to deliver. As one CCG leader put it: “Not many of us really believe the numbers [but] we have been asked to try to show the system in financial balance, so have done this ... by stretching all opportunities beyond realistic levels.”⁷¹

The lack of focus on wider reform could, in part, be due to scepticism that stronger primary care will reduce the pressure on A&E services.⁷² One interviewee said that, although greater focus on prevention is desirable, it is unlikely to deliver short-term efficiency savings. This view is not consistent with research by the Local Government Association, which has found investment in prevention can provide cost savings in less than a year.⁷³ Using technology to monitor people from a distance, for example, has a cost benefit of £2.68 for every £1 spent.⁷⁴

2.2.5 Limited inclusion of clinicians

The sheer number of General Practices and primary-care providers have meant they are the most difficult subset to involve in STPs.⁷⁵ A 2016 British Medical Association survey of 614 GPs and secondary care consultants in London found that 66 per cent of GPs had not heard of STPs and 87 per cent were not formally consulted about their STP.⁷⁶ Furthermore, the survey found 53 per cent of consultants had not heard of STPs and 85 per cent had not received information about STPs from their trust.⁷⁷

The pressure on clinicians’ time has resulted in some STPs depending on management consultants rather than frontline staff, an arrangement that leaders were concerned was unsustainable and inhibited STPs from developing their own capacity.⁷⁸ One STP paid private firms £2.3 million for support in drawing up the plans.⁷⁹ However, clinical involvement is imperative. As one health and social care manager said, by not involving clinical staff “they will carry on doing what they’ve always done”.⁸⁰

2.2.6 Public excluded

Until proposals were formally approved, NHS England instructed local leaders not to make their STPs public and to reject Freedom of Information requests.⁸¹ Whilst this is understandable in the very early stages to allow space to discuss proposals, it has led to insufficient public involvement in the process. It follows that, as former Minister of State for Community and Social Care, Norman Lamb, recognised: “Local people faced with a proposal either to close or slim down their local hospital do not begin to understand, and neither should they, the complex judgments that have to be made about the best allocation of resources. They will simply resist.”⁸²

2.2.7 Inconsistency of political support

Interviewees doubted whether local politicians will always support reform proposals. They note that reforms can be controversial, and that in the past some constituency MPs have rallied against changes to hospital provision, even when their own government has been in favour of them. For example, when proposals to merge four A&E centres in Liverpool received press attention in Autumn 2016, both Labour and Conservative MPs spoke out

71 Dave West, ‘Survey Finds Few Local Leaders Confident STPs Will Deliver’, *Health Service Journal*, 25 October 2016.

72 Edwards, *Sustainability and Transformation Plans: What We Know so Far*.

73 Local Government Association, *Prevention: A Shared Commitment. Making the Case for a Preventative Transformation Fund*, 2015.

74 *Ibid.*

75 Alderwick et al., *Sustainability and Transformation Plans in the NHS: How Are They Being Developed in Practice?*.

76 British Medical Association, ‘Half of London’s Doctors Haven’t Heard of STPs, Survey Finds’, Press release, (1 November 2016).

77 *Ibid.*

78 Alderwick et al., *Sustainability and Transformation Plans in the NHS: How Are They Being Developed in Practice?*.

79 Peter Blackburn, ‘Private Firms Earn £2.3m from STP’, *BMA News*, 19 January 2017.

80 Institute of Healthcare Management, *Swimming Together or Sinking Alone: Health, Care and the Art of Systems Leadership*, 12.

81 Alderwick et al., *Sustainability and Transformation Plans in the NHS: How Are They Being Developed in Practice?*.

82 Norman Lamb, ‘The Long-Term Sustainability of the NHS: Oral Evidence’ (House of Lords Select Committee on the Long-Term Sustainability of the NHS, 13 December 2016).

against them.⁸³ Overall, politicians have shown little engagement with the STP process, but as plans are implemented, their support will be pivotal.

2.3 An inconsistent vision

STP participants report that messages from NHS England and NHS Improvement are inconsistent. NHS England is focused on supporting local services to improve the quality and efficiency of services, develop new models of care and improve prevention strategies. NHS Improvement is principally concerned about financial sustainability. In a document sent to trust directors in July 2016, Jim Mackey, CEO of NHS Improvement, described the achievement of quarterly financial targets as a “binary on/off switch” to secure access to trusts’ share of the Sustainability and Transformation Fund.⁸⁴

There has also been a lack of coherent vision within each of these national organisations. Interviewees described a disconnect between the formal guidance, which focused on delivering the whole *Five Year Forward View* and the informal message, which focused on saving money and making changes to acute hospital services. These issues have been identified in previous STP research.⁸⁵ One interviewee suggested that national bodies have deliberately created constructive ambiguity to enable the system to evolve organically but that this type of flexibility is not something NHS bureaucracy is used to. They also said there is a culture of looking upwards and working rigidly that is hard to break. There have been instances where the message from the top has contradicted messages coming from further down the line, resulting in confusion for STP leaders as to whose advice to follow.

2.4 Lack of executive authority

Interviewees consistently reported that within the STP decision-making process it is difficult to come to collective agreements. The STPs have no executive authority. In areas with no history of collaboration, STPs have found it particularly difficult to establish what their role is in the system.

STPs are not legal bodies in their own right. Instead they comprise a group of separate organisations, each with its own statutory responsibility and individual accountability.⁸⁶ Participants expressed frustration at the lack of an executive decision-making authority within the STP.⁸⁷ One interviewee explained that this has been less of a problem in Greater Manchester, where devolution arrangements have created a chief officer who does have executive authority. However, even this arrangement is restricted by existing legal frameworks. In Greater Manchester, the chief officer had to be someone from NHS England so there would be a high level NHS England official maintaining ultimate accountability for provision and thereby fulfilling NHS England’s assurance role as well as its regional commissioning function for primary care.⁸⁸

The response of national leaders to concerns over the lack of STP executive functions is that they are simply a means to get people together to talk about the issues and they do not need executive leadership, but a new type of leadership: a ruling-by-consensus approach.⁸⁹ That being said, the limited authority and accountability Health and Wellbeing Boards hold has stunted their progress with some involved questioning whether the lack

83 Phil McCann, ‘Merseyside and Cheshire NHS: Plans to Downgrade Three A&Es Considered’, *BCC News*, 4 November 2016; Joshua Taylor, ‘MP Warns of Hospital Bed Closures and Job Cuts as NHS Battles £999m Black Hole’, *Liverpool Echo*, 16 September 2016.

84 NHS Improvement, *Sustainability and Transformation Fund 2016/17: Criteria to Access the Fund*, 2016, 2.

85 Alderwick et al., *Sustainability and Transformation Plans in the NHS: How Are They Being Developed in Practice?*; Edwards, *Sustainability and Transformation Plans: What We Know so Far*.

86 House of Commons Library, ‘NHS Sustainability and Transformation Plans’, Web Page, (12 September 2016).

87 Alderwick et al., *Sustainability and Transformation Plans in the NHS: How Are They Being Developed in Practice?*.

88 NHS England, *Internal Delegation Arrangements for Greater Manchester Devolution*, 2016.

89 Alderwick et al., *Sustainability and Transformation Plans in the NHS: How Are They Being Developed in Practice?*.

of executive power has made them simply “talking shops”.⁹⁰ Some STPs have created MoUs to establish shared objectives. Although these have no legal status, they are useful in establishing consensus. In a guidance document, NHS Providers advises establishing an STP board:

*This will not be a board in any formal sense and it will not be able to make decisions for or otherwise commit the members. Instead, it will be a group which can allow the members, through their representatives, to make aligned decisions.*⁹¹

These alliances are too weak. Even with shared objectives, participants are reporting that existing regulatory and legislative frameworks – which promote competition over integration and organisation-centric policies over system-wide policies – are hampering co-operation.⁹²

2.4.1 Is existing law a barrier to integration?

Despite concerns among some STP participants that competition law is a barrier to integration, existing legislation is a necessary safeguard against anti-competitive practice. The legislation is not a barrier to integration where this is in the best interests of patients. The perception of this barrier, however, is a problem.

2.4.1.1 Competition law

STP participants report concerns that competition law inhibits integration. For example, a report by Lancashire North CCG says that legislative changes will be needed to deliver accountable care models in England.⁹³ The head of policy for NHS Providers argues even vertically integrated models, such as Primary and Acute Care Systems, may be challenged by the Competition and Markets Authority (CMA), the non-governmental department in charge of enforcing competition law.⁹⁴

However, William Sprigge, a legal consultant, argues that the problem is people’s perception rather than the law itself.⁹⁵ He says that if patient benefits outweigh the anti-competitive effects of arrangements, the solution will comply with competition rules. This is supported by guidance for providers published by the CMA and Monitor (now part of NHS Improvement).⁹⁶ It states that “significant” transactions that have a negative impact on competition can happen if benefits to patients outweigh the impact on competition. “Significant” transactions include: new and innovative delivery models; unusual or unfamiliar structures; and operating outside of the normal area of business.⁹⁷ This is also the view of Jim Mackey, Chief Executive of NHS Improvement, who said: “I think we can all do a hell of a lot more than we are within the current legal framework. And at times people hide behind the potential risks and constraints of [competition regulation].”⁹⁸

2.4.1.2 The Health and Social Care Act 2012

In addition to the implications of competition law for integration, legislation specific to the health sector is perceived to raise issues. An amendment to the National Health Service Act 2006, introduced by the Health and Social Care Act, is interpreted by some to mean that the board of directors of NHS trusts cannot legally put the broader interests of

90 David J. Hunter et al., *Evaluating the Leadership Role of the Health and Wellbeing Boards as Drivers of Health Improvement and Integrated Care across England: Interim Report 2* (Durham University, The University of Sheffield, London School of Hygiene and Tropical Medicine, 2015).

91 Hempsons and NHS Providers, *Governing for Transformation: STPs and Governance*, 12.

92 Alderwick et al., *Sustainability and Transformation Plans in the NHS: How Are They Being Developed in Practice?*

93 NHS Lancashire North Clinical Commissioning Group, *Better Care Together – An Accountable Care System for Morecambe Bay*.

94 Amber Davenport, ‘We Need Clarity around How Competition Law Will Affect New Care Models’, *Health Service Journal*, 6 August 2015.

95 William Sprigge, ‘Competition Cannot Be Ignored in a Reconfigured NHS’, *Health Service Journal*, 20 February 2015.

96 Competition and Markets Authority and Monitor, ‘Guidance: Transactions Involving New Care Models’, Web Page, (2015).

97 Ibid.

98 Crispin Dowler, ‘Mackey: Regulatory Duties Must Not Stop NHS Improvement Helping Trusts’, *Health Service Journal*, 10 November 2015.

patients over the short-term interests of their own organisations.⁹⁹ The law now reads:

*The general duty of the board of directors, and of each director individually, is to act with a view to promoting the success of the corporation so as to maximise the benefits for the members of the corporation as a whole and for the public.*¹⁰⁰

However, following a consultation process, integrative practice has been achieved in Greater Manchester and other areas.

2.4.2 Payment systems and outcomes

The current regulatory system and funding model focuses on individual organisations rather than collective accountability. In a survey of 99 CCG leaders carried out from September to October 2016, 60.6 per cent said that organisational priorities trumping those of the STP was a significant barrier to success.¹⁰¹

NHS payment systems do not support organisations to plan and deliver care co-operatively. Primary care contracts tend to pay per capita, whereas hospital contracts usually have a large activity based element. This provides no financial incentive for primary care to deliver preventative measures or early intervention to prevent expensive hospital admissions. In turn, acute providers are keen to increase activity to boost finances. These funding models inherently prevent integrated working.

Furthermore, there is little incentive to practice preventative care: a General Practice that invests in an obesity strategy to reduce the number of obese patients on its register will ease the pressure on secondary care. It will not, however, reap financial reward for its hard work.

Separate health and social care budgets are also a barrier to integrated care. The current system incurs waste as siloed systems leave patients waiting for social care in acute hospital beds, costing £400 each day.¹⁰² In the community, health and social care systems are repetitive and difficult to navigate. Citizens regularly undergo multiple different assessments as the NHS and local authority replicate one another's work. Individuals often go on to receive care twice or not at all.¹⁰³

Misaligned targets are seen at contractual level as well, where organisations are hamstrung by requirements that do not contribute to achieving population-wide outcomes. For example, a primary care contract that requires a certain number of appointments to be delivered by GPs, thereby preventing the Practice from using other members of its multi-disciplinary trust to deliver community care.¹⁰⁴

99 Hempsons and NHS Providers, *Governing for Transformation: STPs and Governance*.

100 HM Government, *Health and Social Care Act 2012*, Section 152.

101 Dave West, 'Exclusive: Survey Reveals STPs' Service Change Priorities', *Health Service Journal*, 25 October 2016.

102 data.gov.uk, 'NHS Hospital Stay', Web Page, (24 August 2015).

103 Chris Ham, Anna Dixon, and Beatrice Brooke, *Transforming the Delivery of Health and Social Care: The Case for Fundamental Change* (The King's Fund, 2012).

104 Leo Ewbank, Alexander Hitchcock, and Thomas Sasse, *Who Cares? The Future of General Practice* (Reform, 2016).

3

Saving STPs

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At heart, the STP process aims to bring organisations together at a local level to improve health outcomes and deliver value for money to taxpayers. There has been encouraging progress so far, particularly in areas that were already committed to this agenda prior to the introduction of STPs. The real challenge, however, will be turning proposals into plans and plans into practice. This paper has outlined a number of challenges that have emerged so far. These need to be addressed if STPs are to deliver.

This final section lays out recommendations for an NHS that delivers integration, accountability, competition and, ultimately, high quality care at a fair cost to the taxpayer. A balance needs to be struck between bringing organisations together locally and avoiding the creation of a small number of poor quality large providers, which are too big to fail.

3.1 Shared, locally set outcomes

3.1.1 Aligning incentives through joint outcomes

Individual organisations within STPs strive to deliver the best care for their population. They do, however, have budgets and targets that need to be met, as well as local boards and national bodies to which they are accountable. This system incentivises organisations to protect their own interests at the expense of others. For example, a 9 per cent real terms reduction in adult social care spending from 2010-11 to 2015-16 led to increased pressure on the NHS, with patients in hospital unable to be discharged as they awaited social care.¹⁰⁵ If organisations within STPs are to work together, their incentives must be aligned.

One way to do this would be for all organisations within the STP to be held accountable for the same population-wide health outcomes. This will require CCGs and local authorities to work together and commission services based on common outcomes. Recent consensus is that outcomes-based commissioning is the most cost-effective way to deliver personalised care.¹⁰⁶ This is because it encourages organisations to adopt a more system-wide approach to decision making.¹⁰⁷ Outcomes based commissioning should become the core payment method for the system rather than an additive to current metrics. Only by shifting the national metrics, the system will establish congruency between outcomes and payment.

3.1.2 Setting outcomes locally

Individual STPs and local commissioners are better placed than central government to define these health outcomes that matter to local populations. Health-related quality of life is a good starting point.¹⁰⁸ Within this parameter, STPs can choose the most locally relevant population health outcomes. These should look towards the medium and long term to focus both on health-related quality of life and prevention strategies.¹⁰⁹

As part of Greater Manchester's devolved health project, local health outcomes have been designed to provide a common goal towards which everyone in the project works.¹¹⁰ The outcomes are based on starting well, living well and ageing well. Furthermore, tangible measurements have been put in place to monitor progress (Figure 1).

¹⁰⁵ Richard Humphries and Lillie Wenzel, *Options for Integrated Commissioning: Beyond Barker* (The King's Fund, 2015).

¹⁰⁶ Dan Crowe, Tom Gash, and Henry Kippin, *Beyond Big Contracts* (Institute for Government, 2014).

¹⁰⁷ Harwich, Hitchcock, and Fischer, *Faulty by Design. The State of Public-Service Commissioning*.

¹⁰⁸ The King's Fund, *Measuring NHS Success*, 2005.

¹⁰⁹ Charles Alessi et al., *Operationalising Wellness* (Oliver Wyman, 2014); Crispin Ellison, Cate Reynolds, and Charles Alessi, *Measuring Wellness* (Oliver Wyman, 2014).

¹¹⁰ Greater Manchester Combined Authority and NHS in Greater Manchester, *Taking Charge of Our Health and Social Care in Greater Manchester*, 2015.

Figure 1: Greater Manchester health and social care outcomes

	Outcome	Measure
Start Well	More children will reach a good level of development cognitively, socially and emotionally.	Improving levels of school readiness to projected England rates will result in 3,250 more children, with a good level of development by 2021.
	Fewer babies will have a low birth weight, resulting in better outcomes for the baby and less cost to the health system.	Reducing the number of low birth weight babies in Greater Manchester to projected England rates will result in 270 fewer very small babies (under 2,500 grams) by 2021.
Live Well	More families will be economically active and family incomes will increase.	Raising the number of parents in good work to the projected England average will result in 16,000 fewer children in Greater Manchester living in poverty by 2021.
	Fewer people will die early from cardio-vascular disease (CVD).	Improving premature mortality from CVD to the projected England average will result in 600 fewer deaths by 2021.
	Fewer people will die early from cancer.	Improving premature mortality from cancer to projected England average will result in 1,300 fewer deaths by 2021.
	Fewer people will die early from respiratory disease.	Improving premature mortality from respiratory disease to projected England average will result in 580 fewer deaths by 2021.
Age Well	More people will be supported to stay well and live at home for as long as possible.	Reducing the number of people over 65 admitted to hospital due to falls to the projected England average will result in 2,750 fewer serious falls.

Source: Taking Charge of our Health and Social Care in Greater Manchester, 2016, Greater Manchester Combined Authority, NHS in Greater Manchester

Recommendation 1:

STPs should design their own local health outcomes for which every organisation in the STP is accountable.

3.2 Pooled budgets

The current NHS funding model does not promote integrated working across providers. In primary care, capitated funding means that GPs are incentivised to manage the amount of care they offer. As discussed, this is at odds with hospitals who are largely paid by activity. This arrangement sees care increase in the relatively costly acute sector, the antithesis of the *Five Year Forward View* which aims to move care into the community.¹¹¹

Funding models need to be aligned across the healthcare system. One option would be a capitated budget covering primary and secondary services in a given locality. This should cover the whole of the STP. Providers would be given a set budget for their population and could reinvest any savings made. Delivering care within a set envelope focuses minds on the most cost-effective way to do so for the whole population. Ultimately, this means efforts on health promotion in order to reduce the burden of chronic disease. Furthermore, when individuals do come into contact with the NHS, providers could design services around community provision.

¹¹¹ NHS England, *Five Year Forward View*.

Separate budgets for healthcare, social care and public health are also a barrier to integration. Interviewees explained that in some STPs, local authorities are not being seen as equal partners because “power and money go hand-in-hand” and the NHS budget dwarfs that of social care and public health. For the STPs to deliver integrated community care, local authorities and the NHS must work across organisational and policy silos, as true partners. Joining up budgets could level the playing field between the two and encourage NHS leaders to embrace the important work that local authorities could play in health promotion and community provision. The STPs should take a ‘one-system, one-budget’ approach to health and social care.¹¹²

In the short to medium term, the pooled budget should be allocated to providers by a joint commissioning body. This body would be responsible for commissioning across the whole STP. The body would be able to bring together the commissioning skills of individuals from both CCGs and local authorities within the STP. Commissioning would be based on outcomes across the STP. The body would have the capability to ensure all organisations in the area were working towards the same outcomes. In the medium to long term an elected leader would take responsibility for the budget. This is discussed further in section 3.5.

Recommendation 2:

STPs should take a ‘one-system, one-budget’ approach. NHS, social care and public health budgets should be merged across the STP and commissioned by a single body.

3.3 Competition and integration

Integration is sometimes seen as a threat to competition. As it stands competition is weak within the NHS; primary care contracts rarely come up for renegotiation and most contracts for secondary care are too long and too large for new competitors to enter the market.¹¹³ There is a danger that collaboration and new models of care, such as large ACOs, will monopolise the health and social care system further.

There is a careful balance to be struck and this could be achieved through:

- > maintaining the purchaser-provider split;
- > outcomes based commissioning;
- > regular renewal of contracts, the length of which should be a matter for commissioners to decide;
- > allowing smaller providers to bid for parts of larger contracts; and
- > decommissioning services that are not delivering outcomes.

Recommendation 3:

Commissioners need to regularly evaluate whether providers are delivering on outcomes. Where these are consistently not delivered, services should be decommissioned and broken up to allow smaller providers to bid. Contracts should come up for renewal at regular intervals.

3.4 Clarifying the legislation

There is currently confusion among STP participants as to what is permitted under existing legislation regarding collaborative working, without breaching anti-competition law or the Health and Social Care Act.

¹¹² Nicholas Timmins and Chris Ham, *The Quest for Integrated Health and Social Care A Case Study in Canterbury, New Zealand* (The King's Fund, 2013).

¹¹³ Ewbank, Hitchcock, and Sasse, *Who Cares? The Future of General Practice*.

NHS Improvement should publish updated guidance addressing this issue and explain how the legislation applies in the context of STPs. STP participants need to be clear that legislation should not inhibit collaboration. NHS Improvement must continue to be available locally, so that STPs can consult them about whether plans have negative consequences for competition. This will address the myth of STPs being seen as a way of circumventing the legislative process, and give local leaders the confidence to act in the best interests of their local population.

Recommendation 4:

NHS Improvement should publish guidance clarifying how current legislation surrounding competition applies in the context of STPs.

3.5 Elected leaders

If STPs fail to engage the public, politicians and those working within the health and social care sector, their work will be in vain. The current period of consultation is important but it is a great concern that swathes of employees working in health and social care, and many members of the public, have not heard of STPs.¹¹⁴

STPs will and should make controversial decisions, including the closure of A&E departments. Without consultation on such issues, changes will be seen as cuts to services rather than a movement of care out of hospital and into the community in the best interests of patients.

Introducing a directly elected individual responsible for the STP would allow the public to engage with health and social care provision. The elected individual could provide legitimacy for decisions taken and would be in a position to challenge opposition to the plans. To ensure the elected leader has the appropriate powers, they need to be responsible for the STP budget. The leader would decide how best to design the governance structure for commissioning within the STP. They could continue to use a joint commissioning body (as discussed in 3.4) or construct a new model to better suit their STP.

Elected leaders should deliver integration. With this in mind, elected metro mayors could take responsibility for the STP – indeed in Manchester the newly elected mayor will be responsible for devolved healthcare. A leader that oversees not only health and social care, but also education and policing, would encapsulate the new integrated approach to population wellbeing.

In areas without a metro mayor, an elected Health Care Commissioner could oversee the STP process. Introduction of such a role would take time as reflected by the low turnout in Police and Crime Commissioner (PCC) elections.¹¹⁵ That does not, however, take away from the importance of such a role. The Home Affairs Select Committee found that “PCCs have provided greater clarity of leadership for policing within their areas, and are increasingly recognised by the public as accountable for the strategic direction of their police force.”¹¹⁶ Furthermore, the Committee found instances of PCCs using their power to drive collaboration and efficiency in their area to deliver value for money.¹¹⁷

Recommendation 5:

STP footprints should have elected leaders who are held to account by the public.

¹¹⁴ British Medical Association, ‘Half of London’s Doctors Haven’t Heard of STPs, Survey Finds’.

¹¹⁵ BBC News, ‘Police & Crime Commissioner Elections 2016’, Web Page, (2016).

¹¹⁶ House of Commons Home Affairs Committee, ‘Police and Crime Commissioners: Progress to Date, Sixteenth Report of Session 2013-14’ (House of Commons, May 2014), 20.

¹¹⁷ House of Commons Home Affairs Committee, ‘Police and Crime Commissioners: Progress to Date, Sixteenth Report of Session 2013-14’.

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