



House of Commons
Health and Social Care
Committee

**Integrated care:
organisations,
partnerships and
systems**

Seventh Report of Session 2017–19

*Report, together with formal minutes relating
to the report*

*Ordered by the House of Commons
to be printed 23 May 2018*

Health and Social Care Committee

The Health and Social Care Committee is appointed by the House of Commons to examine the expenditure, administration, and policy of the Department of Health & Social Care.

Current membership

[Dr Sarah Wollaston MP](#) (*Conservative, Totnes*) (Chair)

[Luciana Berger MP](#) (*Labour (Co-op), Liverpool, Wavertree*)

[Mr Ben Bradshaw MP](#) (*Labour, Exeter*)

[Dr Lisa Cameron MP](#) (*Scottish National Party, East Kilbride, Strathaven and Lesmahagow*)

[Rosie Cooper MP](#) (*Labour, West Lancashire*)

[Diana Johnson MP](#) (*Labour, Kingston upon Hull North*)

[Johnny Mercer MP](#) (*Conservative, Plymouth, Moor View*)

[Andrew Selous MP](#) (*Conservative, South West Bedfordshire*)

[Derek Thomas MP](#) (*Conservative, St Ives*)

[Martin Vickers MP](#) (*Conservative, Cleethorpes*)

[Dr Paul Williams MP](#) (*Labour, Stockton South*)

The following Members were members of the Committee during the Session:

[Dr Caroline Johnson MP](#) (*Conservative, Sleaford and North Hykeham*)

[Maggie Throup MP](#) (*Conservative, Erewash*)

Powers

The Committee is one of the departmental select committees, the powers of which are set out in House of Commons Standing Orders, principally in SO No 152. These are available on the internet via www.parliament.uk.

Publication

Committee reports are published on the Committee's website at www.parliament.uk/hscocom and in print by Order of the House.

Evidence relating to this report is published on the [inquiry publications page](#) of the Committee's website.

Committee staff

The current staff of the Committee are Huw Yardley (Clerk), Seth Roberts (Second Clerk), Laura Daniels (Senior Committee Specialist), Lewis Pickett (Committee Specialist), Dr Juliette Mullin (Clinical Fellow), Cecilia Santi O Desanti (Senior Committee Assistant), Ed Hamill (Committee Assistant), and Alex Paterson (Media Officer).

Contacts

All correspondence should be addressed to the Clerk of the Health and Social Care Committee, House of Commons, London SW1A 0AA. The telephone number for general enquiries is 020 7219 6182; the Committee's email address is hscocom@parliament.uk.

Contents

Summary	4
1 Integrating care for patients	8
Need to define outcomes for patients	9
Our inquiry	10
Background	10
Focus of the inquiry	10
Visit to South Yorkshire and Bassetlaw	10
Oral evidence sessions	10
Legal challenges	11
Section 1: Background on integrated care reforms	13
2 Progress towards more integrated care	14
Complexities of integrating health and social care	15
Integration, patient choice and competition	15
Conclusions and recommendations	17
3 NHS Five Year Forward View	18
Section 2: Changes to local planning and delivery of care	21
4 Sustainability and transformation partnerships and integrated care systems	22
Development and status of sustainability and transformation plans	22
Development of sustainability and transformation plans	22
Current status	24
Conclusions and recommendations	24
Status of STP boundaries	25
Conclusions and recommendations	26
Status of Sustainability and Transformation Partnerships	27
Role of sustainability and transformation partnerships	27
Assessing the progress of sustainability and transformation partnerships	28
Conclusions and recommendations	30
Integrated care systems	31
Conclusions and recommendations	33
5 Integrated care partnerships and accountable care organisations	35
Background	35

New models of care	35
Integrated care partnerships	35
Accountable care organisations	36
Current status of proposals to introduce ACOs in the English NHS	37
Arguments for and against ACOs	38
Benefits of a single organisation and aligned financial incentives	38
Strengthening primary care and community services	40
Conclusions and recommendations	41
Concerns about ACOs	41
Privatisation	42
Staff terms and conditions	43
Conclusions and recommendations	44
6 Concerns about the direction of travel	45
Top-down reorganisation of the NHS without public consultation and parliamentary scrutiny	45
Inadequate response to system pressures	46
Smokescreen for cuts	47
Privatisation	47
Paying for healthcare	48
Conclusions and recommendations	49
Integrated care: positive examples of progress across the NHS in England	50
Section 3: The case for change	53
7 Making the case for change	54
Narrative for change	54
Communicating the case for change to patients and the public	55
Conclusions and recommendations	58
Section 4: Barriers to change	59
8 Funding and workforce pressures	60
Funding	60
Financial problems	60
Capital funding	60
Sustainability and Transformation Fund	61
Funding transformation	62
Workforce challenges	63
Workforce shortfalls	63

Workforce engagement	64
Conclusions and recommendations	65
9 Oversight and regulation by national bodies	66
Incoherent approach by national bodies	66
Focus on individual organisations rather than placed-based care	67
Support directed at those furthest ahead	68
Role in accelerating improvement and new care models across the system.	69
Conclusions and recommendations	72
10 Governance and legislation	73
Governance and accountability arrangements	73
Procurement	75
Views on legislative reform	75
Conclusions and recommendations	78
11 Conclusion: A call to action	80
Integrated care: glossary of terms	81
Conclusions and recommendations	83
Annex: Visit to South Yorkshire and Bassetlaw STP	91
Formal minutes	95
Witnesses	96
Published written evidence	97
List of Reports from the Committee during the current Parliament	100

Summary

It is one of the greatest triumphs of our age that people are living longer. Many more of us are doing so with complex health and care needs, including multiple long-term conditions. To meet these needs, people rely on a range of health and care services, which are mostly public but also provided by non-statutory services (charities, social enterprises, community services and private providers), as well as dedicated informal support from families and carers. If these services and sources of support don't join up, don't share information, are not coordinated and fail to put the individual front and centre then this can not only result in a poor experience, but risks health problems escalating and an inefficient use of increasingly stretched resources.

Integrated care is about providing a more holistic, joined-up and coordinated experience for patients. Whilst there is not sufficient evidence that integrated care saves money or improves outcomes in the short term, there are other compelling reasons to believe it is worthwhile.

As health spending across the developed world looks set to consume an increasing share of GDP in the years ahead, integrated care provides a way of getting more value out of the resources we put in and a better experience for those who use services. There have been positive early signs from the new care models about the benefits more integrated health and care services can bring to patients.

Our inquiry

Whilst there have long been efforts to join up services at local and national level, our inquiry explored the development of new integrated ways of planning local health and care services (sustainability and transformation partnerships and integrated care systems) and delivering care (integrated care partnerships and accountable care organisations), which have arisen out of the NHS Five Year Forward View.

We support the move away from a competitive landscape of autonomous providers towards more integrated, collaborative and placed-based care. However, understanding of these changes has been hampered by poor communication and a confusing acronym spaghetti of changing titles and terminology, poorly understood even by those working within the system. This has fuelled a climate of suspicion about the underlying purpose of the proposals and missed opportunities to build goodwill for the co-design of local systems that work more effectively in the best interests of those who depend on services.

Sustainability and transformation partnerships and plans

Sustainability and transformation partnerships (STPs) got off to a difficult start, with limited time to forge relationships, develop plans and make difficult decisions about changes to local health and care services. National media coverage of "secret plans", "developed behind closed doors", reflected the poor communication between local bodies and their communities. This, along with accusations that STPs were a smokescreen for cuts, tainted the STP brand.

The STP process has moved on since the original plans were published in December 2016, with the emphasis now firmly on the performance of the partnerships, rather than the delivery of their plans. The 44 partnerships are now at different stages in their journey towards further integration as integrated care systems (ICSs). Systemic funding and workforce pressures affect almost every area. Some areas have made considerable progress in light of these pressures, but those furthest behind are struggling with rising day-to-day pressures let alone transforming care.

Integrated care systems

ICSs are more autonomous systems in which local bodies take collective responsibility for the health and social care of their populations within a defined budget. A cohort of 10 ICSs, made up of the leading STPs, is currently paving the way for other systems. While these areas have made good progress in difficult circumstances, they are still nascent and fragile.

Accountable care organisations and integrated care partnerships

Integrated care partnerships (ICPs), alliances in which providers collaborate rather than compete, are becoming increasingly prevalent across the NHS, often building on the new care models programme and pre-existing collaborations between services. Two areas have expressed an interest in using an Accountable Care Contract to formalise their partnership into single organisations known as accountable care organisations (ACOs).

Public debate about the introduction of ACOs into the English NHS has been confused by concerns, mostly stemming from organisations with origins in the US which are different but also called ACOs. The main concern is the possibility that these new contracts might extend the scope of private sector involvement in the NHS. Based on our assessment of the evidence, this looks unlikely in practice but steps could and should be taken to reassure the public on this point.

There have also been misleading statements seeking to link ACOs, as proposed in England, with people having to pay for healthcare as in the US. There is no evidence that ACOs will lead to a dismantling of the fundamental principle that the NHS is free at the point of delivery.

The ACO model will entail a single organisation holding a 10–15 year contract for the health and care of a large population. Given the risks that would follow any collapse of a private organisation holding such a contract and the public's preference for the principle of a public ownership model of the NHS, we recommend that ACOs, if introduced, should be NHS bodies and established in primary legislation.

Before this can happen, there are critical questions remaining, particularly whether using an ACO contract to merge services into a single organisation accelerates integration and improves outcomes for patients. Therefore we recommend that ACOs should be subject to careful evaluation.

Removing barriers to integrated care

The legal barriers and fragmentation that arose out the Health and Social Care Act 2012 will need to be addressed. A hung Parliament can make more comprehensive review and revision of legislation difficult, but all sides should work together to try to find agreement which allows for the joining up of services on which people depend.

Simon Stevens, head of the NHS and architect of the Forward View, has described these changes as the greatest move to integrated care of any western country. However, as yet, the scale of this ambition has not been matched by the time and resources required to deliver it. Countries that have made the move to more collaborative, integrated care have done so over 10–15 years and with dedicated upfront investment.

Transformation remains key to sustainability. We have seen and heard of examples of local areas which have made excellent strides forward in difficult circumstances. What is now required is the dedicated national financial and leadership support to enable the NHS to transform at pace. Too often plans are constrained by the upfront funding needed to make them effective.

The NHS is currently in survival mode, with NHS providers struggling to recruit, train and retain staff and balance their books, while maintaining standards in the face of relentlessly rising demand. A long-term funding settlement and effective workforce strategy are essential not only to alleviate immediate pressures on services, but to facilitate the transition to more integrated models of care.

Priorities for change

The Government's announcement of a long-term funding settlement is welcome. As the NHS turns 70, we recommend the Government and national leaders use this opportunity to improve the delivery of joined-up services. The Government and national leaders should:

- a) Develop a national transformation strategy backed by secure long-term funding to support local areas to accelerate progress towards more collaborative, place-based and integrated care;
- b) Commit to a dedicated, ring-fenced transformation fund;
- c) Explain the case for change clearly and persuasively, including why it matters to join up services for the benefit of patients and the public.
- d) Alongside these changes, the Government should facilitate national bodies to work with representatives from across the health and care community, who should lead in bringing forward legislative proposals to overcome the current fragmentation and legal barriers arising out of the Health and Social Care Act 2012. These proposals should be laid before the House in draft and presented to us for pre-legislative scrutiny.

Our report sets out several areas where we feel legislative change may need to be considered, including:

- a statutory basis for system-wide partnerships between local organisations;
- potential to designate ACOs as NHS bodies, if they are introduced more widely;
- changes to legislation covering procurement and competition;
- merger of NHS England and NHS Improvement; and
- Care Quality Commission's regulatory powers.

It must however be kept central to all the plans to create and develop new regional and local structures, partnerships and contracts that these are a means to achieve more coordinated, person-centred and holistic care for patients, particularly patients with long-term conditions.

1 Integrating care for patients

1. The term “integrated care” means nothing to most people. It is also poorly defined. National Voices, a coalition of charities focused on giving people greater control over their health and care, told us that a review of the evidence on integrated care found 170 definitions.¹ Patients and the public, Don Redding, Director of Policy at National Voices, explained:

[...] want to feel that their care is co-ordinated, that the professionals and services they meet join up around them, that they are known where they go, that they do not have to explain themselves every single time, and, therefore, that their records are available and visible.²

2. Patients and the public not only expect care to be integrated, but they believe this is already the case and are surprised when they encounter problems. Kate Duxbury, Research Director at Ipsos MORI, a polling company, told us:

If you say to a person that a hospital might not have access to their GP records and vice versa, they are very surprised about that and will assume it is already happening.³

3. The public are often unaware of the divides between health and social care services, whether that be primary and acute care or NHS and social care. For example, a patient receiving homecare from their local authority is just as likely to think that the service is provided by the NHS.⁴

4. A shared commitment signed by the Department of Health, its arms-length bodies, the Association of Directors of Adult Social Services and the Local Government Association included the following definition which expresses the essence of integrated care from a patient’s point of view:

I can plan my care, with people who understand me and my carers, allow me control and bring together services to help me achieve the outcomes that are important to me.⁵

5. As Simon Stevens, Chief Executive of NHS England, explained, integration occurs along a spectrum, across which services can be more or less integrated. Integration is not necessarily as important for every patient, but is of particular significance to people living with chronic conditions and complex health and care needs.⁶

6. Patients living with complex health and care needs and long-term conditions, together with their families and carers, may draw on a range of public and non-statutory services (charities, social enterprises, community services and private providers) , including digital services. This personalised network may be opaque to health and care services and professionals within it. This has important implications for how policymakers and

1 Q133

2 Q133

3 Q138

4 Ipsos MORI(0104) p4

5 Q151

6 Q268

local services think about integration. Dr Charlotte Augst from The Richmond Group of Charities, a collaboration of 14 leading health and care charities, told us how integration is often thought about from the perspective of the services involved, rather than patients:

Often, I think it is only the patient and their carer who understand who is on the team. Therefore, if you do not start by asking that question, you do not understand which pharmacy, which GP, which hospital consultant and which charity are on the team and therefore what we are co-ordinating. From the patient perspective—the care perspective—it is really important to understand what it is we are trying to co-ordinate so that you are rolling it out from that end rather than from the integration end, which always starts with structures.⁷

7. From a patient’s perspective, integrated care is about how patients experience the health and care services they use. Healthcare has historically been delivered in a paternalistic, siloed fashion. However, patients’ interactions with healthcare services account for only a fraction of their lives. The ability of patients to manage chronic conditions themselves is therefore critical to their health and wellbeing. Adopting a more person-centred approach, in which patients are supported to manage their conditions more independently, requires a radical shift in how health and care is delivered. This would entail, as Don Redding described, services in which:

We (health and care professionals) find out what their (patients) priorities and goals are, we work to support those, and we judge outcomes by the extent to which people can achieve good outcomes.⁸

8. Integrated health and social care has been a longstanding ambition of health policy pursued by successive governments over decades. There are three levels at which care can be integrated: patient level, service level and organisational level. The National Audit Office provide the following examples of each:

- a) Integration at a patient level may consist of joint assessments of a patient’s needs by multiple professionals and services.
- b) An example of integration at a service level is when multiple services are brought together in one place for patients with a particular condition (e.g. diabetes).
- c) Examples of integration at an organisational level include jointly commissioning services or pooling budgets.⁹

Need to define outcomes for patients

9. The remainder of this report focuses on organisational and service level integration, particularly the emerging ways in which local health and care services are being planned (sustainability and transformation partnerships and integrated care systems) and delivered (integrated care partnerships and accountable care organisations).

7 Q136

8 Q135

9 National Audit Office, [Health and social care integration](#), HC 1011 Session 2016–17 8 February 2017, page5

10. For people relying on health and social care, ‘integration’ is about joining up the services they use and putting them as individuals at the centre, sharing information, working collaboratively, supporting them to manage their own health and focusing on what matters to them: their priorities, goals and aspirations.

11. It is absolutely essential not to lose sight of the patient and their families in any debate about NHS and care reform. Organisational and structural changes are merely a means to an end: the litmus test to determine whether these reforms succeed will depend on how effectively these new structures and organisations deliver better integrated care at the patient level.

12. The Department of Health and Social Care, NHS England and NHS Improvement should clearly define the outcomes the current moves towards integrated care are seeking to achieve for patients, from the patient’s perspective, and the criteria they will use to measure whether those objectives have been achieved.

Our inquiry

Background

13. Our predecessors launched an inquiry on Sustainability and Transformation Partnerships, which was cancelled when Parliament dissolved for the General Election. We decided to resume this inquiry and launched our call for evidence in November 2017.

Focus of the inquiry

14. Before starting our oral evidence, we decided to focus our attention on the recent debates about the new forms of integrated care emerging in the NHS (particularly Integrated Care Systems, Integrated Care Partnerships and Accountable Care Organisations). Along with STPs, we have sought during this inquiry to judge the desirability of ICSs, ICPs and ACOs in policy terms, seeking to assess whether, and to what extent, they will improve health and care services for patients.

Visit to South Yorkshire and Bassetlaw

15. On Tuesday 20 February 2018 we visited South Yorkshire and Bassetlaw STP, one of the leading integrated care systems, at which we held a focus group with national and local leaders from the NHS and local government (see Annex 1 for more information about the visit).

Oral evidence sessions

16. We held three oral evidence sessions, during which we heard from stakeholders across the health and care community, including campaign groups, professional bodies and trade unions, representatives of small, medium and large charities, pollsters, think-tanks and academics, representatives of NHS providers, commissioners, and local government, along with ministers and senior officials.

17. We are very grateful to all those who gave evidence to us, both written and oral. We are also grateful to our specialist advisers, Professor Chris Ham and Dr Anna Charles of the King's Fund, and Professor Pauline Allen of London School of Hygiene and Tropical Medicine, for their advice and guidance throughout our inquiry.¹⁰

Legal challenges

18. During our inquiry accountable care organisations have been the subject of two judicial reviews. The first, by 999 Call for the NHS, contends that the ACO contract breaches sections 115 and 116 of the Health and Social Care Act 2012, which includes provisions for the price a commissioner pays for NHS services and the regulations around the national tariff.¹¹

19. The second, by a group known as JR4NHS, disputes whether the consultation process involving the draft ACO contract was legal. JR4NHS argue that the decision to introduce regulations in February 2018 before the ACO contract itself had been consulted on effectively prejudged the lawfulness of the future contract.¹²

20. We have not during this inquiry sought to make any judgement about the legality of ACOs, or any of the other emerging forms of integrated care. These matters are for the courts to decide. Instead, as mentioned earlier, we have sought to judge the suitability of these mechanisms in policy terms: will they help local services to integrate care, maximise the use of resources and, mostly importantly, improve patient outcomes and experience.

10 Professor Pauline Allen declared the following interests: I hold a series of research grants from the Policy Research Programme of the National Institute for Health Research. The following research concerns issues of relevance to the inquiry: 1)Diverse Healthcare Providers: Behaviour in response to commissioners, patients and innovations; Professor Rod Sheaff, Plymouth University is the Principal Investigator and I am a co-investigator. 2) Understanding the new commissioning system in England: contexts, mechanisms and outcomes; Professor Katherine Checkland, Manchester University is the Principal Investigator and I am a co-investigator. 3). National Policy Research Unit in Commissioning and System Management in the NHS; Professor Stephen Peckham of Kent University is director and I am co director with Professor Kath Checkland.

Professor Chris Ham declared the following interests: The King's Fund is working to support accountable care systems in England and some of the funding for this work has been provided by NHS England. Our work on STPs was funded entirely by The King's Fund.

Anna Charles declared the following interests: The King's Fund is providing support to accountable care systems in England. This work has been partly funded by NHS England. Our work on STPs was funded by The King's Fund.

11 [Accountable care organisations](#), Briefing paper: Number CBP 8190, 5 March 2018, page 12

12 [Accountable care organisations](#), Briefing paper: Number CBP 8190, 5 March 2018, page 12–13

Section 1: Background on integrated care reforms

2 Progress towards more integrated care

21. Integrated care has been a longstanding ambition pursued by successive governments. As far back as 1972, a National Health Service Reorganisation white paper described the need for more coordinated care outside hospitals:

There is a need for far more ... services that support people outside hospital. Often what there is could achieve more if it were better co-ordinated with other services in and out of hospital.¹³

22. Progress towards achieving integrated health and social care across England has been slow. Personal health budgets, integrated care pilots, integrated care pioneers, the Better Care Fund, joint strategic needs assessments and joint health and wellbeing strategies, as well as legal duties on NHS clinical commissioning groups and health and wellbeing boards to promote integration, have all been intended to bring about more integrated care.

23. The House of Lords report on the Long-term Sustainability of the NHS and Adult Social Care, published in April 2017 stated:

system-wide integrated services were still very far from being a reality. Integration policy has been discussed for decades but it was clear from the evidence that there was a degree of frustration at the lack of progress on the integration of either funding or service delivery.¹⁴

24. This point was echoed by the NAO, who concluded that 20 years of initiatives to join up health and care has not resulted in integrated services across the system. Instead, “progress with integration of health and social care has, to date, been slower and less successful than envisaged and has not delivered all of the expected benefits for patients, the NHS or local authorities.”¹⁵

25. Integrated care remains the Government’s ambition. The 2015 Spending Review set a target for health and care to be integrated across England by 2020. Local areas were required as part of the Spending Review to develop plans by April 2017, setting out how they plan to achieve this objective. This work was then rolled into sustainability and transformation plans.¹⁶

26. The Government’s mandate to NHS England in 2015/16 also set a target for 20% of the country to be covered by new care models by the end of 2017/18, rising to 50% by 2020. This objective has been rolled into successive versions of the mandate.¹⁷

27. Integrated care has been pursued with the triple aim of improving outcomes, improving patient experience and delivering financial savings. However, as the NAO has highlighted, there is currently insufficient evidence to demonstrate that integrated care

13 Department for Health and Social Security (1972) *National Health Service Reorganisation*: England. HMSO:London

14 House of Lords Select Committee on Long-term Sustainability of the NHS, *Long-term Sustainability of the NHS and Adult Social Care*, April 2017, para 90.

15 National Audit Office, [Health and social care integration](#), HC 1011 Session 2016–17 8 February 2017, page 12

16 National Audit Office, [Health and social care integration](#), HC 1011 Session 2016–17 8 February 2017, page 6

17 Department of Health, [The Government’s mandate to NHS England for 2016/17](#), March 2017

leads to better outcomes, financial savings or reduced hospital activity.¹⁸ The observable benefits of integration for patient experience at an individual level have not yet translated into robust evidence that integrated care leads to better outcomes or saves money.¹⁹ In addition, rather than saving money, more integrated care may also identify currently unmet needs, thereby adding costs in the short term.²⁰

Complexities of integrating health and social care

28. The NAO concluded that slow progress over the last 20 years casts doubt on the Government's plan to deliver integrated health and social care services across England by 2020. The NAO made the following observations of the performance of government departments and national bodies in delivering integrated care:

- a) The bodies are still developing their understanding of how to measure progress on integrating care.
- b) The oversight and governance of initiatives to deliver integrated care is poor.
- c) The main barriers to integrated care are not being systematically addressed.²¹

29. The practicalities of integrating services are complex. Simon Stevens described how structural divides imposed when the NHS was originally founded no longer make sense today: for example, the distinction between an NHS that is free at the point of use and a means-tested social care system, or the contractual separation of general practice from other NHS services.²²

30. Integration depends on building new ways of working and developing relationships between professionals in different services. These health and care services often have different cultural practices, legal accountabilities, payment systems and terms and conditions for staff, all of which create obstacles to integrated care.

31. Nigel Edwards, Chief Executive of the Nuffield Trust, emphasised the significant optimism bias inherent in the ambition of the Department and national bodies, which does not adequately appreciate the scale and nature of the changes required. As Mr Edwards explained:

These models take a long time to develop. They are based largely on changing the way people practise medicine and how complex organisations interrelate, and indeed how individual relationships between different clinicians and organisations change and morph over time. There is very little way of accelerating that process; it has to be learned and developed.²³

Integration, patient choice and competition

32. Alongside efforts to integrate health and social care over the last 20 years, policymakers have also sought to introduce greater choice and competition within health

18 National Audit Office, [Health and social care integration](#), HC 1011 Session 2016–17 8 February 2017, page 7

19 Q233

20 The Nuffield Trust, [Shifting the balance of care: Great expectations](#), March 2017, page 5

21 The Nuffield Trust, [Shifting the balance of care: Great expectations](#), March 2017, pages 9–10

22 Q325 [Simon Stevens]

23 Q228

and care system in England. The NHS Health Service and Community Act 1990 created an internal NHS market, introducing a split between the provision and commissioning of healthcare with the creation of self-governing trusts and GP fund-holders.

33. The NHS internal market continued throughout the 1990s, but accelerated at the turn of the century with a series of reforms, including the introduction of payment by results (PbR) in 2002, the establishment of foundation trusts in 2003 and the introduction of primary care trusts. This period also saw an extended role for the private sector in the NHS, under successive governments.

34. The Health and Social Care Act 2012 was the culmination of the shift towards choice and competition within the NHS. The Act saw the creation of NHS clinical commissioning groups responsible for commissioning services for their local populations. This was supported by reforms designed to support a diverse and competitive landscape of public and non-statutory provision, with an extended role for Monitor as the economic regulator.

35. Rt. Hon Andrew Lansley MP, then Secretary of State for Health, told our predecessor Committee in 2011:

What we are doing, through amendments to the legislation, is to make it absolutely clear that integration around the needs of patients trumps other issues, including the application of competition rules.²⁴

However, despite that reassurance, reforms to extend the NHS internal market, including the role of competition, have impeded rather than supported services to integrate. The NAO concluded that:

shifts in policy emphasis and reorganisations which promote competition within the NHS, such as the move from primary care trusts to clinical commissioning groups in 2013 and the Health and Social Care Act 2012, have complicated the path to integration.²⁵

36. Mr Stevens described how at the heart of the Forward View is the aim to not only work around, at least in the short-term, aspects of the Health and Social Care Act that promote competition over collaboration, but also to lower unhelpful boundaries between services that were imposed from the creation of the NHS.²⁶

37. Competition, and the fragmented provision that arises as a consequence, erects barriers to integrated care. However, patient choice is where these two competing agendas converge. Our view is that a diverse local health and care economy, with a mix of mostly public, but also non-statutory services (private providers, social enterprises, charities, and community and voluntary services), can be arranged so as to enable rather than detract from integrated care. From a patient's perspective, what matters is that these providers, whether public or non-statutory, create coherent and comprehensive services, share information, work together and put patients' needs, priorities and goals at the centre. From the NHS's perspective, non-statutory services must enhance and not undermine the ability of the NHS to serve local populations.

24 The House of Commons Health Committee, [Impact of the Spending Review on health and social care](#), 19 July 2016 HC 139, para 116, footnote 146

25 National Audit Office, [Health and social care integration](#), HC 1011 Session 2016–17 8 February 2017, page 7

26 Q325

38. Patients' ability to choose and access a range of different services and sources of support, from which they may find therapeutic benefit, should be preserved. Public and non-statutory services both have a role to play in a diverse local health and care economy, which favours collaboration and quality over competition.

39. Not only do non-statutory services provide support when statutory services are stretched, but they can in some circumstances be more adept at meeting unmet demands in ways that statutory services may struggle to do. Competition can also be a useful tool but this should be on quality, not a race to the bottom on price. New entrants to the market can provide an incentive for incumbent providers to improve.

40. Having a "free choice system playing in", as Julie Wood, Chief Executive of the representative body NHS Clinical Commissioners, described, does create a challenge for NHS bodies seeking to maximise the value of the NHS pound, as they have to pay for NHS staff and then again for another intervention.²⁷ We appreciate this concern. However, one of the warnings against removing choice and competition is that "there is a danger of creating airless rooms in which you simply have one provider who is there for a huge amount of time."²⁸

Conclusions and recommendations

41. **More joined-up, coordinated and person-centred care can provide a better experience for patients, particularly those with multiple long-term conditions. However, progress to achieving these benefits has been slow. There is no hard evidence that integrated care, at least in the short term, saves money, since it may help to identify unmet need, although there is emerging evidence from new care models that it may help to reduce the relentless increase in long-term demand for hospital services.**

42. **More integrated care will improve patients' experience of health and care services, particularly for those with long-term conditions. However, the process of integrating care can be complex and time consuming. It is important not to over-extrapolate the benefits or the time and resources required to transition towards more integrated care.**

43. **The Government should confirm whether it is able to meet the current target to achieve integrated health and care across the country by 2020, as well as plans for 50% of the country to be covered by new care models. These targets should be supplemented by more detailed commitments about the level of integrated care patients will experience as a result.**

44. **We support the move towards integrated, collaborative, place-based care. To help deliver more integrated care for patients we advocate the cultivation of diverse local health and economies, comprised of mostly public, but also some non-statutory provision, in which the organising principle is centred on collaboration and quality rather than financial competition. We consider that this diversity is important for protecting patient choice and with proper oversight and collaborative working may facilitate, rather than impede, joined-up, patient-centred and co-ordinated care.**

27 Q209 [Julie Wood]

28 Q209 [Niall Dickson]

3 NHS Five Year Forward View

45. Sustainability and transformation plans and partnerships, integrated care systems, new models of care, integrated care partnerships and accountable care organisations are all mechanisms designed to achieve the aims of the NHS Five Year Forward View. This chapter describes the aims of the NHS Five Year Forward View and introduces these new ways of planning and delivering local health and social care services.

46. The NHS Five Year Forward View set a collective vision for how the NHS needed to change between 2015/16 and 2020/21. The vision sought to address persistent variations in health inequalities and the quality of care as well as address the growing gap between resources and patient demand.

47. The NHS Five Year Forward View set out three financial scenarios for closing the NHS's £30 billion funding gap (between patient need and the available resources) by 2020/21. The third of these scenarios suggested that £22 billion of efficiencies could be delivered by 2020/21, meaning that the health service would be required to improve productivity by an average of 2–3% over the period. This is significantly higher than the average rate of productivity growth the NHS has delivered in the past but it also depended on adequate funding of social care and public health.²⁹

48. As well as transforming care, sustainability and transformation partnerships, including integrated care systems, and new models of care are also intended to address the funding gap by managing and redistributing limited resources and improving efficiency by slowing the rate of activity growth in acute services. The Government set out an ambition to deliver £900million in savings from new care models by 2020/21.³⁰

49. The delivery of the NHS Five Year Forward View is based on the following principles:

- Distinguishing ends from means—so the focus remains keeping people healthier for longer than reorganisation for its own sake.
- Evolution not big bang.
- Not a one size fits all approach.
- Co-production with patients and other local stakeholders.
- Support for the energy and leadership from wherever it exists.³¹

50. The new forms of planning local health and social care services (sustainability and transformation partnerships and integrated care systems—see Chapter 4) and delivering care (new care models, integrated care partnerships and accountable care organisations—see Chapter 5) can be seen a manifestation of these principles, although there are examples where these principles have not been adhered to.

51. Unlike previous efforts to reform the NHS, the national bodies have opted to make evolutionary changes within the existing legislative framework rather than introduce changes through primary legislation. As Simon Stevens described:

29 NHS England, [Five Year Forward View](#), October 2014

30 National Audit Office, [Health and social care integration](#), HC 1011 Session 2016–17 8 February 2017, page 9

31 NHS England, [Next Steps on the NHS Five Year Forward View](#), March 2017, page 29

Our whole process of change through the Five Year Forward View has not been just about issuing a single administrative blueprint and then a reshuffling of the administrative deckchairs. It has been entirely grounded in the question of what care should look like and how patients should be looked after, and then everything else, be it funding flows, organisational structures or governance, is the means to the end of trying to get that right. That is what distinguishes this set of changes from just about every other reorganisation the health service has been the victim of since 1948.³²

Section 2: Changes to local planning and delivery of care

4 Sustainability and transformation partnerships and integrated care systems

52. This chapter summarises key changes to the local planning of health and care services across England, including the development, and current status, of sustainability and transformation plans, as well as key issues concerning sustainability and transformation partnerships and integrated care systems, including the geographical boundaries of these areas.

Development and status of sustainability and transformation plans

Development of sustainability and transformation plans

53. The NHS planning guidance in December 2015 set a requirement for local areas to come together and develop blueprints setting out how they planned to deliver the NHS Five Year Forward View. As part of the plans, local areas were required to estimate the funding gap in their area and set out how they planned to fill this gap.³³ This meant local bodies, often without a history of collaborative working, had to come together and make very difficult decisions about changes to health and care services locally. The process was made more challenging by the very tight timeline national bodies set for these plans to be developed.³⁴

54. Local areas had until the end of January 2016 to develop partnerships and submit proposed boundaries, known as footprints. The original deadline for the final plans was in June 2016. However, this was moved back to October 2016 following an initial assessment of the plans by national bodies. Areas with a history of collaborative working and a clearer, meaningful and more practical geographical boundary started with an advantage.³⁵

55. The tight timeframe placed significant strain on the resources of local NHS leaders and senior management. In many cases, management consultants were used to fill gaps in the capacity and capability of local organisations to develop these plans.³⁶

56. There was also limited time and capacity to involve all the key local partners. From the outset, representatives from local government expressed concerns that the process was inherently NHS-centric; many local councils and MPs had limited or no input into the original versions. Representatives from primary care providers also reported similar experiences and wider engagement with staff and local communities, including voluntary

33 NHS England, [Delivering the Five Year Forward View: NHS planning guidance 2016–17 to 2020/21](#), December 2015, pages 4–7

34 The King's Fund, [Sustainability and Transformation Plans in the NHS: How they are being developed in practice?](#), November 2016, pages 67–79

35 The King's Fund, [Sustainability and Transformation Plans in the NHS: How they are being developed in practice?](#), November 2016, page 5

36 The King's Fund, [Sustainability and Transformation Plans in the NHS: How they are being developed in practice?](#), November 2016, page 43

groups and members of the public, was also minimal in many places.³⁷ Public engagement was also limited by instructions from national NHS bodies to “STP leaders to keep details of draft STPs out of the public domain.”³⁸

57. Sustainability and transformation plans for each of the 44 local areas were published by December 2016. These plans contained a series of proposals to redesign the shape of local health and social care provision, including controversial plans to reconfigure acute services and reduce bed capacity.³⁹

58. In many cases, proposals contained within the plans were not supported by robust evidence. An analysis of the 44 sustainability and transformation plans by London Southbank University found that very few of the proposals were based on a robust assessment of population need. Similarly, no detailed workforce plans were evident in two thirds of the original STPs, in which local areas set out how they planned to ensure they have enough staff to deliver the new policies and services proposed in the plans.⁴⁰

59. Over the course of 2016 the media portrayal of the STP process moved from relatively benign reports of progress locally within regional and trade outlets in the early part of the year, through to widespread negative portrayals of the plans in national media in July and August 2016. This reached a peak in late August, with reports of an investigation by 38 Degrees, a campaign group. The King’s Fund’s analysis of media coverage over the period in which STPs developed noted that:

On 26 August, the campaigning group 38 Degrees published an investigation into STPs that was covered by all major newspaper and broadcast outlets. News items focused on the ‘secrecy’ and lack of public consultation on the plans, as well as making frequent links to potential ‘cuts’, ward closures and the downgrading of A&E services.⁴¹

60. In the run up to the final deadline, coverage about the secrecy of plans continued and was accompanied by reports of plans leaked to the press, in which the focus of the coverage was on proposals to close services, reduce bed capacity and reconfigure hospitals.⁴² The STP brand as a consequence was politicised and became seen as a smokescreen for cuts to services. As Professor Chris Ham described:

They were asked to produce a plan by whenever it was—October 2016—that showed how they would balance their collective budgets within the envelope that they knew they had available. That was behind the realistic concern

37 The King’s Fund, [Sustainability and Transformation Plans in the NHS: How they are being developed in practice?](#), November 2016, pages 31–38

38 The King’s Fund, [Sustainability and Transformation Plans in the NHS: How they are being developed in practice?](#), November 2016, page 23

39 The King’s Fund, [Delivering Sustainability and Transformation Plans: from ambitious proposals to credible plans](#), February 2017

40 London Southbank University, [Sustainability and Transformation Plan, How serious are the proposals? A critical review](#), May 2017

41 The King’s Fund, [Sustainability and Transformation Plans in the NHS: How they are being developed in practice?](#), November 2016, page

42 The King’s Fund, [Sustainability and Transformation Plans in the NHS: How they are being developed in practice?](#), November 2016, pages 14–15

that this was about a cost-cutting exercise rather than about transformation of care. Sadly, STPs got off to a very bad start, a very difficult start, because of that.⁴³

Current status

61. Professor Chris Ham described how “most STPs got to the finishing line of October 2016, submitted their plans and breathed a huge sigh of relief. No further work has been done on those STPs. The governance and leadership they brought together remains very weak by comparison with what is happening at the organisational level in most parts of the country.”⁴⁴ The prominence given to the plans has diminished since the Next Steps to the NHS Five Year Forward View was published. The focus has now shifted from “plans” to “partnerships”.⁴⁵ NHS England and NHS Improvement’s written evidence to our inquiry stated that:

it is partnerships—not plans—that matter most. Every local partnership is at a different stage of its integration journey, normally predicated on the strength of local relationships. The most mature partnerships are evolving further to become ‘integrated care systems’.⁴⁶

62. Simon Stevens described the original plans as a “conversation starter”. He confirmed that NHS England is not expecting most of 44 areas to deliver on those plans, although NHS England is backing some of the local areas to make progress. Mr Stevens told us:

In some places, such as Dorset, they had a clear plan, and I think they are able to push on with that. We have backed it with capital and they are progressing well.⁴⁷

63. In other local areas we heard that the thinking has evolved since the plans were published,⁴⁸ as the financial position in 2018/19 is, according to Mr Stevens, “more benign than it was when the plans were drawn up a couple of years ago.”⁴⁹ Consequently, local areas may be revisiting their original proposals, especially given recent commitments of extra funding made by the Prime Minister at the Liaison Committee on 27 March 2018.⁵⁰ However, while the NHS’ overall financial position has improved, it is still far from stable (see Chapter 8).

Conclusions and recommendations

64. STPs got off to a poor start. The short timeframe to produce plans limited opportunities for meaningful public and staff engagement and the ability of local areas to collect robust evidence to support their proposals. Poor consultation, communication and financial constraints have fuelled concerns that STPs were secret plans and a vehicle for cuts. These negative perceptions tarnished the reputation

43 Q274 Professor Chris Ham

44 Q261 Professor Chris Ham

45 NHS England, [Next Steps on the NHS Five Year Forward View](#), March 2017, page 31

46 NHS England STP0107, page 1–2

47 Q314

48 Q312

49 Q312

50 Oral evidence taken before the Liaison Committee on 27 March 2018, HC 905 (2017–19), Q76 [Prime Minister]

of STPs and continue to impede progress on the ground. National bodies' initial mismanagement of the process, including misguided instructions not to be sharing plans, made it very difficult for local areas to explain the case for change.

65. NHS England has rightly decided not to expect every area to deliver against the original sustainability and transformation plans published in December 2016. This is a pragmatic approach given the controversy surrounding the proposals contained within the original plans, and the constraints imposed on areas against engaging key voices locally. However, NHS England needs to learn from the mistakes of the initial roll out of STPs.

Status of STP boundaries

66. The STP footprints, or boundaries between services, were developed in a short space of time. Creating geographical boundaries is extremely difficult since, as Nigel Edwards from the Nuffield Trust described, “there is no real right organisational level for things as complex as healthcare.”⁵¹ Boundary issues are pervasive across many STP areas. Professor Chris Ham provided an example, saying that “Epsom and St Helier is part of the Surrey Heartlands integrated care system, but it is really part of south-west London and the STP there.”⁵²

67. A clear message from our inquiry is that the practical issues arising from STP boundaries have significantly affected progress so far. STPs are in a better position when their geographical boundaries, including sub-sections of the STP, make sense to local people, professionals and services. Unsurprisingly, STP footprints with a smaller population, a smaller number of partners, boundaries that align with patient flows between services and coterminous organisational boundaries between partners tend to be further ahead.⁵³ Boundaries in the more advanced areas tend to align with pre-existing relationships, often built around a geographical area that is clear, practical and recognised locally. Julie Wood, Chief Executive of NHS Clinical Commissioners, told us:

The starting point in history and relationships is very important, also the geography. Some of the geographies the STPs were built on were the same as the places people were working in—for example, Nottinghamshire or Dorset. We heard from Greater Manchester that they have been working in that way for some time. Some of the other geographies did not feel as natural, so it has taken time to get to first base.⁵⁴

68. Councillor Jonathon McShane from Hackney Council, representing the Local Government Association, also argued that areas which are focused on patient flows around acute services, rather than wider community services and assets, including local authority boundaries, have struggled to make progress.⁵⁵

69. Despite the pervasiveness of boundary problems, the evidence we were strongly advised against any national intervention to reconstruct more cohesive geographies, even if, from the perspective of national bodies, this leads to a complicated patchwork

51 Q256 Nigel Edwards

52 Q260 Professor Chris Ham

53 NHS Providers STP0050

54 Q203 Julie Wood

55 Q203 Cllr McShane

of accountabilities.⁵⁶ Instead, encouraging each local area to focus on developing clear, meaningful and practical boundaries, either at the STP level or in sub-sections of the STP, is considered to be the key.

70. It is not essential that the STP footprint as a whole corresponds to an area that might be recognised by local people, professionals and services. Instead, the clear, practical and meaningful boundaries to which we refer above could be set around a sub-section of an STP, where, as Professor Chris Ham described, “it makes sense to focus on the place, the population and how services in this area join up.”⁵⁷ Ian Williamson from Manchester Health and Care Commissioning emphasised this point, saying “if there is one lesson I have taken from the last three or so years, it is place-based focus rather than organisational focus.”⁵⁸

71. Within South Yorkshire and Bassetlaw STP, for example, five separate sub-sections of the footprint (Sheffield, Doncaster, Barnsley, Bassetlaw and Rotherham) had been identified and alliances between providers were being built at this level. In South Yorkshire and Bassetlaw, the governance of the STP was built upon these five sub-sections, as local leaders operated on the principle that decisions would only be taken at an STP level where it made sense to do so.

72. NHS England, in the Next Steps on the NHS Five Year Forward View, made clear that boundaries, while initially imposed in some cases, are not set in stone, but can be adjusted, with national approval, where local areas present a clear benefit to doing so.⁵⁹ In other words there has been an understanding that changes should be initiated at local level rather than imposed from above.

Conclusions and recommendations

73. An STP area, or areas within it, work more effectively where they are meaningful to partners, local health professionals and most importantly the public. STPs, particularly those with more complex geographical boundaries, should be encouraged and supported to allow local areas to identify, define and develop meaningful boundaries within their patch in which local services can work together around the needs of the population.

74. STPs should be encouraged to adopt a principle of subsidiarity in which decisions are made at the most appropriate local level. NHS England and NHS Improvement should set out in their planning guidance for 2019/20 advice and support to achieve these recommendations.

56 Q256 Nigel Edwards

57 Q256 Professor Chris Ham

58 Q194 Ian Williamson

59 NHS England, [Next Steps on the NHS Five Year Forward View](#), March 2017, page 34

Status of Sustainability and Transformation Partnerships

75. The Next Steps in the NHS Five Year Forward View shifted the focus and the name of STPs from sustainability and transformation plans to sustainability and transformation partnerships.⁶⁰ These partnerships were described by Simon Stevens as being on an “evolutionary and developmental journey.”

76. Despite getting off to a difficult start, many local leaders conveyed the benefits they have already seen and the potential of more place-based working. This potential extends beyond the NHS’s traditional role in healthcare. For example, partnerships have facilitated conversations that may not have taken place in the same way before.⁶¹ Ian Williamson from Manchester Health and Care Commissioning explained:

from my background largely as an NHS person, this has given us the opportunity to have conversations about, for example, how we try to reduce childhood obesity, or how we work on emissions in our atmosphere in a way that we have not previously been able to do. Those are real things that impact on people’s health and wellbeing, and it has given us a way to address them.⁶²

77. Many local leaders also spoke with enthusiasm at our visit to South Yorkshire and Bassetlaw about the positive contribution the NHS can make to wider social issues and local economic growth. Rob Webster from West Yorkshire STP described how, with a strong life science sector in his patch, the NHS locally has a potential role to play as a catalyst for innovation and growth. Senior leaders in South Yorkshire also told us how the NHS, as a large employer, could play a critical role in providing career opportunities for young people locally.

Role of sustainability and transformation partnerships

78. Increasingly STPs have become the vehicle for delivering national priorities and targets, improving financial management across the system and managing demands, particularly on acute care, despite the governance and infrastructure being fragile and in development.⁶³ NHS Providers argue:

There needs to be far greater clarity and discipline over what STPs are intended to deliver. There is an increasing tendency for STPs to become the default footprint for delivering national policy initiatives, but they do not currently have the mandate, statutory authority, or infrastructure to deliver these.⁶⁴

60 The NHS planning guidance in December 2015 required local areas to come together to develop sustainability and transformation plans: blueprints for delivering the NHS Five Year Forward View. These plans were originally intended to contribute to filling the gap between patient demand and resources between 2015/16 to 2020/21. 44 plans, one for each local area, were published in December 2016. The Next Steps to the NHS Five Year Forward View shifted the emphasis of from the original plans to partnerships, focusing on driving efficiency and improvements through more collaborative working locally than rather making progress with the proposals described in the original STPs.

61 See Annex

62 Q194 Ian Williamson

63 NHS Providers STP0050, Q261 Professor Chris Ham

64 NHS Providers STP0050

79. National leaders should not lose sight of the fact that local leaders, as well as the wider workforce are rightly far more enthused and motivated by what can be achieved for patients through joint working than by the prospect of how this delivers national policy objectives.

Assessing the progress of sustainability and transformation partnerships

80. NHS England and NHS Improvement have published an STP dashboard which rates the progress in each of the 44 sustainability and transformation partnerships. Each area is rated on the following 4-point scale: Outstanding, Advanced, Making progress and Needs most improvement. The written evidence we received identified a series of concerns about the utility of the dashboard and the indicators chosen. In particular, the indicators selected in the dashboard add further weight to concerns that the national bodies have narrowed their focus away from the original aims of the Five Year Forward View: the indicators chosen to measure the progress of STPs focus on their ability to reduce demand on hospitals, manage financial resources and deliver national priorities in the short term. In future there needs to be greater emphasis on what these deliver in improving the experience and outcomes for patients.

Integration, transformation and prevention

81. Sustainability and transformation partnerships are mechanisms for delivering the NHS Five Year Forward View, which in part, was a vision for making the transition to more integrated models of care. However, the STP Dashboard has no indicators to measure integration or the progress local areas have made in transforming care, such as progress made against their STP plans.⁶⁵

82. Integrated care is difficult to measure and, as noted in Chapter 2, national bodies are still developing their understanding of how to do so.⁶⁶ However, it seems surprising that there are no indicators to measure integration or transformation in the dashboard, particularly given statements characterising STPs as part of the greatest move towards integrated care in the western world.

83. A central part of the NHS Five Year Forward View is the shift to more proactive and preventative delivery of health and healthcare. However, we heard that the indicators chosen to measure prevention narrowly define prevention in terms of reducing demands on acute services.⁶⁷ This is unlikely to help to build the case for change with the public.

Local engagement

84. There is also no measure of how local areas have engaged with key partners and local communities. Engagement with local groups, who are understandably active and vocal about local service changes, is critical for STPs as they begin to transform services.

65 NHS Providers STP0050, Local Government Association STP0027, NHS Clinical Commissioners STP0064

66 National Audit Office, [Health and social care integration](#), HC 1011 Session 2016–17 8 February 2017.

67 Local Government Association STP0027

85. The public and voluntary groups are not only important constituents to engage, but play a critical role in the delivery of the NHS Five Year Forward View. Ian Williamson from Manchester Health and Care Commissioning referred to the importance of situating these partnerships in their wider communities. Mr Williamson stressed:

it cannot stop at just the statutory sector or public-sector bodies; it has to reach out to neighbourhoods, community groups, be they communities of interest or geographical communities, and the voluntary and community sector. It is crucial that this is a journey we go on together, so to speak.⁶⁸

86. Chapter 2 of the Forward View emphasises the need to empower people and communities. However, the prominence given to the role of people and communities has not been carried through to the STP Dashboard. Simon Stevens, in response to a question from Anne-Marie Morris MP at a meeting of the Committee of Public Accounts about whether NHS England should have a target to assess engagement with local voluntary groups, stated that:

we have been discussing, as recently as this morning, the extent to which we should try to build some of that into the processes we use to assess and check how well the STPs are working.⁶⁹

87. We heard that engagement with local voluntary groups was very limited in the development of sustainability and transformation plans, although it has improved in some areas.⁷⁰ Cuts to voluntary sector funding have meant that many charities have struggled to engage with STPs, particularly smaller charities that do not have the same infrastructure as the larger national charities.⁷¹

88. Involvement and engagement of local communities, representatives and voluntary groups are pivotal to realising the changes described in the NHS Five Year Forward View. Progress of STPs, as one of the key mechanisms for delivering the Forward View, should include an assessment of how effectively local communities are involved and engaged.

Local relationships

89. For most local systems, the focus has been on building trust and relationships between local leaders and services. National support and funding for transformation has been directed predominately towards the 10 integrated care systems which are further ahead (discussed in more detail in Chapter 8). These areas, in contrast to those further behind, often drew on a history of collaborative working locally. NHS Providers' written evidence identified the following factors that have affected progress of sustainability and transformation partnerships:

- 'The quality of relationships between all key players in the local system.
- The quality and capacity of local leaders and their ability to engage and mobilise the wider workforce.

68 Q194 Ian Williamson

69 Oral evidence taken before the Public Accounts Committee on 21 March 2018, HC (2017–19) 793, Q118 [Simon Stevens]

70 Q143 [Don Redding]

71 Q144 [Don Redding]

- A collective commitment to prioritise the needs of patients and the system at the expense of the individual institution.
- A focus on a small number of practical priorities and a drive for practical improvements on the ground in chosen priority areas, rather than just trying to build a grand plan.
- A culture of pragmatism meets continuous improvement.”⁷²

90. The strength of local relationships is pivotal to the process. According to NHS Providers, where the factors outlined above are less evident, more time is necessary for local areas to form relationships, build trust and agree local aims and objectives.⁷³ Rob Webster, STP lead in West Yorkshire, characterised the importance of relationships in saying that “change happens at the speed of trust.”⁷⁴ This message was expressed by Simon Whitehouse, STP Director for Staffordshire and Stoke-on-Trent, one of the more challenged local areas:

There is also recognition that as we sit here now STPs in their widest sense are not statutory bodies; they do not exist in an organisational form. It is literally the strength of the relationship and the collaboration that sits underneath it that drives it. We have to keep coming back to why we are here and what we are trying to deliver for the population we serve. For me, you can change the three letters as many times as you want, but we need to serve the local population, improve health outcomes, bring a real focus to rigorous continuous quality improvement at local level and get partners to work collaboratively to drive that change.⁷⁵

Conclusions and recommendations

91. **Sustainability and transformation partnerships provide a useful forum through which local bodies can come together in difficult circumstances to manage finite resources. However, they are not on their own the solution to the funding and workforce pressures on the system. We are concerned that these pressures, if not adequately addressed, may threaten the ability of local leaders to meet their statutory obligations let alone transform services. Overwhelming and unrealistic financial pressure drives them to retreat back to organisational silos. This would seriously undermine the progress local leaders have made in already difficult circumstances.**

92. Sustainability and transformation partnerships have no legal basis, and so depend on the willingness of local leaders to participate. These relationships are fragile: national bodies must be careful not to overburden these partnerships by increasingly making them the default footprint for the delivery of national policies, especially while their relationships, governance and infrastructure are relatively weak in comparison to other parts of the system.

93. **We recommend that the national bodies, including the Department, NHS England, NHS Improvement, Health Education England, Public Health England and CQC,**

72 NHS Providers STP0050

73 NHS Providers STP0050

74 Note on SY&B visit

75 Q194 Simon Whitehouse

develop a joint national transformation strategy. This strategy should set out clearly how national bodies will support sustainability and transformation partnerships, at different stages of development, to progress to achieve integrated care system status. This strategy must not lose sight of patients. National bodies in this strategy should:

- a) **set out how national bodies plan to support local areas to cultivate strong relationships;**
- b) **strengthen the programme infrastructure of STPs;**
- c) **consider whether, and if so how, support, resources and flexibilities currently available to integrated care systems could be rolled out to other areas to help them manage pressures facing their local areas;**
- d) **develop a more sophisticated approach to assess the performance of STPs and their readiness to progress to integrated care status. This should include an assessment of local community engagement, the strength of local relationships and the progress towards preventative and integrated care. An assessment of prevention should encompass a broader definition than preventing demands on hospitals and integration should focus on how to improve patients' experience of and outcomes from services.**

Integrated care systems

94. Integrated care systems are advanced forms of sustainability and transformation partnerships, in which “commissioners and NHS providers, working closely with GP networks, local authorities and other partners, agree to take shared responsibility (in ways that are consistent with their individual legal obligations) for how they operate their collective resources for the benefit of local populations.”⁷⁶

95. The benefits of ICS status for STPs include greater autonomy over funding, such as resources earmarked for transformation, and for services currently commissioned nationally (e.g. primary care and specialised services). However, to qualify for ICS status local areas must demonstrate that they have robust mechanisms for collective governance and decision-making, deliver horizontal and vertical integration across services, have robust measures to continue to provide choice to local residents and are capable of managing population health.⁷⁷

96. The recent NHS planning guidance published by NHS England and NHS Improvement introduced a series of changes which seek to foster greater system-wide management. These changes include a requirement for each ICS to produce a system-wide plan to deliver the system's control total, in other words the limit on its spending,⁷⁸ more streamlined oversight from national bodies, and a series of financial incentives to support

76 NHS England and NHS Improvement, *Refreshing NHS Plans for 2018/19*, February 2018, page 12, para 5.2

77 NHS England, [Next Steps on the NHS Five Year Forward View](#), March 2017, page 36

78 System control totals are overall financial targets for an STP. Each NHS body within an STP also has an individual control. ICS areas, unlike STPs, are able to move resources between partners as long as the system control total is met.

system-wide management of funding. NHS England and NHS Improvement will only assure system-level plans, leaving ICSs to review plans of individual organisations within their area.⁷⁹

97. The first wave of integrated care systems are expected to pave the way for the remaining local systems by developing a pathway to full ICS status, leading on the implementation of specific system-wide efficiencies (e.g. consolidation of back-office functions), and providing lessons, and possibly support, for future cohorts moving to ICS status.⁸⁰

98. Since the Next Steps to the NHS Five Year Forward View announced the creation of accountable care systems (the former title of ICSs), the focus in the first cohort has been on building the capacity of these systems to take collective responsibility for their local system. In doing so, these areas are grappling with complex changes, such as how to align the work of CCGs with wider system plans. The landscape within these areas is also changing rapidly, with the emergence of integrated care partnerships and changes to local commissioning (mergers of CCGs, joint executive teams between CCGs and integrated commissioning between CCGs and local authorities).⁸¹

99. Like STPs, ICSs vary significantly. Greater Manchester covers a population of 2.7 million, whereas Blackpool and Fylde Coast has around 300,000. The number of bodies also varies widely between these areas. The 10 integrated care systems face similar problems to the rest of country, but have been able to demonstrate positive progress in the changes they have made and some of the outcomes they have already achieved.⁸²

100. Despite examples of progress, organisational roles and accountabilities within these areas still cause tensions and difficulties. Local bodies in these areas have competed for many years and, in some cases, may not have worked together for long. Partners within integrated care systems in 2018/19 have flexibility to move funds between organisations to balance the system control totals. However, organisations are having to reconcile system control totals with their own individual controls and use of the provider and commissioner sustainability funds (see Chapter 8).⁸³ The King's Fund has warned that:

if control totals are not realistic, they could create significant financial disincentives to partnership working and bring into question the commitment of NHS organisations to continue working in this way.⁸⁴

101. Even in the more advanced areas, local leaders were worried about how to maintain the cooperation between all the relevant players. Pressures on even the most advanced areas are far from sustainable. South Yorkshire and Bassetlaw had made excellent progress and the areas' financial position was more benign than other local systems, yet the area is not immune from some of the pressures. Primary care in the area, notwithstanding excellent examples such as Larwood Practice, faces significant workforce challenges.

102. While very supportive of the principle and potential of integrated care systems, Professor Chris Ham from The King's Fund, who has been working with NHS England and the first wave of integrated care systems, provided a word of caution, saying:

79 NHS England and NHS Improvement, Refreshing NHS Plans for 2018/19, February 2018, pages 13–14

80 [Exclusive: Accountable care systems will make pathway for steps to follow](#), Health Service Journal 10 July 2017

81 The King's Fund, A progress report on integrated care systems, March 2018

82 The King's Fund, A progress report on integrated care systems, March 2018

83 The King's Fund, A progress report on integrated care systems, March 2018

84 The King's Fund, A progress report on integrated care systems, March 2018

the 10 integrated care systems are beginning to show what is possible through place-based working that goes beyond STPs. Let's not underestimate how nascent and fragile those systems are. They depend on the willingness of organisations to come together in the same room and collaborate, in a system that was not designed to make that the easy thing to do.⁸⁵

Professor Ham went on to say that:

There is clearly a risk that some of them will not be able to build on the progress they have made so far because, with the growing pressures, the focus will be on organisations dealing with their deficits, which may get in the way of systems playing a bigger part in supporting organisations to do that collaboration. I do not want to exaggerate, but I do not want to adopt an overly optimistic view either.⁸⁶

103. A lot of pressure is being put on these frontrunners. The King's Fund argue that they are "writing the manual for system working rather than being readers expected to implement a blueprint written by others."⁸⁷ National bodies need to pay careful attention to how they support these fragile and nascent systems to maintain the progress they have made so far, as well as pave the way for future cohorts.

104. Another dilemma facing national bodies is how they approach areas in which the concept of integrated care systems, as currently envisaged, does not work or is unlikely to work.⁸⁸ A lesson from the foundation trust pipeline is that it is quite possible that the eligibility criteria local areas need to meet to attain ICS status will be outside their reach. While this is entirely possible, an even more likely scenario is that some local areas which manage to achieve ICS status may struggle to maintain their performance, resulting in a scenario where the ICS badge becomes tokenistic. Such a scenario would see a similar pattern to the one that emerged between NHS trusts and foundation trusts, which Simon Stevens described as a "distinction without a difference."⁸⁹

Conclusions and recommendations

105. We support the development of integrated care systems, including plans to give greater autonomy to local areas as part of their ICS status. We are encouraged by the positive progress the first 10 integrated care systems have made in the face of challenges on the systems. However, like STPs more generally, we are concerned that funding and workforce pressures on these local areas may exacerbate tensions between their members and undermine the prospect of them achieving their aims for patients.

106. NHS England and NHS Improvement should systematically capture and share learning from areas that are furthest ahead, including their governance arrangements and service models, to accelerate progress in other areas and also to provide clarity about what is permissible within the current legal framework.

85 Q253 Professor Chris Ham

86 Q253 Professor Chris Ham

87 The King's Fund, A progress report on integrated care systems, March 2018

88 Q226 [Saffron Cordery]

89 NHS Chief backs Monitor and TDA merger, *Health Service Journal*, 10 February 2015

107. We recommend, as part of a joint national transformation strategy, that national bodies clarify:

- a) **how they will judge whether an area is ready to be an ICS;**
- b) **how they will support STP areas to become ICSs;**
- c) **what they will do in areas that fail to meet the criteria;**
- d) **how they will monitor the performance of existing ICS areas and provide support including the necessary funding to ensure they continue to make progress; and**
- e) **how they will address serious performance problems in ICS areas.**

5 Integrated care partnerships and accountable care organisations

Background

108. This chapter explains the changes in the delivery of integrated care that have emerged since the NHS Five Year Forward View was published in October 2014, particularly new care models, integrated care partnerships and ACOs.

109. While ACOs have attracted more attention, there are currently no ACOs in the NHS. The main expression of change to the delivery of care in the NHS has been the emergence of integrated care partnerships. This chapter describes the development of integrated care partnerships and also some of the key issues surrounding the inclusion of ACOs in the English NHS.

New models of care

110. The NHS Five Year Forward View led to the development of new models of care. These models of care blur traditional boundaries between existing health and care services. 50 vanguard sites across the country have piloted these models through, for example, partnerships between hospitals, primary care providers, clinical commissioning groups and care homes.

111. Two of these models, primary and acute hospital systems (PACS) and multispecialty community providers (MCPs), have a greater focus on integration and prevention. NHS England's written evidence to our inquiry set out a series of positive early signs that these new models are improving patient care and reducing demands on the system. However, the evidence for this improvement is not yet statistically robust.⁹⁰

112. The Government's ambition for health and social care to be integrated across the country by 2020 depends on the scale-up and spread of new models of care across the country. As yet, there is no clear plan describing how NHS England plans to fulfil this objective. NHS England is required by the mandate to:

Assess progress of the vanguards and identify models consistent with the multispecialty community providers, integrated primary and acute care systems and enhanced health in care homes vanguard frameworks that can be replicated across the country.⁹¹

Integrated care partnerships

113. The new models of care programme built on pre-existing partnerships between local services in some parts of the country and encouraged the development of partnerships in others. These partnerships were recently defined by The King's Fund as:

90 Q234 [Professor Checkland]

91 Department of Health and Social Care, [The Government's mandate to NHS England for 2018–19](#), March 2018, page 20

alliances of NHS providers that work together to deliver care by agreeing to collaborate rather than compete. These providers include hospitals, community services, mental health services and GPs. Social care and independent and third sector providers may also be involved.⁹²

114. Some of these partnerships have emerged out of the new care models programme, although many predated the new care models initiative. These integrated care partnerships are delivering integrated care without the need to form a single organisation. We heard during our inquiry that by using flexibilities within the current legislation to form alliances, services within the partnerships can agree to collaborate rather than compete.

115. Contractual tools, namely alliance and prime provider contracts, aim to facilitate these arrangements by enabling partners to share financial risks. These contracts can be costly and time-consuming to set up, but initial evidence suggests that where these contracts have been used successfully parties report greater inter-organisational working. However, it is too early to provide empirical evidence of the effectiveness of these contracts in the NHS.⁹³

Accountable care organisations

116. Accountable care organisations do not yet exist in the NHS. Within the English NHS, The King's Fund explain that ACOs are likely to be:

a more formal version of an ICP that may result when NHS providers agree to merge to create a single organisation or when commissioners use competitive procurement to invite bids from organisations capable of taking on a contract to deliver services to a defined population.⁹⁴

117. Two areas, Dudley and the City of Manchester, have expressed an interest in formalising their existing integrated care partnerships into a single organisation if, and when, NHS England makes an accountable care contract available.

118. Organisations called ACOs currently exist in the US: a legacy that has sparked concern that organisations of the same name proposed for England could follow the same formula.

119. ACOs in the US were established by the US Affordable Care Act 2010, but built on models such as Kaiser Permanente in the US and Ribero Salud Grupo in Spain. According to an article in the British Medical Journal there are approximately 1000 ACOs serving over 30 million people in US.⁹⁵

120. The context in the US is very different. The fragmentation of funding and delivery is far more pronounced within the US. For example, the US does not have a nationally funded and centrally controlled national health service and eligibility criteria for access to

92 The King's Fund, Making sense of accountable care, January 2018

93 Sanderson, M., Allen, P., Osipovic, D., Moran, V. (2017) New Models of Contracting in the NHS: Interim Report Policy Research Unit on Commissioning and the Healthcare System; London School of Hygiene & Tropical Medicine

94 The King's Fund, Making sense of accountable care, January 2018

95 Can accountable care organisations really improve the English NHS? Lessons from the United States, British Medical Journal, 2 March 2018

services are wholly different to those of the NHS. Therefore ACOs in the English NHS are likely to be very different from those in the US and other countries.⁹⁶ However, the choice of this terminology was mistaken and has contributed to widespread misunderstanding.

Current status of proposals to introduce ACOs in the English NHS

121. The Department of Health and Social Care has consulted on changes to existing regulations to enable an Accountable Care Contract to be introduced. The outcome of the Department's consultation on the regulations was published in April 2018. NHS England also plans to consult on a draft contract, which will outline "how the contract fits within the NHS, how NHS commissioners and providers party to an ACO contract will perform their existing statutory duties and the arrangements that will be in place to ensure public accountability and patient choice".⁹⁷

122. NHS England has delayed its consultation pending the outcome of our inquiry and two judicial reviews on the legality of the changes it proposes. The Department of Health and Social Care signalled in its consultation response its intentions to consult again on legal directions to ensure "criteria for an ACO delivering primary medical services (GP services) are consistent with the criteria for existing providers of primary medical services."⁹⁸ Once NHS England has implemented a contract, these legal directions will be limited to Dudley and the City of Manchester initially, although other areas may apply to use the contract.⁹⁹

123. We heard concerns that national bodies have an expectation that STPs will develop into integrated care systems which will then lead to the roll-out of accountable care organisations across the NHS. On the contrary, rather than national bodies having a pre-determined expectation that each area will form accountable care organisations, we heard from NHS England that an Accountable Care Contract, if and when it becomes available, will be just one option for local systems. Simon Stevens, Chief Executive of NHS England, told us that:

I doubt that the whole of England, or anything like the majority of it, will be using this particular contractual vehicle, but those who want to integrate funding may do so.¹⁰⁰

124. Dudley and the City of Manchester, while they have both expressed an interest in using an ACO contract, differ in the extent to which this is integral to their plans. Paul Maubech, Chief Executive of Dudley Clinical Commissioning Group, described several reasons why an ACO contract is critical to Dudley's plan. The City of Manchester, in

96 British Medical Journal, Can accountable care organisations really improve the English NHS? Lessons from the United States, March 2018

97 Department of Health and Social Care, Accountable care organisations: Government response on changes to regulations required to facilitate the operation of an NHS Standard Contract (Accountable care models), April 2018

98 Department of Health and Social Care, Accountable care organisations: Government response on changes to regulations required to facilitate the operation of an NHS Standard Contract (Accountable care models), April 2018

99 Department of Health and Social Care, Accountable care organisations: Government response on changes to regulations required to facilitate the operation of an NHS Standard Contract (Accountable care models), April 2018

100 Q280 Simon Stevens

contrast, see the ACO contract as a potential enabler, although there are issues, including different regulations covering VAT exemptions between NHS and local government, which may have significant financial implications for the partners involved.¹⁰¹

125. Stephen Barclay, Minister of State for Health, referred to plans to “pilot” ACOs in Dudley and the City of Manchester.¹⁰² The Government’s response to the proposed regulatory changes to enable an ACO contract stated that legal directions, once consulted on, would be limited to Dudley and the City of Manchester.¹⁰³ However, as yet we have not seen any detailed proposals setting out the parameters of these pilots: the time period, the outcomes they seek to measure, or how the pilot will be evaluated. The Minister also said that pilots of ACOs are in part being carried out to assess the budget that is needed to transform care across the wider NHS:

Of course, there needs to be transformation and that requires a budget, and there is a question as to what that should be. The ACOs involve two areas at the moment. It is very difficult to make an assessment ahead of that. Part of the reason for having pilots is to understand what is involved, and to take that forward.¹⁰⁴

126. We are unclear about Government and national bodies’ plans to pilot ACOs in Dudley and the City of Manchester, and it is not certain that the City of Manchester will go down this route if and when the contract becomes available.

127. The Minister’s evidence also implies that these pilots will be used to assess the level of transformation funding that is required across the NHS. The need for transformation funding in our view is urgent and should not wait for the results of a small pilot of ACOs. Also, the Minister’s comments appear to contradict Simon Stevens’s statement that the ACO contract will be an option for local areas (including those other than Dudley and the City of Manchester).¹⁰⁵

Arguments for and against ACOs

Benefits of a single organisation and aligned financial incentives

128. The purported benefits of using an ACO contract are that it enables an integrated care partnership to merge into a single organisation, streamline decision making and align financial incentives. National and local leaders made the case that merging services into a one single legal entity would reduce complexity, particularly the complexity of internal decision-making processes, and bring health professionals together into one organisation, with the same objectives and incentives.¹⁰⁶

129. As explained in Chapter 2, there are some substantial and persistent obstacles which make the task of integrating health and social care hard to achieve. The case was made

101 Q161 Ian Williamson

102 Q414 Stephen Barclay

103 Department of Health and Social Care, *Accountable care organisations: Government response on changes to regulations required to facilitate the operation of an NHS Standard Contract (Accountable care models)*, April 2018

104 Q414 Stephen Barclay

105 Q280 Simon Stevens

106 Q394 Jonathon Marron, Q184 Paul Maubach

to us that merging partnerships into a single organisation would enable change to occur at a faster pace, as it would help to overcome some of these obstacles (organisational boundaries, cultural practices, terms and conditions, legal accountabilities and payment systems).

130. Paul Maubach from Dudley CCG made the case that, unlike acute hospitals, primary, community and social care services are provided by a more disparate array of services. The NHS Five Year Forward View argues that these traditional divides are no longer fit for purpose. Mr Maubach argued that the proposition of splitting hospital services into separate organisations, with separate management teams, and then asking them to form an alliance to collaborate to provide an acute contract would be undesirable, so why approach services outside hospitals in this fashion? He stated: “we have multiple organisations, but actually the public want one joined-up service.”¹⁰⁷

131. One of the persistent barriers to integrated care, according to the NAO, are misaligned financial incentives.¹⁰⁸ Paul Maubach described how Dudley CCG commission long-term diabetic care from GPs and diabetologists. Those funding the service, clinicians and patients, all want stable management of a patient’s diabetes, yet GPs and diabetologists are paid in different ways. GPs are paid based on their practice population, with incentives to reward the stable management of a patient’s condition, whereas the diabetologists are paid for activity, specifically how often a patient visits, with no link to outcomes.¹⁰⁹

132. Stephen Barclay, Minister of State for Health, described how having a single organisation responsible for the health and care provision of a defined population within a capitated budget over a 10–15 year contract presents an opportunity to frontload investment and focus on outcomes, so services have “more skin in the game.”¹¹⁰

133. The purported benefits of organisational integration, while they appear convincing at a common-sense level, are not supported by studies from organisational or economic literature.¹¹¹ Organisational integration and alignment of financial incentives, through changes to payment systems, remove barriers to integrated care. An analysis of ACOs, particularly in the US, suggests that the benefits of removing such barriers are unlikely to be sufficient to drive improvements in patient care. Instead, evidence presented in the British Medical Journal, which looked at factors contributing to the performance of ACOs in Colorado and Oregon, suggests leadership, culture and management, particularly enhancing the capability of professionals to redesign services, are better explanations of ACO performance.¹¹² Professor Katharine Checkland, from the University of Manchester, who leads the national evaluation of the new care models programme, echoed this view:

107 Q185 Paul Maubach

108 National Audit Office, [Health and social care integration](#), HC 1011 Session 2016–17 8 February 2017, page 10, para 20

109 Q169 Paul Maubach

110 Q393 Stephen Barclay

111 Q236 Professor Katharine Checkland

112 Department of Health and Social Care, *Accountable care organisations: Government response on changes to regulations required to facilitate the operation of an NHS Standard Contract (Accountable care models)*, April 2018

creating an integrated organisation does not necessarily make it easier to do integration work. It is about relationships and communication, and knowing where people are and who to speak to. It is the day-to-day work of integration.¹¹³

Strengthening primary care and community services

134. There has been a longstanding effort to provide more care outside of hospitals. However, hospital services continue to consume the lion's share of healthcare resources compared to the rest of the sector. Problems in the acute sector also consume the attention and resources of policymakers. As Paul Maubach described the centre of gravity in the NHS is towards the acute sector. The Sustainability and Transformation Fund has largely been used to improve the financial position of NHS providers, particularly acute providers.

135. Primary care and community services are currently much smaller, more disparate, organisations, although there has been an increase in GP federations over recent years. According to Paul Maubach from Dudley CCG:

A major challenge at the moment is how to shift that gravity towards integrated care to support people, managing and supporting them to live with the complexity of the conditions they have, in their own homes.¹¹⁴

136. Paul Maubach argued that bringing the disparate array of primary and community health services into a single, much larger, ACO provider would help to shift the balance within the system.¹¹⁵ While this may be the case, the challenge of allocating resources, which are currently limited, within a single organisation does not of itself resolve the problem of moving funding towards out-of-hospital services when demand for acute care is rising. It is possible such an arrangement could also favour secondary care if other sectors are not sufficiently represented and protected within one provider.

137. Another critical reason for using an ACO contract is to improve the resilience of primary care services. Paul Maubach told us how five years ago Dudley had 52 GP practices, but is now losing branch surgeries and practices at the rate of one every six months.¹¹⁶ There are two interrelated reasons for this development. One is that there are not enough doctors coming into general practice. The other that there is rising demand for primary care. Patients are increasingly presenting with complex multi-morbidities, which according to Mr Maubach are better served by a multi-disciplinary approach.¹¹⁷ A key advantage of an ACO contract is the ability to incorporate primary care. Mr Maubach explained that an ACO contract:

offers the opportunity fully to integrate primary care with the rest of the system. There is no other contractual mechanism available to do that. Without the ACO contract, you cannot formally integrate primary care with community mental health and other services.¹¹⁸

113 Q264 Professor Katharine Checkland

114 Q196 Paul Maubach

115 Q171 Paul Maubach

116 Q172 Paul Maubach

117 Q172 Paul Maubach

118 Q172 Paul Maubach

138. The ability of the accountable care organisations to improve the resilience of primary care is largely at the discretion of GPs themselves. Simon Stevens told us that GPs have to “feel that this is a sensible approach and they want to do it, in parts of the country where the health service wants to do it. That is why it should be an option, but it is not a requirement.”¹¹⁹ Most of the GPs in Dudley have opted for partial integration rather than full integration with the ACO contract if and when this becomes available.¹²⁰

Conclusions and recommendations

139. There are questions about whether using an Accountable Care Contract to create a single organisation will accelerate integration. However, there is a strong case for using these contracts to streamline decision making rather than require decisions to be referred back to individual statutory partners. Evidence to date suggest that the most important factor is effective joint working to shift incentives towards preventing ill-health, improve the management of long-term conditions and strengthen services outside hospitals.

140. Given the controversy surrounding the introduction of accountable care organisations in the English NHS, we believe piloting these models before roll-out is advisable. There should be an incremental approach to the introduction of ACOs in the English NHS, with any areas choosing to go down this route being carefully evaluated.

141. **The evaluation of ACOs should seek to assess:**

- a) **the benefits and any unintended consequences of these structures compared with improving joint working through integrated care partnerships.**
- b) **the implications of the scope of the ACO contract, particularly whether hospital services, GP practices and social care should be incorporated, either in a partially integrated or fully integrated capacity.**
- c) **the impact of ACOs on decision-making processes, objectives and incentives for staff and the resilience of services outside of hospitals.**
- d) **the impact on patient choice.**

We do not believe it is in the best interests of patients to return to a system devoid of choice.

Concerns about ACOs

142. There is no doubt that contracting a single organisation to deliver health and care for an entire local population over a 10–15 year period brings with it risks that will need to be managed. In this respect, accountable care organisations represent a significant shift in health policy. In acknowledgement, the Next Steps to the NHS Five Year Forward View, referring to the introduction of ACOs, stated clearly that:

The complexity of the procurement process needed, and the requirements for systematic evaluation and management of risk, means they will not be the focus of activity in most areas over the next few years.¹²¹

119 Q271 Simon Stevens

120 *Aspiring ACO will not fully integrate vast majority of its GPs*, Health Service Journal, 22 March 2018

121 NHS England, [Next Steps on the NHS Five Year Forward View](#), March 2017, page 37

143. Given the risks involved, it is not surprising that many responses to our inquiry expressed significant concerns about the introduction of accountable care organisations in the English NHS. The worries people have cover not only the concept of ACOs and the initial proposals over how they will operate, but also how these contracts will be introduced.

144. The main concerns expressed to us are that accountable care organisations extend the scope for privatisation of the NHS, will worsen terms and conditions for staff or will lead to increased charges and care being rationed.

Privatisation

145. The Government has not ruled out the prospect of private providers bidding or holding an ACO contract because they point out that Clinical commissioning groups are prevented from favouring bidders based on their ownership (e.g. whether they are public or non-statutory services), by the Public Contracts Regulations 2015.¹²²

146. Privatisation of the NHS remains a concern for many people (see Chapter 6). Keep Our NHS Public, on its website, suggest that accountable care organisations, “increase the potential scope of NHS privatisation.”¹²³ According to this website, the introduction of ACOs means:

multiple procurements will be replaced by a single, major, long-term contract to provide health and social care services for an entire area. The draft model contract for ACOs published by NHSE allows for, and is likely to attract, bids from multinational corporations.¹²⁴

147. The main concerns about the prospect of private companies taking responsibility for an ACO contract include:

- a) The type of private provider, including the potential for ACOs to be special purpose vehicles.
- b) The length of the contractual term (a 10–15 year contract).
- c) The ability of private providers to exit the market in the event of failure.

148. Stephen Barclay assured us that there are a “number of checks and balances in the system”. He told us that they include:

- local requirements for CCGs to consult health and wellbeing boards, and oversight and scrutiny committees as well as their local populations; and
- national checks of CCGs through the integrated support and assurance process.¹²⁵

122 Correspondence from Rt. Hon Jeremy Hunt MP, Secretary of State for Health and Social Care to Dr Sarah Wollaston MP, Chair of the Health and Social Care Committee, 22 January 2018, POC_1115906

123 Keep Our NHS Public, *Accountable care: Accountable care organisations, accountable care systems in England*, accessed on 18 May 2018.

124 Keep Our NHS Public, *Accountable care: Accountable care organisations, accountable care systems in England*, accessed on 18 May 2018.

125 Q375 Stephen Barclay

149. There are several reasons why the prospect of a private provider holding an ACO contract is unlikely. Most significantly, while commissioners cannot discriminate based on a bidder's organisational form, CCGs can decide not to tender services if there is only one credible provider.¹²⁶ Using an ACO contract to merge existing services, acute, community, primary, mental health and social care, into one complex contract would effectively narrow the scope of eligible bidders. Integrated care partnerships between NHS bodies looking to use the contract to form a large integrated care provider would have an advantage over non-statutory providers that are less likely to have experience of managing the same scope of services: NHS bodies, therefore, are far more likely to be “credible providers” than non-statutory bodies.

150. Jonathon Marron from the Department of Health and Social Care described this process, saying that the regulations as they currently stand mean, for example, that a competition is not run every year for the “Guy's and St Thomas's contract” as there is no alternative provider.¹²⁷ Rather than increasing private sector involvement, we heard that creating large integrated legal entities through an ACO would enable more services (e.g. community nursing, sexual health) to be incorporated into the organisation, thereby reducing the eligibility of smaller providers to bid for separate contracts and the necessity for commissioners to go out to tender.

151. It was also pointed out that there is little room to extract profits given the available budgets and so these contracts are unlikely to appeal to the private sector in the way that some fear.¹²⁸

152. The two areas considering using the ACO contract, Dudley and the City of Manchester, are looking to work through NHS bodies, rather than with the private sector. Paul Maubach from Dudley CCG explained that an ACO contract becomes a useful vehicle once you have effective partnerships between services in place. Mr Maubach's view was that the concerns surrounding privatisation are a “red herring”, as the existence of effective partnerships means it is harder for independent providers outside a partnership to demonstrate that they could provide greater value than existing, NHS, providers.¹²⁹

153. There is also little appetite from within the private sector itself to be the sole provider of these contracts. NHS Partners Network, a representative of independent sector providers, told us that in the current environment it does not expect private providers to take on an ACO contract for a whole system. NHSPN states that in addition to the political sensitivities involved, it would be a significant financial risk and independent providers would not expect to be ‘bailed out’.¹³⁰ Nigel Edwards, Chief Executive of the Nuffield Trust, explained that transferring staff and assets to a private provider, while theoretically possible, may require primary legislation.¹³¹

Staff terms and conditions

154. There is currently no prescribed organisational form for ACOs. Theoretically they can be public or non-statutory organisations. For many staff, there is a worry that their

126 Q389 Jonathon Marron

127 Q390 Jonathon Marron

128 Q240 Professor Chris Ham

129 Q164 Paul Maubach

130 NHS Partners Network STP0120

131 Q238 Nigel Edwards

employer could end up being outside the NHS, thereby posing a threat to their existing terms and conditions. Such fears have been amplified by a recent increase in the practice of foundation trusts establishing subsidiary companies to make efficiencies. Simon Stevens confirmed that NHS England:

will be making it absolutely clear in our public consultation on the draft contract that subcontracting of that nature would not be permitted without the authorisation of the CCG as exists at the moment, so that there were no new risks arising.¹³²

Conclusions and recommendations

155. We recognise the concern expressed by those who worry that ACOs could be taken over by private companies managing a very large budget, but we heard a clear message that this is unlikely to happen in practice. Rather than leading to increasing privatisation and charges for healthcare, we heard that using an ACO contract to form large integrated care organisations would be more likely to lead to less competition and a diminution of the internal market and private sector involvement.

156. We recommend that ACOs, if a decision is made to introduce them more widely, should be established in primary legislation as NHS bodies. This will require a fundamental revisiting of the Health and Social Care Act 2012 and other legislation. Whilst we see ACOs as a mechanism to strengthen integration and to roll back the internal market, these organisations should have the freedom to involve, and contract with, non-statutory bodies where that is in the best interests of patients.

6 Concerns about the direction of travel

157. There are five key concerns arising out of the NHS Five Year Forward View process. We describe, and respond to, each in this chapter. Some of these concerns reflect genuine obstacles to transformation and risks to the sustainability and cohesion of the health and care system. Others, however, such as assertions that the NHS is being ‘Americanised’ in a way that will lead to people having to pay for care, are creating a climate that risks blocking the joining up of services in the interests of patients.

158. We know from polling that the British public are worried about the future of the national health service.¹³³ The way national bodies communicate has often exacerbated public concerns. For example, the language of the NHS, and the wider health and social care system, is full of unhelpful jargon (See Chapter 7).

159. The positive underlying intention of the NHS Five Year Forward View process is clouded by unhelpful acronym spaghetti. Jargon, we heard from Dr Charlotte Augst from the Richmond Group, is not only ineffective, it raises suspicion. The public do not understand these acronyms, which leads some to think there is a story they are not being told.¹³⁴ Niall Dickson, Chief Executive of the NHS Confederation, made this point:

I suspect that Mr and Mrs Smith walking down the road probably do not know what STP stands for and do not understand a lot of this process. That is part of the problem, but the way it was launched and people’s genuine fears about what might happen have become attached to both the letters and the process, and we have to move on from that.¹³⁵

160. The Government and national bodies must take responsibility for finding effective solutions to address the key funding and workforce pressures on the system. However, we frequently see and receive messages from campaign groups that are inaccurate, misleading and play on the public’s genuine concerns. These messages make it harder for local organisations to make progress. For example, as Niall Dickson described, negative labels attached to the STP brand have tainted the process.¹³⁶

Top-down reorganisation of the NHS without public consultation and parliamentary scrutiny

161. Current changes to regional structures and local organisations, such as STPs, ICSs and ACOs, focus on integration at the organisational level. We have heard concerns that these reforms constitute another top-down reorganisation of the NHS, which is taking place without adequate public consultation or parliamentary scrutiny. This focus, it is argued, is a distraction from the task for integrating care for patients.¹³⁷

162. Dr Graham Winyard, a former National Medical Director for the NHS in England, argued that the NHS has had 35 years of changes to the organisational superstructure.

133 Ipsos MORI ([STP0104](#))

134 Q155 Dr Augst

135 Q206 Niall Dickson

136 Q206 Niall Dickson

137 Q18 Dr Graham Winyard, Q8 Dr Tony O’Sullivan

He told us that integrated care depends on relationships between professionals; the NHS superstructure can either impede or support inter-professional working.¹³⁸ Dr Tony O’Sullivan from Keep our NHS Public echoed this view, saying:

It is top-down. The integration is integration of management systems, of financial purses and of organisations, and, to me, it is at the expense of the integration of true delivery of co-ordinated care that has been going on and did not need Simon Stevens or Jeremy Hunt to tell us to do it.¹³⁹

163. The current suite of NHS reforms is seeking to remove barriers and blur obstructive boundaries between services (see Chapter 2). Examples include the opportunity to use an ACO contract to bring primary care, community services and social care into one organisation to allow more streamlined decision making. Integrated care systems for example, can align incentives (e.g. through the use of capitated budgets) for better preventative care, thereby moving away from tariff arrangements which drive hospital activity.

164. Removing barriers at an organisational level is one part of improving integrated care. However, these changes alone are not the solution. Integrating care at the frontline is also about the workforce challenge, dependent primarily on building relationships between professionals. Simply removing external obstacles will not be sufficient to address the wider cultural and relational challenges of integrating care. So far scarce attention has been paid to the role of national bodies in building and supporting the intrinsic capability and capacity of frontline staff to improve, integrate and transform care.

Inadequate response to system pressures

165. We heard concerns from Keep Our NHS Public (KONP), a national campaigning body, that integrated care is often asserted as a solution to the NHS’s problems. KONP argue that the narrative described in the NHS Five Year Forward View is an inadequate response to fundamental problems facing the NHS: staff shortages, funding levels and the separation of health and social care.¹⁴⁰

166. There is widespread recognition that the moves to more integrated care are not a solution to systemic funding and workforce pressures facing health and social care services. These pressures represent significant barriers to the transformation of care, which if not adequately addressed, will compromise the NHS’s ability to maintain the quality of existing services, let alone enable staff to find the time to transform care. The extent and implications of these barriers are described in more detail in Chapter 7.

167. Sustainability and transformation partnerships, and the more advanced integrated care systems, provide a mechanism to move away from the autonomous competitive arrangements imposed by the Health and Social Care Act 2012, towards a collaborative, placed-based approach to care. **These mechanisms are no substitute for effective solutions to funding and workforce pressures, but if well designed and implemented they can represent a better way to manage resources in the short-term, including using the skills of staff more effectively on behalf of patients.**

138 Q18 Dr Graham Winyard

139 Q8 Dr Tony O’Sullivan

140 Keep Our NHS Public ([STP0093](#))

Smokescreen for cuts

168. A specific requirement of the sustainability and transformation plans was to quantify the funding gap in each footprint, along with proposals to fill this gap. Difficult decisions facing local areas, and the short timeframe in which they had to develop their plans, led to STPs being labelled as a “smokescreen for cuts”.¹⁴¹

169. Helga Pile, Deputy Head of Health at UNISON, argued that the STP initiative is “being seen as a means of delivering cuts to spending, and that means that many of the aims that they have that would benefit patients are not being identified and recognised.”¹⁴² This point was echoed by Dr Chaand Nagpaul from the British Medical Association. Based on information obtained from the BMA’s regional offices, Dr Nagpaul pointed to reports from BMA members that the boards of STPs are “talking about how we make cuts”, rather than how to transform care.¹⁴³

170. STPs originated in a time of financial constraint. These challenging circumstances meant partnerships were faced with difficult decisions from their inception. As Ian Williamson from Manchester Health and Care Commissioning explained:

You asked about cost-cutting. Frankly, we all live in a world where we have budgets that we must stay within, and it is our role to do so. I do not think there is a part of the NHS in the country that is not struggling to manage a set of very competing pressures.¹⁴⁴

171. The main criticism that STPs are a smokescreen for cuts conflates the principle of bringing local leaders together to plan services and manage finite resources with the difficult decisions the current funding envelope imposes on these partnerships. Conflation of these two separate points has unfortunately contributed to the negative, and tainted, perception of STPs.¹⁴⁵

Privatisation

172. Fears that the NHS is being privatised have been projected onto various changes in health policy since 1990. The World Health Organisation in 1995 defined privatisation as “a process in which non-government actors become increasingly involved in the financing and/or provision of healthcare services.”¹⁴⁶ Privatisation encompasses the transfer of government or state assets, organisations and operations to the non-government actors.¹⁴⁷

173. Private sector involvement in the NHS is very different to the private insurance based systems found in other countries (e.g. the US). Private companies have played a role in the NHS throughout its 70-year history; most GP practices are profit-making independent contractors to the NHS and community pharmacies are private businesses for example.¹⁴⁸

141 Keep Our NHS Public ([STP0093](#)) UNISON ([STP0057](#)) Unite the Union ([STP0070](#))

142 Q84 Helga Pile

143 Q86 Dr Nagpaul.

144 Q160 Ian Williamson

145 Q206 Niall Dickson, NHS Clinical Commissioners ([STP0064](#))

146 Full Fact, Ask Full Fact: Does the World Health Organisation think the UK no longer has an NHS? 21 March 2016

147 OECD, Glossary of statistical terms: Privatisation, accessed on 2 June 2018

148 The King’s Fund, Is the NHS being privatised? 22 August 2017

174. The vast majority of the British public support the founding principles of the national health service.¹⁴⁹ No mainstream political party supports shifting the NHS from a tax-funded system to a private insurance model. When given a choice, most people would prefer their NHS-funded care to be provided by the NHS, rather than non-statutory providers (up from 39% in 2015 to 55% in 2017). However, 30% of the population have no preference whether their NHS-funded care is delivered by the public, private or voluntary sector.¹⁵⁰

175. There has been an expansion in the role of the private sector since the early 2000s: for example, the use of private sector investment to fund new hospitals (e.g. private finance initiative) and independent treatment centres to reduce waiting times for elective care. More recently, there has been an increase in non-NHS providers of NHS-funded care, with the most significant increase being in community health services. Community health service contracts have gone to a range of providers including charities, social enterprises and community interest companies as well as private companies.¹⁵¹

176. Keep Our NHS Public have argued that the underlying motive of national bodies is to transfer large parts of local health and care provision into the private sector through the use of an accountable care contract. Dr Tony O’Sullivan, Co-Chair of Keep Our NHS Public, told us that:

these things have been put in place because of the top-down plan to go on a journey, which includes, I am afraid—we have not really discussed this—the assumption of a growing degree of privatisation, to an end form of ACOs that are independent bodies outside the NHS, so you have fragmented the NHS.¹⁵²

177. We heard repeatedly, however, from a series of both local and national leaders, that the direction of travel is more likely to reduce private sector involvement rather than increase it. This is explained in more detail in Chapter 5. However, fears about privatisation have been projected onto the NHS Five Year Forward View process, making the challenge of integrating care more difficult. Niall Dickson from the NHS Confederation argued:

A lot of the comment is misinformed. The idea that this is a secret plot in Jeremy Hunt’s desk to privatise the NHS is palpable nonsense. Everybody involved in the process knows that that privatisation argument is nonsense, but it has certainly tainted the (STP) brand.¹⁵³

Paying for healthcare

178. Doctors for the NHS expressed a concern that blurring boundaries between health and social care could result in charges being introduced for services currently classified as healthcare. For example, Dr Colin Hutchinson, Chair of Doctors for the NHS, explained:

At my local authority health and wellbeing board, the medical side of the collaborative agrees that there are situations where the definition of what

149 Ipsos MORI ([STP0104](#))

150 Ipsos MORI ([STP0104](#))

151 The Health Foundation, Briefing: Provision of community care: who, what, how much? April 2017

152 Q41 Dr Tony O’Sullivan

153 Q206 Niall Dickson

is classified as healthcare and what is classified as social care could become very important, such as the use of intermediate care beds, including the care B&B type of model that has been suggested. Are those health or are they social care? The use of rehabilitation services, particularly if they are delivered in patients' homes, raises the possibility of hotel charges for non-direct medical care for patients staying in hospital. If you are dissolving those boundaries, it does need to be defined, otherwise people will receive unexpected bills.¹⁵⁴

179. Simon Stevens, Chief Executive of NHS England, provided assurance that it is crucial that NHS care remains free and based on patients' need rather than ability to pay. He said that this is "a founding and enduring principle in the NHS, and nothing that is proposed will change it."¹⁵⁵

180. With pooled budgets and alignment of incentives to reduce hospital stays, it is likely that the blurring of boundaries could advantage rather than disadvantage patients by seeing more personal care directly funded by the NHS for limited periods after discharge. For example, the Discharge to Assess model in Sheffield entails patients being discharged when they are medically fit and having their support needs assessed at home by an immediate care or social care team. The model has reduced length of stay and helps to ensure patients receive the right support at the right time.¹⁵⁶

Conclusions and recommendations

181. STPs, ICSs and ICPs currently have to work within the constraints of existing legislation and manage rising pressures with limited resources. This context limits progress towards integrating care for patients.

182. Some campaigns against privatisation confuse issues around integration. Concerns expressed about the 'Americanisation' of the NHS are misleading. This has not been helped by poor communication of the STP process and the language of accountable care, neither of which have been adequately or meaningfully co-designed or consulted on with the public or their local representatives.

183. We recommend that the efforts to engage and communicate with the public on integrated care which we refer to above should tackle head-on the concerns about privatisation, including a clear explanation to the public that moves towards integrated care will not result in them paying for services.

184. We recommend that national bodies take proactive steps to dispel misleading assertions about the privatisation and Americanisation of NHS. The Department should publish an annual assessment of the extent of private sector in the NHS, including the value, number and percentage of contracts awarded to NHS, private providers, charities, social enterprises and community interest companies. This should include an analysis of historic trends in the extent of private sector involvement over a 5–10-year period.

154 Q28 Dr Colin Hutchinson

155 Q271 Simon Stevens

156 The Health Foundation, 'Discharge to assess' at Sheffield Frailty Unit, accessed on 2 June 2018

Integrated care: positive examples of progress across the NHS in England

We have seen and heard of excellent examples of progress local areas have made to deliver more integrated care for patients across the country. Below are some examples from a selection of the integrated care systems, although similar examples are evident in many other parts of the country.

Frimley Health

Frimley is one of the leading integrated care systems and one of the areas involved in the new care models programme. As part of service changes made through the vanguard programme, Frimley has achieved a decrease in hospital activity in 2017/18, despite a growth in emergency admissions in previous years.¹⁵⁷ Frimley is a good example of an area that has implemented changes to bring care out of hospitals and closer to communities. For example, the area has developed urgent care hubs, run by GP practices and other services in the area, to offer same-day appointments. Patients in need of urgent medical care are seen by members of an interdisciplinary team consisting of GPs, nurse practitioners, paramedics and other relevant healthcare professionals.¹⁵⁸

Nottinghamshire

Nottinghamshire provides a good example of how more integrated working between GPs, community services and care homes has helped to improve care and reduce hospital activity. Principia is one of the multispecialty community providers, consisting of a partnership between 12 local practices, which operates within the Nottingham and Nottinghamshire integrated care system. The partnership runs an enhanced GP support service in 22 care homes—including the provision of a named GP for each home—in the Rushcliffe area, which has led to a 29% reduction in A&E attendances and a 23% fall in admissions.¹⁵⁹

Buckinghamshire

Buckinghamshire is an example of where local councils are working closely with the NHS to improve the health and wellbeing of the local population. There are a series of initiatives across a range of issues—such as the promotion of physical activity and health checks, prevention and early diagnosis of diabetes, falls prevention and cancer prevention—that have demonstrated significant progress, including:

- a 57% reduction in falls causing severe harm;
- a 9% increase in the uptake of NHS health checks; and

157 NHS England (STP0107)

158 NHS England (STP0107)

159 Health Foundation, The impact of providing enhanced support for care home residents in Rushcliffe, March 2017; <http://www.health.org.uk/publication/impact-enhanced-support-rushcliffe>

- a 17% reduction in inactivity levels and 20% increase in people achieving recommended levels of activity.¹⁶⁰

Dorset

Dorset is an example of an area which is planning to make changes to its acute hospitals in order to address variations in quality and improve the financial sustainability of the system. The main hospitals in Dorset currently provide many of the same services. However, Dorset has made progress in making more efficient use of hospitals with plans to ensure each hospital specialises in a particular area. Dorset is also planning to introduce community hubs in which GPs, specialist doctors, nurses, physiotherapists and social care workers work in one place and provide more timely and effective support to rural communities within the county.

Dorset has also been using technology to help patients manage their long-term conditions. For example, patients with diabetes, chronic obstructive pulmonary disease and heart disease use mobile phone apps to manage these conditions.¹⁶¹

160 NHS England (STP0107)

161 NHS England (STP0107)

Section 3: The case for change

7 Making the case for change

Narrative for change

185. The NHS's history has been one of repeated reorganisations. In contrast to previous reforms, we heard that the NHS Five Year Forward process, rather than spending time redrawing the map of the NHS, is supposed to focus on improving the relationships and behaviours between local services.¹⁶² This is a pragmatic approach, particularly given there is little appetite within the service for another set of legislative reforms in the wake of the Health and Social Care Act 2012.

186. National bodies have attempted to harness local support and energy across the health and care community, at a time of rising pressures and limited resources. However, a key message from our inquiry is that there needs to be a clearer narrative to explain the direction of travel: what are these reforms trying to achieve; what does the end state look like; what are the risks and what the benefits for patients and taxpayers.

187. There has been great variation in the extent to which local communities and their representatives have been informed and involved. Nigel Edwards, Chief Executive of the Nuffield Trust, explained:

perhaps the biggest weakness, not just with the STP process but arguably with the “Five Year Forward View”, is the lack of a very strong story about what we are trying to achieve, where we think we are going, what the advantages of that are and what the risks might be. That has been largely absent.¹⁶³

188. Based on the evidence we have heard, a compelling narrative should:

- a) **articulate what high-quality integrated care looks like, its benefits and the litmus test for success from the patient perspective.** A compelling narrative would describe integrated care from a patient perspective. The NHS Five Year Forward View was a vision for how the system needed to change. It articulated the benefits of change primarily from a system perspective.¹⁶⁴ However, when it comes to communicating the case for change locally, describing the benefits for the system as a whole is not the best starting point.

The public want to know how proposed changes will improve care for them, their families and their local communities.¹⁶⁵ Despite this, many of the original sustainability and transformation plans used the Forward View as the starting point for the local service changes proposed within these documents. London Southbank University's analysis of the South Yorkshire and Bassetlaw STP highlighted that it was one of the few plans that did not use the NHS Five Year Forward View as driver behind the plan.¹⁶⁶

162 Oral evidence taken before the Public Accounts Committee on 5 March 2018, HC (2017–18) 793, Q133 [Sir Chris Wormald]

163 Q262 Nigel Edwards

164 Q150 Dr Augst

165 Ipsos MORI (STP0104), Richmond Group of Charities (STP0102)

166 London Southbank University, STP analysis South Yorkshire and Bassetlaw STP, June 2017

- b) **focus on reform from the bottom up by supporting frontline staff and removing barriers to integrated care.** There is widespread support for integrating care at patient and local level across the health and care community. The benefits of delivering holistic, joined up care for patients are recognised by staff. Dr Nagpaul from the British Medical Association made clear that “the workforce does not go into a hospital or a GP’s surgery thinking “STP.” People look at their lives in terms of looking after patients within the setting they are in.”¹⁶⁷

There is widespread support for changes that support health and social care staff to integrate care from the bottom up and to remove barriers to joined up working and information sharing. We heard that many frontline staff have spent large parts of their professional careers trying to integrate care for patients, often working around policies that construct rather than remove barriers to integrated care at local level.

- c) **provide clarity on what the shape of the health and care system will look like.** One of the problems arising from the lack of a clear narrative, according to Dr Charlotte Augst from the Richmond Group, is that the “ ill-defined nature of the STP endeavour means that people can project on to it whatever anxieties or hopes they have about it.”¹⁶⁸

NHS providers, clinical commissioning groups and local government have called for greater clarity over the future shape of health and social care, particularly the role some of the current functions, such as commissioning, should play within a more collaborative, placed-based structure.¹⁶⁹

- d) **be based on a realistic, open and honest dialogue with the public.** Nigel Edwards from the Nuffield Trust cautioned that it is important not to over-extrapolate the benefits of integrated care and the time and money required for transformation.¹⁷⁰ Professor Katherine Checkland from Manchester University, who leads the evaluation of the new care models programme, told us “at the micro-level, as Nigel said, there is good evidence that integration is good for patients, but it is not at all clear that it will reduce overall activity or costs. There is a lot of fairly clear evidence that that is not the case.”¹⁷¹

Communicating the case for change to patients and the public

189. The vast majority of the British public continue to support the principles of a national health service that is tax-funded, comprehensive and free at the point of delivery.¹⁷² Most people agree that the NHS is crucial to British society and that everything must be done to maintain it. According to Ipsos MORI this has been a popular and stable belief for almost two decades. From 2000 to 2017 the percentage of people agreeing with this statement has ranged from a low of 73% to a high of 79%.¹⁷³

167 Q93 Dr Nagpaul

168 Q143

169 NHS Providers STP0050, NHS Clinical Commissioners STP0064, Local Government Association STP0027

170 Q230 [Nigel Edwards]

171 Q233 [Professor Checkland]

172 Ipsos MORI ([STP0104](#))

173 Ipsos MORI ([STP0104](#))

190. Compared to other countries, British people are more worried about the future of the health system. For example, 47% of British respondents to an Ipsos MORI survey expect the quality of care to get worse over the coming years - higher than all the other countries surveyed.¹⁷⁴ The public increasingly recognise that the NHS is struggling with funding and workforce pressures.¹⁷⁵

191. Health reforms in western countries are often controversial. However, pressures on the health and social care system, and the public's perception of these pressures and their causes, make the challenge of transforming care even more difficult.

192. Trust in Government, politicians and system leaders has long been low and despite doctors and nurses enjoying high levels of public trust compared to other professions,¹⁷⁶ mistrust among the public plays into local changes to services. Ipsos MORI are regularly commissioned by NHS organisations to support consultations involving local changes to healthcare services. Kate Duxbury from Ipsos MORI told us that the company is finding higher levels of mistrust among the public in this work.¹⁷⁷

193. The campaign groups we heard from during this inquiry described how trust in national leaders, including NHS leaders, has eroded following a series of reforms to extend the role of choice and competition within the NHS.

194. Public distrust is also fuelled by the way national and local bodies communicate. The use of jargon heightens suspicions among the public, thereby making the challenge of implementing changes even more difficult.¹⁷⁸

195. Communicating the case for change is not a simple task. Kate Duxbury from Ipsos MORI described how within an STP there are so many "different issues that matter to many different people in different ways that actually it is very difficult to engage with the public and represent everything they are saying."¹⁷⁹ National bodies are aware of the need for greater public and community engagement and are taking steps to support it.¹⁸⁰

196. Despite overwhelming support for a national health service, making the case for change based on the benefits for the system does not resonate with the public. Depicting the health service as being in crisis and therefore in need of radical reform does not in many cases chime with people's actual experience.¹⁸¹ The Richmond Group in 2014 and 2016 commissioned Britain Thinks, an insight and strategy consultancy, to research the most effective messages and communications approaches for engaging the public in service changes. Britain Thinks found that people are reluctant to label the system as in crisis as they feel it is disloyal. However, recognition that funding and staff shortages are growing creates more openness to change.¹⁸²

197. Britain Thinks found that saving money is not regarded by the public as a justifiable basis for health service reform. Patients and the public need to know how changes will

174 Ipsos MORI (STP0104)

175 The Richmond Group of Charities STP0102

176 Ipsos MORI STP0104

177 Q153 [Kate Duxbury]

178 Q155 [Dr Augst], Q206 [Niall Dickson]

179 Q154 [Kate Duxbury]

180 NHS England ([STP0132](#))

181 Richmond Group of Charities ([STP0102](#))

182 Richmond Group of Charities ([STP0102](#))

benefit them, their families and friends and their local communities. Focusing on tangible changes to treatment processes or problems that are recognised locally works better. Imelda Redmond, National Director of Healthwatch England, described a good example:

I saw some very nice work done by Suffolk and North East Essex STP. They did all their deliberative events with the public and they could interpret what people were saying. They could understand the difference in life expectancy between Southwold and Jaywick, which are both in their patch—I cannot remember how many years it is—so they could quickly get to, “The public think that is not fair.” Then they can relay back to people in very tangible ways, “We will improve the life expectancy,” “We will reduce that gap,” or, “We will have a zero tolerance on suicides in our patch.” These are tangible things that people get, which is quite a different language to, “We will improve the pathway for people who need tertiary care on blah.”¹⁸³

198. The public also have a strong emotional attachment to local services, particularly hospitals.¹⁸⁴ Hospitals signify safety, somewhere people can go in emergencies and receive expert treatment.¹⁸⁵ For many people hospitals and GP practices are the two access points they rely on.¹⁸⁶ From the public’s point of view any changes to these services are much more “radical” than any of the changes the health community considers radical (e.g. risk stratifying patients).¹⁸⁷ Therefore, it is important the public continue to recognise the services they depend on (hospitals, GP surgeries etc) in whatever changes are proposed.

199. Ipsos MORI explained that there is strong support for ensuring the public is engaged in decisions about local service changes. For example, 44% of the public said that they wanted to have a say on their local STP. Similarly, even though 39% did not want to be personally involved, they believed the public should have a voice.¹⁸⁸

200. Often the NHS has consulted with the public in a manner which can feel very tokenistic for those involved. As Niall Dickson from the NHS Confederation described:

The history of the health service has, frankly, long struggled with public engagement. The traditional means by which you consulted the public was to have a very firm plan. You took that plan out, you went through a period of time and you either got it through or you did not. The way STPs started was probably not terribly helpful; they were seen as secretive.¹⁸⁹

201. We heard that the NHS can improve the way it engages by initiating an early dialogue with the public and local groups about the direction of travel rather than waiting until they have a concrete plan. As Niall Dickson described, that could take the form of a conversation which begins with saying “this is the direction we want to go in; these are the trade-offs.” The evidence we received is that the public recognise the need to make trade-offs and are willing to engage in a constructive dialogue. Niall Dickson told us that:

183 Q147 [Imelda Redmond]

184 Ipsos MORI ([STP0104](#)) Richmond Group of Charities ([STP0102](#))

185 Richmond Group of Charities ([STP0102](#))

186 Q152 [Dr Augst]

187 Q152 [Dr Augst]

188 Ipsos MORI ([STP0104](#))

189 Q205 [Niall Dickson]

Going forward, there is a real prospect that we can go out and have very grown-up conversations, hopefully supported by local and national politicians, because there are some difficult conversations, as well as ones that explain how the new models of care will work.¹⁹⁰

Conclusions and recommendations

202. There has not been a sufficiently clear and compelling explanation of the direction of travel and the benefits of integration to patients and the public. National and local leaders need to do better in making the case for change and how these new reforms are relevant to those who rely on services. The language of integrated care is like acronym soup: full of jargon, unintelligible acronyms and poorly explained.

203. The Department of Health and Social Care and national bodies should clearly and persuasively explain the direction of travel and the benefits of these reforms to patients and the public. We recommend the Department and national bodies develop a narrative in collaboration with representatives of communities, NHS bodies, local government, national charities and patient groups. The messaging should be tested with a representative sample of the public. A clear patient-centred explanation, including more accessible, jargon-free, language, is an essential resource for local health and social care bodies in making the case for change to their patients and wider communities.

204. Making the transition to more integrated care is a complex communications challenge covering a range of different services and patient populations. The case for change must be made in a way that is meaningful to patients and local communities. In addition to providing a clear narrative, in accessible language at a national level, the Department of Health and Social Care, NHS England and NHS Improvement should explain how they plan to support efforts to engage and communicate with the public.

205. NHS England and NHS Improvement should make clear that they actively support local areas in communicating and co-designing service changes with local communities and elected representatives.

Section 4: Barriers to change

8 Funding and workforce pressures

Funding

206. The NHS is over halfway through the most austere decade in its history. Simon Stevens told us that over the last five years constraints on NHS funding have contributed £27billion to the country's deficit reduction. If health spending had kept pace with historic trends then the NHS would be expected to receive an extra £8.8billion next year than is currently planned.¹⁹¹

207. Bringing local health and social care services together through STPs and ICSs to plan and organise care within their footprints is a much better way to manage constrained resources than the siloed, autonomous and competitive arrangements imposed by the Health and Social Care Act 2012. Our view is that STPs and ICSs are a pragmatic response to the current pressures on the system, rather than a smokescreen for cuts, but that these mechanisms are not a substitute for adequate funding of the system. Funding them properly, including access to ring-fenced transformation money, is necessary and would allow a far better assessment of their potential.

Financial problems

208. The systemic pressure on the finances of the NHS and social care has shaped the context in which local organisations have come together. In some cases, where financial problems are looming, yet less serious, the circumstances facing local areas have acted as a catalyst for constructive conversations. However, there are local areas with deeply entrenched financial problems. Areas in greater financial distress can be consumed by maintaining day-to-day levels of performance and find it very difficult to find the capacity to engage in longer-term transformation. Nigel Edwards, Chief Executive of the Nuffield Trust, told us that:

A significant number of systems are under such financial distress that even the task that they have been set to try to agree shared control totals is causing problems. One of the reasons why many change programmes fail at the system level is that people stop working in a system way and go back to managing the financial objectives of their organisations. There is a significant number of systems where the level of financial distress is such that the time and space to be able to deal with some of the bigger transformational changes that we all know need to be made is being diverted by the search for financial balance.¹⁹²

Capital funding

209. Since 2014/15 the Department of Health and Social Care has relied on transfers from its capital budget to finance day-to-day running costs.¹⁹³ The Department, in evidence to the Committee of Public Accounts, confirmed that capital to revenue transfers are set to

191 Q304 Simon Stevens

192 Q246 Nigel Edwards

193 National Audit Office, Sustainability and transformation of the NHS, January 2018 Session 2017–19 HC 719, para 118

continue during this Parliament.¹⁹⁴ Using capital resources to fund day-to-day running and maintenance means there is less within the existing budget to transform care. Sir Robert Naylor’s report on the NHS estate set an ambition for capital investment of £10billion in the NHS, with half going on transformation and the other half on addressing the backlog of maintenance within the system.¹⁹⁵

210. In March 2017, the Chancellor announced £325million in capital funding for the most advanced STPs. An extra £3.5billion over the next four years was subsequently announced in the Autumn Budget in November 2017. Most of this funding, £2.6billion, has been earmarked to help STPs deliver their plans.¹⁹⁶

211. The Government’s intention is for this funding to be supplemented by £3.3billion from the sale of surplus land and buildings and “private finance investment in the health estate where this provides good value for money.”¹⁹⁷ In addition, NHS England is investing £1billion in primary care infrastructure and £808million for national priorities.¹⁹⁸

212. The capital resources provided so far fall short of Sir Robert Naylor’s estimate and the amount of capital resource local areas are calling for. London South Bank University’s analysis of all the 44 sustainability and transformation plans calculated the capital requirement to be over £14billion.¹⁹⁹ Nigel Edwards from the Nuffield Trust echoes the concern that the capital resources available to local areas are going to be significantly less than what they are calling for. Mr Edwards told us:

We also know that, where they have made capital requirement estimates, they are significantly in excess of what is likely to be available, even if there are substantial land sales. The London STPs alone would account for an entire year’s capital allocation, and more.²⁰⁰

Sustainability and Transformation Fund

213. The Department of Health’s original intention was for the Sustainability and Transformation Fund (STF) to restore the NHS to financial balance and support the transformation of care. However, the use of the STF to date has predominately been to address NHS deficits, rather than fund transformation.²⁰¹ The Fund, and the way it is allocated, has helped NHS organisations to improve their financial discipline.²⁰² However, according to the NAO, the remaining deficit continues to create problems for future years and leaves less funding available for transformation.²⁰³

194 Oral evidence to the Committee of Public Accounts on 5 March 2018 Session 2017–19 HC 793 Q41 [Sir Chris Wormald]

195 Department of Health and Social Care, NHS Property and Estates: Why the estate matters for patients. An independent report by Sir Robert Naylor for the Secretary of State for Health, March 2017

196 HM Treasury, Autumn Budget 2017, November 2017 (Session 2017–19) HC587, page66 para 6.8

197 HM Treasury, Autumn Budget 2017, November 2017 (Session 2017–19) HC587, page66 para 6.9

198 National Audit Office, Sustainability and transformation in the NHS, January 2018 Session 2017–19 HC719

199 London Southbank University, Sustainability and transformation plans: How serious are the proposals? A critical review, June 2017

200 Q247 [Nigel Edwards]

201 National Audit Office, Sustainability and transformation in the NHS, January 2018 Session 2017–19 HC719

202 Oral evidence to the Committee of Public Accounts on 5 March 2018 Session 2017–19 HC793 Q55 [Sir Chris Wormald]

203 National Audit Office, Sustainability and transformation in the NHS, January 2018 Session 2017–19 HC719

214. The NHS planning guidance recently split the Sustainability and Transformation Fund in two: the Provider Sustainability Fund and the Commissioner Sustainability Fund.²⁰⁴ Simon Stevens told the Committee of Public Accounts that “I think the “T” was probably a misnomer and that’s why we dropped it.”²⁰⁵ The Government and national bodies have committed to the two Sustainability Funds for the next financial year, at which point they can choose to use this resource differently.²⁰⁶

Funding transformation

215. A clear message from our inquiry is that transformation is key to sustainability. Ian Dalton, Chief Executive of NHS Improvement, described the difficult dilemma facing national and local leaders, saying that:

if we do not make the changes to care, we will be committing to dealing with potentially an ageing population, and the consequent rising demand, with care models that were designed for a different era, and we know that that is not the way forward either.²⁰⁷

216. The OECD’s analysis of health systems across Europe acknowledges that making the transition to more efficient ways of delivering acute and chronic care is likely to require upfront investment.²⁰⁸ We heard how many health systems that have undergone a similar journey to more integrated models of care have done so over 10–15 years, with dedicated upfront investment reserved for transformation.²⁰⁹ As health spending looks set to consume an increasing proportion of GDP in western countries over the coming decades, investing in more integrated care is a way of getting better value for patients and taxpayers.

217. The NHS is “still very much in survival mode”, according to the Public Accounts Committee.²¹⁰ Simon Stevens confirmed this view, stating that within the “aggregate funding available” national bodies decided to focus on supporting services in the “here and now,” which left less resources available “for pump-priming and extending wider changes.”²¹¹

218. The King’s Fund and the Health Foundation in 2015 identified the following key components for funding transformation in health services: physical infrastructure, programme infrastructure, staff time and double running of services, in which new services are run alongside incumbent services before the latter can be safely decommissioned.²¹²

204 NHS England and NHS Improvement, Refreshing NHS plans for 2018–19, February 2018

205 Oral evidence to the Committee of Public Accounts on 5 March 2018 Session 2017–19 HC793 Q67 [Simon Stevens]

206 Oral evidence to the Committee of Public Accounts on 5 March 2018 Session 2017–19 HC793 Q55 [Sir Chris Wormald]

207 Q359 [Ian Dalton]

208 OECD, *Health at a Glance: Europe 2016. State of Health in the EU Cycle*, November 2016

209 NHS Providers ([STP0050](#))

210 House of Commons Committee of Public Accounts, Sustainability and transformation in the NHS, March 2018 Session 2017–19 HC793

211 Oral evidence to the Committee of Public Accounts on 5 March 2018 Session 2017–19 HC793 Q85 [Simon Stevens]

212 The King’s Fund and the Health Foundation, [Making change possible: a transformation fund for the NHS](#), July 2015, page 6

219. Rather than changing administrative structures, the sort of change required to design and implement integrated care is often at a micro-level and concerns how frontline staff work together. Staffing is not the only component, but a clear message from our inquiry is that investment in staff capacity is critical for service transformation.

220. Quantifying the amount of funding required to deliver new and more integrated models of care across the NHS is very difficult, given both the scale of the transformation and the length of time needed to deliver the changes. We are disappointed that neither the Department of Health, NHS England nor NHS Improvement were able to provide an estimate of the scale of funding needed to deliver new models of care at scale or the approach they would take to make such an assessment. Greater Manchester had a £450million transformation fund over 5 years. Multiplying the level of transformation funding provided to Greater Manchester for the whole population of England comes to a figure of £9billion over 5 years.

Workforce challenges

Workforce shortfalls

221. Integrated care at the patient, service or organisational level is dependent on relationships between people working in health and social care. Whether patients experience holistic, coordinated and person-centred care depends on staff working together across acute, community, primary care, mental health, social care services and the voluntary sector.

222. The capacity, capability and motivation of staff to engage in transformation is also critical. Moving to new models of more integrated care requires:

- a) the capacity and capability of staff to participate in complex service redesign;
- b) engagement in dialogue with healthcare professionals and unions;
- c) time to train staff with new skills; and
- d) funding the staffing costs associated with double-running.²¹³

It should also include time for meaningful local engagement with those who rely on services both now and in the future.

223. National bodies are endeavouring to transform care during a period in which NHS and adult social care services are struggling to recruit, train and retain sufficient numbers of staff to cope with rising, and increasingly complex, demands. We have heard throughout this inquiry and our recent inquiry into the nursing workforce that professionals often worry about their ability to maintain professional standards when confronted with relentless, complex or unmanageable caseloads.

224. Moving care out of hospitals is only acceptable if there is adequate provision already in place within community and primary care settings to meet changes in demand. This depends on having sufficient numbers of suitably qualified staff within these settings.

213 The King's Fund and the Health Foundation, [Making change possible: a transformation fund for the NHS](#), July 2015

However, recent workforce trends run counter to this objective. The acute workforce has grown at a faster rate than primary, community and mental health services, some of which have seen numbers of staff drop considerably in recent years.²¹⁴ Where communities see highly valued resources, such as community hospitals, closed down before the promised new services to replace them are up and running, it seriously undermines trust in future service changes.

225. More collaborative, place-based ways of working, through sustainability and transformation partnerships and integrated care systems, provide an opportunity for local areas to deploy and retain limited pools of existing health professionals in the short term. However, without effective delivery of Health Education England's workforce strategy, collaborative working may be put at risk as staffing pressures encourage organisations to compete rather than look to share limited pools of staff.

Workforce engagement

226. NHS and social care professionals are likely to be the best advocates for more integrated care. Effectively communicating service change to the public depends on who presents the message as well as the message itself.²¹⁵ Public trust in nurses (93%) and doctors (91%) is significantly higher than politicians (17%), Government ministers (19%) and journalists (27%).²¹⁶ Alongside the NHS's strong brand, Ipsos MORI argue public trust in these health professions is a key advantage in making the case for change to the public, although Ipsos acknowledge:

...while this can be a benefit to be harnessed, it can also work in the opposite direction: a reform or message without NHS staff backing is unlikely to be popular with the public where staff are vocal, and the impact of this should not be underestimated.²¹⁷

227. The NHS Constitution, the Royal College of Nursing told us, includes a requirement for NHS-funded organisations to “engage staff in decisions that affect them and the services they provide.”²¹⁸ Staff engagement was limited in the development of the original plans. Professional bodies, including royal colleges and trade unions, continue to perceive staff engagement in sustainability and transformation partnerships as insufficient, poor and patchy.²¹⁹

228. Local GPs appointed by the Royal College of General Practitioners to act as regional ambassadors in the development and implementation of STPs have “struggled to find a voice or influence on key STP boards.”²²⁰ Similarly, allied health professionals (e.g. physiotherapists, occupational therapists, paramedics, speech and language therapists), we heard, have also struggled to find a voice in the leadership of STPs. None of the clinical leads on STP boards come from the ranks of allied health professionals.²²¹

214 Q110 [Lara Carmona] Q105 [Dr Nagpaul].

215 Ipsos MORI ([STP0104](#))

216 Ipsos MORI ([STP0104](#))

217 Ipsos MORI ([STP0104](#))

218 Royal College of Nursing ([STP0048](#))

219 British Medical Association (BMA) ([STP0063](#)) Royal College of Emergency Medicine ([STP0015](#)) Royal College of General Practitioners ([STP0043](#)) Royal College of Nursing ([STP0048](#))

220 Royal College of General Practitioners ([STP0043](#))

221 The Royal College of Speech and Language Therapists ([STP0049](#))

229. We also heard reports of limited clinical engagement in proposals that clearly affect specific professional groups. For example, despite plans to reconfigure acute hospitals within many of the plans, the Royal College of Emergency Medicine reported that clinical engagement of its members was widely considered to be poor or patchy.²²²

Conclusions and recommendations

230. Funding and workforce pressures on NHS, social care and public health services present significant risks to the ability of the NHS even to maintain standards of care, let alone to transform. Funding and workforce pressures, if not adequately addressed, risk compromising these fragile local relationships which are pivotal to transforming care. We are concerned about workforce and funding shortfalls in community services, primary care and mental health, which are seriously limiting the capacity to shift more services closer to individuals within their communities.

231. The NHS and local government have not been given adequate investment, support and time to embark on the scale of transformation envisaged. Transformation depends not only on having sufficient staff to maintain day-to-day running of services, but in the capacity and capability of staff to redesign services, engage in dialogue and consultation and develop new skills. Transformation also requires funding the staff costs associated with double-running new services, while old models are safely decommissioned.

232. The Government's long-term funding settlement should include dedicated, ring-fenced funding for service transformation and prevention. We recommend that the Government commit to providing dedicated transformation funding when it announces its long-term funding settlement this summer.

233. The task of determining the scale of funding and the most appropriate ways to allocate and manage such resources is a complex challenge. To inform this work we recommend:

- **Building on experience from the new care models programme and Greater Manchester, national and local bodies should form an estimate of the transformation funding they require to transition to new models of care at scale. This should include an estimate of funding required in each area to provide staff with the capacity to engage in transformation, develop new skills and facilitate the double running of services.**
- **Government and national bodies should develop clear proposals on how to allocate and manage this resource to ensure the best value for money.**

9 Oversight and regulation by national bodies

234. The health and social care landscape includes a complex national system of executive agencies, non-departmental public bodies and regulators, as well as the Department of Health and Social Care. The roles, responsibilities, legal powers and functions of these national bodies in many cases were introduced in statute by the Health and Social Care Act 2012.

235. These bodies are responsible for a complex range of interrelated and interdependent functions. The extent to which these bodies collaborate has a significant bearing on the operating landscape NHS and social care providers work within. This chapter describes the key concerns we heard about the role of national bodies in the development of sustainability and transformation plans.

Incoherent approach by national bodies

236. There is a widespread perception, particularly from health and social care providers and commissioners, including their representative bodies, of competing priorities between the key national bodies, particularly the Department of Health and Social Care, NHS England, NHS Improvement and the Care Quality Commission. This incoherence is manifested not only through conflicting policies, but also through the mixed messages local organisations receive from these national bodies.

237. Incoherent messages and priorities between NHS England and NHS Improvement have been evident since the beginning of the STP process in December 2015.²²³ The King's Fund's report on the development of the original sustainability and transformation plans concluded that there was a need for closer alignment, and clearer messages, between NHS England and NHS Improvement as well as from regional teams within these organisations.²²⁴ These inconsistencies between NHS England and NHS Improvement have persisted.

238. Local organisations, according to the National Audit Office, have continued to receive inconsistent messages from NHS England and NHS Improvement. For example, NHS England has encouraged local areas to explore the use of new payment systems that incentivise better ways of managing demands, whereas NHS Improvement has advised NHS providers to use payment by results to maximise their income, thereby improving the financial position of their individual organisations rather than that of the system.²²⁵

239. Simon Stevens, Chief Executive of NHS England, and Ian Dalton, Chief Executive of NHS Improvement, both acknowledged that their organisations need to do more to provide consistent messages to those on the frontline. Ian Dalton said that:

223 The King's Fund, [Sustainability and Transformation Plans in the NHS: How they are being developed in practice?](#), November 2016, para 3.17

224 The King's Fund, [Sustainability and Transformation Plans in the NHS: How they are being developed in practice?](#), November 2016

225 National Audit Office, Sustainability and transformation in the NHS, January 2018 Session 2017–19 HC719

if we expect the NHS to integrate and to work together across different bits of the NHS, then we, as the local superstructure that supports the front-line, even if we do not deliver care directly to patients, must give consistent and clear messages.²²⁶

240. Since our oral evidence session, NHS England and NHS Improvement have published commitments setting out how they intend to work more collaboratively. From September 2018, the seven regional teams of NHS England and NHS Improvement will be led by one regional director working for both organisations. Also, where possible, the two bodies will integrate and align national programmes and activities. These changes are intended to ensure both organisations provide coherent messages, reduce duplication, use resources more effectively and, most importantly, are better equipped to work with commissioners and providers in breaking down barriers between health and care services.²²⁷

241. We welcome these commitments, although we are aware that sometimes the rhetoric of national leaders can be at odds with local bodies' experience of their regional arms. Professor Chris Ham, Chief Executive of The King's Fund, told us:

They are becoming more aligned, and they are making efforts to do that by having a single regional director across the two regulators to relate to places like Cornwall, but the lived experience of leaders in the NHS is that it often does not feel like that. There may be alignments at the top between Simon Stevens and Ian Dalton, or indeed at a regional level, but when it comes to the day-to-day interactions of places like Cornwall you get very mixed messages.²²⁸

242. To assess whether the commitments by NHS England and NHS Improvement to align priorities and incentives at national level have made a tangible difference to those on the frontline, we encourage those organisations to conduct a joint survey one year after their announcement on 27 March 2018. The real test will be whether this makes a positive difference at local level.

243. More joint working, clear priorities and consistent messages are positive steps forward. However, it is not clear how the suite of national bodies, particularly the Department of Health and Social Care, NHS England, NHS Improvement, Health Education England, Public Health England and CQC, and their respective roles, functions, policies and powers, interact to provide an effective approach to driving the move towards more integrated care.²²⁹

Focus on individual organisations rather than placed-based care

244. Structurally, the main problem with the existing national bodies is that they were originally created, in some cases, to drive improvement through choice and competition between a diverse and autonomous landscape of providers. Since the NHS Five Year Forward View was published national bodies have taken positive steps, within the scope of their existing legal structures, to promote more placed-based care. Ian Dalton, Chief

226 Q361 [Ian Dalton]

227 NHS England, NHS England and NHS Improvement: working closer together, 27 March 2018 accessed on 2 June 2018

228 Q243 Professor Chris Ham

229 The Health Foundation ([STP0116](#))

Executive of NHS Improvement, argued that the Single Operating Framework for NHS trusts and foundation trusts makes clear that NHS providers should “work together to join up care for their populations, and to be part of that strategic move locally.” Ian Dalton argued that:

We have moved a long way from the caricature of a hospital being able clinically to stand on its own. That is not the model that necessarily exists going forward. We will play our part.²³⁰

245. This is encouraging, although the widespread perception, particularly from NHS providers and commissioners, is that the operation of the national system, whether fully intended or not, continues to perpetuate behaviours that act against the needs of local systems. NHS Clinical Commissioners described how even more recent policy changes present barriers to place-based care:

The development of different control totals for providers and commissioners, the focus of the inspection and regulatory regime on individual organisations, and the supportive interventions that are undertaken, often with a lack of cross-organisational communication, all undermine the development of a coherent local approach to service development and delivery and encourage a retreat into organisational silos. Our members’ view is that top-down intervention and performance measurement may be the greatest barrier to local relationship building.²³¹

246. To introduce a national structure that is more conducive to place-based care would in many instances require primary legislation.

Support directed at those furthest ahead

247. We heard repeatedly during our inquiry how the allocation of support and resources by national bodies have been targeted towards those local areas that are furthest ahead, leading to the likelihood of perpetuating “success to the successful”, with the risk of leaving less advanced local health economies further behind.²³²

248. As well as preferential receipt of funding, particularly capital funding, the more advanced local areas, particularly integrated care systems, have benefited from more autonomy and support, which are described in more detail in Chapter 4. Describing the factors that have contributed to differences in the progress of local areas so far, Saffron Cordery from NHS Providers told us that:

One of the factors that underpins the diversity is that those right at the front, the top five—I do not want to rank them necessarily—that have been making real progress have been fully supported by the national system, so there is a full support programme in place.²³³

230 Q360 Ian Dalton

231 NHS Clinical Commissioners ([STP0064](#))

232 Q248 [Nigel Edwards]

233 Q203 [Saffron Cordery]

249. Niall Dickson described how STPs in the middle of the performance curve often feel neglected by national bodies, while often those at the bottom find that the approach adopted centrally exacerbates, rather than alleviates, the difficulties they experience.²³⁴ Speaking about those at the bottom of the performance curve Niall Dickson said that:

There is a sense in which some organisations find themselves in a really difficult position. Just taking their STF money away from them is like somebody digging a hole. Instead of the regulator helping them to get out of the hole, they jump in with a larger spade and dig even faster. I think the regulators have started to do some of those things, but the whole system of how we performance-manage the process needs to be looked at.²³⁵

250. Instead of targeting resources at those furthest ahead, we heard that national bodies should describe how they plan to offer “differential support to different STPs depending on where they are on their journey.”²³⁶ Professor Chris Ham from The King’s Fund told us how NHS England and NHS Improvement have begun to provide this sort of development and support at a small scale.²³⁷

251. One option is to extend some of the benefits given to integrated care systems to other areas. For example, Simon Whitehouse from Staffordshire and Stoke-on-Trent STP argued the case for greater autonomy, funding and resources to be targeted towards areas that are less advanced:

With Staffordshire and Stoke-on-Trent being one of the more challenged areas in terms of both performance and financial viability, we have a real challenge. We need some of the flexibilities that are being offered and talked about in the more successful parts of the patch to enable us to make the scale of changes we need to make, but the resource, effort and focus is going to areas that are doing really well; they are advanced and probably had strong and robust relationships in place previously to enable some of that to happen. I would make the case, and articulate really strongly, that while we understand that and we need to learn from those areas, if all of that resource and effort goes into the ones that are at the leading or cutting edge, we are creating an even greater gap in terms of what that looks like.²³⁸

Role in accelerating improvement and new care models across the system.

252. There is a widespread concern that the pace of transformation is too slow. A survey of NHS trusts and foundation trusts by NHS Providers in April 2017 found that 62% of local leaders were concerned that their local area was not transforming fast enough.²³⁹ Nevertheless, during our inquiry we have seen and heard of encouraging examples where local efforts to pilot new, more integrated, ways of delivering care, such as the vanguard

234 Q226 [Niall Dickson]

235 Q226 [Niall Dickson]

236 Q203 [Saffron Cordery]

237 Q252 [Professor Chris Ham]

238 Q181 [Simon Whitehouse]

239 NHS Providers ([STP0050](#))

programme or local initiatives such as the Primary Care Home Model, have resulted in benefits to patient care. However, it is unclear how these positive examples will be scaled up and spread at pace across the system.

253. The Department of Health and Social Care and the other national bodies recognise the widespread variation in performance and progress across the system. The Minister of State for Health, Stephen Barclay MP, said:

The NHS is very good at pilots and innovation, partly because it has brilliant people who will innovate. Where I think its performance needs to improve is in how it industrialises that innovation across the system.²⁴⁰

254. National bodies are clear that a critical task will be to accelerate progress in local areas that are less well advanced. NHS England's National Medical Director, Professor Steve Powis, told us:

I agree that that is the challenge, to focus on how those systems that are further back in their development can be brought up to the levels of the systems that we have been describing.²⁴¹

255. The 10-point efficiency plan described in the Next Steps to the NHS Five Year Forward View mandated a series of efficiency opportunities to be pursued across the NHS to contain rising cost pressures on the system. Within the list of mandated efficiencies, there are several recommendations which relate to improving patient care and experience through prevention, better self-management of existing conditions and more joined-up working between services.²⁴²

256. What is not clear from the evidence we have received during this inquiry, including from national bodies themselves, is how the arms-length bodies, particularly NHS Improvement and NHS England, are seeking to accelerate the scale-up and spread of transformative changes to the delivery of care, such as the new models of care.

257. Three main ways national bodies described their role in accelerating transformation were clinical leadership, intelligent transparency and opportunities to learn from those furthest ahead, either through direct support or the sharing of best practice. However, there was no clearly articulated approach which explained the role of national bodies.

258. Efforts by national bodies to facilitate learning and share best practice have included “speed-dating” sessions for local leaders in different health systems to learn from those furthest ahead, such as South Yorkshire.²⁴³ NHS England is also planning to publish learning reports to share best practice from the vanguard programme.²⁴⁴ Similarly, with regard to intelligent transparency (the use data to highlight variations in performance), Simon Stevens informed the Committee of Public Accounts that initiatives such as NHS Right Care are programmes that are “now being layered across the country.”²⁴⁵

240 Q396 Stephen Barclay

241 Q311[Professor Powis]

242 NHS England, [Next Steps on the NHS Five Year Forward View](#), March 2017, pages 38–54

243 Q311 [Steve Powis]

244 Q397 Jonathon Marron

245 Oral evidence to the Committee of Public Accounts 5 March 2018, Session 2017–19, HC 793 Q103 [Simon Stevens]

259. We support all of these approaches. Holding up a mirror to local organisations so that stark variations in the quality and efficiency of patient care are clear is undoubtedly a useful tool to drive improvement, especially where such programmes are led by those with clinical expertise, as is the case with NHS Right Care and the Getting it Right First Time initiative.

260. Opportunities to share best practice between local areas, particularly from vanguards and integrated care systems, also have their place. For example, Professor Chris Ham described how the experience of integrated care system leaders could be utilised to accelerate progress:

Part of it is drawing on the experience of those already in the advance guard, if you like, of STPs and, now, integrated care systems, and using their experience and expertise to help those coming along behind. If we have 10, hopefully, in a year's time we will have 20, and the people leading this work in Manchester, Nottingham, Bedfordshire, Luton, Milton Keynes and elsewhere will be able to free up some of their time to work with the second wave and perhaps the third wave coming along behind.²⁴⁶

261. There are challenges and trade-offs for national bodies in the approach they decide to take to capture and share lessons from the first wave of integrated care systems. For example, introducing buddying arrangements to enable those furthest ahead to support the less well-advanced areas could arguably slow the progress of the frontrunners.²⁴⁷ This is not a valid reason not to capture and share lessons, but rather a risk that should be considered and mitigated. However, the greatest risks to accelerating progress are the lack of proper finance and the workforce capacity to design and implement change.

262. We also support NHS England and NHS Improvement's intention to explore the role clinical leadership can play in accelerating changes across the system. There is ubiquitous support and enthusiasm for integrated care across health and social care, including clinical leaders and senior managers. A clear message from this inquiry is that many have spent large parts of their careers trying to integrate care for patients.

263. Simon Stevens has acknowledged that frontline staff and local leaders across the health and social care sector "are busy people and they are not out touring the country on fact-finding missions."²⁴⁸ Many are overwhelmed by the task of maintaining quality standards and making efficiencies in the face of significant shortfalls in staff.

264. National bodies' answer to the question of how they drive improvement fails to acknowledge the importance of ensuring staff have the capacity to engage in transformation by finding time outside of the day job to build relationships and think through the complexities of how different services and professionals collaborate. In such a scenario, Professor Chris Ham argued that:

Part of what the national bodies can do is no harm, and to get out of the way, facilitate and support people at a local level to do more of the good things already happening, and extend that to more areas. I want to be

246 Q251 [Professor Chris Ham]

247 Q253 [Professor Chris Ham]

248 Oral evidence to the Committee of Public Accounts 5 March 2018, Session 2017–19, HC 793 Q106 [Simon Stevens]

realistic, being a natural optimist: given the huge financial pressures on the system, and that there is absolutely a focus on sustainability as well as transformation, this will take time.²⁴⁹

Conclusions and recommendations

265. Local bodies' experience of their national counterparts is one of competing priorities that perpetuate existing divides between services and encourage organisations to retreat into individual silos. While this appears to be improving, we have not heard clear and compelling evidence that the interventions of national bodies reinforce and enable more integrated, place-based care. Incoherence in the approach of national bodies is a key factor holding back progress.

266. We heard, and saw, outstanding examples of great care that frontline services have been able to build, implement and maintain even in periods of constrained resources. We also heard of promising results from the new care models programme. However, how national bodies plan to scale up and spread best practice and accelerate transformation across the system remains unclear.

267. We recommend that the Department of Health and Social Care and national bodies, particularly NHS England, NHS Improvement, Health Education England and the Care Quality Commission, clearly describe as part of a national transformation strategy how each of the bodies will work together to support transformation.

268. We request a joint response from the Department of Health and Social Care, NHS England, NHS Improvement, Health Education England and CQC setting out, against each of the following headings, how their roles, responsibilities, functions and policies support the following factors that are critical to transformation and integrated care.

- Skills and capacity of frontline staff;
- NHS leadership;
- Financial incentives;
- Infrastructure, particularly digital infrastructure; and
- Coherent oversight and regulation.

The response should include details of plans the national bodies have over the next year to make progress on each of these areas.

269. NHS England and NHS Improvement should systematically capture, distil and disseminate key lessons from the local areas that are furthest ahead, including the governance arrangements and service models used in these areas. Careful attention should be played to striking a balance between learning from the frontrunners and not overburdening these areas. We recommend that NHS England and NHS Improvement undertake a review of the first cohort of integrated care systems starting in April 2019, and make the key findings available to all STP areas. That should include the level of financial support underpinning transformation.

10 Governance and legislation

270. The current legislation does not prohibit collaborative working or integrated care, but neither was it designed to enable it.²⁵⁰ Rather, the legislation was intended for a different purpose: to facilitate choice and competition within the NHS. As described in Chapter 2, reforms by successive governments from the 1990s through to the Health and Social Care Act 2012 extended the role of market forces in the NHS. These reforms, and structural divides imposed since the NHS's creation, in some instances present obstacles to collaborative working.

271. Procurement regulations covering the tendering of NHS contracts and criteria for mergers between NHS organisations, as well as the autonomy and flexibilities provided to foundation trusts (e.g. their ability to generate income from private work) were designed to facilitate choice and competition. Chapter 8 describes how the legal duties and powers of national bodies in many instances were set up to oversee, protect and incentivise diverse local health and care economies in which autonomous organisations compete.

272. Sustainability and transformation partnerships, integrated care systems, integrated care partnerships and an Accountable Care Contract, if and when it is introduced, are all pragmatic responses to constraints imposed by the current legal framework in which health and social care services operate.

273. Some witnesses told us that introducing STPs, integrated care systems and accountable care organisations into legislation would be a significant undertaking. However, there are trade-offs to make. As we describe in this chapter, working within the existing legislation means health and social care services are operating with significant governance risks, and this has potential implications for patients and local communities.

274. This chapter sets out the main problems and challenges posed by the current legislation and views on legislative reform, particularly the timing of primary legislation and the Government's approach to legislative reform.

Governance and accountability arrangements

275. Remaining within the existing legislation carries significant risks for local bodies. Sustainability and transformation partnerships and integrated care systems bring together clinical commissioning groups, NHS trusts and foundation trusts and local councils. The governance arrangements of these organisations are complex for the following reasons:

- a) The legal decision-making powers rest with the organisations involved rather than the STPs or ICSs. These constituent NHS and local government bodies have different legal duties and powers. For example, local councils are democratic institutions in their own right, and are unable to run a deficit, unlike NHS bodies.
- b) STPs and ICSs often have a large number of bodies. The smallest partnership is made up of six organisations, whereas the largest has 42.

- c) The size of the population covered by these partnerships also varies considerably, from 312,000 to 2.8million patients.
- d) All partnerships were formed in a short space of time and the boundaries of some areas were imposed. These boundaries do not always align with organisational boundaries or patient flows.
- e) For many local leaders, the relationships in these partnerships are still relatively new. Many do not have the same history of collaborative working, which is evident in the leading integrated care systems.

276. In the Next Steps on the NHS Five Year Forward View, NHS England and NHS Improvement announced a basic governance structure to support sustainability and transformation partnerships. The document prescribed that from April 2017 each local sustainability and transformation partnerships must form an STP board from existing partners, including local government and primary care where possible, and establish “formal CCG Committees in Common or other appropriate decision-making mechanisms where needed for strategic decisions between NHS organisations.”²⁵¹

277. Despite the fact that STPs and ICSs are not legal entities, national bodies in their oral evidence sought to assure us of the strength and clarity of the legal accountabilities of the local bodies. Ian Dalton, Chief Executive of NHS Improvement, stated:

Certainly when I was a hospital chief executive, before I came to NHSI, I was very interested in joining up care, but I also felt that both in law and in my own personal aspirations for patients that the quality of care was on my shoulders, as the person running the health services provided by those five hospitals. None of the arrangements that we have been talking about today in any way alters that.²⁵²

278. The concern that was expressed to us was that the local health and social care providers and commissioners are operating with significant risks to their governance and decision-making, as these arrangements increase the distance of decision-makers from the decisions they are taking.²⁵³ For example, Saffron Cordery, Deputy Chief Executive of NHS Providers, explained that STPs and ICSs “impact on the level of risk, and on governance, accountability and lines of sight over what we are doing.”²⁵⁴

279. Operating in this way is also time consuming. Proposals agreed at an STP level must be taken back and approved by the boards of the partner organisations.²⁵⁵ Local leaders we have heard from during this inquiry described the concerns they have about ensuring all the bodies continue to collaborate. As Rob Webster, Chair of the West Yorkshire STP, told us, “change proceeds at the speed of trust.”²⁵⁶

251 NHS England, [Next Steps on the NHS Five Year Forward View](#), March 2017, page 33

252 Q351 [Ian Dalton]

253 Q209 Saffron Cordery

254 Q209 Saffron Cordery

255 Q222 Julie Wood

256 See Annex 1

280. Julie Wood, Chief Executive of NHS Clinical Commissioners, explained that “what the systems are trying to do locally is make sure that their governance and accountability, where they are working across a bigger geography, is clear, so that there is clear accountability for the decisions they are taking.”²⁵⁷

Procurement

281. The most limiting aspect of the existing framework are requirements covering clinical commissioning groups’ procurement of NHS services. Julie Wood explained that procurement regulations pose immediate obstacles to collaborative working:

It is where our current systems are running close to where the legislation ends. Our new system of working together in an integrated way depends much more on collaboration between organisations, and at one point that pushes up against the procurement and competition elements you talked about earlier.²⁵⁸

282. NHS commissioners through these arrangements are unable to discriminate between bidders based on the type of ownership (e.g. whether they are public, private or voluntary). Unless the scope of services contracted means there is only one credible bidder, NHS providers compete with each other, as well as non-statutory providers, for NHS contracts. As well as the consequent fragmentation of service delivery, this process is widely described as time-consuming and costly. For example, Paul Maubach from Dudley CCG explained:

It would be quite helpful if we were not legally required to go through a procurement process, because it is very time-consuming. If we have a system that is working well, to be able to switch from the current NHS standard contract to an ACO contract without the need for procurement would be extremely helpful because it would speed up the process significantly.²⁵⁹

Views on legislative reform

283. The legal requirements imposed by the Health and Social Care Act 2012, and its ethos around competition, are widely considered to be a barrier to integrating care. During our inquiry we heard that the law will need to change if we are to best realise the transition to more integrated, place-based care. However, demands on parliamentary time and civil services resources posed by Brexit create an extremely challenging background for introducing primary legislation. The arithmetic of a hung parliament may be a disincentive to bring forward health reforms, but also presents an opportunity if there is goodwill for cross-party collaboration.

284. This scenario has left national and local leaders with an imperative to move towards more collaborative working, but with little room for manoeuvre in which to do so. The current position of national bodies is that the changes that are being made are legal (although the legality of an ACO contract is subject to a judicial review) and that:

257 Q223 Julie Wood

258 Q209 [Julie Wood]

259 Q197 [Paul Maubach]

What we are not doing, as the NHS, is sitting back and projecting on to you guys as Parliament, and saying, “Until you do something, we are just going to sit here and let things fizzle on.” We are getting on with doing what we can to improve care for patients.²⁶⁰

285. We heard that repeated top-down reorganisations of the health service, including the changes made by the Health and Social Care Act 2012, mean there is little appetite from local leaders of health and social care services for major legislative reform, even if it would make the changes local leaders are making easier.

286. The existing legal context does not necessarily enable the collaborative relationships local leaders are building, and in places adds significant complexities for them to grapple with. However, the absence of prescriptive legislative proposals has meant local leaders can focus on developing their relationships and how local bodies work together. Imposing legislative reforms while local systems are still evolving was regarded as a potential distraction from transforming care.²⁶¹

287. This argument is echoed by national leaders. Noting that the history of the NHS “has not been short of reorganisations”, Sir Chris Wormald, Permanent Secretary at the Department of Health and Social Care, told the Committee of Public Accounts that the Department and national bodies had taken the decision not to spend “another several years redrawing the map of the NHS,” but instead to focus on relationships between professionals. According to Sir Chris:

Most of the things we are describing as transformation come down to how clinicians and others relate to each other, not the organisations that they sit within.²⁶²

288. Proponents of introducing more immediate changes to primary legislation made the case that working around the existing legal framework bypasses the important role Parliament plays in providing public accountability and scrutiny. Dr Graham Winyard, former National Medical Director for the NHS and an advocate of integrated care, expressed grave concerns about the way integrated care is being implemented. The crux of Dr Winyard’s argument is that:

In normal times, there would be absolutely no doubt that changes of this magnitude would be brought about by primary legislation following public consultation and proper Parliamentary scrutiny. Instead Parliament is perceived as paralysed, not least by Brexit, and incapable of addressing serious NHS issues. The resultant work-arounds being adopted by NHS England, with commercial contracts introduced to enable ACOs to function, themselves introduce a whole range of real dangers to the NHS.²⁶³

289. Professor Allyson Pollock and Dr Graham Winyard argued that it is possible to introduce primary legislation that allows changes to be worked out from the bottom up

260 Q319 [Simon Stevens]

261 SY&B note

262 Oral evidence to the Committee of Public Accounts on 5 March 2018 Session 2017–19 HC793 Q113 [Sir Chris Wormald]

263 Dr Graham Winyard ([STP0069](#))

and without any need to impose these changes on local bodies until they are ready, but with the advantage of providing clear public accountability when they do. According to Professor Pollock:

I think this is a false binary. It is perfectly possible to have legislation that allows for proposals to be worked out on the ground, and indeed Scotland did it over health and social care. They passed an Act of Parliament and it was worked out bottom up from the ground.²⁶⁴

290. There are strong arguments for wider changes to primary legislation. In the meantime, we support the current evolutionary approach to the development of STPs, integrated care systems, integrated care partnerships and accountable care organisations. However, lines of accountability for changes to local services must be clear and robust and decisions must be taken in a transparent way.

291. There are also immediate legal obstacles that the Government and national bodies should seek to address to enable local areas to progress before primary legislation can be introduced. One example of an immediate obstacle was presented to us by Ian Williamson, Chief Accounting Officer for Manchester Health and Care Commissioning, who described how differences in VAT exemptions covering NHS and local government pose significant financial implications for the local area's plans to introduce accountable care.²⁶⁵

292. Simon Stevens did not suggest any aspects of the current legal framework that need to change imminently, although he committed to keeping us informed of any frictions that arise as the NHS proceeds towards more integrated care. We welcome NHS England's commitment to keep us informed and we will be following this matter closely.

293. Niall Dickson, Chief Executive of the NHS Confederation, presented a view which was echoed by many stakeholders, in saying:

There will come a time when Parliament will have to intervene and set out a new form of legislation. I hope it is approached in a very different and much more consultative way, which allows for greater flexibility at local level, but nevertheless gives ordinary users of the service guarantees about what they can find in their local area, because it is still a national service and still needs to be. It needs visible governance and accountability.²⁶⁶

294. There is widespread support for a bottom-up and evolutionary approach to change, but we also heard calls, often from the same organisations, for more clarity about what the future health and social care landscape will look like, including the roles and functions of bodies within it.²⁶⁷ For example, clarity is needed on the role of commissioners within the system and which of the new structures are likely to be a permanent fixture and which are temporary solutions.

264 Q48 [Professor Pollock]

265 Q161 [Ian Williamson]

266 Q209 [Niall Dickson]

267 See Chapter 6.

Conclusions and recommendations

295. **Positive progress has been made within the constraints of the current legislative framework but sometimes requiring cumbersome workarounds. Our view is that national and local leaders have had little room for manoeuvre in which to transform care. We are concerned that many local areas are operating with significant risks in terms of their governance and decision-making.**

296. The law will need to change to fully realise the move to more integrated, collaborative, place-based care. There is an opportunity for the Government and the NHS to rebuild the trust previous reforms have eroded by developing legislative proposals. These proposals should be led by the health and care community to shape the future health and social care landscape. In the meantime, Government and national bodies should do more to provide clarity and guidance on what is possible within the current legal framework.

297. **The law will need to change. We recommend that Parliamentarians across the political spectrum work together to support the legislative changes to facilitate evolutionary change in the best interests of those who rely on services.**

298. **The Department and national bodies should adopt an evolutionary, transparent and consultative approach to determining the future shape of health and care. The Department and NHS England should establish an advisory group, or groups, comprised of local leaders from across the country, including areas that are more advanced and those further behind, and representatives from the health and care community, to lead on and formulate legislative proposals to remove barriers to integrated care. The proposals should be laid before the House in draft and presented to us to carry-out pre-legislative scrutiny.**

299. **The purpose of legislative change should be to address problems which have been identified at a local level which act as barriers to integration in the best interest of patients. We wish to stress again that proposals should be led by the health and care community.**

300. **Evidence we have heard from representatives from NHS and local government has identified the following legislative areas that may need to be considered:**

- a) **A statutory basis for system-wide partnerships between local organisations;**
- b) **Potential to designate ACOs as NHS bodies, if they are introduced more widely;**
- c) **Changes to legislation covering procurement and competition;**
- d) **Merger of NHS England and NHS Improvement; and**
- e) **CQC's regulatory powers.**

Where barriers are identified and can be removed with secondary legislation, this may represent a less complex way forward.

301. **Until legislation is introduced, national bodies should support local areas to develop transparent and effective governance arrangements that allow them to make**

progress within the current framework. National bodies should also provide greater clarity over what is permissible within current procurement law and develop support for local areas in working through these issues. National bodies should set out the steps they plan to take to provide clarity, guidance and support to local areas on these matters in response to this report.

11 Conclusion: A call to action

302. Integrating care leads to clear benefits to patients' experience of care, particularly those living with long-term conditions. Support for integration of care at local level is widespread across the health and care community. Local leaders spoke with energy and enthusiasm about the potential of more integrated, placed-based care not only to improve the delivery of health and care services, but to address wider social problems and contribute to the growth and prosperity of local areas.

303. For these reasons, we support the move towards integrated care, in which collaboration, rather than competition, is the organising principle of the health and social care system in England.

304. Historically, progress towards integrated care has been slow. Serious pressures facing the system have led national bodies to narrow their focus away from transformation and towards achieving financial balance. The Government and national bodies must act quickly to take the health and social care system out of survival mode and onto a more sustainable long-term footing. The current financial and workforce shortfalls present the greatest threat to successful transformation as organisations under extreme pressure have no space for reform.

305. Transformation is key to sustainability. To accelerate the progress towards integrated care, we recommend that the Government, together with the national bodies, develop over the next year a national transformation strategy, supported by:

- a) a dedicated transformation fund; and
- b) a clear narrative which describes the benefits of integrated care from the patient's perspective.

306. Whilst we recognise the need to make evolutionary progress within the current legal framework, there are strong arguments for wider changes to primary legislation. The purpose of legislative change should be to address problems which have been identified at a local level which act as barriers to integration in the best interest of patients. We wish to stress that proposals should be led by the health and care community. We recommend that Parliamentarians across the political spectrum work together to support the legislative changes that will facilitate evolutionary change in the best interests of those who rely on services.

307. Patient care must remain the focus. Delivering better care for patients at the front line is what motivates and unites health and care professionals and the wider sector. Integration depends on services putting patients at the centre, joining up around them, sharing information and working with them to meet their needs, priorities and goals. The recommendations of this report are intended to assist the Department of Health and Social Care, national bodies, local NHS organisations and local government to achieve those aims. The most important test of all, however, is whether this translates into better care for patients.

Integrated care: glossary of terms

Integrated care

There are numerous definitions of integrated care. There are also different levels at which care can be integrated: patient-level, service-level and organisational-level (see Chapter 2). NHS England's current definition of integrated care is care that is "person-centred, coordinated, and tailored to the needs and preferences of the individual, their carer and family. It means moving away from episodic care to a more holistic approach to health, care and support needs, that puts the needs and experience of people at the centre of how services are organised and delivered."²⁶⁸

Placed-based care

Place-based care involves local service providers collaborating and sharing the resources available to them to improve health and care for the populations they serve. This concept has been extended to planning and commissioning of services through examples such as sustainability and transformation partnerships and integrated care systems.

Accountable care

Accountable care refers to an organisation or organisations taking responsibility for the health and care of a defined population within a set budget. Accountable care, according to The King's Fund, is a synonym for integrated care, as it is built on organisations working together to meet the needs of their local population.²⁶⁹ Another benefit of accountable care is that holding a set budget for the health and care of a local population incentivises providers to improve population health. ICSs, ICPs and ACOs are all expressions of accountable care.

Sustainability and transformation partnerships

Sustainability and transformation partnerships are made up of NHS organisations, including clinical commissioning groups (CCGs), NHS trusts and foundation trusts and primary care services, as well as local authorities. They were originally established to produce a plan setting out how they planned to deliver the NHS Five Year Forward View, but have since become a mechanism for delivering other national priorities. There are 44 partnerships across England. The number of bodies involved in these partnerships and the size of the STP population varies considerably. They are a mechanism in which local bodies can plan changes to the shape of health and social care services locally. However, the partnerships are not legal entities and do not have authority to take forward decisions themselves. Decisions must be agreed separately by the organisations involved.

The forty-four footprints cover the whole of England, but vary considerably in the size of the area they cover and the populations they serve.

268 NHS England, Integrated care and support, accessed on 2 June 2018

269 The King's Fund, Making sense of accountable care, January 2018

Sustainability and transformation plans

NHS organisations were asked to come together, with local government and primary care where possible, to create local blueprints for delivering the NHS Five Year Forward View, known as sustainability and transformation plans (STPs). These plans were published in December 2016 (see Chapter 4).

Sustainability and transformation footprints

Sustainability and transformation footprints refer to the geographical boundaries of STPs (see Chapter 4).

Integrated care systems (ICSs)

According to The King's Fund, integrated care systems in an area are taking more collective responsibility for “planning and commissioning care for their populations and providing system leadership” (see Chapter 4). ICSs have evolved from STPs, but are not legal entities. There are 10 ICSs which are setting a path for the remaining areas to progress to this status.²⁷⁰

New care models

The NHS Five Year Forward View announced the creation of new ways of delivering care which blurred the traditional boundaries between services. These have been piloted across 50 sites in England. For example, integrated primary and acute systems, is a new model of care which joins up hospitals with community and mental health services as well as primary care.

Integrated care partnerships (ICPs)

ICPs are alliances between hospitals, community services, mental health services and GPs, but may also include social care and third sector providers. Providers in these alliances collaborate rather than compete to deliver health and care services for their local populations.

Accountable care organisations (ACOs)

ACOs in the US were established by the US Affordable Care Act 2010. ACOs vary widely. This is important as they are likely to take a very different form when introduced to the NHS in England. The King's Fund argue ACOs are likely to be:

a more formal version of an ACP that may result when NHS providers agree to merge to create a single organisation or when commissioners use competitive procurement to invite bids from organisations capable of taking on a contract to deliver services to a defined population.²⁷¹

270 The King's Fund, Making sense of accountable care, January 2018

271 The King's Fund, Making sense of accountable care, January 2018

Conclusions and recommendations

Integrating care for patients

1. The Department of Health and Social Care, NHS England and NHS Improvement should clearly define the outcomes the current moves towards integrated care are seeking to achieve for patients, from the patient's perspective, and the criteria they will use to measure whether those objectives have been achieved. (Paragraph 12)

Progress towards more integrated care

2. More joined-up, coordinated and person-centred care can provide a better experience for patients, particularly those with multiple long-term conditions. However, progress to achieving these benefits has been slow. There is no hard evidence that integrated care, at least in the short term, saves money, since it may help to identify unmet need, although there is emerging evidence from new care models that it may help to reduce the relentless increase in long-term demand for hospital services. (Paragraph 41)
3. More integrated care will improve patients' experience of health and care services, particularly for those with long-term conditions. However, the process of integrating care can be complex and time consuming. It is important not to over-extrapolate the benefits or the time and resources required to transition towards more integrated care. (Paragraph 42)
4. The Government should confirm whether it is able to meet the current target to achieve integrated health and care across the country by 2020, as well as plans for 50% of the country to be covered by new care models. These targets should be supplemented by more detailed commitments about the level of integrated care patients will experience as a result. (Paragraph 43)
5. We support the move towards integrated, collaborative, place-based care. To help deliver more integrated care for patients we advocate the cultivation of diverse local health and economies, comprised of mostly public, but also some non-statutory provision, in which the organising principle is centred on collaboration and quality rather than financial competition. We consider that this diversity is important for protecting patient choice and with proper oversight and collaborative working may facilitate, rather than impede, joined-up, patient-centred and co-ordinated care. (Paragraph 44)

Sustainability and transformation boundaries, plans, partnerships and integrated care systems

6. STPs got off to a poor start. The short timeframe to produce plans limited opportunities for meaningful public and staff engagement and the ability of local areas to collect robust evidence to support their proposals. Poor consultation, communication and financial constraints have fuelled concerns that STPs were secret plans and a vehicle for cuts. These negative perceptions tarnished the reputation of STPs and continue

to impede progress on the ground. National bodies' initial mismanagement of the process, including misguided instructions not to be sharing plans, made it very difficult for local areas to explain the case for change. (Paragraph 64)

Sustainability and transformation boundaries

7. An STP area, or areas within it, work more effectively where they are meaningful to partners, local health professionals and most importantly the public. STPs, particularly those with more complex geographical boundaries, should be encouraged and supported to allow local areas to identify, define and develop meaningful boundaries within their patch in which local services can work together around the needs of the population. (Paragraph 73)
8. STPs should be encouraged to adopt a principle of subsidiarity in which decisions are made at the most appropriate local level. NHS England and NHS Improvement should set out in their planning guidance for 2019/20 advice and support to achieve these recommendations. (Paragraph 74)

Sustainability and transformation partnerships

9. Sustainability and transformation partnerships provide a useful forum through which local bodies can come together in difficult circumstances to manage finite resources. However, they are not on their own the solution to the funding and workforce pressures on the system. We are concerned that these pressures, if not adequately addressed, may threaten the ability of local leaders to meet their statutory obligations let alone transform services. Overwhelming and unrealistic financial pressure drives them to retreat back to organisational silos. This would seriously undermine the progress local leaders have made in already difficult circumstances. (Paragraph 91)
10. We recommend that the national bodies, including the Department, NHS England, NHS Improvement, Health Education England, Public Health England and CQC, develop a joint national transformation strategy. This strategy should set out clearly how national bodies will support sustainability and transformation partnerships, at different stages of development, to progress to achieve integrated care system status. This strategy must not lose sight of patients. National bodies in this strategy should:
 - set out how national bodies plan to support local areas to cultivate strong relationships;
 - strengthen the programme infrastructure of STPs;
 - consider whether, and if so how, support, resources and flexibilities currently available to integrated care systems could be rolled out to other areas to help them manage pressures facing their local areas;
 - develop a more sophisticated approach to assess the performance of STPs and their readiness to progress to integrated care status. This should include an assessment of local community engagement, the strength of local relationships and the progress towards preventative and integrated care.

An assessment of prevention should encompass a broader definition than preventing demands on hospitals and integration should focus on how to improve patients' experience of and outcomes from services. (Paragraph 93)

Integrated care systems

11. We support the development of integrated care systems, including plans to give greater autonomy to local areas as part of their ICS status. We are encouraged by the positive progress the first 10 integrated care systems have made in the face of challenges on the systems. However, like STPs more generally, we are concerned that funding and workforce pressures on these local areas may exacerbate tensions between their members and undermine the prospect of them achieving their aims for patients. (Paragraph 105)
12. NHS England and NHS Improvement should systematically capture and share learning from areas that are furthest ahead, including their governance arrangements and service models, to accelerate progress in other areas and also to provide clarity about what is permissible within the current legal framework. (Paragraph 106)
13. We recommend, as part of a joint national transformation strategy, that national bodies clarify:
 - a) how they will judge whether an area is ready to be an ICS;
 - b) how they will support STP areas to become ICSs;
 - c) what they will do in areas that fail to meet the criteria;
 - d) how they will monitor the performance of existing ICS areas and provide support including the necessary funding to ensure they continue to make progress; and
 - e) how they will address serious performance problems in ICS areas. (Paragraph 107)
14. Given the controversy surrounding the introduction of accountable care organisations in the English NHS, we believe piloting these models before roll-out is advisable. There should be an incremental approach to the introduction of ACOs in the English NHS, with any areas choosing to go down this route being carefully evaluated. (Paragraph 140)
15. The evaluation of ACOs should seek to assess:
 - the benefits and any unintended consequences of these structures compared with improving joint working through integrated care partnerships.
 - The implications of the scope of the ACO contract, particularly whether hospital services, GP practices and social care should be incorporated, either in a partially integrated or fully integrated capacity.
 - the impact of ACOs on decision-making processes, objectives and incentives for staff and the resilience of services outside of hospitals.

- the impact on patient choice.

We do not believe it is in the best interests of patients to return to a system devoid of choice. (Paragraph 141)

Accountable care organisations

16. We recognise the concern expressed by those who worry that ACOs could be taken over by private companies managing a very large budget, but we heard a clear message that this is unlikely to happen in practice. Rather than leading to increasing privatisation and charges for healthcare, we heard that using an ACO contract to form large integrated care organisations would be more likely to lead to less competition and a diminution of the internal market and private sector involvement. (Paragraph 155)
17. We recommend that ACOs, if a decision is made to introduce them more widely, should be established in primary legislation as NHS bodies. This will require a fundamental revisiting of the Health and Social Care Act 2012 and other legislation. Whilst we see ACOs as a mechanism to strengthen integration and to roll back the internal market, these organisations should have the freedom to involve, and contract with, non-statutory bodies where that is in the best interests of patients. (Paragraph 156)
18. These mechanisms are no substitute for effective solutions to funding and workforce pressures, but if well designed and implemented they can represent a better way to manage resources in the short-term, including using the skills of staff more effectively on behalf of patients. (Paragraph 167)

Making the case for change to the public

19. STPs, ICSs and ICPs currently have to work within the constraints of existing legislation and manage rising pressures with limited resources. This context limits progress towards integrating care for patients. (Paragraph 181)
20. Some campaigns against privatisation confuse issues around integration. Concerns expressed about the ‘Americanisation’ of the NHS are misleading. This has not been helped by poor communication of the STP process and the language of accountable care, neither of which have been adequately or meaningfully co-designed or consulted on with the public or their local representatives. (Paragraph 182)
21. We recommend that the efforts to engage and communicate with the public on integrated care which we refer to above should tackle head-on the concerns about privatisation, including a clear explanation to the public that moves towards integrated care will not result in them paying for services. (Paragraph 183)
22. We recommend that national bodies take proactive steps to dispel misleading assertions about the privatisation and Americanisation of NHS. The Department should publish an annual assessment of the extent of private sector in the NHS, including the value, number and percentage of contracts awarded to NHS, private

providers, charities, social enterprises and community interest companies. This should include an analysis of historic trends in the extent of private sector involvement over a 5–10-year period. (Paragraph 184)

23. There has not been a sufficiently clear and compelling explanation of the direction of travel and the benefits of integration to patients and the public. National and local leaders need to do better in making the case for change and how these new reforms are relevant to those who rely on services. The language of integrated care is like acronym soup: full of jargon, unintelligible acronyms and poorly explained. (Paragraph 202)
24. The Department of Health and Social Care and national bodies should clearly and persuasively explain the direction of travel and the benefits of these reforms to patients and the public. We recommend the Department and national bodies develop a narrative in collaboration with representatives of communities, NHS bodies, local government, national charities and patient groups. The messaging should be tested with a representative sample of the public. A clear patient-centred explanation, including more accessible, jargon-free, language, is an essential resource for local health and social care bodies in making the case for change to their patients and wider communities. (Paragraph 203)
25. Making the transition to more integrated care is a complex communications challenge covering a range of different services and patient populations. The case for change must be made in a way that is meaningful to patients and local communities. In addition to providing a clear narrative, in accessible language at a national level, the Department of Health and Social Care, NHS England and NHS Improvement should explain how they plan to support efforts to engage and communicate with the public. (Paragraph 204)
26. NHS England and NHS Improvement should make clear that they actively support local areas in communicating and co-designing service changes with local communities and elected representatives. (Paragraph 205)
27. Bringing local health and social care services together through STPs and ICSs to plan and organise care within their footprints is a much better way to manage constrained resources than the siloed, autonomous and competitive arrangements imposed by the Health and Social Care Act 2012. Our view is that STPs and ICSs are a pragmatic response to the current pressures on the system, rather than a smokescreen for cuts, but that these mechanisms are not a substitute for adequate funding of the system. Funding them properly, including access to ring-fenced transformation money, is necessary and would allow a far better assessment of their potential. (Paragraph 207)

Funding and workforce challenges

28. The NHS and local government have not been given adequate investment, support and time to embark on the scale of transformation envisaged. Transformation depends not only on having sufficient staff to maintain day-to-day running of services, but in the capacity and capability of staff to redesign services, engage in

dialogue and consultation and develop new skills. Transformation also requires funding the staff costs associated with double-running new services, while old models are safely decommissioned. (Paragraph 231)

29. The Government's long-term funding settlement should include dedicated, ring-fenced funding for service transformation and prevention. We recommend that the Government commit to providing dedicated transformation funding when it announces its long-term funding settlement this summer. (Paragraph 232)
30. The task of determining the scale of funding and the most appropriate ways to allocate and manage such resources is a complex challenge. To inform this work we recommend:
 - Building on experience from the new care models programme and Greater Manchester, national and local bodies should form an estimate of the transformation funding they require to transition to new models of care at scale. This should include an estimate of funding required in each area to provide staff with the capacity to engage in transformation, develop new skills and facilitate the double running of services.
 - Government and national bodies should develop clear proposals on how to allocate and manage this resource to ensure the best value for money. (Paragraph 233)

National oversight and regulation

31. To assess whether the commitments by NHS England and NHS Improvement to align priorities and incentives at national level have made a tangible difference to those on the frontline, we encourage those organisations to conduct a joint survey one year after their announcement on 27 March 2018. The real test will be whether this makes a positive difference at local level. (Paragraph 242)
32. Local bodies' experience of their national counterparts is one of competing priorities that perpetuate existing divides between services and encourage organisations to retreat into individual silos. While this appears to be improving, we have not heard clear and compelling evidence that the interventions of national bodies reinforce and enable more integrated, place-based care. Incoherence in the approach of national bodies is a key factor holding back progress. (Paragraph 265)
33. We heard, and saw, outstanding examples of great care that frontline services have been able to build, implement and maintain even in periods of constrained resources. We also heard of promising results from the new care models programme. However, how national bodies plan to scale up and spread best practice and accelerate transformation across the system remains unclear. (Paragraph 266)
34. We recommend that the Department of Health and Social Care and national bodies, particularly NHS England, NHS Improvement, Health Education England and the Care Quality Commission, clearly describe as part of a national transformation strategy how each of the bodies will work together to support transformation. (Paragraph 267)

35. We request a joint response from the Department of Health and Social Care, NHS England, NHS Improvement, Health Education England and CQC setting out, against each of the following headings, how their roles, responsibilities, functions and policies support the following factors that are critical to transformation and integrated care.
- Skills and capacity of frontline staff
 - NHS leadership
 - Financial incentives
 - Infrastructure, particularly digital infrastructure, and
 - Coherent oversight and regulation.

The response should include details of plans the national bodies have over the next year to make progress on each of these areas. (Paragraph 268)

36. NHS England and NHS Improvement should systematically capture, distil and disseminate key lessons from the local areas that are furthest ahead, including the governance arrangements and service models used in these areas. Careful attention should be played to striking a balance between learning from the frontrunners and not overburdening these areas. We recommend that NHS England and NHS Improvement undertake a review of the first cohort of integrated care systems starting in April 2019, and make the key findings available to all STP areas. That should include the level of financial support underpinning transformation. (Paragraph 269)

Governance and legislation

37. Positive progress has been made within the constraints of the current legislative framework but sometimes requiring cumbersome workarounds. Our view is that national and local leaders have had little room for manoeuvre in which to transform care. We are concerned that many local areas are operating with significant risks in terms of their governance and decision-making. (Paragraph 295)
38. The law will need to change. We recommend that Parliamentarians across the political spectrum work together to support the legislative changes to facilitate evolutionary change in the best interests of those who rely on services. (Paragraph 297)
39. The Department and national bodies should adopt an evolutionary, transparent and consultative approach to determining the future shape of health and care. The Department and NHS England should establish an advisory group, or groups, comprised of local leaders from across the country, including areas that are more advanced and those further behind, and representatives from the health and care community, to lead on and formulate legislative proposals to remove barriers to integrated care. The proposals should be laid before the House in draft and presented to us to carry-out pre-legislative scrutiny. (Paragraph 298)

40. The purpose of legislative change should be to address problems which have been identified at a local level which act as barriers to integration in the best interest of patients. We wish to stress again that proposals should be led by the health and care community. (Paragraph 299)
41. Evidence we have heard from representatives from NHS and local government has identified the following legislative areas that may need to be considered:
 - a) A statutory basis for system-wide partnerships between local organisations;
 - b) Potential to designate ACOs as NHS bodies, if they are introduced more widely;
 - c) Changes to legislation covering procurement and competition;
 - d) Merger of NHS England and NHS Improvement; and
 - e) CQC's regulatory powers.

Where barriers are identified and can be removed with secondary legislation, this may represent a less complex way forward. (Paragraph 300)

42. Until legislation is introduced, national bodies should support local areas to develop transparent and effective governance arrangements that allow them to make progress within the current framework. National bodies should also provide greater clarity over what is permissible within current procurement law and develop support for local areas in working through these issues. National bodies should set out the steps they plan to take to provide clarity, guidance and support to local areas on these matters in response to this report. (Paragraph 301)

Annex: Visit to South Yorkshire and Bassetlaw STP

On Tuesday 20 February 2018 five members of the Health and Social Care Committee visited South Yorkshire and Bassetlaw STP, at which we held a focus group with national and local leaders from NHS and local government.

South Yorkshire and Bassetlaw (SY&B), led by the Chief Executive of Sheffield University Hospitals NHS Foundation Trust, Sir Andrew Cash, is part of the first wave of integrated care systems announced in March 2017. As well as being one of the leading local areas, SY&B was an example of a large, politically diverse area with some challenging population health needs. For example, governance in SY&B is very complex, with 20 local bodies involved in the STP, including a mix of both Labour and Conservative councils.

SY&B is an excellent example of an STP in which integrated care partnerships—alliances between local providers—have formed around subsections of the STP population. Within SY&B, five integrated care partnerships have formed in the five main towns, cities and areas covered by the STP: Sheffield, Doncaster, Rotherham, Barnsley and Bassetlaw. These partnerships are working to integrate services in these five sub-sections of the population. The area decided to opt for an alliance between organisations (an integrated care partnership model), rather than adopt an accountable care contract.

The following Committee members attended the visit:

- Dr Sarah Wollaston MP
- Dr Paul Williams MP
- Diana Johnson MP
- Ben Bradshaw MP
- Andrew Selous MP.

This note provides an outline of the visit and a summary of the key points heard.

Visit to Doncaster Royal Infirmary

The Committee visited Doncaster Royal Infirmary to hear from frontline staff about two local initiatives, Consultant Connect and the Integrated Discharge Team. Consultant Connect is an initiative that enables GPs at the borough's 43 practices to ring hospital specialists at Doncaster Royal Infirmary for immediate advice about how to manage a patient's condition, often while the patient is still in the consulting room.

The Integrated Discharge Team is a partnership between Doncaster and Bassetlaw Hospitals, Nottinghamshire County Council and Nottinghamshire Healthcare NHS Foundation Trust, where services work together to plan the safe discharge of patients from hospital.

Visit to Larwood Practice

Larwood Practice is one of several practices in the area involved in the Primary Care at Home initiative—a way of working that connects primary care, secondary care, social care and the voluntary sector.

Focus group in Sheffield

The Committee held a focus group in Sheffield with senior representatives from the NHS, including STP leads and national leaders, and local government, including councillors and chief executives. The group represented STPs at different stages of development, including representatives from integrated care systems. The discussion was facilitated by Professor Chris Ham, Chief Executive of The King's Fund and specialist advisor to the Committee's inquiry. The discussion covered the following five themes:

- Governance arrangements
- Regulatory and legislative framework
- Local relationships
- Management of the process so far
- Communication and engagement.

Summary of discussion

The following section provides a summary of the key points that were raised in discussion.

Governance arrangements

The governance arrangements vary between STPs and some are extremely complex, because of the number of organisations involved. The group opened with a discussion of the governance arrangements in Greater Manchester from one of the local councillors. The Committee heard the number of partners involved brought significant gains, but also challenges.

More generally leaders spoke about the fragility of the system. The governance arrangements are largely considered to be workarounds of the existing legal framework. However, local leaders were clear that they retained responsibility for their individual organisations. The point was made that local leaders do not cede responsibility unless they agree to do so through a joint board.

As in many other leading areas, there was a strong focus on sub-sections of the STP population, often at a neighbourhood level. For example, local representatives mentioned how Greater Manchester had concentrated on the formation of neighbourhood units covering 30,000–50,000 people.

Regulatory and legislative framework

Despite the fragility of the arrangements in place in many areas, there was little appetite for imposing top-down legislative and regulatory requirements on the system as it is evolving. However, it was acknowledged that there needs to be “some bite somewhere.” For example, one participant mentioned that a lot of the changes are built on a consensus between the partners involved. Therefore, if one organisation says no then there is “an immovable object in the system.”

While there are aspects of the legislation, particularly competition and procurement regulations, that local bodies are working around, there are also aspects of the law that require collaboration, for example, Joint Strategic Needs Assessments by Health and Wellbeing Boards.

There was an acceptance that changes to primary legislation would be needed eventually. One of the senior local leaders described the need to “dock in” with a legislative superstructure at some point. Matthew Swindells from NHS England mentioned that he expects “two to three flowers to bloom” out of the models that are evolving locally. There was wide support for an evolutionary approach in which successful arrangements locally inform future changes to primary legislation.

There was also brief discussion about how the regulatory structure would need to change. In particular, there was a sense that regulators need to embrace a genuine acceptance of local decision-making. Similarly, regulators perception of failure is needs to be carefully considered, given the risks involved in transformation.

Local relationships

Local relationships were widely perceived as pivotal to the process. There was a strong sense that it is not possible to mandate the sort of changes that are happening locally, but rather that these changes need to be created by local leaders. A critical aspect of this is building relationships locally and identifying a shared purpose. Working to achieve consensus was also considered to be very important. Leaders spoke about a need to broker deals between parts of the system and to be aware and mitigate risks to the different partners involved, particularly in relation to their accountabilities. Rob Webster from West Yorkshire STP described the importance of local relationships saying that “change proceeds at the speed of trust.”

Relationships between the NHS and local government was another theme of the discussion. One representative from local government spoke about the challenge for councils in joining STPs and the importance of focusing on how these partnerships can help councils with their problems not just the NHS’s, such as housing. There were areas of shared interest such as IT, workforce and public health. For example, the point was made that local government can borrow money cheaper than NHS. This is an advantage for local areas if the focus is not on hospitals, but on the wider community, health and jobs.

Participants spoke with enthusiasm about the prospect of contributing not just to health and care, but to the wider local economy. The NHS was seen as a critical part of the local infrastructure. Therefore, links between STPs and local enterprise partnerships

was another area for potential development. Rob Webster, STP Lead in West Yorkshire, described the potential role the NHS could play in supporting the life science industry in his patch, thereby contributing to local economic growth.

Management of the process so far

There was an appreciation that realistically the NHS is 5 years into a 15-year transformation. There are significant challenges in the short-term. Funding and workforce pressures were mentioned as significant problems that limit the ability of the system to transform. There is a recognition that different local areas are at different stages. As such it is important to move a piece at a time.

Community engagement

There was concern that the prominence given to communities in the NHS Five Year Forward View has been diluted. However, participants spoke about the importance of realising the value of community assets and the value people can bring to changing their own lives. Participants spoke about the need to co-produce plans with stakeholders, including staff and local communities. This involves sitting down and understanding their perspectives.

One participant described how locally the NHS and local councils through the STP went out to hard-to-reach groups with low levels of engagement (e.g. commuters). The council helped NHS colleagues to target these groups, which was then used to develop a public panel with 2000 people to go out too.

Formal minutes

Wednesday 23 May 2018

Members present:

Dr Sarah Wollaston, in the Chair

Luciana Berger Johnny Mercer
Mr Ben Bradshaw Dr Paul Williams
Dr Lisa Cameron

Draft Report (*Integrated care: organisations, partnerships and systems*), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 307 read and agreed to.

Annexes agreed to.

Summary agreed to.

Resolved, That the Report be the Seventh Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

[Adjourned till Tuesday 5 June at 2pm.]

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the [inquiry publications page](#) of the Committee's website.

Tuesday 27 February 2018

Dr Colin Hutchinson, Chair, Doctors for the NHS, **Dr Tony O'Sullivan**, Co-Chair, Keep Our NHS Public, **Professor Allyson Pollock**, Professor of Public Health and Director of the Institute of Health and Society, Newcastle University, and **Dr Graham Winyard CBE**, Former Chief Medical Officer for NHS in England [Q1–80](#)

Lara Carmona, Assistant Director of Policy, Public Affairs UK and International, Royal College of Nursing, **Dr Chaand Nagpaul**, Chair, British Medical Association, and **Helga Pile**, Deputy Head of Health, UNISON [Q81–131](#)

Imelda Redmond, National Director, Healthwatch England, **Dr Charlotte Augst**, Partnerships Director, The Richmond Group, **Don Redding**, Director of Policy, National Voices, and **Kate Duxbury**, Research Director, Ipsos MORI [Q132–156](#)

Tuesday 6 March 2018

Ian Williamson, Chief Accountable Officer, NHS Manchester Clinical Commissioning Group, **Paul Maubach**, Chief Executive Officer, Dudley Clinical Commissioning Group, and **Simon Whitehouse**, STP Director, Staffordshire and Stoke-on-Trent STP [Q157–201](#)

Councillor Jonathan McShane, Local Government Association, **Niall Dickson**, Chief Executive, NHS Confederation, **Saffron Cordery**, Deputy Chief Executive and Director of Policy and Strategy, NHS Providers, and **Julie Wood**, Chief Executive, NHS Clinical Commissioners [Q202–226](#)

Professor Chris Ham, Chief Executive, The King's Fund, **Professor Katherine Checkland**, Professor of Health Policy and Primary Care, University of Manchester, and **Nigel Edwards**, Chief Executive, The Nuffield Trust [Q227–264](#)

Tuesday 20 March 2018

Professor Steve Powis, National Medical Director, NHS England, **Professor Jane Cummings**, Chief Nursing Officer and Executive Director, NHS England, and **Simon Stevens**, Chief Executive, NHS in England [Q265–345](#)

Ian Dalton, Chief Executive, NHS Improvement, and **Ben Dyson**, Executive Director, Strategy, NHS Improvement [Q346–370](#)

Jonathan Marron, Interim Director General, Community and Social Care, Department of Health and Social Care, and **Stephen Barclay**, Minister of State for Health, Department of Health and Social Care [Q371–417](#)

Published written evidence

The following written evidence was received and can be viewed on the [inquiry publications page](#) of the Committee's website.

STP numbers are generated by the evidence processing system and so may not be complete.

- 1 ADASS ([STP0024](#))
- 2 Age UK ([STP0084](#))
- 3 Allied Health Professions Federation ([STP0061](#))
- 4 All-Party Parliamentary Group on Obesity ([STP0062](#))
- 5 All-Party Pharmacy Group ([STP0123](#))
- 6 Alzheimer's Society ([STP0076](#))
- 7 Association of Directors of Public Health ([STP0014](#))
- 8 Assura ([STP0056](#))
- 9 Bliss ([STP0011](#))
- 10 British Medical Association (BMA) ([STP0063](#))
- 11 British Red Cross ([STP0081](#))
- 12 Cancer Research UK ([STP0065](#))
- 13 Care Provider Alliance ([STP0032](#))
- 14 Chartered Society of Physiotherapy ([STP0075](#))
- 15 CIPFA ([STP0023](#))
- 16 Cllr Martin Shaw ([STP0085](#))
- 17 Councillor Mike Allen ([STP0006](#))
- 18 Department of Health and Social Care ([STP0117](#))
- 19 Devon STP ([STP0044](#))
- 20 Diabetes UK ([STP0013](#))
- 21 Doctors for the NHS ([STP0092](#))
- 22 Doctors for the NHS ([STP0105](#))
- 23 Doctors for the NHS ([STP0122](#))
- 24 Dr David Kirby ([STP0003](#))
- 25 Dr Graham Winyard ([STP0069](#))
- 26 Dr Gurjinder Sandhu ([STP0087](#))
- 27 Dr Sally Ruane ([STP0079](#))
- 28 Dudley CCG ([STP0118](#))
- 29 Ealing save Our NHS ([STP0037](#))
- 30 East London Health & Care Partnership ([STP0040](#))
- 31 Epilepsy Action ([STP0077](#))
- 32 Faculty of Public Health ([STP0059](#))
- 33 Good Governance Institute ([STP0106](#))
- 34 HCSA ([STP0018](#))
- 35 Healthcare Audit Consultants Ltd ([STP0008](#))

- 36 Healthcare Financial Management Association ([STP0041](#))
- 37 Healthwatch Birmingham ([STP0071](#))
- 38 Healthwatch Cornwall ([STP0038](#))
- 39 Healthwatch County Durham ([STP0020](#))
- 40 Healthwatch England ([STP0066](#))
- 41 Healthwatch Northumberland ([STP0039](#))
- 42 Healthwatch Stockport ([STP0129](#))
- 43 Healthwatch Worcestershire and Healthwatch Herefordshire ([STP0054](#))
- 44 Ipsos MORI ([STP0104](#))
- 45 Keep Our national Health Service Public Sunderland & District ([STP0036](#))
- 46 Keep Our NHS Public ([STP0093](#))
- 47 Keep Our NHS Public ([STP0127](#))
- 48 Keep Our NHS Public - Cornwall ([STP0022](#))
- 49 Kevin Donovan ([STP0028](#))
- 50 Leicester Mercury Patients' Panel ([STP0009](#))
- 51 Lifeways ([STP0019](#))
- 52 London Borough of Hammersmith & Fulham ([STP0097](#))
- 53 Macmillan Cancer Support ([STP0030](#))
- 54 Manchester Health and Care Commissioning ([STP0119](#))
- 55 medConfidential ([STP0099](#))
- 56 Medical Technology Group ([STP0025](#))
- 57 Mind ([STP0100](#))
- 58 Mr Colin Standfield ([STP0026](#))
- 59 Mr James Guest ([STP0088](#))
- 60 Mr John Popham ([STP0002](#))
- 61 Mr Michael Vidal ([STP0098](#))
- 62 Mr Mike Llywelyn Cox ([STP0017](#))
- 63 Mr Mike Scott ([STP0005](#))
- 64 Ms Barbara Martin ([STP0078](#))
- 65 Ms Carol Ackroyd ([STP0112](#))
- 66 Ms Celia Minoughan ([STP0010](#))
- 67 Ms Elizabeth Lloyd ([STP0091](#))
- 68 National Voices ([STP0101](#))
- 69 NHS Clinical Commissioners ([STP0064](#))
- 70 NHS Clinical Commissioners ([STP0124](#))
- 71 NHS Confederation ([STP0115](#))
- 72 NHS England and NHS Improvement ([STP0108](#))
- 73 NHS Partners Network ([STP0042](#))
- 74 NHS Partners Network ([STP0120](#))
- 75 NHS Partners Network ([STP0121](#))

- 76 NHS Providers ([STP0050](#))
- 77 NHS Support Federation ([STP0060](#))
- 78 Norfolk & Waveney STP Stakeholder Board ([STP0109](#))
- 79 North East London Save Our NHS ([STP0031](#))
- 80 Nuffield Trust ([STP0080](#))
- 81 Optical Confederation and LOCSU ([STP0046](#))
- 82 Otford Medical Practice Patient Group ([STP0016](#))
- 83 Paediatric Continence Forum ([STP0068](#))
- 84 Parkinson's UK ([STP0045](#))
- 85 Paul Bunting ([STP0114](#))
- 86 Pharmaceutical Services Negotiating Committee ([STP0074](#))
- 87 Professor Allyson Pollock ([STP0126](#))
- 88 Professor Allyson Pollock and Mr Peter Roderick ([STP0094](#))
- 89 Professor Kath Checkland ([STP0103](#))
- 90 Reform ([STP0047](#))
- 91 Richard Taylor ([STP0086](#))
- 92 Richmond Group of Charities ([STP0102](#))
- 93 Royal College of Anaesthetists ([STP0096](#))
- 94 Royal College of Emergency Medicine ([STP0015](#))
- 95 Royal College of General Practitioners ([STP0043](#))
- 96 Royal College of Nursing ([STP0048](#))
- 97 Royal College of Nursing ([STP0125](#))
- 98 Royal College of Physicians ([STP0095](#))
- 99 Royal College of Psychiatrists ([STP0082](#))
- 100 Royal College of Radiologists ([STP0058](#))
- 101 Royal Pharmaceutical Society ([STP0110](#))
- 102 Save Our Hospitals ([STP0089](#))
- 103 ST@P Campaign Group Lutterworth ([STP0083](#))
- 104 The Health Foundation ([STP0116](#))
- 105 The Local Government Association ([STP0027](#))
- 106 The Royal College of Speech and Language Therapists ([STP0049](#))
- 107 The Shelford Group ([STP0052](#))
- 108 Together for Short Lives ([STP0067](#))
- 109 Totnes Mansion Art ([STP0035](#))
- 110 UNISON ([STP0057](#))
- 111 Unite the Union ([STP0070](#))
- 112 West Sussex County Council ([STP0073](#))

List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the [publications page](#) of the Committee's website. The reference number of the Government's response to each Report is printed in brackets after the HC printing number.

Session 2017–19

First Report	Appointment of the Chair of NHS Improvement	HC 479
Second Report	The nursing workforce	HC 353
Third Report	Improving air quality	HC 433
Fourth Report	Brexit: medicines, medical devices and substances of human origin	HC 392
Fifth Report	Memorandum of understanding on data-sharing between NHS Digital and the Home Office	HC 677
Sixth Report	The Government's Green Paper on mental health: failing a generation: First Joint Report of the Education and Health and Social Care Committees of Session 2017–19	HC 642
Eighth Report	Childhood obesity: Time for action	HC 882
First Joint Special Report	Children and young people's mental health—the role of education: Government Response to the First Joint Report of the Education and Health Committees of Session 2016–17	HC 451