NOTHING IS CERTAIN AND EVERYTHING IS POSSIBLE

CCG LEADERS’ VIEWS ON THEIR SUSTAINABILITY AND TRANSFORMATION PLANS

By James Peskett,
PA Healthcare Commissioning Expert
PA Consulting Group and the HSJ’s second survey of clinical commissioning group (CCG) leaders received 99 responses, representing 47 per cent of all 209 CCGs. A number of key themes were seen in the results.

The first of these was the continuing focus on moving services out of hospitals and into the community. Another more worrying finding was that CCG leaders have markedly low confidence about the impact their STPs will have on finance and performance. They felt the scale of the funding gap, the contradictory regulatory environment and opposition from key stakeholders would all be barriers to their STP’s success.

However, while CCG leaders were concerned about their own organisation’s capacity to manage change they still saw a significant role for CCGs in setting strategy. Most respondents thought commissioning functions would increasingly be delivered jointly with other CCGs, but less so with providers or local authorities.

Overall, the results suggest a key sector of the NHS sees STPs as work-in-progress. That means commissioners still have the opportunity to shape those plans and define a clear role for themselves in delivering them.
Can STPS deliver sustainability and transformation?

All 44 sustainability and transformation (STP) footprints have now submitted their plans and some STP partners have begun publishing them online. In our survey, CCG leaders report those plans will include:

• an increased focus on ‘neighbourhood’ community health services (73 per cent)
• expansion of other services at primary care locations (58 per cent)
• increased access to out of hours primary care services (59 per cent)
• a transfer of budgets to primary care (49 per cent).

Several leaders highlighted plans to develop locality hubs to deliver place-based models of healthcare, with an increased focus on prevention; and supporting greater integration with social care and the voluntary sector. Much of this is not new, commissioners have aspired to this approach since PCT days, raising the question of whether STPs have found a better approach.

Figure one: STPs and service change

Q. What changes are taking place, or are likely in the next 12-18 months, as part of the STP process and implementation, to the services provided in your STP area?

- Stronger attempts to discourage unhealthy behaviour
- Develop "neighbourhood" primary/community teams
- More care records and data shared across sites/organisations
- Significant amount of provider back-office centralised
- More GP practices accessible at weekends and evenings
- Expansion of clinics/diagnostics in primary care
- Removing inpatient beds, or closing, one or more community hospitals
- Significantly more people accessing NHS services digitally
- A larger share of NHS budgets going to primary care
- Pathology services centralised
- Increase in step up/step down beds
- Overall reduction in inpatient NHS beds
- One or more elective services centralised on a single hospital site
- Closing urgent care centres or similar
- One or more hospital sites stopping a full, 24-hour A&E unit
- Overall reduction in WTE staff working in acute services
- One or more hospital sites stopping consultant-led maternity services
- One or more hospital sites stopping inpatient paediatrics
- Any other important changes not covered
- One or more hospital sites stopping acute medicine

Source: HSJ and PA Consulting (October 2016) n=98
Can STPS deliver sustainability and transformation?

The shift in care to out-of-hospital settings is mirrored by a reconfiguration of acute providers and a reduction in acute hospital beds. However CCG leaders thought these developments were likely to be hampered by the present payment system and the sustainability and transformation fund process.

The financial reset has also increased the focus on consolidating support functions with 60 per cent of CCG leaders reporting their STPs would centralise back office functions and 49 per cent pathology services. However, plans to bring together individual clinical services on fewer sites were much less common: for elective services 44 per cent; urgent and emergency care 31 per cent; maternity and paediatrics 22 per cent and 21 per cent respectively; and acute medicine 11 per cent.

Several leaders reported their local STPs were a rebadging of plans already in development or underway. CCG leaders variously said, “Much of this was happening under existing CCG-led transformation programmes across our patch” and the STP was “only adding value in terms of attempting to control provider spend through a single control total.” CCG leaders showed reasonable confidence that the vision and objectives of their STP would be fully reflected in contracts with providers for 2017/18-18/19 (60 per cent moderate, high or very high confidence). This is in spite of the added complexity of agreeing contract values within the constraints of individual organisation and collective STP control totals and all three months earlier than normal. Time and central contract trackers will reveal whether this is justified optimism or wishful thinking.
One particularly concerning finding was that CCG leaders were not optimistic about whether their STPs would actually make a difference. Sixty-five per cent had low or very low confidence their STP will have the planned impact on financial and operational performance in 2017/18.

That lack of confidence stemmed from the view there were organisational and financial barriers in the way. These included chronic underfunding and the sheer scale of the financial gap over the next five years. Nearly three quarters of respondents mentioned a lack of capital funding and 72 per cent a lack of revenue funding as the problems. (Figure 3) One leader commented, “The scale of the [combined] deficit is such that it is difficult to see how the gap can be closed to the level demanded by NHSE without affecting delivery of service and NHS constitutional standards.”

However, CCG leaders were more evenly split on their own organisations’ financial outlook, with 48 per cent reporting it unlikely or very unlikely they will finish in financial balance or surplus by the end of 2016/17 and 49 per cent reporting it likely or very likely.
Another area of concern was about data, with CCG leaders expressing scepticism about the figures contained in STPs. One commented, “We are being forced to submit costed plans without the time to really sense check the figures.” A further barrier was seen as the contradictions and constraints of the regulatory system, which leaders saw as an obstacle to system-wide working and which made it more difficult for CCGs to maintain a meaningful role. Overall, 61 per cent thought existing organisational duties would still trump new whole system priorities (figure 3).

**Figure three: Barriers to STP success**

Q. Please identify likely significant barriers to the success of your STP.

- Lack of capital funding
- Lack of revenue funding
- Lack of change/improvement capacity and capability
- Organisational duties/priorities trumpping whole system plans
- Political opposition to planned changes
- NHS payment systems
- NHS provider opposition or resistance to planned changes
- Public opposition to planned changes
- Inability to control demand
- GP opposition or resistance to planned changes
- Flawed STP proposals/plans
- National NHS bodies opposition to planned changes
- Other clinical opposition
- STP footprint is the wrong size
- CCG opposition or resistance to planned changes
- Poor STP leadership
- Other (please specify)

Source: HSJ and PA Consulting (October 2016) n=99

CCG leaders also drew clear distinctions between those stakeholders they thought would help and those who would hinder STPs. Politicians (60 per cent), providers (54 per cent) and the public (54 per cent) were seen as the main sources of opposition or resistance. Those less likely to oppose change were GPs (40 per cent), other clinicians (27 per cent) and their own organisations (14 per cent).
CCG leaders did not think there was anything wrong with their STP proposals (29 per cent), STP footprints (22 per cent) or STP leadership (14 per cent). (Figure 3) However, they did see potential issues with the change management capacity and capability in their area (68 per cent thought it was lacking). They were also sceptical of their ability to control patient demand (52 per cent thought they could not). As both of these are core responsibilities of any commissioning function, this raises real questions about CCGs’ ability to bring about change.

More than two thirds of respondents cited concerns about primary care resilience and the capacity to transform primary care as their main worries. Contracting for new care models (58 per cent) and outcome-based commissioning (38 per cent) were also areas of concern. However, respondents were more confident about designing new models of care with only 26 per cent thinking this was an area of concern.
Can CCGs deliver their STPs?

When we asked what STPs were doing to address the challenges they faced, the majority said improving local relationships (78 per cent) and introducing STP control totals (70 per cent) were the key actions. However, their ability to truly drive change was undermined by the fact that only a quarter felt that the STP leader would take responsibility for performance and finance across the footprint. Instead, there was a slight preference for STP leaders to take responsibility for service change (29 per cent).

The survey also revealed a number of other contradictions. Forty per cent of CCG leaders thought providers would become more dominant in system leadership. Yet 47 per cent still thought CCGs would take on a bigger role in setting strategy and only 14 per cent thought substantial commissioning functions would pass to providers, suggesting a real confusion about who will take the lead in driving STPs forward.

In terms of the kind of models CCGs want to see emerging, there was a marked preference for the multispeciality community provider (MCP) model of care rather than the primary and acute care system (PACS) model (42 per cent to 16 per cent respectively). Several respondents mentioned establishing alliance contracts as a model, suggesting a preference for accountable care systems/partnerships over accountable care organisations. We saw a similar preference in our previous survey.*

Figure four: How CCGs are planning to commission STPs

Q. What changes are taking place, or are likely in the next 12-18 months, as part of the STP process and implementation, to the way services are commissioned, run, led and funded in your STP area?

<table>
<thead>
<tr>
<th>Change Description</th>
<th>Per cent of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCG's role dominated by work to improve relationships</td>
<td>80</td>
</tr>
<tr>
<td>Introducing a whole system financial control total</td>
<td>70</td>
</tr>
<tr>
<td>CCG having a bigger role setting, plans across the whole STP-footprint</td>
<td>60</td>
</tr>
<tr>
<td>Introducing MCP contract</td>
<td>50</td>
</tr>
<tr>
<td>Providers becoming more dominant in system planning</td>
<td>40</td>
</tr>
<tr>
<td>STP leader becoming responsible for service change and implementing</td>
<td>30</td>
</tr>
<tr>
<td>CCG has less of a role in setting strategy, planning and service change</td>
<td>20</td>
</tr>
<tr>
<td>STP leader becoming responsible for performance and finance</td>
<td>10</td>
</tr>
<tr>
<td>Introducing the PACS contract</td>
<td>0</td>
</tr>
<tr>
<td>Other (please specify)</td>
<td>0</td>
</tr>
<tr>
<td>Change in STP leader</td>
<td>0</td>
</tr>
<tr>
<td>Substantial commissioning functions passed to a provider or providers</td>
<td>0</td>
</tr>
</tbody>
</table>

Source: HSJ and PA Consulting (October 2016) n=99

*HSJ and PA Consulting survey of CCG leaders, April 2016
Can CCGs deliver their STPs?

Whatever model emerges, respondents felt there would be more joint decision-making between CCGs (76 per cent), including sharing functions (63 per cent) and - to a lesser extent – shared leadership (43 per cent). However, few plan to go any further than this, with only 26 per cent considering merging with another CCG and 16 per cent considering devolving some or all of their functions to a local authority. Pooled budgets did, however, prove more popular, with 60 per cent of CCG leaders considering them with their local authority.

Figure five: Commissioning evolution, not revolution

Q. How is the nature of your collaborative commissioning relationships with other CCGs and local authorities changing?

Currently considering:
- Taking more key commissioning decisions in partnership with other CCGs
- Sharing more functions (excluding leadership/governance) with other CCGs
- Pooling budgets with local authorities for some health/social care services
  - Increased shared leadership e.g. chief officer with other CCGs
  - Increasing joint investments with one or more local authorities
  - Closer collaboration with non-health local authority services
- Maintain the current level of joint investment held with your local authority
- Merging with another CCG
- Devolving some functions to an appropriate local government body
- Reducing the joint investments currently held with your local authority
- Other (please specify)
- Working more autonomously from other CCGs

Source: HSJ and PA Consulting (October 2016) n=99
Conclusions

STPs can tell powerful stories. These can either focus on the problems facing the organisation – the ‘do nothing’ scenario. Alternatively, they can be stories that call for collective action and make the case for change.

The problem is, as the results of our survey show, the STP story is still confusing and contradictory. Many CCG leaders had limited confidence in their own STP plans despite several of those leaders describing those plans as a continuation of existing programmes of work. Most CCG leaders prioritised primary care investment but saw primary care transformation as a problem. And many CCG leaders still see a significant role for their organisations in shaping local strategy but were concerned about their organisations’ change management capacity. Finally, CCG leaders tended to externalise many of the barriers to success. All this makes reading the future role of commissioning in the new system architecture difficult and open to interpretation.

But we should suspend our disbelief in strategic commissioning a while longer because CCG leaders have demonstrated a significant level of insight into the issues they face and the potential solutions that could prevent or frustrate the delivery of STPs. We are not at the final chapter in the STP story, nor has the role of CCGs yet been written out. There is a still a real possibility strategic, place- and population-based commissioning can play a vital role in transforming the NHS over the next five years.
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