Written evidence from the British Medical Association
Sustainability and Transformation Partnerships (STPs)

The BMA is a voluntary professional association and independent trade union, representing doctors and medical students from all branches of medicine across the UK and supporting them to deliver the highest standards of patient care.

The BMA welcomes the Committee’s timely inquiry into Sustainability and Transformation Partnerships (STPs) which also covers Accountable Care Systems (ACSs). We are critical of the manner in which STPs have been developed nationally and believe that they can only succeed if they are properly funded and have improving patient care, rather than cost savings, as their primary priority. As outlined in NHS England’s Next steps on the five year forward view, in the future STPs are expected to evolve into ACSs, and subsequently Accountable Care Organisations (ACOs). If ACSs are to succeed, they must have appropriate accountability, transparency and scrutiny, be based on thorough consultation with clinicians and the public, and be given the funding and time they need to develop.

Executive Summary

- The BMA believes that STPs have not been given sufficient resources to be successful. STPs must be properly funded and have improving patient care as their primary priority, not cost cutting. An investigation from the BMA found that STPs require at least £9.5 billion of capital funding to make the necessary changes. The funding set aside for STPs in the Budget is not sufficient to allay our concerns and meet the needs of patients.

- Poor workforce planning has resulted in the NHS facing huge recruitment and retention problems across a number of specialities and we are concerned that there is an insufficient number of doctors to successfully implement STP plans. There is very little detail in many of the STP plans to suggest that they have the necessary workforce and many identify issues with workforce shortages, challenges with an ageing workforce, and problems with recruitment and retention.

- The level of clinical engagement with STPs has been insufficient throughout the process and, in some areas, local authorities and clinicians have been excluded from the process. The BMA has consistently warned that engagement has not been good enough and without sufficient engagement with the clinicians expected to deliver these plans, STPs will not be successful.

- Many of the plans to reconfigure secondary care services do not appear to be realistic, evidence based, or have the support of clinicians. The BMA supports the principle of moving care into the community but it essential, before any hospital or service closure, that the community has sufficient capacity to manage additional demand placed on these services.

- If ACSs are expected to succeed in integrating health and social care services, they must be developed with greater transparency than STPs have been, be subject to proper consultation
with clinicians and the public, and be given the appropriate level of funding and time they need to develop.

- Moving to a fully integrated ACO would entail radically altering the current model of general practice and is likely to be incompatible with GP independent contractor status. The deterioration of the independent contractor status risks breaking the personal relationship between local communities and GPs.

- ACOs must not lead to a fragmented system which breaks down nationally agreed pay, terms and conditions for NHS staff.

- Competition and procurement regulations, currently enshrined by the Health and Social Care Act, pose substantial risk to continuity of NHS services, particularly under a new ACO model, and should be repealed.

How effective have STPs been in joining up health and social care across their footprints, and in engaging parts of the system outside the acute healthcare sector, for example primary care, local authorities, public health, mental health and voluntary sector partners?

1. STPs have not been given sufficient resources to integrate services in a meaningful way and it has become clear, with budgets under significant pressure, that NHS leaders are unlikely to have anything like the capital required to fund these plans properly. STPs can only succeed if they are properly funded and have improving patient care at the core of their development. Unfortunately, from the beginning of the process it has been clear that the focus of STPs is not on delivering the best possible patient care but in achieving cost savings to meet overstretched NHS budgets.

2. Doctors identify improved integration across health and social care as the number one opportunity for STPs but many of the plans for reconfiguring services do not appear to be realistic, evidence based or have the support of the clinicians working in those services. It is essential that before any hospital or service closure there is sufficient capacity in the community to manage the additional demand on community services that any closures will inevitably cause. The timelines for the STP process and the lack of additional resourcing for community care, currently give little assurance of this.

3. Since the beginning of the process our members have raised significant concerns about clinicians continuing to be under represented on STP boards, and little or no clinical or public engagement by the STP within their area. It is crucial that STPs ensure that clinicians are involved in the development process, and that where necessary they help support clinicians to become involved in a way that will not overburden them and impact upon their clinical commitments. Without sufficient engagement with the clinicians expected to deliver the plans, STPs will not be successful.

4. To support implementation of the integration described in the NHS Five Year Forward View, NHS England set aside a Sustainability and Transformation Fund (STF). However, in 2016/2017, only £0.3 billion of the £2.9 billion set aside for the fund was allocated to the transformation of
services. In 2017/18 this will increase to £1.1 billion but it is still far below what is necessary. References to the STF in many of the STP plans appear to imply that the money will be used to plug deficits, meaning less money is available to successfully achieve transformation. The National Audit Office has confirmed this to be the case.¹

5. The BMA believes that it is vital that upfront transformation funding is provided to enable services to address long term challenges or to achieve many of the aims set out in STP plans including the successful integration of community and public health services. An investigation from the BMA, in February 2017, found that STPs require at least £9.5 billion of capital funding to make the necessary changes, demonstrating further the funding deficit STPs are experiencing. Further information on our investigation is included in point 7 of this submission².

How effectively are they engaging local communities and their representatives?
N/A

How reliable are the ratings in the Sustainability and Transformation Partnerships Progress Dashboard, and what do they tell us about the state of the plans and the relationships that underpin them?

6. The new dashboard aims to provide a measure for improvements made by STPs across 17 indicators, including waiting times, leadership, and mental health, with a ratings system summarising their performance from outstanding to poor. We are concerned that the progress dashboard is too narrow in scope to accurately reflect how plans are being implemented and to measure improvements in care. By only considering these specific indicators, there is the potential that perverse incentives will be created whereby trusts and CCGs will be incentivised to focus resource on the indicator areas at the expense of areas not included. We do not believe that the ratings system can be viewed as an accurate representation of an STPs’ likelihood to achieve both savings and implement the individual objectives set out in its plan to achieve improvements in patient care.

7. It is concerning that given many STPs recognise that workforce shortages are a major challenge, particularly in certain fields such as psychiatry, emergency medicine and general practice, that workforce shortages are not included as an indicator within the dashboard. Whilst it is encouraging that many STPs recognise the challenges faced by the lack of workforce capacity, and many are carrying out baseline mapping of the workforce trends and gaps locally, we are concerned that the current workforce issues are not being properly addressed.

What does the available evidence, and experience so far, tell us about the deliverability of STP plans given the financial and workforce pressures across the NHS and local government? Are the demands being made of STP plans through the NHS Mandate and the NHS Shared Planning Guidance deliverable, and can STPs ensure the fulfilment of the requirements of the NHS Constitution?

Looking across all STPs, are there any major areas where the content of the plans needs to be tested for credibility and realism? Are there any major gaps? For example, are proposals in some

plans to reduce bed capacity credible?; are the NHS efficiency estimates in STPs robust?; is the workforce available to enable the implementation of STPs?; or is the timescale for the changes proposed in STPs realistic?

8. As previously mentioned, an investigation by the BMA in February 2017 found that STPs require at least £9.5 billion of capital funding to make their proposed changes. These findings were echoed by the Naylor review which concluded that an increase of £10 billion in capital funding was necessary to deliver the proposals\(^3\). The BMA found that more than half of the STP footprint areas have told NHS England they would need more than £100 million of upfront funding to make the necessary changes whilst some footprints require more than £500 million, including Manchester, Cambridgeshire, Peterborough and West Yorkshire\(^5\).

9. Considerable funding shortfalls in social care across many STP footprint areas raise further doubts about how realistic many of the STP plans are. BMA analysis found that hospitals and social care services will have to reduce £26 billion from their budgets by 2021\(^6\). Staffordshire and Stoke-on-Trent STP, for example, predicts a £256 million shortfall in social care whilst the eight London authorities in north-east London face a social care shortfall of £238 million and a £578 million shortfall in the wider NHS\(^7\). STPs are primarily focused on resolving issues within the NHS, however, this will be almost impossible to do in areas where there are also significant gaps in social care funding.

10. The funding set aside for STPs in the Autumn Budget does very little to allay our concerns and although additional capital investment in the NHS is welcome, the £2.6 billion allocated to STPs falls far short of the £9.5 billion needed. It is also unclear how this money will be distributed as only 10% has been allocated so far to projects across 10 STPs\(^8\).

How will the development of STPs into Accountable Care Systems (ACSs) change the delivery of care in an area?

What governance, management and leadership arrangements need to be created to enable STP planning and implementation to be carried out effectively? Are additional, or different, arrangements required for areas which are developing ACSs?

What legislative, policy and/or other barriers are there to effective STP and ACS governance and implementation, and what needs to be done by national bodies and national leaders in the NHS to support the implementation of STPs and ACSs?

11. The BMA is greatly concerned about the lack of information regarding how STPs will be developed into ACSs and how this will be developed into national coverage. Current ACS vanguard plans are public, but as they only cover a relatively small section of the country and do

---


\(^4\) Ibid


not give an adequate picture of what national coverage would entail. Moving to any new model of care will require considerable time and investment and the success of this process will be severely hampered without such resources.

12. Given the potential scale of the changes local health systems will undergo in moving to an ACS model, there is a need for much greater public awareness raising, consultation and debate at both local and national level. There must be a system-wide evaluation of the existing vanguard sites, as well as a comprehensive impact assessment of ACS proposals before any amendments should be made. The ACO proposals emerged out of MCP (multi-speciality community provider) contract development, which involved some engagement with primary care. However, this engagement must be broadened to include all areas of the health system. Engagement with NHS staff and patients is essential for any service redesign and it is vital that NHS England and the Department does so regarding the formation of new integrated providers.

13. ACSs or ACOs may have the potential to bring forward the end of the purchaser-provider split, whilst ring-fencing core GP funding. While we recognise this could be a positive development, policy makers must be patient in expecting them to deliver cost savings.

14. The BMA has consistently called for Government and NHS leaders to ensure proper governance frameworks are in place before changing structures, and it is particularly worrying that STPs, ACSs and ACOs all currently sit outside of legislative oversight, so accountability still ultimately rests with CCGs and other statutory bodies.

15. When setting up ACOs, given how complex contracting arrangements can be, it is crucial that there is an agreed understanding to ensure consistency in their design and implementation across the country. This is particularly important given that the governance and legal framework of ACOs is still to be confirmed. NHS England and the Department must, therefore, invite full and proper scrutiny of the current proposals, with maximum transparency. We do not believe that the current ACO consultation process, based on the narrow technical legal aspects of required regulatory changes, properly allows for this. Furthermore, we believe that the scale of change is such that partially and fully integrated ACO proposals should be guaranteed to undergo appropriate parliamentary scrutiny, to formalise their role and responsibilities, as well as to ensure appropriate accountability is in place.

16. We are greatly concerned that where multiple services are combined into one contract, as would be the case in an ACO, there is a risk of commercial providers taking over the provision of care for entire health economies, as the contract would be subject to open competition rules as per the Health and Social Care Act.

17. Potentially further instability could be created through the contracts being for a fixed term duration, together with the ability for the ACO contract holder to terminate the contract. This highlights that current procurement regulations as defined in the Health and Social Care Act work directly against integration and collaboration, and we believe that it should be a priority for government to repeal this element of legislation, allowing NHS resources in England to be used to support coordination of NHS services as opposed to fragmentation. The BMA strongly supports the ongoing provision of a publicly funded and publicly provided NHS, and calls for the government to clarify what safeguards will be in place to ensure that ACOs do not enable an increase in the role of commercial providers.
18. On top of legislative and governance-based concerns, the BMA also believes that there is a fundamental question regarding the statutory duties trust boards and organisations will have for hitting performance targets, duties of care and financial accountability. We are concerned as to how there can be clear accountability for these targets if organisations are merged, autonomy given up and responsibilities shared. For example, in Humber, Coast and Vale STP there are six CCGs where the resource flow is entirely different, meaning that if CCGs are merged or are subsumed into one STP then resource allocation runs the risk of exacerbating existing health inequalities by diverting funding away from areas most in need.

19. Moving to a fully integrated ACO would also entail radically altering the current model of general practice and is likely to be incompatible with GP independent contractor status. The national GMS contract underpins fair and consistent health service delivery in England, enabling GPs to act as independent advocates for their patients and local communities. The deterioration of the independent contractor status risks losing this, and breaking the personal relationship between local communities and GPs.

20. There is also a lack of clarity regarding how implementation of ACOs would affect patient care in border areas with Wales and Scotland (where care might be provided by a GP practice in another country with different arrangements and/or patients are referred across country borders). Again, we believe that greater scrutiny and consultation is required to ensure patient safety is not compromised. Areas such as Berkshire, Oxford, and Buckinghamshire which crosses three health care economies that are not traditionally linked, will have added complexity, particularly when one area is in an ACS but the rest is not, rather than facilitating join up we fear that this approach may result in patients ‘falling through the crack’, and being subjected to increasing instances of a ‘postcode lottery’ effect.

21. There is a systematic lack of clarity regarding how staff would be employed within an ACO and the BMA strongly asserts that all doctors within ACOs should be employed on national terms and conditions. We are particularly concerned by the possibility that due to commissioning decisions, doctors may have little choice but to end up working for a commercial provider, if they are the only employer commissioned by a particular ACO. Commercial providers may not offer the same protections and safeguards in their contracts as an NHS provider and this could significantly impact both doctors and patients.

What public engagement will be necessary to enable STPs/ACSs to succeed, and how should that engagement be undertaken?

22. Proposals should be presented to the public and a wider consultation held on their implementation. Doctors are greatly concerned by the lack of publicly available information and the awareness of STPs and ACSs amongst patients. The content of the Devon STP website, for example, features the STP plan submitted in October 2016 and the upcoming events section cites events happening in February and March 2017, nearly a year old. We are concerned that patients who read this website are left wondering what has happened since then. This is a common concern raised amongst our members, and a similar lack of up to date information has been reported to us across the country.

---

9 Devon STP, Upcoming events: [http://www.devonstp.org.uk/get-involved/upcoming-events/](http://www.devonstp.org.uk/get-involved/upcoming-events/)