STPs: Summary of HCSA Recommendations and Next Steps

Hospital Consultants & Specialists Association
November 2017

HCSA is not against many of the intended principles behind STPs. We recognise that they offer potential for organisations across the health and social care systems to work together to develop health policies suited to local needs. However, without adequate funding, a realistic timeframe, or an accompanying process of consultation and engagement with NHS staff and the public, they are likely to miss their key objectives.

HCSA believes that many of our recommendations can be implemented immediately. Others should be implemented as soon as possible. These elements should have been introduced at the start of the process, so waiting any longer will increase the chances of STPs producing a negative outcome and ultimately failing.

1. Financial Investment

Greater financial investment is needed to support sustainable reforms to health and social care. Underfunding will prevent STPs from having a positive impact as the majority of funding will be used to fill deficits, resulting in limited, if any, funds to introduce an effective reform agenda.

In order to arrive at an appropriate figure, HCSA recommends that each STP footprint undergoes a full financial analysis, or "stress-test", to fully examine the level of funding needed.

Additional funding ring-fenced for a properly thought-out transformation, and not to fill deficits, is required for the kind of a systemic overhaul envisaged. Otherwise, we believe STPs will simply become a vehicle for worsening services.

2. Engagement and Consultation with Clinicians

More information needs to be distributed to hospital clinicians. There needs to be robust, proactive and systematic engagement with doctors. STPs have taken steps to incorporate clinical engagement in their plans – for example, several STPs have indicated that they have engaged with a reference group who advises the board – but there is a lack of consistent engagement with the wider clinical community.

The views and expertise of hospital doctors need to be listened to and integrated into the content of the plans. HCSA proposes the establishment of a Clinical Oversight Group that is attached to each STP.

This group would scrutinise proposals and advise the STP Board. The Clinical Oversight Group would have the power to postpone plans and action, and request and expect further information, clarification, or assessment. The Clinical Oversight Group would also act as a vehicle for information distribution to the wider clinical environment.

There needs to be a realistic timescale for implementation of the plans. A timeframe that recognises the complexity of the task, and appreciates how long it takes for innovations in care to become established and deliver results. STPs are more than implementing a new policy, they are attempting to implement a new culture of co-operation across systems and

in a system recently devised for "market" competition. STPs require the development of new relationships and the establishment of new ways of working.

HCSA believes that service transformation of this scale requires, and merits, several years to develop processes and undertake consultation before an appropriate implementation strategy can be prepared.

Based on the results of our survey, significantly more time is needed to engage with clinicians, consult on plans, undertake stress-testing in each footprint, and allow time for learning, engagement, and adjustment between footprints.

We feel that a still optimistic but more attainable target would be to aim for the period after the Five Year Forward View, looking at the more advanced STPs, using the current period for preparation and development and beginning, to implement plans in 2020.

But we would prefer a move away from a "big bang" approach and towards staggered implementation. This would create space to learn lessons and make alterations before rolling STPs out to other areas.

While this process would take considerably longer to reach all parts of the country, perhaps well over a decade, this would allow for a systemic overhaul at a pace that would create a more effective, "evidence-rich" transformation.

This approach would allow appropriate time for deep structural change.

3. Engagement and Consultation with Trade Unions

There needs to be effective and meaningful engagement and consultation with Trade Unions. STPs will bring about significant changes for clinicians as well as all their medical, nursing and paramedical colleagues. The process could have significant knock-on impact on workforce well-being, morale and retention. Therefore, trade unions should be involved in the process. Trade union involvement is needed to ensure that employment status, terms and conditions of employment, pay and pension arrangements are protected. Trade unions should also be engaged with the process in order to ensure that issues such as transfer and protection arrangements, staffing levels, and staff well-being are taken into consideration during this large-scale reconfiguration.

4. Governance and Leadership

The priorities need to be clearly reaffirmed. For STPs to work, it must be emphasised that they are concerned with positive transformation and improvement of services, not just meeting financial targets within a reducing budgetary envelope. A fixation on financial efficiencies is incompatible with improvements to care. This needs to be recognised and priorities need to be clearly restated.

Clarity is needed over how organisations are to be held to account. The main issue is the lack of clarity over how STPs operate, and therefore how they are held to account.

An assessment of the 44 STPs has shown that the official documentation for each STP is either vague, or not present, and when it does exist it is difficult to locate. Each STP should be required to produce, and publish, documents that state their governance arrangements.

HCSA proposes that NHS Improvement/NHS England produce a skeleton framework document which answers key questions, including for example who is on the board, how it operates, what the decision-making process is, and what the accountability arrangements and mechanisms are. Each STP should then populate and publish this document, making it accessible to NHS staff and the public.

Stronger emphasis should be placed on the role of STP Leads to achieve successful collaboration. It is important that STP Leads demonstrate a commitment within the local area to build relationships and gain the trust required among clinical staff to drive effective change.

5. Evidence-informed Policy-making

A clear evidence base for change should be sought and then integrated into the transformation process, and communicated to clinicians and the public.

Current plans need to be "stress tested" to ensure that they are reliable, and that that service changes they propose are attainable.

A proper "stress test" would assess whether the assumptions that underpin STPs, and the expectations that they are working to, are desirable and in line with stated priorities. It would assess whether expectations are attainable and highlight possible issues and side effects. It would also perform a financial evaluation to assess affordability and deliverability.

A footprint-by-footprint "risk and impact analysis" would help identify potential risks around the lack of funding and restricted timeframes.

It will also force STPs to address the lack of detail and fill the gaps that are currently present – they would be forced to ground themselves in evidence, rather than floating about on assumption and hope.

From what we have seen there has been no systematic process of this kind. Where individual STPs have performed some degree of evaluation and assessment, it appears to have been adhoc and has not been granted an appropriate degree of significance.

What we are proposing, it should be noted, is distinct to NHS England's current "STP progress dashboard," which represents a rather rudimentary progress review, rather than an appropriate assessment and analysis of the plans.