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A two-way street

What can CCGs teach us
about accountability in STPs?

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About the report

The NHS has developed a complex machinery to hold both providers and commissioners of NHS services to account – a machinery that has become even more complex with the advent of 44 sustainability and transformation partnerships (STPs). These partnerships, made up of health and social care organisations in a defined geography, are working collaboratively to deliver their local sustainability and transformation plan.

This report draws on analysis and insights from the current system, and explores the challenges and opportunities presented by STPs for accountability in the NHS.

It reflects on accounts given in 13 interviews by senior CCG leaders and NHS England policy-makers, whom we interviewed in September 2016. We also draw on discussions at the learning networks that we established for leaders in providers and commissioning organisations; and on evidence from research and evaluations of former commissioning structures in England. We also explore how commissioners and providers respond to different approaches to accountability and performance management.

We then consider the implications of this learning from current and past experience for the future development of STPs, accountable care organisations and accountable care systems.

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1   Key points

- Accountability arrangements in the NHS are complex, and experience shows that the tension between separate accountability arrangements for commissioners and providers magnifies that complexity further.

- Furthermore, performance management systems for CCGs are not well designed to capture those measures that are meaningful, measurable and within the direct influence of CCGs. Nor are they implemented consistently across the country.

- Despite NHS England policies to devolve more power to the local level, some leaders still felt a lack of control and autonomy over their organisations, particularly around the ability to set strategic direction.

- Leading a CCG through this period of change for commissioning has been difficult in the context of a lack of certainty and clarity about the future role of CCGs and what this means for their staff.

- At a time of extreme pressure on the NHS as a whole, these issues, coupled with an apparent lack of structured support for CCG leaders, have led to significant stress for those individuals.

- The majority of STPs are still developing the blueprint for their governance arrangements. These will have significant consequences for all the commissioners and providers involved – and will need to reflect the ways in which the STP and the organisations that form it are held to account.

- The recommendations we make as a result of our findings are addressed in the National Framework for Improvement and Leadership Development, published almost a year ago. As we approach the anniversary of that publication, we look forward to seeing NHS England and NHS Improvement set out the changes they have made as that framework is implemented, and to hearing the response to that from our networks of CCG, trust and STP leaders.

2 Introduction

The NHS has developed a complex machinery to hold both providers and commissioners of NHS services to account. This machinery has become even more complex with the advent of 44 sustainability and transformation partnerships (STPs). These partnerships, made up of health and social care organisations in a defined geography, are working collaboratively to deliver their local sustainability and transformation plan.

This report draws on analysis and insights from the current system, particularly the experience, in the case of current CCGs, of being held to account by NHS England, and explores the challenges and opportunities presented by STPs for accountability in the NHS.

The report reflects on accounts given in 13 interviews by senior CCG leaders and NHS England policy-makers, whom we interviewed in September 2016. Although care was taken to speak to people with a range of views and circumstances, these results in no way seek to be fully representative of the views of commissioning leaders. However, they illustrate the challenges experienced throughout the system at this time of significant pressure and change in the NHS. We also draw on discussions at the learning networks that we established for leaders in providers and commissioning organisations; and on evidence from research and evaluations of former commissioning structures in England. We also explore how commissioners and providers respond to different approaches to accountability and performance management.

In the discussion section, we consider the implications of this learning from current and past experience for the future development of STPs, accountable care organisations (ACOs) and accountable care systems (ACSs).

Although our research for this report focused on CCG leaders, we also know from our other work with providers that they are also raising similar questions about their relationship with other providers, commissioners and regulators,

and therefore this learning will be relevant to them and the wider system, especially in the establishment of ACOs and ACSs.

We have found that the current mechanisms that hold CCGs to account are seen by a number of local commissioners as unhelpful and the cause of stress among their leaders – and that there is recognition of this among at least some of those operating those mechanisms. We believe that much of this tension stems from:

- a confusion between the definition, purpose and implementation of accountability and performance management arrangements for commissioning both locally and nationally

- the rising pressures created by the current climate of austerity and intense focus on operational performance

- diverse patterns of behaviour, potentially based on underlying beliefs about what drives performance – the balance between the 'carrot' and the 'stick'.

Without a reflective evaluation of the limitations of the accountability and performance management arrangements in the current structures, it is likely that the new structures – in which accountability relationships need to apply to systems and not just organisations – will replicate or worsen these concerns.

The structures within which the NHS operates now were established in the context of a vision where CCGs, once authorised, would operate with a significant degree of autonomy and independence, with accountability exercised through their membership, not unlike the original foundation trust model. And like that model, CCGs were established at a time when there was a policy expectation that an effective market would operate in the NHS, and that CCGs would be able to exercise leverage over providers through their commissioning decisions. Over the last few years, that vision has eroded to a significant extent, and the intention now set out clearly in NHS England's *Next steps on the NHS Five Year Forward View* is that CCGs and providers will collaborate effectively in local systems, with service change being delivered through planning rather than through the market.

The changes that are emerging will leave the NHS's commissioning and provider functions being organised in different ways across the country, adding greater complexity to the system. The development of ACSs and ACOs has very significant implications for commissioners. It is likely to mean that a significant number of current CCG commissioning functions will be done through these new organisations and structures.

Published material from NHS England and NHS Improvement on the way ACOs, ACSs and STPs should be operating is sparse. Without clarity over the form and function of STPs, it is unclear whether we are looking at yet another short-lived reform to the commissioning system or a much more fundamental shift with a lasting impact on local accountability and service delivery. All of these factors mean that these questions about accountability, ways of working and how the system works will need to be frequently revisited.

3 CCG accountability and the relationship with NHS England

To those working in leadership roles in the NHS, accountability can be described as something that is *felt* – in contrast with more procedural mechanisms like performance management tools, which are imposed. This connection to the role and sense of responsibility is at the heart of many of the issues discussed in this report. Levels of stress and feelings of a lack of control or support are arguably linked to the weight of accountability NHS leaders feel for their role.

Under current arrangements, as shown in Figure 1 on page 7, the Secretary of State for Health has overall responsibility for the performance of the NHS. However, as the diagram indicates, the network of relationships between national and local organisations below the Department of Health is extraordinarily complex. NHS England has day-to-day responsibility for strategic decisions about the commissioning and delivery of services, and the allocation of the majority of the commissioning budget and accountability for local service performance to CCGs, who in turn hold providers to account for delivery. Where NHS England has serious concerns about the performance of a CCG, it can issue it with legal directions or special measures. These could, for example, include forcing a change in leadership or intervening to redesign their financial plans. (For more detail on accountability arrangements, see NHS Commissioning Board, 2013.)

Figure 1: The structure in England

Figure 1: The structure in England

| National | Funding stream | Support or oversight |
| Local or regional | Service delivery | |
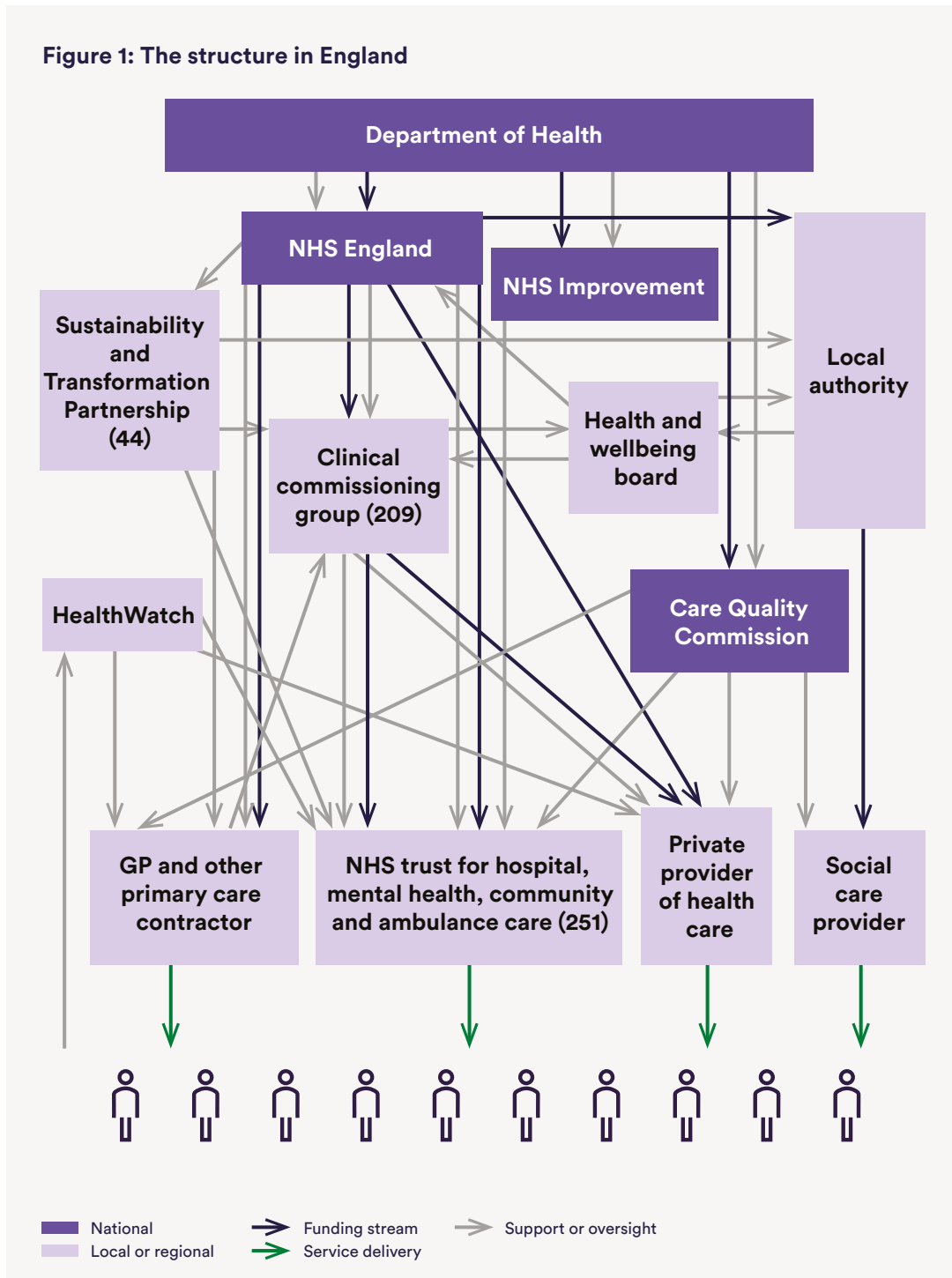
Source: Dayan and Edwards (2017)

*Sustainability and Transformation Partnerships are not statutory bodies, but rather groups bringing together the different bodies shown to draw up joint plans. The extent to which they have an ongoing role overseeing local systems is still evolving, and varies between regions.

In their original *Improvement and Assurance Framework* document published in 2014, NHS England state that 'space and freedom' will be granted to local leaders. Box 1 below sets out the ways of working that were agreed between NHS England and NHS Clinical Commissioners, acting on behalf of all CCGs. Over the past few years, there have been a number of policies that have sought to devolve certain responsibilities to a local level, such as primary care commissioning. However, although this has permitted more freedom in terms of decision-making in some areas, there are still high levels of scrutiny.

Box 1: Agreed principles for behaviours and interactions of NHS England and CCGs
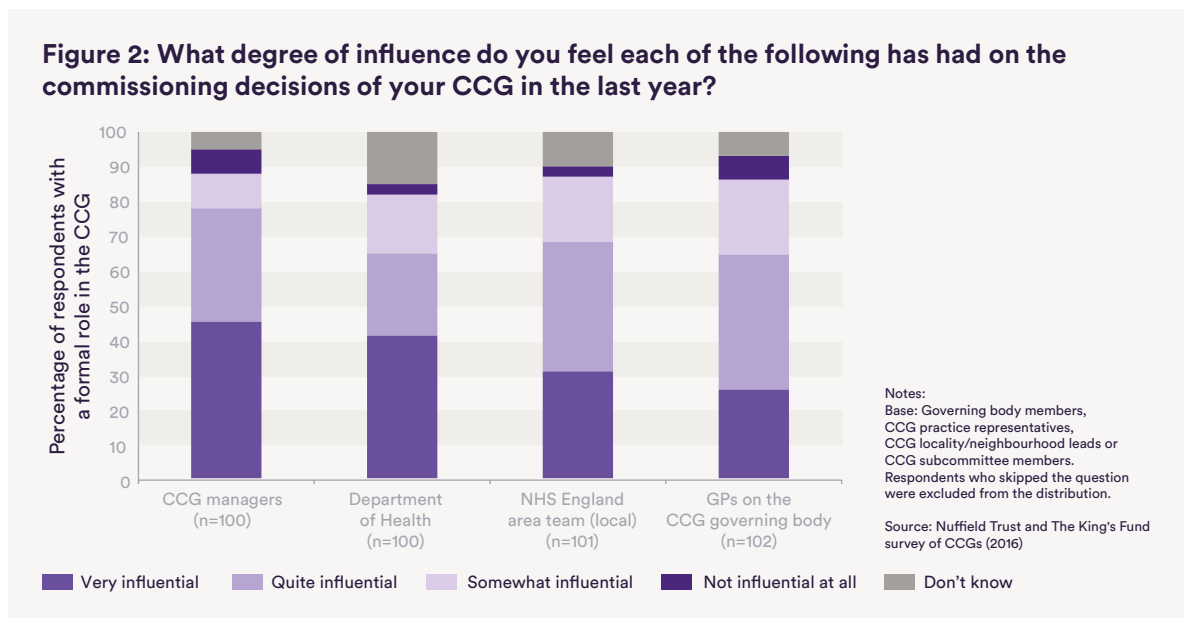
Local leadership and accountability:

- We recognise and respect the different roles, responsibilities and accountabilities we each have for leading the commissioning system.

- We create space and freedom to lead and operate, seeking to open up the innovation and improvement for the benefit of patients.

- We are clear about our decision-making powers, decision-making processes and the rules for intervening, and we operate these mindfully and consistently.

Source: NHS England (2014)

The reality of the commissioning system as it presently stands is somewhat different from this account of how the system is intended to work. The primary divergence is around the level of autonomy and control CCG leaders feel they have. CCGs are membership organisations, and the governing bodies of CCGs feel strong accountability relationships to their constituent GP practices. In addition, CCGs see accountability to their local populations as core to their role.

However, rather than being clinically led and driven by local need, our research suggests that some CCGs feel their agenda has been set by NHS England – who use their authority in holding CCGs to account to determine the work of these local organisations – and that at times, these top-down strategies were poorly coordinated with one another.

A project that followed six CCGs over a four-year period, and included surveys with CCG leaders, GPs and practice managers, found that CCG managers, the Department of Health and NHS England were perceived to be more influential than local clinicians on governing bodies and far more influential than groups representing patients or the general public (see Figure 2).

Figure 2: What degree of influence do you feel each of the following has had on the commissioning decisions of your CCG in the last year?

Notes:
Base: Governing body members, CCG practice representatives, CCG locality/neighbourhood leads or CCG subcommittee members. Respondents who skipped the question were excluded from the distribution.

Source: Nuffield Trust and The King's Fund survey of CCGs (2016)

Legend: Very influential | Quite influential | Somewhat influential | Not influential at all | Don't know

Source: Holder and others, 2016

This issue also presents itself in variations in CCGs' perception of authority at the local level. Tensions have also arisen as the result of providers' relationships with multiple regulators. Research following the Francis Review showed that providers have felt caught between meeting financial targets set by NHS Improvement (then Monitor) and meeting quality targets set by the Care Quality Commission (Thorlby and others, 2014). Unless regulation and oversight is aligned at a national level, and implemented consistently through regional and sub-regional teams, those tensions will persist.

NHS England is responsible both for supporting the development of CCGs and holding them to account. In 2013, NHS Clinical Commissioners commissioned Ipsos Mori to undertake an independent survey of CCG leads in England (Ipsos Mori, 2013). That report, published early in the life of CCGs, showed a recognition of positive intent in local relationships, but some divided opinion on how effective the connections between national, regional and local teams were in practice.

Since 2013, the tension between these two roles has become more evident. Due to budget reductions at NHS England, the number of staff based in local areas has reduced since their establishment, and in 2014 local teams were consolidated across wider areas. This has led to concern about workloads and the ability of these teams to provide adequate levels of support to CCGs (discussed further in the 'Leadership challenges' section on page 17). Good accountability systems rely on trust and openness, which in turn rest on a foundation of good working relationships (NHS Leadership Academy, 2013). These connections are achieved when facilitated by having sufficient amounts of time and resource.

CCG and NHS England leaders interviewed for this research echoed much of this previous research, indicating that the current arrangements were poorly coordinated at a national level, resulting in difficulties in knowing which policies to prioritise; difficulties in working with providers who feel they are receiving conflicting recommendations from their commissioners and regulators; and a lack of autonomy in terms of being able to set their own direction. For example, other research has found that the majority of CCGs have not been able to use commissioning and contracting as a tool to significantly reshape or influence secondary care providers (Robertson and others, 2016). Some attribute this to a lack of clarity on the relative importance of competition or collaboration at the local level (Allen and others, 2016).

NHS England leaders we spoke to described the role of their organisation as shaping the national and local-level strategic direction, acting as a conduit for information from CCGs to the national decision-makers, undertaking quality surveillance work and providing support to the organisation to continually improve their performance.

However, NHS England interviewees agreed with some CCG leaders that, at times, there seemed to be a lack of coordination of policies issued by national leaders and that some of these policies were not seen to be informed by local-level evidence. An interviewee from NHS England suggested that NHS England was "not very well joined up internally" and that this could lead to tension within the local-level operations teams, with very senior colleagues being asked to implement things they have not been involved in developing. As an accountable officer noted:

> "We get a lack of understanding of local positions and often that is delivered by people who have absolutely no idea what it's like to work in a frontline NHS organisation. [Their views can be] completely divorced from reality."
> Accountable officer

In terms of autonomy to make decisions, all of the CCG leaders described what one leader summarised as "the weight" of NHS England, receiving the phone call "when you are told what to put in your plan". Another leader was extremely concerned about having submitted – after a great deal of negotiation with NHS England – strategic plans that they felt were "unrealistic". The CCG was then being held to account for those plans and had been told that they would face legal directives if there was a failure to deliver. In contrast with that, one of the high-performing CCGs had been asked to amend their operational plan with suggestions that were, in their words, "counter-productive", but had pushed back and managed to stick to their original plan.

Coupled with this directive behaviour, our research found what many CCG and NHS England leaders cited as a lack of coordination between NHS England and NHS Improvement. For example, CCGs' influence and credibility over providers and contract negotiation was felt to have been hampered by NHS Improvement telling providers how to increase their income by insisting on the use of the tariff when the CCG and provider were content to set a global budget to control spending. As one NHS England leader reported, "the difficulty is ensuring that, as regulators, we coordinate and behave in a consistent way".

Over the last year NHS England and NHS Improvement, individually and jointly, have recognised this issue and made some steps to address it, for example through the establishment of joint posts in regional teams. Notwithstanding this, it remains true that accountability is meaningless unless there is clarity on that for which individuals are to be held to account. It is clear that there is more to do in terms of:

- consistency between and within regulators
- clarity about what is wanted
- agreeing the scope of autonomy
- avoiding NHS England second guessing CCGs or telling them 'the answer'.

In the next section, we discuss learning from the performance management framework for CCGs.

4 Performance management and CCGs

CCGs undergo regular assessment, culminating in the annual application of the *Improvement and Assessment Framework* (revised in 2016/17; NHS England, 2016a). The Framework assesses the CCG on 60 indicators, including progress made by the CCG and its local providers towards the achievement of nationally set priorities. NHS England recognises the importance of positive working relationships between itself and CCGs, stating that "a critical factor in the success of the new framework will be the quality of the relationships between the NHS England local teams and CCGs. We are in it together – with joint responsibility for helping each other transform and sustain the NHS" (NHS England, 2016a).

Through local planning, effective contract management and the threat of sanctions, CCGs are expected to have significant influence on the current performance and future development of local providers in line with national policies and priorities. Some of the indicators that CCGs are monitored against reflect this objectively and quantitatively. Others seek to ensure CCGs are working with providers on future developments to deliver national policies such as new models of care, and tend to be measured more subjectively and qualitatively.

NHS England documents stress the intention to work collaboratively with CCGs: "The focus is on unlocking improvement and enabling change rather than an assurance process and giving ratings" (NHS England, 2016b). However, as we will discuss, increasing pressure on performance and the expansion of the performance management framework has, for some, resulted in increased levels of bureaucracy and a reduction in the amount of local autonomy. As a result, contrary to policy rhetoric, commissioners are actually driven to be more involved in the day-to-day running of providers, rather than moving away from this model towards strategic commissioning. In the short term at least, commissioners are still being used to encourage certain provider

actions, perhaps because they remain an accessible mechanism or lever for national policy-makers. For example, the inclusion in the national standard contract of a clause prohibiting the sale of sugary drinks from the premises of NHS trusts and foundation trusts.

Research conducted by NHS Clinical Commissioners found that CCGs were concerned about the increasing frequency of requests for information from NHS England, and a consequent pressure about the resources that would be required to respond to this request (NHS Clinical Commissioners, 2015 unpublished research). They also uncovered significant geographic variation in terms of the quantity of information requested, suggesting the lack of a uniform approach by NHS England in regional and/or local areas. Over a third of the reports requested were perceived by CCGs to be of low or unclear value to either themselves or NHS England. In response to these findings, NHS England set up a task group to review the reporting requests. However, NHS Clinical Commissioners maintain that further work is needed.

An NHS England leader suggested that the pressure put on CCGs to demonstrate progress and positive results reflected high levels of anxiety in the NHS and indeed in the Treasury, and led to "absolutely ridiculous" amounts of data collection. Politicians were seen to be "losing patience" with the NHS, resulting in a return to the "command-and-control" style of management and focus on specific performance metrics. This pressure, coupled with a lack of capacity at regional levels of NHS England, meant that for the directors of commissioning operations interviewed for this report, there was a noticeable shift in expectation centrally away from operating as supportive developers of CCGs to becoming interventionist performance managers. As one NHS England leader commented:

> "There's a quality angle to it [the role] but if you looked at my diary, about 80 per cent of my time is spent on performance management."
> NHS England leader

Another NHS England leader said that in the first couple of years they had been "coaching" CCGs to achieve, but now they are "requiring" them to make necessary changes.

It is worth observing that this is not a new experience within the NHS. In 2002 a health authority director was quoted as saying "99.9 per cent of our time is going to be spent on all other things [on which] I know that I'm going to have a 'phone call from the Secretary of State. [It's] a direct hotline if I have an 18-month-plus waiter" (Exworthy and others, 2002).

NHS England and CCG leaders interviewed as part of this project highlighted concerns about NHS England's capacity to support improvements, and expressed varying views on levels of trust and the culture underpinning the relationship between the organisations. CCG leaders viewed regulation and performance management as a necessary part of the NHS, as for any public sector body. They suggested that:

- ideally, the assurance process should be overseen by people who understood the local area and who had done similar leadership roles themselves

- time should be taken to build relationships with leaders

- the process should go beyond reviewing targets and other performance measures

- the process should be consistently applied across the country

- the process should be supportive of organisations when the need for improvements was identified.

Three of the CCG leaders – all from high-performing CCGs – thought that aside from lacking a helpful or educational element, the assurance process and its implementation was fine. One stated that their performance ratings had granted them "earned autonomy" that allowed them to "push back" on NHS England at times. They felt they now had a relatively good relationship with NHS England, describing the organisation as relatively permissive.

However, four other leaders – who had received less favourable ratings – were more critical of the process, describing it as lacking in transparency and, for some, open to being used as a political tool. For example, one CCG leader suggested that process was purposefully vague and that NHS England

was "making the rules up as they go along". One CCG leader said that the regulatory framework had been used as a threat to force them to collaborate with STP plans, having been told by NHS England that their CCG would be put into a failing category if they did not cooperate. As well as varying by ranking, these CCGs were also spread across the country and there were suggestions that organisations were affected by very different leadership styles across regions within NHS England.

Others commented on a lack of collaboration in the assurance process. One CCG leader viewed NHS England like a headteacher – someone to mark your homework rather than support you. Another leader was explicitly told that interaction with NHS England would only be when it was concerned about performance, that "if you don't hear from me and I don't respond to your emails, it's because I'm not worried about you". This was further illustrated by an NHS England leader who commented that "some CCGs think they don't see enough senior people but they should see that as a sign of their success".

There are some striking dissonances in this area. Performance management for CCGs seems to be heavily skewed to provider performance and short-term delivery, rather than the issues that might be of concern to frontline clinicians or improvements in long-term population health. Despite an avowed interest in improvement, most of the emphasis appears to be on assurance, and some of this can be unnecessarily burdensome. There also appear to be issues about the nature of the relationships of some (but by no means all) CCG leaders with NHS England.

5 Leadership challenges

Accounts from leaders we spoke to for this research highlighted issues related to: capacity and capability of CCG leaders, the need for a greater focus on succession planning, concerns around levels of pressure and stress in these roles, and difficulties caused by the uncertainty of the future of CCGs.

All interviewees, whether in CCGs or in NHS England, described a commissioning structure that was under pressure, and also referenced the difficulties facing local authorities as commissioners. CCGs were singled out as being subject to requests to implement a large number of activities and achieve efficiency savings, all within a tightening financial situation – "the amount of change we [NHS England] are asking them to [deal with] is overwhelming".

Given this context, CCG interviewees had differing views about whether or not they were enjoying the role and whether they wanted to continue for the foreseeable future. One CCG accountable officer firmly stated "it would take a lot for me to give this job up". However, others described the increasing pressures as a balancing act that was making the role "virtually impossible" and risked "destroying the morale" of leaders, as illustrated by another CCG leader:

> "For years and years I always said 'I'm so lucky, I've got the best job, I absolutely love it'. And probably for the last year, I don't feel like that... I would have no hesitation walking away."
> CCG accountable officer

Interviewees cited levels of bureaucracy, assurance regimes and a lack of local-level autonomy as sources of difficulties in the role. Submitting initial STP plans was felt by many to have been a particularly stressful time as it was work expected alongside ongoing demands such as year-end processes. One leader likened it to being "under siege" and said it felt like "non-stop pressure" to an extent that they had not felt in 30 years of working in the NHS.

Nearly all CCG interviewees felt there was very little support available to them. Some leaders had sought out local or national peer support networks but others described the job as "lonely" and as though they had been hired into the role and then "dumped". Although there seemed to be support for aspiring leaders, or from NHS Improvement for leaders in the provider sector for example, most of the CCG accountable officers felt that there was no support for them – even leaders who were seen to be failing. Reflecting on primary care trusts and strategic health authorities, an NHS England leader acknowledged the lack of peer support available to accountable officers in comparison to what had been available previously, and described individuals in some areas as being quite isolated.

Leading an organisation that may not exist in a year or so, or that might be in some way reduced or repurposed, was difficult for some. One leader had already been asked questions by members of staff about their future (as had two other interviewees). The leader felt there was a complete void in terms of vision, clarity or support to draw upon. Another leader described the future of commissioning as "a massive mess", and felt that the process of redefining the relationship between providers and commissioners was "undermining" the role of CCGs without being clear and saying this was the motivation. Another said that they felt as though NHS England had not properly described the new models of care and the potential for a different relationship with CCGs: "They have thrown all these things on the table and then just walked away… it feels a bit chaotic and it's horrible for staff."

Some CCG leaders described a culture of blame towards leaders, some of which was described as evident across the NHS, not just within commissioning, and also as something that was not a new phenomenon. One leader summarised it in the following way: "It seems that the natural behaviour at senior echelons of the NHS is to think it's motivating to threaten you with your job. It doesn't motivate me."

A different CCG leader reported that they had been told recently that they would be removed from post if the financial position of their local provider did not improve. In recent months there has been significant 'churn' in CCG leadership, related to performance issues in CCGs and local systems.

It would be unfair to characterise these responses from CCG leaders as evidence of a 'victim mentality'. NHS Clinical Commissioners has recently published a report on the future of strategic commissioning that clearly shows that CCG leaders are giving a great deal of thought on how their roles should be exercised in future (Simon, 2017), and that morale among CCG leaders is "higher than anticipated". However, the report also indicates that CCG leaders are frustrated by a perceived lack of policy clarity from NHS England. It is not clear that NHS England has well-developed plans for motivating future CCG leaders to come forward on this subject. This theme is considered further in the next section of this report.

The leadership environment for CCG chief officers is clearly not as supportive as might be hoped, and is some way from the aspirations that the NHS has for itself in terms of creating a positive context for leadership to flourish. The key issues that emerge from our interviews and research include:

- the consequences of coping with austerity and a system under stress
- excessive reporting demands
- a culture of blame
- lack of development and support
- high turnover – loss of experience and skills.

In addition to this, there is also some significant uncertainty about the future shape and role of commissioning as ACOs and ACSs start to emerge.

6 Discussion

Commissioning organisations have been redesigned and restructured seven times since 1991. The creation of STPs and ACSs represents an eighth change – but unlike previous changes the creation of ACSs (and the closely related ACOs) also impacts directly on provider organisations. Arguably most, if not all, of these changes were driven by a view that previous accountability and performance management systems were not fit for purpose to drive better outcomes for patients and value for money for taxpayers.

As a forum for collaborative decision-making and a vehicle for system-wide budgeting, risk-sharing and performance management, STPs reflect a commonly held belief that commissioner and provider integration should lead to better outcomes and value. They are an attempt to rebuild what has become an increasingly fractured system, notwithstanding the absence of legislative change that might be desired to heal those fractures more effectively. So how do we ensure that STPs avoid rather than replicate the problems of the past?

STPs across the country are at markedly different stages of their journey towards becoming fully functional forums for decision-making and delivery. Some areas are still trying to establish good working relationships between partner organisations in what they would regard as an unnatural or unhelpful geographical footprint. Others are much further ahead, using their STP as a vehicle for continuing long-established collaborations. Eight STPs will go even further and pioneer the journey to developing an ACS (Brennan, 2017).

What is clear is that the majority of STPs (and national organisations) are still developing the blueprint for their governance arrangements. These will have significant consequences for all the commissioners and providers involved – and of course the ways in which the public and others can engage with and scrutinise actions. High levels of trust will be needed between NHS England, NHS Improvement, other national bodies and these embryonic STPs.

The stakes are high. STPs by definition touch every part of the NHS. If they cannot be supported to work effectively, collaboratively and with transparent accountability arrangements, the consequences will surely be as widespread.

Looking beyond policy design to current experience, evidence from CCG and NHS England leaders presented in this report can be summarised as follows:

- Despite NHS England policies to devolve more power to the local level, some leaders still felt a lack of control and autonomy over their organisations, particularly around the ability to set strategic direction. Many felt uncomfortable at having to implement policies perceived to have been developed without consultation and, at times, contrary to local interests.

- Levels of trust and collaboration with NHS England were extremely low in some areas, leading to some CCG leaders feeling unsupported and personally criticised.

- Performance management frameworks were seen to be over-burdensome and without use to the commissioners themselves.

- There was a perceived gap with regard to learning and development of CCG leaders.

- Leading a CCG through this period of change for commissioning – and the implications for CCG mergers and/or smaller CCG teams – was difficult because of the lack of certainty and clarity from national leaders around the next few years for CCGs and what this meant for their staff.

We have a number of recommendations for both national and local leaders.

- **Give STPs the flexibility, space and autonomy to implement local objectives alongside national priorities**.
- **Clarify lines of accountability for organisations and STPs**.
- **Hold STPs and organisations to account for plans and targets that they are able to influence**.
- **Motivate and support STP leaders and leaders in their constituent organisations**.

Local areas must have security to make long-term plans, to take certain risks and to engage the public in difficult conversations. They also need to have a clear idea of what should be prioritised, in and among the dense policy landscape, and what 'good' looks like. Although difficult to achieve in a financially constrained situation, fundamentally this requires trust and the delegation of autonomy from the centre.

The Department of Health, NHS England and NHS Improvement should be clear on how STPs' performance will be judged, and whether and how they will also continue to judge the performance of the individual organisations for which they are responsible. In turn, local leaders need to consider how accountability will work between the organisations that form the STP, including, where relevant, local government and non-NHS provider organisations. They will need to put explicit agreements in place to ensure local organisations are clear on their individual roles and responsibilities in delivering outcomes, how and where decisions are taken collectively, and where individual organisations retain 'sovereignty' and how disputes should be handled.

At both national and local level, there should be clarity on the rewards for strong performance, the sanctions for poor performance and, perhaps most importantly, the support offer in place where performance clearly requires improvement.

The success of STPs will depend heavily on the ability of their leaders to unite their partners and align organisational objectives. STP leaders have an enormous task ahead of them. They will need support in continuing to establish the forums and in implementing the plans. Leaders will need to feel confident in moving away from a 'heroic' model of leadership to one where responsibility and decision-making capabilities are shared.

Our recommendations will be familiar to a large extent to those who have experienced past organisational changes in the NHS, and past attempts to corral organisations to work together across a local geography. The experience of the commissioning leaders we interviewed suggests that there are lessons from the past that have yet to be learned. However, shortly after we were conducting the initial interviews for this research, in December 2016, NHS England, NHS Improvement and the other arm's-length bodies of the

Department of Health published the National Improvement and Leadership Development (National Improvement and Leadership Development Board, 2016). This document contained a number of relevant recommendations, summarised in Figure 3.

Figure 3: Summary of proposed actions in the National Improvement and Leadership Development framework

Source: Department of Health and others, 2016

In addition, the national bodies made the following three pledges in the published framework (National Improvement and Leadership Development Board, 2016: 12):

* We will model in all our dealings with the service and in our own organisations the inclusive, compassionate leadership and attention to people development that establish continuous improvement cultures.

* We will support local decision-makers through collectively reshaping the regulatory and oversight environment. In particular, we owe local organisations and systems time and space to establish continuous improvement cultures.

- We will use the framework as a guide when we do anything at a national level concerning leadership, improvement and talent management, so we engage across the service with one voice.

These are honourable commitments, and highly relevant in the context of our findings on the experience of CCGs at the time of our interviews.

Particularly relevant to this report are the actions relating to Condition 5 of the framework: *Enabling, supportive and aligned regulation and oversight*. We note with interest that in this section there is a specific action that in 2017 the national bodies will "establish mechanisms for organisations to feed back constructively experiences in their dealings with national bodies that are not in keeping with the framework's expectations, and to make sure this information is regularly reviewed and acted upon" (National Improvement and Leadership Development Board, 2016). Also that over the next one-to-three years, "all national regulatory and oversight bodies [will] ensure that their organisational development approach supports and enables all their staff to behave in line with the principles of the National Improvement and Leadership Development framework, including development in holding supportive conversations and understanding improvement methods" (National Improvement and Leadership Development Board, 2016).

As we approach the first anniversary of the publication of the framework, NHS England, NHS Improvement and the other national bodies engaged in this work should set out clearly how those actions, and the others set out in the framework, are now being implemented, and the effect measured – so that the experiences of some CCG leaders described in this report are not replicated for leaders in the organisations of the future.

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