STP analysis Cheshire and Merseyside

http://www.westlancashireccg.nhs.uk/wp-content/uploads/Cheshire-Merseyside-STP.pdf

The STP Process

Q1. Version Control:

- **Date of first publication;**
- **Subsequent publication of versions;**
- **Date of final/latest version;**
- **Official consultation launched/closed.**

STP was first published in June 2016. Version was submitted to NHS England on 21 October 2016. Health Service Journal, BBC, and Liverpool Echo obtained copies and on 4 November 2016 Liverpool Echo reported on and published the plan. This did not include Appendices covering Technology, Estates, Workforce, Financial model highlights, Communications and Engagement Plan, and Cross cutting Clinical Programme PIDs (Project Initiation Documents). These were also omitted when CCG published STP 'final version' on 16 November 2016 but appeared on 24 November. (These details come from Keep Our NHS Public Merseyside). STP final version was published on 24 November 2016 (version 4.4) – see front page.

STP provides no plan for consultation on Plan as a whole, which covers 3 'Local Delivery Systems' (LDSs): North Mersey, the (Mid-Mersey) Alliance, and Cheshire & the Wirral (p5). Each LDS is developing its own proposals, some of which will then be required to go through a formal consultation. However removal from earlier version of STP of proposals to downgrade 4 A&E services (Macclesfield, Southport, Whiston and Warrington) may mean local consultation not required.

STP states (p35), public consultation on future of Liverpool Women's Hospital to begin in January 2017, with a final decision in May/June 2017.

The STP mentions consultation with respect to its "service by service review" of the acute care model. Thus (p16, our emphasis), "This will be a single programme of work that will run in parallel to the emerging LDS-led reviews and work undertaken by the NW Specialised Commissioning team", and, "Our view is that the definition and specification of the local District General Hospital will be sustainably supported through a network of specialist provider services, making a virtue of Merseyside's strong cohort of tertiary centres. This big idea is underpinned by health and social care integrated at the core", and, "The review will be undertaken rapidly with an outcome on the direction of acute provision being available for the next stage of consultation by March 2017 (subject to further discussion and agreement)".

Consultation is also mentioned in context of NHS Southport & Formby CCG review, looking at services provided by Southport and Ormskirk NHS Trust, to ensure long term clinical and financial sustainability and to meet the particular needs of this population. Thus (p17), "The review process will be conducted by a multi-stakeholder partnership that will develop a case for change which will inform plans for the future of these services.

- Process, Governance and Stakeholder Mapping (Jan-March 2017)
- Case for Change (April-June 2017)
- Pre-consultation engagement (July-September 2017)".

Q2.Stakeholder sign up:

- **Who has agreed it?**
- **Who has not agreed it?**
- **Dates of agreement could be affixed to all named stakeholders.**

STP gives long list of relevant organisations within the large footprint on cover page,

- CCGs – Knowsley, South Sefton, Southport and Formby, Eastern Cheshire, Wirral, Liverpool, Halton, St Helens, South Cheshire, Vale Royal, West Cheshire, Warrington

- LAs: Knowsley, Sefton, Liverpool, Halton, St Helens, Cheshire East, Cheshire West and Chester, Warrington, Wirral

- Providers: Liverpool Heart and Chest Hospital NHS Foundation Trust, Alder Hey Children's NHS Foundation Trust, Royal Liverpool NHS Foundation Trust, Countess of Chester NHS Foundation Trust, St Helens and Knowsley Hospitals Trust, Walton Centre for Neurology and Neurosurgery, Bridgewater Community Healthcare NHS Foundation Trust, Wirral University Teaching Hospital NHS Foundation Trust, Mersey Care NHS Foundation Trust, East Cheshire NHS Trust, Cheshire and Wirral Partnership NHS Foundation Trust, Wirral Community NHS Foundation Trust, Liverpool Women's Hospital NHS Foundation Trust, Warrington and Halton NHS Foundation Trust, 5-Boroughs Partnership NHS Foundation Trust, Mid-Cheshire Hospital NHS Foundation Trust, North West Ambulance Trust, Aintree University Hospitals NHS Foundation Trust, Clatterbridge Cancer Centre NHS Foundation Trust, Southport and Ormskirk Hospitals Trust, Liverpool Community Trust.

However STP does not claim that all of these are 'partners' in the project, and goes on to emphasise that it is a stage in the process of seeking agreement(p58), "The strategic aim of the STP to deliver a work stream entitled 'How We work together to Make it Happen' is progressing but now needs to accelerate to agree the draft Memorandum of Understanding that has been circulated, define the governance bodies going forward (evolving the current Membership Group, Executive Group and Working Group) and cement the growing relationship with local Authorities. In due course, it is likely that a number of the decisions required may face public resistance and political challenges. We therefore need to have mature and well oiled governance mechanisms to receive and involve the concerns of our staff and our communities with their representatives".

STP does not indicate any opposition to the Plan. However on 16 November 2016 Cheshire West & Chester Health and Wellbeing Board declined to endorse the plan, pending full consultations with the Local Authority, patients and the public. On 17 November 2016 Sefton Council voted almost unanimously to deplore the plan, publicise its likely impact, and to notify the Merseyside and Cheshire NHS Sustainability and Transformation Programme lead and the Secretary of State for Health of its opposition to any programme of cutbacks or privatisation locally and nationally in the NHS created to meet underfunding by the Conservative Government[1].

On 1 December 2016 the Mayor of Liverpool Joe Anderson added more local government dissent, in a speech to the Health and Wellbeing Board complaining that "There has been no, I repeat no, consultation or engagement with the city."[2]

Q3. Does the STP seem to be introducing new governance arrangements that will delegate authority to new organisations?

- **Will decisions still be made locally?**
- **Are there proposals to create ACOs?**
- **Does the plan include integration with local government or an additional tier?**

STP states (p57), "The strategic aim of the STP to deliver a work stream entitled 'How We work together to Make it Happen' is progressing but now needs to accelerate to agree the draft Memorandum of Understanding that has been circulated, define the governance bodies going forward (evolving the current Membership Group, Executive Group and Working Group) and cement the growing relationship with local Authorities".

Structure of governance regime of STP is unusual in that there is no central authoritative Board running formal decision-making, but 3 Leadership Groups drawn from the 3 distinct LDSs, feeding their views to STP Membership Group, membership of which is not explained in STP, to which Cross-Cutting Clinical Programme Board reports (p17).

STP states (p52) at next tier down, with an advisory role, is STP Working Group, taking input from STP Clinical Congress, 4 Strategic Programme Steering Groups and 8 Enabling Programme Steering Groups, while delivery management is in the hands of STP Portfolio and Programme Management, supported by a Programme Management Office.

STP proposes to establish ACOs, and in some areas hopes to establish other new models of care which, like ACOs are drawn from FYFV. STP indicates varied progress across the area (p13),

"Ambition - There is significant variation in the progress made on developing ACOs across the STP; most are at an elementary stage. St Helens has made the most progress having commissioned advisors to consider the options for an accountable care management system. Further work is required in most localities to fully define the vision and outcomes. Care Model - Greater focus could be paid on ensuring primary care is at the centre of care models and ACOs are built on GP registered lists. Additionally, processes to engage primary care need to be determined. In parts of the system there is some ambition to build the ACOs around multispecialty community providers. The connection between ACOs and already established/proposed care models in some areas needs to be clearer e.g. the Caring Together programme in Eastern Cheshire.

Delivery Model - There is significant variation in the form of ACOs being proposed and developed across the STP. For instance, in some areas an 'accountable care management system' is being developed whilst in others a 'partnership' is envisioned. In almost all areas there is no defined operating model agreed and no delivery plans in place for implementation.

Capabilities - Learning should be shared as much as possible by those areas who are leading in the development of their ACOs. The process to understand the capabilities required for the successful implementation of an ACO is in place in some areas. Further work is required on the approach to sharing accountability amongst partners include

risk and gain sharing. There needs to be a real focus on the development of an STP wide framework to help design the right ACO model for each locality".

STP makes general proposals for 'integration' of health and social care (especially in the summaries pp36-45), but provides no clear plans to integrate with local government.

Q4. Is there an explicit timetable:

- **For delivery of the STP?**
- **For obtaining agreement to it?**
- **For delivery of the changes that the STP proposes?**
- **List any short term deliverables in 2016/17.**
- **Is there start and end date? If so, what are they?**

STP does not provide explicit timetable for delivery but there is Pace of Change graphic (p51) that charts projected progress of £908m 'Do Nothing gap' to 2021, compared with 'Do Something' scenario.

Q5. Is there reference to a STP Board and its Chair/Leader? List who these are.

The governance structure does not appear to have single leading Board, and there is no information in STP on whether there is an independent chair, or perhaps more than one, or at what level they may operate. However nominated lead of the area is Louise Shepherd, Chief Executive, Alder Hey NHS FT (p1).

Panels of individuals are also named as members of working bodies seeking to deliver on various specific aspects of the STP: Improve the health of the C&M population (p10); Improve the quality of care in hospital settings (p15); Optimise direct patient care – reduce the cost of administration (p19); Optimise direct patient care – efficient clinical support services (p21); Mental Health (p24). However there is no information on which organisations these individuals come from, making it difficult to judge the extent to which the NHS bodies are working with each other and with local government.

Q6. Are the future costs of the STP process made clear? Are there projections for:

- **Budgets?**
- **Personnel?**

Many of the staff for running the STP will be drawn on secondment from existing senior management in NHS and local government and therefore there will be costs (p53), "A programme of this size and complexity will need strong leaders with sufficient knowledge, experience and skill to operate at C&M level, while having a national network", and "These leaders should also be freed up from their day job in order to provide the necessary system leadership to deliver at pace".

STP indicates each of local tiers of STP requires its own support (p55), "The Portfolio Management Office will reside at the centre of the STP, as the engine room, meeting the demands and requests of external stakeholders while directing and assuring the programmes (as appropriate and cognisant of local governance arrangements) that fall within the agreed scope of the STP", and, "Similar structures will need to be agreed and

mobilised, where they do not already exist, for the work of the Local Delivery Systems and each of the programmes within the Portfolio".

STP also indicates Portfolio Management Office will include at minimum 4 directors, 2 of them requiring expert advisors, 4 Programme Directors, also requiring expert advice, plus 12 managers, designers and analysts – in addition to the clerical and support staff to keep them working (p51).

So total staffing of STP leadership bodies must on this basis be substantial: however no costings or overall staff levels are provided in STP.

The STP Content

Q7. Is the start point for the STP clear in terms of population at 2016?

- **Is there a needs analysis in STP (or reference to Health and Well Being Board needs analysis) for STP catchment area?**

STP states population is 2.571m people (front page) but no source or dates are given; no projection of future population is provided.

STP provides no system-wide needs assessment, and makes no reference to such a requirement. STP does not refer to local HWBB needs analyses.

Q8. Does the plan reflect the national template ie:

- **Expansion of primary care? If so, are proposals concrete, costed and timetabled?**
- **New models of care and proposals for more self-care? If so, do plans rely on new digital technology?**
- **Preventative measures as way of reducing demand on acute services, and reducing deficits? If so is there an estimated timescale and value put on savings?**

Unlike many STPs, Cheshire and Merseyside does not take as starting point approach set out in NHS Five Year Forward View identifying three 'gaps' – health and wellbeing, care and quality, and finance and efficiency.

Primary care

STP is predominantly concerned with changes in acute hospital sector; however, STP Executive Summary states (p3), "Investment in improving the resilience of services delivered outside of hospital settings (primary care, social care, community care, mental health) is essential for us to transform our system and move towards both lower cost and higher quality care delivery".

Each of 3 LDSs approaches the issue of primary care differently. The Alliance plans mention primary care only in context of savings from GP prescribing (p30) and alleviating pressure on other services (p32).

North Mersey LDS plans for Demand Management propose (p37),

- Transformation of primary care aligned to the GP Forward View and forming an essential component of the Community Model of Care

- Consideration of the Liverpool GP Specification across NM

And to handle the pressure of minor/primary care cases on A&E

- Addressing activity at the front door of NM AEDs through the provision of GP streaming

- Developing capacity and utilization of primary care through the creation of primary care hubs in the community for routine and urgent care 7 days a week.

Cheshire & Wirral LDS, under High Impact Community Based Integrated Care Schemes proposes to strengthen and expand primary and community care services with: Integrated Community Teams; New Models of Primary Care; Long Term Conditions Management; Intermediate Care; Care Homes Support; Integrated Discharge Processes; and Community Services MCP. It states (p44), "This will be done with reference to the Five Year Forward View for General Practice and the development of integrated health and social care. It is recognised that to support Primary and Community Care, resources are required to deliver these changes".

However STP does not provide concrete proposals for development that are costed with timetables attached.

New models
STP includes proposals for more self-care linked to new technology.

North Mersey LDS proposes (p39), "Patients to be enabled to use assistive technology to manage their care and interact with professionals, and to access information about their own health and conditions to support them to self care".

The Alliance plans include (p30),"Identifying individuals to support better self care to provide them with IT equipment in their own home to monitor their conditions to reduce emergency admissions", and North Mersey LDS also has plans for patients with long term conditions (p37), "Full telehealth monitoring for patients with COPD, Diabetes or Heart Failure with a risk of admission above 25% and also pass the clinical suitability gateway, and "Provision of 'light touch' and self care telehealth systems and apps for patients below 25% risk and for a wider range of diseases".

Prevention
STP proposes (p4) system-wide to promote 'prevention at scale. 3 STP-wide projects have been agreed, on Alcohol Harm reduction, High Blood Pressure, and Antimicrobial Resistance (pp9-10). Each LDS has projected cash saving from this, totalling £18.2m across the STP by 2020/21 (p10).

Q9. Overall, are the objectives of the STP clearly expressed in SMART terms (specific, measurable, assignable, realistic and time related)?

STP does not provide objectives that can be viewed using SMART criteria.

Q10. Clarity of plan: local context:
Provide any details of local stakeholders and details of historical, current and projected financial deficits and any long-standing issues, as available from STP.

STP area is second largest in the country encompassing services for 2.6m population: 12 CCGs, 20 providers and 9 different local authorities (p1 and for long list of local bodies involved see Q2 above).

No details are given in the STP of current and previous performance of NHS, and there is no specific reference to the finances of local government and social care.

STP states projected 'Do Nothing' financial deficit is £908m (p50) which is reduced to projected deficit of just £1.9m by 2020/21 through range of measures (p50).

However STP goes on (p51), "In addition to addressing the issues noted above our focus now will be on strengthening the financial modelling through development of a demand and capacity model at STP level. This will enable us to more accurately and quickly reflect the impact of our solutions through a more thorough understanding of the drivers of costs across the system". There is much still to do.

Q11. Clarity of plan: finances

- **Are full financial projections included, or financial appendices published?**
- **Are important details still to be published or withheld?**
- **Are savings targets broken down by service and provider?**
- **Are revenue implications for providers made clear?**
- **Are capital requirements made clear?**

STP provides no financial projections and does not refer to financial appendices.

The STP is inconsistent in its presentation and confusingly structured. Some of the plans for STP-wide savings (from p9) set out their savings targets (p10,14) whereas most of them do not. The Alliance proposals begin with a table setting out target savings, and more details for specific plans follow (pp30-33): but the North Mersey plans are set out completely differently (from p34) and appear to have no clear savings targets. The Cheshire and Wirral section from p41 is set out differently again, and has an extensive series of target savings (pp42-45).

There is no combined table to correlate and reconcile these targets with the overall figures that are presented on pages 50 and 51: STP is not one plan but three or maybe four.

STP projects that referral management scheme will save £61.5m if applied across the area in line with the 8 high impact changes proposed by NHS England (p11) while the Alliance projects it will reduce outpatient activity by 20% (150,000) and save £22.5m by 2020/21,

with a smaller reduction in elective and day cases (7,000) saving £7m a year after 1-2 years (p30). Cheshire & Wirral estimates management of demand to "match best decile NHS England performance" could save between £30m and £60m in that LDS alone (p45).

Some savings targets are broken down by service and by intervention, but none are broken down by provider: there is nothing in the Plan that addresses details of the 20 NHS providers. Even at an aggregate level there is only summary chart available (p51). This does not constitute a financial plan.

STP stresses dependence upon availability of substantial additional £755m capital to facilitate new development, reconfiguration and centralisation: it recognises it is unlikely all of this will be available from the constrained national pot of investment and transformation funding (p51), "We recognise that these plans are heavily dependent upon capital – up to £755m additional funding requirement in current plans as shown below", and, "However we recognise there is still significant work to do before these high level requirements are turned into robust business case ready solutions. In particular to fully articulate the cost/benefits associated with the proposed investment", and, "We also understand that Capital funding is extremely limited and that we will need to focus investment in those schemes that provide the most beneficial impact on our STP plans. In doing so we recognise that there may be schemes that do not get approved and the STP will therefore the benefits will also need to be reassessed [sic]".

However a total of £1.68bn of capital is required across the STP area if 'Business as Usual' capital requirements are also included, as they must be (p52).

Q12. Clarity of plan: services

- **Are the service implications clear?**
- **Which services are cut back?**
- **Which expanded?**
- **List any acute services cut, sites closed.**
- **List any A&E departments closed.**
- **What staff posts are reduced?**
- **Community services cut/ sites closed, or opened**
- **Primary care services expanded**
- **Other out-of-hospital services expanded**
- **Staffing and service implications in terms of posts created, downgraded, or lost.**

STP does not provide clear view of service implications. STP does not identify A&E units or acute sites for closure or downgrade in final version of STP – although earlier drafts did.

However in each locality there are discussions of acute services that could result in substantial change. But no specific details are given.

For example, Mid Mersey Alliance discusses alternative models of Urgent Care Systems that could have the effect of downgrading one or two A&E departments (p31) and a Review of Paediatrics that could also bring what would amount to downgrading (p32), "Move from 3x level 2 units to:

2x high acuity units & 1 lower acuity unit or
1x high acuity units & 2 lower acuity unit or Higher and Lower levels of Acuity".

North Mersey discusses reconfiguration of 35 adult acute services across RLBUH, AUH and LHCH, "to establish single service, system-wide services" with detailed service reconfiguration plan to be set out in an Outline Business Case, currently in development: this could mean "Site rationalisation across 4 to 5 hospital sites in the city" (p35).

Cheshire & Wirral LDS discusses remapping of elective and emergency care models in Eastern Cheshire in which (p46), "A number of emerging clinical models are being developed and will form the basis of an option appraisal. Clinical modelling covers emergency care (including options to retain the A&E department or the development of an urgent care centre) and elective care. The frailty pathways being developed will be explored to share best practice with other parts of Cheshire and Wirral."

A separate exercise in Central Cheshire aims to "Agree long term models for elective and emergency care in Central Cheshire based on strategic relationship both within Cheshire and Wirral and surrounding localities so as to reflect patient flows."

Cheshire & Wirral also wants to (p46), "Explore an option to consolidate elective care between the Countess of Chester Hospital NHS Foundation Trust and Wirral Teaching Hospital NHS Foundation Trust on the Clatterbridge Hospital site", and "Explore the consolidation of Acute Care Alliance between Countess of Chester Hospital NHS Foundation Trust and Wirral University Teaching Hospital NHS Foundation Trust – creation of integrated low and high dependency units for women's and children's services".

STP provides no detail about plans for development of community-based services or primary care services.

STP provides no detail on staffing implications of proposals, other than savings on administration and support that are seen as STP-wide initiative (p19).

Q13. Clarity of plan: Workforce

STP does not provide Workforce Plan, although it is listed as one of the unpublished Appendices (p58).

There is no substantial discussion of workforce strategy.

Q14. Is social care included? What assumptions are made?

STP provides little discussion of social care. There is no reference to projected deficit by 2020/21 in social care, and no specific measures are discussed relating to dealing with this.

This STP reads almost entirely as acute hospital-led NHS programme.

Q15. Is there a model that describes the plan?

- **Has the model been made available?**
- **Are assumptions made clear?**
- **Do they appear realistic?**

STP provides no model underlying its Plan, and there is no discussion of assumptions. However there are some references to development of financial models (p51), "In addition to addressing the issues noted above our focus now will be on strengthening the financial modelling through development of a demand and capacity model at STP level. This will enable us to more accurately and quickly reflect the impact of our solutions through a more thorough understanding of the drivers of costs across the system", and "Financial model highlights" is one of the unpublished Appendices (p58).

Q16. Is there any reference to evidence supporting the plan?

- **Is this robust and credible?**

STP provides no reference to research or academic evidence and no sources are cited for data used in STP.

Q17. Is there risk analysis?

- **If so, are risks quantified and probability attached?**
- **What are top three risks cited?**

STP does not provide risk analysis that quantifies or assesses probability of risks and impact, or provides a set of mitigating factors.

However STP outlines following under 3 headings: strategic; decision-making; and internal capacity.

STP states under heading 'Strategic Risks' that projected figures on size of the 'gap' by 2020/21 and on value of potential savings to bridge the gap are very likely to be wrong, by quite a margin (p57),
"Financial Sustainability challenge. Since the June 2016 submission of the Cheshire & Merseyside STP, we have taken the opportunity to commence some initial steps to create a common standard of assurance across the footprint. What we have since received in the STP Working Group is a set of high level assurance assessments, both documented and verbally, which demonstrates that our current plans are extremely unlikely to close this gap.

The size of the current gap is an estimate and more work to agree the future assurance framework is yet to be completed. However, two dimensions can be described in that: firstly, the current level of planning has no level of contingency (indicatively 25-50%) that would normally be associated with programmes of this size and complexity; secondly, the robustness of the 'plans' and associated risks regarding measurability, capability and deliverability all serve to make us discount the current value of the whole by a figure of 30% equating to some £300m".

STP states under 'Decision-making' (p57),
"In due course, t is likely that a number of the decisions required may face public resistance and political challenges. We therefore need to have mature and well oiled governance mechanisms to receive and involve the concerns of our staff and our communities with their representatives".

And STP states under 'Internal Capacity' the need to move much faster to develop leadership for STP, which requires freeing up "key members of staff from other duties (p57), "We are at a watershed moment and the Membership Group has recently agreed to consider all requests for capacity and skills in the light of insufficient progress being made to exploit the goodwill and discretionary efforts of all those contributing to this plan to date".

[1] http://www.southportvisiter.co.uk/news/southport-west-lancs/sefton-council-pledges-fight-local-12196845

[2] http://www.liverpoolecho.co.uk/news/liverpool-news/mayor-anderson-comes-out-fighting-12264453