STP analysis Durham, Darlington, Teesside, Hambleton, Richmondshire and Whitby

http://nhsbetterhealth.org.uk/wp-content/uploads/2016/11/STP-Draft-Plan-on-Page-Final-1.pdf

The STP Process

Q1. Version Control:

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

Published October 2016 (p1). The STP talks about iterations but no dates given (p3).

The STP states (p42), "Our objectives are to ensure legal duties to engage and consult are met whilst maintaining public confidence in health and social care and supporting safe and robust reconfiguration of services".

Formal consultation on the STP is intended – no dates given – which will inform decision-making.

Q2.Stakeholder sign up:

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

There is no mention in the STP of stakeholder sign-up. However the STP states (p9), "Stakeholders across the STP geography have approved a strategy and a set of quality standards which set out the ambition to deliver person-centred outcomes".

The STP mentions (p43) stakeholder forum events carried out under the Better Health Programme: with, Local Authorities, Voluntary Sector, Healthwatch, CCG patient participation groups, Joint Overview and Scrutiny Committee, and Health and Wellbeing Boards. Also have engaged the local community and provided them with information so they can influence decision-making on 'Fit 4 the future' proposals. Formal consultation was carried out from July to September 2016.

However there is no indication that all stakeholder bodies have agreed the STP as presented.

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?**

The STP states (p44), "We envisage the need to streamline the contracting process and reduce transactional activity at individual provider and commissioner level".

And (p44), "... recognising that there are provider cost reductions that are not picked up in PBR tariffs, we are working towards a capitation based approach across the system. This will require the development of appropriate financial flows and incentives to support delivery across Acute, Community (including Social Care) and Primary Care pathways".

STP states (p44) the approach will require strong collaborative commissioning arrangements working across current organisational boundaries. There is also mention of strengthening integration arrangements with social care, and the aim was to have arrangements in place in shadow form by 2016 with further development in 2017 so that fully integrated commissioning approaches are in place by the autumn of 2017. An unreadable and frankly incomprehensible graphic describing these arrangements is provided on p45.

There is no mention of ACOs; nor is there any mention of formal integration with local authorities although the notion of improving integration with social care is mentioned (pp8,44); and implementing integration of health and social care as part of community model (p25).

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?**

No timetable is provided for delivery of the STP as a final document.

There is an implicit timetable for delivering financial savings and cuts in activity (p47) – up to 2020/21. A delivery timetable is laid out for each of 4 programmes of work: early intervention and prevention; neighbourhood and communities; acute hospital reconfiguration; and digital care and technology (pp19-35), with milestones from 2016/17 (baseline) to 2020/21 and key outcome measures (p36). An 'indicative' timetable for estates is also provided (pp38-39) although only up to June 2017.

Deliverables in 2016/17 tend to be process rather than outcome. These can be found (pp19-35) and at this stage where they are measurable they form more of a baseline against which future improvement can be measured.

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

The STP is said to be building on work done under the Better Health Programme (BHP). The STP states (p43) a draft governance framework has been developed in partnership with the CCGs, NHS FTs (all providers) and Local Authorities. There is an STP Programme Board (Chair Alan Foster, CE, North Tees & Hartlepool NHS FT) and Programme Management Office but no detail of membership is given. In addition there is a Joint CCG Committee whose terms of reference are being refined with the transition from BHP to STP, and will

now have been approved by each CCG. The NHS FT Committee in Common has agreed terms of reference subject to approval by respective Boards in November.

The STP goes on to state (p43) "the Local Authority statutory decision-making arrangements are clear and will focus on co-design of strategy development in the Programme Board". This does not give a clear idea of how this will operate.

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

There is no indication of the costs of the process, nor of number of staff involved.

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?**

The STP states the population is 1,091,710 (p4). No year or reference is given for the data. No population projections are provided. On p4 there is a graphic illustration of some key characteristics of the population: 20% smoke; 69% overweight or obese; 6% unemployed; 4% minority ethnic group.

There is no reference to an overall needs assessment for the STP area, nor to any Health and Wellbeing Board analyses. However the STP indicates (p25) an intention to organise care based on "a risk assessment based proactive approach to care looking at a whole population model (based on populations of 30k-50k)". This could lead to a needs-based approach in the future.

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?**

As with most STPs, this takes as starting point approach set out in NHS Five Year Forward View identifying 3 'gaps' – health & wellbeing, care & quality, and finance & efficiency (p5). It places emphasis on improved primary care access, new models of care and self-care, and prevention.

Primary care
Thus there will be CCG investment into developing and supporting Primary Care, delivery of extended access, and implementation of new models of care (p19).

The aim is to ensure sustainability of general practice by implementing GP Five Year Forward View, ensuring local investment meets or exceeds minimum required levels, increasing number of doctors working in general practice, Investing in training practice staff and stimulating the use of online consultation systems, changing skill mix for GP workforce, introducing care navigation roles, and extending and improving access in line with requirements for new national funding.

The following benefits are hoped for (p26),
- Increase in GP numbers and skill mix with healthcare professionals
- Improved access times to primary care
- Increased 111 access to general practice appointment systems
- Improved information sharing and data flows across health services
- Increased scope of services available in primary care
- Improved satisfaction rates for access to primary care
- Increased funding in primary care
- Increase inter practice referrals and greater use of technologies e.g. Skype and telehealth
- Reduction in A&E attendances

This requires extra resources as listed (p26),
- Access to and utilisation of Estates and Technology Transformation Funding
- Additional investment to primary care access through the sustainability and transformation package of support from 17/18 to 18/19
- Additional workforce capacity through working practice and innovation and increased recruitment and retention
- Transformation resource to support the implementation of new models of care

But no detailed proposals, costs or timetable is provided for this programme of change.

New models
Similarly the STP mentions new models of care eg Community Hub model, and lists widespread benefits as a result (p25), but no detailed proposals, costs or timetable is provided. Improvements require improved IT throughout the system but do not seem to depend on the introduction of new digital technology to patients. Little is said about self-care although it is mentioned in passing (pp11,27,34). Digital care and technology is presented as an enabler (p34) but relates more to using shared data across the system.

Prevention
Prevention is one of key principles of the STP involving (p9),
- Promotion of health, wellbeing and independence;
- Patients supported to self-manage their condition and maintain healthy lifestyle; and,
- Directory of services of health, care and support services in each local community.

Key areas of focus are lifestyle: smoking, alcohol and overweight or obese (p12).
The STP suggest there will be joined-up targeted public health response across the STP footprint with (p19),
- Focused input to identify, and work with, hard to reach groups and deprived communities
- Support for primary care to manage worklessness and support people with LTC back into employment

- Multi disciplinary workforce to ensure that every contact counts underpinned by a long term plan for workforce recruitment to the NE and not based on individual organisations
- Continuous improvement and awareness of pathway developments across the footprint through a robust training and education plan
- Additional resource through working practice and innovation to improve secondary prevention in primary care and secondary care

Prevention is expected to help reduce deficit through reductions in demand but although savings figures are given (p48), there is no detail given on how it will work, what the investment costs are, and what timescale is.

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

Objectives of STP are not clearly expressed in SMART terms. Some measurable objectives are provided eg 5% reduction in A&E attendances (p36), but often these are couched in general terms eg reduction in top 10 childhood illnesses (p22). Moreover generally these are no set against specific programmes, and no clarity on timescale is provided.

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.

The STP consists of 5 CCGS – Durham Dales, Easing ton and Sedgefield; Darlington; South Tees; Hartlepool & Stockton-on-Tees; and, Hambleton, Richmondshire & Whitby (p1); currently 6 acute hospitals – James Cook, Darlington, North Tees, Bishop Auckland, Hartlepool, and Friarage, 2 ambulance providers – North East Ambulance and Yorkshire Ambulance, one mental health provider, and 7 councils – Durham, Darlington, Hartlepool, Middlesbrough, Redcar & Cleveland, Stockton, and North Yorkshire (p14).

The financial position is discussed in a Financial Appendix (pp47-48). Although financial position in 2016/17 is mentioned as basis for projections, no figure is actually given for this in the STP, nor of the projections in the financial part. However it is projected there will be a deficit of £281m by 2020/21 driven by increased demand (p5). This will be met by savings in 4 areas: acute reconfiguration £110.7m; neighbourhoods & communities £42.9m; early intervention & prevention £9.6m; and 'Other' £100.8m.

Acute reconfiguration(plus estimated savings) includes:
- Consolidation of A&E departments on to two sites £2.2m
- Consolidation of Acute Medicine onto two site £7.2m
- Consolidation of Acute Surgery onto two sites £2.0m
- Consolidation of Providers: Reduced corporate costs
    - Consolidation of provider Boards £2.0m
    - Corporate and Admin reduction £39.1m
- Carter opportunities: Reducing unwarranted variation £36.6m
- Pathology Collaboration: Consolidation of pathology services £21.7m

Early intervention and Prevention includes:
• Consolidation across sites of obstetrics £4.8m
• Consolidation across sites of paediatrics services £4.2m
• Consolidation across sites of NICU £0.6m

Neighbourhood & communities includes:
• Role substitution £11.0m
• Primary care Demand Management £16.5m
• Not in hospital £15.4m

Other includes:
• Business as usual CIP £42.8m
• STF Funding £41.5m
• Commissioning Efficiencies £5.9m
• Medicines management savings £10.6m

A large part of these savings are not dependent on the STP but would arise anyway through various ongoing efficiency programmes.

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?**

Full financial projections are not included. There is no mention of financial appendices; just a 2-page financial appendix published with the STP (pp47-48 as referred to in Q10). Savings targets are broken down by high-level programme (see Q10); not provided by at provider level and revenue implications for providers are not mentioned. Capital requirements are not made clear. Estates section (p38) recognises the need for capital expenditure on acute sites in order to create effective patient flow and service efficiency in line with Better Health Programme proposals. Additional specialist resource is required for delivery of acute reconfiguration including substantial capital programme across multiple sites.

The STP states with no further detail the assumption that the plan will require potential capital investment of £115m. But that is as far as it goes.

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.**

Part of the STP 'vision' is (p13), "The potential reconfiguration of the specialist hospital based emergency services ... it demonstrates a system wide approach underpinned by a clinical network of services with local care provided by the local hospitals (this is under development and subject to consultation)".

Although it is stated that the potential reconfiguration is under development and subject to consultation, it seems the STP's aim is to reconfigure acute hospital services by downgrading 4 sites to local hospital while 2 remain with full A&E facilities (pp14-16). Hartlepool, Bishop Auckland and Friarage are designated local hospitals, James Cook as acute hospital, and either Darlington or North Tees acute hospital with the other as a local hospital. All would have urgent care centres but only James Cook, Friarage and either Darlington or North Tees would retain A&E. However, this may not be the chosen option (see pp15-16 for decision criteria from which we believe inclusion of A&E at Friarage on p14 may be a typo).

There is no mention of losses of staff as a result of these changes to acute services.

The STP is projecting substantial reductions in number of people using acute services by 2019/20: first consultant outpatient appointment down almost 20%, non-elective down almost 26%, A&E down almost 23%, elective down over 6% (p47).

It is intended to extend primary and community and out of hospital services but no specific details given on estate implications, location, costs, staffing.

The Estates section (p38) mentions a review of Community Hospitals to support Not in Hospital Care, and that this may produce medium term consolidation and saving opportunities; also states 'Not in Hospital care model' supported by GP community hubs and primary care led urgent care imply need for evaluation of estates implications. It is clear from next steps on p39 that there is still much work to do in understanding implications of these changes. This suggests that there are no robust estimates underlying this plan.

Q13. Clarity of plan: Workforce
Is there a detailed plan to ensure an adequate workforce will be in place?

Workforce is one of the 'enablers' for the STP (p40). There is no detailed plan but this page outlines resources, capacity and capability required within the system. Actions to date and ongoing include (p40),

- Investment in the primary care workforce, this includes increasing the numbers of staff working in primary care in substantive posts and training schemes, developing the entire primary care workforce, including practice nurses, pharmacists, health care assistants, practice management staff

- Investment in bands 1-4 workforce to reflect their increasingly patient facing role. Including enhancing their competencies to ensure that they can deliver their current roles but also, where appropriate, deliver additional roles traditionally done by other staff.

- Introduce new roles \ change skill mix and expansion of staff working in different roles, eg advanced practitioners and healthcare scientists taking on roles previously done by medics and physician's associates, working across secondary and primary care in a variety of services.

- Ensure continuing workforce development of staff is reflected in the investment by employers but also by HEE NE.

- Continued work, including via HEE NE, with care homes, hospices and the voluntary sector to understand their education and workforce issues. This includes making education and training available to those working outside of NHS employment.

- Work collectively and individually to reduce turnover and increase retention of the workforce and seek to deliver a more efficient and effective use of bank and agency staff.

The STP refers to a template that has not been made available (p40), "For greater detail relating to assumptions made on workforce projections please refer to the separately submitted finance and activity template".

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

Although social care is mentioned throughout in the context of the health and social care system, no detail is provided. It is not clear to what extent the STP has been developed in partnership with colleagues in local government but the evidence for it is sparse.

There is no mention of social care in the finance appendix (pp47-48). The projected £281m deficit reported only refers to the NHS (p5). We do not know from this document what the position is in local government.

Q15. Is there a model that describes the plan?
- **Has the model been made available?**
- **Are assumptions made clear?**
- **Do they appear realistic?**

No model is made available. It seems a lot of modelling work remains outstanding eg estates section refers to need for external resource for healthcare planning and modelling that was intended to be delivered by November 2016; also identifies need to work with CCGs to understand hub proposals and model cost and delivery options (p39).

The financial appendix provides a list of 'strategic' assumptions (p47),
- The underlying financial position is based on 2016/17 financial plans
- The cost and tariff inflation used when modelling the financial gap is based on the 5 year planning guidance, covering 2016/17 to 2020/21

- The activity growth included in future years modelling is based on NHS England's growth percentages, issued to individual STP footprints
- Significant shift in activity from hospital based services to community based provision
- Shift in frail older people currently admitted for NEL purposes from acute to a community based provision
- Current A&E activity will shift to urgent care centres
- Potential capital investment of £115m

Without further detail it is impossible to evaluate these assumptions.

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

- **Is this robust and credible?**

No evidence is provided in the STP. There is only one instance where 'evidence' is referred to but it is never made explicit (p33), "The medical evidence shows that where patients are admitted to specialist centres with staff seeing a high volume of patients with similar problems, and meeting high clinical standards, the outcomes for patients are much improved".

In particular no evidence is produced to justify the assumptions of large reductions in activity that underlie the plan (see Q15).

Q17. Is there risk analysis?

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

No risk analysis is provided.

The STP states what are workforce issues common across the NHS (p40), "At a regional level, some medical specialties are at risk such as Psychiatric workforce, Emergency Medicine, General Internal \ Acute Medicine, Clinical Radiology, Community Sexual and Reproductive Health, Oral and Maxilo Facial Surgery, Immunology, as is general practice; and, there is a high proportion of GPs over the age of 50. This is a risk in terms of the number of GPs expected to retire in the next 10 years; the challenge is in ensuring that there are enough newly qualified GPs to replace this cohort".

Finally, there is a bald statement (p48), "By nature of the complexity of the change this makes delivery high risk. Arrangements are in place through the governance framework to mitigate these risks".

But any such arrangements are not discussed in the governance section, and no attempt has been made to present quantified risks with possible mitigation.