STP analysis Greater Manchester

http://www.gmhsc.org.uk/assets/GM-STP-3-Implementation-Delivery-Narrative-FINAL-251116.pdf

The STP Process

Q1. Version Control:

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

Exact status of STP itself (document referenced above) is confused.

STP is dated 10/18/2016 (p1); confusingly it entitles itself an Implementation and Delivery Plan and claims (see below) that the earlier "Taking Charge" document in December 2015 (GM's BCF response) is its main authority and has been the subject of public consultation. http://www.gmhsc.org.uk/the-plan/

STP states (p5), "This is the second update to the GM HSC Partnership team delivery plan (the first version was developed in June) and should be considered in the context of 'Taking Charge' [presumably the Dec 2015 version] along with 10 locality and programme plans for the GM transformation themes and cross-cutting programmes". This gives some sense of the complexity of these proposals and difficulty most people may find in understanding and responding.

STP states (p6), "This plan is a live document, which will not have a final version. We will review it regularly, so that as a system we can identify what has been delivered and agree our next set of priorities, but also where there have been challenges to delivery, so that we can work together to resolve them".

And (p6), "At the end of our first year of devolved health and social care, this plan will be fully reviewed, along with all the constituent plans (transformation themes, programmes and localities) and refreshed to create a plan for 2017/18".

So it appears it is not intended to produce a final definitive STP.

STP goes on to say (p5) "Greater Manchester has published its STP-Taking Charge as a full strategic narrative and a public facing version. It has been extensively consulted upon with the residents of Greater Manchester, as this narrative outlines in later sections."

If there was any doubt about this, it claims on page 5 again " the principles of transformation are agreed...and...has moved into the implementation phase".

The clear message is that the STP is not for public consultation but has moved into its implementation and delivery phase.

This seems to be stretching interpretation of consultation surrounding the December 2015 version of 'Taking Charge'. This document was more interested in the principles of devolved governance rather than the specifics of what is being proposed by way of

significant changes to health services. Even now the delivery plan remains vague on this and there remains clear need to consult with the public and stakeholders on details of significant changes at right time, once business cases are completed and prior to formal agreement to plans and implementation.

Our impression is of a very much top-down driven process rather than a local process taking account of people views and needs.

Q2.Stakeholder sign up:

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

STP states (p5), "The Greater Manchester Health and Social Care system is comprised of:

- 12 CCGs
- 14 acute, community and MH Trusts & 1 ambulance Trust
- 500 GP Practices
- 450 General Dental Services
- 700 community pharmacies
- 300 community optometry services
- At least 300,000 carers
- 10 local Authorities
- 27 social housing providers
- 14,500 voluntary and community organisations
- GM Police
- GM Fire & Rescue Service
- 2.8m residents".

However, STP does not claim these stakeholders are all in agreement but states they are (p6), "working together on the radical reform of public services"; it also makes the remarkable claim that (p6). "The £6 billion we currently spend on health and social care has not improved the long term outcomes for people living in GM".

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 proposes new governance systems through GM HSC Partnership (p11),

- "Ensure the Partnership is able to effectively direct transformation and connect effectively with enablers for day to day delivery

- Ensure the focus of the Partnership's leadership is appropriately balanced across all areas of its responsibility

- Ensure clarity on governance structures, supported by effective delivery mechanisms through focussed programme and delivery boards

- Avoid duplication of review and reporting on specific issues
- Support the alignment of the Partnership team's capacity across the full range of its responsibilities

- Ensure the Partnership has a clear line of sight on delivery and assurance issues across Quality; Finance; Performance and Delivery; Strategic Plan Implementation and Transformation Fund Management."

There is Executive team (pp12,13), "The Greater Manchester Health and Social Care Partnership Team is the group of people who came together on April 1, from the former Health and Social Care devolution team and the former NHS England Greater Manchester team. Executive team is now in place:

- Chief Officer – Jon Rouse
- Chief Operating Officer – Nicky O'Connor
- Executive lead Finance and Investment – Steve Wilson
- Executive Lead Quality – Dr Richard Preece
- Executive Lead Strategy and System Development – Warren Heppolette
- Executive Lead Commissioning and Population Health – tbc".

STP goes on (p14), "The Transformation Portfolio Board will bring together locality leadership with the GM transformation theme and programme leads to oversee and drive delivery of the GM transformation portfolio, direct and prioritise key GM level programmes of work and resolve key delivery issues/risks that are GM wide", and, "It will be responsible for overseeing the implementation, delivery, alignment and prioritisation of the transformation portfolio and ensuring progress is being made across all areas; and, "... to support the delivery of the Portfolio of Transformation, the HSC Partnership team will formally establish a PMO function within the team."

So although governance proposals are couched as proposals, executive team has been appointed (p16) and is formally establishing a Portfolio Management Office (PMO).

Land and buildings will be subject to new governance as STP states (p27), "Maximising value from the public estate to underpin public service reform and economic growth requires new governance structures. New governance structures will enable public sector occupiers including providers, commissioners, local authorities and other local/national bodies to work together to make decisions in relation to land and property assets that are strategically co-ordinated and aligned to maximise benefit across GM".

STP goes on (p42), "The GM Sustainability and Transformation Plan (STP) is Taking Charge and this was approved by the GM governance and NHS England (through the Programme Board) in December 2015. The accompanying Strategic Financial Framework was the basis upon which we have agreed a Transformation Fund of £450k with NHS England, in order to accelerate our system reform plans".

There seems to be intention to devolve implementation to 10 localities and programme plans mentioned above (see Q1) on basis of locality plans presented. Detailed governance arrangements have not yet been agreed however and there is risk the PMO approach described in STP (pp14,15) could be in overall control.

There is no mention of ACOs although the Local Care Organisations described in STP (p20) amount to the same thing.

On integration with local government the STP states (p17), "The 10 localities in GM have plans in place for the comprehensive integration of health and social care building on the approach undertaken to deliver the BCF".

This all suggests that rather than the STP taking over previous plans within 'Taking Charge', 'Taking Charge' has subsumed the STP within its ambit.

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 a timetable for delivery of STP as such. No specific service developments or deliverables are listed for 2016/17.

STP states (pp42,43), "The starting point for the GM approach to the 2017-2019 planning round will be Taking Charge and the 10 5-year Locality financial plans ('roll-ups')".

These roll-ups detail locality forecast 5-year 'do nothing' financial deficits as whole. This is broken down by organisation (CCG, NHS acute provider and LA). These plans then outline interventions that will take place (via POD) to close forecast gap, by organisation, in finance and activity terms. This is demonstrated on an annual basis.

In response to national planning guidance, the GM Health and Social Care Partnership Team has issued a letter to all 37 organisations in the area confirming how as a system, it intends to approach the planning round. This means however that detailed plans are yet to be agreed.

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

STP describes STP Board thus (p11), "Governed by the Health and Social Care Partnership Board, which meets in public each month, the Partnership comprises the 37 local authority and NHS organisations in Greater Manchester, plus representatives from primary care, NHS England, the community and voluntary sectors, Healthwatch, Greater Manchester Police and the Greater Manchester Fire and Rescue Service".

This Board is chaired by Lord Peter Smith Chair of the Greater Manchester combined authority. No further detail of membership of Board is given in STP itself but it does refer to further appendices, which have not been available to the public (p57); these purportedly discuss governance and board assurance framework and may provide more details.

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

STP does not provide information on direct costs of running STP process but we know there will be direct costs of running Executive Team and the portfolio management structure.

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 there are 2.8m residents but source and year not given (p5). There is no STP-wide needs assessment provided, nor does STP refer to needs analysis by health & wellbeing boards. Instead STP assumes needs issues were addressed in 'Taking Charge' stating (p8), "The 10 localities in GM have mapped their locality plan outcomes and deliverables to the 7 population health outcomes we agreed in the Taking Charge plan to ensure we are all contributing to the delivery of outcomes that improve the life course for our population".

Although STP lists unpublished appendices (p56), the list does not include a needs assessment.

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 the approach set out in NHS Five Year Forward View identifying 3 'gaps' – health & wellbeing, care & quality, and finance & efficiency (p17).

STP does reflect national template (pp18-39).

Primary care
STP provides just general outline of what will be done (p21) but no concrete proposals, no costs and no timeline.

New models
STP says little about what new models of care will mean in practice (pp29,53). There is one reference to self-care (p6) and references to digital developments are in relation to bids for additional funding rather than a discussion of what difference access to new technology will mean to clinical practice (pp48,54).

Prevention
Only two references are made to preventative care (pp19,21) and these in a spirit of preventative care being a good thing.

There are references to measures that will have the effect of reducing demand eg (p27), "through the combined effect of a radical upgrade in prevention, scaling up primary care, the integration of community health and social care and the standardisation of clinical support and back office services, there should be a reduced need for hospital capacity due to inappropriate demand" but such remarks are very general and at high level.

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

The key objective of the STP seems to be to establish new governance arrangements first and then take forward more detailed plans afterwards. More detailed plans (locality plans) are seen as responsibility of localities (p46).

This objective is not expressed in SMART terms.

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.

No detail is provided on current STP-wide deficits, in particular for 2015/16 and 2016/17.

STP refers (p45) to deficit of £2bn projected in 'Taking Charge' GM BCF bid (2015). New projection (p45) is £1.1bn by 2020/21 "due to the different assumptions underpinning the modelling". These assumptions are not elaborated upon.

STP states (p45), "There remain significant issues with Social Care including the profiling of the Social Care gap and the mechanism by which Social Care precept and Better Care Fund (BCF) will impact. These factors could undermine GM transformational efforts over the next 18 months and potentially jeopardise the achievement of NHS savings over the four years".

Thus there is large projected deficit (albeit now much reduced by making changes to assumptions) and savings plans have been made largely to eliminate this (if social care imbalances are ignored). Funding of social care seems to have potential to derail plans and is a major unresolved issue for the STP.

Table 1 is based on STP (p45).

Table 1: Projected position in 2020/21, £000s

	Do Nothing	Solutions	Do Something
Commissioner surplus/(deficit)	(241,272)	279,822	38,550
Provider surplus/(deficit)	(655,739)	602,873	(52,866)
STP NHS surplus/(deficit)	**(897,011)**	**882,695**	**(14,316)**
Social Care surplus/(deficit)	(176,350)		(176,350)
STP surplus/(deficit)	**(1,073,361)**		**(190,666)**
Potential STF Allocation 2020/21		170,000	170,000

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 does not provide full financial projections. STP describes supporting appendices (p56) but these have not been made available to the public. Moreover these do not contain more detailed financial appendices.

It seems that detailed planning, as mentioned earlier (Q9), is responsibility of localities.

STP presents broad assumptions of how savings will be made (p47),

Table 2: Impact of planned solutions over time

Solution	2016/17	2017/18	2018/19	2019/20	2020/21
Better care	0	199,102	256,730	267,718	233,259
Commissioning efficiencies	0	32,151	65,160	99,056	134,066
Provider efficiencies	0	99,208	202,057	308,218	418,335
Specialised commissioning efficiencies	0	22,700	46,390	71,107	97,035
Total	**0**	**353,162**	**570,337**	**746,099**	**882,695**
'Do Nothing' deficit					(1,073,361)
'Do Something' deficit					(190,666)

The discussion in the STP (p47) on how this deficit is to be eliminated indicates that although there is an understanding deficit is to be eliminated in 2016/17 precise details and contribution of STF funds are yet to be confirmed.

STP provides no breakdown of savings targets nor of revenue implications for providers.

On capital requirements, STP states (p48), "The level of capital included within the return remains at £1.6bn as per the previous submission; this comprises of £900m BAU capital and £700m capital required for transformation. It is acknowledged that this figure does not take into account the expected impact of efficiencies made from improvements in

utilisation of existing estate; this is one of the issues that will be addressed by the GM estates strategy along with flexibilities for off balance sheet funding.

Consistent with GM's requirement to access their share of the digital integration fund and transformational funding, we will ultimately expect to gain control of a delegated GM share of national capital and Capital Departmental Expenditure Limit (CDEL) – i.e. the ability to spend capital funds, for local allocation".

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 detailed service implications. There are no detailed references to changes in A&E services, or reductions in numbers of acute beds. STP mentions changes in acute capacity (p27), "through the combined effect of a radical upgrade in prevention, scaling up primary care, the integration of community health and social care and the standardisation of clinical support and back office services, there should be a reduced need for hospital capacity due to inappropriate demand".

STP provides no detail on staffing implications in terms of posts created, downgraded, or lost.

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

No workforce plan is provided. Workforce issues are discussed (pp24,25) but solutions are the responsibility of the localities to be developed in future time rather than being identified in the STP itself. No further detail is listed in appendices (p56).

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

There is very little included on social care. STP discusses social care funding under GM Financial Planning (p45),
"Health and Social Care gap: If the social care financial challenge of £176m is included in the position then the GM Health and Social Care gap at 2020/21 is forecast to be a deficit of £1,073m. The social care gap is the same in the 'do nothing' and 'do something' scenarios. This is due to limited information being available to identify solutions to the financial pressures within social care. The 'do something' includes additional protected social care funding but does not address the efficiencies required to close the social care gap".

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

STP refers to modelling of finance, activity and workforce (pp5,25,42) but the models are not made available and key assumptions not discussed.

Q16. Is there any reference to evidence supporting the plan?
- **Is this robust and credible?**

STP states proposals are based on principle of there being strong evidence base for changes (p38). However, this is only reference to evidence in the document and there is no effort or reference to evaluate and present such evidence as necessary to justify the STP.

Q17. Is there risk analysis?
- **If so, are risks quantified and probability attached?**
- **What are top three risks cited?**

STP sets out arrangements for risk management (p44) and major risks and mitigations are identified (pp47,48),

- "A number of GM providers are currently in discussion with NHS Improvement [NHSI] regarding their control totals and STF for 2017/18 and 2018/19. The current provider plans included within the STP do not include £42m of the £93m STF available for GM as the control totals for these providers represent a material difference from current locality plans. Where the receipt of STF has been assumed in the STP this has not yet been confirmed by individual organisations agreeing to control totals. However in these cases the NHSI control totals are broadly aligned with the locality plans. GM continues to work with providers and NHSI to agree control totals for the next two years. It is our intention through these discussions to:

    - Maximise the opportunity for GM to access sustainability funding for local providers;

    - Allow for alignment between locality plans (including Transformation Fund investment agreements) and locality control totals for providers and commissioners;

    - Allow in year flexibility to protect draw down of STF monies agreed for GM and to allow for local management of service changes.

- The STP submission required the estimated investment required to deliver the five year forward view requirements ('national must dos') in order to estimate the level of transformational funding required to deliver these priorities. GM has already secured £450m of transformational funding as part of the Devolution agreement. As part of the investment agreements that localities are required to sign to access this funding, they must also sign up to delivery of these priorities. Where localities have not yet submitted

applications to the Transformation Fund, they have not included transformational funding in their plans and may not have included the full cost of delivery of these national priorities. As locality plans mature and transformation funding is agreed, the GM financial model will need to be updated to reflect any further costs. Until all localities have agreed Investment Agreements, there is a risk that the cost associated with the delivery of these 'must dos' have not been captured in full in the locality submissions and therefore the STP. The £170m recurrent funding added to the GM solutions in 2020/21 represents the expected value of the national sustainability and transformation funding of £3.8bn following the end of the STP period.

- Recurrent delivery of the 2% BAU efficiency requirement by GM providers will present a challenge due to the previous work on efficiency that providers have undertaken. Whilst there is variation in the level of efficiencies that providers have been required to achieve in previous years, it is acknowledged that future years' efficiencies will need to be transformational in nature in order to deliver savings.

- Alignment between provider and commissioner plans is variable with some specific areas (e.g. NE sector) not currently aligned in terms of commissioner expenditure and provider income. GM is working with the NE Sector Board to aid resolution of these differences.

- There is also the risk that the STP is not consistent with operational plans that organisations are currently in the process of submitting. Where there are areas of significant misalignment, this will need to be revisited as operational plans are submitted (and reconciled to Investment Agreements for localities that have been funded).

- There is likely to be an element of double count within all solutions contained in locality plans. This is likely to manifest within activity where activity flow increases and decreases have not been consistently modelled between providers; Healthier Together is an example where this is likely to occur.

- The solutions identified in the STP are solely those contained within the locality plans. Whilst this is a significant step forward from a plan predicated on GM level top down assessments of savings from Theme 3 and Theme 4. It will not include the opportunities presented by pan GM work in those two themes. This represents an opportunity to mitigate the risk described above.

Work continues to further quantify these risks and mitigations to ensure the financial plan is as robust as possible".

These seem major risks that introduce major uncertainties about funding, savings delivery and alignment of planning assumptions and they remain unresolved and unmitigated.