STP analysis Humber, Coast & Vale

http://humbercoastandvale.org.uk/

The STP Process

Q1. Version Control:

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

STP is dated 21 October 2016 (p1), and is v2.0 indicating there have been previous versions, although dates of these not listed.

As part of what STP calls its 'communications and engagement plan' it is intended there will be feedback on STP through democratic engagement in January 2017, followed by formal consultation on STP in February 2017. STP states this consultation will inform strategic plan for STP footprint in May 2017, and there will be consultation around specific interventions from summer 2017 (p35).

Q2.Stakeholder sign up:

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

There are references to partnership organisations (e.g. p33) but no formal statements of stakeholder sign-up or dates thereof.

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?**

New systems are being created. Strategic Partnership Board is group where all key recommendations made about STP are discussed. Senior leader of each partner organisation is on the Board. MoU (Memorandum of Understanding) in place outlining way partners will work together on this group. STP Executive group is responsible for delivering the plan. Chaired by the STP lead, this group includes all priority and locality leads: most of these are at Chief Officer level (p33).

The STP indicates range of decisions will be made locally although some will be at STP level eg 'creating single acute network' (p27). STP states (p8), "In some cases, particularly where resources are stretched, we will need to be prescriptive around how individual initiatives are implemented. However for many initiatives, particularly the implementation of integrated multi-disciplinary locality teams, high level guidance and implementation support will be given to localities but the detail will be planned and implemented locally".

STP mentions development of Accountable Care Partnerships and ACO commissioning as part of place-based care (p27), and signals intention from April-June 2018 to commission

new ACOs in localities (p28). In N Lincolnshire and NE Lincolnshire STP claims (p29), "Through Healthy Lives, Healthy Futures (HLHF) we are developing locality approaches from March 2017 that will operate within our Accountable Care Partnerships (ACP)", and in Vale of York (p29), "Organisations in the Vale of York will work together in a new way (called an Accountable Care System –ACS) and develop locality teams to provide a new approach to service delivery from April 2017".

No further explanation of these systems is provided.

There is no mention of integration 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?**

No mention of further versions of STP and hence no timetable.

There is 'Delivery Roadmap' (p28) which sets out some deliverables in terms of 6 priorities from October 2016 to March 2019. From this, first phase to April 2017 is one of 'preparation and detailed design', the second to April 2018 is roll-out of new pathways, piloting and consultation on acute reconfiguration, and third to March 2019 is intended to move into 'business as usual' mode.

There is a timetable for reduction of estimated deficit but no actions are timetabled (p31).

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

STP lists Strategic Partnership Board not by name but by organisational position (pp40-41). There appear to be 36 members.

Board comprises: Northern Lincolnshire and Goole Hospitals NHS Foundation Trust Chief Executive; Rotherham Doncaster And South Humber NHS Foundation Trust Chief Executive; Tees, Esk & Wear Valleys NHS Foundation Trust Chief Executive; York Teaching Hospitals NHS Foundation Trust Chief Executive; Hull and East Yorkshire Hospitals NHS Trust Chief Executive; NHS Humber Foundation Hospitals Trust Chief Executive; York Teaching Hospitals NHS Foundation Trust Director of Community Services; Yorkshire Ambulance Service NHS Trust Director of Business Development; East Midlands Ambulance Service NHS Trust Chief Executive; NHS East Riding of Yorkshire Clinical Commissioning Group Chief Officer; NHS Vale of York Clinical Commissioning Group GP representative; NHS Hull Clinical Commissioning Group & HCV STP Lead Chief Officer; NHS Hull Clinical Commissioning Group Chief Finance Office; NHS North East Lincolnshire Clinical Commissioning Group Clinical Chief Officer; NHS North Lincolnshire Clinical Commissioning Group Chief Officer; NHS Scarborough & Ryedale Clinical Commissioning Group Chief Officer; Yorkshire & Humber Partners Academic Health Sciences Network Limited Chief Operating Officer; North Yorkshire County Council Associate Director

Integration; North and East Lincolnshire Council Chief Executive; North Lincolnshire Council Chief Executive; City of York Council Senior Strategic Community Development Lead; East Riding of Yorkshire Council Chief Executive; East Riding of Yorkshire Council Director of Corporate Strategy and Commissioning; Hull City Council Chief Executive; Hull City Council Director of Public Health and Adult Social Care; Care Plus Group Charitable Trust Chief Executive; City Health Care Partnership CIC (Community Interest Company) Chief Executive; Focus Independent Adult Social Work CIC Chief Executive; NAViGO Health and Social Care CIC Chief Executive

The above seem to be local leaders. In addition there are national figures on Board. These include: Royal College of General Practitioners GP Forward View ambassador; NHS England (North Yorkshire & Humber) Locality Director (North); NHS England (North Yorkshire & Humber) Director; NHS England (North Yorkshire & Humber) Assistant Director Specialised Commissioning; NHS Improvement Delivery & Development Manager; NHS Property Services Limited Head of Property Services; NHS Property Services Limited Property Strategy Manager.

There is also STP Executive Board (p39). This comprises named individual with no organisational assignment: Emma Latimer STP Lead / SRO of Strategic Commissioning; Emma Sayner STP Finance Lead; Peter Melton STP Clinical Lead; Nigel Pearson STP Local Authority Rep; Mike Proctor SRO of Enablers Workstream; Karen Jackson SRO of Acute & Specialised Workstream; Jane Hawkard SRO of Cancer Workstream; Andrew Burnell SRO Out of Hospital Workstream; Tim Allison SRO Prevention; Helen Kenyon SRO of Urgent & Emergency Care; Chris Long SRO of Hull & East Riding of Yorkshire; Simon Cox SRO of Vale of York and Scarborough and Ryedale; Liane Langdon SRO of Mental Health Workstream and North & North East Lincolnshire.

Emma Latimer signed STP Foreword (p2), and is STP Lead as well as Chief Officer NHS Hull CCG.

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

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

No costs of process are given and no personnel requirements outlined.

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 (p12), 23% of our 1.4 million population live in the most deprived areas of England; 8.9% are over 75; variation in life expectancy for men is 20 years and for women 17 years across the best and worst part of area. No source or date given for population.

STP does mention improving health and life expectancy of the population by reducing proportion of population with colorectal, breast and cervical cancers diagnosed at late

stage; reducing proportion of population smoking; and, reducing proportion of elderly patients experiencing fall (p16). But these are just recognised national issues. No needs analysis is presented nor is there any reference to work of Health & Wellbeing Boards.

STP does state (p24), "Technology is now available that allows us to get a thorough understanding of the needs of small populations, right down to street level, and we will be using this to make sure the services we plan really meet local needs, in addition to asking what is important to patients and citizens", but no further detail offered.

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 (p12).

Primary care

There is focus on primary care under place-based care heading (p17). But there is no concrete detail on levels of expansion, no costs given, nor detailed timetable.

STP states (p17), "a significant amount of additional investment will be allocated to our local practices in line with the GP Forward View. This takes the total expenditure in primary care to 10% of the overall STP resource". And, "The GP Forward View programme is intended to increase the number of GPs".

There is emphasis on integration of GPs with other services in community (p17), and primary care review and redesign is mentioned (p28).

New models

Little is said about new models of care although as means of preventing unnecessary hospital stays new models are mentioned under mental health heading (p27). Similarly little on self-care although "interventions to develop self care skills for mental health and well being" are mentioned (p22).

It is impossible to say how much new models rely on digital technology as so little information is actually provided.

However, STP does state (p17), "Digital technology will be used to support citizens in their home so that we understand how their health is progressing and people can look after their own health without the need to go to hospital". And, with respect to urgent care (p18)"digital solutions to help citizens identify where they need to go via apps or online self-help". The STP goes on to state there will be (p37), "information hub for citizens to access their health records and provide information on how to manage their health and to help them find out about other health and care services available to them".

Prevention
STP states it will (p6), "Implement prevention activities that we know work well across all localities –areas where these may typically be focused include obesity, alcohol misuse and tackling falls. On p8 STP emphasises prevention of cancer.

There is claim (p16), "Focussing on prevention could save the Humber, Coast and Vale Health Economy an estimated £11m through reducing un-planned and planned stays in hospital" but no evidence offered for this. Again, on p24, it is claimed, "Keeping people healthy through emphasis on prevention should help us keep more people out of hospital".

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

Objectives are not stated in SMART terms. Where there are measurable targets e.g. 62-day quality of care target (p28), no timescale offered; no action assigned.

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 covers Hull, East Riding of Yorkshire, North Lincolnshire, North East Lincolnshire, Vale of York, Scarborough and Ryedale with 20 organisations: 6 CCGs; 3 acute trusts; 3 mental health trusts; 6 Local Authorities; and, 2 Ambulance Trusts. In addition, there are other health and care organisations including community providers and community and voluntary sector organisations (p12).

STP states (p31), "If we do nothing, we forecast we will have a £420m funding gap by 2020/21". Although it is not clearly laid out (in fact it looks like the graph confuses 'do nothing' and 'do something'), the deficit in 2015/16 was around £100m, forecast to be < £50m in 2016/17, with STP plans in place (so-called 'do something'), similar in 2017/18 and 2018/19, £100m deficit in 2019/20, and breakeven in 2020/21. Under so-called 'do nothing' the deficit is shown as around £420m in 2020/21.

STP provides graph on p32 showing estimated reductions in deficit at 2020/21 from what it calls 'solutions'. These include: QIPP, CIP, Ambulance CIP, LA efficiency savings, STP funding 2020/21 (all of which do not appear to be dependent on STP); and 'helping people stay well', 'creating the best hospital care', place-based care, strategic commissioning, and supporting people with their mental health. No figures are provided for each of these. However it is clear from the graph on p32 that bulk of savings comes from first group i.e. usual cost improvements plus STP funds, with second group having minor impact. As no detail is provided we can make no further comment.

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?**

Only minimal detail given on financial position now and in future as stated in Q10 above. Full financial projections are not included, and no financial appendices have been published.

STP states (p31) it will operate a single control total for whole area, and that is working ensure STP as whole finishes 2016/17 in best possible financial position; single control total will operate formally from 2017/18. Also states it will look at establishing alternative payment mechanisms from 2017/18 that have collective focus on managing activity levels and reducing cost. States "The underpinning finance template shows clearly the impact on activity, benefits (costs and returns), capacity, workforce and investment requirements over time". However this has not been published.

STP claims its finance submission meets the required validation checks and an analysis of the impact of the recently notified control totals for 2017/18 and 2018/19 has been undertaken (p31).

STP has assumed receipt of STF for 2017/18 and 2018/19 within the finance template and it is anticipated that the residual gap for these 2 years will be covered by access to residual CCG drawdown as well as STP Transformation funding.

STP states (p31), "The capital requirements of the current ongoing projects are included in the 'do nothing' position. Capital plans linked to delivering the interventions are fairly embryonic and further work to refine these is required. We accept that we are in a capitally constrained environment, and will be actively exploring alternative sources of funding e.g. Public Private Partnership Arrangements that deliver value".

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.**

Service implications are not made clear. It is necessary to read between the lines.

Thus, STP implies in Delivery Roadmap (p28), there will be "Detailed review and options appraisals: Elective, Acute Network, Specialised Commissioning, Back-office and pathology", and this will lead to design and implementation across all acute hospitals.

STP states (p18), "As we have seen from our case for change 40% of people who go to accident and emergency did not need to be there and could have received care closer to home. We need to simplify the system and make sure there are services in place that mean people don't need to go into hospital".

P19 provides some more detail indicating focus on Dermatology, Ophthalmology, Orthopaedics, Orthodontics and Maxillo-Facial; plans to review complex rehabilitation services, paediatrics, neonatal intensive care and specialised orthopaedics over the next 5 years. STP claims (p20), "The case for change sets out the reasons why the current level of hospital care cannot remain as it is now and one of the main aims of this plan is increasing the level of care that patients receive close to home so they do not need to go into hospital. Any changes to services would be developed alongside patients, public and staff. Change would also be subject to appropriate public involvement".

However we find degree of circularity in this exposition with no actual detail provided in the document. The STP states there will be changes to model of care in Scarborough and also in North Lincolnshire & Goole Hospitals where there are currently 3 hospitals (p20). We suspect this implies some reduction in acute facilities but nothing is made explicit in this document. Similarly there is statement (p20), "will be establishing a Local Maternity System" but no indication of what this means for facilities.

STP targets (p17), reduction in number of people attending A&E; and, reduction in number of un-planned stays in hospital. No detail offered. There is claim focussing on place-based care could save estimated £32m.

STP states (p17), "The GP Forward View programme is intended to increase the number of GPs", but no numbers are provided. On p18 "We propose to improve the capability and capacity of the care market by undertaking a review of home care, active recovery and residential home capacity, and then rapidly implementing a plan where additional capacity is required. This will help ensure the sustainability of the care sector and see investment in services in people's own home, for example domiciliary care". Again no detail provided.

In Vale of York there will new mental health in-patient facilities for the local area in 2019 (p29).

No mention of any planned reductions in staff as result of any of these changes.

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

STP refers to (p30), "Developing the workforce for tomorrow – to address shortages of skills and help make sure doctors focus their time on things that no one else can do we

are implementing 2 training programmes: support staff at scale and advanced practice at scale".

These programmes are being taken forward by Local Workforce Action Board (p34). However, there is no indication that detailed workforce plan for whole area has been developed or is under development.

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

Social care is mentioned throughout as part of place-based services (pp6,17) but no detail offered. For example (p6), STP discusses implementation of "new integrated multi-disciplinary locality teams to join up local services to make sure the health system works for everyone. Local teams will coordinate and deliver as much care as possible in the community so people only go to hospital if required. These teams will in general include GPs, community services, social care, some services normally found in a hospital and potentially services from our vibrant local community and voluntary sector".

The STP addresses 'Health & Social Care integration and support' thus (p18), "We propose to improve the capability and capacity of the care market by undertaking a review of home care, active recovery and residential home capacity, and then rapidly implementing a plan where additional capacity is required". And, "GPs, community services and councils will work together to understand the citizens most likely to require long term care or be admitted to hospitals. They will then jointly help them to identify support and activities so they can look after themselves and stay healthy for longer. Examples of this kind of care include fitness programmes, dietary support, and loneliness programmes".

STP states (p29), "Scarborough will be implementing a integrated multi-disciplinary team structure (called a Multispecialty CommunityProvider -MCP) October 2017. It will bring together social care and primary care under a single organisation so care should feel more 'joined up' for people who live in the area". There are similar statements about other localities (p29).

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 has been made available and so we cannot assess its assumptions; however, by chance while searching the document we find reference that has been deleted on p32 to "Further information can be found in appendix 4 –detail of financial model".

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

No evidence is provided although the STP makes assertions like (p12):

- 40% of A&E patients require no treatment.
- 25-50% of hospital beds are used by people who don't need to be there

• 27% of people seen by GPs could have had their issue resolved another way.
• 36.5% of A&E patients went there because GP practice was unavailable or closed.

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

No risk analysis is provided. STP states (p32), "Our STP priorities are ambitious from many perspectives and HCV STP will require a conversation with NHS Improvement and NHS England representatives about the process for managing resources across these respective sector boundaries. Collective financial risk management protocols and ways of working are being drafted in order to be in place no later than 1 April 2017".