STP analysis Lancashire and South Cumbria

http://www.lancashiresouthcumbria.org.uk/sustainability-and-transformation-plan

The STP Process

Q1. Version Control:

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

Third submission to NHS England dated 21 October 2016. First submission 9 April 2016; Second submission 30 June 2016 (p3).

No date given for official launch of consultation on plan. There have been engagement events but these are not consultations. As of 21 October 2016, over 20 public engagement events were undertaken in 3 of the 5 LDP areas, with plans for the other 2 area programmes to start in November 2016 – this is in addition to staff side solution design events and digital, social media and advertising activity. Phase A: July-December 2016, Phase B: January-June 2017, Phase C: June-December 2017 (p35).

The STP states (p35), "We have already undertaken Westminster MPs briefings, established an MPs panel, offered quarterly 121s with each MP, attended regular HWBs, attended Oversight & Scrutiny Committees and briefed Council Groups at both unitary, County and District levels of local Government. We intend to share the STP with MPs and Council Groups in the coming days".

This suggests the STP has not been developed with the local government bodies.

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 Lancashire Health Overview & Scrutiny Committee discussed it (18 October) and its challenge was noted. A specially convened Joint Blackburn, Blackpool and Lancashire Health & Wellbeing Board discussed it (19 October) and agreed to support with no amendments. Cumbria County Council Cabinet discussed it (20 October) and agreed to support with one minor amendment (p3). No information provided on challenges or amendments.

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 there is an agreed and working governance structure for L&SC designed to allow collaborative decisions at the required pace of change (p12). But states (p24),

"No significant history of joined up plans across the STP footprint, that include our local authority and voluntary sector colleagues."

STP states NHS provider trusts in the area are working to develop a proposal for an NHS Provider Trust Forum that will act as collaborative, with agreed structure and governance arrangements (p16).

ACOs are mentioned as new model of care (p25) but no detail provided of plans to move to this model. However, the executive summary states (p9), "This STP sets out ambitious plans to develop a sustainable services platform in respect of developing local accountable care systems"; and, a table on p34 lists an initiative 'to establish 5 Accountable Care Systems/Organisations' across the L&SC system through Local Development Plans.

STP indicates that looking at developing proposals for an integrated commissioning function for Lancashire, building on the existing Collaborative Commissioning Board and the Joint Committee of CCGs responsible for the decisions around the Healthier Lancashire & South Cumbria Programme. However no mention of integration with local government (p15).

No further information on governance given in STP although there is an annexe on Governance.

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 provided. There is a list of initiatives that will be focus of STP in 2017/18 and 2018/19 on pp33-34; states milestones in heading of table but none provided.

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

STP lead is Amanda Doyle, Chief Clinical Officer, Blackpool CCG.

No reference to STP Board or Chair.

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

No information provided on costs of STP process.

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 provides GP-registered population in 2016/17 by 9 CCGs for L&SC (only part of Cumbria CCG is included). Total population is 1.735m (p7). Figures for population per sq km are also provided.

Provides a list of population characteristics (p14) though no reference to a needs assessment for L&SC or to any Health & Wellbeing Boards needs analyses,

- "The population is ageing with increasingly complex needs
- Economic deprivation in pockets across Lancashire and South Cumbria is contributing to poor health outcomes
- Heart failure, peripheral arterial disease, COPD, asthma and depression are particularly prevalent across the footprint
- Issues relating to alcohol consumption, smoking and poor diet are leading to avoidable long term conditions and emergency admissions related to harmful alcohol intake and self-harm
- Quality of life for people with long-term mental health conditions and long-term conditions is poor
- Depression prevalence is higher than the national average in all CCG areas."

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 many STPs, this takes 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 (pp5,9,11), although it does make explicit the link between these gaps and the Forward View.

Primary care
There is a clear intention to expand primary care (see Q12 below) by 20% (pp17,30). The STP states its model for primary care (p20), "Primary care providers working at scale through wider use of primary care staff and embracing new roles with access to routine medical care 7 days per week underpinned by high quality primary care estate, maximised use of technology with the integration and maximised utilisation of all 4 independent primary care contractors".

The STP recognises significant issues with primary care including fact Health Education England North West Region has the lowest GP coverage of any other region having 63.4

GPs per 100,000 population, and sets forth a 9-point plan to improve upon this (p25) enabling increased access to services.

There is reference to primary care plan in an annexe (which is on website) where there may be more detail; however, STP does not contain costed, timetabled plan for expanding primary care.

New models
The Plan emphasises improvements through better use of digital technology – not just in reference to self-care but across new models of care and prevention (p38). Thus (p17), "Our digital health strategy will support the delivery of our triple aim through the electronic sharing of health records to support safe effective care; implement digital tools to support self care; deploy technology enabled care to support independence; and underpin changes to our acute sector configuration".

And with respect to prevention,(p38), "Using apps with health coaching to support the whole systems prevention model; digital health literacy; online access to records, health & wellbeing apps, online resources.

Prevention
The STP certainly sees prevention as way of reducing demand (pp9,31), "Implement short term high-impact secondary prevention measures to reduce demands on services, whilst mobilising our population health model to implement primary prevention initiatives".

There is estimate of savings in 2017/18 and 2018/19 though only partially due to prevention measures (p33), "Starting NMoC [New Models of Care] roll out (avoidance of growth in acute demand of £36m in 17/18 and £72m in 18/19) – with emphasis on prevention, early intervention in the community and support for early discharge".

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

Although there are some statements of expected savings from STP initiatives and these are used to meet the projected financial deficit in the system, there is nothing made available that meets SMART criteria. There are annexes including a financial annex that have not been made available, and that may contain more detailed information about measurable objectives, costs and timescale.

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.

Lancashire & South Cumbria STP covers 33 NHS and local government organisations, along with Third Sector partners, forming 5 local delivery areas across the region: Central Lancashire; Pennine Lancashire; West Lancashire; Fylde Coast; and, Bay Health & Care Partners. Each has its own local transformation programme. There are 9 CCGS (only south part of Cumbria); 18 local councils; 6 NHS trusts. In addition there is NW Ambulance Service, Lancashire County Council, Lancashire Care FT and Merseyside Trust (pp6,39).

The L&SC deficit in 2015/16 was £91m: £78m was NHS provider; £32m local authority ASS with CCG surplus of £19m. Total CCG budget allocation in 2016/17 was £3b (p7).

The L&SC financial deficit is forecast to be £91m in 2016/17. This is projected to grow to £572m (£443m for Health and £129m for social care) by 2020/21 on a 'do nothing' scenario. The Carter review (in 15/16) identified total efficiencies of £176m across acute providers within L&SC. The RightCare Commissioning for Value packs identified total efficiencies of £118m across CCGs (p14).

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 provided. There is financial annex but it has not been published and we have no information on when it might be released.

Revenue implications for providers are not made clear.

There is a statement that (p34), "Constraints on capital are understood and the option of non-NHS sources will be examined carefully across the geography".

There is a brief discussion of capital requirements (p34), "In 2017/18 and 2018/19 it is estimated that about £95m will be required to enable services to be hospital specialties to be consolidated across all the hospital sites and (£65m) to enable premises in the community to be adapted and/or built to facilitate the transformational aspects of primary and community services developments, excluding the requirements being discussed by NHSE/I and Morecambe Bay partners. A further £35m will be required in 2019/20 for onwards for primary and community service changes plus another £69m for NHS providers. These will be subject to the usual business case process to determine investment priorities".

L&SC aims to achieve break-even finances over the next 2wo years. CCGs plan to meet their business rules for 2017/18 onwards, which means at least an in-year break-even position. NHS providers are planning to meet their control totals, which in aggregate is a deficit of £65m in 2017/18 and a deficit of £49m in 2018/19 before STF funds are applied. These forecasts are based on the assumption that each organisation will deliver their financial plans in 2016/17. It is reported that some significant risks were apparent at month 6 (p31).

The key financial assumptions are:

- Potential provider expenditure increases are estimated at £355m, comprising £212m inflation and £143m related to demand growth.

- Additional spending on new models of care of £132m enables demand growth to be avoided. Primary and Community services will be developed and implemented to consume the demand growth through a combination of primary and secondary prevention, better management of exacerbations of underlying conditions, delaying the onset of serious chronic conditions, reductions in Delayed Transfers of Care and reduced lengths of stay.

- Additional Primary and Community services will be designed to achieve parity of esteem for mental health and integration of health and social care enables the effects of local authority funding cuts on those services to be mitigated.

- Providers will need to meet their inflation costs through efficiency savings and the opportunities identified by Carter will comprise a large proportion of their savings. Programme management arrangements have been agreed by providers to ensure that the collaborative working across them can be assured.

- As the additional Primary and Community services develop, they will, in years four and five, enable some acute capacity to be reduced in response to a reduction in demand for inpatient and outpatient services.

- In 2017/18 and 2018/19 commissioners will focus on extracting efficiencies identified through the RightCare methodology to reduce drugs costs (£23m) and reduce elective demand in providers (£53m). This reduction in demand is pending the extra community and primary care services coming on-stream to take over the main driver of demand avoidance from 2018/19 onwards.

- Any surpluses in CCGs will be used to offset the potential shortfalls in providers and as we develop our plans the means by which commissioners are able to share these gains will be finalised so that financial resources are deployed where they are needed.

- L&SC is looking for one control total but with special recognition of the position in Morecambe Bay, where high level discussions with NHSE/I have yet to be concluded.

- L&SC estimates that it will require £160m across 2017/18 and 2018/19 in order to develop new models of care and achieve the changes in hospital services (there is a reference to estates slide (p34) and so we assume this is a capital requirement although this is not clearly stated).

- L&SC will seek proportion of the transformation funding available to the STP from 2017/18 in order to enable ICT, prevention and workforce changes to be implemented, in addition to the STF support for providers: £21.7m in 2017/18, £26.7m in 2018/19 and £14.6m in 2019/20 to support transformational activities.

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.**

There are some confusing statements regarding plans to reduce acute capacity. The plan is to increase provision of primary care and community services (but limited details given in STP). The STP states (p30),

- "We are planning to hold hospital capacity broadly at current levels and make these organisations as efficient as possible so that we are able to deliver services with the staffing establishments we have now. We do not expect or plan for reductions in hospital activity. Our aim is to prevent growth in this areas by prevention and out of hospital care closer to home initiatives.

- Overall health services funding will increase by just over 11% between now and 2020/21 and we plan to use this to develop more and better primary and community services - this will require more staff to be employed in this sector and overall we plan to have more staff by 2020/21 than we do now.

- The planned 20% increase in primary and community services will enable us to stop the increase in demand for expensive hospital services and will also enable us to work with our populations on preventing and/or delaying the onset of serious chronic illness".

However also and not necessarily contradictory (p16) – no detail given, "As we invest in prevention interventions, primary care and develop a modern 7 day health care service giving us world class outcomes and which remains financially sustainable into the future - then we need to configure and deliver some of our acute and specialist services differently".

But what does seem to contradict (p31) first bullet point above, "As the additional Primary and Community services develop, they will, in years four and five, enable some acute capacity to be reduced in response to a reduction in demand for inpatient and outpatient services".

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

A workforce plan is summarised on p37 but detail is fairly sparse The plan claims (p37) there will be: extra staff in primary and community services of around 3,200 WTEs to allow growth in demand for acute services to be avoided; reduction in the paybill commensurate with reductions in acute capacity; better use of scarce staffing in specialised services; and reduction in agency staffing.

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

STP states (p15), "Local Authority colleagues have always been, and remain integral members of Healthier Lancashire & South Cumbria. Local Authority Chief Executives, Operational, Finance and Communications & Engagement officers are contributing hugely both in their local districts and Local Delivery Plans, but also the STP footprint workstreams as well as in the decision making process."

STP discusses deficits that will arise in local authority budgets and lists reasons for this (p15). States (p15), "These additional challenges in the our Health and Care System are driving priorities within our Healthier Lancashire and South Cumbria Programme".

Goes on to state (p30), "Funding for local authority services will continue to reduce over the next four years and if this is not resolved it will pose a major challenge to the delivery of our STP."

Q15. Is there a model that describes the plan?

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

There is no model presented, and STP states (p16), "We have commenced a piece of detailed modelling work to review options for optimal configuration of acute services, focusing initially on those services where a different delivery model will significantly improve clinical outcomes, those where workforce issues make it difficult or impossible to offer a robust service from multiple locations, and those services where rota consolidation may offer significant financial efficiencies".

However the STP also claims but does not provide justifying model (p32), "The system is experiencing increasing demand on services and our modelling of the demography and financial challenges clearly shows that we need to respond with much greater transformation if we are to address our 'do nothing' gap of £572m by 2020/21".

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

- **Is this robust and credible?**

There is no systematic presentation of evidence underlying the assumptions of the STP. However the STP claims (p21), "there is a detailed evidential case for change which has informed the assumptions and principles that partners are working on in their local systems and a consistent and well tested process to bring about the transformation on the required size and at the necessary speed that our population needs require".

There is much reference to 'evidence-based' but no presentation of evidence so it is impossible to judge whether it is robust and credible.

Q17. Is there risk analysis?

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

Under financial assumptions, STP mentions there are some significant risks at month 6 (p31).

There is no formal risk analysis. A list of risks for sustainability and transformation initiatives is given in the tables on pp37-38, but no quantification, no suggested mitigation.

Table 1 : Sustainability initiatives and risks in 2017-19

Initiative	Risk
1. Delivery of Carter and other provider efficiencies (£67m in 17/18 and £121m in 18/19)	Speed of delivery
2. Delivery of RightCare Savings – Medicines management (£15m in 17/18 and £23m in 18/19)	National pricing decisions
3. Delivery of RightCare Savings – ILCV (£10m in 17/18)	Thresholds are lower than expected
4. Delivery of RightCare Savings - £10m in 17/18 and £35m in 18/19 for elective services	Double counting the benefits
5. Starting NMoC roll out (avoidance of growth in acute demand of £36m in 17/18 and £72m in 18/19) – with emphasis on prevention, early intervention in the community and support for early discharge.	Scale and speed at which NMoC can be implemented, staff recruitment
6. Risk stratification to identify individuals most at risk of hospital admission as focus for extensive care support. Transform the 'regulated care' market including a comprehensive capacity and demand analysis and market management	Ability of community based solutions to avoid demand in secondary care
7. Specialised services, mitigation of demand growth, price efficiency measures and service consolidation (£11m in 17/18 and £23m in 18/19)	Speed at which upstream measures can be implemented, speed of service consolidation
8. Primary care - continue implementation of GP 5 Year Forward View. Delivery 7 day access, implement second wave of new models of care and shift focus to early intervention.	Investment requirements

Table 2: Transformation initiatives and risks in 2017-19

Initiative	Risk
Urgent and Emergency Care Review - Data / evidence base.	Lack of analytical & BI capacity & capability across the system. Lack of stakeholder engagement to tackle issues
Maximising potential of Apprenticeships levy provides	Implementation, not been done previously, orgs may struggle to support apprentices
Implement Digital Roadmap	Capacity & Capability, access to funding
Establish 5 Accountable Care Systems/ Organisations	Failure to agree approach or gain commitment locally – need right people, right relationships
Acute and Specialised workstream - consolidation of resources and map interdependencies and agree priorities. Develop plans to address the delivery of the most fragile clinical services within the context of the service consolidation intentions of specialised commissioners.	Failure to agree approach, capacity & capability
Solution Design Process – across priority workstreams, from quality standards, to shortlisting of options and involving the public, staff, politicians and utilising a robust evidence base	Capacity & capability, agreement of resources
Prevention and population health implement plans for high impact initiatives and national must dos, (primary and secondary prevention)	Current planned reductions in public health funding