# STP analysis Northumberland, Tyne and Wear and North Durham

http://www.newcastlegatesheadccg.nhs.uk/wp-content/uploads/2016/11/NTWND-STP-final-submission-combined.pdf

**The STP Process**

**Q1. Version Control:**

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

The STP is dated 21 October (p1). There is no STP website and no ready source of additional supporting information, although some CCGs have posted Q&As about the STPs; e.g. http://www.northdurhamccg.nhs.uk/wp-content/uploads/2016/11/NTWND-Q-and-As-updated-10-11-2016-v3.pdf.

We can find no traces of earlier versions or updates. It is the only one marked "DRAFT Official Sensitive: Commercial."

STP states in Foreword about future consultation plans (p2), "Robust mechanisms of involvement, consultation and scrutiny based on existing partnerships exist, but clearly 'fresh conversations' continue to take place around the scale and pace of our STP proposals. Consequentially, there is recognition that a significant amount of work and support continues to be required to operationalise and refine our STP proposals to ensure delivery".

Interestingly and perhaps cynically, public consultation features in the risk analysis as a risk to be mitigated "through the Governance Model for decision-making" (p14).

Arrangements for public engagement are laid out in the STP (p53), which stresses that the "approach to date has involved utilising the successful communication and engagement methods which are already in place to support existing transformation plans in each of the LHE areas".

**Q2.Stakeholder sign up:**

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

The STP states (p2), "We are building on a long history of partnership working and through that collaboration the results have been positive and greater than any individual organisation could have achieved alone. As a footprint, NHS and Local Authority organisations in Northumberland Tyne and Wear and North Durham (NTWND) have come together to work in collaboration on closing the three gaps of health and wellbeing, care and quality and financial sustainability. We do so working at scale across the STP footprint and as distinct Local Health Economy (LHE) Areas: Northumberland and North Tyneside, Newcastle and Gateshead, South Tyneside, Sunderland and North Durham."

There is no obvious source of disagreement, although the flaws in the STP, eg "The plan has been developed for the footprint undertaking a top down approach using national

indicators, benchmarking and pre application of local intelligence" (p55) are readily acknowledged.

It appears that "fresh conversations" (see Q1) will be required if implementation is to occur.

**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?**

Robust description is given of governance structure and accompanying mechanisms proposed (pp47-51).

"A systems-wide Health and Social Care Leadership Board is being developed, linked to the NECA Leadership Board (the seven LA leaders) to ensure strategic oversight of delivery of the STP and the outcomes of the Health and Social Care Commission. This will meet twice a year. An Executive Delivery Group is being formed with senior representation from partners to provide oversight at a more operational level and including programme sponsorship from NHS and LA chief executives. This will oversee delivery of those transformation areas, including enablers being tackled at a STP / NECA level" (p47).

STP has 18 references to ACOs and, specifically, there is reference to the establishment of a Northumberland ACO in 2017/18. Details are elaborated on p21.

A PMO (Programme Management Office) is to be established (p49), "To support the successful delivery of our plans our Programme Management Office (PMO) is to be further expanded and will ensure close working relationships with neighbouring STP footprints and local Vanguard programmes – identifying opportunities for at scale working and delivering 'once'. It will be staffed by nominated representatives from Trusts and Local authorities and have budgets for consultancy support".

In effect, the PMO will be a new executive body charged with implementing the STP.

**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?**

Section 3 of the STP, which is wholly devoted to Delivery plans, has been numbered pages 1 to 15 and seems to be a standalone addition after the last page of the main STP document. Although the delivery plans describe how timetabled activity over a number of years will 'fully deliver' preventative care by 2019/20 for example (p2) and will achieve optimal use of the acute sector (p10); in reality, the detail is not present to judge whether targets are achievable. The Delivery Plan refers a lot to application of national benchmarks as way of improving extent and quality of services.

Nevertheless there is evidence of diligence in that there are 88 references to delivery, timetabled in each of the main areas of activity from 2016/17 or 2017/18 and carried through to the later years of the programmes. Some delivery areas list actions planned for 2016/17 so that it will be possible to monitor progress, but it is likely that most relate to action being planned in any event, e.g. closure of 42 beds in Learning Disability Care (p8).

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

As mentioned in Q3, governance arrangements are being established. The SRO, Mark Adams, Chief Officer, NHS Newcastle Gateshead CCG, is the only named executive.

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

No specific figures are quoted but staffing structure and need for budgets for consultancy support are flagged (p49) and risk is identified of not having sufficient management staff (p56).

**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 population is stated as 1.7m (p1) but no source or year is provided.

There appears to be a very good use of population-based statistics, both to identify shortfalls in services and to inform the development of plans and future services. It also appears to be a strong basis for the planning in the area; for example (p22), reference is made to "using population intelligence (which) defined the following four gaps:

- Poor early-years outcomes as a result of child poverty and deprivation
- Potentially preventable illness
- Excess premature mortality (cancer, cardiovascular and respiratory diseases)
- An ageing population with multiple social and health challenges".

However it is not possible to check statistics used as they are not referenced. It is important to be able to confirm that sources for needs-based analyses of local populations and localities are up-to-date and complete.

The STP claims (p8), "Our understanding of the current position against the three gaps set out within the NHS Five Year Forward View has been developed through a process of robust analysis and modelling utilising for example JSNAs, scrutiny of clinical quality and safety data, patient and carer feedback, evaluations and organisational financial information".

**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 (p8).

**Primary care**

STP states plan of (p2), "Scaling up of the New Care Models from our Vanguards and development of a resilient and robust primary care sector".

Superficially impressive looking plans are presented in each of 3 main localities for improving primary care and out-of-hospital services (pp16-35) but when the detail is examined there remains lot to do; for example (p28), "Our focus in years 2017/18 and 2018/19 in Newcastle Gateshead LHE will be to: Work with Newcastle Upon Tyne Hospitals NHS FT, Newcastle City Council and the primary care and voluntary/third sectors to identify the most appropriate model for the provision of integrated care in Newcastle".

STP provides case studies. For example, in Newcastle Gateshead small savings of £3m over five years are only projected on basis of scaling up evidence from 1,300 patients to 84,000 in the full cohort. In Sunderland no savings for the NHS have been identified at this stage (although there would be benefits to local government). One page summary (p5 of section 3) on transforming General Practice is good at stating ambitions of programme but rather less at demonstrating how success will be achieved.

In general, proposals are still not concrete, costed and timetabled.

**New models**

Northumberland has been test bed for Vanguard projects promoting new models of care. These are discussed in section 2 of STP (no page numbers). Vanguards aim was to make 50% savings. Results to date appear mixed but are positive in aggregate; but as noted above these rely on estimates of future benefits.

New models of care will rely on new digital technology with attendant risks attached. Digital Care and Technology (p13) makes it clear that both self-care and primary care will be reliant on this.

**Prevention**

Preventative measures are less reassuring as each measure is still subject to the risks and limitations discussed in Q17. For example, on scaling up prevention, health and well being STP states (p22), "Our priorities are based on what we feel we can achieve as a health and care system in support of the broader aspirations of the NECA proposals:

- Reduce the prevalence of smoking and obesity, and reduce the impact of alcohol,
- Radical upgrade in our approach to ill health prevention and secondary prevention,
- Collaborate across the system to ensure the best start in life,
- Create a network approach to support community asset -based approaches to support people to be healthy and well at home, including social prescribing, working closely with the third sector
- Collaborate with NECA partners to support the long term unemployed back into work,
- Enhance people's ability to self -care, increase their independence, self -esteem and self -efficacy - roll out Making Every Contact Count (MECC) as an integral part of our workforce strategy with HENE".

And goes on, "We have calculated that if healthy life expectancy among all NECA constituent local authority populations was to rise over the next 10 years to reach the national average healthy life expectancy, this would mean that there would be an additional 400,000 healthy life years lived across the 10 year period. Therefore, by 2020/21 we aim to:

- Give every child the best start in life by having the best maternity outcomes in the country,
- Support the long term unemployed back into work, particularly targeting those with mental health and MSK problems
- Reduce the prevalence of lifestyle and behavioural risks, reduce preventable ill health, and upgrade our approach to primary and secondary prevention
- Enhance people's ability to self -care, increase their independence, self -esteem and self-efficacy
- Improve workplace health and support a health promoting workforce in health and social care"

However there is lack of detail supporting these aspirations and high level of top-down assumptions.

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

Conscientious efforts have been made to translate high-level aims into SMART objectives and plans.

**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 provides contextual summary (p9) identifying nature of the three gaps in health, care and funding. It paints a picture of high levels of need, gaps in care and large £641m financial problem in healthcare (by 2020/21) and £903m if the problems in local authority social care are included.

No current details of existing spending deficits are presented.

Figures are provided for how the 2020/21 NHS deficit will be managed.

| | £m |
|---|---|
| **Financial deficit 2020/21** | **641** |
| | |
| Solutions | |
| Out of Hospital expansion | 89 |
| Shared back Office | 31 |
| Acute Consolidation | 39 |
| CCG efficiencies | 105 |
| Specialist services | 44 |
| Provider efficiencies | 241 |
| Prevention | 18 |
| Pathology | 9 |
| STF Funding | 65 |

**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?**

Financial projections and plans are at a very high strategic level. It is therefore practically impossible to discern detailed implications of plans for providers, staff and for services, except at most abstract level.

No explicit summary of capital resources required is made but estates strategy identifies £76.5m of external funds as required (p14).

**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 refers to global activity assumptions; for example, in the context of Out of Hospital services, the following shifts are planned (p40),

**Table: Activity shifts**

| | Core | Stretch |
|---|---|---|
| Non-elective | -10% | -15% |
| Elective | -10% | -10% |
| Outpatients | -10% | -10% |
| A&E | -15% | -15% |

However, Workforce section of STP (numbered p15 but p100 of whole STP) refers to only a small reduction of 1% in overall hospital activity. It is not clear what source of this apparent contradiction is. It may be due to growth in demand that is offset by activity shifts.

STP contains no references to planned A&E closures but there is reference (p9) to "A&E Delivery Boards and stakeholders to radically transform the system at scale and pace which could not be delivered by a single A&E Delivery Board alone"; this implies there may be some future change planned.

STP states services in primary care will be expanded but no detail is offered (p5). In out-of-hospital care, references to specific services being expanded include "Discharge to assess services, frail elderly rapid access clinics, intermediate care plus services, MSK community services and implementation of extended access to primary care for vulnerable adults (p9).

The workforce summary profile shows a reduction in the overall workforce from 42,057 to 40,386 (p15). This is a reduction of 1,671 WTE (4%).

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

Workforce issues are discussed, but no Workforce Plan is provided. STP states (p3), "there is a need for a long term plan for workforce recruitment to the NE and not based on individual FTs" and that "a workforce review focused on diagnostics is due next month from which the scale of some of the issues facing the system will be known".

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

STP acknowledges that if the government withdraws further funds from adult social care budgets, there will be adverse consequences for the STP; thus, "Local Authority funding pressures and the potential for additional costs across the health and social care economy with respect to such issues as increases in DTOC have not been modelled in the financial plan" (p55).

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

The STP states (p55), "High level modelling suggests the net benefit estimated for the Out-of-hospital solutions assumes that an equal amount is invested into providing

community services for patients seen outside of an acute environment. More specifically, the estimated net benefits of c. £64m from the out-of-hospital model are predicated on a recurrent investment into enhanced services outside the acute sector of £64m per annum", and, "High level modelling" is further explained as "a top down approach using national indicators, benchmarking and pre application of local intelligence".

However STP does not provide access to the model that lies behind activity, workforce and financial calculations.

Key activity outcomes are listed (see Q12), and these will be seen as a driver for savings calculations. But we are unable to comment on assumptions as these have not been made available.

Limitations and risks section of STP (pp53-55) points to issues including, "A simple rules based approach to SF costs has been taken, in line with the functionality in the top-down Solution Model. This does not account for a detailed analysis of sf costs elasticities linked to rota efficiencies; however assumptions drawn from the local system are used instead". Not only does the STP not explain what SF denotes in this context, but it appears to provide a huge caveat to the calculations of savings made.

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

There are many (16 we counted) references to implementing evidence-based plans and models of care. But no evidence is provided to support the plans.

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

There is a Limitations and Risks section at the end of the STP (pp53-55), but this is not a full risks analysis in that it does not attempt either to quantify the risks, propose mitigation or advise on the effect that mitigation will have. Instead, there is an admission to the crude methodology used and to the existence of these residual but major risks:

**Financial Risks**
- Underachievement of the savings planned
- Under realisation of the savings from reduced national tariffs
- Unplanned increases in the m of non-elective hospital activity
- Unplanned increases in either volume or price of the prescribing
- LA funding reductions and the potential for additional cost pressures for the Health Economy.

**System Risks**
- Primary care engagement and changing clinical behaviours
- Changing the lifestyles and behaviours of our population
- Delivering the plan with fewer management staff.

**Implementation Risks**

• Plans are not executed to the timing, depth and intensity required."(p56)

There are therefore significant risks attached to the STP.