STP analysis West, North and East Cumbria

http://www.northcumbriaccg.nhs.uk/about-us/STP/documents-and-files/stp-october-final--pdf.pdf

The STP Process

Q1. Version Control:

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

No date is given on publication but date on pdf of STP is 21/11/2016.

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 no formal statements of stakeholder sign-up or dates thereof. STP lead is Stephen Eames (p4).

The following organisations are listed on p1 of STP:

- Cumbria CCG
- Cumbria County Council
- Cumbria Partnership NHS Foundation Trust
- North Cumbria University Hospitals NHS Trust
- North West Ambulance Service
- Primary Care Organisations
- Tertiary and Network Providers (Newcastle Upon Tyne Hospitals NHS Foundation Trust, Northumbria Healthcare NHS Foundation Trust, Dumfries & Galloway Health Board)
- Healthwatch Cumbria.

However there is no specific indication that all of these have signed up to STP as it stands; it is reasonable to presume some involvement, but in fact as the following quote shows, position of the council is by no means predetermined.

STP states (p4), "All partners are working actively to deliver the Health and Wellbeing strategy for Cumbria. In line with statutory duties Cumbria CCG are formally consulting the public about proposed NHS service changes in WNE Cumbria. Cumbria County Council are scrutinising the proposals contained within the public consultation in accordance with their statutory duty to do so and the Council will also be formally responding to the consultation. The development of this STP plan and submission as required within nationally set timescales in no way prejudges or predetermines the outcomes of the consultation that is currently underway or the local authority's position (now and in due course) on the consultation and the service changes that are proposed".

In addition Health Education England, NHS England (specialised commissioning), and Community & Voluntary Sector partners are listed on p1 of STP.

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; there is potential to create ACO that would include integration with local government.

STP states (p10), "To govern our STP from planning to delivery phase we have agreed to work within a system governance and leadership structure". This structure was implemented from 1 October 2016.

Thus, STP states (p3), "We have based this STP on a new local health and wellbeing system led by the local authority and a new and more comprehensive clinical service strategy led by the NHS". It goes on (p10), "STP has been developed concurrently with the consideration of potential system development towards Accountable Care models. All organisations have commenced discussions and intend to follow a shared process to take forward an options appraisal to consider the case for new organisational arrangements".

The STP talks of (p32), "Creating a collaborative leadership environment across local health and social care organisations", and states local providers will formally join the Health and Wellbeing Board by end of 2016 to ensure whole system engagement in strategic transformation and implementation. It goes on, "This will ensure alignment with the strategies and plans of Cumbria County Council Adult & Children's services and Public Health and Communities programmes".

This is all under development but is expected to be agreed collectively by March 2017 (p10).

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 provides timetable for implementation (p33). This seems to indicate PCBC has been prepared and formal consultation had taken place by October 2016, as well as STP system governance agreed & put in place by same date; implementation plans are being prepared including FBC by April 2017 at the same time as 'post-consultation decision-making'; Health & Wellbeing system should be in place by April 2017; 'Integrated Care Communities' initiated between October 2016 and April 2019; consultation outcomes delivered between April 2017 and April 2019; and 2016/17 and 2017/18 efficiencies delivered.

However these are all high-level deliverables with no further explanation.

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

This area is under control of national Success Regime initiative (see Q10 below for discussion of this). STP states (p10) there is STP lead CEO (from local CEO cohort), STP Coordinating Director (from local Director cohort), STP CEO leadership Group consisting of local NHS CEOs plus County Council CEO, DASS, DPH, and Success Regime, and STP Coordination Group consisting of NHS organisations, Social Care & Public Health.

There is Systems Leadership Board (with Chair and vice-Chair) that uses Success Regime (SR) and STP leadership. This is said to be transitional with STP leadership taking over from SR leadership in due course. In addition sponsoring CEOs have been identified for key work areas. There is no reference as to who Chair is or membership of Board. STP (p11) and Annex A (p35) provide diagrams of governance arrangements but provide little clarity about how this works or who makes decisions.

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

Cost of STP process itself is not discussed in STP. However costs of making changes are discussed (see Q10 for these).

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?**

P8 states total population of WNE Cumbria is around 327,000 (resident population) and geographically, is defined as the districts of: Allerdale (96,471); Copeland (69,832 of which around 8,400 are in Lancashire & South Cumbria STP area); Carlisle (108,022); and Eden (52,630). WNE Cumbria is around 65% of wider Cumbria population. No year or reference is given but STP states further details on populations including impact of growing numbers of younger people are available in Joint Strategic Needs Assessment.
See http://www.cumbriaobservatory.org.uk/health/JSNA/2015/homepage.asp

STP states (p5), "Our STP, builds on the Cumbria Health & Wellbeing Strategy 2016- 2019, it brings together organisations across health and social care to work on a shared agenda to transform care in WNE Cumbria over the next five years".
See http://www.cumbria.gov.uk/publichealth/

It goes on (p10), "We have therefore utilised both the democratic mandate and value of the pre-existing Cumbria Health and Wellbeing Strategy".

However little evidence is produced in the STP from this strategy, and there is no link made between needs and demands on the system, and how these will be impacted by changes proposed by STP.

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 the approach set out in NHS Five Year Forward View identifying three 'gaps' – health and wellbeing, care and quality, and finance and efficiency (p11).

Primary care, new models of care and prevention feature in STP and are covered in other questions. There are no concrete proposals for primary care. New models of care relate to developments in digital technology. There are several mentions of self-care but no detail provided.

While there is expectation that demand on acute services will be reduced, there is no clear assignment to prevention measures, and so we cannot put timescale and value on savings.

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

System objectives are mentioned (p15-16) but are rather general. There is no presentation of objectives in SMART terms although some measurable activity, population outcome and finance targets are stated with a timeline given by 2020/21 deadline (pp29-31, 43-45).

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.

This STP area was identified by national NHS as one in need of national support and so it was placed in 'Success Regime', what would have been called failure in the past. Success Regime is initiative led by 2 national NHS bodies - NHS Improvement and NHS England who provide support, expertise and resources, but also hold health and care system to account for delivering strategy and plans agreed as part of programme.

The need for Success Regime may be implied from following statements from STP (p32), "The health economy has delivered limited improvements against its efficiency targets over the past years. The STP partners have all agreed and commenced action to achieve control totals in 16/17 and associated S&T fund performance requirements as well as significant improvements in constitutional standards", and goes on, "Local pressures may inhibit the ability to deliver transformational change in a fast and efficient manner. The STP partners have made progress on stabilising actions and have enhanced levels of resilience arrangements in place through the local A&E Board".

STP reports (p29), projected deficit of £81m in 2016/17, and this will increase to £168m by 2020/21 (including specialist commissioning). STP claims costs are higher than average in the area, and activity levels are above norms, especially in non-elective care.

STP puts forward following ways of dealing with projected deficit. Table 1 is based on STP (p29). STP states (p30), "Initial estimates suggest potential implementation costs would be approximately £22m over the 4 years 2017/18 and 2020/21".

Table 1: Projected impact of mitigation on 2020/21 deficit

BaU (Business as Usual) efficiency	Provider efficiencies, shared organisational arrangements, & CCG & specialist commissioning efficiencies.	£86m
Services outside hospital	'Out-of-Hospital' model shifts patients to more cost effective settings of care, often closer to home. Primary mechanism is integrated care communities (ICCs).	£42m (Reduced cost of hospital services is £63m less £21m investment in 'out-of-hospital' services).
Acute hospital reconfiguration	Preferred options involve maternity, children's services and acute & emergency care.	£1.2m
Community service reconfiguration	This could involve reduction of sites and beds	£0.9m
Total		£130.1m
'Do Nothing' deficit		£168m
Residual deficit		£38.1m

STP provides almost illegible diagram (p30) that does not relate precisely to figures in above table. Bottom line is claim there is still £46m residual projected deficit after mitigation activities are successfully carried out. Further mitigations are then suggested[1].

STP suggests (p30) additional initiatives could save £6m by 2020/21: consolidation savings through developing networks to deliver pathology services; role development within workforce delivery to support greater staffing efficiencies; and potential economies of scale opportunities within GP services. It goes on that greater 'Out-of-Hospital' service change could save further £6m: this is achieved by assuming more reduction in non-elective admissions over 5 years from 19% to 25%; and reducing reinvestment rate required to deliver out-of-hospital services as part of ICCs from 50% to 40%.

STP claims this would reduce residual projected deficit to £34m. it goes on to discuss STF funding of £25m that will be available to area stating (p31), "Of the £25m additional funding, it is understood that £13m relates to service transformation and £12m for sustainability. The transformational funding is fully utilised within the STP plans; £6m within the out of hospital and hospital services initiatives described above and a further £7m to deliver national priorities around primary care, cancer and mental health. Receipt of the full £25m STF will therefore reduce the residual gap by a further £18m in 2020/21".

If this were the case, there would remain deficit of £16m.

STP also states (p31), "Revenue support in the form of transitional funding is required to account for the phasing in of the mitigations considered. The overall transitional funding

requirement is in the region of £167m to £247m. The transitional implementation funding requirement (£22m) [referred to above] would be in addition to this.

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. Q10 above provides most of financial detail that has been made available. More details of some of finances are provided elsewhere eg in PCBC published by Cumbria CCG in June 2016.

STP also provides table (p14) showing projected impact of its mitigations over time. STP states (p14) "The increased deficit in 2019/20 reflects the assumption that there will be no Sustainability and Transformation funding in that year. The residual deficit in 2020/21 relates to the South Cumbria element of the CPFT deficit, which is outside the WNE Cumbria footprint". This seems contrary to STP statements on pp29-31.

Table 2: STP table of impact of mitigation on projected changes, 2016/17 – 2020/21

	2016/17	2017/18	2018/19	2019/20	2020/21
'Do Nothing'	£81m	£110m	£128m	£148m	£168m
'Do Something'	£81m	£50m	£35m	£40m	£4m

STP does not provide breakdown of savings targets by provider, or by service, and revenue implications for providers are not made clear.

It is clear that changes envisaged in STP will require capital eg community and acute hospital developments but little detail is provided on this (pp39-40 discuss Estates issues) and no figures for capital costs are provided in STP. STP does state (p30), "There are a number of excluded capital expenditures for example investment in specialised services, primary care and the Cumbria wide mental health strategy subject to future business cases and capital financing" 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.**

STP makes it clear that it envisages considerable changes to range of services, and CCG is already consulting ('The Future of Healthcare' consultation) on:

- Changes to acute urgent and emergency care;
- Changes to paediatric services;
- Changes to maternity services; and,
- Changes to community hospital services.

STP states this is (p28) "all within the context of our overall STP care model". STP's preferred options are (p29),

- **Maternity services:** provision of consultant-led maternity unit, an alongside midwife-led maternity unit and special care baby unit at CIC along with full range of antenatal and postnatal care.

- At WCH, standalone midwife-led maternity unit for low risk births, open 24 hours a day 365 days a year, with antenatal and postnatal care delivered by both consultants and midwives and with consultants on site between 8am and 8pm.

- **Women's & Children's services,** development of inpatient paediatric unit serving West, North and East Cumbria based at CIC along with short stay paediatric assessment unit.

- At WCH there would be short-stay paediatric assessment unit for children requiring short-term observation and treatment. There would also be some overnight beds for children with less acute, low risk illnesses but children who needed more acute inpatient admission would be transferred to Carlisle.

- **Community hospitals:** options for consolidating the total number of inpatient sites from 9 to 6 with a total bed base of 104.

- **Acute and emergency care:** although STP is not specific, p22 implies West Cumberland Hospital, Whitehaven (WCH) A&E would be downgraded to 'minor trauma' with Cumberland Infirmary Carlisle (CIC) is only A&E.

STP provides no information on expected impact of these changes on staff numbers.

STP does recognise importance of transport and travel issues both for patients and staff. STP states (p37), "The region presents significant challenges in relation to distance from home to (and between) health and care sites (including tertiary centres). In addition, there is poor road access, and unusually high reliance on public transport in some areas (particularly in West Cumbria)", and provides list of actions to ameliorate this (p38).

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

STP does not provide detailed workforce plan. There is some mention of workforce, and STP states (p38), "... in order to deliver the scale of change needed all STP partners have developed a "ten-point plan" with detailed implementation plans to drive this work

forward, the high level actions are outlined below". But point 1 on that list is 'produce a workforce and implementation plan'.

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

STP provides some detail on social care; thus (p19), "WNE Cumbria has a number of key gaps in the social care. These include a higher than required reliance on care home based care with resultant under development of supported self-care, re-ablement, domiciliary care and assisted technology enabled care. The provider market requires development to provide the range and presence of services required in future. As a result of these issues social care services are under significant pressure with long term admissions to residential and nursing homes higher than similar places, we have a shortage of services for people with dementia provision and the need to re-provision services to facilitate early discharge and prevent admission",

And offers general solutions, "In future the local authority sector will be targeting investment in services which prevent, reduce or divert demand, enabling individuals and activating communities to become more resilient by providing more support themselves. There will be investment in Extra Care Housing, high quality dementia and nursing care, assistive technologies, digital solutions to support self-help, telecare and support from the community sector. This will reduce the need to send people a long way from home, and reduces the risk of hospital admissions and increases the potential to achieve recovery and independence". However, STP also states (p19), specific plans are "subject to local agreement of partners".

In addition 'Integrated Care Communities' are intended to bring together public health, general practice, social care, community services, mental health services and community assets, including community hospitals to act as single integrated hubs (p21).

STP states (p8) "local social care facing significant decreases in funding available"; however projected local government deficits are not include in STP total.

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 STP financial model (p29) but no detail is provided. Again (p44), "The expected reductions in overall non-elective admissions have been modelled in line with the Out of Hospital Model" but no detail is provided other than table showing projected reductions in demand. Assumptions are not provided and so cannot be assessed.

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

- **Is this robust and credible?**

STP states (p9), "In order to positively change we have identified in our STP a mix of innovative, radical, contentious, evidence based proposals including some difficult decisions we believe are essential for the future".

However, although STP mentions evidence-based several times in context of its work (p10,13,25,26,37,39), it provides no references. Nearest it comes is on p27 where it refers to "recently published Five Year Forward View for Mental Health makes 58 recommendations to be implemented by 2020/21. The national commission for the review of psychiatric inpatient care for adults makes a further 12 recommendations. This compelling evidence". SO it is not possible to assess evidence on which STP is based.

Q17. Is there risk analysis?

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

No formal risk analysis is presented. Instead STP mentions mixture of so-called issues and risks. Thus it states key risks and issues are (p32),

- **Leadership:** Across recent periods, local health economy has witnessed significant change within leadership positions of key organisations;
- **Governance structure:** achieving significant transformational change in short period requires well-structured and fast-paced governance approach which may be difficult to achieve within local context;
- **Challenging track record:** health economy has delivered limited improvements against its efficiency targets over the past years;
- **Immediate pressures:** local pressures may inhibit ability to deliver transformational change in fast and efficient manner;
- **New care models:** working to harness the full potential of emerging new care models we will utilise them in practice to support our overall system STP.