STP analysis West Yorkshire and Harrogate

http://www.southwestyorkshire.nhs.uk/wp-content/uploads/2016/10/Final-draft-submission-plan.pdf

The STP Process

Q1. Version Control:

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

Published October 2016, the STP is an 84-page document. It is not really a plan as is made clear on p78, "The STP sets out the strategic context in West Yorkshire and Harrogate and high-level proposals for how we might get there. Our focus now shifts ... to developing meaningful coproduction for turning these high-level proposals into more detailed implementable plans. Our next important milestone is the two-year operational NHS planning process through which we will translate into delivery."

No formal consultation on overall plan mentioned; several individual consultations either around specific geographic areas (Calderdale p31; Kirklees p37) or diseases (cancer p52; stroke p53), or acute reconfiguration at Calderdale & Huddersfield FT (pp59,60).

Q2.Stakeholder sign up:

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

Reports that the CCGs have agreed a common commissioning approach (pp61,62).

STP states (p69), "Local plans have been developed and approved by local Health and Wellbeing Boards (or equivalent structures). Healthwatch is a key partner in our STP and provide leadership, assurance and challenge acting as the voice of the patient. We will always fulfil our legal duties to consult and we are already consulting formally with our populations on some of our proposals e.g. reconfiguration of hospital and community services in Calderdale and Huddersfield."

And (p69), "Local place-based plans have been designed and approved by all local Health and Wellbeing Boards (HWB) or equivalent and are in the public domain. Council leaders and Chairs of the HWB meet on a regional level. We are fully committed to sharing all proposals with our population and will publish our plan and public summary during the week commencing 31 October 2016".

In cancer, STP claims to have secured stakeholder agreement for CE-led Alliance Board, but no details of who has agreed and when.

No mention of overall stakeholder sign-up. STP states there is a Programme Management Office (p69) but no further detail about how it operates.

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?**

It seems some decisions will be made locally but no overall plan is presented; the STP is an amalgam of plans for the 6 areas, with some discussion of work at the 'footprint' level.

Within these we find Wakefield refer to new governance arrangements and ACOs (p43), "Our five GP Federations are working in partnership with us to execute the Five Year Forward View and are fully aligned to development of an Accountable Care System. We have developed strong governance and accountability through our Health and Wellbeing Board supported by our STP which has clear lines of accountability."

Wakefield plan goes on (p43),

"By January 2017 we will have an operational plan which is aligned to activity and interventions with clear lines of accountability.

- Development of a Joint Committee in across commissioners and providers for our MCP (Meeting the Challenge) by January 2017 to support the development of an Accountable Care System.
- Final business case approval for the MCP October 16.
- Engagement process for MCP starting Oct 16 and market engagement Dec 16.
- Develop Accountable Care Organisation by 2020/2021 bringing provision and integrated commissioning together to improve quality of delivery for community care.
- Business case for integrated support services through Local Services Board 2017.
- Full implementation of the Meeting the Challenge reconfiguration of services to deliver 7 day services for all acute care by 2019."

The MCP is a plan to centralise surgery and paediatrics: no details given but is likely to be in other documents that are not part of the STP.

Overall the STP talks of (p73), "Establishing appropriate governance arrangements to allow us to work more closely and take decisions collectively across commissioners, providers, health and social care."

This involves 3 aspects (p74),

- West Yorkshire & Harrogate wide commissioning / contractor function dealing with acute and some specialist services,
- Place-based commissioner bringing together the functions of LAs, CCGs and NHS England (primary care) commissioning
- local 'commissioning' function embedded within ACO models.

The first involves extension / formalisation of the CCG joint committee arrangements with identification of services that need to be commissioned on a WY basis. The second involves organisations collaborating on a defined geographic footprint with collective

accountability (note this include LAs). The third involves ACOs working to a capitated budget deciding how resources are used to best meet population needs (p74).

The following are identified as being right for commissioning at WY level: Low volume, high cost, high risk planned care; emergency centres and co-dependencies; specialised & tertiary services; inpatient mental health services; 'hard-pressed' specialties; specialised diagnostics; high volume, low cost, low risk planned care; whereas the following should be at local level: diagnostics; primary and community care; social care; long-term conditions management; frailty services; community mental health (p74).

The STP states Health and Wellbeing Boards are the key mechanism for taking decisions on place-based proposals at local level. But it is intended that arrangements change in line with increased responsibilities placed on STP areas. Over the course of the next 12 months it is intended to move to more formal joint decision-making arrangements to support collective decision-making. The STP embraces closer working and decision-making across traditional sector boundaries as decisions are taken that put place over organisation (p75).

A timetable for changing decision-making process is discussed on p76 – see Q4 below.

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?**

In 2016/17 decisions still taken by individual organisations with some informal collaboration between commissioners and providers. In 2017/18 it is intended to have formalised collaborative structures of commissioners and providers to support collective decision-making, and to run new commissioning model in shadow form. By 2018/19 it is hoped to have joint decision-making function where appropriate, or in the best interests to do so representing commissioners and providers supported by formal collaborative structures established in 2017/18. Some description of timetable for joint commissioning and what is involved (p62). This is as much detail as is given (p76).

There is very little detail given about the STP itself. Everything is very much discussed in terms of local plans. Hence no timetable for delivery, no mention of obtaining overall agreement to it, nor agreement to the changes proposed within it.

On the other hand there are timetables for developments in individual local areas (pp26-43); and for developments at the WY level (pp46,50,52,54,60).

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

- There is no reference to an STP Chair or Board. The document's Foreword is signed by Rob Webster on behalf of the leadership of West Yorkshire & Harrogate (p2).

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

No information given on budgets or personnel for the 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 states the population is 2.6m (p3); 2.64m (p5). But no year given, no further detail, no projections, no source for the figure.

There is some reference to needs but no overall needs analysis provided. Link back to local needs strategies is signalled by statement on p13, although no detail provided, "The foundation of these proposals is the six place based health and wellbeing strategies (based on Joint Strategic Needs Assessments and owned by Health & Wellbeing Boards). These strategies are grounded in a clear understanding of local population needs and preferences."

Individual local area plans mention needs at times but no systematic view is offered (pp26-43). STP states there is an 11 year variation in life expectancy for males across Leeds; there is a 10.2 year variation in life expectancy for females across Calderdale (p16). Some discussion on p8 on nature of deprivation in the area but no detail and no references. STP lists key health and wellbeing issues (p17),

- 18.6% of our population smoke. This is higher than average and is the main preventable cause of cancer.
- 8 of 11 CCGs have significantly higher than average childhood obesity levels. 1.3 million people (50% of population) are overweight.
- Only around half of all cancers are diagnosed at a curable stage. Significant inequalities in outcomes across ethnic groups.
- There are around 455,000 binge drinkers in West Yorkshire and Harrogate. This has major health consequences and adds significant burden on services.
- We have a higher prevalence of anxiety disorders and depression and a higher than average suicide rate.
- All West Yorkshire Authorities have significantly worse rates for CVD mortality in under 75s when compared to England.

And states following aspirations,

- To reduce smoking rates to 13% by 2020-21 -approximately 125,000 fewer smokers compared to 2015-16.
- There are 226,000 people at risk of diabetes in West Yorkshire and Harrogate. Our aspiration is that 50% of these are offered diabetes prevention support, with a 50% success by 2021.
- Increase in survival rate from cancers to 75% by 2020-21, with the potential to save 700 lives each year.

- To reduce alcohol related hospital admissions by 500 a year and achieve a 3% reduction in alcohol related non-elective admissions.
- A zero suicide approach to prevention, aspiring to a 75% reduction in numbers by 2020-21
- Reduce cardiovascular events by 10% by 2020-21.

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 (p15).

Primary care

On p11, prevention, expanding access to primary care and supported self care are listed as actions to drive impact in place-based plans. New models of care are also mentioned.

These initiatives tend to be mentioned within the locality statements. Bradford & Craven will shift additional resources into primary care (£1.8m by 2018/19) (p27) and achieve 7-day access for 100% of population. Others talk of new models of primary care and improving access. Overall the plan is to have 24/7 primary care in WY&H area (p48). Also mention development of primary care workforce (p66). However, no concrete, costed, timetabled proposals included.

New models

STP proposes (p11) supported self-care defined as, "Evidence based, person- centred approaches, which support people to take greater control and management of long-term health conditions. Training of the workforce to facilitate this elevated level of independence". References to promotion of self-care can be found within individual locality plans (pp31,32,42).

The STP has a section, "Digital and Interoperability". This includes record-sharing as well as technology to support knowledge, education and self-care (p67).

Prevention

Prevention is mentioned in context of diabetes and suicide with aspirations – presumably therefore not regarded as specific targets to be measured against (p17). All local plans have lines on prevention though little detail.

At WY&H level, looking to reduce alcohol and smoking related admissions to hospitals and reduce through healthy living programmes people contracting diabetes (p45). P46 provides expectations of reduced demand for hospital admission from prevention measures and savings. Thus, an investment of £825k for five Alcohol Care Teams would lead to a reduction of 500 alcohol related admissions a year, resulting in a £3.17m ROI per year. An

investment of £450k would lead to a reduction of 50,000 smokers over 5 years at a saving to the NHS of £9m. WY&H has an estimated 226,000 people at high risk of diabetes, if 50% attend and 50% do not go on to diabetes the savings are £62.5m -£160m over 5 years.

All of these are areas where the STP states expected efficiency gains but no detail of programme offered other than amount of savings (p21).

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

No objectives for the STP are stated. Although some aspirations and targets are mentioned there is nothing that could be said to be framed in a SMART way.

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.

The STP is based on plans of 6 local areas: Bradford District & Craven; Calderdale; Harrogate & Rural District; Kirklees, Leeds; and, Wakefield. The STP provides a view of each of these plans in turn (pp26-43). There are 11 CCGs, 8 local authorities, 6 acute trusts, 4 mental health trust, 3 community providers, 366 GP practices, and Yorkshire Ambulance Service. In addition there are 650 care homes, 319 domiciliary providers, 10 hospices, 8 large independent sector providers, and thousands of voluntary and community sector organisations (p5).

STP assumes "organisations collectively will deliver their control totals in 2016/17, which would bring significant risk to the outer years if these are not achieved" (p22).

Sector	15/16 £m	16/17 £m	17/18 £m	18/19 £m	19/20 £m	20/21 £m
Providers						
CCGs						
Specialist Commissioning						
Primary Care						
Total NHS						809
Social Care						256
Total health and social care						1,070

STP forecasts £4m surplus for CCGs in 2017/18, not taking account of any investment in the GP5YFV and the MH5YFV; and, a £36m deficit for providers (before receipt of any transformation funding). This means £39m would be required to achieve the control totals set by NHS Improvement (p23). The basis for these assumptions is not made clear.

A graph of financial projections is provided on p20. However the only numbers provided are separate totals for the NHS and for social care in 2020/21: a deficit of £256m in social care budget and £809m in NHS budget if nothing else changes.

A small deficit is suggested in 2016/17 for both NHS providers and NHS commissioners; there is no indication of the position of local authorities (p20). It looks like the NHS

position is projected to worsen considerably in 2017/18 and then to increase linearly from then on; a deficit is introduced for local authorities in 2017/18 and it this also increase linearly to 2020/21 (p20).

Resources across the health sector are projected to grow from £4.2b (year unspecified) to £4.7b (2020/21).

On p21 the STP provides a table showing how it is intended to address this deficit. Operational efficiencies account for £539m: of which, provider efficiencies: Carter programme – Estates £8m; Provider efficiencies: Carter programme - All other £93m; Provider efficiencies: Non-Carter £329m; Primary medical care (GP) £7m; CCG other efficiencies (eg CHC, prescribing, admin, other) £102.2m.

Activity moderation efficiencies account for £143m: of which, specialised commissioning QIPP £30m; Urgent and Emergency Care £10m; New Care Models £34m; RightCare £36m; Self Care £1m; Prevention £31m; Low value interventions £1 3m.

Social care is expected to deliver savings of £131m, and West Yorkshire Programme and Opportunities will save £93m.

Total savings are estimated at £906m. This is offset against the projected deficit of £1,075m (we note slight discrepancy in figure compared with p20), leaving a residual deficit of £169m. It is assumed there will be £172m of money made available through the STP Fund of which £95m will be used for effecting change, leaving £77m that can be used to offset the residual deficit. This still leaves a residual deficit of £92m (£91m in the STP document), and the STP claims the NHS would be in surplus of £43m while local authorities would have a deficit of £135m.

No detail is given in the STP on how any of these efficiencies have been calculated; figures for 2020/21 are all that have been made available. The largest savings are operational efficiencies; these would not seem to be dependent on the STP.

Each of the 6 localities also present how they will reduce their deficits. Information is presented neither consistently nor clearly but table below shows where the deficit is, what savings they are looking to make, and what gap will remain. (pp26-43):

	Deficit £m	**Total efficiencies £m**	**Difference £m**
Bradford & Craven	221	168	53
Calderdale	79	N/A	N/A
Harrogate	38.9	N/A	17.6
Kirklees	208	N/A	40
Leeds	300	N/A	46
Wakefield	229	185	0
WY&H	**1075.9**		**156.6**

Leeds deficit of £300m is our estimate as no figure given.

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?**

No financial appendices published. Projections are incomplete as discussed above.

It does not state that more details are to follow.

Savings targets are broken down by service in some instances – see Q10 – but insufficient detail given.

Revenue implications for providers are not mentioned.

No detail provided on capital required other than STP states (p22), "Transformational capital is required to enable the service reconfiguration and back office efficiency gains of our provider sector, to deliver financial sustainability and tackle the long term structural challenges."

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 is no mention of any service closures or cuts in staffing. However the overall vision for WY&H talks of, "acute needs will be met through services that are "safesized" with an acute centre in every major urban area, connected to a smaller number of centres of excellence providing specialist care"(p6). And some of the local plans hint at closures of acute services. Kirklees states without an explicit statement (pp35-37), "Change the configuration of acute services to improve quality and create efficiencies through the implementation of RCRTRP, Meeting the Challenge and Healthy Futures plans (UEC, Cancer, Specialist MH, acute stroke etc.)". P53 mentions the need to reconfigure hyper-acute stroke services but no detail given.

While it is clear the STP is based on improved access to primary care, more care delivered closer to home, etc, there is little overall detail provided on locations, numbers, costs etc., although local plans mention new resources sometimes.

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

The STP clearly recognises the need for a workforce plan (p65).

Has established West Yorkshire and Harrogate STP Local Workforce Action Board; chair Dr Ros Tolcher (Chief Executive, Harrogate and District NHS Foundation Trust); Co-chair: Mike Curtis (Health Education England). Initiatives set up with leads in several areas.

P66 discusses 5 areas and lays out visions, core outputs and workstreams to be developed: Primary Care, Community Care and Public Health; Registered Workforce Initiatives; Non-registered Workforce Initiatives; Prevention at Scale; Workforce Flexibility and Resilience Enablers.

This is as far as planning seems to have progressed at this stage.

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

Social care is mentioned in terms of the projected deficit of £265m (p20). Local plans mention various working with social care – eg Calderdale has Integrated Gateway to Health and Social Care (p31); Bradford (p28); Harrogate is "exploring organisational forms and contractual options and having early discussions on integrated health and social care commissioning and delivery models" (p34); Kirklees (p35);

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 mention of a model underlying the plans.

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

No evidence is provided although the term 'evidence-based' is often used, and there is mention of evidence that is not provided (eg pp47,48).

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

There is no risk analysis provided. Harrogate locality mentioned £3.1 unmitigated risk (p33) and Harrogate mention need for further evaluation of system risk (p37). Managing workforce risk at system level is mentioned on p59 but that is as far as it goes.