Committee: Cabinet

Date: 3 July 2017

Wards: All

Subject: **Sustainability and transformation plans (STPs)**

Lead officer: Simon Williams Director of Community and Housing

Lead member: Councillor Tobin Byers

Contact officer: Simon Williams

Recommendations:

A. Cabinet is asked to note the contents of this report

B. Cabinet is asked to endorse the summary of Merton's position as set out in the bullet points on p8 of this report, including the Council's commitment made on several occasions to vigorously oppose any proposals to close or downgrade St Helier Hospital

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1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1. This paper summarises the thinking behind STPs at a national level before going on to set out local progress and how local authorities including Merton are engaged.

2 DETAILS

What are STPs?

STPs were announced in NHS planning guidance in December 2015. They are five year plans for health and social care, 2016-2021. NHS organisations have been asked to collaborate to respond to the challenges facing local services. They are based on 44 geographical "footprints" across England, the average size of which is around 1.2m population.

The original core purpose of STPs was threefold:

- To improve quality and develop new models of care
- To improve health and wellbeing and give more emphasis on prevention
- To improve the efficiency of services

STPs represent a shift in NHS policy on improvement and reform. The Health and Social Care Act 2012 sought to strengthen the role of competition with the healthcare system. NHS organisations are now being told to collaborate rather than compete to plan and provide local services, on a "place based" basis. In support of this, encouragement is being given to move away from the transactional and competitive financial systems under "payment by results" and towards a sharing of financial risks under one shared system control total.

Draft plans were submitted in July 2016, and "final" plans in October 2016. There was some confusion over whether these were intended to be public documents: initially the view was that they were not (and they were not published in the July drafts), but by October in many places non NHS organisations unilaterally published them, and the NHS subsequently agreed that this should happen. This was mirrored in south west London, where Merton and other local authorities published the draft October plans before the NHS did.

The plans submitted in October 2016 have been subject to further appraisal and development. The focus has now shifted to delivery over the two years 2017-2019, with the priorities for 2017/18 set out in the "Next Steps on the NHS Five Year Forward View":

- Improving A&E performance
- Strengthening access to high quality GP services
- Improvements in cancer services (including performance against waiting time standards) and mental health

all within the constraints of delivering financial balance

How has implementation gone nationally?

The Kings Fund published its own appraisal of progress in its report published in November 2016: "Sustainability and Transformation Plans in the NHS. How are they being developed in practice?"

(https://www.kingsfund.org.uk/publications/stps-in-the-nhs)

Overall, despite considerable energy being put into this, the picture is generally one of progress being difficult for some key reasons:

- Capacity among NHS staff to do the work alongside the more day to day pressures
- Immediate service and financial pressures crowding out the more strategic planning required for the STP
- Forming complex alliances of NHS and other organisations
- The new emphasis on collaboration being against the provisions of the 2012 Health and Social Care where competition was given a more central role

The process in South West London

The "footprint" for the local STP is southwest London, including the 6 boroughs/CCGs of Croydon, Kingston, Merton, Richmond, Sutton and Wandsworth. Because Epsom hospital is in the same NHS Trust as St Helier, there also has to be a relationship with the NHS (Surrey Downs CCG) and local authority (Surrey County Council) for the relevant population.

Alongside the local authorities and CCGs, this footprint includes 4 acute hospital Trusts (St Georges, Kingston, Croydon and Epsom/St Helier) and 2 mental health Trusts (South London and the Maudsley for Croydon and Southwest London and St

Georges for the rest). There are also 5 providers of NHS community services and six GP Federations co-terminous with CCGs.

Whilst there is significant local authority engagement at officer level and considerably more than in previous programmes of this nature, this is an NHS programme and decisions are ultimately made by the NHS through their statutory decision making bodies, acting together where they agree to do so. There has been and is no suggestion that the councils will have to formally ratify the plans at Cabinet or Council.

Key elements of the arrangements for drawing up and delivering the plan are:

- A Programme Board which exercises overall oversight of the STP, with a chair from outside southwest London. Given the number of organisations involved, this is a large body. Local authorities have been represented through designated representatives on behalf of all of them, namely one local authority chief executive (Ged Curran since summer 2016) and one DASS (usually Simon Williams since December 2015).
- There is one designated Senior Responsible Officer (SRO) for the programme. This is the Accountable Officer for the 4 CCGs (Kingston, Merton, Richmond and Wandsworth) under the new shared management arrangements.
- CCGs hold ultimate commissioning responsibility and authority for the plan. They may choose to exercise this in a shared way through the Commissioning Collaborative, or more formally through a “Committee in Common”.
- NHS acute providers have their own Boards, but have sometimes agreed to do shared pieces of work through their own collaborative arrangement. Local authority input to this work is currently through Simon White the interim People Director for Kingston.
- There is a Clinical Board to coordinate and oversee any work involving clinicians and specifically where a clinical view is needed.
- There is a weekly/fortnightly Executive Group to ensure that the programme is progressing. There is a place for one local authority representative.
- There is a finance group charged with all financial modelling, forecasting and collective monitoring. There has been a designated local authority finance lead to input into this work, although in reality engagement has been limited.
- There is a Right Care Best Setting board giving oversight to the model of care outside hospitals, co-chaired by the Director of Adult Social Care for Richmond and Wandsworth.
- At a more local level, the past six months has seen the emergence of Local Transformation Boards, charged with the more detailed design of new models of care both outside hospitals and within hospitals. There are four of them broadly based on acute hospital catchment areas, so Merton inputs into two: one for Merton and Wandsworth with St Georges hospital, and one for Sutton with Merton and St Helier Hospital. In the latter case due to the complexities of the Trust’s catchment area, it is intended that the Local Transformation board focusses more on the out of hospital model of care and is more focussed on

Sutton, and the work on hospitals including Epsom and St Helier will be through a wider Sustainability Board which will also include Surrey representatives.

- Plans are made at a Merton level for the model of care for the whole Merton population, involving the council, CCG, NHS community services, the GP Federation, the mental health Trust, and the voluntary sector. A further workshop was held on 13 June on this subject. This means that there are emerging shared plans for care in Merton, and that these plans can in turn be fed into the other mechanisms described above.
- For local authority members, there is a Collaborative Leadership Group, co-chaired by the Leader of Sutton Council, and with the Health and Wellbeing Board chairs from all six local authorities. This meets about every two months. For the Overview and Scrutiny function there is a Joint Health Overview and Scrutiny Panel, hosted by Richmond and Wandsworth.

All these arrangements are currently subject to a review of governance led by the SRO, with some draft recommendations now made but not at this stage publicly available.

What does the published October 2016 plan say?

The draft South West London Five Year Forward Plan was published on line in October 2016. It can be found at http://www.swlccgs.nhs.uk/wp-content/uploads/2016/11/SWL-Five-Year-Forward-Plan-21-October-2016.pdf.

The plan sets out a case for change. This is in two parts:

- A care and quality case for change: hospitals are not offering 7 day a week services and not meeting waiting times targets, too many patients are unnecessarily in hospital, the quality and accessibility of primary care needs to improve, needs of people with mental illness and dementia are not being consistently met, diagnosis of cancer needs to occur earlier, care at the end of life needs to improve, and services need to work more seamlessly around the needs of patients. Three underlying factors are set out: lack of workforce, inadequate provision of preventative and proactive care outside hospitals, and the design of services doesn't achieve the best clinical outcomes.
- A financial case for change. At present the south west London health economy is overspending by £140m a year, this will rise to £828m a year by 2021 if nothing is done to tackle this.

A summary of the plan is on page 5 of the document and is set out in full in italics below.

'Our plan suggests we should:

- *Set up locality teams across south west London to provide care to and improve health for defined populations of approximately 50,000 people. The teams will*

align with GP practice localities and have the skills, resources and capacity to deliver preventative health and support self-care

- *Use our workforce differently to give us enough capacity in community, social care and mental health services to bring care closer to home and reduce hospital admissions*
- *Review our acute hospitals to ensure that we meet the changing demands of our populations, and to ensure that acute providers deliver high quality, efficient care. Our working hypothesis is that we will need four acute hospital sites in south west London, but we need to do further work on this*
- *Address both mental and physical needs in an integrated way, because we know this improves the wellbeing and life expectancy of people with severe mental illness and reduces the need for acute and primary care services for people with long term conditions*
- *Introduce new technologies to deliver better patient care (e.g. virtual clinics and apps)*
- *Make best use of acute staff through clinical networking and redesigning clinical pathways*
- *Review specialised services in south London. With NHS England, we have initiated a programme of work to identify the best configuration of the eight acute specialised providers in South London to be clinically and financially sustainable and deliver the best patient care'*

Regarding acute hospitals, in view of resident interest in this point it is worth setting out a little more of the underpinning thinking. The plan on p28 sets out hypotheses:

'The evidence suggests that we could reduce the number of acute sites run by the four acute trusts from the current five and this could improve the quality of care. Through the development of this five year forward plan the system has tested two hypotheses:

- *That **four** acute sites is an appropriate configuration to deliver clinically and financially sustainable care in south west London; and*
- *That **three** acute sites is an appropriate configuration to deliver clinically and financially sustainable care in south west London*

The system has tested these against some initial considerations. These have been used only for the purpose of testing the hypotheses at this stage; a full list of formal criteria will be discussed in public engagement before being used to make decisions about which options would be formally shortlisted for consultation.'

This chapter goes on to list the considerations being used at this stage: clinical quality, workforce availability, travel times, support from commissioners, broad clinical support, robustness against a range of future scenarios, risk during transition, and capital costs. It concludes with an overall assessment of three and four sites at this stage:

'System leaders in south west London have reviewed the evidence available at this stage and our view at this point is that:

- *Five sites does not allow us to meet the clinical standards*

- *Three sites is unlikely to be deliverable, and is likely to have higher capital costs than four sites*
- *Four sites perform better against most of the considerations listed above. In order to optimise our clinical outcomes (including 7 day standards) it is likely that the four sites will need to work very differently from the current approach, for example by networking clinically and working collaboratively to provide the best solution for patients.'*

Having settled on four sites as a preferred hypothesis for further testing, the chapter summarises some issues for each of the five sites, before concluding that *the only site which we believe is a fixed point is St Georges Hospital in Tooting, since it provides hyper-acute stroke, major trauma and other services which are serviced by highly specialised equipment and estates, which would be very expensive to re-provide elsewhere in south west London….Going forward, through public engagement on decision making criteria, we will consider whether any other sites should be designated as fixed points, as well as looking at the options more widely.*

What has happened since October 2016?

The local NHS has continued a process of engagement with local people to discuss the plan, which was published in summary form. In order to do this it has set up Health and Care Forums in each borough, with an intention that these meet every six months. Unfortunately due to difficulties in finding dates and the general election being called, the forum for Merton has yet to meet, but is now confirmed for the evening of June 29.

The further work on acute hospitals referred to above remains work in progress, with some time initially taken to scope and cost the best way of doing this. It is likely that the Local Transformation Boards referred to above will take a greater role in looking at any necessary changes.

Local Transformation Boards have been asked to report to the programme board in September 2017 about their planned models of care, including how this effects finances

As set out above, there is now a greater focus on financial and operational sustainability over the next 2 years 2017-19, with the local NHS being required to set out its analysis and plans.

How has Merton along with other councils inputted to this process?

At an officer level:

- The STP has throughout had a designated local authority chief executive to provide a local authority view to the programme. This was the chief executive of Richmond until August 2016 and since then has been the chief executive of Merton.
- At director level, the NHS has tended to look towards directors of adult social care (DASSs) for much of the input, in view of the high level of inter-dependency between adult social care and health services. There is a group of

DASSs across south west London, which has among other things coordinated input to the STP, including setting out what social care can both offer to the STP and what it requires the STP to address, looking at options to commission residential care collaboratively across south west London, providing a financial appraisal of potential costs to social care from the STP plans, and agreeing who should input into key workstreams of the STP. Merton's Director of Community and Housing chairs this group and has also represented local authorities at chief officer level more broadly where necessary

- Directors of Public Health have worked together to provide input to the prevention aspect of the plan. Merton's Director of Public Health has co-ordinated the work
- Directors of children's services have worked to ensure that the needs of children and young people are not overlooked in this process, which can be challenging when there is so much emphasis on older people. Merton's Director of Children Schools and Families has offered some coordination of this and has also chaired a clinical reference group for children.
- All six local authorities have contributed to a programme manager post which has coordinated input, taken forward specific pieces of work, and assisted with ensuring that everyone including members are kept informed

At member level:

- Chairs of Health and Wellbeing Boards have been members of the Collaborative Leadership Group referred to above, along with CCG lead clinicians . In Merton this is the Cabinet member for Adult Social Care and Health. The group has a declared intention to move from being recipients of information to doing more shaping of the plan.
- In Merton the Health and Wellbeing Board has received updates on progress for the STP, but given the confusion over publication it did not formally receive the draft at the time when it was published.
- Local Overview and Scrutiny panels including Merton's have at times asked for updates, and also collaborate at a south west London level for the Joint Panel.
- Reports were not brought to Merton's Cabinet prior to or at the times of submission of draft plans to NHSE (July and October 2016) because the NHS had not published the plans at this point and it was not envisaged that they would be in the public domain., As stated above, there is no requirement for Cabinet approval given that this is an NHS plan.
- However on both occasions the draft plans were shared, on the basis of not being in the public domain, with the relevant Cabinet members, on the understanding that they would remain confidential. In Merton a response was made through the Cabinet member writing back to the SRO, making comments on the plan in line with the Council's position (see below).

Merton's position has been to:

- Recognise the pressures on the NHS along with social care
- Welcome attempts from the NHS to (compared with previous programmes) work in a more collaborative way with local authorities, to give greater recognition of the contribution from and pressures on social care and other council services, and to give greater emphasis to care outside hospitals including prevention and self care
- Collaborate with the NHS in finding common solutions and remodel care out of hospital, subject to the point about St Helier Hospital below. Such remodelling has included the work on east Merton and the Wilson hospital, integration of service delivery across a range of children's and adult services, and some shared commissioning.
- Be clear that it will oppose any closure or downgrading of St Helier Hospital. Recent Council Motions to this effect state:
    - "this council reiterates its strong opposition to any plan that could result in the downgrading or closure of St Helier Hospital" and later in the motion repeats its "absolute opposition to any closure or downgrading of St Helier Hospital" (February 2017)
    - "this council re-iterates its policy to vigorously oppose proposals to close accident and emergency and maternity services at St Helier Hospital and its resolve to continue to do everything in its power to keep St Helier's accident and emergency, maternity services and other related services open" and later in the motion "we will not allow (…) the STP to be used as a cover for the resurrection of proposals to close or downgrade St Helier Hospital". (July 2016)
    - "reiterates our clear commitment to keeping our local hospital open" and "makes clear that Merton Council will continue its fight to protect our local hospital". (April 2015)

What will happen next?

There has been speculation about the future of STPs given political positions taken during the general election campaign. They now look likely to continue. Whatever the naming and structures given to planning in the NHS, it is likely that they will include an emphasis on working collaboratively in geographical areas, remodelling care to improve outcomes for patients, meeting certain core standards on a more consistent basis, recognising the inter-dependency with social care, and finding efficiencies in order to achieve greater financial resilience.

Merton Council's aim will be to be on the side of its residents at all times. It will therefore support collaborative work which genuinely improves care for residents and which makes better use of the overall resources across the system. It will oppose work which fails to do this, specifically any plans to close or downgrade St Helier Hospital.

3 ALTERNATIVE OPTIONS

3.1. The STP process is set out nationally and allows little room for manoeuvre within the NHS, although within the process a range of alternative scenarios may be identified.

4 CONSULTATION UNDERTAKEN OR PROPOSED

4.1. The Council has not undertaken specific consultation for the purpose of this report, but has over the years remained in continuous dialogue with local residents about the shape of local health care, and has engaged in consultation exercises run by the NHS in order to ensure that the local resident voice is understood

5 TIMETABLE

5.1. For the STP, a local delivery plan focussing on short-medium term financial and quality improvement is expected by the end of June 2017, and a plan setting out next steps for the STP by the end of September 2017.

6 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

6.1. The STP is essentially about NHS services, with financial sustainability for the NHS at its heart, with a wider aspiration for whole system sustainability. However there is potentially a knock on financial impact to the council from any plans, especially those involving shifting more care into community settings. Councils collectively in south west London are keeping this in focus.

7 LEGAL AND STATUTORY IMPLICATIONS

The Council is not a decision maker in terms of the STP. The NHS is governed by various pieces of legislation in doing its planning

8 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

None for the purpose of this report

9 CRIME AND DISORDER IMPLICATIONS

None for the purpose of this report

10 RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

There are no relevant health and safety implications for the purpose of this report.

11 APPENDICES – THE FOLLOWING DOCUMENTS ARE TO BE PUBLISHED WITH THIS REPORT AND FORM PART OF THE REPORT

BACKGROUND PAPERS

Draft South West London Five Year Forward Plan October 2017

NHS Five Year Forward View October 2014

Next Steps on the NHS Five Year Forward View May 2017

The Kings Fund: Delivering sustainability and transformation plans February 2017