Papers for the STP Programme Board meeting

4 April 2017

This meeting of the Programme Board focused on the interim findings of a review and refresh of the STP.

The following papers follow:

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Sussex and East Surrey STP programme board

21 March STP workshop outputs

STP review and refresh deliverables

		Timelines
1 **Tailored place-based support**	• Agree with place-based leads what specific support is required • Rapid review of place-based plans and financial plans supplemented by interviews • Individual sessions with each place to self evaluate and review • Develop recommendations and next step plan for each of the places	Feb – mid Mar
2 **Recommendations for STP-wide priorities**	• Review STP-wide workstreams and identify dependencies and interdependencies • Deliver a workshop (21 Feb) with leaders to align on the functions of STP and the places • Develop recommendations for a revised STP strategy based on findings • Develop recommendations for 17/18 priorities to improve STP financial position • Deliver an STP refresh workshop (21 Mar) with leaders to agree the way forward	Review by 21 Feb
3 **Recommendations for programme governance and decision making processes**	• Review and revise STP governance architecture setting out accountability, roles and responsibilities of leadership, reporting and monitoring mechanism • Identify resources (skills and capacity) required to support delivery • Establish and then support a clinical steering group for the STP	Refresh by end of Mar
4 **Facilitate commissioner development**	• Facilitate CCG AO and Chair discussions on ways of working together and roles of strategic commissioning in the context of STP	By end of Mar

Agenda

Commissioning reform update

Acute services update

Place-based planning arrangements

STP priorities

STP resourcing and leadership

There is a strong case for changing commissioning arrangements in Sussex and East Surrey

- The **deteriorating financial position and increasing financial risk**, which requires a joint response in the short and longer-term
- The **changing nature of provision** including the development of larger providers and accountable care arrangements
- **Commissioners need to be as cost efficient** as possible, making best use of scare resources
- The need to maximise **limited capacity and capability**
  - Leadership in this commissioning environment faces extraordinary demands and challenges
  - There is finite experienced and skilled workforce available in the system to plan and implement the transformation
- The need to provide **system leadership** as required by the STP process
- In responding to these challenges commissioners will need to operate within the constraints of the existing legal framework. It will also be essential to preserve the strengths of the current arrangements such as the clinical leadership and engagement provided by CCGs.

CCG leaders have agreed to establish a commissioning reform work programme

Objectives of the work programme

- Redefine the commissioning model for Sussex and East Surrey
- Create a strategic commissioning entity
- Develop a new approach to contracting and contract management
- Enable the development of accountable care providers
- Collaborate to manage risks relating to resource allocation across the STP
- Engage local government in the design and transition to a future structure

Timeline

- The commissioning reform joint forum will be in place from April 2017, moving to a Committee in Common as quickly as is feasible
- The aspiration is for shadow arrangements to be in place from October 2017 and the new arrangement from April 2018

Key discussion points

- It was recognised that good progress has been made over the last month to begin the development of a strategic commissioner across all SES CCGs.
- Key discussion included:
  - The direction of travel is welcome, although much remains unclear and it needs to be developed quickly
  - Consideration should be given to whether there will be an impact on contracting arrangements with providers and therefore if the work would benefit from the input of providers
  - It was noted that the commissioning reform forum will be a place for collaborative working and is not to create another layer of assurance
  - This work has only recently started but all CCGs are committed to working together to develop it quickly.

Next steps

- The workstream is to be mobilised imminently
- Further feedback can be provided at the 4 April programme board

Agenda

- Commissioning reform update
- **Acute services update**
- Place-based planning arrangements
- STP priorities
- STP resourcing and leadership

You have asked us to consider acute sector capacity issues, particularly in respect to the Royal Sussex County Hospital

Questions posed:

- What is the demand for the acute services provided at Royal Sussex County Hospital (RSCH), from now until the opening of the second phase of the 3Ts in 2023/24?
- Will there be sufficient capacity at RSCH to accommodate these services plus the fully functioning MTC and HASU, both before and after the 3Ts redevelopment opens?
- If not, what are the options for managing demand and capacity by moving services off RSCH and onto other sites across Sussex and East Surrey?

Four scenarios have been generated based on input from the Clinical Board, the Finance Group and the Modelling Group

Scenario	Activity forecast	Length of stay assumption	Rationale for forecast	15/16 – 23/24 growth (beddays)
A1 Do nothing	• NEL: weighted IHAM • EL: Provider plans*	• Continues to follow historic trend at each site	• IHAM agreed by finance modelling group • Low IHAM elective growth highlighted by modelling group – therefore provider plans selected	+24%
A2 Do nothing + emergency floor at RSCH	• As above, except at RSCH • ALOS reduction from emergency floor at RSCH • 37 additional assessment beds at RSCH: 50% in January 2018, 50% in January 2019			+22%
B Do something	• 2016/17: "do nothing" • Provider plans thereafter	• Site specific assumptions, as advised by medical/clinical directors (see later)	• All organisations agree that the demand management assumptions in provider plans can be delivered	+19%
C Do more	• Stems activity growth, keeping overall levels within the CCG resource envelope • Based on an extrapolation from CCG plans	• As above; plus • 50% of all opportunity in bed audit captured, begin mid-2018/19, evenly phased through to 2023/24	• There is no agreement between organisations of a reasonable 'do more' • This scenario denotes a level of acute activity that is within the affordability envelope	-12%

Common assumptions across all scenarios:
- 90% occupancy target from 17/18
- BSUH becomes a compliant MTC
- BSUH continues to provide local emergency services typical of a DGH
- No repatriation from London/ private sector

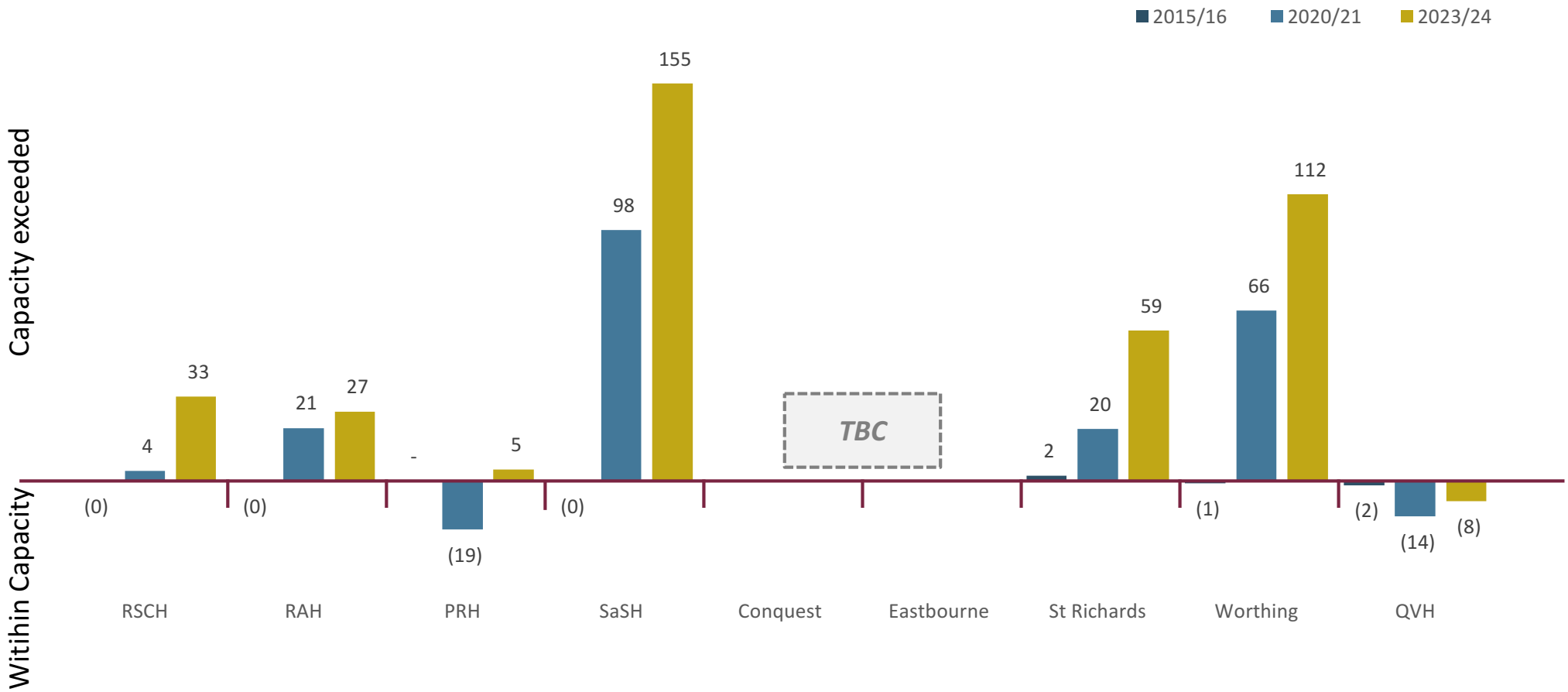
*The modelling group recommended reviewing elective activity growth against referral growth. At time of writing, we do not have the data for referrals from all providers. The data we do have suggests provider plans are a more realistic 'do nothing' for the elective scenarios

** Approval is being sought to expand the ED at RSCH, adding 40 beds (including 3 resus) and 30 trolleys. This scenario reflects current assumptions; these are not finalised and are subject to change

Source: Carnall Farrar methodology

A1 In the do nothing scenario, the majority of providers will exceed their bed capacity

SES acute capacity vs. demand by site: ”do nothing” scenario (90% capacity)

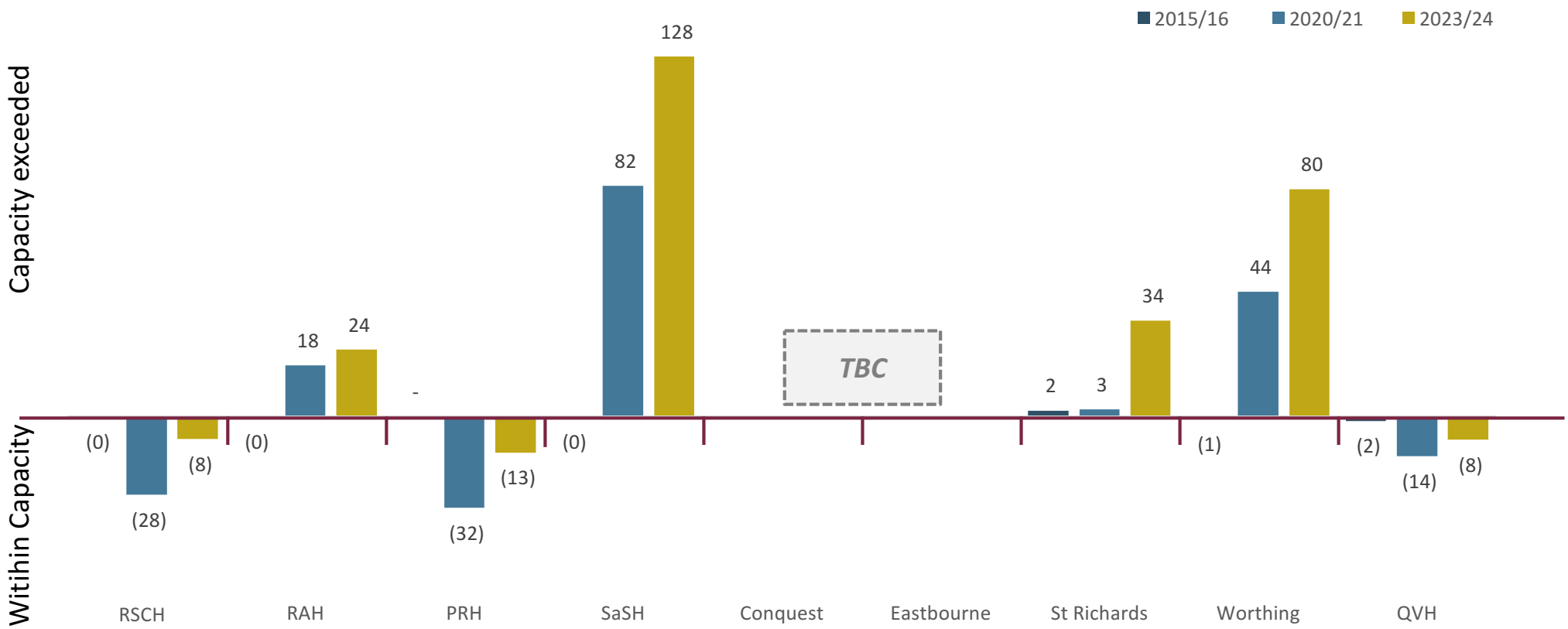


Notes: Data for ESHT sites currently being validated, 90% occupancy target set from 17/18

Source: Provider submitted data, Carnall Farrar analysis

B The do something scenario suggests a shortfall of acute beds across some sites in the system

SES acute capacity vs. demand by site: ”do something” scenario (90% capacity)

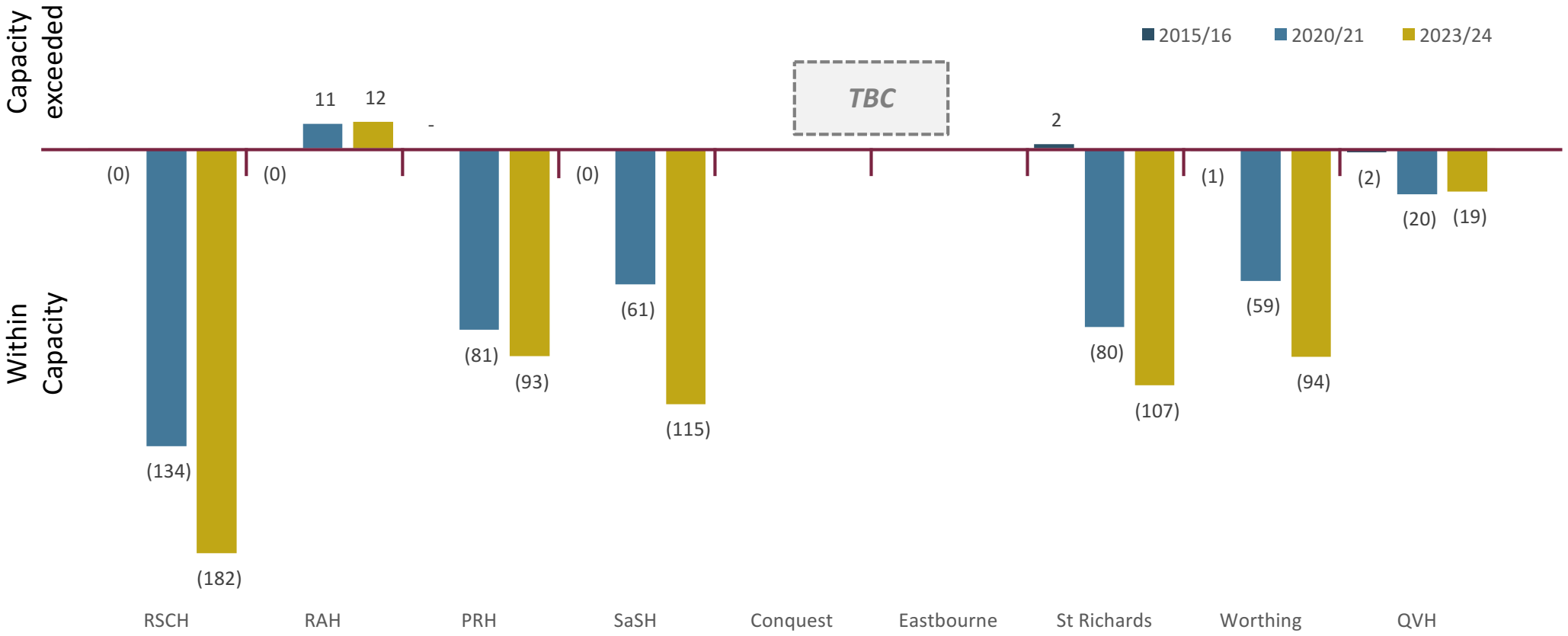


Notes: Data for ESHT sites currently being validated, 90% occupancy target set from 17/18

Source: Provider submitted data, Carnall Farrar analysis

C The do more scenario suggests there would be sufficient acute capacity to meet the demand

SES acute capacity vs. demand by site: ”do more” scenario (90% capacity)



Notes: Data for ESHT sites currently being validated, 90% occupancy target set from 17/18

Source: Provider submitted data, Carnall Farrar analysis

Each scenario has consequences that have to be considered

Demand scenario	15/16 activity (beddays)	20/21 activity (beddays)	15/16 CCG affordability (%)	20/21 CCG affordability (%)	20/21 capacity gap (beds)
A1 Do nothing	• 869,510	• 1,003,860 • 15% increase from 15/16	51% of allocation	73% of allocation	-(383)
A2 Do nothing + RSCH EM beds	• 869,510	• 987,928 • 14% increase from 15/16	51% of allocation	71% of allocation	-(294)
B Do something	• 869,510	• 969,887 • 12% increase from 15/16	51% of allocation	69% of allocation	-(237)
C Do more	• 869,510	• 807,180 • 7% reduction from 15/16	51% of allocation	51% of allocation	+598

Notes: Excludes figures from Conquest and Eastbourne sites, which are currently being verified

Source: Carnall Farrar methodology

Key discussion points

- All scenarios exceed commissioner resource envelope except the “do more” scenario
- The “do more” scenario is less aggressive in reducing acute activity than the CCG plans within the STP, as CCGs also need headroom to invest in new models of care in the community
- Note: this work has reviewed demand and capacity requirement, not the financial positions of organisations or the system
- Key points of discussion included:
  - It is important to note that resources aren’t removed but redistributed across the system
  - The Brighton development may reduce pressure on that site but the rest of the acute sites will faces significant challenges if the current trends continue
  - The plans to support the “do more” scenario are not robust and more work is needed to develop them
  - Work needs to be done to understand the financial impact, the transitional costs and investment required.

Next steps

- The “do more” scenario requires further work; in particular, credible plans to deliver this level of activity needs to be developed and tested.

Agenda

- Commissioning reform update
- Acute services update
- **Place-based planning arrangements**
- STP priorities
- STP resourcing and leadership

Coastal Care update

Objectives for the Coastal Care partnership session:

- Re-establish collective understanding of accountable care
- Re-energise system working with the development of a new roadmap
- Agree what we will do collectively going forward
- Understand how Coastal Care fits into the broader STP structure

Key discussion points and agreement

All partners are aligned on the following:

- The case for change is pressing
- Accountable care is needed for the Coastal West Sussex population
- The local community networks are the building blocks of delivery
- All agreed that resourcing is significantly lacking, both in terms of delivery and programme resources

More work is needed to:

- Define the key characteristics of local community network delivery, but leave flexibility for local variation
- Define the outcomes for accountable care
- Develop the business case underpinned by a financial model
- Develop the organisational form and contracting mechanism

Next steps

- Another partnership session early May to review the revised business case
- Embark on a reframing exercise for all partners to develop the details of accountable care arrangements

East Sussex Better Together update

Objectives for the East Sussex Better Together (ESBT) partnership session

- Discuss what ESBT should deliver and what is needed from the wider STP, in particular in relation to the sustainability challenge
- Understand the interdependencies between STP-wide workstreams and ESBT
- Discuss the impact of the emerging STP governance and where decisions should be made

Key discussion points and agreement

- The ACO model in ESBT will be accountable for the population in ESBT; it will also be accountable for resolving the system deficit that relates to this population. Accountability will operate through NHS and council governance
- In order for ESBT to fully respond to the sustainability challenges, progress is required on STP-wide workstreams, in particular acute services. ESBT leaders are also committed to taking on the shared responsibility for delivering a sustainable system across STP
- There are challenges that are common to the wider system, which make sense to work together on, for example workforce, information and potentially estates; but organised effort is needed to make collective working worthwhile
- There needs to be a clear understanding of the role of the STP leadership. It makes sense for places to work together to enable collective delivery, but it is important to avoid double, or even triple, assurance if some of the regulatory functions are being taken on at STP-level as well

Next steps

- Collectively discuss and clarify the role and approach of dedicated STP leadership
- Further develop (collectively) the opportunities across STP and be clear on the focus and purpose of STP-wide workstreams

North CSESA update

Objectives for the North CSESA partnership session

- Align on the key issues we need to address (the case for change)
- Understand what accountable care means for North CSESA and what a future model may look like
- Review whether North CSESA is a place
- Agree concrete steps to take this forward

Key discussion points and agreement

- Organisations in the North CSESA footprint need to work collectively to develop a new model of care, given the challenges of the imbalance of resources in the system around SaSH
- As a principle, care should be more accountable and integrated. The model of accountable care (including contracting mechanisms) need to be further developed
- The group needs a shared understanding of the data and evidence base to align on priorities and actions that need to be taken
- Agreement that primary care is integral to any accountable care models, and that a close working relationship with the acute is required to address the system challenges

Next steps

- Develop an OD agenda for the executive group and formalise agreement for working together
- Develop analytical evidence and identify the priorities for North CSESA to focus on collectively
- Establish a follow-up session to develop thinking on accountable care models further
- An initial step is to test the approach on some priority segments of the population e.g. the frail and elderly

South CSESA update

- Due to the fragility of the South CSESA system, the current thinking is to plan at scale across the Brighton and Hove, High Weald Lewes Havens and lower part of Horsham and Mid Sussex patches to ensure there are consistent pathways and approaches
- The aim is to have a local delivery approach within Brighton and Hove, and a separate one in High Weald Lewes Havens that focuses on local integration of health and care - with a particularly strengthened model for Primary Care
- The lower part of Horsham and Mid Sussex will operate in a collaborative way to ensure we are developing fully synergised services
- As the South system begins to stabilise this may be revisited, but in the meantime the focus will be to push faster on developing out of hospital model with community and local authority partners
- A regular stocktake of progress will be taken as we move forward

Key discussion points

The role of the place-based planning groups:

The group agreed that a place is

- Accountable for the health and care of their local population
- A delivery footprint for local care
- An interim, collaborative forum for developing new models of care for the local population
- A potential footprint for developing accountable care provider vehicles
- Responsible for its population share of the total system deficit
- Not a new commissioning level (strategic commissioning will be developed at the STP level)

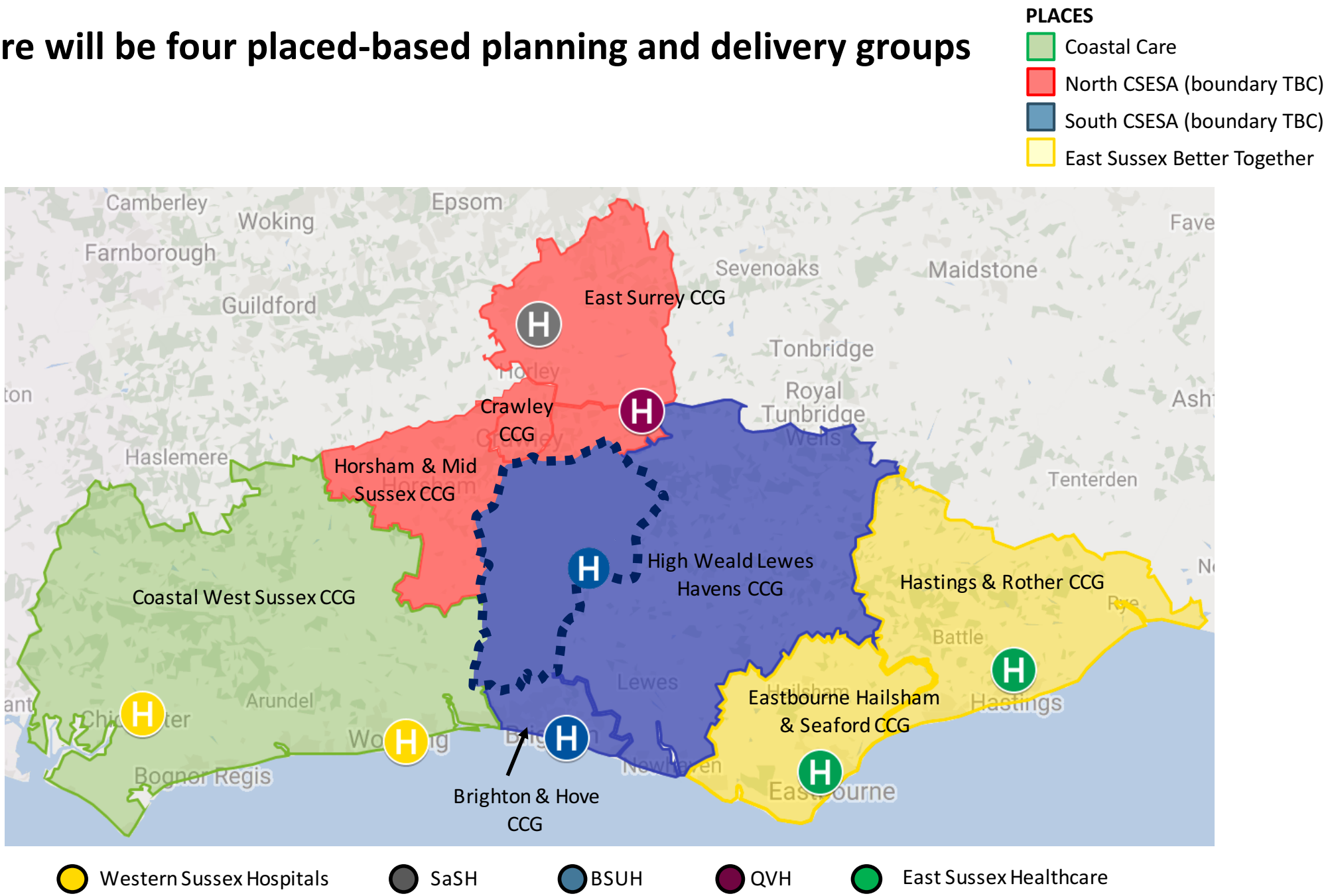
Further development of places will need to take the following into consideration:

- Integration with social care should be led by places, including the integration with social care budgets where appropriate
- The aspiration should be to develop a single population based budget
- Clarity is needed to articulate how place accountability will mean for GPs within the current contracting arrangements
- There is a need to further develop accountability within places which may need agreeing with regulators

Agreement on place footprints

- Coastal care and East Sussex Better Together will continue to be place-based planning footprints
- CSESA will split into two places with North and South partners working together to develop respective plans.
- Further discussion and agreement is needed to define the North and South CSESA boundaries

There will be four placed-based planning and delivery groups



- Note: The hospital sites identified on this map are major acute inpatient sites only

Agenda

- Commissioning reform update
- Acute services update
- Place-based planning arrangements
- **STP priorities**
- STP resourcing and leadership

STP priorities for 2017/18: objectives for this session

- Understand the collective challenges facing the STP in 2017/18 and beyond
- Review the priorities we previously agreed on and which have been mobilised
- Collectively agree the priorities for 2017/18

A priority for 17/18 should:

- ***Make a material impact on the financial, health and quality challenge***
- ***Be adequately resourced and accountable***
- ***Have a plan with a clear scope, deliverables, approach and timeline***

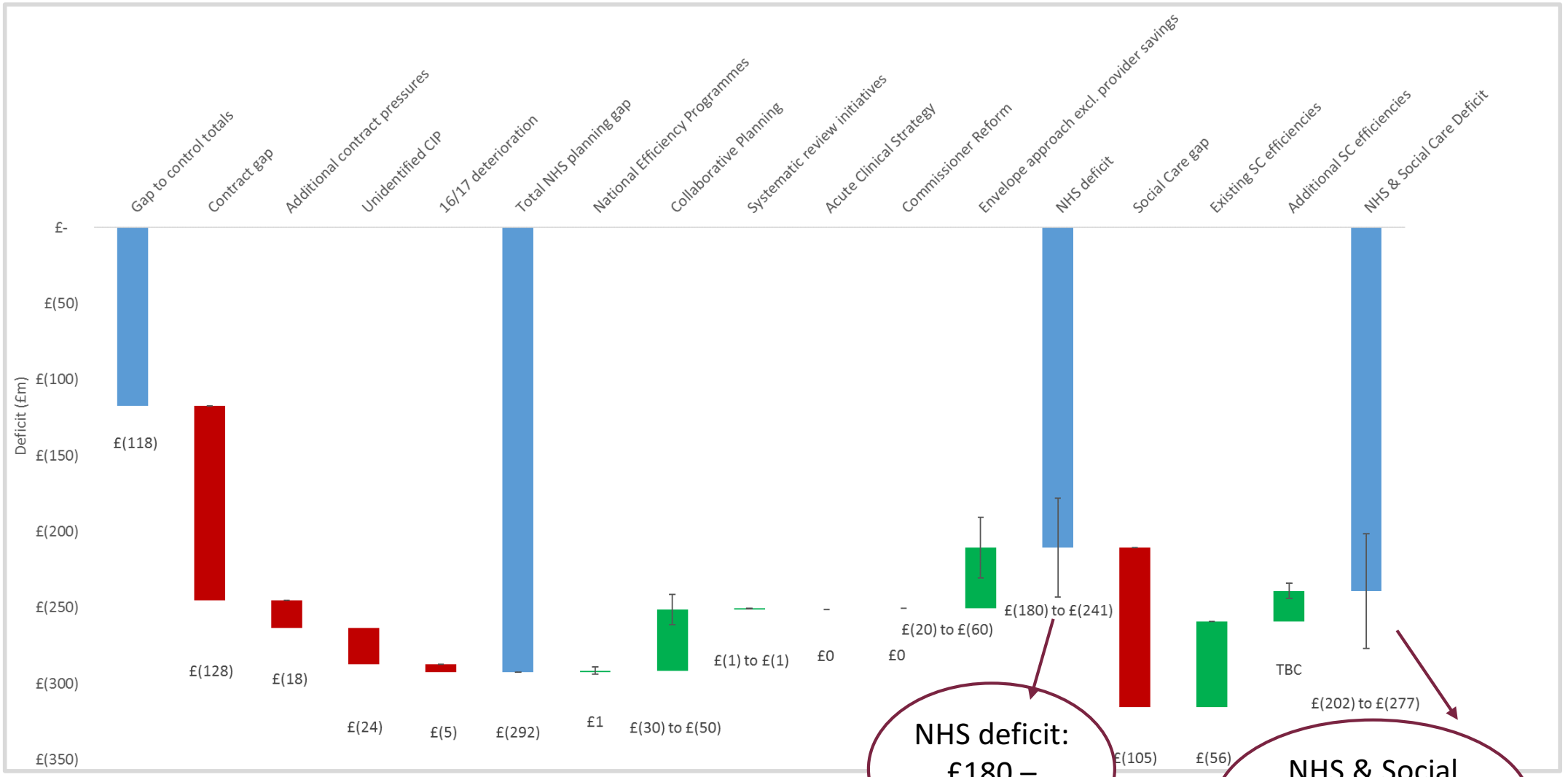
There are currently six STP-wide priorities mobilised in addition to three place-based programmes

STP-wide workstream mobilised
1. Acute services
2. Urgent and emergency care
3. Provider productivity
4. Workforce
5. Digital
6. Estates

Place-based plans
1. Coastal Care
2. East Sussex Better Together
3. CSESA (not mobilised)

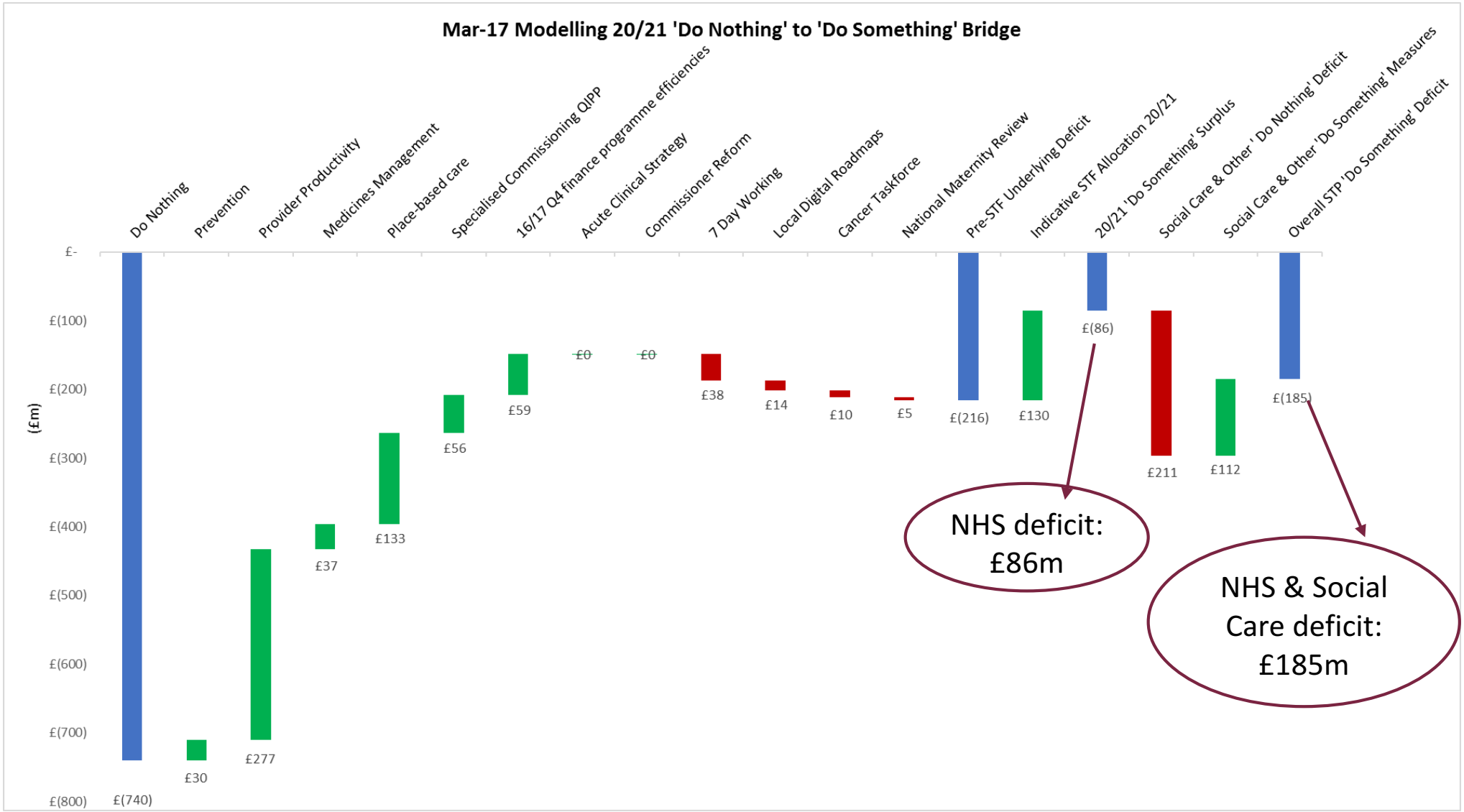
STP-wide priorities in the submission but not mobilised
7. Communications and engagement
8. Mental health
9. Frailty
10. Primary care
11. Prevention
12. Medicines management
13. Specialised commissioning
14. Seven day services
15. Cancer taskforce
16. National maternity review

The current 2017/18 forecast has a significant financial gap…



SOURCE: Finance sub-group draft for discussion 17 March

…This challenge is not resolved by 2020/21

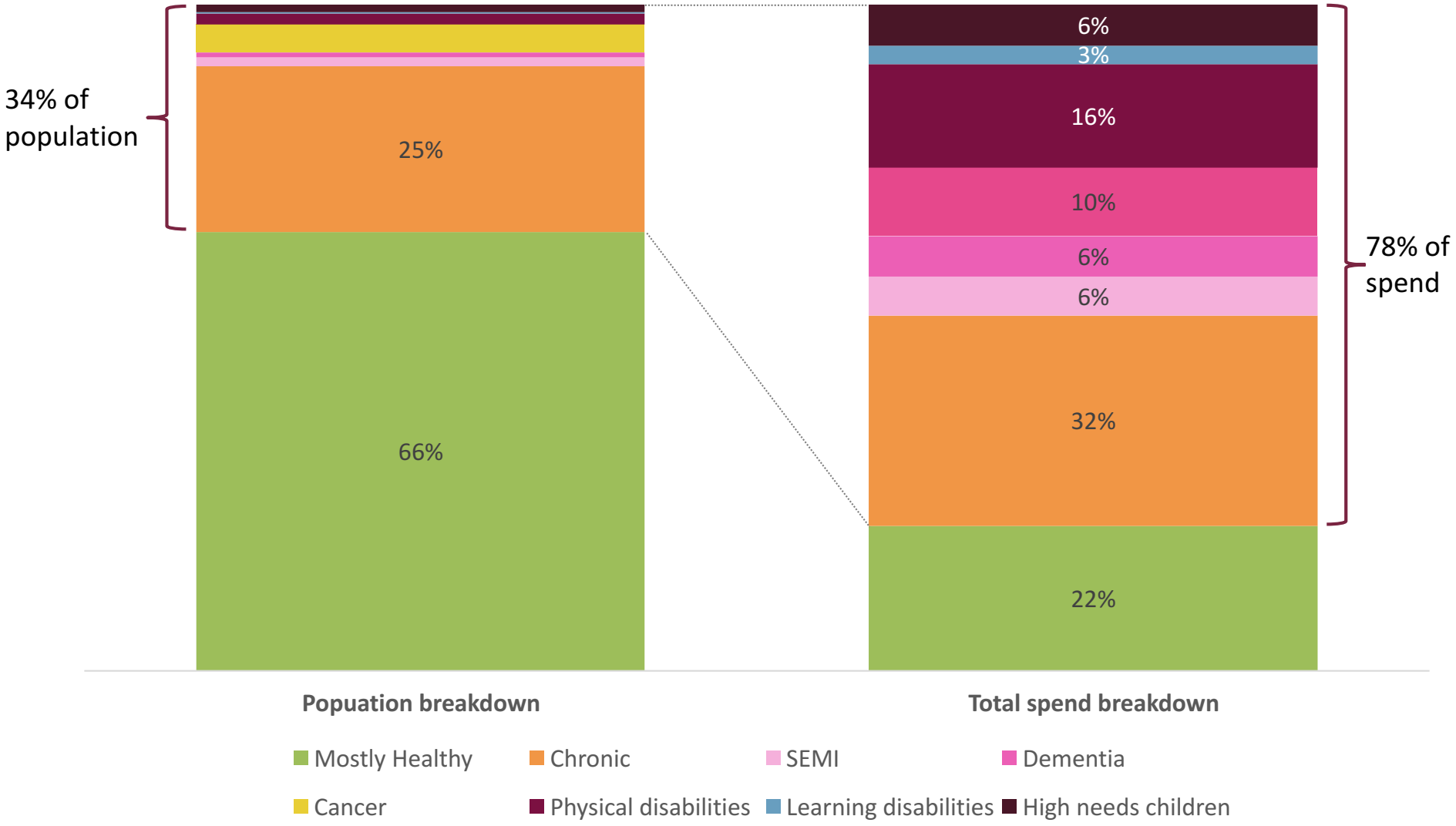


SOURCE: Finance sub-group draft for discussion 17 March

Populations segmentation of Sussex and East Surrey can be used to help identify priorities

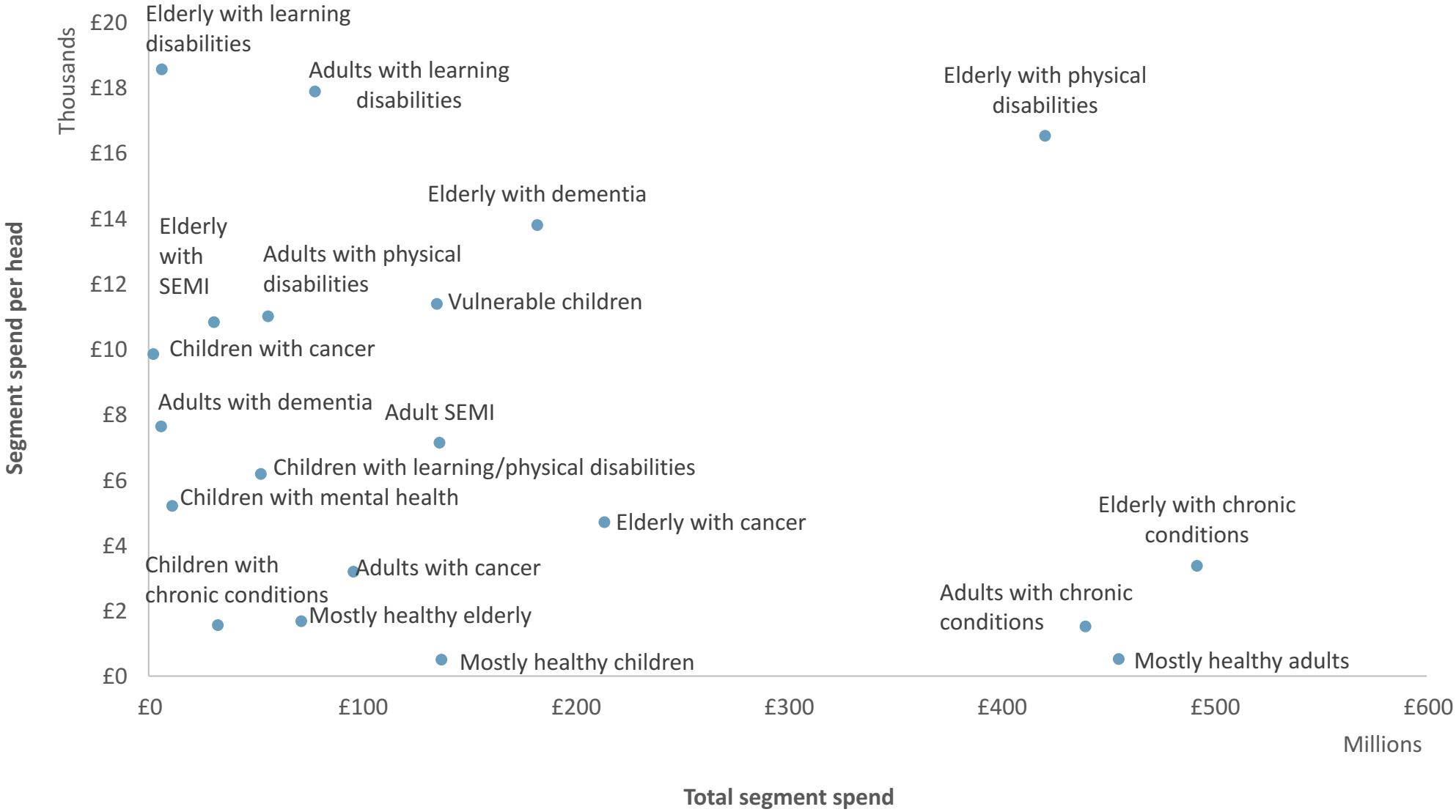
SOURCE: Carnall Farrar analysis

Across Sussex and East Surrey, 34% of the population is consuming 78% of the health and care resources



SOURCE: Carnall Farrar analysis

Segments with the highest spend per head but also a high total segment spend should be considered as potential priorities



SOURCE: Carnall Farrar analysis

Potential priorities for 2017/18 – for discussion

Category	Priorities	Delivery level
Service transformation	Place-based care (strengthening local care)	Place
	Primary care	STP and place
	Mental health (tier 3 and 4)	STP
	Urgent and emergency care	STP and place
	Acute services	STP
	Productivity (including workforce)	STP and place
Enabler	Workforce	STP
	Digital	STP
	Commissioning reform	STP
	Accountable care provider vehicles	Place
STP infrastructure	Leadership and OD	
	Overarching strategic financial framework	
	Communications and engagement	

Key discussion points

- There was general agreement that the proposed priorities should be the priorities for 2017/18 (and although long it would be difficult to take some off)
- The population segmentation is very helpful to illuminate a few key population groups that need particular attention (including mental health, elderly with long term conditions)
- It was noted that impact on care and outcomes needs to be taken into consideration when looking at which cohorts of population to focus on (as well as financial impact)
- Elective care was raised as a potential priority since SES are performing worse than their peers.
- It is important to consider the population cared for rather than the pathways – this is a key learning from successful accountable care systems
- A collective picture on priorities (both STP-wide and places) should be developed to understand 1) the value of working together to tackle the priorities; 2) how the total system financial deficit will be addressed

Next steps

- Engage clinical leadership to further develop the priorities
- Ensure opportunities are maximised for the biggest impact (financial and care outcomes)
- Share learning from good work within the SES system which is not currently being taken advantage of

Agenda

- Commissioning reform update
- Acute services update
- Place-based planning arrangements
- STP priorities
- **STP resourcing and leadership**

Key discussion points

- The amount of resource dedicated to the Sussex and East Surrey STP is significantly lower than that of neighbouring STPs
- There was general consensus that dedicated leadership and resources are needed
- This includes resourcing the places – resources are very stretched in place-based programmes and yet this is a core priority for the STP
- There should be investment in OD for the leadership community to support the development of trust so that collective action can be taken and historic issues addressed
- General reflection that too much resource is focussed on low-value and transactional interactions between commissioners and providers. Resources need to be refocussed onto the transformational agenda of the STP
- However, it was noted that a lot of work needs to be done to enable resources to be refocussed and that a interim set of arrangements will be needed to facilitate the transition
- It was also noted that without a resource agreement, it will be difficult to recruit a dedicated leadership team to take the STP forward

Next steps

- Further develop resourcing requirements and approach to securing resources among a small group of leaders
- NHS England have offered resources and this should be taken into consideration when shaping the resource requirement

ACTION: STP convenor, the commissioner STP SRO, the four place-based leads, the finance group chair, the clinical group co-chairs and the programme director to meet to develop the resourcing proposition