STP summary paper
Contents

STP summary paper

1. Northumberland, Tyne and Wear 3
2. West, North and East Cumbria 7
3. Durham, Darlington, Tees, Hambleton, Richmondshire and Whitby 10
4. Lancashire and South Cumbria 13
5. West Yorkshire and Harrogate 16
6. Coast, Humber and Vale 19
7. Greater Manchester 23
8. Cheshire and Merseyside 26
9. South Yorkshire and Bassetlaw 29
10. Staffordshire & Stoke-on-Trent 32
11. Shropshire and Telford and Wrekin 35
12. Derbyshire 38
13. Lincolnshire 40
14. Nottinghamshire 44
15. Leicester, Leicestershire and Rutland 47
16. The Black Country 50
17. Birmingham and Solihull 53
18. Coventry and Warwickshire 56
19. Herefordshire and Worcestershire 59
20. Northamptonshire 62
21. Cambridgeshire and Peterborough 65
22. Norfolk and Waveney 68
23. Suffolk and North East Essex 71
24. Bedfordshire, Luton and Milton Keynes 74
25. Hertfordshire and West Essex 77
26. Mid and South Essex 80
27. North West London 83
28. North Central London 86
29. North East London 89
30. South East London 92
31. South West London 95
32. Kent and Medway 99
33. Sussex and East Surrey 101
34. Frimley Health 105
35. Surrey Heartlands 107
36. Cornwall and the Isles of Scilly 111
37. Devon 113
38. Somerset 116
39. Bristol, North Somerset and South Gloucestershire 119
40. Bath, Swindon and Wiltshire 122
41. Dorset 124
42. Hampshire and the Isle of Wight 126
43. Gloucestershire 128
44. Buckinghamshire, Oxfordshire and Berkshire West 131
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Northumberland, Tyne and Wear
1. Northumberland, Tyne and Wear

**Population:** 1.4 million

*Link to plan*[1]

**Lead:** Mark Adams, Newcastle Gateshead CCG (Clinical Commissioning Group)

Contact your regional coordinator about your STP: aheeley@bma.org.uk

**Priorities are:**

1. Scaling up prevention, health and wellbeing to improve the physical and mental health of our population and reduce inequity.
   a. Ensuring every child has the best start in life
   b. Reduce the prevalence of smoking and obesity and reduce the impact of alcohol
   c. Radical upgrade in approach to ill health prevention and secondary prevention
   d. Enhance ability to self-care, increase self-esteem and self-efficacy
   e. Roll out Making Every Contact Count

2. Out of hospital collaboration to develop alternative service models, reduce variation and raise quality of care in community settings.
   a. Maximise opportunities to integrate health and social care
   b. Implement the GP Forward View

3. Optimal use of the acute sector to improve experience of care, achieve better outcomes and create a sustainable model.
   a. Improve access to high quality care
   b. Acute services collaboration across clinical pathways and service models
   c. Specialist commissioning

**Key points:**

- The STP is largely coterminous with the North East Combined Authority Area. It contains three local health economies: Newcastle Gateshead; Northumberland and North Tyneside; South Tyneside, Sunderland and North Durham.
- It is a National Transformation Area so extra investment support is available, and as a result progress is intended to proceed at a faster pace than the rest of the country.
- The health and wellbeing gap compared to the rest of the UK remains stubbornly high.
- There are currently seven acute sites within the STP. The plan looks at options to consolidate services across sites following the example of City Hospitals Sunderland and South Tyneside FT (Foundation Trust).
- The priority areas for the GPFV (General Practice Forward View) are care re-design, workload, workforce, voice for GP, quality, investment and co-commissioning.
- MCP (Multispeciality Community Providers) and PACS (Primary and Acute Systems) are expected to become the key delivery mechanisms for the North East, and at an accelerated rate compared to the rest of the country.
- The priority to date has been understanding existing hospital work programmes and exploring opportunities for STP-wide alignment across care pathways, service lines, back office sharing and pathology.

The next priority is to agree a range of clinical options to deliver 7-day clinical services across the footprint. The services to be used as drivers for change and therefore modelled and assessed are:

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Clinical Options</th>
<th>Ancillary Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E</td>
<td>Critical care (level 2&amp;3)</td>
<td>Consultant led obstetrics</td>
</tr>
<tr>
<td>Acute medicine</td>
<td>Interventional radiology</td>
<td>SCBU</td>
</tr>
<tr>
<td>Hyper-acute stroke</td>
<td>Inpatient paediatrics</td>
<td>Neonates</td>
</tr>
<tr>
<td>Acute surgery</td>
<td>SSPAU</td>
<td>Midwifery led (stand alone)</td>
</tr>
<tr>
<td>Specialist vascular surgery</td>
<td>Elective care (linked to critical care)</td>
<td>Midwifery led (co-located)</td>
</tr>
</tbody>
</table>

There are detailed delivery plans with details of leads in the appendices to the plan.

**Northumberland and North Tyneside LHE (local health economy):**
- Focus for 2017/18 and 2018/19 is to continue developing the Northumberland ACO (Accountable Care Organisation), supported by a new commissioning arrangement with the local authority to test and evaluate the PACS model and explore how Newcastle Gateshead CCG and North Tyneside CCG could work with a joint management team.
- From 2019/20 onwards, stakeholders will look at identifying the most appropriate care model for North Tyneside.
- Likely candidate to become an ACS (Accountable Care System).

**Newcastle Gateshead LHE:**
- Continue developing work on the re-procurement of community services and the development of the Teams around Practices concept.
- Complete the proof of testing around the Enhanced Care in Care Homes Vanguard to enable the model to spread across the STP area.
- Support Newcastle Upon Tyne Hospitals NHS FT and Gateshead Health NHS FT to collaborate on the provision of acute services.

**Sunderland, South Tyneside and North Durham LHE:**
- Focus on Sunderland MCP Vanguard and the South Tyneside Integrated Pioneer work.
- Investigate “rebalancing” services across South Tyneside and Sunderland hospitals.
- Undertake a clinically led service review programme across all clinical services. The timeline for this is in the plan.
- From 2019/20 onwards, develop collaborative arrangements for the acute provision of care at University Hospital of North Durham and the South Tyneside and Sunderland Healthcare group.

**Engagement:**
- Engagement on the current draft was carried out from 23rd November to 20th January. Feedback could have been given through links on the webpage or at public events. A feedback report will be published.
- Any future NHS reconfiguration will still require its own case for change and a formal consultation process in line with NHS statutory duties.
- Gateshead & South Tyneside and Newcastle & North Tyneside LMCs (local medical committees) submitted a joint response with their views on the STP.
**Finances:**

*Financial gap by 2020/21*

- Healthcare: £641 million
- Social care: £263 million
- Combined: £904 million

*Savings proposed (only healthcare):*

- Out of hospital care: £89 million
- Shared back office: £31 million
- STF (Sustainability and Transformation Fund): £65 million
- Acute consolidation: £39 million
- CCG efficiencies: £105 million
- Specialised services: £44 million
- Provider efficiencies: £241 million
- Prevention: £18 million
- Pathology: £9 million

**Total: £641 million**

**Capital funding required: £77 million**

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2 This is the gap between the funding available to the STP in 2020/21 and the funding that the plan predicts will be needed based on the current health and social care model and expected demand.
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West, North and East Cumbria
2. West, North and East Cumbria

Population: 300,000

Link to plan

Lead: Stephen Eames, North Cumbria University Hospitals NHS Trust
Contact your regional coordinator about your STP: mcheetham@bma.org.uk

Priorities are:
1. Prevention, self-caring and promoting independence
2. Social care/community based care
3. Primary care development
4. ICCs (Integrated care communities) & Community Hospitals
5. Local secondary care

Key points:
- The STP is aligned to the proposals set out in the success regime and builds on the Cumbria Health & Wellbeing Strategy 2016-2019.
- Relatively small population over large geographical footprint.
- All organisations have started discussions about system development towards an ACO. They will be following a shared process to take forward an options appraisal to consider the case for new organisational arrangements. A forward road map for this is expected to be agreed collectively in advance of March 2017, to be implemented from 2017/18 onwards.
- The governance arrangements are detailed in the plan and have been in place since October 2016.
- The current quality of general practice is high, but pressures on these services are increasing, and recruitment and retention is now a significant risk.
- Some acute hospital services (eg urgent & emergency care, secondary care diagnosis & treatment) are not always provided sufficiently promptly and core constitutional standards are not consistently met.
- To stabilise and sustain primary care the plan suggests extending the role of community pharmacists, enabling practices to collaborate to deliver an enhanced range of services. This will involve proposals to the Estates and Technology transformation fund, improving access by allowing practices to work together to coordinate provision of extended access, introducing a new quality improvement scheme and exploring more attractive models of employment (eg salaried GPs, integrated same-day demand services, portfolio careers).
- Care outside of hospitals is to be optimised through Integrated Care Communities. These will bring together public health, general practice, social care, community services, mental health services and community assets, including community hospitals, to act as a single integrated hub, with active support from key secondary care specialists, such as geriatrics, as well as providing access to acute based diagnostics. As they mature, locality budgets will be developed drawing on a range of services commissioned at STP and County level.
- Emergency and acute care – the plan proposes developing a single-service model across the two acute sites (Cumberland Infirmary Carlisle & West Cumberland Hospital). Elements of this proposal have been consulted on (see below).
- There is a plan to develop stronger clinical networks. They have started the process of formally partnering with Newcastle Hospitals NHS FT and Northumbria Healthcare FT to provide clinical network support in areas such as radiology/oncology and specialist children’s services.

4 http://www.cumbria.gov.uk/publichealth/
It is a priority to renew the specialised radiotherapy infrastructure at the CIC (Cumberland Infirmary Carlisle) site. A proposal has been developed with NHSE (NHS England) specialist commissioners and a tertiary services provider. A case for capital investment needs to be prepared and accepted for this to be successful.

Plans to continue to establish the West Cumberland Hospital as a high volume elective centre creating capacity for CIC for unplanned and high risk surgery. Redesign of MSK (musculoskeletal) and ophthalmology pathways and the introduction of integrated models for chronic pain and surgical pre-assessment is also planned.

Whole-system step change in how mental health crisis support is delivered, putting it on a par with other emergency services 24/7, and providing a greater range of care and support close to home.

Engagement

The plan states that widespread engagement with communities, staff and health and care organisations has taken place and public consultation commenced in September 2016. The Healthcare for the Future consultation ran from September to December 2016 and is now closed. The BMA submitted a response. The consultation put forward the following two options as the preferred options and a decision was expected in March 2017. It also put forward different options for removing 29 community hospital beds from nine sites to six as well as removing 24/7 A&E care at one of the two hospitals.

Preferred option for maternity services is the provision of a consultant led maternity unit, alongside a midwife-led maternity unit and a special care baby unit at CIC along with a full range of antenatal and postnatal care. At West Cumberland Hospital in Whitehaven a 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.

Preferred option for children’s services is the development of an inpatient paediatric unit serving West, North and East Cumbria based at CIC along with a short stay paediatric assessment unit. At West Cumberland Hospital, Whitehaven there would be a short stay paediatric assessment unit for children requiring short term observation and treatment. There would also be some overnight beds at Whitehaven for children with less acute, low risk illnesses.

North West Ambulance Service responded to the consultation expressing concerns that the maternity transfer plans from Whitehaven to Carlisle are not clinically safe. They claimed that the transfer times quoted have been underestimated and that the proposals fail to meet vital guidance on emergency caesareans and they even state that paramedics could refuse to transport patients if they felt it was unsafe.

Finances:

Financial gap by 2020/21

£168 million

Savings proposed:

Business as usual efficiencies: £86 million (provider efficiencies, shared organisation arrangements, CCG and specialist commissioning efficiencies)

Services outside of hospital: £42 million (reduced cost of hospital services of £63 million less £21 million investment in “out of hospital” services)

Hospital service reconfiguration: £1.2 million (maternity services, children’s services, new ways of working across acute and emergency care)

Community service reconfiguration: £0.9 million (consolidating the total number of inpatient sites from nine to six)

The identified savings leave a residual financial challenge in 2020/21 of £46 million. Some additional areas are identified which could further reduce the financial challenge. Overall transitional funding required is in the region of £167 million to £247 million, in addition to the £22 million implementation costs.

Capital funding required: £140 million
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Durham, Darlington, Tees, Hambleton, Richmondshire and Whitby
3. **Durham, Darlington, Tees, Hambleton, Richmondshire and Whitby**

**Population:** 1.3 million

**Lead:** Alan Foster, North Tees and Hartlepool NHS FT

Contact your regional coordinator about your STP: aheeley@bma.org.uk

**Priorities:**
1. Preventing ill health and increasing self-care
2. Health and care in communities and neighbourhoods
3. Quality of care in our hospitals — "Better Health Programme"
4. Use of technology in health care

**Key points:**
- There are plans to develop health and social care hubs each covering a population of 30,000 to 50,000 people (primary care home model).[^5]
- Plan to strengthen links between and integrate commissioning functions where it makes sense, including increasing the number of patients and service users who have access to a Personal Health Budget.
- A proposal to consolidate acute emergency care services is currently under development and will be subject to consultation, although no timelines are mentioned. The plan proposes two specialist hospitals for the region: James Cook University Hospital in Middlesborough and either the Darlington Memorial Hospital or University Hospital of North Tees in Stockton on Tees. The hospitals will provide A&E — with James Cook offering a 24 hour consultant service and the other a 16 hour consultant service — as well as specialist care and acute surgery, and potentially consultant led obstetrics and inpatient paediatrics. James Cook will continue to host the major trauma centre.
- The hospital not chosen is likely to have their A&E closed and will provide day-case and outpatient elective care, urgent care services, a frail assessments unit, short stay paediatrics, specialist elective care, midwife led obstetrics unit. Friarage, Hartlepool and Bishop Auckland hospital will provide similar services. The more rural Friarage site in Northallerton, is believed to retain its A&E.
- The plans states that new contracting and funding approaches are needed to manage capitated budget for out of hospital care.
- Predicted reduction in activity by 2019/20: Consultant led first outpatient appointment (20%), Elective (1%), Non elective (23%), Accident and Emergency (22%). This shift in activity is expected to move to community based provision, including urgent care centres.

**Engagement:**
- The leader of Hartlepool Borough Council raised concerns about the transparency of the STP process.
- The STP lead has offered the BMA a meeting with the medical director and clinical leads.
- Contact necsu.STP@nhs.net for further information.

[^5]: [https://nhsbetterhealth.org.uk/about-better-health/sustainability-transformation-plans-stp/](https://nhsbetterhealth.org.uk/about-better-health/sustainability-transformation-plans-stp/)

[^6]: Primary care home is a model developed by the NAPC (National Association of Primary Care), being taken forward by a number of rapid test sites. It is highlighted by NHS England as one possible way of developing the ‘building blocks’ of an MCP. More information is available on the [NAPC website](https://napc.org.uk/).
**Finances:**
*Financial gap by 2020/21*
- Combined health and social care: £281 million

*Savings proposed:*
- Neighbourhoods & communities: £42.9 million
- Acute reconfiguration: £110.7 million
- Early intervention & prevention: £9.6 million
- Other: £100.8 million

**Capital funding required: £115 million**
STP summary paper

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4. Lancashire and South Cumbria

Population: 1.6 million

Link to plan

Lead: Dr Amanda Doyle, Blackpool CCG

Contact your regional coordinator about your STP: mcheetham@bma.org.uk

Priorities:
- Greater emphasis on achieving sustainability
- Introduce population health model at scale across the footprint
- Maximise learning from the vanguards
- One service approach to physical and mental health services
- Understand the impact and roadmap for implementation of technology, workforce, partnerships and estates

Key points
- The plan is made up of LDPs (Local Development Plans) across five areas: Central Lancashire, West Lancashire, Pennine Lancashire, Fylde Coast and the Bay Health & Care Partners area.
- Blackpool & Fylde Coast is a likely candidate to become an ACS (Accountable Care System), with the potential to spread to other parts of the STP area at a later stage.
- It includes a proposal for a NHS Provider Trust Forum – which will have an agreed structure and governance – and through which provider trusts will work together and more effectively develop and provide services.
- The plan outlines the need to consolidate acute and specialised services on fewer sites, but largely sets out high level intentions rather than detailed options or proposals. The plan mentions starting a piece of detailed modelling work to review options for the reconfiguration of acute services.
- It is planned that the best new models of care from the vanguards will be rolled out to other areas starting now and continue over the next 12 months.
- The plan does not include assumptions on reducing hospital activity, but to hold it broadly at the current levels by using prevention and out of hospital care closer to home.
- There is a focus on the sustainability of Southport Hospital.
- The plan mentions a 3,200 WTE (Whole Time Equivalent) increase in staff working in primary and community care, with reductions in the acute sector pay bill from reducing reliance on agency staff. Overall, the plan expects there to be more staff in 2020/21 than now.
- The lack of social care funding will be a major challenge in delivering the STP.
- The annexes have also been published and are on the website.

Engagement:
- The plan mentions holding engagement events in addition to staff side solution design events. Phase B takes place from January – June 2017 and includes consideration of workstream models, refining and developing for local ‘fit’, advice on local involvement and providing materials for local involvement.

http://www.lancashireouthcumbrria.org.uk/sustainability-and-transformation-plan
**Finances:**

*Financial gap by 2020/21*

- Healthcare: £443 million
- Social care: £129 million
- Combined: £572 million

The plan will need a proportion of the transformation funding available to the STP from 2017/18 in order to enable ICT (Information and Communication Technology), prevention and workforce changes to be implemented. In addition to the STF support for providers the plan needs £21.7 million in 2017/18, £26.7 million in 2018/19 and £14.6 million in 2019/20 to support transformational activities.

**Capital funding required: £264 million**
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West Yorkshire and Harrogate
5. **West Yorkshire and Harrogate**

**Population:** 2.64 million
**Link to plan**
**Lead:** Rob Webster, South West Yorkshire NHS FT

Contact your regional coordinator about your STP: emcavoy@bma.org.uk

**Priorities are:**
1. Prevention
2. Primary and community services
3. Mental health
4. Stroke
5. Cancer
6. Urgent and emergency care
7. Specialised commissioning
8. Hospitals working together
9. Standardisation of commissioning policies

**Key points:**
- Plan is to focus on prevention, early intervention and inequalities with a focus on community services. Acute needs will be focused on an acute centre in every major urban area, connected to a smaller number of centres providing specialist care.
- There is little detail about the financial, services and workforce modelling.
- There are seven vanguards across the area.
- In some areas local services will evolve into accountable care systems, with a single commissioning arrangement between CCGs and local authorities.
- Plan to share back office functions and estate where possible.
- Planning, leadership and increasingly decision making for work programmes will take place at a West Yorkshire and Harrogate level through the collaboration of statutory organisations. Implementation is delivered through six localities (see below).
- Each locality drew up their plans separately – they state these have strong buy in and that the plan has been approved by health and wellbeing boards.

1. **Bradford District and Craven:**
   - Plan to reduce non-elective admissions by 4% by 2020/21.
   - Aim for a total population accountable care system to go live by 2018.
   - Workforce/estates/digital strategy still to be created.

2. **Calderdale:**
   - First point of contact for health and social care to be delivered by spring 2017.
   - Roll out of integrated community services by spring 2017.
   - Full implementation of new care models in community and primary care by 2018.

3. **Harrogate and rural district:**
   - Plan to reduce emergency admissions by 16% by 2020/21.
   - Exploring organisational forms and contractual options and having early discussions on integrated health and social care commissioning and delivery models.
   - Working with GP federation and 17 GP practices on GPFV and transformation plan to deliver extended access and primary care at scale.

[http://www.southwestyorkshire.nhs.uk/west-yorkshire-harrogate-sustainability-transformation-plan/]
4. Kirklees:
   - Proceeding to full business case on CHFT (Calderdale and Huddersfield NHS Foundation Trust) acute changes.
   - Local delivery plans for GPFV in place by December 2016. Models to deliver primary care at scale to be worked up in 2017/18.

5. Leeds:
   - Building on 13 integrated neighbourhood teams.
   - Early implementer of 7-day services at Leeds Teaching Hospital 2017/18.

6. Wakefield:
   - Continued reconfiguration of Mid Yorkshire hospital footprint.
   - Further transformation of provision of acute care at region or sub-region level.
   - MCP final business case approved in October 2016 and engagement starting in December 2016.

Engagement:
   - Leaders of five councils wrote to NHS England saying they have not had proper scrutiny of the STP (November 2016), although they had seen the local plans.
   - There is an engagement and consultation mapping document on the website that presents the findings from all relevant engagement and consultation activity which took place between April 2012 and October 2016.
   - The website says that there will be future opportunities to get involved and that any proposals for change will be subject to specific engagement and consultation where needed. There is also space to give feedback on the website.
   - Initial engagement was started in February 2017 on West Yorkshire and Harrogate stroke services, inviting views from patients. Consultation will follow later in the year, as appropriate, with any final decision made by CCGs in 2018.
   - Health and wellbeing boards are the key mechanism for making decisions at local levels. Plan is to move towards a joint decision-making function in 2018/19.

Finances:
Financial gap by 2020/21
   - Healthcare: £809 million
   - Social care: £265 million
   - Combined: £1,074 million

Savings proposed:
   - Operational efficiencies (Carter programme, provider efficiencies, CCG efficiencies): £539 million
   - Activity moderation efficiencies (specialised commissioning), QIPP (Quality, Innovation, Productivity and Prevention), Urgent and Emergency Care, New care models, RightCare, self-care, prevention): £143 million
   - Social care: £131 million
   - West Yorkshire programmes and opportunities: £93 million
   - STF: £172 million

£95 million of STF funding is expected to be used to deliver change. The plan also states that the scale and scope of the transformation “requires significant revenue and capital investment in the early years”. The plan assumes that organisations will deliver their control totals in 2016/17, and states that it will bring significant risk in later years if these were not achieved.

After these savings, the final position is a deficit of £91 million, made up of a NHS surplus of £43 million and a gap of £135 million in social care.

**Capital funding required: £732 million**
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6. Coast, Humber and Vale

**Population:** 1.4 million

**Lead:** Emma Latimer, Hull CCG

Contact your regional coordinator about your STP: emcavoy@bma.org.uk

**Priorities are:**

1. Helping people stay well
2. Place based care
3. Creating the best hospital care
4. Supporting people through mental health
5. Strategic commissioning

**Key points:**

- Plan to invest significantly through the implementation of the GP Forward View in general practice to improve access to GPs, allow practices to modernise and transform the way they work and, over time, increase the numbers of GPs.
- Implement new multi-disciplinary locality teams to join up local services. These will include GPs, community services, social care, some services normally found in a hospital and potentially services delivered by the local voluntary sector.
- Plans to transform urgent and emergency care.
- Develop high quality, networked and sustainable specialist services. There are plans to review complex rehabilitation services, paediatrics, neonatal intensive care and specialised orthopaedics over the next five years.
- Share support services, in particular pathology, pharmacy, procurement and imaging.
- Workforce plans are to invest in training additional support staff and using current staff differently. As well as investing in developing ‘advanced practitioners’ both in hospital and the community, which will ‘help fill gaps in the workforce’. The programme will begin in 2017 and staff will take two years to qualify.
- While priorities are described at footprint level, initiatives will be delivered within the six localities: East Riding of Yorkshire, Hull, North Lincolnshire, North East Lincolnshire, Vale of York, and Scarborough & Ryedale.
- Scarborough health and social care economy is considered unsustainable both financially and clinically. Local partners are looking at options to rectify this, based around significant improvements to out of hospital care, and identifying the hospital services needed to support this approach. These will be subject to engagement and involvement with the community over the coming months.
- North Lincolnshire and Goole Hospital Trust has developed options around how services will change across the three hospitals in the trust. These need to be consulted on more widely before they can be implemented. Full engagement is expected in summer 2017.
- The six localities propose:
  1. **Vale of York**
     - Organisations will work together in an Accountable Care System and develop locality teams by April 2017.
  2. **Scarborough & Ryedale**
     - Implementing an integrated MCP by October 2017, with social care and primary care under single organisation.

3. **Hull and East Riding**
   - Implementing integrated multi-disciplinary locality teams from April 2017 across the two localities.

4. **North Lincolnshire and North East Lincolnshire**
   - Through ‘Healthy Lives Healthy Futures’ developing locality approaches from March 2017 that will operate within Accountable Care Partnerships.
   - In North Lincolnshire the approach will be delivered through three care networks wrapped around GP practices for smaller populations of 50,000-60,000 people which began working together in April 2016.
   - In North East Lincolnshire the model is being provided across two areas. Teams are clustered around GP practices and build on the experiences of the local social enterprise providers.

**Engagement**
- The plan refers to a clinical reference group within their governance structure.
- There will be formal consultation on the STP from February 2017, with consultation to inform the strategic plan for the STP footprint in May 2017 and consultation around specific interventions from summer 2017.
- There is a link on the website to get in touch and let them know what you think of the plan.

**Finances:**

*Financial gap by 2020/21*
- Combined health and social care: £420 million

*Savings proposed:*
- Prevention: £11 million
- Place-based care: £32 million
- Hospital efficiency savings: £130 million
- Review of pharmacy, diagnostics and estates: £15 million
- Mental health: £5 million
- Strategic commissioning: £10 million

The plan discusses looking at alternative payment mechanisms for 2017/18 onwards, focused on managing activity levels and reducing cost. There is reference to an underpinning finance template that shows the impact on activity, benefits, capacity, workforce and investment requirements.

**Capital funding required: £271 million**

The capital requirements are “fairly embryonic” and further work to refine them is required. The plan accepts that it is a “capitally constrained environment” and talks about actively exploring alternative sources of funding, eg Public Private Partnership Arrangements that deliver value.
STP summary paper

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7. Greater Manchester

**Population:** 2.8 million

[Link to plan](http://www.gmhsc.org.uk/delivering-the-plan/)

**Lead:** Sir Howard Bernstein, Manchester City Council

The STP is *Taking charge of our Health and Social Care in Greater Manchester*, which was published in 2015 following the GM devolution deal.11

Since then Greater Manchester have published a [delivery and implementation plan](http://www.gmhsc.org.uk/delivering-the-plan/) in October 2016.12 Each locality also has its own plan. The plan is a live document, which will not have a final version.

Contact your regional coordinator about your STP: mcheetham@bma.org.uk

**Priorities are:**
1. Radical upgrade in population health prevention
2. Transforming community based care and support
3. Standardising acute and specialist care
4. Standardising clinical support and back office services

**Key points:**

- In February 2015 the 37 NHS organisations and local authorities in GM (Greater Manchester) signed a devolution deal with the Government to take charge of health and social care spending and decisions in GM. Responsibility for the £6 billion combined budget was devolved in April 2016.
- There is a long history of collaboration across Manchester. In 2011 the GMCA (Greater Manchester Combined Authority) was established and the 12 CCGs formed the Greater Manchester Association of CCGs.
- A MOU (memorandum of understanding) was signed between the Government, the GM health bodies and local authorities and NHSE (NHS England). While health services in Manchester remain under central control and are still, for example, subject to the NHS Mandate, the MOU outlines the process for a significant devolution and integration of health and social care funding. It covered all services including acute care, primary care, community services, mental health services, social care and public health.
- Working to transform care in localities by integrating primary, community, acute, social and third sector care through the development of new locally accountable platforms with single integrated commissioning hubs to facilitate clinical co-ordination. This includes aligning CCG and local authority commissioning functions to develop a single commissioning plan and creating single service models in each locality, delivered through integrated neighbourhood teams. Across GM there is a commitment to pool £2.7 billion.
- The plan is built from 10 locality plans, provider reform plans and a range of GP strategies. Each of the localities also have a place-based plan, which is where the detail is contained.
- There are GM wide strategies for some of the challenges that exist across all localities. These include primary care, specialised services, mental health, public service reform programmes, cancer, learning disabilities, dementia and GM information sharing.
- All 37 statutory organisations across GM have formally agreed to a new governance system.
- Local GPs are expected to drive new models of care and LCOs (local care organisations). These will be delivered through the range of models described in the SYFV but will hold a range of common features. These include introducing multi-disciplinary teams to

co-ordinate care for a defined group of people using evidence-based clinical pathways, and providing alternatives to A&E when crises occur.

- Following the agreement of three Transformation Fund bids, three LCO models are in the process of being implemented in Salford and Tameside & Glossop (PACS), Stockport (MCP working on a capitated contract for out of hospital care and urgent care and developing new provider vehicle to take the contract). The City of Manchester is also due to initiate the procurement of its LCO.
- The plan proposes that NHS providers across GM increasingly work together and collaborate across a range of clinical services, as well as standardising clinical support and back office functions.
- Eight clinical areas have been identified and prioritised for clinical redesign. These are paediatrics, maternity and obstetrics, respiratory and cardiology, MSK and orthopaedics, breast, urology, neuro-rehabilitation and vascular.
- Delivery of the new care models needs to be delivered through new, innovative, evidence-based contracting models and pricing mechanisms. Payment by results is judged to be failing to deliver whole system outcomes.
- The plan proposes to have shared, single site services. One of the hospitals within each of the single services will specialise in emergency medicine and abdominal general surgery for patients with life-threatening conditions.
- The two acute Trusts of Central Manchester, University Hospitals NHS Foundation Trust and University of South Manchester NHS Foundation Trust, are in the process of merging as the first stage in the formation of a new Trust for the City of Manchester. As part of this, discussions are taking place with medical staff about merging a list of clinical services. The Competition and Markets Authority have launched an investigation into the merger.
- GM is one of the three partner areas in the National Cancer Vanguard. There is a GM cross-cutting programme for cancer in the STP.
- The Healthier Together programme precedes the STP and should start to be implemented from April 2017. This involves linking of high risk general surgery across NHS Trusts in four sectors of GM, with some Trusts being identified as ‘specialist’.
- The merger of North, South and Central Manchester has now been approved by NHS E to be implemented in April. The new CCG will form a single commissioning organisation with Manchester City Council, although a full merger cannot be pursued under current legislation.
- Given the lack of estates funding, GM are developing a Capital Financing Strategy that will include consideration of a Public Private Finance model for Greater Manchester.
- The plan is to develop a skills and employment passport to enable more flexible movement of the workforce. It is not specified whether this includes doctors.
- Lengthy analysis of risks in delivery of the plan.
- Likely candidate to become an ACS (Accountable Care System).

Engagement

- The LMCs of GM have been represented in discussions on GP plans. Trust Medical Directors also report that they have been involved in consultation. No evidence of any other medical staff involvement. Staff engagement is intended to be led by each organisation.
- Engagement with trade unions has been established via the NW Social Partnership Forum and a sub group called the GM Workforce Engagement Forum.
- There is a space on the website to say what you think of the plans. There was also formal consultation on the Healthier Together reconfiguration.

Finances:

Financial gap by 2020/21

- Healthcare: £1.824 billion
- Social care: £176 million
- Combined: £2 billion
This reduces in the delivery and implementation plan (November 2016) due to “different assumptions underpinning the modelling”.

– Healthcare: £897 million
– Social care: £176 million
– Combined: £1.073 billion

The plan is clear that the profiling of the social care gap has significant issues, including the impact of the social care precept and the Better Care Fund. These factors are considered to be at risk of undermining GM transformation efforts and potentially jeopardising savings.

Savings proposed:

– Better care: £233 million
– Commissioner efficiencies: £134 million
– Provider efficiencies: £418 million
– Specialised commissioning efficiencies: £97 million

These have been derived directly from locality plans, and are owned by health and social care organisations. After the changes have been implemented the financial gap is expected to be £191 million.

GM received additional one-off transformation funding of £500m to support the delivery of the savings opportunities within the locality. This will consist of £77m one-off costs to enable delivery of change and £423 double running costs to support implementation of the new care models and change to existing models. Some proposals have been received and been allocated money and more are anticipated over the coming months. However, the majority of the funding has not yet been spent.

GM has been allocated sustainability and transformation funding of £170 million in 2020/21. Given the level of risks and uncertainty in assumptions this is being considered contingency funding.

**Capital funding required:** £1.6 billion, comprised of £900 million BAU capital and £700 million capital required for transformation.
STP summary paper

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Cheshire and Merseyside
8. Cheshire and Merseyside

**Population:** 2.6 million

**Link to plan**[^13]

**Lead:** Louise Shepherd, Alder Hey Children’s NHS FT

Contact your regional coordinator about your STP: mcheetham@bma.org.uk

**Priorities are:**
1. Improve the health of the Cheshire and Merseyside (C&M) population.
   a. Promoting physical and mental wellbeing
   b. Improving the provision of physical and mental care in the community
2. Improve the quality of care in hospital settings.
   a. Reducing the variation of care
   b. Delivering the right level of care in the most appropriate setting
   c. Enhancing delivery of mental health care
3. Optimise direct patient care.
   a. Reduced administrative costs
   b. Effective clinical support services

**Key points:**
– The STP is working across three LDSs (Local Delivery Systems) – North Mersey, the Alliance and Cheshire & Wirral. There is a page setting out at what level responsibility sits (eg there are no budgets or quality standards held at STP level).
– The plan is high level without many concrete proposals. It is clear that there is yet to be a STP-wide review of clinical services; acute care will be the first step.
– There is an understanding that these changes shouldn’t happen overnight.
– The plan has a “portfolio structure” that brings together 20 distinct, but interrelated programmes of work, including eight clinical programmes looking at the way care is delivered and five programmes to support and enable the plan.
– The public health focus is on reducing alcohol abuse, blood pressure and antimicrobial resistance.
– The plan discusses working on creating a framework for the development and implementation of an ACO, although the structure has not yet been decided.

**North Mersey**
– Build on the plans already put forward in Healthy Liverpool[^14], including a merger of Royal Hospital and Aintree and a “major service review” at Southport and Ormskirk Hospital Trust.

**The Alliance**
– A vision for hospital reconfiguration has been developed, and locality has started to develop a range of options. A plan for the assessment and design of these services was to be completed in December 2016.

[^14]: http://www.liverpooltalkshealth.info/
Cheshire and Wirral

- Short term plan to rapidly address variation and reconfigure hospital services across Cheshire and Wirral, including confirming future configuration of women’s and children’s services. Caring Together\(^ {15} \) is looking at financial modelling for two care model options. Options for the future of high risk general surgery are currently under review. A final decision is expected in early 2017.

Engagement:
- Contact: mlcsu.cmstp@nhs.net
- The review of hospital reconfiguration across the STP was intended to be ready for the next stage of consultation by March 2017.
- The Liverpool Mayor spoke out against the STP and it was rejected by the Council and Board for a lack of appropriate consultation and failing to address the key issues facing residents.\(^ {16} \) Angela Eagle MP has also spoken out against the plan.

Finances:
Financial gap by 2020/21

- Combined health and social care: £908 million

After the LDS plans were modelled the STP forecasts a surplus of £49 million by 2021. However, the plans “require further analysis and challenge to convert them from sound ideas into robust plans”.

Capital funding required: £755 million

The STP recognises that these plans are heavily dependent on capital and that some schemes may not get approved for funding and their benefits will need to be reassessed. The current plan does not demonstrate delivery against the control total for both 2017/18 and 2018/19.

\(^ {15} \) A well-established transformation programme within Eastern Cheshire, looking at improving the health and wellbeing of the population by implementing enhanced integrated community care supported by clinically and financially sustainable hospital services.

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South Yorkshire and Bassetlaw
9. **South Yorkshire and Bassetlaw**

**Population:** 1.5 million

[Link to plan](http://www.smybndccgs.nhs.uk/what-we-do/stp)

**Lead:** Sir Andrew Cash OBE, Sheffield Teaching Hospitals NHS FT

Contact your regional coordinator about your STP: [emcavoy@bma.org.uk](mailto:emcavoy@bma.org.uk)

**Priorities are:**
1. Healthy lives, living well and prevention
2. Primary and community care
3. Mental health and learning disabilities
4. Urgent and emergency care
5. Elective care and diagnostics
6. Maternity and children’s services
7. Cancer
8. Spreading best practice and collaborating on support services

**Key points**
- Likely candidate to become an ACS (Accountable Care System).
- Networked approach in areas such as maternity services and simplified urgent and emergency care system.
- Develop a regional centre of excellence for skills and flexible career pathways, as well as a specialist training pathway for nurses and therapists aligned to new ways of working.
- By 2021 integrated commissioning between health and care.
- Independent review of hospital services due to take place in 2016/17.
- Reshaping and investing in primary and community care with general practice at the centre. GPs will be senior decision makers in a wider multidisciplinary team. This will be done by developing accountable care organisations, implementing the general practice forward view and improving self-care and management of long-term conditions.
- Early integration areas are: collaboration on support office services, developing a network approach to services, review hospital services & resources, new model of hyper acute stroke services, children’s surgery and anaesthesia services, vascular services and chemotherapy services.
- In Sheffield, bringing back people from out of area placements has enabled the Sheffield Health and Social Care Foundation Trust to invest £2m in extra community services.
- Alongside improved mental health services in the local community, the widespread implementation of the successful model already in use in Birmingham, RAID (Rapid, Assessment, Interface and Discharge), whereby everyone in hospital has access to a team with psychiatric expertise and specialist mental health training, the number of psychiatric re-admissions is predicted to fall by 1,800 over 12 months.
- Ambitions for reduction in activity:
  - 25% fewer 15-64 year olds being admitted to hospital, visiting their GP and needing medication for heart disease and strokes
  - 15% fewer people being admitted to hospital for all other conditions
  - 1.4% fewer A&E attendances from social prescribing
  - 2.6% fewer emergency admissions
  - 3% fewer A&E attendances from better care co-ordination
  - 3.6% fewer unnecessary outpatient appointments
  - 63% fewer out of area placements
Engagement:
- Contact: helloworkingtogether@nhs.net
- Consultations are currently open on service changes to children’s surgery and hyper acute stroke services. Final decisions about the future of these services were due to be made in April 2017.
- Engagement period between December 2016 and March 2017 involving conversations with staff at each partner organisation and local communities.

Finances:
Financial gap by 2020/21:
- Healthcare: £464 million
- Social care: £107 million
- Combined: £571 million

Considerable work is required to assess whether the financial modelling is realistic and capable of being implemented, as a high degree of risk is attached to delivery of some of the changes. The plan assumes that the footprint will receive all of the £105 million indicative share of national sustainability and transformational funding by 2020/21.

Capital funding required: £200 million

http://www.nhsbndccgs.nhs.uk/get-involved
STP summary paper

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10. Staffordshire & Stoke-on-Trent

Population: 1.1 million

Lead: Penny Harris
Contact your regional coordinator about your STP: aroberts@bma.org.uk

Priorities are:
1. Focused prevention
2. Enhanced primary (ie GP) and community care
3. Effective and efficient planned care
4. Simplified urgent and emergency care system
5. Reduced cost of services

Mental health and learning disabilities are a part of all of these areas.

Key points:
- Plan to increase the proportion of care in the community rather than hospitals and develop a workforce plan to cope with the changes in training, roles and demand for different kinds of professionals.
- Suggested alternatives to hospital include improved access to GPs with a wider range of services available; access to walk-in centres and specially trained pharmacists or developing centres of excellence that focus on specific health needs, such as cancer or diabetes.
- Local clinical leaders have been working on a new community 'model of care' in which a number of health and care professionals with different skills will work in small multi-disciplinary teams.
- The plan assumes 23 of these teams based around local populations of 30,000 – 70,000.
- The plan is explicit that this is likely to mean fewer hospital beds, less staff working in a hospital setting and more specialist services in fewer hospitals. As part of this there is an expectation that there will be a move from three to two A&Es and one Urgent Care Centre and an exploration of potential options, though no decisions on the locations of these services has been made.
- Agency costs are estimated to be at least 7% of total pay spend. The national average is 4%.
- Management costs – Staffordshire & Stoke-on-Trent has six separate CCGs and five NHS providers which results in duplication of management costs and back office services.
- Plan for a 30% reduction in A&E non-admitted and 20% reduction in A&E admitted.
- Reduced length of stay and emergency readmissions also targeted.
- Closure of 105 community beds (85 at Longton and Cheadle Hospital, 20 at Haywood Hospital), with “further identified community beds...closed in 2016/17”. There will be an 11% saving in staffing and variable costs at Haywood Hospital in line with the numbers of beds reduced at the hospital.
- Planned care reconfiguration projects at UHNM and Burton, 20% of orthopaedic patients will be converted to daycases, and 1% of all other inpatient spells converted to daycase. LoS (Length of Stay) will be improved by 5%. 30% of follow-up attendance reduced due to efficiencies or new technology. 50% reduction in cost of follow-up appointments.
- A number of beds will be procured based upon need and remaining community hospital capacity will be utilised in line with the service specification.
- In 2015/16 the STP area had the largest number of community beds when compared to its peers. It also reported the highest occupancy rate of 96% (significantly above the peer average of 67% in Q3 2015).
Engagement:
- Contact: programme director, penny.harris@staffordshire.gov.uk
- Invited the BMA to meet with their clinical director in advance of formal engagement and consultation.
- Over 100 public consultation meetings but no real details provided. Focus on public rather than clinical staff. The discussions were expected to inform any future consultations about major changes.
- HealthWatch Staffordshire and HealthWatch Stoke-on-Trent were provided a more detailed report to be used to inform ongoing engagement.

Finances:
Financial gap by 2020/21:
- Healthcare: £286 million
- Social care: £256 million
- Combined: £542 million

£120 million of one-off revenue is needed by 2021 to help deliver £286 million of recurrent savings.

Savings proposed:
A £4.2 million saving is projected from the reduction in 105 community hospital beds. Largest savings include:
- 2% efficiency savings from total provider expenditure from 2017/18 onwards — £130.5 million
- Estimation of impact of delivering the ‘RightCare initiative’, assuming top six opportunity areas for Staffordshire & Stoke-on-Trent will be implemented — £27 million
- Improved care for frailty and LTC (Long-Term Conditions) resulting in lower admissions — £15.2 million
- Improved cancer care: £7.3 million
- Improved end-of-life care: £6.7 million
- Planned care reconfiguration: £15 million, plus £6.5 million in additional savings based on analysis from reducing GP referrals.

Capital funding required: £20 million
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11. Shropshire and Telford and Wrekin

Population: 470,000

Lead: Simon Wright, Shrewsbury and Telford Hospital NHS Trust

Contact your regional coordinator about your STP: aroberts@bma.org.uk

Priorities are:
1. Going local – how to tackle the causes of poor health in local communities using a neighbourhood model
2. Safe and effective hospital care
3. Into the future – using new technologies to help people access help and support for their health and to manage long-term illness
4. Staffing and financial challenges

Key points:
- Full review of all community beds is proposed, with a model due to be in place by March 2017.
- Major review of Orthopaedics/MSK services planned. Suggestion is that services are currently fragmented and too expensive — projected completion date for review was December 2016.
- Currently estimated that around 20% of consultations in primary care are for a non-health need.
- Move to a neighbourhood model of more locally based care with 11 neighbourhoods across the STP footprint.
- By 2020/21, modelling suggests that at least 4,215 non-elective admissions will be able to be managed locally through these neighbourhoods. This is 8.6% of all non-elective admissions (assumes ‘7 day working in medicine’).
- Recruitment and rostering of acute physicians and critical care staff across multiple sites is increasingly difficult and there is now a 15% vacancy rate in medical staffing in secondary care.
- Proposed increase of 8.5 WTE consultants, reduction of six SAS (Specialist and Associate Specialist) and 10 junior doctor posts.
- Plan talks about possibility of joint partnership with private providers — no further detail on this.
- Closure of Emergency Department at Telford Hospital following a reconfiguration of the two hospitals which make up the Trust. Those living in Telford will have to travel around 18 miles to an A&E department if the one in Telford closes.
- Includes review of community beds – including care homes, local authority and community hospital beds. Initial modelling of beds being undertaken, due for completion in March 2017.
- National Orthopaedic Alliance vanguard includes trusts in Shropshire.

Engagement:
- Contact: communications@sath.nhs.uk
- Plan talks about a digital engagement group being set up, but is light on details and funding.
- Public consultation planned between Jan and March 2017. Events detailed but no detail of how unions will be engaged with.
- Plan says that 300 clinicians involved in looking at how to develop hospital services: work is ‘clinically led, with widespread involvement and engagement of staff, patients and the public’.
- Updated versions of the plan will be published periodically. The latest version was made available on 24/02/17.
- Shropshire Council and Telford and Wrekin Council in the West Midlands said they are unlikely to approve the STP in its current form because not enough resources are promised to primary care.

Finances:
Financial gap by 2020/21:
- Combined health and social care: £131 million

Savings proposed:
- Provider CIP: £117 million
- Carter review: £22 million
- Use of transformation funds: £13 million
- Hospital reconfiguration: £27 million
- Community hospitals: £9 million
- Orthopaedic rebasing: £9 million
- Repatriation: £15 million
- Hospital sites rationalisation: £4 million
- External transfer: £4 million

Capital funding required: £311 million
STP summary paper

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12. Derbyshire

**Population:** 1.0 million

[Link to plan](http://www.southernderbyshireccg.nhs.uk/publications/joinedupcarederbyshire/)

**Lead:** Gary Thompson, Southern Derbyshire CCG

Contact your regional coordinator about your STP: jstringer@bma.org.uk

**Priorities are:**
- To do more to prevent ill health and help people take good care of themselves
- To tailor services to look after and focus on people in their communities
- To make it easy for people to access the right care, whenever it is needed
- To get health and social care working seamlessly together
- To make organisations as efficient as possible

**Key points:**
- 1% of the population (c.10,000 people) account for 25% of NEL (non-elective) admissions and 64% of our NEL beds. Of these patients, once admitted patients who stay more than 14 days account for 573 beds, of which 477 beds are used by patients aged over 65. These patients are usually complex in terms of the support they require and a fall often plays a part in their admission to hospital. In addition, >95% inpatient community hospital care supports people >65 years.
- 535 fewer beds by 2020/21: c. 400 acute, c.85 community hospital and c. 50 mental health:
  - This will mean c. 12 fewer acute wards, c. 4-5 fewer community wards, c. 1-2 fewer specialist mental health and one fewer dementia care ward.
  - Infrastructure costs reduced by 10% from £197 million to £182 million by greater collaboration and reducing estates costs.
  - Integration of existing Minor Injury Units and Walk-in Centres with primary care and general practice to establish urgent care centres.
  - By 2020/21 step-up care will be provided to avoid 15,300 admissions, avoiding 52,000 OBSs (occupied bed days) and step-down care for 10,000 episodes, avoiding 111,000 OBSs.
  - Target to limit growth in referred elective activity by 1% p.a. by 2020/21 – focus on MSK, PLC, ophthalmology and dermatology in years 2 and 3.
  - ACCs (ambulatory care centres) at RDH and CRH to be expanded in year 2.
  - Total 5% productivity improvement via workforce optimisation, avoiding increase in workforce spend.
– Reduction in costs of back-office functions to no more than 6% through shared functions and services.

– NHS commissioners have agreed contracts with providers for services up to 2019. Funds initially intended to be invested in creating new ways of providing services, as suggested in the STP document, have now had to be committed elsewhere in the health and social care system. As a result, priorities and work will be moved on and updated to reflect the current circumstances.

– The plan assumes that £247 million more care will be delivered in the community by 2020/21 (30% to 39% of all care delivered). This will mean 2,500 more staff delivering community-based care (c.10% of current workforce).

**Engagement:**

– Contact: enquiries@southernderbyshireccg.nhs.uk

– Healthwatch Derbyshire and Healthwatch Derby, and the voluntary sector, are helping to finalise plans for how, and when, the footprint can start holding events so they can share the latest information.

– Lack of ‘buy-in’ to STP identified as major risk, particularly from GPs – mitigated by ‘specific actions with GP stakeholders’, including working with the LMC on briefing materials and engagement groups.

– Clinical Leads on the STP work streams have been appointed and their role to disseminate and collate feedback has been clarified.

– To support robust clinical engagement a ‘Place’ section on the South Derbyshire CCG website has been developed.

– North Derbyshire CCG organised a practice engagement event to explore the Sustainability and Transformation Plan and what it means in North Derbyshire and engagement events with both North Derbyshire and South Derbyshire Volunteer forums have been held.

– Health and Wellbeing Boards in Derby and Derbyshire continue to be briefed at each meeting and have agreed to commence joint meetings.

**Finances:**

*Financial gap by 2020/21:*

– Healthcare: £219 million
– Social care: £136 million
– Combined: £355 million

The plan assumes that £247 million worth of care will be delivered in the community by 2020/21 (30% to 39% of all care delivered). This will mean 2,500 more staff delivering community-based care (c.10% of current workforce).

**Capital funding required: £42 million**
STP summary paper

Sustainability and transformation plans are five year plans detailing how local areas will work together to modernise health and care and achieve financial balance by 2020. In March 2016, England was divided into 44 geographic ‘footprints’ to create plans based on the local health needs. These plans were submitted to NHS England and NHS Improvement in October 2016 and have since all been published. The plans are still in development and areas will simultaneously start to implement the sections of the plan furthest ahead whilst continuing to work on other sections.

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If you would like to send comments on the STP process nationally then please email Holly Higgs (hhiggs@bma.org.uk).
13. Lincolnshire

**Population:** 700,000

[Link to plan](http://lincolnshirehealthandcare.org/en/stp/)

**Lead:** Allan Kitt, South West Lincolnshire CCG

Contact your regional coordinator about your STP: jstringer@bma.org.uk

**Priorities are:**
1. Clinical redesign
2. Capacity optimisation
3. Operational efficiency
4. Workforce productivity and redesign
5. Right Care and Commissioning priorities

**Key points:**
- The plan builds on the work of the Lincolnshire Health and Care programme.
- Proposals will be put forward next year to centralise maternity services — with an option to keep consultant led births on only two hospital sites and emergency children’s surgery moved to a single hospital site.
- New service models for specialties — those likely to change include dermatology, pain management, neurology, ophthalmology and diabetes.
- Proposed movement of planned care activity into the community (possibly to include, diabetes medicine, dermatology, ophthalmology, orthodontics, pain management, endocrinology, neurology, rheumatology — depending on outcome of a cost-benefit analysis).
- Proposals in development for a community model of care in mental health and more acute mental health beds for those who need inpatient care.
- Learning disability reconfiguration: plan promises to continue the consultation on the closure of Long Leys Court, temporarily closed since June 2015.
- Key performance indicators or ‘success factors’ include:
  - Non elective admissions reduced by 29,377 (accumulative) equivalent to 10% by 2021.
  - The number of emergency admissions stopped in 2021 is equivalent to 28 per day.
  - Target of 3.8 day length of stay by 2021, equivalent to 118 acute beds being closed at 90% bed occupancy.
  - Five urgent care centres alongside proactive care services will divert 244,063 A&E attendances by 2021 which is equivalent to 235 per day.
  - Delivery of integrated care for 38,434 people by 2021 which is 5% of the population
  - Reduction of c.750 whole time equivalent staff by 2021.

**Engagement:**
- Contact lhac@lincolnshireeastccg.nhs.uk
- No final decisions will be made until the public have had a chance to express their views through a full public consultation likely to start in May 2017.
- Similarly, a consultation will be held on emergency and acute care, proposing the closure of Grantham A&E (Q1, 2017/18).
- A consultation on maintaining stroke services on two sites but with a dedicated hyper-acute stroke facility is also likely to take place (Q1, 2017/18).
- Engagement with over 18,000 people; plan developed for further engagement and involvement in the future; website fully operational with information about the STP.
- Clinical leadership through the “care design groups” and “expert reference groups”; several workshops, events and briefings to engage and involve clinicians; incorporating the work of ULHT’s clinical strategy, which was developed by their clinicians.
— Lincolnshire County Council opposed the STP – contentious elements were closure of Grantham A&E to an urgent care centre, midwifery service at Boston also downgraded. Major trauma moved out of the county.

**Finances:**
*Financial gap by 2020/21*
— Combined health and social care: £182 million

Provider/commissioner split of £85 million and £97 million respectively

**Savings proposed:**

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<tr>
<th>Financial Bridge</th>
<th>Impact of Solutions</th>
<th>Do Something</th>
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**Capital funding required: £205 million**
Sustainability and transformation plans are five year plans detailing how local areas will work together to modernise health and care and achieve financial balance by 2020. In March 2016, England was divided into 44 geographic ‘footprints’ to create plans based on the local health needs. These plans were submitted to NHS England and NHS Improvement in October 2016 and have since all been published. The plans are still in development and areas will simultaneously start to implement the sections of the plan furthest ahead whilst continuing to work on other sections.

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14. Nottinghamshire

**Population:** 1.0 million

[Link to plan](http://www.nottinghamcitycare.nhs.uk/stakeholders/stp.html/)

**Lead:** David Pearson, Nottinghamshire County Council

Contact your regional coordinator about your STP: jstringer@bma.org.uk

**Priorities are:**
1. Promote wellbeing, prevention, independence and self-care
2. Strengthen primary, community, social care and carer services
3. Simplify urgent and emergency care
4. Deliver technology-enabled care
5. Ensure consistent and evidence-based pathway in planned care

**Key points:**
- Likely candidate to become an ACS (Accountable Care System), with an early focus on Greater Nottingham and the southern part of the STP.
- Indicative workforce changes include 12% cut in band five and similar roles; 24% increase in community and primary care workforce. The core skills group would have a net reduction of more than 640 posts, with the largest falls in urgent and planned care. There would also be a drop of 116 mental health and learning disability posts but an increase of 38 in primary care.
- Within the illustrative example there would also be a net reduction of foundation skills staff, typically bands 1-4 staff, which would drop by more than 200. There would be growth in what the STP calls “enhanced” and “advanced” staff, which it defines as bands 6-7 staff and junior doctors and consultants, GPs and advanced nurse practitioners. Bands 6-7 posts would grow by 2% and the other roles by 7%, an increase of almost 300 posts.
- Across all staff groups, the example suggests there would be a net reduction of 562 staff – 2.7%.
- 13 services currently being delivered by Nottinghamshire University Hospitals will be re-tendered next year. All affected services are outside the national tariff payment system. Some services may not continue in their current form or if ‘de-commissioned’ may not run at all. Services will be affected from July 2017.
- 200 hospital beds to be cut over the next two years in acute settings.
- Improved emergency care expected to reduce emergency admissions by 5%, reduce mental health related emergency attendances and admissions over the next two years by 10%.

**Engagement:**
- Contact: STP@nottscc.gov.uk
- Workforce modelling session was held in January that the BMA attended.
- General feedback was sought with a deadline of 16/02/17 for submissions/contributions.

**Finances:**

Financial gap by 2020/21
- Healthcare: £473 million
- Social care: £155 million
- Combined: £628 million
Savings proposed:
- Strengthening primary, community, social care and carer services: £50 million
- Simplified urgent and emergency care (acute bed reduction of 200 over two years): £8 million
- Simplified urgent and emergency care: new model of urgent care (based on UEC vanguard value proposition): £8 million
- Consistent, evidence based pathways in planned care: £21 million
- Reduction in system variation: £45 million
- Maximise estates utilisation: £20 million
- Promotion of wellbeing, prevention, independence and self-care: £31 million

If planned organisational efficiencies and transformational plans are successfully delivered, the 2017/18 remaining gap is expected to total £40 million.

To support this, the STP would need additional transition funding of £26 million in 2017/18 and £19 million in 2018/19 to be invested in out of hospital care.
Sustainability and transformation plans are five year plans detailing how local areas will work together to modernise health and care and achieve financial balance by 2020. In March 2016, England was divided into 44 geographic ‘footprints’ to create plans based on the local health needs. These plans were submitted to NHS England and NHS Improvement in October 2016 and have since all been published. The plans are still in development and areas will simultaneously start to implement the sections of the plan furthest ahead whilst continuing to work on other sections.

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15. Leicester, Leicestershire and Rutland

**Population:** 1.0 million

**Lead:** Toby Sanders, West Leicestershire CCG

Contact your regional coordinator about your STP: jstringer@bma.org.uk

**Priorities are:**
1. New models of care focused on prevention, moderating demand growth
   a. Place based integrated teams
   b. A new model for primary care (working in networks with GPs supporting the most complex patients)
   c. Effective and efficient planned care
   d. Integrated urgent care offer
2. Service configuration to ensure clinical and financial sustainability (subject to consultation)
   a. Consolidating care onto two hospital sites (the Leicester Royal Infirmary and the Glenfield)
   b. Consolidation of maternity provision onto one site at the Royal Infirmary
   c. Moving from eight community hospitals with inpatient beds to six and redesign services in Lutterworth, Oakham and Hinckley
3. Redesign pathways to deliver improved outcomes for patients and deliver core access and quality
   a. Improve long-term conditions
   b. Improve wellbeing
   c. Increase prevention, self-care and harnessing community assets
   d. Cancer, mental health and learning disabilities
4. Operational efficiencies
   a. Reduce variation and waste
   b. Provide more efficient interventions and support financial sustainability – the Carter recommendations
   c. Provider cost improvement plans
   d. Medicines optimisation and back office efficiencies
5. Getting the enablers right
   a. Workforce
   b. IM&T (Information Management & Technology) (shared record)
   c. Engagement
   d. Health and adult and children social care commissioning integration

**Key points:**
- The STP builds on the work of the Better Care Together programme, where plans were quite advanced already, and contained a lot of detail about proposals.
- General practice is key to the plan, with the individual practice patient list retained as the foundation of care but with an increasingly significant proportion of care delivered across networks.

**Key workforce changes 2016/17 to 2020/21**
- Primary care up 10% from 2271 WTE to 2505 WTE
- Provider workforce down 4% from 19805 to 18303

Key bed changes 2016/17 to 2020/21
- Acute beds down 243 from 1940 to 1697
- Community hospital beds down 38 from 233 to 195

The reduction of 128 beds is expected to be covered by using of integrated locality teams.

Engagement:
- Contact: bctcomms@leicspart.nhs.uk
- Formal consultation on elements of the STP is due to start "after Christmas". There is detailed information in the STP about exactly what service configuration proposals would form the main part of the formal public consultation.
- One event held in February (23rd) – Proposals for the future of health and social care services in Leicester.
- Two events were held in March (27th & 30th) – The future of health and care in Leicester, Leicestershire & Rutland.

Finances
Financial gap by 2020/21
- Healthcare: £341.6 million
- Social care: £57.7 million
- Combined: £399.3 million

To make the necessary savings the plan needs £98.4 million from the Sustainability and Transformation Fund as well as £350 million in capital.
STP summary paper

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The Black Country
16. The Black Country

Population: 1.3 million
Link to plan 25

Lead: Andy Williams, Sandwell West Birmingham CCG
Contact your regional coordinator about your STP: aroberts@bma.org.uk

Priorities are:
1. Developing local models of care: place-based care
2. Hospitals working together
3. Mental health and learning disability
4. Maternity and infant health

Key points:
– The two MCPs in Dudley and Sandwell and West Birmingham are being looked at with an aim of spreading the model across the whole population by April 2019 — with similar models being explored in Walsall and Wolverhampton — where they are using Primary Care Home.
– The percentage of people in The Black Country and West Birmingham ‘able to get an appointment to see or speak to someone here’ decreased from 81.8% in June 2013 to 79.1% in July 2016 (GP Practice Survey).
– The delivery of GP services will be redesigned to facilitate patient consultation through modern technologies and digital platforms to increase access, productivity and reducing barriers associated with traditional consulting systems.
– The new Midland Metropolitan Hospital opens in October 2018, the new emergency department will replace the A&E services at Sandwell (where there will still be an urgent care centre) & City hospitals. The maternity service will replace the Serenity Unit and labour wards at City Hospital. It will also be where surgery for people needing longer than an overnight stay will take place.
– Rheumatology services in Walsall have been identified as being unsustainable.
– Commissioning at greater scale: including the possible opportunity to align The Black Country and West Birmingham CCG’s shared approach to commissioning services with specialised services framework commissioning through. This would create an integrated Black Country & West Birmingham approach to the commissioning of all major acute services.

Engagement:
– Contact: swbccc.time2talk@nhs.net (NB this is the address for the relevant CCG)
– Key aspects of the plans, such as the development of the Midland Metropolitan Hospital, have already been subject to public engagement and consultation.
– There are ostensibly plans to hold events, including STP roadshows, in local communities to ensure plans reflect the views of local people.
– A CRG (Clinical Reference Group) has been formed for the STP in order to provide clinical support to the Transformation Groups in redesigning services and also to Quality Assure final clinical models, accessing external expertise where necessary. Membership of the CRG includes provider medical directors and chief nurses, CCG clinical leads and representatives from public health, local authorities and pharmacists.

25 http://sandwellandwestbhamccg.nhs.uk/better-health-and-care
**Finances:**

*Financial gap by 2020/21*
- Healthcare: £512 million
- Social care: £188 million
- Combined: £700 million

Large potential saving (£16.7 million) from reducing admissions for those attending A&E with a primary diagnosis of mental health issues.

*Other proposed savings include:*
- £81 million demand reduction through local place-based models of care
- £189 million through efficiency at scale via extended hospital collaboration
- £20 million improving mental health and learning disability services
- £14 million ‘workforce enabler’
- £27 million ‘infrastructure enabler’ (estates and technology)
- Social care deficit to be tackled through local authority investment and savings plans

The STP partners are committed to an increased investment of £25 million in primary care by 2020/21 to offset the challenges in general practice and to achieve the desired outcomes of the GP Forward View.

**Capital funding required: £103 million**
STP summary paper

Sustainability and transformation plans are five year plans detailing how local areas will work together to modernise health and care and achieve financial balance by 2020. In March 2016, England was divided into 44 geographic ‘footprints’ to create plans based on the local health needs. These plans were submitted to NHS England and NHS Improvement in October 2016 and have since all been published. The plans are still in development and areas will simultaneously start to implement the sections of the plan furthest ahead whilst continuing to work on other sections.

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Birmingham and Solihull
17. Birmingham and Solihull

**Population:** 1.1 million

[Link to plan](https://www.birmingham.gov.uk/stp) 26

**Lead:** Mark Rogers, Birmingham City Council

Contact your regional coordinator about your STP: aroberts@bma.org.uk

**Priorities are:**
1. Creating efficient organisations and infrastructure
2. Transformed primary, social and community care (community care first)
3. Fit for future secondary and tertiary services

**Key points:**
- The footprint includes the Solihull Together for Better Lives Vanguard (which focuses on urgent and emergency care, as well as integration of primary and community care services).
- Birmingham and Solihull CCGs combined have the second lowest ratio of GPs and practice nurses per 100,000 population. Target to improve this by delivering the GP Forward View.
- Analysis shows that if nothing changes an additional 430 inpatient beds would be required to manage increasing demand. The plan is designed to avoid this need.
- Plan to deliver a care model that moves activity away from secondary care into primary and community care settings. This will be through 4/5 new urgent care centres, enhanced general practice and multi-disciplinary teams that will support patients with long-term conditions.
- The plan is to develop and implement a children’s network across Birmingham and Solihull by 2018 that is likely to involve a redistribution of services.
- Several trusts in footprint with extremely high occupancy; between April and June 2016, HEFT (Heart of England FT) had second highest occupancy percentage amongst its peer group (90.5%) – UHB (University Hospitals Birmingham FT) had highest occupancy (99.1%).
- Projected reductions:
  - 17% reduction in A&E attendances in adults, 22% in children
  - 72% reduction in delayed transfers of care
  - 15% reduction in emergency admissions

**Engagement:**
- Contact: bsolSTP@nhs.net
- Details of events run to share information on the plans will be published on the website.
- Engagement relating to transformation of primary, social and community care apparently includes LMCs.
- “Regular meetings” are also taking place about Community Care First (which moves activity from secondary care into primary and community settings) with GP providers and GP Alliance, LMCs, urgent care teams, acute and community providers.
**Finances**

Financial gap by 2020/21
- Healthcare: £582 million
- Social care: £130 million
- Combined: £712 million

Largest potential savings include:
- £45 million from specialised commissioning (QIPP programme)
- £249 million from improving productivity (reducing inefficiencies, variation, incidents of unplanned care)
- £35 million from buying better (improving market management)
- £35 million from community care (new models of care for high cost patients, end of life care, long term conditions, and improved use of the 3rd sector to keep people well in the community)
- £30 million from better management of demand (reduced demand for acute services, embedding the prevention agenda)
- £30 million from Fit for Future Primary and Secondary Services (reduction in variation in clinical services, improvements in clinical outcomes, especially when combined with definition of new clinical pathways)

Additional saving beyond 2% productivity saving delivered by merger of BCH (Birmingham Children's Hospital) and BWH (Birmingham Women's Hospital) and potentially UHB and HEFT, if the case for change is supported by both Boards.
STP summary paper

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18. Coventry and Warwickshire

**Population:** 900,000

*Link to plan*[^27]

**Lead:** Andy Hardy, University Hospitals Coventry and Warwickshire NHS Trust

Contact your regional coordinator about your STP: aroberts@bma.org.uk

**Priorities are:**
1. Proactive & preventative care
2. Urgent & emergency care
3. Planned care
4. Maternity & paediatrics
5. Productivity & efficiency

**Key points:**
- Consolidation of maternity and paediatrics services.
- Review and reform of Coventry and Warwickshire A&E/urgent care to provide a "clinically sustainable" service and move towards "integrated delivery" – includes out of hours service, a new stroke pathway and "simplified access" to urgent & emergency care.
- Greater integration of clinical, operational and financial services between George Eliot Hospital NHS Trust and University Hospitals Coventry and Warwickshire NHS Trust.
- Plan references the establishment of a new renal unit in a community facility in Coventry city centre bringing activity off acute site.
- Pathway redesign starts with MSK (musculoskeletal) services (creating a common referral pathway across the footprint) before rolling out to other pathways at quarterly intervals.
- Better back office collaboration and clinical support collaboration could create savings/ greater efficiency and productivity.
- Reduction in activity focuses on A&E/non-elective activity for complex patients, length of stay, outpatient activity:
  - Proactive & Preventative Care: 21,000 reduction in attendances and 10,000 reduction in admissions against do-nothing growth
  - Urgent & emergency care: 21,000 reduction in attendances and 2,000 admissions against do-nothing growth
  - Planned care: 189,000 attendances and 12,000 admissions against do nothing growth

**Engagement:**
- Contact: communications@uhcw.nhs.uk
- ‘Good’ engagement with secondary care sector on urgent and emergency care – the plan advises pursuing greater engagement with primary care colleagues to ensure that in-hours and out of hours solutions are integrated into the pathway.
- GP and acute hospital clinicians, commissioners, providers and PH directors were all engaged on the plans for planned care, notably in taking forward the MSK work – clinical reference groups ‘critical’ in taking forward the workstream activity.
- No engagement on maternity and paediatrics at time of publishing plan.
- Warwickshire County Council rejected the plan for lacking detail about where savings would be made, not written in plain English and not drawn up with involvement of the Council, despite cobadging it. They have given conditions for it to meet to get its support.

**Finances:**

*Financial gap by 2020/21*
- Healthcare: £267 million
- Social care: £33 million
- Combined: £300 million

*Savings proposed:*
- £34.7 million from proactive and preventative care (includes out of hospital, acute mental health and emergency care)
- £24.5 million from planned care
- £7.1 million from productivity and efficiency (this includes maternity and paediatrics)
- £141.2 million assumed savings from business as usual efficiencies within the model

Total financial impact of £207.5 million by 2020/21 (excluding social care).

The system is also expected to receive £63 million in STP funding in 2020/21 to support transformation.

**Capital funding required: £36.5 million**
STP summary paper

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Herefordshire and Worcestershire
19. Herefordshire and Worcestershire

Population: 780,000

Link to plan:

Lead: Sarah Dugan, Worcestershire Health & Care NHS Trust

Contact your regional coordinator about your STP: aroberts@bma.org.uk

Priorities are:
1. Maximise efficiency and effectiveness across clinical, service and support functions
2. Reshape approach to prevention
3. Develop improved out of hospital care model
4. Establish sustainable services through developing networks and collaborations in the following areas: urgent care, cancer care, elective care, maternity services, specialist mental health and learning disability services.

Key points:
- The plan states that it will “prioritise investment” to ensure delivery of the GPFV (General Practice Forward View).
- Reduce physical access points to emergency care but retain three A&E sites.
- Will be one of the four NHS Improvement ‘Pathfinder’ STPs. Unclear exactly what this entails but will mainly affect back office staff.
- Primary care workforce will be redesigned, sharing resources across primary and secondary care to provide resilience and sustainability as well as capacity.
- During 2018/19, primary and community services will be organised and provided from locality based Multi-Speciality Community Providers (Worcestershire) and similarly formed alliance model (Herefordshire).
- Single maternity service under common management structure working across both counties.
- A greater proportion of routine elective activity will be undertaken on “cold” sites to reduce the risk of cancellations and to improve clinical outcomes.
- The benefits from integration in pathology, radiology and pharmacy services across the footprint will be explored.
- Use of “external partners” to help deal with peak elective capacity issues.
- Modelling undertaken independently identified the need for a 15% increase (34 beds) in the number of acute beds in Herefordshire; there is the potential for a 62% reduction in community hospital beds in Herefordshire (60 beds), and a 44% reduction in Worcestershire (142 beds). The number of acute beds in Worcestershire will stay roughly the same.
- 42% of West Mids GP workforce expect to retire or reduce hours in the next five years – plans will consider new roles and extended roles to support a potentially smaller GP workforce in the future

Engagement:
- Contact: whcnhs.yourconversationhw@nhs.uk
- List of events and roadshows available here: http://www.hacw.nhs.uk/yourconversation/events-and-roadshows/
- There are a number of public consultations currently open. More details available here: http://www.hacw.nhs.uk/yourconversation/our-current-consultations/
**Finances:**

*Financial gap by 2020/21*

- Healthcare: £253 million
- Social care: £84 million
- Combined: £337 million

If the national planning assumptions of 1% demand mitigation and 2% provider efficiency gains are achieved (in addition to QIPP savings) then local modelling suggests that the deficit will be reduced by £168 million, leaving a financial gap in the NHS of £61.5 million. Additional transformational scheme savings of £34.6 million have been identified, leaving £26.9 million to be covered by the STF money.

**Capital funding required: 61 million**
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20. Northamptonshire

Population: 700,000

Link to plan

Lead: John Wardell, Nene CCG

Contact your regional coordinator about your STP: istringer@bma.org.uk

Priorities are:
1. To increase the ability for patients and users to self-care
2. To increase the amount of Integrated Care delivered Closer to Home
3. To appropriately manage the patient flow through urgent care
4. To increase provider collaboration
5. To deliver clinical and financial sustainability

Key points
- High level plan with little concrete proposals.
- Primary care delivery will be delivered through a network of practices and/or hubs within each Federation, with services available from early morning into the evening, seven days a week.
- GP federations/super practices will be developed, ensuring the sustainability of primary care services, the delivery of out-of-hospital services and the development of MCPs.
- Next steps involve implementing the LDR (local digital roadmap) to support integrated working across the system, developing a system wide estates strategy to support new models of care over the next two to 15 years, and developing the workforce strategy and detailed implementation plans to support new models of care.
- A new delivery service model for scheduled care will be created for specialties eg dermatology and rheumatology which will predominantly be delivered in the community through effective partnership working.
- Musculoskeletal and orthopaedic services will have community based clinics ensuring that patients are appropriately assessed and navigated through clear, LEAN pathways. Those that need procedures and surgical interventions will be delivered in an acute care setting.
- A single model of acute care will be developed across Northamptonshire, initially focusing on 10 specific specialties, but then broadening into a review of all specialties within the acute sector.
- Progress has been maintained in the three key specialties that are resourced (orthopaedics, rheumatology and dermatology). Some developments in cardiology and pathology with the agreement to deliver single service models across the two hospitals (Kettering General Hospital & Northampton General Hospital). The remaining services will move towards implementation as resources become available.

Engagement:
- Contact: northamptonshirestp@nhs.net
- Part of the primary care ‘vision’ entails joint working with the LMC and HEE (Health Education England) to increase GP training capacity and increase recruitment.
- The STP SRO group has a clinical oversight group attached – the ‘delivery layer’ of the plan also includes a clinical engagement advisory group.
- In relation to the organisation development, leadership and cultural transformation, it is important to find ‘clinical champions who will help drive significant change’, while ‘building a strong cohort of senior clinical, professional, managerial and political leaders to articulate a clear patient-centric vision and case for change, and also empower teams to collaborate’.

**Finances:**

*Financial gap by 2020/21*

- Combined health and social care: £230 million

*Potential savings:*

- CIP (Cost Improvement Program)/QIPP/Decom: £116 million
- Urgent care: £12 million
- Complex care: £27 million
- Scheduled care: £11 million
- Prevention/wellbeing: £5 million
- Provider development: £33 million
- STP funding: £48 million
STP summary paper

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21. Cambridgeshire and Peterborough

**Population:** 930,000

[Link to plan](http://www.fitforfuture.org.uk/what-were-doing/publications/)

**Lead:** Tracy Dowling, Cambridgeshire & Peterborough CCG

Contact your regional coordinator about your STP: nmason@bma.org.uk

**Priorities are:**
1. At home is best
   a. People powered health and wellbeing
   b. Neighbourhood care hubs
2. Safe and effective hospital care, when needed
   a. Responsive urgent and expert emergency care
   b. Systematic and standardised care
   c. Continued world-famous research and services
3. We're only sustainable together
   a. Partnership working
4. Supported delivery
   a. A culture of learning as a system
   b. Workforce: growing our own
   c. Using our land and buildings better
   d. Using technology to modernise health

**Key points:**
- Changes appear to be less controversial than other areas but still lack detail. Much is about progressing previous plans.
- The plan details three rural urgent primary care hubs, which will focus on integrating local primary, MIU (Minor Injury Units) and community services and will move on to include developing point-of-care testing and consultant support via telemedicine link.
- Centralising specialised orthopaedic trauma services (such as fragility fractures from falls) at Peterborough City Hospital and Addenbrooke's Hospital. MIUs won’t close but community hubs will be developed.
- Hinchingbrooke Community MIU could relocate to Peterborough.
- There will be a move to rehabilitate in homes so as to free up community inpatient beds.
- The STP involves taking forward the Uniting Care older persons project and the Urgent Care Vanguard.
- The express intention to move to becoming a fully-fledged ACO.
- The community model will start by working with three ‘testbeds’ (groups of seven to 10 practices, supporting populations of 30,000-50,000 patients) to improve efficiency by implementation of the 10 High Impact Actions set out in the GP Forward View.
- Papworth is relocating to the Cambridge Biomedical Campus.
- Hinchingbrooke and Peterborough Trusts are merging. Proposed savings from this may be optimistic. There is a risk that Hinchingbrooke A&E will be downgraded at some point.
- There is a huge general practice shortage, despite this they are expected to play a key part in savings.
- The aim is to reduce current total community bed stock by 2018 and instead support care at home.
- Success relies on reducing demand, reducing hospital length of stay and improving workforce utilisation.
**Engagement:**
- contact@fitforfuture.org.uk
- STP lead has been active in offering to speak to BMA members and spoke to local Divisions.

**Finances:**
*Financial gap by 2020/21*
- Combined health and social care: £504 million

**Capital funding required: 800 million (including the relocation of Papworth Hospital)**

Cambridgeshire CCG is the most financially challenged CCG in England and the footprint is more financially challenged considering the size of its population than any other footprint.
STP summary paper

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22. Norfolk and Waveney

**Population:** 1.0 million

**Link to plan**

**Lead:** Dr Wendy Thomson, Norfolk County Council

Contact your regional coordinator about your STP: nmason@bma.org.uk

**Priorities are:**
1. We want more care closer to home
2. We need a thriving and sustainable acute (hospital) sector
3. We must focus on preventing illness and promoting wellbeing
4. We can do more by closer and integrated working
5. We have got to provide services in the budget we have – affordability is vital

**Key points:**
- The annual NHS allocation in 2016/17 is £1.168 billion, in 2020/21 it’s £1.327 billion.
- Whilst the emphasis is on a shift from acute care to primary care, there is a lack of specific and clear detail as to how this translates into a model for provision.
- All STP partners to commit to developing a STP workforce strategy which envisages significantly more highly trained staff.
- There will be a review to determine whether there is a need to redesign A&E to relieve pressure on the three acute providers and examine a potential ACAD (Ambulatory Care and Diagnostics centre) based in the Greater Norwich area.
- Planned land disposal will be reappraised to ensure it fits with STP objectives.
- Significant predicted savings from reducing A&E attendances and non-elective admissions, as well as acute bed days.
- One acute provider has a waiting list of 40,000 patients – NHS Improvement estimate that this is 10,000 patients above the point of sustainability. A service reconfiguration is therefore required.
- 45% of patients currently in acute beds could be treated elsewhere.
- One of the poorest performing footprints regarding IT connectivity.
- Potential targets include a 20% reduction in A&E attendances and non-elective admissions, a 20% reduction of acute bed days delivered by growth of out of hospital activity, a 15% reduction in acute bed days delivered by improving hospital processes, and the achievement of national cancer waiting time and RTT standards.
- There is also a projected 20% reduction in mental health related A&E attendances, and a 10% reduction in frequent attendances by people with mental health conditions.

**Engagement:**
- Contact: no email address available.
- Commitment to public consultation as plan is further developed but no specific proposals. Further commitment to consult with doctors.
- A key risk of the plan is identified as the issue of shortfalls in workforce and/or staff being insufficiently trained to deliver quality service during the transformation. Proposed solution entails ‘engagement and co-production with staff via Clinical and Professional Design Authority’.

http://www.healthwatchnorfolk.co.uk/ingoodhealth
Finances:
Financial gap by 2020/21
– Healthcare: £317 million
– Social care: £99 million
– Combined: £415.6 million

Savings proposed by STP reduce deficit to £50.1 million by 2021.

Savings proposed include:
– Prevention & wellbeing: £12.7 million
– Primary, community and social care: £56.5 million
– Acute care: £25.8 million

The STP envisages increased investment in primary care (£15 million).
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23. Suffolk and North East Essex

**Population:** 900,000

**Link to plan:** [31](http://www.healthwatchsuffolk.co.uk/NEESuffolkSTP/)

**Lead:** Nick Hulme, Ipswich Hospital NHS Trust

Contact your regional coordinator about your STP: [nmason@bma.org.uk](mailto:nmason@bma.org.uk)

**Priorities are:**
1. Self-care & independence and community based care
   a. Safer, stronger, resilient communities
   b. Integrated out of hospital care
   c. Mentally healthy communities
   d. Primary care transformation
2. Hospital reconfiguration and transformation
   a. New models of care
   b. Improving care pathways
   c. Ipswich and Colchester Hospital Partnerships
3. Collaborative working across commissioners
   a. Managed care
   b. Collaborative working across commissioners

**Key points:**
- Plan focused on promoting community based care and self-care but little detail.
- Suffolk primary care partnership – a group of about 14 GP practices in East and West Suffolk – are forming a partnership for GPs to share resources and work together from April 2017.
- A Local Workforce Action Board has been developed with representation from all organisations within the systems and Health Education England, Higher Education Institutions and the voluntary sector.
- Current planning at strategic level indicates a growth in workforce of around 1.4% over the next five years.
- Suffolk CCGs and GP Federation have commissioned clinical leadership development for 60 GPs that are actively pursuing further development in leadership and continuous improvement.
- Improving Care Pathways. This system-wide programme will identify the right place and right professionals to manage patients across a number of clinical specialties.
- West Suffolk and Ipswich Hospitals have both been working with community, social care, mental health and primary care partners across Suffolk to design two ACOs which will transform outcomes and experience for patients. Care will be based around localities and neighbourhoods, rather than around organisations.
- Specialist commissioning team have planned a range of QIPP initiatives that will make efficiencies over the five years; particular areas of focus include neonatal review, spinal, medicines management, renal, chemotherapy.

**Engagement:**
- Contact: [info@healthwatchsuffolk.co.uk](mailto:info@healthwatchsuffolk.co.uk)
- The plan is informed by more than 40 separate pieces of public and voluntary sector engagement over the last two years to develop strategies for housing, mental health, including learning disabilities, primary care, end of life, maternity, cancer and hospital plans. Healthwatch Suffolk are asking for comments on the plan.
**Finances:**

*Financial gap by 2020/21*

- Combined health and social care: £248 million

Aim to save £32.5 million on primary care prescribing by 2020/21 based on 'product switches, improved prescribing and reduced item cost'. Plus focus on reducing variation in prescribing by supporting outlier practices.

The 2016/17 in year deficit largely sits with the system’s three main acute providers: £27.1 million IHT (Ipswich Hospital), £11.1 million WSH (West Suffolk FT), £41.7 million CHUFT (Colchester Hospital University FT) with a further £4.8 million with the mental health trusts.

Anticipated non-recurrent revenue transformation costs:

- 2017/18: £6.2 million
- 2018/19: £12.2 million
- 2019/20: £13.6 million
- 2020/21: £10.5 million

*Proposed annual savings by 2020/21:*

- Specialised commissioning: £25.1 million
- MH SYFW: £7.2 million
- Inpatient pathway: £19.3 million
- OP demand management: £13.7 million
- A&E non-elective: £24 million
- Meds management: £32.6 million
- Collaboration: £26.2 million
- 2% efficiency (reduction in provider cost base year on year): £88 million.
STP summary paper

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24. Bedfordshire, Luton & Milton Keynes

**Population:** 900,000

**Link to plan**[33](http://www.blmkstp.co.uk/)

**Lead:** Pauline Philip, Luton & Dunstable University Hospital NHS FT

Contact your regional coordinator about your STP: nmason@bma.org.uk

**Priorities are:**
1. Illness prevention and health promotion
2. Primary, community and social care
3. Secondary care
4. Digital programme
5. Demand management and commissioning

**Key points:**
- Likely candidate to become an ACS (Accountable Care System).
- The BLMK health economy has significantly overspent its NHS allocation in recent years: Coming into 2016/17, the three CCGs brought forward a combined accumulated deficit totalling £84.5 million, whilst two of the three hospital Trusts had built up a combined accumulated deficit of £154.1 million.
- There are considerable challenges with regard to social care: vacancies are higher than the national average, and typically remain open for longer; the independent sector care home market in BLMK is ‘fragile and showing serious signs of distress’; there is also a higher than average staff turnover.
- All hospital clinical, clinical support and non-clinical services to be examined and target leadership, management and operational models determined, including any recommended service change.
- Unified leadership, management and operations across all three hospitals on the patch. The three Trust Boards are currently examining options that would enable each to delegate and pool some formal decision-making powers to a jointly governed vehicle operating across the three Trusts.
- New IT system to be introduced in secondary care.
- No closures planned but proposed partnership working will involve sharing services including pathology. Opportunity for clinical staff for professional development and specialisation.
- Single clinical hub and SPoA (Single Point of Access) to be created (via a single inbound call centre, dealing with urgent and non-urgent enquiries (including calls, texts, chats, etc) that brings together 111, 999 and NurseLine and other provider services) that offers informed triage to direct physical and mental health (requires recurrent STP investment of additional 94 WTEs to 2020/21).
- Public health is a priority but there is little detail of how this will be achieved or any extra funding. There is mention of the need to fund six areas that will have the highest local impact on the health status of the population: 1) Giving every child the best start in life; 2) Improving screening and immunisations coverage; 3) Tackling the four lifestyle behaviours (smoking, alcohol consumption, exercise and healthy eating); 4) Promoting mental health and well-being, prioritising, in particular, peri-natal mental health and the emotional well-being of vulnerable children and young people; 5) Achieving healthy workforce and healthy estates; 6) Empowering communities and self-management.
Engagement:
- Contact: [http://www.blmkstp.co.uk/contact-us/](http://www.blmkstp.co.uk/contact-us/)
- A discussion [paper](#) summarises the key areas and presents some specific ideas about hospital-based care. The deadline for submitting feedback was 31 March 2017. These will inform a ‘Case for Change’ published in May 2017.
- Significant changes to secondary care services that might emerge will involve close engagement with STP partners and will involve appropriate statutory consultation with the general public.
- Bedford local authority were unhappy with the plan and published it early.

Finances:
Financial gap by 2020/21
- Healthcare: £203 million
- Social care: £108 million
- Combined: £311 million

Capital funding required: £168 million

STP summary paper

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25. Hertfordshire and West Essex

**Population:** 1.4 million

**Link to plan**

**Lead:** Tom Cahill, Hertfordshire Partnership University NHS FT

Contact your regional coordinator about your STP: nmason@bma.org.uk

**Priorities are:**

1. Prevention:
   a. Supporting communities to make the right lifestyle choices
   b. Helping people with long term conditions to live as well as possible for as long as possible

2. Integrated primary and community services:
   a. Supporting people to maintain their independence
   b. Locating frequently used services close to where people live
   c. Delivering the priorities expressed in the ‘Five Year Forward View’
   d. Shared vision for the future of the NHS (including Mental Health and Primary Care)
   e. Reducing demand for hospitals, relocate services from hospitals

3. Acute hospital services partnerships between East and North Hertfordshire NHS Trust and Princess Alexandra Hospital NHS Trust, and West Hertfordshire Hospitals NHS Trust and the Royal Free London NHS Foundation Trust, in order to support improved patient care, clinical and financial sustainability and deliver services more efficiently
   a. Reducing variations in care and services standardising protocols and pathways.

**Key points:**

- No vanguards at present. Aim to create an accountable care partnership in west Essex including “elements” of MCP and PACS models of care that will help enable the “future ambition” of establishing an accountable care organisation.
- Suggested changes to the workforce with £109m of savings identified from “other provider productivity/staff changes”. The plan does not specify if staffing numbers will be cut but will “develop short term actions and long term strategies” to help solve agency, recruitment and retention issues, as well as matching staffing plans with new care models. The plan cites use of physician’s assistants in Worcestershire as a good example of introducing new clinical roles.
- Agreement in principle for West Hertfordshire Hospitals to “formally” be part of the Royal Free hospital group by April 2018.
- Greater partnership working between East and North Hertfordshire and The Princess Alexandra, with the trusts looking to create “pan-provider” pathways across vascular surgery, paediatric urology, specialist cancer surgery and others, as well as integrating back office support services.
- Development of a single health record.
- Collaborative commissioning between the three CCGs on the patch, with the aim for each to save 20% by 2021. They will set up joint teams and committees that have “delegated authority” as well as developing common specifications and threshold criteria for treatments.
- The STP warned the infrastructure at West Hertfordshire is ‘extremely poor’.

Engagement:
No email address available but there is a feedback form on the website.

Finances:
Financial gap by 2020/21
- Healthcare: £397 million
- Social care: £151 million
- Combined: £548 million

The plan says there is "significant uncertainty about the ability to maintain the planned year-end financial position for 2016/17", which it says puts at risk the ability for the STP to succeed. The plans still leaves a total system gap of £101 million which is attributable directly to social care.

Capital funding required: £328 million
Sustainability and transformation plans are five year plans detailing how local areas will work together to modernise health and care and achieve financial balance by 2020. In March 2016, England was divided into 44 geographic ‘footprints’ to create plans based on the local health needs. These plans were submitted to NHS England and NHS Improvement in October 2016 and have since all been published. The plans are still in development and areas will simultaneously start to implement the sections of the plan furthest ahead whilst continuing to work on other sections.

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26. Mid and South Essex

**Population:** 1.2 million

[Link to plan](http://www.successregimeessex.co.uk/)

**Lead:** Dr Anita Donley, Independent Chair, Success Regime

Contact your regional coordinator about your STP: nmason@bma.org.uk

**Priorities are:**

1. Manage demand for healthcare
   - b. Online tools, face-to-face health-checks; personalised plans; shared records
   - c. Redesigned Urgent and Emergency Care system
2. Reconfiguration of acute services
   - a. Three hospitals working as a group
   - b. Re-designate emergency centres
   - c. Separate elective and non-elective care
   - d. Consolidate services
3. Build capacity outside the hospital
   - a. Release GP capacity
   - b. Organise care around natural communities (“localities”)
   - c. Integrate with social care
   - d. Optimise mental health

**Key points:**

- Network of 26 practice groups across mid and south Essex. Changes to the GP role: concentrate on the highest risk and oversee multidisciplinary team to reduce avoidable hospitalisations.
- 190 additional GPs required by 2020/21 under traditional workforce model. However, planning new roles and up-skilling in line with GPFV (GP Foward View) means 100 FTEs (Full-Time Equivalents) required to support primary care capacity, and 80 FTEs required for targeted new services and to support change management.
- Main element likely to concern members and the public is that the three hospitals (Basildon, Southend and Chelmsford) in the area are to share ‘management and support services’ and are considering new models of A&E.
- Having a full time STP lead has been applauded and according to a recent King’s Fund report has borne some benefits by creating a virtual structure[37].
- Will be one of the four NHS Improvement ‘Pathfinder’ STPs. It is unclear exactly what this entails but will involve cutting back office staff. It could also affect pathology services.
- The plan suggests linking mental health expertise to GP practices and local teams. A new mental health strategy for Essex, due for publication in early 2017, will include investment in 24/7 crisis support for people at home and in the community, avoiding hospital admissions wherever possible.
- Projected reduction of 484,000 attendances at acute hospitals by 2020/21 of which:
  - 424,000 are outpatients
  - 13,000 are EL (Elective) admissions
  - 36,000 are A&E attendances
  - 11,000 are NEL admissions
- By 2020/21, a quarter of GP appointments will be released by shifting to alternative channels.

[36] http://www.successregimeessex.co.uk/
[37] The King’s Fund (2016). *Sustainability and transformation plans in the NHS: How are they being developed in practice?*
Engagement:
- Contact: england.essexsuccessregime@nhs.net
- Dates for discussion events are due to be published “soon” (as of 02/03/17).
- South Essex were praised for initial consultation and engagement although unclear how involved LMC have been.
- Currently in a period of “discussion and engagement, leading to consultation and decision-making in 2017”.
- The plan states that “robust clinician engagement is continuously led by clinicians — not just those in management positions but also other influential clinicians from all relevant clinical services”.

Finances:
Financial gap by 2020/21
- Healthcare: £407 million
- Social care: £164 million
- Combined: £571 million

Savings projected:
- £308.9 million from CIPs and QIPPs
- £53 million from local health and care & SR (Success Regime) initiatives (£23.7 million from speciality pathway redesign, £7.5 million from complex care, £7.5 million from common offer in-hospital, £9.6 million from system-wide transformations, £5.0 million from urgent care).
- £27.6 million from Success Regime initiatives (£17.1 million from acute reconfiguration, £10.5 million from clinical support and back office consolidation).

Capital funding required: £449.5 million
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27. North West London

Population: 2.0 million

Link to plan 38

Lead: Dr Mohini Parma, Ealing CCG

Contact your regional coordinator about your STP: abarton@bma.org.uk

Priorities are:
1. Support people who are mainly healthy to stay mentally and physically well, enabling and empowering them to make healthy choices and look after themselves
2. Improve children’s mental and physical health and wellbeing
3. Reduce health inequalities and unequal outcomes for the top three killers: cancer, heart diseases and respiratory illness
4. Reduce social isolation
5. Reduce unfair variation in the management of long-term conditions – diabetes, cardiovascular disease and respiratory disease
6. Ensure people access the right care in the right place at the right time
7. Improve the quality of care for people in their last phase of life, enabling them to die in their place of choice
8. Reduce the gap in life expectancy between adults with serious and long-term mental health needs and the rest of the population
9. Ensure services and experiences are of a high quality every day of the week

Key points:
– The ‘Shaping a Healthier Future’ review in North West London predated the STP.
– Challenges are most acute at Ealing Hospital and the current clinical model is not financially sustainable with costs of staffing and safety larger than the activity and income for the site. This will be prioritised over the STP period.
– Focus for the first two years is to develop the proactive model of care and address the immediate demand and financial challenges. No substantial changes to A&Es in Ealing will be made until there is sufficient alternative capacity out of hospital or in acute hospitals. There is a similar vision for Charing Cross Hospital, although no planned changes to the A&E.
– In 2012 consulted on plans to reduce the number of major hospitals in NW London from nine to five. Central Middlesex Hospitals, Hammersmith Hospital, Ealing Hospital and Charing Cross Hospital would become urgent care centres without 24/7 accident and emergency departments. Chelsea and Westminster Hospital, Hillingdon Hospital, Northwick Park Hospital, St Mary’s Hospital and West Middlesex Hospitals would retain full A&Es. So far, Central Middlesex, Hammersmith hospitals have been downgraded to urgent care centres. Ealing Hospital has not, although maternity and paediatric inpatient services have been removed.
– The draft submission also outlines plans to consolidate back office functions including; finance, HR and payroll, IM&T, procurement, estates and facilities, governance and risk and legal services. According to the document a business case was due to be submitted to NHS Improvement in October.
– The STP draft says it intends for Ealing and Charing Cross hospitals to specialise in the management of the frail elderly with frailty units piloted at both sites, before full roll out.

**Engagement:**
- Contact: media@nw.london.nhs.uk
- NWL governance bodies for LDR (Local Digital Roadmap) (Digital Programme Steering Group, Design Authority, Digital IG Governing Group and CIE Project Steering Group) incorporate Lay Partner/patient representation.
- Local CCG governing groups, including Health & Wellbeing Boards, incorporate patient representation, and are generally open to the public.
- A public consultation programme regarding the STP is in progress (according to Digital Roadmap published in January).
- Ealing and Hammersmith & Fulham Councils do not support the STP due to proposals to reconfigure acute care.

**Finances:**
*Financial gap by 2020/21*
- Healthcare: £1.113 billion
- Social care: £298 million
- Combined: £1.4 billion

£20 million financial gap remaining in 2020/21 after the savings, mainly due to a social care deficit of £35 million. Savings of £114 million have been estimated from moving care closer to home. To support implementation of the transformation the area is seeking early access to the transformation fund to pump prime the new proactive care model.

Financial modelling for social care within the STP references an assumption of the patch having a fully pooled health and social care budget by 2020/21.

**Capital funding required: £435 million**
STP summary paper

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**Population:** 1.4 million

[Link to plan](http://www.candi.nhs.uk/about-us/north-central-london-sustainability-and-transformation-plan)

**Lead:** Helen Pettersen, Joint Chief Officer of five local CCGs

Contact your regional coordinator about your STP: abarton@bma.org.uk

**Priorities are:**
1. Prevention
2. Service transformation
3. Health and care closer to home
4. Mental health
5. Urgent and emergency care
6. Optimising the elective pathway
7. Consolidating specialties
8. Cancer
9. Productivity
10. Enablers: workforce, estates, digital, new delivery models and new commissioning arrangements

**Key points:**
- High numbers of people are admitted to hospital: the rate of inpatient admissions in NCL is 828 per 100,000, compared to 587 England-wide.
- It is estimated that 15% of NHS building space is not being used, incurring £20-25 million a year in running costs. A large number of primary care buildings are also not fit for purpose – around 33% of GP premises in London need replacing.
- Plan to bring together funding used for GP LCS (Locally Commissioned Services) and the premium spent on PMS (Primary Medical Services) to establish one LCS contract framework across the whole of NCL.
- STP plan mentions primary care being delivered in "modern purpose-built/design facilities" but no mention of funding or timescales.
- Redevelopment of the Barnet, Enfield and Haringey Mental Health Trust St Ann's site and Camden and Islington FT St Pancras site (in conjunction with the proposed relocation of Moorfields to the St Pancras site); redesigned orthopaedics pathway. Further specialties identified for focused pathway redesign but not worked out yet; further reconfiguration possible but no decisions made yet. Large scale reorganisation may take longer than the five year timescale.
- There is a shortfall in investment on top of transformation funding pump priming (£6 million for 2017/18, and £10 million for 2018/19) of £3.3 million for 2017/18 and £13.4m for 2018/19 to implement the full ambitions. Currently there is a risk that the increased investment will be focused on meeting demand growth in the short term, rather than funding the transformational initiatives which are necessary to manage demand in the longer term.
- Projected reductions in activity using care closer to home model:
  - 150,000 fewer emergency department attendances
  - 63,000 fewer non-elective admissions
  - 35,000 fewer outpatient attendances
  - More than 50% of people experiencing a first episode of psychosis to commence treatment with a NICE (National Institute for Health and Care Excellence) approved care package within two weeks of referral.
Engagement:
- Contact: nclstppmo@nhs.net
- There is ostensibly an on-going programme of engagement and discussion with local people which we expect to continue over the coming months.
- Insufficient clinical leadership & engagement have been identified as possible risks; potential solutions include:
  - Digital programme is led by Chief Clinical Information Officer
  - Establish Clinical Informatics Advisory Group
  - Establish CCIO network across the sector
  - Maintain links with STP Clinical Cabinet
- In January, the NCL JHOSC (Joint Health Oversight and Scrutiny Committee) presented a report including a number of recommendations. The STP leads’ response to the recommendations can be read here.  
- Better engagement with representatives of the local workforce will be achieved through a weekly STP newsletter set up for those working within the organisations of the STP; more internal newsletters and bulletins along with more frequent updates from Chief Execs; running events within our membership organisations to showcase the range of work which is happening across NCL and to ensure staff understand the current plans, and how they may affect them as we progress into implementation.

Finances:
Financial gap by 2020/21
- Healthcare: £876 million
- Social care: £308 million
- Combined: £1.184 billion

The financial gap not balanced by 2020/21

Capital funding required: £542 million

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29. North East London

Population: 1.9 million

Link to plan[^41]

Lead: Jane Milligan, Tower Hamlets CCG

Contact your regional coordinator about your STP: abarton@bma.org.uk

Priorities are:
1. The right services in the right place
2. Encourage self-care, offer care closer to home and make sure secondary care is high quality
3. Financial sustainability
4. Improve specialised care by working together
5. System-wide decision making model that enables place-based care and involves key partner agencies
6. Using infrastructure better

Key points
– Population in NE London is predicted to grow at the fastest rate in London. Even with successful prevention, the high birth rate may mean a need for increased infrastructure.
– Plans to develop accountable care systems with integrated commissioning with Local Authorities and capitated budgets.
– Foundation of the community model is primary care collaboration at scale with hubs, networks and federations treating populations of up to 70,000 people, accessible 8am to 8pm, seven days a week.
– Plan to enhance triage in urgent and emergency care settings so patients receive the appropriate care at the right time. Only patients who require more intensive care will be admitted, improving bed capacity. Develop ambulatory care hubs at each hospital.
– Each borough has detailed delivery plans for integrating health and social care, which show how they meet the requirements of the Better Care Fund.
– Starting to implement personal health budgets for children and young people in parts of NE London from 2016/17.
– In 2016/17 there is a focus on redesigning the following pathways: Ear, nose & throat, orthopaedics, gastroenterology, ophthalmology, gynaecology, GP specialist advice service, renal.
– Transforming Services Together was a previous review in Newham, Tower Hamlets and Waltham Forest.[^42] The STP continues to develop its proposals. Tower Hamlets has developed an Integrated Provider Partnership called THT (Tower Hamlets Together) with Barts Health, East London NHS Foundation Trust, the London Borough of Tower Hamlets and Tower Hamlets GP Care Group, which will provide community health services and form the basis of their ACS (Accountable Care System). The model is based on outcomes rather than activity.
– Exploring creating surgical centres of excellence at each site.
– Plans include devolution pilot schemes. Both devolution pilots are exploring the potential for integrating health services more closely with other public services.

[^41]: http://www.netstp.org.uk/
[^42]: http://www.transformingservices.org.uk/
1. **Barking, Havering and Redbridge:**
   
   – Includes bringing together an Accountable Care System with pooled health and social care budgets. There would be a single leadership team.

2. **Hackney:**

   – Involves developing a fully integrated commissioning function across the CCG and the two LAs (Local Authorities). This includes an integrated care model underpinned by an alliance contract, a health and social care independence team that focuses on intermediate care and re-ablement, and a fully integrated mental health service.

**Engagement:**

– Contact: nel.stp@towerhamletsccg.nhs.uk

– Timetable of engagement events available [here](http://www.nelstp.org.uk/engagement.htm)

**Finances:**

*Financial gap by 2020/21*

– Healthcare: £578 million

– Social care: £238 million

– Combined: £816 million

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**Capital funding required: £500 million**
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30. South East London

Population: 1.7 million

Link to plan

Lead: Amanda Pritchard, Guy's and St Thomas' FT

Contact your regional coordinator about your STP: abarton@bma.org.uk

Priorities are:
1. Developing consistent and high quality community based care, primary care development and prevention
2. Improving quality and reducing variation across both physical and mental health
3. Improving productivity and quality through provider collaboration
4. Developing sustainable specialised services
5. Changing how we work together to deliver the transformation required

Key points:
- Local care networks are to be developed; to include a shift in focus to prevention; federations and networks; adopting population-based budgets and risk based contracts; this also includes reference to drawing on others from across the health, social care and voluntary sector.
- Plan to develop two elective orthopaedic centres and developing the pathway pre- and post-admission to ensure standardisation.
- Integrating MH (mental health) services including establishing a pan London procurement approach in mental health providers and a shared approach to legal support across south London.
- A joint approach across south London managing the budget for forensic provision with potential extension to specialised commissioning of mental health services for children and young people; collaborative approaches to MH estates planning (presumably with release of assets).
- Collaboration between the three south London mental health trusts to take on the specialised commissioning budget for adult secure services — once this is assessed the approach could be extended to other areas.
- Improved ambulance times with the establishment of a clinical hub with experienced clinicians.
- The report comments on a considerable overlap of services in south London where there are eight acute specialised providers including three large providers — GSTT (Guy's and St Thomas’ FT), Kings and St George's; further comment is made about the proximity of GSTT, Kings and St George's.
- In terms of pathway reviews the priority areas are paediatrics, cardiovascular, specialist cancer, renal, near rehabilitation, neurosurgery, vascular services, HIV, adult secure mental health, CAMHS (Child and Adolescent Mental Health Services) and transforming care partnerships.

Engagement:
- Contact: ourhealthiersel@nhs.net
- Engagement plan published here.

44 http://www.ourhealthiersel.nhs.uk/about-us/
Finances:
Financial gap by 2020/21
- Healthcare: £854 million
- Social care: £242 million
- Combined: £1.1 billion

Savings include:
- £262 million from efficiencies achieved at 1.6% per annum
- £225 million from collaborative productivity measures to reduce provider expenditure
- £116 million from reduction in demand and variation as consequence of the implementation of Local Care Networks
- £134 million from indicative sustainability and transformation funding

A separate, comprehensive financial summary has been published and can be read here. 46

Capital funding required: £169 million

STP summary paper

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31. South West London

**Population:** 1.5 million

[Link to plan](http://www.swlccgs.nhs.uk/our-plan/our-plan-for-south-west-london/)

**Lead:** Sarah Blow, joint Chief Office of five local CCGs

Contact your regional coordinator about your STP: abarton@bma.org.uk

**Priorities are:**
1. Use our money and staff differently to build services around the needs of patients
2. Invest in more and better services in local communities
3. Invest in our estates to bring them up to scratch
4. Try to bring all services up to the standard of the best

**Key points:**
- Study in February 2016 in SWL found 55% being cared for in hospital did not need to be there but other services not available to pick up the care.
- Sutton nursing home vanguard has reduced LAS (London Ambulance Service) call outs by 5.8% and A&E attendance by 10%, as well as a reduction of length of hospital stays and cost savings on medications through regular reviewing. Further work is needed on the funding implications of expanding the Sutton vanguard – to date there has been a level of national funding which we understand will not be available going forward.
- 10% reduction in A&E attendance also forecasted from extension of GP surgery opening hours.
- According to the plan, 13% of patients could have avoided admission to acute hospital beds, 42% would have benefited from early discharge to community based care.
- Current bedded community capacity will be reviewed at a SWL level – in terms of capacity and current use of the beds – to ensure correct capacity across the SWL system and that beds are used as effectively as possible. A provision of £10m has been included for future development of community beds. There are likely to be some minor disposals to support this investment.
- Modelling to argue reducing five acute sites to four but beyond this five year plan. Some service may not be in all four sites and some workforce would need to work across more than one site
- Pathway redesign for urgent and emergency care, mental health, maternity, children’s care and care of the elderly.
- Five CCGs (not Croydon) will work under one accountable officer from 2018.
- St George’s and Epsom & St Helier investigating ways to work collaboratively in the future.
- The main driver for reconfiguration of the acute sector is the view of clinicians, as expressed through the Clinical Board, that south west London will not be able to meet key clinical quality standards across five acute sites.

**Engagement:**
- Contact: swlccgs@swlondon.nhs.uk
- Promise of consultation with public on any significant changes. There will be public consultation on the acute site criteria during 2017.
**Finances:**

*Financial gap by 2020/21*

- Healthcare: £679 million
- Social care: £149 million
- Combined: £828 million

£99m of the healthcare deficit is from specialist commissioning – this is being addressed by measures currently under development by the specialist commissioners for London working in conjunction with the main specialist service providers in south London.

**Savings projected:**

- Right Care in the Best Setting (eg preventative & proactive care, planned care, A&E, outpatient redesign): £112 million
- Productivity: £293 million
- Collaborative productivity opportunities for providers: £55 million
- Other (eg other QIPP, public health initiatives): £56 million

**Capital funding required: £313 million**
STP summary paper

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32. Kent and Medway

**Population:** 1.8 million

[Link to plan](https://www.kmpt.nhs.uk/information-and-advice/stp.htm)

**Lead:** Glenn Douglas, Maidstone & Tunbridge Wells NHS Trust

Contact your regional coordinator about your STP: [htownsend@bma.org.uk](mailto:htownsend@bma.org.uk)

**Priorities are:**
1. Prevention of ill-health
2. Local care – better access to care and support in people's own communities
3. Mental health – just as important as physical health
4. Hospital care – excellent wherever it is delivered

**Key points:**
- Merger of back office functions (finance, payroll, HR, legal). One of four back office merger “pathfinders”.
- Mentions development of a K&M medical school for undergrad and postgrad.
- Seems to favour scaling up primary care into clusters and hub based MCP models.
- Plan suggests consolidation of emergency and elective services achieving savings of £90m but does not identify where.
- Further consolidation and co-location of specialist services such as pPCI (primary percutaneous coronary intervention); vascular, renal, head and neck; urology; hyper-acute stroke; haemat-oncology and gynae-oncology inpatient services.
- Huge savings from moving care to the community but doesn’t specify how the ‘local care’ model will be funded or resourced.
- Partnership working between hospital sites and explore the creation in east Kent of:
  - one emergency hospital centre with specialist services, including planned care
  - one emergency hospital centre, including planned care
  - one planned care hospital centre focusing on planned inpatient orthopaedic surgery or treatment, supported by rehabilitation services, and a GP-led urgent care centre
- Eight hubs are planned to provide more specialist and out of hours services.
- Site of Encompass Vanguard, comprising 16 practices (170,000 patients) in east Kent which is operating as an MCP.
- Assuming reducing activity, length-of-stay and sustainable occupancy, required bed capacity should be 10% smaller by 2020/21 (approx. 300 less beds).

**Engagement:**
- Contact: [engagement.secsu@nhs.net](mailto:engagement.secsu@nhs.net)
- In the New Year more detailed information about the STP will be published along with a timetable for engaging with the public in Kent and Medway from June 2017. Final decision on consultation + implementation December 2017. In the meantime a survey is available on the website but focused on patients rather than staff groups.

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– No involvement of LMC or LNCs (Local Negotiating Committees) up to November 2016. STP lead has now responded to contact from IRO (Industrial Relations Officers) (23/11) with details of the STP. LMC has been invited to attend Programme Board (from January 17).

**Finances:**

*Financial gap by 2020/21*

– Healthcare: £441 million
– Social care: £45 million
– Combined: £486 million

*Savings proposed:*

– QIPP: £50 million
– Specialised commissioning: £51 million
– Care transformation: £102 million
– Productivity enablers: £190 million
– System leadership: £12 million
– STF: £122 million

**Capital funding required: £75 million**
STP summary paper

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33. Sussex and East Surrey

Population: 1.8 million
Link to plan\(^{50}\)
Lead: Michael Wilson, Surrey & Sussex Healthcare NHS Trust
Contact your regional coordinator about your STP: htownsend@bma.org.uk

Priorities are:
1. Urgent and emergency care
2. Frailty
3. Primary care

Key points:
- All about MCPs and partnerships. 20 care hubs (each serving a 30,000-50,000 population)
- mix of informal alliances, federations and super-partnerships.
- W. Sussex asked by NHS Improvement to put their Exec team into BSUH (Brighton and Sussex University Hospitals) from April 2017 to 'help and improve'. Brighton and Worthing (Western Sussex Hospitals NHS Foundation Trust) are exploring a merger with Royal Sussex County Hospital as Brighton University NHS Trust bosses wrestle with a projected £60m overspend at the Royal Sussex.
- This STP includes taking forward plans begun in 2014 under East Sussex Better Together\(^{51}\)
- Increased focus on community care could result in a reduction of (up to) 18% in total bed use within an acute care setting within first two years.
- Emergency care 'vision' entails all urgent & Emergency Care Centres being networked and linked with an ED, and embedded in a primary care community of practice, to enable a highly responsive service and for patients to be cared for as close to home as possible.
- STP is comprised of three ‘places’ responsible for locally driven community and integrated care with the aim of improving health outcomes for communities and reducing avoidable illness and health and care expenditure. Each place is building a model that responds to local health needs and will oversee clinical transformation of LTCs (Long Term Conditions), frailty, mental health community, social care, general practice and urgent services.
- Coastal Care: accountable care model with one capitated budget. Benefits include enhanced primary care, sustainable community, mental health and social care provision, improved access to specialists, a reduction in spending on traditional hospital care of £44 million
- Central Sussex & East Surrey Alliance MCP. Benefits include reduction in emergency and planned admissions, more episodes of care in the community, sustainable & stable workforce, a reduction in spending on traditional hospital care of £80 million
- East Sussex Better Together: ACP (Accountable Care Partnership) with capitated funding and pooled budgets. Benefits include sustainable and affordable cost of care, reduction in spend on traditional hospital care by £44 million.

\(^{50}\) http://www.healthwatcheastsussex.co.uk/stp/
\(^{51}\) https://news.eastsussex.gov.uk/east-sussex-better-together/
Engagement:
- Contact: enquiries@healthwatcheastsussex.co.uk
- The LWAB (Local Workforce Action Boards) has held several stakeholder events to develop an action plan to meet the requirements of the STP. Meetings on the 25th July and 30th September have helped to shape this work, building on existing work, identified challenges and key priority areas that have been highlighted through stakeholder engagement sessions, which have included all organisations, both health, social care, education and trade unions.
- Medical director on board. Plans developed through workshops.

Finances:
Financial gap by 2020/21
- Healthcare: £653 million
- Social care: £212 million
- Combined: £864 million

2020/21 overall ‘do something’ deficit of £160 million.

£296.4 million proposed saving from moving elective care from hospital into the community. Elective care appointments would be moved to day cases; day cases would be moved to outpatient appointments; outpatient appointments would be moved into community settings.

Other savings from:
- £47.4 million from reducing the number of outpatient appointments.
- £21.2 million from treating the elderly in “frailty units” rather than admitting elderly patients to hospital via A&E.
- £8.1 million from moving elderly patients who don’t need to be in hospital into “alternative settings”.

Capital funding required: £492 million
STP summary paper

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34. Frimley Health

**Population:** 750,000

**Link to plan**[^53]

**Lead:** Sir Andrew Morris, Frimley Health NHS FT

Contact your regional coordinator about your STP: htownsend@bma.org.uk

**Priorities are:**
1. Making a substantial step change to improve wellbeing, increase prevention, self-care and early detection
2. Action to improve long term condition outcomes including greater self-management and proactive management across all providers for people with single long term conditions
3. Frailty Management: Proactive management of frail patients with multiple complex physical and mental health long term conditions, reducing crises and prolonged hospital stays
4. Redesigning urgent and emergency care, including integrated working and primary care models providing timely care in the most appropriate place
5. Reducing variation and health inequalities across pathways to improve outcomes and maximise value for citizens across the population, supported by evidence

**Key points**
- For ‘support staff’ looking at more flexible working geographically and possibly ‘standard TCS’ (Terms and Conditions of Service).
- Workforce changes include creating new roles such as health coaches, care navigators, clinical pharmacists and integrated mental health leads working alongside mental health clinical staff and general practitioners. No plans to reduce doctor numbers from what I can see. It refers to career development and support for shortage workforces.
- Set out plans to establish a new model of large scale GP but stopped short of proposing full formal integration of acute and primary care. Creation of 14 primary care “hubs” to be phased in by 2018. Single point of access for social, mental and physical health care. Physiotherapy will also be offered in GP – expected to lead to a 20% reduction in physiotherapy and secondary care referrals.
- Frimley Health FT is already in the process of establishing PACS in north east Hampshire and Farnham.
- Likely candidate to become an ACS (Accountable Care System).

**Engagement:**
- Contact: shccg.communications@nhs.net
- The Surrey Health CCG held a public engagement meeting on 11/05/17 – although not explicitly on the subject of STPs. Some governing body meetings are also open to observers; a timetable is on the website[^53].

**Finances:**
*Financial gap by 2020/21*
- Healthcare: £187 million
- Social care: £49 million
- Combined: £236 million

[^53]: [http://www.surreyheathccg.nhs.uk/about/frimley-health-care-stp](http://www.surreyheathccg.nhs.uk/about/frimley-health-care-stp)
The plan states that ensuring that shared electronic care records are up and running will need added funding. The partnership is already planning to invest £30 million of capital and £8 million of revenue on technology, but a further £33 million of capital and revenue needs to be invested between now and 2020/21 to make the Frimley system a “truly digitally enabled economy”, the STP says.

Total primary care expenditure will rise from £111 million in 2016 to £136m, over 21% by 2020/21 – a larger increase than either the acute or the mental health sectors. A further £8.5 million will be spent on transformation.

**Capital funding required: £42 million**
STP summary paper

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Surrey Heartlands
35. Surrey Heartlands

**Population:** 800,000

**Link to plan:** [54](#)

**Lead:** Julia Ross, North West Surrey CCG

Contact your regional coordinator about your STP: htownsend@bma.org.uk

**Priorities are:**
1. Achieve consistent clinical pathways and remove unwarranted variation – via a Surrey Heartlands clinical academy
2. Deliver a system which is sustainable and designed to deliver quality, efficiency and access in care in physical and mental health
3. Secure buy-in for change and personal responsibility for health
4. Speak with one voice and act with one mind – moving to one budget and one overall plan for the area

**Key points:**
- Devolution plans include integration of health into the Surrey County Council One Public Estate pathfinder project.
- No plans to reduce doctor numbers – but talks about need for ‘new and innovative roles’; networking expertise and ‘cross skills’ and ‘sharing resources’.
- Royal Surrey and Ashford and St Peters were considering a merger but now considered not financially viable. Only major change is stroke services.
- Whilst Epsom is in the Surrey Heartlands plan, St Helier is in the SW London one (even though they are one Trust). It appears that the hope is for a new hospital in the Sutton/Merton area but that seems unlikely. This could add additional complexities.
- Suggests MCPs as a major saving.
- A local trust (St Helier University Hospitals) and Surrey Downs CCG lobbied for vanguard status for EHC (Epsom Health and Care), an initiative focusing on transformation of care for complex, elderly patients. The bid failed, but the CCG is still committing its entire efficiency requirement for non-elective care in the Epsom area to be delivered through EHC for the 2016/17 planning round, resulting in a business case delivering substantial savings, but with a substantial investment requirement. The scheme has already reduced acute length of stay for unplanned admissions by 8.4% and bed days attributable to delayed transfers of care by 25%.

**Engagement:**
- Contact: No email address provided.
- Not clear what clinical engagement has taken place. Lots of comments that clinicians resist such changes.
- Patchy engagement with medical staff but LMC is on the Board.

[54](http://www.nwsurreyccg.nhs.uk/surreyheartlands/Pages/default.aspx)
**Finances:**

*Financial gap by 2020/21*
- Healthcare: £451 million
- Social care: £164 million
- Combined: £615 million

Heartlands Academy proposals aim to save 45 million of the total £115 million of planned efficiencies by 2021.

*Savings proposed:*
- QIPP: £44.2 million
- Specialised commissioning: £68.7 million
- Identified trust CIP: £64.2 million
- Identified ASC efficiencies: £74.5 million
- STF: £56 million

**Capital funding required: £100 million**
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Cornwall and the Isles of Scilly
36. Cornwall and the Isles of Scilly

Population: 500,000

Link to plan: [55](http://www.cornwall.gov.uk/health-and-social-care/shaping-the-future-of-health-and-social-care-services/)

Lead: Philip Confue, Cornwall Partnerships NHS FT

Contact your regional coordinator about your STP: scusack@bma.org.uk

Priorities are:

1. Prevention and Primary Care
   a. The wider determinants of health (education, lifestyle, mental health)
   b. Primary and secondary care prevention
   c. Transforming primary care
   d. GP sustainability and GP commissioning

2. Community care and support
   a. Community recovery
   b. Re-ablement and rehabilitation
   c. Case management and co-ordination
   d. Care home support
   e. Community based care
   f. End of life support

3. Urgent and Emergency Care
   a. NHS 111
   b. Out of hours services
   c. Urgent Care Centres and Emergency Department development

4. Clinical pathways, provider and commissioner reform
   a. Improving clinical pathways for specific patient groups such as those with stroke, diabetes, musculoskeletal or heart conditions
   b. Specialist services and organisational reform to focus on the individual citizen

5. Productivity and efficiency
   a. Workforce
   b. Administration
   c. Procurement
   d. Estates
   e. Information Management & Technology
   f. Lord Carter recommendations

Key points:

- There are no proposals to reduce the number of doctors. More GPs and community workers will be recruited to address the fact that 20% are due to retire within five years.
- No hospital closures are explicitly identified, but the plans indicate that several sites are not fit for purpose (specifically a number of minor injury units) – some sites would not be possible to bring up to acceptable levels of functional suitability regardless of investment, although no clarification offered on which sites.
- 35% of community hospital bed days are being used by people fit to leave.
- The current model (wide variation in the size of practices and populations) is deemed to be unsustainable. There will be a much larger emphasis on working at scale through GP clusters. This will facilitate the planned increase in evening and weekend appointments and an expanded range of services. First three localities and 10 clusters operating at scale by October 2017.
- The majority of the interventions in the plan that are approved will further need detailed design and appraisal work to be carried out between February and June 2017. The full business case will be approved in August.
Terms and conditions flagged as an issue, insofar as they do not allow for people to work across organisational borders. The plan calls for funding to cover potential amendments to terms and conditions. Disparity between health and care sector terms and conditions, making creation of integrated teams more challenging, also resulting in competition for staff across organisations. No concrete changes proposed, only identification of related issues.

Engagement:
- Contact: KCCG.Engagement@nhs.net
- In early 2016, 3,000 people were asked about their views on the health and social care system – an initial report was published (Shaping the future of health and social care in Cornwall and the Isles of Scilly). It was independently reviewed by the University of Exeter.
- From November 2016 till 20/01/17 there was further engagement with local communities based on the contents of the plan.
- Engagement document subsequently produced can be read here,56
- The plan claims that there was wide professional and clinical practitioner involvement in the development of the system model and priority interventions.
- There was also clinical involvement in producing the Outline Business Case. Each of the five system redesign programmes included a Design Authority, consisting of health and care professionals. Each programme was also led by a dedicated clinical lead.

Finances:
Financial gap by 2020/21
- Combined health and social care: £264 million

The STP will work with NHS England to ensure GP practices receive their share of the additional £2.4 billion GPFV funding. The plan will deliver the GP Forward View 10 high impact actions.
STP summary paper

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37. Devon

**Population:** 1.2 million
**Link to plan**\(^{57}\)

**Lead:** Angela Pedder OBE, Royal Devon and Exeter NHS Trust
Contact your regional coordinator about your STP: scusack@bma.org.uk

**Priorities are:**
1. Ill health prevention and early intervention
2. Integrated care model
   a. Shift resources from community to hospital
   b. Health and social care integration
3. Primary care
   a. Delivering the GP forward view
   b. Work towards delegated commissioning
   c. Developing integrated GP/primary care
4. Mental health and learning disabilities
   a. Improve mental illness prevention in primary care
5. Acute hospital and specialist services
   a. Review high priority services (stroke, urgent and emergency care, maternity/paediatrics/neonatal)
   b. Review small and vulnerable services
6. Increasing service productivity
   a. Improve the cost-effectiveness of the care delivered per head of population
   b. Implement Carter’s recommendations in ‘Reducing Variations’ report
   c. Rationalise the ‘back-office’ services
   d. Procurement efficiencies in clinical supplies and drugs
   e. Review spending on continuing health care (CHC)
7. Children and young people

**Key points:**
- NEW (North Eastern and Western) Devon CCG (Clinical Commissioning Group) has been part of the Success Regime since 2015.
- Phase 1 is to engage, design and consult on a new model of integrated care to ensure an equal spread of services across Devon and reduce reliance on bed-based care (expected to release savings of £90m).
- Phase 2 is to engage, design and consult on reconfigured new models of care for mental health, acute and specialist services, reduce duplication and variation and improve user experience.
- Some services such as stroke, paediatrics and maternity are not clinically or financially sustainable in the long term without changes to the way they are delivered.
- Commitment to invest in community, primary and social care services.
- Proposed changes would result in “a significant reduction in the number of acute and community beds”. NEW Devon CCG is engaging on proposals for the overall strategic direction of travel.
- In South Devon and Torbay implementation of the care model set out in the ICO (Integrated Care Organisation) has already started. However, South Devon NHS FT have already told the Council they are withdrawing from a ‘risk sharing agreement’ due to unexpected overspend by the ICO.
- The STP area is one of 11 national pilot sites for the new assistant nurse roles: 76 places will be available from January 2017.

57 [http://www.devonstp.org.uk/](http://www.devonstp.org.uk/)
– Primary care workforce development is a key area for attention given the Devon GP age profile and the key role primary care will play in our future integrated model of care.

– Re-provision of up to £60m per year to deliver the new care delivery arrangement interventions could provide for between 1,000 and 1,500 redesigned roles. High-level estimates indicate a requirement for 900 staff to undertake different roles (these were based on traditional roles and ways of working, and require development) and many of these roles would be filled by staff relocating their work and expertise from existing services.

Engagement:

– Contact: D-CCG.CorporateServices@nhs.net

– The plan is being presented to all partner organisations currently. Following this, there will be an engagement exercise involving citizens, patients, service users, their representatives and voluntary sector groups.

– Events were held throughout February and March 2017 to discuss plans with local communities, specifically about what is important to people for acute services; calendar available here. 58

– Public consultation on specific proposals to close a number of community hospital beds in the eastern locality closed in January 2017. Decisions are expected from March.

Finances:

Financial gap by 2020/21

– Healthcare: £451 million

– Social care: £106 million

– Combined: £557 million
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38. Somerset

**Population:** 500,000

**Link to plan:**

**Lead:** Dr Matthew Dolman, Somerset CCG

Contact your regional coordinator about your STP: scusack@bma.org.uk

**Priorities are:**

1. Driving improvement in the system-wide financial and performance position
   a. Focus on prevention to develop a sustainable system
2. Redesign of out of hospital services
   a. Primary care
   b. Community services
   c. Tackling delays in transfers
3. Address clinical and financially unsustainable acute service provision
   a. Sustainable acute service provision
   b. Acute hospital urgent care
   c. Specialised services
4. Create an Accountable Care System by April 2019

**Key points:**

- As at June 2016 there were circa 2,000 bed days per month across the two acute hospitals lost as a consequence of delayed transfers. This is costing between £300,000 and £400,000 per month. In addition, there are a further 600 – 700 bed days per month relating to delayed transfers within the community hospitals and circa 250 bed days per month relating to delayed transfers within mental health wards.
- There is a heavy emphasis placed on moving towards a wider multi-disciplinary approach, developing new roles and utilising new technology.
- The importance of a move away from acute secondary care is extensively highlighted. Potential solutions to related issues such as high occupancy and delayed transfers include hospital at home, re-ablement homecare, rapid response and care home support, all of which would require the purchase of additional care home beds.
- Acute services are deemed clinically and financially unsustainable.
- A projected decrease of 60 in the number of GPs at surgeries is predicted over the next five years, from 414 in 2016/17 to 354 in 2020/21. However the total number of staff working at GP practices would increase by 650 in the same period, due to the increase in the number of other health care workers who would be affiliated with primary care (eg health coaches, paramedics, pharmacists etc.).
- Weekend working and seven day services is an important component of the plan.
- There’s little in the way of clarification on the question of the way in which money will be allocated and what will be prioritised.
- South Somerset Symphony Project (PACS Vanguard site) has been widely used for financial modelling, and a number of future outcomes are based on the Symphony model.
- There aren’t any plans to close hospitals, and there’s no discussion of reducing the number of beds (beyond proposing a greater emphasis be placed on care in the community).
- Consolidation of acute services across Taunton and Somerset and Yeovil District Hospital also planned. Paediatrics, maternity, dermatology, oral maxillofacial surgery, urology and oncology have been prioritised for redesign this year. For maternity and paediatrics, a joint approach to redesign is being taken with Dorset, with the possibility that services at Yeovil District Hospital could be networked with Dorset County Hospital FT. Notice has

been given to decommission existing MSK interface services – a new delivery model is scheduled to be implemented by May.

**Engagement:**
- STPfeedback@somersetccg.nhs.uk
- A consultation will be conducted between May and July 2017, based on a pre-formal consultation from January to April.
- Part of the governance includes a clinical reference group. There isn’t a huge amount of clarification about the nature of the group’s role. The plan does say that they have “Developed closer, networked arrangements through a clinical reference group including lead clinicians (secondary and primary care), Public Health and Social Care (including LMC) focussed on the STP”. The plan claims that the model has been endorsed “by a wide range of local clinical leaders”.
- The Somerset LMC is being consulted on which aspects of the plan to take forward. The LMC also supports the redesign of out of hospital services proposed in the plan.

**Finances:**

Financial gap by 2020/21
- Combined health and social care: £596 million

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</tr>
</tbody>
</table>

**Capital funding required: £78.5 million**
STP summary paper

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39

Bristol, North Somerset and South Gloucestershire
39. **Bristol, North Somerset and South Gloucestershire**

**Population:** 900,000

**Link to plan**[^60]

**Lead:** Robert Woolley, University Hospitals Bristol NHS FT

Contact your regional coordinator about your STP: [scusack@bma.org.uk](mailto:scusack@bma.org.uk)

**Priorities are:**
1. Standardise and operate at scale
2. Develop system wide pathways
3. Develop a new relationship with our population to simplify access to the health and care system
4. Develop a new relationship between organisations and staff
5. Build on existing digital work as a driver and enabler of cultural change

**Key points:**
- Want to enhance the teams in GP practices with new roles, such as practice-based pharmacists and physiotherapists, as well as health coaches, leaving GPs to handle the most complex cases.
- There are three core transformation portfolios: 1. Prevention, early intervention and self-care 2. Integrated primary and community care 3. Acute care collaboration.
- Established an integrated primary care portfolio which details how the General Practice Forward View is being tackled.
- Discussions around which organisational forms will be required in the future are still in progress.
- The phase one priority projects for acute care collaboration are effective care pathways (musculoskeletal/trauma and orthopaedic/stroke), pathology, Weston, medicines optimisation, corporate services consolidation, urgent care, specialised services. Timelines for all these are contained in the plan.
- Projected 30% reduction in admissions and attendances by STP year three for certain LTCs (Long Term Conditions), from care homes and at end of life.
- Delivering a best case 15% avoidance of primary and community health contacts.
- Assumed reduction in outpatient appointments by 15%.
- Assumed reduction in length-of-stay by 20%.
- The three CCG's (Clinical Commissioning Groups) involved have already taken steps to establish a Joint Commissioning Structure across Bristol, North Somerset and South Gloucestershire.

**Engagement:**
- Contact: [contactus.bccg@nhs.net](mailto:contactus.bccg@nhs.net)
- Events calendar [here](https://www.bristolccg.nhs.uk/events/) There were meetings of the Bristol CCG governing body on 28/03/17, and 25/04/17.

[^61]: [https://www.bristolccg.nhs.uk/events/](https://www.bristolccg.nhs.uk/events/)
Finances:
Financial gap by 2020/21
- ‘Do nothing’ deficit across the STP is £305.5 million
- 184.3 million from providers
- 121.2 million from commissioners

So far savings of £138.9 million have been identified.

Savings proposed include:
- Organisational savings (corporate overheads, pathology, productivity)
- Major, system wide transformational changes
- Receipt of sustainability funding

Capital funding required: £60 million
STP summary paper

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40. Bath, Swindon and Wiltshire

Population: 920,000

Link to plan

Lead: James Scott, Royal United Hospitals Bath NHS FT

Contact your regional coordinator about your STP: scusack@bma.org.uk

Priorities are:
1. Create locality based integrated teams supporting primary care
2. Shift the focus of care from treatment to prevention and proactive care
3. Develop an efficient infrastructure to support new care models
4. Establish a flexible and collaborative approach to workforce
5. Better collaboration between acute providers

Key points
- Six specialities have been identified by the Chief Executives, Chairs and Medical Directors of the three acute trusts for the first round of clinical review group workshops, based on sustainability concerns from one or more providers.
- NHS 111 call handlers will continue to give advice but with the ability to directly book GP appointments.
- Integrate primary and acute skill sets so that care can be delivered in the most appropriate setting.
- Integrated urgent and emergency care services will improve patient experience by enabling appropriate triage and signposting to services, not always involving attendance at A&E in line with the South West Urgent Emergency Care Network proposals. The aim is to establish one point of access for triage, with one call centre across the footprint, modified to fit local need and service provision.
- 30% of urgent care activity to be delivered through ambulatory care by March 2018, reducing emergency admissions and length of stay.
- Reduction in activity from ‘patients being cared for in the right location. This is expected to achieve the following by 2020/21:
  - 11% reduction in emergency admissions from care homes
  - Reduction in the number of deaths in hospital which is currently 37.8% (lowest in region)
- Workforce flexibility to build system resilience: requires ability to establish new roles related to domiciliary care, primary care at scale, volunteers, portfolio careers and rotational posts across all levels of health and care.
- Agency spend as % of total workforce spend varies from 1.9% to 6.4% across the three acute trusts; potential reduction in agency spend of 41.7% if all three trusts were at 1.9%.

Engagement:
- Contact: ruh-tr.STP-BSW@nhs.net
- Plans for future engagement will be published on the website, although as of 03/03/17, there was no information available.

Finances:
Financial gap by 2020/21
- Healthcare: £240 million
- Social care: £50 million
- Combined: £290 million

STF is £65 million over three years (2016/17 to 2018/19); will only be released if financial performance targets and some key service targets are delivered.

Service transformation expected to deliver £260 million worth of savings.

http://www.bathandnortheastsomersetccg.nhs.uk/get-involved/project/sustainability-and-transformation-plan
STP summary paper

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Dorset
41. Dorset

**Population:** 800,000

**Link to plan:**

**Lead:** Tim Goodson, Dorset CCG

Contact your regional coordinator about your STP: scusack@bma.org.uk

**Priorities are:**
1. Prevention at scale
2. Integrated community services
3. One acute network of services
4. These are supported by two enabling programmes:
   a. Leading and working differently
   b. Digitally-enabled Dorset

**Key points:**
- Likely candidate to become an ACS (Accountable Care System).
- The plan mentioned a reduction in the number of GP sites and the development of community hubs. The plan states that the RCGP Ambassador and local medical committee have indicated their support for the approach and continue to be involved in the consultation.
- Royal Bournemouth Hospital could become ‘major emergency hospital’. The accident and emergency unit at Poole Hospital would be replaced by an urgent care centre. Obstetric led maternity and inpatient paediatrics would also be removed from Poole, and provided for at Royal Bournemouth. Poole Hospital would become a “hospital for major planned care...away from the disruption that urgent and emergency care can create”. Dorset County Hospital would retain its A&E though some major emergencies would be transferred to Bournemouth. There will also be potential networking or downgrading of maternity and children’s services at Dorset County Hospital.
- Substantial changes to preventative and community based services. These include removing beds (1570) from several community hospitals, and the potential closure altogether of a small number of community hospital sites. The consultation says “community hubs” will be developed which will “provide a joint health and social care approach to caring for patients, particularly the elderly and frail” allowing outpatient appointments outside of acute hospitals with an extended multidisciplinary team with health and care staff working from a single location. This will help meet the 25% reduction in unplanned medical admissions and the 20% reduction in unplanned surgical admissions required for proposals for improving acute hospital care.
- The STP will develop a shared service contract for ‘back office’ functions of HR, finance, procurement and estates.

**Engagement:**
- Contact: feedback@dorsetccg.nhs.uk
- Formal consultation taken place on changes that make up major part of the STP. The consultation ran until 28th February. Consultation can be found here.

**Finances:**

*Financial gap by 2020/21*
- Healthcare: £299 million
- Social care: £70 million
- Combined: £299 million

**Capital funding required:** £148 million

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62 http://www.dorsetccg.nhs.uk/aboutus/sustainability.htm
64 https://www.csr.dorsetsvision.nhs.uk/2016/12/01/csr-public-consultation-launch/
STP summary paper

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42. Hampshire and the Isle of Wight

**Population:** 1.8 million

[Link to plan](http://www.westhampshireccg.nhs.uk/stp)

**Lead:** Richard Samuel, Fareham and Gosport CCG, South East Hampshire CCG

Contact your regional coordinator about your STP: htownsend@bma.org.uk

**Priorities are:**
1. To deliver a radical upgrade in prevention, early intervention and self-care
2. To accelerate the introduction of new models of care in each community
3. To address the issues that delay patients from being discharged from hospital
4. To ensure the provision of sustainable acute services
5. To improve the quality, capacity and access to mental health services

**Key points:**
- The plan says acute trusts were working as an “alliance” to reconfigure unsustainable services and to “consolidate clinical support services for the population in Southern Hampshire and the Isle of Wight”. The best option for a sustainable configuration of acute services in mid and North Hampshire was being determined.
- They have been told the pace of change is not sufficient.
- The plan includes taking forward work on [Hampshire Better Local Care vanguard](http://www.betterlocalcare.org.uk/).
- Place based system of care are bedrock of the plan – which involves integrated primary care hubs.
- Includes a number of local delivery systems:
  - North and Mid Hampshire
  - Portsmouth and South East Hampshire
  - Isle of Wight
  - Southampton
  - South West Hampshire
  - Frimley Health (noting that whilst the Frimley Health system operates as a self-contained STP, it continues to have a critical relationship with the Hampshire and Isle of Wight health and care system).

**Engagement:**
- whccg.info@nhs.net
- Calendar of CCG board meetings available [here](http://www.westhampshireccg.nhs.uk/board-meetings-and-papers).
- Further engagement is ostensibly planned for 2017. No timetable available for this however.
- Wessex LMC have seat on board.

**Finances:**

*Financial gap by 2020/21*
- Healthcare: £719 million
- Social care: £350 million
- Combined: £1.069 billion

The plan requests £194 million in capital funds but have been told it is highly unlikely they will get it. This is for redesigned facilities which facilitate increased mobile working, working closely with the digital and workforce enabling teams.

**Capital funding required:** £194.7 million

65 [http://www.westhampshireccg.nhs.uk/stp](http://www.westhampshireccg.nhs.uk/stp)
STP summary paper

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43. Gloucestershire

Population: 600,000

Lead: Mary Hutton, Gloucestershire CCG

Contact your regional coordinator about your STP: scusack@bma.org.uk

Priorities are:
1. Enabling active communities
   a. Radical self-care and prevention plan
2. One place, One Budget, One System
   a. Place based commissioning
   b. Reset urgent care and 30,000 community model
3. Clinical Programme Approach
   a. Reset pathways for dementia and respiratory
   b. Deliver the mental health 5YFV
4. Reducing clinical variation
   a. Choosing wisely medicines optimisation
   b. Diagnostics review
5. System enablers are:
   a. Primary care
   b. Joint IT strategy
   c. Joint estates strategy
   d. Workforce

Key points:
– Plan to have 16 health and social care communities based around clusters of existing GPs and the county’s market towns. These would have a minimum of 30,000 population. These are being piloted at the moment. There is likely to be a consultation on the urgent care system model in June 2017.
– Priority to redesign the urgent care system. In year one this will mean developing pilots for an urgent primary care service in key locations throughout the county, which will have GP services but also other highly trained staff.
– Developing place based commissioning approach for responsive and urgent care.
– New locality led ‘models of care’ pilots will be carried out during 2016/17 to test and learn from their implementation – the focus will be on redesigning responsive community based care. Design of the pilots will be devolved to locality levels.
– Year one will focus on delivery of new pathways for respiratory disorders and dementia
– Closing the gaps “may require redesign of services”.
– If ‘upper decile’ performance is achieved, there will be an approximate reduction of 3,900 emergency admissions, 3,900 elective admissions, 125,000 fewer outpatient appointments and 6,700 fewer A&E attendances by 2021.
– By 2021, the plan will have developed new ‘urgent care centres’ across localities to allow the majority of patients to access them within a maximum of 30 minutes driving; delivered easier and more convenient access to GP practice services including additional slots for urgent appointments; ensured urgent care offer is fully integrated; delivered a countywide bed model making best use of sites and resources.
– ‘Locality Urgent Care Hubs’ established in each area, meeting the particular needs of these local communities – these will provide a focus for urgent care within geographical localities and will include GP, community hospital and other community services working together.

http://www.gloucestershireccg.nhs.uk/gloucestershire-stp/
**Engagement:**
- Contact: GLCGC.enquiries@nhs.net
- There is a survey available on the website and details on public drop in sessions where you can find out more information.
- A number of meetings were scheduled for January; the details of further meetings will be published here.  

**Finances:**

*Financial gap by 2020/21*
- Healthcare: £190 million
- Social care: £36 million
- Combined: £226 million

*Opportunities to address 2020/21 residual gap:*
- Enabling active communities: £20 million
- Clinical Programme Approach: £20 million
- Reducing clinical variation: £20 million
- One Place, One Budget, One System: £9.5 million
- Joint IM&T Strategy: £5 million
- Local authority schemes: £36 million
- Other: £52 million (Carter Review, reconfiguration of acute services, and reducing variation in community and mental health providers)

**Capital funding required: £130.8 million**
STP summary paper

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44

Buckinghamshire, Oxfordshire and Berkshire West
44. Buckinghamshire, Oxfordshire and Berkshire West

Population: 1.7 million

Lead: David Smith, Oxfordshire CCG

Contact your regional coordinator about your STP: htownsend@bma.org.uk

Priorities are:
1. Improving the wellbeing of local people by helping them stay healthy, manage their own care and identify health problems earlier
2. Organising urgent and emergency care so that people are directed to the right services for treatment, such as the local pharmacy or hospital accident and emergency department for more serious and life threatening illnesses
3. Improving hospital services, for example making sure that maternity services can cope with the expected rise in births
4. Enhancing the range of specialised services, such as cancer, and supporting Oxford University Hospitals NHS Foundation Trust as a centre of excellence to provide expert services in the region
5. Developing mental health services, including low and medium secure services, more specialised services for children and teenagers, and improving care for military veterans and services for mums and babies
6. Integrating health and care services by bringing together health and social care staff in neighbourhoods to organise treatment and care for patients
7. Working with general practice to make sure it is central to delivering and developing new ways of providing services in local areas
8. Ensuring the amount of money spent on management and administration is kept to a minimum so that more money can be invested in health and care services for local communities
9. Developing our workforce, improving recruitment and increasing staff retention by developing new roles for proposed service models
10. Using new technology so patients and their carers can access their medical record online and are supported to take greater responsibility for their health

Key points:
– The draft STP says its workforce plans would mean that an otherwise projected workforce growth of 4,526 full-time equivalent staff would instead be an increase of just 978. It forecasts that over the period the area’s health service will experience a 15% increase in “patients”.
– The challenge to integrate three Local Healthcare Economies with established delivery models
  – Buckinghamshire
  – Berkshire
  – Oxfordshire
  – West Berkshire is a likely candidate to become an ACS (Accountable Care System).
– There are eight STP-wide workstreams.
– New commissioning executive to commission across the STP footprint taking over from seven CCGs.
– The plan makes reference to ‘reductions in acute bed based care across Oxfordshire’.

The plan makes reference to service changes at the Horton Hospital in Banbury (part of Oxford University Hospitals Foundation Trust). This will see patients having to travel to the John Radcliffe for some services.

There is to be a review of Bucks Healthcare Pathology Services.

General Practice Forward View identified as deliverable for the primary care programme with specific funding attached.

Engagement:
- Contact: SCWCSUoxfordhealthcaretransformation@nhs.net
- Lots of online engagement taking place here. There were a number of consultation events in March, there is a discussion forum online, and there is a consultation survey to be completed as well.
- Oxford City Council contest the reduction in services and call for more consultation.

Finances

Financial gap by 2020/21
- Health and social care combined: £479 million

The plan proposes to save £34 million through a “reduction in nursing grade input” and greater use of “generic support workers”.

This STP is also looking to cut back on prescribing with an ambition to save £15 million (7%) from the £213 million GP prescribing budget by 2020/21. The plan said this amounted to ‘business as usual’ CCG savings but GPs expressed concern that cuts at that level could not be made without denying patients access to vital drugs. The area has a population of two million, which means savings of £7 per patient.

The largest commissioning saving, of £45 million, is to come from acute care. £10 million will be invested in general practice via GP Forward View funding streams, including for extending access.

Capital funding required: £150 million

http://www.oxonhealthcaretransformation.nhs.uk/get-involved