Leeds Health & Wellbeing Board

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Report of: Matthew Ward (Chief Operating Officer, Leeds South and East CCG)

Report to: Leeds Health and Wellbeing Board

Date: 21 April 2016

Subject: Development of the Sustainability and Transformation Plan

Are there implications for equality and diversity and cohesion and integration?	☐ Yes	☒ No
Is the decision eligible for Call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Appendix number:	☐ Yes	☒ No

Summary of main issues

On 22 December 2015, NHS England (NHSE) published the 'Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21'[1] with pages 4–9 describing the initial requirements for each 'footprint' in partnership to produce a Sustainability and Transformation Plan (STP) as well as linking into appropriate regional footprint STPs (at a West Yorkshire level) by the end of June 2016.

The NHS Shared Planning Guidance asked every health and care system to come together to create their own ambitious local blueprint for accelerating implementation of the Five Year Forward View. Sustainability and Transformation Plans (STPs) will be place-based, multi-year plans built around the needs of local populations. They will help ensure that the investment secured in the Spending Review does not just prop up individual institutions for another year, but is used to drive a genuine and sustainable transformation in patient experience and health outcomes over the longer-term.

This paper provides an overview of the STP development in Leeds at a West Yorkshire level and highlights some of the areas that will be addressed in the final STP once it is developed through April – June 2016.

Recommendations

[1] https://www.england.nhs.uk/wp-content/uploads/2015/12/planning-guid-16-17-20-21.pdf

The Health and Wellbeing Board is asked to:

- Endorse the approach described within this paper for the development of the STP;
- Approve the key areas of focus identified in this report as the ones that the Leeds STP will focus on and will support the delivery of the Joint Health and Wellbeing Strategy;
- Ensure that staff and resources from the organisations represented by the Board are made available to support the development and implementation of the STP;
- Review and comment on the draft STP in June 2016 prior to its submission to NHSE on 30 June 2016.

1 Purpose of this report

1.1 The purpose of this report is to provide the Health and Wellbeing Board with an overview of:

- The national requirement to develop a STP;
- The key points from the Health and Wellbeing Board workshop which took place on 17 March 2016 to inform and shape the development of the STP;
- The relationship between the Leeds STP and the West Yorkshire STP.

1.2 Seek assurance from the Board that it supports the:

- Approach being undertaken and the progress being made to develop the Leeds Sustainability and Transformation Plan;
- Key areas which will be developed April – June 2016 as part of the Leeds STP;
- Delivery of the Joint Health and Wellbeing Strategy.

2 Background information

2.1 Leeds has an ambition to be the Best City in the UK by 2030. As part of this, we want to be the Best City for Health and Wellbeing and we think we have the ambition, organisation and people to succeed. The vision in our Joint Health and Wellbeing Strategy (JHWS) is that, “Leeds will be a healthy and caring city for all ages, where people who are the poorest will improve their health the fastest”.

2.2 Since the first JHWS for Leeds in 2013, we have seen many changes in Leeds, and the health and wellbeing of local people continues to improve, and the city has a robust and growing economy with good employment rates. The health and social care community in Leeds has been working collectively towards creating an integrated system of care that seeks to wrap care and support around the needs of the individual, their family and carers and helps to deliver on our wider vision.

2.3 Some notable achievements so far include:

- Leeds continues to have a strong and growing economy, and fared better than many of our neighbours during the recession;
- Outcomes for children and young people are good and improving;
- Potential Years of Life Lost (a measure of premature death) is decreasing;
- People’s level of satisfaction with the quality of services is increasing.

2.4 This is good news, but there is a lot more to do to achieve our ambition that Leeds will be the best city in the UK for health and wellbeing. We are currently finalising our second JHWS, which will be coming to the 21 April 2016 Health and Wellbeing Board for sign-off, and which explains how we will create the best conditions in Leeds for people to live healthy, happy and fulfilling lives. This means how we create a healthy city and provide high quality services with everyone in Leeds having a stake in creating a city that does the very best for its people.

2.5 We recognise that even though as a system we have made progress, it has not been enough and we are developing our infrastructure and workforce to be able to respond to the challenges ahead.

2.6 On 22 December 2016, NHS England (NHSE) published the 'Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21'[2] with pages 4–9 describing the initial requirements for each 'footprint' in partnership to produce a STP as well as linking into appropriate regional footprint STPs (at a West Yorkshire level) by the end of June 2016.

2.7 The NHS Shared Planning Guidance asked every health and care system to come together to create their own ambitious local blueprint for accelerating implementation of the Five Year Forward View. Sustainability and Transformation Plans will be place-based, multi-year plans built around the needs of local populations. They will help ensure that the investment secured in the Spending Review does not just prop up individual institutions for another year, but is used to drive a genuine and sustainable transformation in patient experience and health outcomes over the longer-term. See appendices for a summary of the key national STP requirements.

2.8 Key emphasis of the guidance was:

- Requirement for 'footprints' to develop a STP;
- Strong emphasis on system leadership;
- Need to have placed based planning;
- Must cover all areas of CCG and NHS England commissioned activity;
- Must cover better integration with local authority services, including, but not limited to, prevention and social care, reflecting local agreed health and wellbeing strategies;
- Need to have an open, engaging and iterative process clinicians, patients, carers, citizens, and local community partners including the independent and voluntary sectors, and local government through health and wellbeing boards;
- STPs will become the single application and approval process for being accepted onto programmes with transformational funding for 2017/18 onwards.

2.9 The national guidance is largely structured around asking areas to identify what action will take place to address the following three questions:

- *How will you close the health and wellbeing gap?*

[2] https://www.england.nhs.uk/wp-content/uploads/2015/12/planning-guid-16-17-20-21.pdf

- *How will you drive transformation to close the care and quality gap?*
- *How will you close the finance and efficiency gap?*

3 Main issues

3.1 Footprint

3.1.1 NHS England (NHSE) has developed the concept of a 'footprint' which is a geographic area that the STP will cover and have identified 44 'footprints' nationally. It has been prescribed by NHSE that Leeds is within a West Yorkshire footprint which also includes Bradford, Kirklees, Calderdale, Wakefield and Harrogate.

3.1.2 Leeds, as have other areas within West Yorkshire, made representation regionally and nationally that each area within West Yorkshire should be recognised as its own footprint.

3.1.3 The emerging STP for Leeds and West Yorkshire will be multi-tiered. The primary focus for Leeds is a plan covering the Leeds city footprint and will focus on citywide change and delivery. It will sit under the refreshed Joint Health and Wellbeing Strategy and will encompass all key organisations in the city. When developing the Leeds STP, consideration will be given to appropriate links/impacts at a West Yorkshire level.

3.1.4 Current areas being considered at a West Yorkshire STP level include: Urgent & Emergency Care, Cancer, Mental Health and Specialised Services.

3.1.5 Leaders across West Yorkshire are working on the principle that as much as can be delivered locally should be, but that when developing each local STP, consideration must be given to how these link to, and what the impacts are a West Yorkshire level.

3.1.6 Rob Webster (currently Chief Executive, NHS Confederation and shortly taking up the position of Chief Executive designate of South West Yorkshire Partnership NHS Foundation Trust), has been appointed by NHSE as the lead for the West Yorkshire STP. He will be taking up this role from mid-May 2016.

3.1.7 The Programme Management Office support to the development of the West Yorkshire STP is being managed by Healthy Futures (formerly 10CC).

3.1.8 A series of workshops have been arranged focusing on the different priority areas for West Yorkshire with representatives from across the CCGs, NHS providers and local authorities in attendance.

3.1.9 It is important to recognise that at the time of writing this paper the West Yorkshire STP is still in its infancy and the links between this and the six local STPs are still being developed and worked through.

3.2 Approach taken in Leeds

3.2.1 The development of our second JHWS, the refreshed Joint Strategic Needs Assessment (JSNA) and the discussions at the Health and Wellbeing Board STP workshop have been used to help identify the challenges and gaps that Leeds needs to address and the priorities within our Leeds STP.

3.2.2 Any plans described within the STP will ensure that they directly link back to the refreshed JHWS.

3.2.3 A joint virtual team with representatives from the statutory partners are undertaking the analysis and overseeing the project management and the development of the STP. This team is being led by the Chief Operations Officer, Leeds South and East CCG and under the strategic leadership of the Health and Wellbeing Board.

3.2.4 The Health and Wellbeing Board through its workshop provided direction on the areas the Leeds STP needed to focus on as described below.

3.3 Health and Wellbeing Board STP Workshop 17 March 2016

3.3.1 The workshop reiterated the Health and Wellbeing Board's commitment to the Leeds footprint.

3.3.2 The Board also had a strong emphasis on taking our asset-based approach to the next level. This is enshrined in a set of values and principles and a way of thinking about our city, which identifies and makes visible the health and care-enhancing assets in a community. It sees citizens and communities as the co-producers of health and well-being rather than the passive recipients of services. It promotes community networks, relationships and friendships that can provide caring, mutual help and empowerment. It values what works well in an area and identifies what has the potential to improve health and well-being. We support individuals' health and well-being through self-esteem, coping strategies, resilience skills, relationships, friendships, knowledge and personal resources. Empowers communities to control their futures and create tangible resources such as services, funds and buildings. We are using these principles to refocus many council and health service programmes of change.

3.3.3 The members of the Board also placed the challenge that as a system we needed to think and act differently in order to meet the challenges and ensure that "Leeds will be a healthy and caring city for all ages, where people who are the poorest will improve their health the fastest".

3.3.4 The Board considered gaps around: health and wellbeing; care and quality; and finance and efficiency and what could be undertaken to address the gaps, summarised below.

3.3.5 *Health and wellbeing gap*

It was recognised that, despite best efforts, health improvement is not progressing fast enough and health inequalities are not currently narrowing. Life expectancy for men and women remains significantly worse in Leeds. The gap between Leeds

and England has narrowed for men, whilst the gap between Leeds and England has worsened for women. Cardiovascular disease mortality is significantly worse than for England. However, the gap has narrowed. Cancer mortality is significantly worse than the rest of Yorkshire and the Humber (YH) and England with no narrowing of the gap. There is a statistically significant difference for women whose mortality rates are higher in Leeds than the YH average. The all-ages-all-cancers trend for 1995-2013 is improving but appears to be falling more slowly than both the YH rate and the England rate, which is of concern.

Avoidable Potential Years of Life Lost (PYLL) from Cancer for those under 75 years of age is a new measure which takes into account the age of death as well as the cause of death. Deaths from cancer are the single largest cause of avoidable PYLL in the city, accounting for 36.3% of all avoidable PYLL. PYLL from cancer is twice the level in the deprived Leeds quintile than in Leeds non-deprived. Infant mortality has significantly reduced from being higher than the England rate to below it. Suicides have increased, after a decline, and are now above the England rate. Within Leeds, for the big killers there has been a significant narrowing in the gap for deprived communities for cardiovascular disease, a narrowing of the gap for respiratory disease but no change for cancer mortality. There are 2,200 deaths per year <75 years. Of these 1,520 are avoidable (preventable and amendable) and, of these, 1,100 are in non-deprived parts of Leeds and 420 in deprived parts of Leeds.

The following opportunities were discussed as some of the areas where action to address the gap may be identified:

- Scaling up – Scaling up of targeted prevention to those at high risk of Cardio-vascular disease, diabetes, smoking related respiratory disease and falls. In addition scaling up of children and young people Best Start and childhood obesity / healthy weight programmes already in existence.
- Look at options to move to a community based approach to health beyond personal/self-care. Scale up the Leeds Integrated Health Living System; aligning partner Commissioning and provision, inspire communities and partners to work differently – including physical activity/active travel, digital, business sector, developing capacity and capability.
- Increased focus on prevention - for short term and longer term benefits.

3.3.6 *Care and quality gap*

The following were identified as gaps:

There are a number of aspects to the Care and Quality gap. In terms of our NHS Constitutional Key Performance Indicators (KPIs) the areas where significant gaps have been identified are Mental Health (including Improving Access to Psychological Therapies), Patient Satisfaction, Quality of Life, Urgent Care Standards, Ambulance Response Times and Delayed Transfers of Care (DTOC*).*

The importance of ensuring that the data sets used when informing the STP accurately reflects the Leeds context was highlighted. Whilst performance on the Urgent Care Standard is below the required level, performance in Leeds is better than most parts of the country. There is a need to ensure that a greater level of

regional data is used to reflect the places where Leeds residents receive care. While Harrogate was referenced, there is a need to include data from Wakefield, Bradford, etc.

General Practice - There are 4 significant challenges facing General Practice across the city. The need to align and integrate working practices with our 13 Neighbourhood Teams, the need to provide patients with greater access to their services; this applies to both extended hours during the "working week", and also at weekends, the severe difficulties they are experiencing in recruiting and retaining GPs and practice nurses and the significant quality differential between the best and worst primary care estate across the city.

There is a need to ensure that there is a wider context of Primary Care, outside of general practices that must be considered. Furthermore, that access relates to waiting times in addition to estates.

Out of area treatments and gaps around mental health need to be included.

The following opportunities were discussed as some of the areas where action to address the gap may be identified:

- Self-management.
- Development of a workforce strategy for the city which considers: increasing the 'transferability' of staff between the partner organisations; widespread up-skilling of staff to embed an asset based approach to the relationship between professionals and service users; attracting, recruiting and retaining staff to address key shortages (nurses and GPs); improved integration and multi-skilling of the unregistered workforce and opportunities around apprenticeships; workforce planning and expanding the content and use of the our citywide Health and Care workforce database.
- Partnerships with university and business sector.
- Maternity services - Key areas requiring development include the increased personalisation of the maternity offer, better continuity of care, increased integration of maternity care with other services within communities, and the further development of choice.
- Children's services - In a similar way, for children's services the key area requiring development is that of emotional and mental health support to children and younger people. Key components being the creation of a single point of access; a community based eating disorder service; and primary prevention in children's centres and schools both through the curriculum and anti-stigma campaigns.

3.3.3 *Finance and efficiency gap*

The following were identified as gaps:

The projected deficit that would emerge in the 4 statutory delivery organisations if no action was taken is approximately £706m. This is driven by inflation, volume demand, lost funding and other local cost pressures.

The following opportunities were discussed as some of the areas where action to address the gap may be identified:

Citywide savings will need to be delivered through more effective collaboration on infrastructure and support services. To explore opportunities to turn the 'demand curve' on clinical and care pathways through: investment in prevention activities; focusing on the activities that provide the biggest return and in the parts of the city that will have the greatest impact; maximising the use of community assets; removing duplication and waste in cross-organisation pathways; ensuring that the skill-mix of staff appropriately and efficiently matches need across the whole health and care workforce e.g. nursing across secondary care and social care as well as primary care; and by identifying which services offer least value to the Leeds £ and citizens and do less of these.

3.4 Emerging Leeds STP – supporting the Leeds Health and Wellbeing Strategy

The STP will have specific themes which will look at what action the health and care system needs to take to help fulfil the priorities identified within the JHWS. These emerging themes include:

3.4.1 **Social contract with citizens** – which supports the ethos of the refreshed JHWS and sees citizens and communities as the co-producers of health and wellbeing rather than the passive recipients of services. Supports individuals' health and well-being through self-esteem, coping strategies, resilience skills, relationships, friendships, knowledge and personal resources. This will also support JHWS Priority 3 – 'Strong, engaged and well connected communities' and Priority 9 'Support self-care, with more people managing their own conditions' - using and building on the assets in communities. We must focus on supporting people to maintain independence and wellbeing within local communities for as long as possible. People need to be more involved in decision making and their own care planning by setting goals, monitoring symptoms and solving problems. To do this, care must be person-centred, coordinated around all of an individual's needs through networks of care rather than single organisations treating single conditions.

3.4.2 **Prevention, Proactive Care and Rapid Response to in time of crisis** – which directly relates to the Priority 8 - 'A stronger focus on prevention' - the role that people play in delivering the necessary focus on prevention and what action the system needs to take to improve prevention, and JHWS Priority 12 'The best care, in the right place, at the right time'. Services closer to home will be provided by integrated multidisciplinary teams working proactively to reduce unplanned care and avoidable hospital admissions. They will improve coordination for getting people back home after a hospital stay. These teams will be rooted in neighbourhoods and communities, with co-ordination between primary, community, mental health and social care. They will need to ensure care is high quality, accessible, timely and person-centred. Providing care in the most appropriate setting will ensure our health and social care system can cope with surges in demand with effective urgent and emergency care provision.

3.4.3 **Efficient and Effective Secondary Care –** which also contributes to JHWS Priority 12 'The best care, in the right place, at the right time'. This is ensuring that we have streamlined processes and only admitting those people who need to be admitted. As described above this needs population–based, integrated models of care, sensitive to the needs of local communities. This must be supported by better integration between physical and mental health and care provided in and out of hospital. Where a citizen has to use secondary care we will be putting ourselves in the shoes of the citizen and asking if the STP answers, 'Can I get effective testing and treatment as efficiently as possible?

3.4.4 **Innovation, Education, Research -** which relates to JHWS Priority 7 – 'Maximise the benefits from information and technology' – how technology can give people more control of their health and care and enable more coordinated working between organisations. We want to make better use of technological innovations in patient care, particularly for long term conditions management. This will support people to more effectively manage their own conditions in ways which suit them. JHWS Priority 11 – 'A valued, well-trained and supported workforce', and priority 5 – 'A strong economy with quality local jobs' – through things such as the development of a Leeds Academic Health Partnership and better workforce planning ensuring the workforce is the right size and has the right knowledge and skills needed to meet the future demographic challenges.

3.4.5 Mental health and physical health will be considered in all aspects of the STP within the Leeds STP but also there will be specific focus on Mental Health within the West Yorkshire STP, directly relating to JHWS Priority 10 – 'Promote mental and physical health equally'.

3.4.6 When developing the STP, we will keep the citizen at the forefront and asking the following questions identified in the JHWS:

- Can I get the right care quickly at times of crisis or emergency?
- Can I live well in my community because the people and places close by enable me to?
- Can I get effective testing and treatment as efficiently as possible?

4 Health and Wellbeing Board Governance

4.1 Consultation and Engagement

4.1.1 The purpose of this report is to share information about the progress of development of the STP. A primary guiding source for the Leeds STP has been the refreshed JHWS which was been widely engaged on through its development.

4.1.2 The final draft of the STP will be presented to the Health and Wellbeing Board prior to submission to NHSE on 30 June 2016.

4.1.3 As part of the final STP, there will a clear roadmap for delivery of the STP which will identify when and on what topics of engagement and consultation and coproduction with staff and citizens of solutions and changes will take place over the next 5 years.

4.1.4 Any change programmes of work undertaken as a result of delivery of the STP will need to ensure that they undertake appropriate consultation and engagement as part of their work in accordance to organisational obligations.

4.2 Equality and Diversity / Cohesion and Integration

4.2.1 Any future changes in service provision arising from this work will be subject to equality impact assessment.

4.3 Resources and value for money

4.3.1 The final Leeds STP will have to describe the financial and sustainability gap in Leeds, the plan Leeds will be undertaking to address this and demonstrate that with our changes will ensure that we are operating within our likely resources. In order to make these changes, we will require national changes/support in terms of local flexibility around setting of targets, financial flows and non-recurrent investment whilst we make the changes.

4.3.2 As part of the development of the West Yorkshire STP, the financial and sustainability impact of any changes at a West Yorkshire level and the impact on Leeds will need to be carefully considered.

4.4 Legal Implications, Access to Information and Call In

4.4.1 There are no access to information and call-in implications arising from this report.

4.5 Risk Management

4.5.1 Failure to have robust plans in place to address the gaps identified as part of the STP development will impact the sustainability of the health and care in the city.

4.5.2 Two key overarching risks present themselves, given the scale and proximity of the challenge and the size and complexity of Leeds:

- Potential unintended and negative consequences of any proposals as a result of the complex nature of the health and social care system and its interdependencies. Each of the partners have their own internal pressures and governance processes they need to follow.
- Ability to release expenditure from existing commitments without de-stabilising the system in the short-term will be extremely challenging as well as the risk that any proposals to address the gaps do not deliver the sustainability required over the longer-term.

4.5.3 The effective management of these risks can only be achieved through the full commitment of all system leaders within the city to focus their full energies on the developing a robust STP and delivery of the STP within an effective governance framework.

5 Conclusions

5.1 Our STP will be built on taking our asset-based approach to the next level to help deliver the health and care aspects of the JHWS. This is enshrined in a set of values and principles and a way of thinking about our city, which:

- Identifies and makes visible the health and care-enhancing assets in a community;
- Sees citizens and communities as the co-producers of health and well-being rather than the passive recipients of services;
- Promotes community networks, relationships and friendships that can provide caring, mutual help and empowerment;
- Values what works well in an area;
- Identifies what has the potential to improve health and well-being the fastest;
- Supports individuals' health and well-being through self-esteem, coping strategies, resilience skills, relationships, friendships, knowledge and personal resources;
- Empowers communities to control their futures and create tangible resources such as services, funds and buildings;
- Values and empowers the workforce and involves them in the coproduction of any changes.

5.2 The final STP will describe the detail of how we will deliver health and care elements of the refreshed JHWS.

6 Recommendations

6.1 The Health and Wellbeing Board is asked to:

- Endorse the approach described within this paper for the development of the STP;
- Approve the key areas of focus identified in this report as the ones that the Leeds STP will focus on and will support the delivery of the Joint Health and Wellbeing Strategy;
- Ensure that staff and resources from the organisations represented by the Board are made available to support the development and implementation of the STP;
- Review and comment on the draft STP in June prior to its submission to NHSE on 30 June 2016.

Appendix 1 – Summary of key national requirements for developing the STP
Planning guidance published 22nd December 2015

In summary the guidance stated:

- STPs to be reviewed nationally in July 2016

- Requirement to accelerate work on prevention and care redesign

- Maintaining standards in emergency care

- Placed-based planning requiring:
    a. System leadership - producing a STP is not just about writing a document, nor is it a job that can be outsourced or delegated.
    b. Local leaders coming together as a team; to develop a shared vision with the local community, which also involves local government as appropriate;
    c. Programming a coherent set of activities to make it happen;
    d. Execution against plan and learning and adapting.

- STPs must cover all areas of CCG and NHS England commissioned activity including:
    a. Specialised services, where the planning will be led from the 10 collaborative commissioning hubs;
    b. Primary medical care, and do so from a local CCG perspective, irrespective of delegation arrangements.
    c. The STP must also cover better integration with local authority services, including, but not limited to, prevention and social care, reflecting local agreed health and wellbeing strategies.

- Access to future transformation funding
    - STPs will become the single application and approval process for being accepted onto programmes with transformational funding for 2017/18 onwards.
    - Funding is available for initiatives such as the spread of new care models through and beyond the vanguards, primary care access and infrastructure, technology roll-out, and to drive clinical priorities such as diabetes prevention, learning disability, cancer and mental health.
    - Most compelling and credible STPs will secure the earliest additional funding from April 2017 onwards and will consider:
        a. Quality of plans, particularly the scale of ambition and track record of progress already made;
        b. A clear and powerful vision;
        c. Create coherence across different elements, for example a prevention plan; self-care and patient empowerment; workforce; digital; new care models; and finance.
        d. Will systematically borrow good practice from other geographies, and adopt national frameworks;
        e. Reach and quality of the local process, including community, voluntary sector and local authority engagement;
        f. Strength and unity of local system leadership and partnerships, with clear governance structures to deliver them;

g. Clear sequence of implementation actions.

- Transformation footprints
  - STP will be the umbrella plan, holding underneath it a number of different specific delivery plans, some of which may be on different geographical footprints. For example, planning for urgent and emergency care, specialist commissioned services etc.

- National 'must dos'
  - By March 2017, 25 percent of the population will have access to acute hospital services that comply with four priority clinical standards on every day of the week, and 20 percent of the population will have enhanced access to primary care.
  - Expect the development of new care models will feature prominently within STPs.
  - There are three distinct challenges under the banner of seven day services:
    a. Reducing excess deaths by increasing the level of consultant cover and diagnostic services available in hospitals at weekends. During 16/17, a quarter of the country must be offering four of the ten standards, rising to half of the country by 2018 and complete coverage by 2020;
    b. Improving access to out of hours care by achieving better integration and redesign of 111, minor injuries units, urgent care centres and GP out of hours services to enhance the patient offer and flows into hospital;
    c. Improving access to primary care at weekends and evenings where patients need it by increasing the capacity and resilience of primary care over the next few years.
  - The guidance has listed nine 'must dos' for 2016/17 for every local system:
    1. Develop a high quality and agreed STP, and subsequently achieve what we determine are our most locally critical milestones for accelerating progress in 2016/17 towards achieving the triple aim as set out in the Forward View.
    2. Return the system to aggregate financial balance. This includes secondary care providers delivering efficiency savings through actively engaging with the Lord Carter provider productivity work programme and complying with the maximum total agency spend and hourly rates set out by NHS Improvement. CCGs will additionally be expected to deliver savings by tackling unwarranted variation in demand through implementing the RightCare programme in every locality.
    3. Develop and implement a local plan to address the sustainability and quality of general practice, including workforce and workload issues.
    4. Get back on track with access standards for A&E and ambulance waits, ensuring more than 95 percent of patients wait no more than four hours in A&E, and that all ambulance trusts respond to 75 percent of Category A calls within eight minutes; including through making progress in implementing the urgent and emergency care review and associated ambulance standard pilots.

5. Improvement against and maintenance of the NHS Constitution standards that more than 92 percent of patients on non-emergency pathways wait no more than 18 weeks from referral to treatment, including offering patient choice.
6. Deliver the NHS Constitution 62 day cancer waiting standard, including by securing adequate diagnostic capacity; continue to deliver the constitutional two week and 31 day cancer standards and make progress in improving one-year survival rates by delivering a year-on-year improvement in the proportion of cancers diagnosed at stage one and stage two; and reducing the proportion of cancers diagnosed following an emergency admission.
7. Achieve and maintain the two new mental health access standards: more than 50 percent of people experiencing a first episode of psychosis will commence treatment with a NICE approved care package within two weeks of referral; 75 percent of people with common mental health conditions referred to the Improved Access to Psychological Therapies (IAPT) programme will be treated within six weeks of referral, with 95 percent treated within 18 weeks. Continue to meet a dementia diagnosis rate of at least two-thirds of the estimated number of people with dementia.
8. Deliver actions set out in local plans to transform care for people with learning disabilities, including implementing enhanced community provision, reducing inpatient capacity, and rolling out care and treatment reviews in line with published policy.
9. Develop and implement an affordable plan to make improvements in quality particularly for organisations in special measures. In addition, providers are required to participate in the annual publication of avoidable mortality rates by individual trusts.

Further guidance published February 16th

On February 16th, NHSE sent a letter to Accountable Officers / CEOs of CCGs, NHS Trusts and Local with further STP guidance.

Key points from this letter:

- Reiterating the emphasis of good governance and leadership.
- Reiterating the emphasis on engagement.
- Need to understand the scale of the challenge for each footprint around 3 gaps and the priorities to address each gap:
    1. Closing the health and wellbeing gap
    2. Drive transformation to close the care and quality gap
    3. Closing the finance and efficiency gap)

Updated set of national deadlines:

- 15th April - Short return, including priorities, gap analysis and governance arrangements
- w/c 22nd April - Outline STPs presented at regional events to discuss emerging plans with peers and national bodies
- 30th June – Each footprint to submit their STP
- July – NHS England assurance of STPs