Mid and South Essex Success Regime
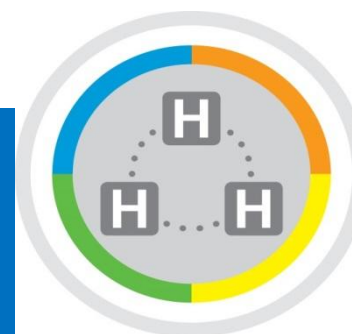
A programme to sustain services and improve care

STP Update

October 2016

STP Update: about these materials

This narrative, and the supporting annexes, are intended to provide a <u>selected update</u> to the June submission of the Mid and South Essex STP – and should be read in conjunction with that document.

The focus for this update will be on four specific areas:

(1) **Local Health and Care: addressing the specific feedback from the June 2016 submission**
   - Describing our primary and community care strategy (i.e. our "Local Health and Care Model"), setting out how we will accelerate delivery of the GP 5YFV and system response to social care

(2) **In Hospital: providing an update on acute reconfiguration options, clinical and corporate support**

(3) **Financial Impact: providing an updated position on the financial bridge**

(4) **Delivery: addressing the specific feedback from the June 2016 submission**
   - Describing approach to accelerate timetable in order to progress consultation plans

Whilst not the focus of this document, some selected further information is included in backup
   - Manage demand for healthcare – Urgent and Emergency Care
   - Optimise mental health: integrated, joined up services across sectors

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<u>Please note:</u> This STP sets out proposed changes to health and care that, as well as ensuring there are sustainable services, return the overall system to financial balance by 2020/21. These system solutions are currently being translated to the organisational level as part of the 2017/19 operational plans. The document identifies a range of financial risks, including: any slippage against 2016/17 plans; QIPP and CIP plans in the outer years are not yet fully developed; and a number of the system solutions set out here require public consultation so are subject to change. Provider control totals have yet to be considered and agreed by Boards due to the differing timelines for Boards to respond to NHSI. The CCG's are in discussion with NHS England with respect to the debt repayment profile covering the planning period with a view to agreeing a repayment plan that supports the economy in delivering year on year control totals. A detailed update on our financial plans will be presented in our Pre Consultation Business Case later in 2016.
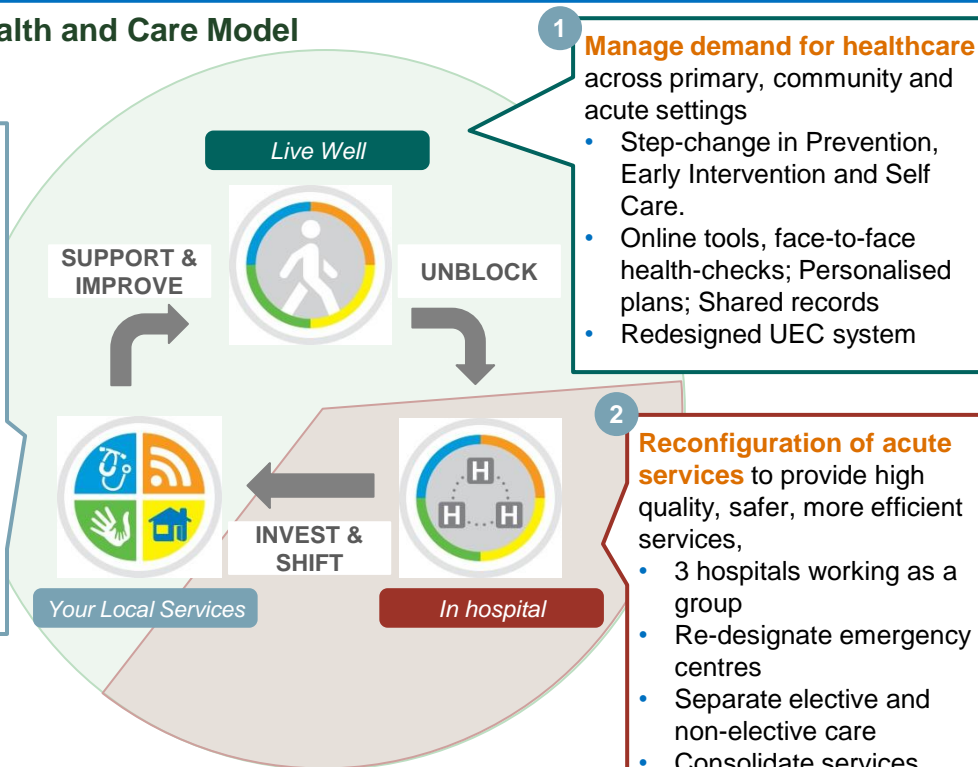
Contents

Where we are now: the plan on a page

Introduction and context	• Mid and South Essex covers ~1.2 million people; including 5x CCGs, 3x Acute Trusts, 3x local authorities, MH and community providers • Clear case for change: quality issues (access targets e.g., A&E waiting times consistently not met); workforce pressures (e.g., 2.5k vacancies across patch, 13% of NHS workforce) and financial challenges ('do nothing' deficit of £406M by 2020/21, not including CIPs and QIPPs) • Patch have been working together as a Success Regime since June 2015. • Focus is on developing new models of care for 'in hospital' and 'local health and care' in order to meet our core STP priorities • Patch developing a pre-consultation business case – with a view to going to full public consultation in early 2017

Mid and South Essex model of care and key priorities

Local Health and Care Model

3 Build capacity outside the hospital to support more complex care needs
- Release GP capacity
- Organise care around natural communities ("localities")
- Integrate with social care
- Optimise Mental Health

Live Well

SUPPORT & IMPROVE

UNBLOCK

INVEST & SHIFT

Your Local Services

In hospital

1 Manage demand for healthcare across primary, community and acute settings
- Step-change in Prevention, Early Intervention and Self Care.
- Online tools, face-to-face health-checks; Personalised plans; Shared records
- Redesigned UEC system

2 Reconfiguration of acute services to provide high quality, safer, more efficient services,
- 3 hospitals working as a group
- Re-designate emergency centres
- Separate elective and non-elective care
- Consolidate services

In Hospital Model

Developments since July submission

Model development and planning
- Refinement of local health and care model – with enhanced focus on releasing GP capacity
- Commenced detailed locality level planning via five 'Deep Dives'
- Development of Acute Reconfiguration options

Governance
- Identification of Senior Responsible Owners
- Establishment of Programme Board
- Acute group model – agreement to form a single executive team
- CCGs developing joint decision making arrangement

Engagement and consultation
- Public engagement ramped up – delivering 13 public workshops in September / October 2016

Financial summary (2020/21)	**Do nothing deficit: -£407m** CIPs and QIPPS savings: £309m Local health and care & SR savings: £53m In hospital savings: £28m Total STF funding allocation: £78m New investments: -£53m **Gap 20/21:~£0**

Note: Mental health (formerly key priority four) has been integrated into priority one to reflect its importance in supporting the transformation of care in the community

Key facts: the impact and benefits of delivering our vision

IMPACT FOR PATIENTS

Better access
- Greater range of services delivered locally e.g., outpatients
- Wider range of professionals providing advice and care
- More effective use of technology to help patients monitor their own health

Better care
- Consistent high-quality care across MSE including mental health
- Right care first time
- Longer consultations for those who need it
- Fewer cancelled elective operations
- Tailored advice and support from health coaches

ACTIVITY IMPACT (by 2020/21)

Acute hospitals[1]
~484k fewer attendances
- ~424k fewer outpatients (-16%)
- ~13k fewer EL admissions (-6%)
- ~36k fewer A&E attendances (-13%)
- ~11k fewer NEL admissions (-10%)

~24k fewer ambulance dispatches (-13%)

Local health and care
A quarter of GP appointments released by shifting to alternative channels[2]
- ~10% to other clinicians
- ~8% to social prescribing, self-care, other[3]
- ~5% to virtualisation

Further GP workload reduction through
- Less bureaucracy
- Increased collaboration

WORKFORCE IMPACT (by 2020/21)

Acute hospitals
Single management across sites
- Compliant clinical rotas
- Common training and appraisal
- Use of technology and telemedicine

New role development
- E.g., increased use of therapists to facilitate patient discharge

Local health and care
Require ~190 additional GPs under traditional work force model[4]

However, planning new roles and up-skilling in line with GP5YFV
- ~100 additional FTEs to support primary care capacity
- ~80 FTEs for targeted new services and to support change management

FINANCIAL IMPACT (by 2020/21)

Efficiency savings of £308.9m from CIPs and QIPPs
- £108.6m from commissioner QIPPs and non-acute common offer
- £129.3m from trust CIPs
- £70.9m from other org. CIP/QIPPs (including specialised comm. from CCGs)

System savings of £53m from LHC-SR initiatives
- £23.7m from specialty pathway redesign
- £7.5m from complex care
- £7.5m from common offer in-hospital
- £9.6m from system-wide transformations
- £5.0m from urgent care

System savings of £27.6m from IH-SR initiatives
- £17.1m from acute reconfiguration
- £10.5m in savings from clinical support and back office consolidation

Notes: 1. All changes based on 'do nothing' scenarios, all by 2020/21, 2. Audit of ~1400 consultations in Brentwood, Southend and Dengie 3. Includes self-care, social prescribing and acute hospital demand 4. 72 GP appts per 1000 patients = 86k appts for patch; 115 appts per GP, implies deficit of ~190 GPs from current FTE count of ~560 (Safe working in general practice, BMA 2016)
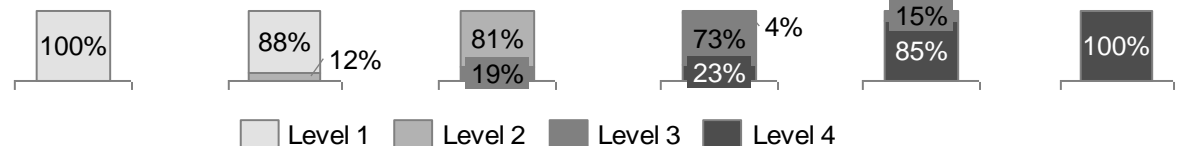
Key facts: STP performance targets

Metric		2016/17 YTD	2016/17 Target	2017/18 Target	2018/19 Target	2019/20 Target	2020/21 Target
A&E performance (4 hour wait times)	BTUHFT	82.6%	95%	95%	95%	95%	95%
	MEHT	78.6%	90%	95%	95%	95%	95%
	SUHFT	87.0%	95%	95%	95%	95%	95%
RTT performance[1]	BTUHFT	89.2%	92%	92%	92%	92%	92%
	MEHT	92.2%	92%	92%	92%	92%	92%
	SUHFT	90.0%	92%	92%	92%	92%	92%
Hospital total bed days / 1000 people	Combined	296.4	299.6	293.6	275.3	275.7	277.7
Emergency hospital admissions / 1000 population	Combined	91.3	92	91.8	87.4	88.0	89.5
Progress vs Cancer Taskforce Implementation Plan[2] (62 Day cancer standard)	BTUHFT	65.4%	85%	85%	85%	85%	85%
	MEHT	86.6%	85%	85%	85%	85%	85%
	SUHFT	83.0%	85%	85%	85%	85%	85%
	Combined	80.1%	85%	85%	85%	85%	85%
Progress vs MH 5YFV[3] Implementation Plan		We are developing an STP MH oversight group that will monitor progress against the following mental health areas: children and young people; perinatal; adult (common and community); acute; health and justice and suicide prevention					

Progress vs. GP5YFV[4] (Localities at each level of primary care working)

2016/17 YTD	2016/17 Target	2017/18 Target	2018/19 Target	2019/20 Target	2020/21 Target
100%	88% / 12%	81% / 19%	73% / 23% / 4%	15% / 85%	100%

☐ Level 1   ☐ Level 2   ☐ Level 3   ■ Level 4

1. We will eliminate 52 week waits within 16/17 and that the existing 18 week backlog stands at 7045 across the STP. We are developing plans with the trusts to address this backlog within the STP
2. YTD figures for July, performance is monitored via a pan-STP oversight group 3. As per the document 'Implementing the Mental Health Forward View Gateway Reference 05572". 4. Please see pg. 10 for a full description of the levels of primary care working

①

The future model of Local Health and Care aims to deliver two principal objectives

② Contributes to Local health and care savings - see Financial Bridge pg 21

The challenge

Primary care is under pressure: rising workload...

- 81% of GPs report rise in complexity[1]; move to 7 day working; need for same day appointments to relieve urgent care pathway (2 out of 5 CCGs have chronic ACSC[2] emergency admissions above the national average)

...with significant workforce challenges

- Amongst worst in country for staff due to retire in next 5-10 years e.g., 20% of practices have all of their GPs aged over 54 years[3]

Urgent and emergency care pathway also under strain

- Rising demand for A&E (above national average growth at c. 4% for past two years) and ambulance services (18% increase y-on-y[4])
- Complex system with little coordination or PC capacity for emergency appointments

GP and 5YFV[5] encourage move towards a larger footprint with greater integration between practices...

- Fragmented care: ~180 GP practices operating across M&SE

...and to provide a wider, more integrated array of services

- Changed GP role: concentrate on the highest risk and oversee multidisciplinary team to reduce avoidable hospitalisations

...supported by additional £48m funding over 5 years in line with £2.4b national investment to take forward GP5YFV programmes

Two objectives to address the challenge

① **Manage demand**

Manage demand for healthcare across primary, community and acute settings, by:

- Delivering a step change in **Prevention, Early Intervention and Self Care**
- **Developing integrated pathways** for Frail and End of Life patients that put individuals and their families at the centre
- Strengthening capacity in the **UEC pathway** to be able to 'hear and treat', 'see and treat'
- Integrating with **social care**, joined services
- Optimising **mental health,** new pathways

③ **Build capacity**

Focus of this update

Build capacity outside the hospital to support more complex care needs, by:

- **Releasing General Practitioner capacity** through the use of other health and care professionals and technology
- **Organising care around natural communities** ("localities") – delivering more services at a local level
- **Delivering care using a population segmented management approach**

1. Five Year Forward View (2015) and GP Forward View (2016) 2. Ambulatory care sensitive conditions 3. HEE, STP workforce intelligence (2016) 4. Increase in red demand over the same period last year 5. Five year forward view

Vision for the locality approach: "Joined up health and social care planned, delivered and coordinated around patient needs"

② Contributes to Local health and Care savings - see Financial Bridge pg 21

Core elements of the locality vision

1	**General practice will form the heart of the locality**	• General practice will act as a key hub, providing a new offer for patients to access the care and support they need • To enable this, resources will be invested to grow capacity in the community • Ultimately, services will shift from hospital into the community, reducing demand on the acute sector
2	**Care planning and delivery will be joined up**	• GPs will work with a range of professionals to ensure joined up care planning and delivery, including: social workers, district nurses, occupational therapists, mental health, pharmacists, voluntary sector and the police • Care will be delivered by multidisciplinary teams (MDTs) working jointly in NHS/council premises. MDTs will plan care, help patients to self-manage and support prevention. They will focus on those with the most complex needs • Social care will be integrated e.g., by locating a social worker at a GP practice, with central resources such as the Single Point of Referral and Access team • Integrated pathways across the whole system to allow for co-ordinated patient care close to home e.g., through enhanced 111 and Out of Hours services and improved ability of paramedics to treat people on scene
3	**GP practices will work more collaboratively**	• Practices will group together to provide integrated out-of-hospital care – bringing together community services, hospital specialists, nurses and others; 24/7 MDT assessment and enhanced triage service centred around 111 • A majority of outpatient hospital consultations and ambulatory care will shift to these practices, delivering care to patients in a more convenient and suitable setting
4	**Wider healthcare workforce will be developed**	• A different workforce mix will be required – new roles will be developed, skills and expertise of existing professionals maximised e.g., enhanced use of specialist paramedics • Localities will become training hubs – developing professionals and incentivising them to stay and deliver services in this new way of working
5	**Services will be locally designed and responsive**	• Each locality will be different – reflecting the needs of that area e.g., a locality with a large number of care homes will provide enhanced support for frail and elderly patients, such as targeted care home support • Patients will be empowered to use local resources to help them self-care and take responsibility for prevention e.g., through developing and promoting patient community networks

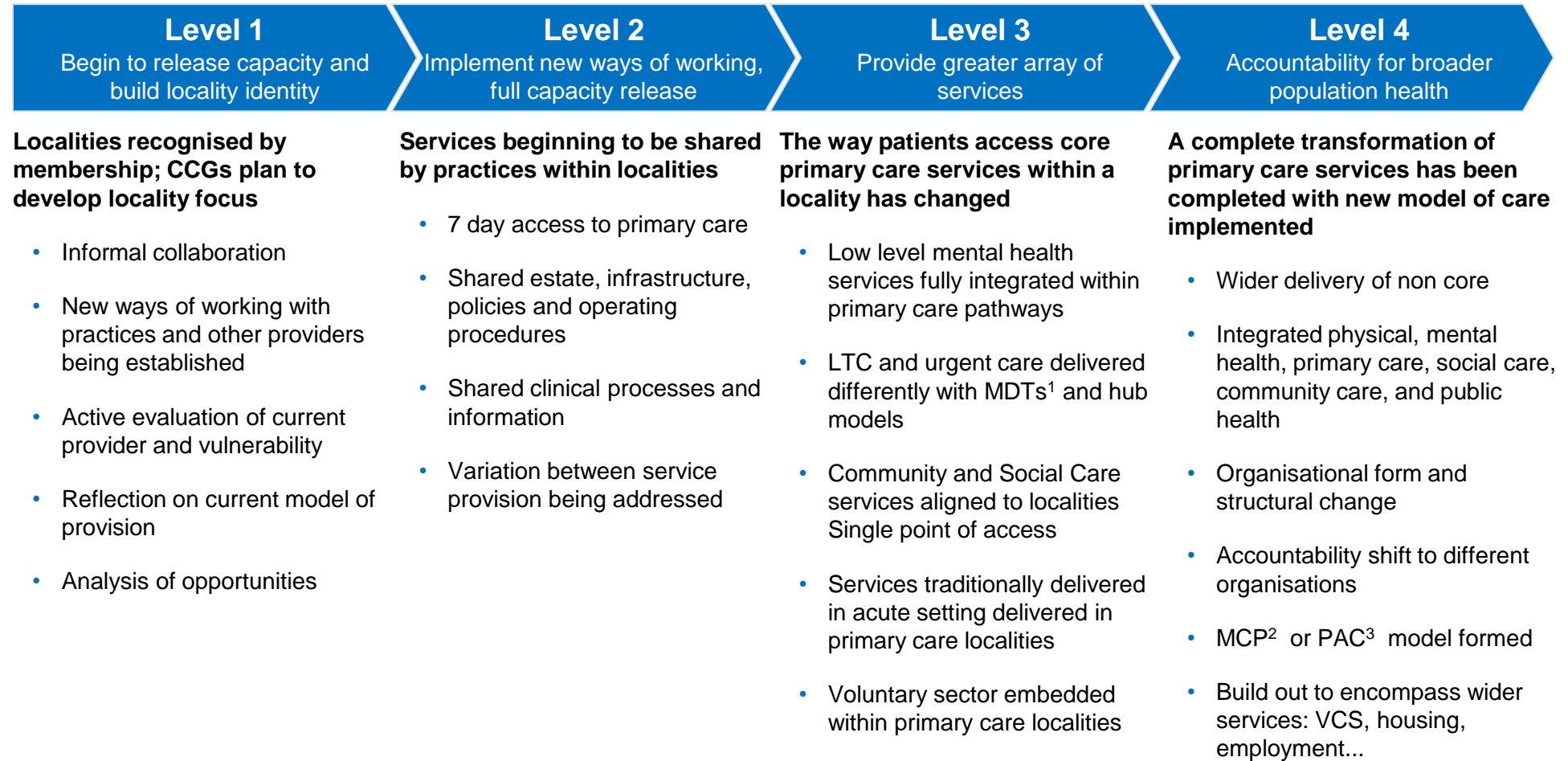# Five locality deep dives completed: priorities for each locality will differ depending on their starting point

2   Contributes to Local health and Care savings - see Financial Bridge pg 21

	Rayleigh *Urban Affluent*	Brentwood *Urban Affluent*	Southend EC[1] *Urban Deprived*	Tilbury *Urban Deprived*	Dengie *Rural*
Context					
	Strong PC, but limited collaboration between practices. Very good integration with SC/CS Care co-ordination, enhanced MDT, named GP Risk stratification tool in place	Strong PC, good relationships between practices, but limited functional collaboration Scope to improve integration with SC/CS Limited risk-stratified management, tool in place but not well used	4 of 9 practices are single-handers Many care homes - 10 Risk stratification tools in place but poorly utilised Limited history of localities - just emerging	Significant GP shortage; limited collaboration between practices MDTs and 7 day working nascent but emerging Variable engagement with social care	Little history of working as a locality Strong affiliation with traditional model of general practice reflecting rural geography MDTs in some but not all practices
Approach					
	Expansion of care co-ordination: <u>locality based</u> + cover LTC cohort Common tools (e.g. Triage) MCPs – potentially with capitated budgets Enhanced self-care offer – incl. utilising technology	Strengthen working with SC/CS, with teams aligned to practices Promote practice collaboration through development team that can explore efficiencies Build triage system to support risk stratified management – supported by AHPs, enhanced RH/NH support & care navigation	Stabilised primary care – shared back office etc -integrated model <u>Locality based</u> enhanced MDTs to organize, co-ordinate and deliver care for high risk cohorts – incl. focus on large care home popn. Focus on integration of social care and health. Integrated team approach to prevention and rising risk cohorts	Locality hub – new health and wellness centre – 7 day services and co-location of services Focus on vertical collaboration (CS, MH) vs practice collaboration <u>Practice-based </u>MDTs with SC alignment Focus on LTCs - greater use of nursing staff for this cohort	Stabilisation of Primary Care core priority Increased joint working between PC across patch incl. with neighbouring localities - supporting 7 day working as first step Strengthen <u>practice-based</u> MDTs with focus on Frailty

1. Southend East Central locality

Transformation of primary care to occur through 4 levels

2 Contributes to Local health and Care savings - see Financial Bridge pg 21

Level 1	Level 2	Level 3	Level 4
Begin to release capacity and build locality identity	Implement new ways of working, full capacity release	Provide greater array of services	Accountability for broader population health

Localities recognised by membership; CCGs plan to develop locality focus

- Informal collaboration

- New ways of working with practices and other providers being established

- Active evaluation of current provider and vulnerability

- Reflection on current model of provision

- Analysis of opportunities

Services beginning to be shared by practices within localities

- 7 day access to primary care

- Shared estate, infrastructure, policies and operating procedures

- Shared clinical processes and information

- Variation between service provision being addressed

The way patients access core primary care services within a locality has changed

- Low level mental health services fully integrated within primary care pathways

- LTC and urgent care delivered differently with MDTs[1] and hub models

- Community and Social Care services aligned to localities Single point of access

- Services traditionally delivered in acute setting delivered in primary care localities

- Voluntary sector embedded within primary care localities

A complete transformation of primary care services has been completed with new model of care implemented

- Wider delivery of non core

- Integrated physical, mental health, primary care, social care, community care, and public health

- Organisational form and structural change

- Accountability shift to different organisations

- MCP[2] or PAC[3] model formed

- Build out to encompass wider services: VCS, housing, employment...

1. Multidisciplinary teams 2. Multispecialty community provider 3. Primary and acute care systems 4. Voluntary and community sector

Draft and confidential – for discussion purposes only

Locality implementation: phasing

② Contributes to Local health and Care savings - see Financial Bridge pg 21

CCG		Localities	2016/17	2017/18	2018/19	2019/20	2020/21
Mid Essex	1	Braintree	Level 1	Level 2	Level 3	Level 4	
	2	Witham	Level 1	Level 2	Level 3	Level 4	
	3	Chelmsford 1	Level 1	Level 2	Level 3	Level 4	
	4	Chelmsford 2	Level 1	Level 2	Level 3	Level 4	
	5	Colne Valley	Level 1	Level 2	Level 3	Level 4	
	6	Dengie	Level 1	Level 2	Level 3	Level 4	
	7	Prosper	Level 1	Level 2	Level 3	Level 4	
	8	Maldon	Level 1	Level 2	Level 3	Level 4	
	9	South Woodham	Level 1	Level 2	Level 3	Level 4	
B&B	10	Billericay	Level 1	Level 2	Level 3	Level 4	
	11	Brentwood	Level 1	Level 2	Level 3	Level 4	
	12	Wickford	Level 1	Level 2	Level 3	Level 4	
	13	East Basildon	Level 1	Level 2	Level 3	Level 4	
	14	West Basildon	Level 1	Level 2	Level 3	Level 4	
Thurrock	15	Grays	Level 1	Level 2	Level 3	Level 4	
	16	South Ockendon	Level 1	Level 2	Level 3	Level 4	
	17	Tilbury	Level 1	Level 2	Level 3	Level 4	
	18	Corringham	Level 1	Level 2	Level 3	Level 4	
CP&R	19	Rochford	Level 1	Level 3		Level 4	
	20	Rayleigh	Level 1	Level 3		Level 4	
	21	Benfleet and Hadleigh	Level 1	Level 3		Level 4	
	22	Canvey Island	Level 1	Level 3		Level 4	
SE	23	Southend East	Level 1	Level 2	Level 3	Level 4	
	24	Southend East Central	Level 1	Level 2	Level 3	Level 4	
	25	Southend West	Level 1	Level 2	Level 3	Level 4	
	26	Southend West Central	Level 1	Level 2	Level 3	Level 4	

▲ - Investment required

Pump priming required to deliver Local Health and Care model
Preliminary view of forthcoming PCBC investment case – to be refined

2 Contributes to Local health and Care savings - see Financial Bridge pg 21

Highly provisional – subject to refinement

Investment (£m)	2017/18[1]	2018/19[1]	2019/20[1]	2020/21
Pump priming[1]				
Workforce changes to support GP capacity release • AHPs, Nurses, Paramedics etc.	6.2	3.6		
Virtualisation	3.5	3.5	7.0	
Up-skilling Primary Care • E.g. diabetes lead, community geriatrician...	2.6	1.0	0.5	
Targeted new services • Care home support; rapid response etc.	2.4	2.4		
Public culture change • E.g. self-management campaigns	1.3	0.5		
Others[2] • Social prescribing pilots, locality back office support and leadership development	1.2	0.8	0.6	
Change Management	1.0	1.0		
Apps/self-care technology	1.0			
IT infrastructure • E.g. Shared care records	1.0	1.0		
Training to up-skill existing workforce • E.g. Non-medical prescribers; GPswSI; care navigators	1.0			
Total transition costs	**21.2**	**13.8**	**8.1**	**0.0**
Cap. Locality Hubs	4	4	4	
Extension to GP practices	4	4	4	
Total capital costs	**8.0**	**8.0**	**8.0**	**0.0**

Note: Recurrent costs are expected to become self-funding

1. Represents costs which are expected to become self-funding from released costs e.g., through fewer NELs 2. Represents costs each less than £1m p.a.
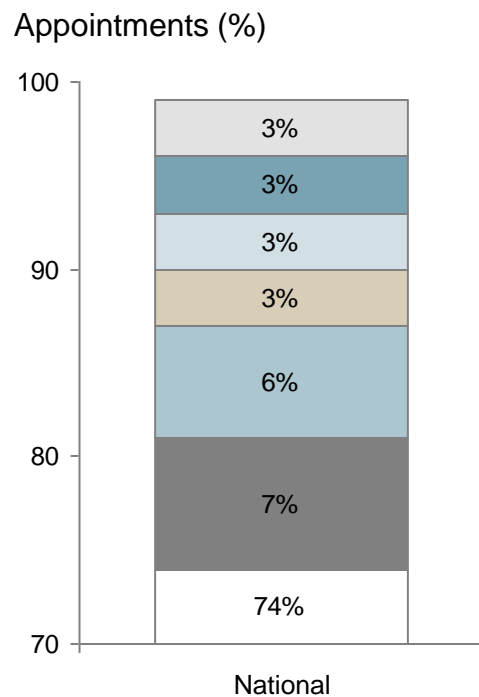
A quarter of GP consultations could be avoided
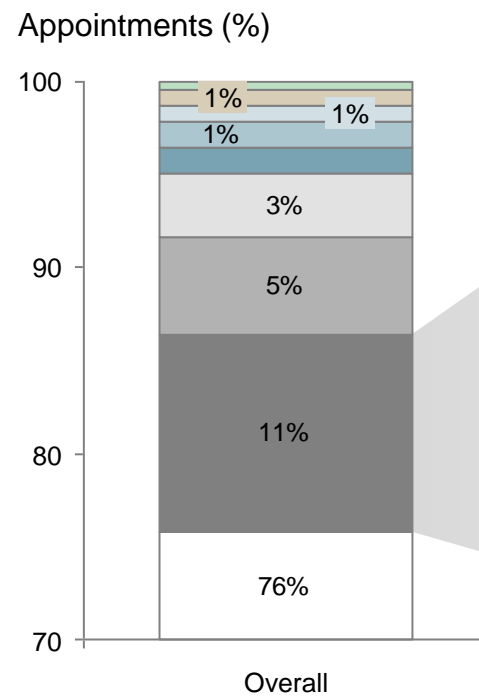## Audit of GP practices across five localities in Mid and South Essex

② Contributes to Local health and Care savings - see Financial Bridge pg 21

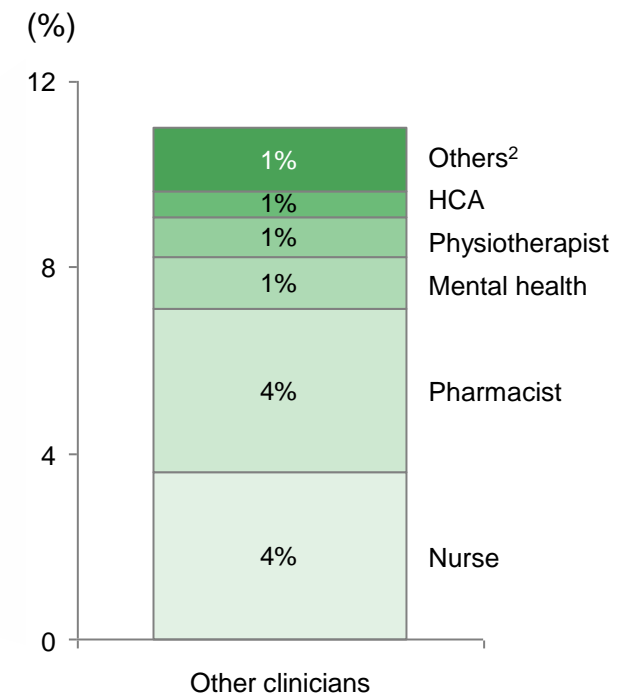**See annex for full channel definitions**

Nationally, 26% avoidable ...

Appointments (%)

- 3%
- 3%
- 3%
- 3%
- 6%
- 7%
- 74%

National

... 24% avoidable[1] in M&SE …

Appointments (%)

- 1%
- 1%
- 1%
- 3%
- 5%
- 11%
- 76%

Overall

… 11% through other practitioners

(%)

- 1% Others[2]
- 1% HCA
- 1% Physiotherapist
- 1% Mental health
- 4% Pharmacist
- 4% Nurse

Other clinicians

Legend:
- Care home spt.
- Acute hosp. gen.
- Non-health related[3]
- Self-care
- Social prescribing
- Other - could avoid or no medical need
- Virtualisation
- Other practitioners
- Unavoidable

1. Avoidable includes consults that were classified as having no medical need, suitable for an alternative appointment type or avoidable by the responsible GP; Audit included a mix of emergency and routine appointments 2. Others includes COPD team, dentist, dietician, hospice at home, midwife, optometrist and sexual health (all <1% share) 3. Includes fit notes and DWP req.
Source: GP Forward View 2016 (Audit of ~5000 GP consultations); 2016 Audit of practices in five localities in Mid and South Essex(~1400 consultations)

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Potential GP appointment channel shift
Analysis based on primary care audit in five localities

2 Contributes to Local health and Care savings - see Financial Bridge pg 21

50 patients	Appointment type	Risk group	Today	Future	Interactions with other core services
	Extended		3 (6%)	7 (15%) (+4)	MDTs, Community Health, Social Care
	Standard		30 (62%)	19 (38%) (-11)	
	AHP		13 (25%)	17 (33%) (+4)	
	Non-health related		4 (7%)	1 (1%) (-3)	Co-location, Signposting
	Virtual consultation		0 (0%)	3 (6%) (+3)	
	Self-care/ app-based support		0 (0%)	3 (7%) (+3)	Voluntary sector, Community Sector

Non-appointment workload
- Reduction in acute-generated work between appointments due to system-wide agreements
- Move to group model to reduce bureaucracy

Source: based on GP audit of c. 1400 consultations in Brentwood, Dengie and Southend

Delivering closer integration with social care

Our model of health and care cannot succeed without closer integration with adult and children's social care

Prevention	**Delivery**	**Enablers**	**Joint working**
"Supporting our communities"	*"Seamless services in localities"*	*" Innovation to boost efficiency"*	*" Working across boundaries"*
Promote resilient communities, health and wellbeing by initiatives including:	**Re-designed and integrated pathways for people who are Frail and End of Life**	**Multi-skilled workforce**	**Complex landscape with three upper tier local authorities**
• Screening for depression in older people and supporting them using social prescribing	• e.g., social workers as an integral part of MDT	• e.g., up-skilling frontline staff to cross-cover health and care roles	**Joint working with social care and joint commissioning**
• Using the "Don't Bottle it Up" Alcohol tool and MECC[1]	**Personalised services**	**Leveraging technology**	• Working to develop closer strategic commissioning dependent on provider, ranging from alignment to full integration
• Encouraging the "Daily Mile" in schools to prevent obesity	• Wrapped around service users which meet their whole needs and build on their strengths	• e.g., shared health and care records	**Change required in face of social care deficits**
	Multi-agency approach to urgent and emergency care	**Shared approach to estates** (e.g., multi-service hubs)	• e.g., ECC social care funding gap could be £122.6m by 2020/21 in a 'do nothing scenario'
Whole population	**Service users**	**Our workforce/ infrastructure**	**Our organisations**

1. Making Every Contact Count

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Case study: 'Discharge to assess' model in a Southend care home

'Discharge to assess' model in a care home jointly commissioned by CCG and council ...

Southend CCG and Southend Borough council jointly commissioned a 24-hour reablement and assessment service
- Focus on promoting an individual's skills of independence, and reducing dependence on future care and support

- Structured discharge planning program, with the aim of reducing future re-admissions and the costs of community care provision

6-bed 'discharge to assess' model launched in February 2016 in a care home setting (Priory House)

Integrated staff working to deliver new model
- GP service commissioned by Southend CCG
- Therapy staffing from Southend University hospital
- Social workers involved

... savings of ~£8k per week to Southend CCG, from short stay in care home

Delivered savings to the CCG by increasing community capacity and supporting vulnerable patients to become more independent and remain in their own homes
- Savings of ~£8k per week, ~£400K per year, following a short stay in Priory house, versus traditional pathway of direct discharge to community

- Aims to reduce re-admissions into the hospital and minimise the requirement for primary care services, supporting patients to maintain independent health

Very high satisfaction rate amongst adults and patients using the service and from relatives and professionals

Plans to expand capacity within the system to ensure that additional beds are available to safely discharge patients from hospital

The In Hospital model of care intends to achieve three goals

③ Contributes to In hospital savings - see Financial Bridge pg 21

Context

Mid and South Essex operates three acute hospitals, with most services delivered at all three sites

While there are many examples of excellent care, the hospitals are facing rising non-elective demands, and clinical workforce gaps

This is leading to increasing operational and financial pressures

Building stronger health and care localities, and decompressing the non-elective pathway is core to meeting these challenges

Reconfiguration, supported by redesign of clinical pathways, then has the potential to address the quality and safety concerns and deliver care more sustainably

- Greater specialisation of clinical staff and equipment, and increasing focus to provide senior medical cover ...
- ...with the potential to deliver 7-day services and other emerging standards within current staffing levels

The work has originated from the 5YFV[1] and is built on national guidance

- There are no deviations from national guidance[2] at this point

Goals

	National guidance	Quality and financial benefits
Redesign-ate emergency centres	Willets	**Improve rotas / sustainable workforce** **Reduced agency spend**
Separate elective and non-elective	Willets; Briggs	**Improve efficiency** **Greater reliability**
Consolidate services	Briggs	**Higher volumes / specialisation → improve outcomes** **Greater productivity**

1. Five year forward view 2. Keogh Urgent and Emergency Care Review – Willets ; Getting it Right First Time – Briggs; Better Births: Improving outcomes of maternity services in England – Cumberlege 3. All savings based on 'Do nothing' deficit by 2020/21 Source: The Nuffield Trust. The reconfiguration of clinical services. What is the evidence? November 2014

Draft and confidential – for discussion purposes only

Three potential service delivery models

Preliminary – subject to further stakeholder refinement

❸ Contributes to In hospital savings - see Financial Bridge pg 21

Service	H Specialist emergency hospital	H Emergency hospital with elective	H Elective centre with A&E	Givens

Emergency care	• 24/7 A&E: accepts all ambulances
	  - +/- co-located frailty assessment unit, surgical assessment unit, acute medical unit, urgent care centre
	• Acute inpatient medicine
	• Specialist services: hyper acute stroke
	• Emergency inpatient surgery incl. low volumes / overnight
	• Acute-acute step-down beds
		• 24/7 selective A&E: accepts daytime and "given" ambulances
		  - +/- co-located frailty assessment unit, surgical assessment unit, acute medical unit, urgent care centre
		• Acute inpatient medicine
		• Daytime emergency and schedulable non-elective inpatient surgery
		• Acute-acute step-down beds
			• 24/7 selective A&E: accepts GP referral and "given" ambulances only
			  - +/- co-located frailty assessment unit, surgical assessment unit, acute medical unit, UCC
			• Acute-acute step-down beds
				Burns and plastics @ MEHT
				
				Cardiothoracic centre @ BTUHFT

Paeds	• Outpatients • Paediatric assessment unit • Inpatients, high dependency unit	• Outpatients • Paediatric assessment unit • Inpatients, high dependency unit	• Outpatients • Paediatric assessment unit (<24hrs) / ambulatory unit	High dependency unit @ MEHT
	Paediatric surgery @ 1 site (tbc)			
Women's	• Specialist obstetrician-led maternity unit for high risk births +/- co-located midwife-led unit • Local Neonatal Unit (L2)	• Obstetrician-led maternity unit +/- co-located midwife led unit • Local Neonatal Unit (L2)	• *Option 1* – Obstetrician-led maternity unit >2500 births & Local Neonatal Unit (L2) • *Option 2* – Obstetrician- led maternity unit <2500 births & Special Care Baby Unit (L1) +/- co-located midwife led unit	+/- standalone midwife led units @ community hospital sites
Elective surgery	• Day surgery • Elective surgery by exception only e.g. plastics / cardiothoracics	• Day surgery • Elective surgery (consolidated onto one site on a sub specialty level)	• Day surgery • Elective surgery (consolidated onto one site on a sub specialty level)	Cancer centre @ SUHFT Spec. urology centre @ SUHFT
Critical care	• Full service intensive care unit	• Full service intensive care unit	• Elective surgical intensive care unit	
Other	• Full range of diagnostic and therapeutic services • Outpatients and ambulatory services	• Full range of diagnostic and therapeutic services • Outpatients and ambulatory services	• Selected diagnostic services • Outpatients and ambulatory services	

Draft and confidential – for discussion purposes only

... which could be delivered in five site configurations

③ Contributes to In hospital savings - see Financial Bridge pg 21

Option	BTUHFT	MEHT	SUHFT
1A	**H** Essex Cardiovascular Centre MS Essex spec. emergency hospital MS Essex specialist obstetric centre	**H** Essex Plastics & Burns Centre Emergency centre MS Essex elective surgical hospital	**H** MS Essex Cancer Centre Emergency centre MS Essex elective surgical hospital
1B	**H** Essex Cardiovascular Centre Emergency centre MS Essex elective surgical hospital	**H** Essex Plastics & Burns Centre MS Essex spec. emergency hospital MS Essex specialist obstetric centre MS Essex children's centre	**H** MS Essex Cancer Centre Emergency centre MS Essex elective surgical hospital
1C	**H** Essex Cardiovascular Centre Emergency centre MS Essex elective surgical hospital	**H** Essex Plastics & Burns Centre Emergency centre Elective surgical hospital	**H** MS Essex Cancer Centre MS Essex spec. emergency hospital MS Essex specialist obstetric centre
2A	**H** Essex Cardiovascular Centre MS Essex spec. emergency hospital MS Essex specialist obstetric centre	**H** Essex Plastics & Burns Centre Emergency centre MS Essex elective surgical hospital	**H** MS Essex Cancer Centre Local emergency centre MS Essex elective surgical hospital
2B	**H** Essex Cardiovascular Centre Emergency centre MS Essex elective surgical hospital	**H** Essex Plastics & Burns Centre MS Essex spec. emergency hospital MS Essex specialist obstetric centre MS Essex children's centre	**H** MS Essex Cancer Centre Local emergency centre MS Essex elective surgical hospital

... which will share clinical and corporate support services

③ Contributes to In hospital savings - see Financial Bridge pg 21

The Mid and South Essex Success Regime will develop single clinical and corporate support services, delivering high quality, cost-effective services in a hub-and-spoke model as informed by the Carter review
- Ambition is to develop sustainable and scalable services that can support local provider organisations in the system

Clinical Support Services

Radiology
- Centralise IT systems to enable sharing of radiological images across trusts
- Align services and practices to drive savings and develop a service strategy to meet increased demand

Pharmacy Services
- Outsource Pharmacy Dispensary to retail company
- Centralise TPN[1] service to one hub

Pathology Services
- Market test at MEHT
- Review pathology workforce to identify areas of alignment and generate a reduction in agency spend.

Centralise administrative services
- Identify options to improve patient experience and access, with consideration given to aligning patient-facing administrative services across the three trusts

Corporate Support Services

Estates and Facilities
- Standardise lease cost arrangements across the three Trusts; consolidate services and maximise current estate
- Develop a single capital investment strategy

HR – agency and bank
- Reduce non-permanent staffing
- Review HR strategy across the three trusts

Occupational Health –
- Establish a single shared service

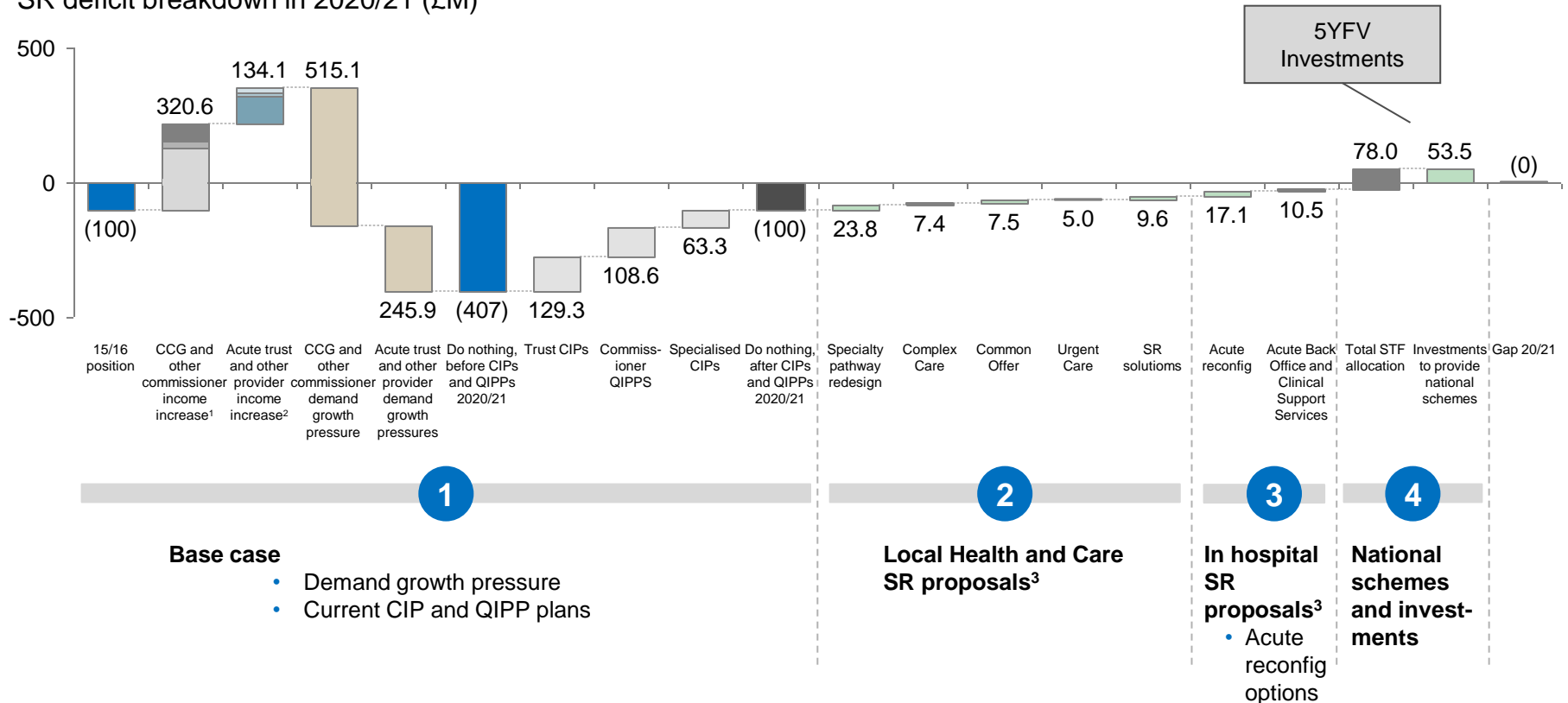**Single merged procurement service**

Single merged IT services
- Ensure common systems across the Trusts including: common email address & address book, single document management system

1. Total parenteral nutrition

Figures per 21stOctober

Overview: forecast financial system bridge

2020/21 financial position driven by three categories of savings under existing and future model of care

SR deficit breakdown in 2020/21 (£M)

Base case
- Demand growth pressure
- Current CIP and QIPP plans

Local Health and Care SR proposals[3]

In hospital SR proposals[3]
- Acute reconfig options

National schemes and invest-ments

1. Demand growth pressure is the increased demand between 2015/16 in-year position and 2020/21 in-year position for services based on demographic and non-demographic demand growth projections based on national and local projections per organisation 2.Income uplift is the increase in allocations between 2015/16 in-year position and 2020/21 in-year position based on projected allocations to trusts, CCGs and other NHS organisations 3. Savings shown are net savings, accounting for investments

Note: This document identifies a range of risks including: any slippage against 2016/17 plans; QIPP and CIP plans in the outer years that are not yet fully developed; and potential changes to the system solutions following the required public consultation; FYFV investments have been identified across the system and, by 2020/21, will total £32.9m in-year spend funded from STF allocation. In preceding years, we have assumed a level of investment that can be funded locally, but will be bidding for national funding to ensure that all investments are funded over the next four years

Source: STP Submission 16.9.16, SR workstreams, Trust & CCG financials

Implementation approach

Diagnosis
- Identify case for change – key challenges facing local health economy
- Determine key areas of focus for Success Regime to achieve sustainable improvements in health and social care outcomes
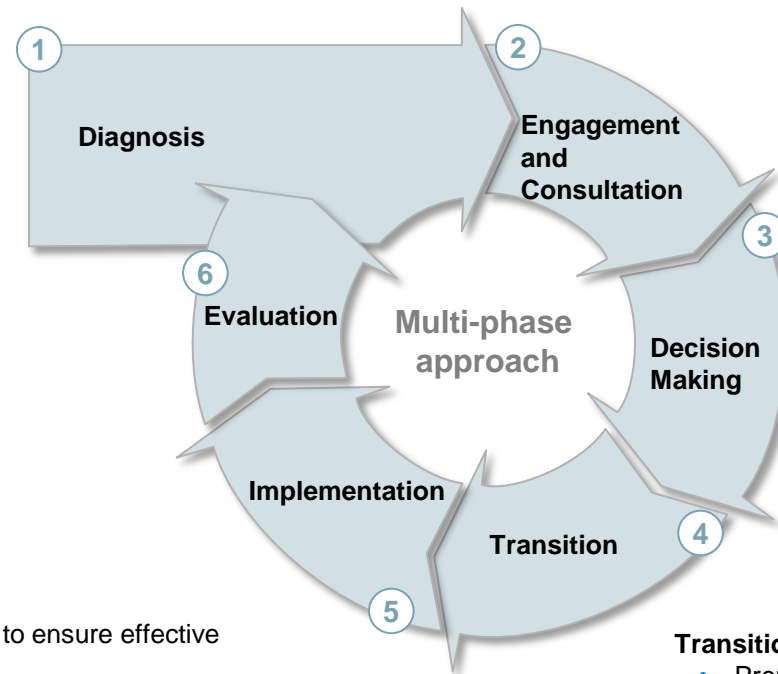
Engagement and Consultation
- Engage with key stakeholders to test, shape and refine potential solutions
  - Identify potential end-state service options and models of care
  - Prioritise potential options; understand potential benefits and trade-offs
  - Define delivery approaches; align organisations to facilitate delivery of proposed plans
- Formal consultation, where appropriate

Evaluation
- Identify lessons learnt to inform future delivery
- Evaluate and track impact of delivery
- Refine and enhance the programme to ensure maximum benefits to patients and the wider workforce

Decision making
- Consider outcomes of engagement and consultation
- Develop detailed transformation and implementation plans
- Determine concrete actions and next steps to realize ambition

Implementation
- Roll out initiatives in managed way to ensure effective implementation
- Test and refine approach to ensure delivery of desired benefits
- Embed residual planning and delivery into future operational plans

Transition
- Prepare services for transformational change
  - Identify and put in place key enablers – incl. training, IT, change management
  - Pilot service changes ahead of full-scale roll out
- Ensure organisations readiness for change

Diagram — Multi-phase approach (circular):
1 Diagnosis
2 Engagement and Consultation
3 Decision Making
4 Transition
5 Implementation
6 Evaluation

Current status and timeline to delivery of public consultation

Context

Partners in Mid and South Essex have been working to develop a Pre-Consultation Business Case, seeking three requests:

i. **Permission to move to full public consultation** on proposed changes to health and care services in Mid and South Essex

ii. **Capital funding,** to support the reconfiguration of the local acute hospitals and enable a shift of services into primary and community settings

iii. **Non-recurrent pump priming revenue funding** to accelerate the implementation of the transformation

Progress to date

Case for change signed-off by CCG & provider boards

Local health and care model developed
- Reviewed by >30 senior leaders at the System Leadership Group

Five potential options for hospital services developed
- Led by a group of >70 clinicians

Both models of care reviewed at two clinical senates

Extensive engagement undertaken with service users and other stakeholders
- including local councillors and MPs

Extensive activity and financial modelling to understand the impact of the new models of care

Development of a clear consultation and engagement strategy

Completion of equality and privacy impact assessments on proposals

Timeline to public consultation

22-29 November: Options Appraisal workshops

1-7 December: Clinical Senate #3

w/c 5 December: Sign off of PCBC by CCG and Acute boards

15 December: Regional Checkpoint

10 January 2017: NHSE Investment Committee

30 January 2017: Public Consultation begins

Approach to ensuring consensus across the STP footprint

Clear governance in place to ensure consensus

Strong track record of collaboration and joint working developed through the Success Regime process

Success Regime governance provides mechanisms to ensure alignment between NHSE, NHSI, CCGs , Acute Providers
- Development of joint teams and governance evidence of aligned approach

System Leaders Group provides broader engagement from across stakeholders – including Community and Mental Health providers, HealthWatch and Local Authorities

Programme Board now in place with council, user and external input

All local stakeholders involved in joint work to develop a pre-consultation business case – seeking permission to move to full public consultation on proposals for new models of care
- Proposals being taken through all CCG and Acute Trust boards in October / November 2016
- Also taken to provider boards, HOSCs and Health and Wellbeing Boards for input and comment

System change supported by simplified landscape

Acutes Group model	• Historically, three DGHs with duplication of services, and all struggling operationally and financially • Group model established with single clinical and support teams... • ... and setting up a legal framework to be able to transact business in a joined up way with commissioners and regulators
CCG joint decision making	• Historically, complex commissioning landscape; limited collaboration; contracting for activity – not outcomes; >300 contracts with >100 providers • CCG Chairs and AOs have proposed a joint decision making arrangement
Joint acute commissioning	• Block acute contracts put in place for 2016/17 – proposed to extend block arrangements to 2017/18 • Development of a single acute commissioning team across STP footprint, to lead negotiations for 2017/18 • Oversight for acute commissioning to be delegated to new shadow CCG governance

Summary high-level implementation timeline

	2016/17				2017/18				2018/19				2019/20				2020/21			
Quarter:	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4

In Hospital

Clinical support
7 projects including diagnostic imagining strategy option appraisal to the STP footprint
Next step: develop pipeline of projects (including Local Health & Care priorities)

Corporate support
Tranche 1: In-year savings
Tranche 3: New operating model/sourcing (Carter 7% and 6% spend targets)
Tranche 2: Standardisation

Acute reconfiguration
Clinical reconfiguration: 3 hospital operating model to develop centres of excellence in compliment to local services

Clinical and specialist pathway redesign
Tranche 1: Diagnostic to evaluation, rapid project cycle
Tranche 2: Include UEC, LTCs, Frailty
Tranche 3: Delivery of national schemes

Local Health & Care

Manage demand for healthcare
Prevention, early intervention, self-care
Integrated pathways – Frailty, EOL and LTCs
Urgent and emergency care
Mental health
Primary care
Localities

Build capacity outside the hospital

Mid-Essex	Level 1	Level 2	Level 3	Level 3	Level 4
B&B	Level 1	Level 2	Level 3	Level 3	Level 4
Thurrock	Level 1	Level 2	Level 3	Level 3	Level 4
Southend	Level 1	Level 2	Level 3	Level 4	Level 4
CP&R	Level 1	Level 2	Level 3	Level 4	Level 4

Specialised pathways
Acute commissioning
Common offer

Enablers
Estates
Technology and innovation
Workforce

25

Delivery: Risks and mitigations (I/II)

Risk	Description	Impact	Likelihood	RAG	Mitigation
Delivery	Limited experience with large-scale transformative change	4	4	R	SR infrastructure and support are put in place Partnerships with external organisations (e.g. UCLP for leadership training) are established
	Lack of redesign skills	4	3	AR	Training/collaboration/support is provided so that professionals and staff are better able to design care pathways and cope with clinical and organisational needs
	Drop in clinical quality and safety levels as attention shifts away from day-to-day operations	5	2	AR	SR/STP workplan put in place to address immediate performance issues Emphasis put on monitoring and reporting KPIs of quality and safety
Financial	Unfulfilled savings opportunities – savings identified may deliver less than anticipated	4	3	AR	Assumptions made in savings calculations are validated Specific risks behind each initiative are identified to create detailed mitigation plans
	Insufficient capital – significant change requires capital, but investment capital may not be available nationally, or access to funding may be unavailable	4	3	AR	Plan around funding schedule is created and strictly followed . Ongoing dialogue with the NHSE/I central teams about capital
Social care funding	High demand for social care, but constrained funding, risk of spill-over demand to healthcare	4	3	AR	Integrated working of health and social care, to improve efficiency
Resources	Insufficient resources (in terms of capacity and expertise) to deliver the programme objectives within the agreed timeframe	4	1	A	Programme Director and SROs regularly monitor and review programme timeline and resources to confirm that they are adequate for carrying out the workplan
Political	Lack of political support for Future Model of Care	5	1	A	Ongoing active engagement strategy with regular update of emerging solutions
Regulatory	Disagreement between regulatory bodies around key proposals	4	3	AR	Communication strategy with regulators (see governance section)
Public	Lack or loss of public confidence in and support for the Future Model of Care	4	3	AR	Public consultations to be held regularly Public feedback to be considered in improving programme implementation

Impact:	**5** Major impact – Future Model of Care is not or only poorly implemented; state of MSE health system deteriorates	**3** Moderate impact – Future Model of Care is not generated within agreed timeframe / does not generate desired benefits	**1** Minor to no impact – Future Model of Care is fully implemented and generates desired benefits; state of MSE health system deteriorates
Likelihood:	**5** Likely to happen	**3** Might happen to some degree	**1** Unlikely to happen

Delivery: Risks and mitigations (II/II)

Risk	Description	Impact	Likelihood	RAG	Mitigation
Press	Negative press damages the health sector in MSE	4	3	AR	Robust communications plan is developed prior to commencement of programme implementation Continuous communication is established to ensure widespread support for the programme
Joint decision making	Joint CCG decision making proposed, but complicated – risk it fails to fully develop	4	3	AR	Ongoing engagement with CCG boards to ensure buy-in
	Lack of alignment between Local Health and Care plans and In Hospital plans	3	3	A	Cross-representation of workstream teams is established (i.e. representatives of IH staff in LHC and vice versa) to ensure close integration during implementation phase
Workforce	Difficulties in recruiting appropriately skilled staff	3	3	A	Pro-active work around recruiting is ensured and training programmes for staff are made available
	Difficulties in retaining staff during reorganisation, within localities and acute sites	5	2	AR	Benefits case for end goal is clearly articulated, with comprehensive communication and engagement plan
	Lack of staff support for the Future Model of Care; reluctance to change	5	3	R	Close working relationship is nurtured with all local stakeholders (including key public representatives) throughout, to ensure a "no surprises" approach and avoid time-consuming or obstructive reactions from different stakeholder groups; Continued involvement and support of staff is ensured via a comprehensive engagement plan
	Lack of clinical support for the Future Model of Care	4	3	AR	Robust clinician engagement is continuously led by clinicians – not just those in management positions but also other influential clinicians from all relevant clinical services
	Lack of collaborative leadership behaviour that inhibits system-wide transformational change	4	3	AR	Working groups are created to boost collaboration and strengthen links between different providers; Close working relationship between primary, secondary, community providers and CCGs from the outset, and where appropriate, they are invited to give formal approval of the plans

Impact:	5	Major impact – Future Model of Care is not or only poorly implemented; state of MSE health system deteriorates	3	Moderate impact – Future Model of Care is not generated within agreed timeframe / does not generate desired benefits	1	Minor to no impact – Future Model of Care is fully implemented and generates desired benefits; state of MSE health system deteriorates
Likelihood:	5	Likely to happen	3	Might happen to some degree	1	Unlikely to happen

Delivery: Enablers

	Workforce	**Estates**	**Technology and innovation**
Context	**Workforce undersupply – high vacancies, imminent retirements and insufficient training pipeline** • Currently 13% vacancy rate in patch vs. 7% nationally across NHS workforce[1]	**Wide variation in functional suitability of estates in M&SE** • GP practice facilities report issues with space and suitability • Acute sites all extensively utilised	**NHS in M&SE lagging in deployment of technology to deliver effective care** • e.g., Lack of connected systems across GP practices, hospitals, local authorities, community providers, ambulance
Approach	**Need to move to innovative models of working to deliver quality care:** • Newly formed LWABs will provide governance and drive workstreams • Essex workforce strategy developed to support transition to future workforce • Initiatives beginning to be implemented e.g., ANPs leading LTC management with support of specialist therapists such as podiatrists	**CCGs and Success Regime developing estates strategy to support in-hospital and local health and care models** • Ongoing updates to Estates strategy as STP work develops • Working in partnership with local authorities to develop a Growth and Infrastructure Framework, providing "joined up" planning for assets and investments over the next twenty years	**A number of key work-streams are emerging to deliver the technology transformation such as:** • Service transformation and rapid benefits delivery • Creating a digital ecosystem • Utilising 'Big Data' • Virtualisation of care delivery
Impact	**Essex branded as a place to work and stay** • Rotational programs and portfolio positions to allow breadth and flexibility • Enhanced training – collaboration with royal colleges and educational providers e.g., Anglia Ruskin University and the University of Essex • Emphasized research to improve quality of care and develop local expertise • Increased training pipeline, staff recruitment and retention	**Maximised efficiency of estates assets, enabling a sustainable service offering** • Estates configured so that they function at a neighbourhood rather than a system level, facilitating transfer of acute services to the community • Increased sharing of estates between health and social care • Maximised use of core estate and minimised use of estates for non-clinical purposes	**Digital transformation, innovation to improve efficiency and release capacity** • Enable integrated, multi-agency working e.g., more effective sharing of information via shared care records, interoperability • Facilitate the shift of activity out of acute hospitals e.g., by providing channels by which patients and staff in the community can access specialist acute input remotely and virtually

1. Workforce includes NHS nursing, AHPs, therapists, medical and dental staff
Source: HEE workforce forecasts May 2016

Backup

The future of urgent and emergency care

The context and challenge

Challenge
- Rising demand for A&E and ambulance services, both with growth above national average
- Complex system with little coordination or primary care capacity for emergency appointments

Context
- Take a whole systems approach in managing and developing urgent and emergency care provision
- Improve the public's understanding of, and appropriate access to, urgent care through multiple channels
- Help all service users to be directed to the right service, first time, including support to self-care
- Where clinically appropriate, people who can care for themselves will be provided with information, advice and reassurance to enable self-care
- Where possible, people will have their problem dealt with over the phone by a suitably qualified clinician
- People requiring further care or advice will be referred to a service that has the appropriate skills and resources to meet their needs
- People facing an emergency will have an ambulance dispatched without delay
- 999 will continue to provide an emergency service whilst 111 will take all calls requiring urgent but not emergency care

Two approaches to address the challenge

1 **Two points of entry**

Clearly define pathways into Emergency Care, by

- Emergency—999 through new operating model of increased triage, 'hear and treat/see and treat', reducing conveyance to A&E

- Urgent Care—111 through clinical hub linked to localities and A&E

2 **Manage emergency demand**

Manage demand for healthcare across primary, community and acute settings, by

- Clinical hub with combined 111 and Out Of Hours service

- Redirection from A&E into appropriate pathways

- Strengthening capacity in the UEC pathway to be able to 'hear and treat' and 'see and treat'

- Designated Emergency Centres

Integrated planning: mental health

Context

There are certain challenges within the mental health system
- An imbalance between the level of support provided and the patient needs
- Essex remains an outlier in certain areas e.g., higher than average rates of suicide, common mental health conditions (Southend is highest in the East of England)

The Essex Mental Health Strategic Review was conducted between June and September 2015
- Commissioned jointly by the 7 CCGs across Essex, Essex County Council, the 2 unitary authorities, and the providers

Following the strategic review, an Essex-wide strategy has been developed by the 10 commissioners
- This will go to boards for approval in December/January 2015/16
- An Essex-wide action plan will then be determined to implement the strategy
- The STP is leading the formation of an all age mental health joint commissioning team to commission services on behalf of Essex CCGs and local authorities

Strategic priorities

Adult
- Ensure 24/7 Crisis care
- Reduce waiting times and increase capacity in IAPT
- Increase capacity of approved medical practitioners

Children
- Develop three crisis response teams
- Provide three children's single point of access
- Provide services for parenting and family groups

Learning disability
- Increase capacity in the LD intensive support team
- Pilot community forensic services
- Reduce inpatient stays through increased community provision, crisis support and systematic care and treatment review
- Improve transition from children's to adult learning disability service
- Enhance services for Autism spectrum disorder