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 selected update 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

Please note: 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.
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**Backup**

**Annex**

- Annex 1 - In Hospital
- Annex 2 - Local Health and Care
- Annex 3 - Enablers extract: Estates Strategy
- Annex 4 - Implementation

*Separate document*
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

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

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

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**
- ~484k fewer attendances (-16%)
  - ~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
  - ~10% to other clinicians
  - ~8% to social prescribing, self-care, other
  - ~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

**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

<table>
<thead>
<tr>
<th>Metric</th>
<th>2016/17 YTD</th>
<th>2016/17 Target</th>
<th>2017/18 Target</th>
<th>2018/19 Target</th>
<th>2019/20 Target</th>
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<tr>
<td>A&amp;E performance (4 hour wait times)</td>
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<td>BTUHFT</td>
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<td>RTT performance¹</td>
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<td>SUHFT</td>
<td>90.0%</td>
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<td>92%</td>
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<td>Hospital total bed days / 1000 people</td>
<td>Combined</td>
<td>296.4</td>
<td>299.6</td>
<td>293.6</td>
<td>275.3</td>
<td>275.7</td>
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<td>Emergency hospital admissions / 1000 population</td>
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<td>92</td>
<td>91.8</td>
<td>87.4</td>
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<td>Progress vs Cancer Taskforce Implementation Plan² (62 Day cancer standard)</td>
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<td>BTUHFT</td>
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<tr>
<td>MEHT</td>
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<tr>
<td>SUHFT</td>
<td>83.0%</td>
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<td>Combined</td>
<td>80.1%</td>
<td>85%</td>
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<tr>
<td>Progress vs MH 5YFV³ Implementation Plan</td>
<td>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</td>
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¹ RTT performance: 2017/18 Target 92% for BTUHFT, 92% for MEHT, 92% for SUHFT; 2018/19 Target: 92% for BTUHFT, 92% for MEHT, 92% for SUHFT; 2019/20 Target: 92% for BTUHFT, 92% for MEHT, 92% for SUHFT; 2020/21 Target: 92% for BTUHFT, 92% for MEHT, 92% for SUHFT

² Progress vs Cancer Taskforce Implementation Plan: 2017/18 Target: 85% for BTUHFT, 85% for MEHT, 85% for SUHFT; 2018/19 Target: 85% for BTUHFT, 85% for MEHT, 85% for SUHFT; 2019/20 Target: 85% for BTUHFT, 85% for MEHT, 85% for SUHFT; 2020/21 Target: 85% for BTUHFT, 85% for MEHT, 85% for SUHFT

³ Progress vs MH 5YFV: 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

⁴ Progress vs. GP5YFV: Localities at each level of primary care working
The future model of Local Health and Care aims to deliver two principal objectives

The challenge

Primary care is under pressure: rising workload...
- 81% of GPs report rise in complexity; move to 7 day working; need for same day appointments to relieve urgent care pathway (2 out of 5 CCGs have chronic ACSC 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

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)
- Complex system with little coordination or PC capacity for emergency appointments

GP and 5YFV 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 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

2. 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

Focus of this update


Contributes to Local health and care savings - see Financial Bridge pg 21
**Vision for the locality approach:** "Joined up health and social care planned, delivered and coordinated around patient needs"

### Core elements of the locality vision

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<thead>
<tr>
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<tbody>
<tr>
<td><strong>1</strong></td>
<td>General practice will form the heart of the locality</td>
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<tr>
<td></td>
<td>• General practice will act as a key hub, providing a new offer for patients to access the care and support they need</td>
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<td>• To enable this, resources will be invested to grow capacity in the community</td>
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<td></td>
<td>• Ultimately, services will shift from hospital into the community, reducing demand on the acute sector</td>
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<td><strong>2</strong></td>
<td>Care planning and delivery will be joined up</td>
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<td>• 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</td>
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<td>• 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</td>
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<td>• 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</td>
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<td>• 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</td>
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<td><strong>3</strong></td>
<td>GP practices will work more collaboratively</td>
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<tr>
<td></td>
<td>• 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</td>
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<td>• 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</td>
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<td><strong>4</strong></td>
<td>Wider healthcare workforce will be developed</td>
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<td>• 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</td>
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<td>• Localities will become training hubs – developing professionals and incentivising them to stay and deliver services in this new way of working</td>
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<tr>
<td><strong>5</strong></td>
<td>Services will be locally designed and responsive</td>
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<td></td>
<td>• 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</td>
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<td>• 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</td>
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### Contributes to Local health and Care savings - see Financial Bridge pg 21
Five locality deep dives completed: priorities for each locality will differ depending on their starting point

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

Contributes to Local health and Care savings - see Financial Bridge pg 21
Transformation of primary care to occur through 4 levels

**Level 1**
Begin to release capacity and build locality identity

- 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

**Level 2**
Implement new ways of working, full capacity release

- 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

**Level 3**
Provide greater array of services

- 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

**Level 4**
Accountability for broader population health

- 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...

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Contributes to Local health and Care savings - see Financial Bridge pg 21
Locality implementation: phasing

**CCG**

**Localities**

<table>
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<tr>
<th>CCG</th>
<th>Localities</th>
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<td><strong>Mid Essex</strong></td>
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<td>1</td>
<td>Braintree</td>
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<td>Witham</td>
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<td>Chelmsford 1</td>
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<td>Chelmsford 2</td>
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<td>26</td>
<td>Southend West Central</td>
</tr>
</tbody>
</table>

**2016/17** - **2020/21**

| Year       | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 |
|------------|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
| 2016/17    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| 2017/18    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| 2018/19    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| 2019/20    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| 2020/21    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
## Pump priming required to deliver Local Health and Care model

### Preliminary view of forthcoming PCBC investment case – to be refined

<table>
<thead>
<tr>
<th>Investment (£m)</th>
<th>2017/18</th>
<th>2018/19</th>
<th>2019/20</th>
<th>2020/21</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workforce changes to support GP capacity release</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• AHPs, Nurses, Paramedics etc.</td>
<td>6.2</td>
<td>3.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Virtualisation</td>
<td>3.5</td>
<td>3.5</td>
<td>7.0</td>
<td></td>
</tr>
<tr>
<td>Up-skilling Primary Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• E.g. diabetes lead, community geriatrician...</td>
<td>2.6</td>
<td>1.0</td>
<td>0.5</td>
<td></td>
</tr>
<tr>
<td>Targeted new services</td>
<td>2.4</td>
<td>2.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Care home support; rapid response etc.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public culture change</td>
<td>1.3</td>
<td>0.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• E.g. self-management campaigns</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Others²</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Social prescribing pilots, locality back office support and leadership development</td>
<td>1.2</td>
<td>0.8</td>
<td>0.6</td>
<td></td>
</tr>
<tr>
<td>Change Management</td>
<td>1.0</td>
<td>1.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Apps/self-care technology</td>
<td>1.0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IT infrastructure</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• E.g. Shared care records</td>
<td>1.0</td>
<td>1.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Training to up-skill existing workforce</td>
<td>1.0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• E.g. Non-medical prescribers; GPs and care navigators</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total transition costs</strong></td>
<td><strong>21.2</strong></td>
<td><strong>13.8</strong></td>
<td><strong>8.1</strong></td>
<td><strong>0.0</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cap.</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Locality Hubs</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Extension to GP practices</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td><strong>Total capital costs</strong></td>
<td><strong>8.0</strong></td>
<td><strong>8.0</strong></td>
<td><strong>8.0</strong></td>
<td><strong>0.0</strong></td>
</tr>
</tbody>
</table>

**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

Nationally, 26% avoidable...

<table>
<thead>
<tr>
<th>Appointments (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>100</td>
</tr>
<tr>
<td>90</td>
</tr>
<tr>
<td>80</td>
</tr>
<tr>
<td>70</td>
</tr>
<tr>
<td>60</td>
</tr>
<tr>
<td>50</td>
</tr>
<tr>
<td>40</td>
</tr>
<tr>
<td>30</td>
</tr>
<tr>
<td>20</td>
</tr>
<tr>
<td>10</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Care home spt.</td>
</tr>
<tr>
<td>Acute hosp. gen.</td>
</tr>
<tr>
<td>Non-health related³</td>
</tr>
</tbody>
</table>

... 24% avoidable¹ in M&SE ...

<table>
<thead>
<tr>
<th>Appointments (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>100</td>
</tr>
<tr>
<td>90</td>
</tr>
<tr>
<td>80</td>
</tr>
<tr>
<td>70</td>
</tr>
<tr>
<td>60</td>
</tr>
<tr>
<td>50</td>
</tr>
<tr>
<td>40</td>
</tr>
<tr>
<td>30</td>
</tr>
<tr>
<td>20</td>
</tr>
<tr>
<td>10</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Others²</td>
</tr>
<tr>
<td>HCA</td>
</tr>
<tr>
<td>Physiotherapist</td>
</tr>
<tr>
<td>Mental health</td>
</tr>
<tr>
<td>Pharmacist</td>
</tr>
<tr>
<td>Nurse</td>
</tr>
</tbody>
</table>

... 11% through other practitioners

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

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**

“Supporting our communities”

Promote resilient communities, health and wellbeing by initiatives including:

- Screening for depression in older people and supporting them using social prescribing
- Using the “Don’t Bottle it Up” Alcohol tool and MECC
- Encouraging the "Daily Mile" in schools to prevent obesity

**Delivery**

“Seamless services in localities”

Re-designed and integrated pathways for people who are Frail and End of Life

- e.g., social workers as an integral part of MDT

Personalised services

- Wrapped around service users which meet their whole needs and build on their strengths

Multi-agency approach to urgent and emergency care

**Enablers**

"Innovation to boost efficiency"

Multi-skilled workforce

- e.g., up-skilling frontline staff to cross-cover health and care roles

Leveraging technology

- e.g., shared health and care records

Shared approach to estates

(e.g., multi-service hubs)

**Joint working**

"Working across boundaries"

Complex landscape with three upper tier local authorities

Joint working with social care and joint commissioning

- Working to develop closer strategic commissioning dependent on provider, ranging from alignment to full integration

Change required in face of social care deficits

- e.g., ECC social care funding gap could be £122.6m by 2020/21 in a 'do nothing scenario'

---

1. Making Every Contact Count
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)

Integrating 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

<table>
<thead>
<tr>
<th>Context</th>
<th>Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mid and South Essex operates three acute hospitals, with most services delivered at all three sites</td>
<td><strong>National guidance</strong></td>
</tr>
<tr>
<td>While there are many examples of excellent care, the hospitals are facing rising non-elective demands, and clinical workforce gaps</td>
<td>Improve rotas / sustainable workforce</td>
</tr>
<tr>
<td>This is leading to increasing operational and financial pressures</td>
<td>Reduced agency spend</td>
</tr>
<tr>
<td>Building stronger health and care localities, and decompressing the non-elective pathway is core to meeting these challenges</td>
<td><strong>Quality and financial benefits</strong></td>
</tr>
<tr>
<td>Reconfiguration, supported by redesign of clinical pathways, then has the potential to address the quality and safety concerns and deliver care more sustainably</td>
<td></td>
</tr>
<tr>
<td>• Greater specialisation of clinical staff and equipment, and increasing focus to provide senior medical cover ...</td>
<td></td>
</tr>
<tr>
<td>• ...with the potential to deliver 7-day services and other emerging standards within current staffing levels</td>
<td></td>
</tr>
<tr>
<td>The work has originated from the 5YFV¹ and is built on national guidance</td>
<td></td>
</tr>
<tr>
<td>• There are no deviations from national guidance² at this point</td>
<td></td>
</tr>
</tbody>
</table>

### Three potential service delivery models

<table>
<thead>
<tr>
<th>Service</th>
<th>Specialist emergency hospital</th>
<th>Emergency hospital with elective</th>
<th>Elective centre with A&amp;E</th>
</tr>
</thead>
</table>
| **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 |
| **Paeds**         | • Outpatients  
  • Paediatric assessment unit  
  • Inpatients, high dependency unit  
  **Paediatric surgery @ 1 site (tbc)** | • Outpatients  
  • Paediatric assessment unit  
  • Inpatients, high dependency unit | • Outpatients  
  • Paediatric assessment unit (<24hrs) / ambulatory unit  
  **High dependency unit @ MEHT** |
| **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 | **Burns and plastics @ MEHT**  
  **Cardiothoracic centre @ BTUHFT**  
  **/+ 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 |
... which could be delivered in five site configurations

<table>
<thead>
<tr>
<th>Option</th>
<th>BTUHFT</th>
<th>MEHT</th>
<th>SUHFT</th>
</tr>
</thead>
</table>
| 1A     | Essex Cardiovascular Centre  
MS Essex spec. emergency hospital  
MS Essex specialist obstetric centre | Essex Plastics & Burns Centre  
Emergency centre  
MS Essex elective surgical hospital | MS Essex Cancer Centre  
Emergency centre  
MS Essex elective surgical hospital |
| 1B     | Essex Cardiovascular Centre  
Emergency centre  
MS Essex elective surgical hospital | Essex Plastics & Burns Centre  
MS Essex spec. emergency hospital  
MS Essex specialist obstetric centre  
MS Essex children's centre | MS Essex Cancer Centre  
Emergency centre  
MS Essex elective surgical hospital |
| 1C     | Essex Cardiovascular Centre  
Emergency centre  
MS Essex elective surgical hospital | Essex Plastics & Burns Centre  
Emergency centre  
Elective surgical hospital | MS Essex Cancer Centre  
MS Essex spec. emergency hospital  
MS Essex specialist obstetric centre |
| 2A     | Essex Cardiovascular Centre  
MS Essex spec. emergency hospital  
MS Essex specialist obstetric centre | Essex Plastics & Burns Centre  
Emergency centre  
MS Essex elective surgical hospital | MS Essex Cancer Centre  
Local emergency centre  
MS Essex elective surgical hospital |
| 2B     | Essex Cardiovascular Centre  
Emergency centre  
MS Essex elective surgical hospital | Essex Plastics & Burns Centre  
MS Essex spec. emergency hospital  
MS Essex specialist obstetric centre  
MS Essex children's centre | MS Essex Cancer Centre  
Local emergency centre  
MS Essex elective surgical hospital |
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

---
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)

<table>
<thead>
<tr>
<th>Category</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute trust and other provider income increase</td>
<td>320.6</td>
</tr>
<tr>
<td>15/16 position</td>
<td>(100)</td>
</tr>
<tr>
<td>CCG and other commissioner demand growth pressure</td>
<td>108.6</td>
</tr>
<tr>
<td>Do nothing, after CIPs and QIPPs</td>
<td>(100)</td>
</tr>
<tr>
<td>Trust CIPs</td>
<td>245.9</td>
</tr>
<tr>
<td>Do nothing, before CIPs and QIPPs</td>
<td>(407)</td>
</tr>
<tr>
<td>Commissions</td>
<td>134.1</td>
</tr>
<tr>
<td>Specialised CIPs</td>
<td>515.1</td>
</tr>
<tr>
<td>Do nothing, after CIPs and QIPPs</td>
<td>(2020/21)</td>
</tr>
<tr>
<td>Specialty pathway redesign</td>
<td>23.8</td>
</tr>
<tr>
<td>Complex Care</td>
<td>7.4</td>
</tr>
<tr>
<td>Common Offer</td>
<td>7.5</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>5.0</td>
</tr>
<tr>
<td>SR solutions</td>
<td>9.6</td>
</tr>
<tr>
<td>Acute reconfig</td>
<td>17.1</td>
</tr>
<tr>
<td>Acute Back Office and Clinical Support Services</td>
<td>10.5</td>
</tr>
<tr>
<td>Total STF allocation</td>
<td>78.0</td>
</tr>
<tr>
<td>Investments to provide national schemes</td>
<td>53.5</td>
</tr>
<tr>
<td>Gap 20/21</td>
<td>(0)</td>
</tr>
</tbody>
</table>

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.

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
# 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:

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

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

3. **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
## 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, and 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

<table>
<thead>
<tr>
<th>Acutes Group model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Historically, three DGHs with duplication of services, and all struggling operationally and financially</td>
</tr>
<tr>
<td>Group model established with single clinical and support teams...</td>
</tr>
<tr>
<td>... and setting up a legal framework to be able to transact business in a joined up way with commissioners and regulators</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CCG joint decision making</th>
</tr>
</thead>
<tbody>
<tr>
<td>Historically, complex commissioning landscape; limited collaboration; contracting for activity – not outcomes; &gt;300 contracts with &gt;100 providers</td>
</tr>
<tr>
<td>CCG Chairs and AOs have proposed a joint decision making arrangement</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Joint acute commissioning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Block acute contracts put in place for 2016/17 – proposed to extend block arrangements to 2017/18</td>
</tr>
<tr>
<td>Development of a single acute commissioning team across STP footprint, to lead negotiations for 2017/18</td>
</tr>
<tr>
<td>Oversight for acute commissioning to be delegated to new shadow CCG governance</td>
</tr>
</tbody>
</table>
## Summary high-level implementation timeline

### Corporate support
- **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 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

### Underpinning strategic priorities
- Prevention, early intervention, self-care
- Integrated pathways – Frailty, EOL and LTCs
- Urgent and emergency care
- Mental health
- Primary care
- Specialised pathways
- Acute commissioning
- Localities
- Enablers
  - Common offer
  - Estates
  - Technology and innovation
  - Workforce

### Regional priorities
- **Mid-Essex**
  - Level 1
  - Level 2
- **B&B**
  - Level 1
  - Level 2
- **Thurrock**
  - Level 1
  - Level 2
- **Southend**
  - Level 1
  - Level 2
  - Level 3
- **CP&R**
  - Level 1
  - Level 2
  - Level 3

### Timeline

<table>
<thead>
<tr>
<th>Year</th>
<th>Quarter 1</th>
<th>Quarter 2</th>
<th>Quarter 3</th>
<th>Quarter 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016/17</td>
<td></td>
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<tr>
<td>2017/18</td>
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<tr>
<td>2018/19</td>
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<tr>
<td>2019/20</td>
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<tr>
<td>2020/21</td>
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</tbody>
</table>
## Delivery: Risks and mitigations (I/II)

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

**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)

<table>
<thead>
<tr>
<th>Risk</th>
<th>Description</th>
<th>Impact</th>
<th>Likelihood</th>
<th>RAG</th>
<th>Mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Press</strong></td>
<td>Negative press damages the health sector in MSE</td>
<td>4</td>
<td>3</td>
<td>AR</td>
<td>Robust communications plan is developed prior to commencement of programme implementation. Continuous communication is established to ensure widespread support for the programme.</td>
</tr>
<tr>
<td><strong>Joint decision making</strong></td>
<td>Joint CCG decision making proposed, but complicated – risk it fails to fully develop</td>
<td>4</td>
<td>3</td>
<td>AR</td>
<td>Ongoing engagement with CCG boards to ensure buy-in.</td>
</tr>
<tr>
<td></td>
<td>Lack of alignment between Local Health and Care plans and In Hospital plans</td>
<td>3</td>
<td>3</td>
<td>A</td>
<td>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.</td>
</tr>
<tr>
<td><strong>Workforce</strong></td>
<td>Difficulties in recruiting appropriately skilled staff</td>
<td>3</td>
<td>3</td>
<td>A</td>
<td>Pro-active work around recruiting is ensured and training programmes for staff are made available.</td>
</tr>
<tr>
<td></td>
<td>Difficulties in retaining staff during reorganisation, within localities and acute sites</td>
<td>5</td>
<td>2</td>
<td>AR</td>
<td>Benefits case for end goal is clearly articulated, with comprehensive communication and engagement plan.</td>
</tr>
<tr>
<td></td>
<td>Lack of staff support for the Future Model of Care; reluctance to change</td>
<td>5</td>
<td>3</td>
<td>R</td>
<td>Close working relationship is nurtured with all local stakeholders (including key public representatives) throughout, to ensure a &quot;no surprises&quot; 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.</td>
</tr>
<tr>
<td></td>
<td>Lack of clinical support for the Future Model of Care</td>
<td>4</td>
<td>3</td>
<td>AR</td>
<td>Robust clinician engagement is continuously led by clinicians – not just those in management positions but also other influential clinicians from all relevant clinical services.</td>
</tr>
<tr>
<td></td>
<td>Lack of collaborative leadership behaviour that inhibits system-wide transformational change</td>
<td>4</td>
<td>3</td>
<td>AR</td>
<td>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.</td>
</tr>
</tbody>
</table>

**Impact:**
- **5** Major impact – Future Model of Care is not or only poorly implemented; state of MSE health system deteriorates.
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**Likelihood:**
- **5** Likely to happen.
- **3** Might happen to some degree.
- **1** Unlikely to happen.
## Delivery: Enablers

### Workforce

**Context**
- Workforce undersupply – high vacancies, imminent retirements and insufficient training pipeline
  - Currently 13% vacancy rate in patch vs. 7% nationally across NHS workforce

**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

**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

### Estates

**Context**
- Wide variation in functional suitability of estates in M&SE
  - GP practice facilities report issues with space and suitability
  - Acute sites all extensively utilised

**Approach**
- 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

**Impact**
- 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

### Technology and innovation

**Context**
- 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**
- 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**
- 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

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1. Workforce includes NHS nursing, AHPs, therapists, medical and dental staff

Source: HEE workforce forecasts May 2016
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

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

Two points of entry

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

<table>
<thead>
<tr>
<th>Adult</th>
<th>Children</th>
<th>Learning disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensure 24/7 Crisis care</td>
<td>Develop three crisis response teams</td>
<td>Increase capacity in the LD intensive support team</td>
</tr>
<tr>
<td>Reduce waiting times and increase capacity in IAPT</td>
<td>Provide three children's single point of access</td>
<td>Pilot community forensic services</td>
</tr>
<tr>
<td>Increase capacity of approved medical practitioners</td>
<td>Provide services for parenting and family groups</td>
<td>Reduce inpatient stays through increased community provision, crisis support and systematic care and treatment review</td>
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<tr>
<td></td>
<td></td>
<td>Improve transition from children's to adult learning disability service</td>
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<tr>
<td></td>
<td></td>
<td>Enhance services for Autism spectrum disorder</td>
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</table>