Mid and South Essex Sustainability and Transformation Partnership
A programme to sustain services and improve care

Pre-consultation Business Case
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<tbody>
<tr>
<td>A&amp;E</td>
<td>Accident and Emergency</td>
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<tr>
<td>ACSC</td>
<td>Ambulatory or primary care sensitive conditions</td>
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<td>AHP</td>
<td>Allied Health Professional</td>
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<td>AI</td>
<td>Artificial Intelligence</td>
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<tr>
<td>B&amp;B</td>
<td>Basildon &amp; Brentwood</td>
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<tr>
<td>BMA</td>
<td>British Medical Association</td>
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<tr>
<td>BTUH</td>
<td>Basildon &amp; Thurrock University Hospitals NHS Foundation Trust</td>
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<tr>
<td>C&amp;R</td>
<td>Castle Point &amp; Rochford</td>
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<tr>
<td>CCG</td>
<td>Clinical Commissioning Group</td>
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<td>CHS</td>
<td>Community Health Services</td>
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<td>CHUFT</td>
<td>Colchester Hospital University Foundation Trust</td>
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<td>CIPs</td>
<td>Cost Improvement Plans</td>
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<td>CMHT</td>
<td>Community Mental Health Team</td>
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<td>CSF</td>
<td>Critical success factor</td>
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<td>CSR</td>
<td>Comprehensive Spending Review</td>
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<td>CSU</td>
<td>Clinical Support Unit</td>
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<td>DH</td>
<td>Department of Health</td>
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<td>DtOC</td>
<td>Delayed Transfer of Care</td>
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<td>ED</td>
<td>Emergency Department</td>
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<td>EIA</td>
<td>Equality Impact Assessment</td>
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<td>EEAST</td>
<td>East of England Ambulance Services Trust</td>
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<td>EOL</td>
<td>End of Life</td>
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<td>ESR</td>
<td>Essex Success Regime</td>
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<td>EU</td>
<td>European Union</td>
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<td>FTE</td>
<td>Full time equivalent</td>
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<tr>
<td>FYFV</td>
<td>Five Year Forward View</td>
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<tr>
<td>GDHI</td>
<td>Gross Disposable Household Income</td>
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<td>GMS</td>
<td>General Medical Services</td>
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<tr>
<td>GP</td>
<td>General Practitioner</td>
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<td>GPFV</td>
<td>GP Forward View</td>
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<tr>
<td>HCA</td>
<td>Health Care Assistant</td>
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<td>HCSW</td>
<td>Health Care Support Worker</td>
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<td>HDU</td>
<td>High Dependency Unit</td>
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<td>HEE</td>
<td>Health Education England</td>
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<td>HOSC</td>
<td>Health Overview and Scrutiny</td>
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<td>HR</td>
<td>Human Resources</td>
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<td>HSJ</td>
<td>Health Service Journal</td>
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<td>HW&amp;B</td>
<td>Health and Wellbeing Board</td>
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<td>ICU</td>
<td>Intensive Care Unit</td>
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<td>IG</td>
<td>Information Governance</td>
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<td>IHI</td>
<td>Institute for Healthcare Improvement</td>
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<td>IMD</td>
<td>Index of Multiple Deprivation</td>
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<tr>
<td>IT</td>
<td>Information Technology</td>
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<td>ITT</td>
<td>Innovation and Technical Tariff</td>
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<td>ITU</td>
<td>Intensive Treatment Unit</td>
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<td>JHWS</td>
<td>Joint Health and Wellbeing Strategy</td>
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<td>JBW</td>
<td>Joint Working Board</td>
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<td>JSNA</td>
<td>Joint Strategic Needs Assessment</td>
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<tr>
<td>LTC</td>
<td>Long Term Condition</td>
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<td>LWAB</td>
<td>Local Workforce Action Board</td>
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<tr>
<td>M&amp;SE</td>
<td>Mid &amp; South Essex</td>
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<tr>
<td>MCP</td>
<td>Multi Community Provider</td>
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<tr>
<td>MDT</td>
<td>Multi-Disciplinary Team</td>
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<td>MEH</td>
<td>Mid Essex Hospital NHS Trust</td>
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<tr>
<td>MH</td>
<td>Mental Health</td>
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<tr>
<td>MHA</td>
<td>Mental Health Act</td>
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<tr>
<td>MLU</td>
<td>Midwifery Led Unit</td>
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<tr>
<td>MRI</td>
<td>Magnetic resonance imaging</td>
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<tr>
<td>MSK</td>
<td>Musculoskeletal</td>
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<td>NELFT</td>
<td>North East London Foundation Trust</td>
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<td>NHS</td>
<td>National Health Service</td>
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<td>NHSE</td>
<td>NHS England</td>
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<td>NHSI</td>
<td>NHS Improvement</td>
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<td>NICE</td>
<td>National Institute for Health and Care Excellence</td>
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<tr>
<td>OOH</td>
<td>Out of Hours</td>
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<tr>
<td>ORCHA</td>
<td>Organisation for the review of care and health apps</td>
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<td>PAC</td>
<td>Public Accounts Committee</td>
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<td>PAH</td>
<td>Princess Alexandra Hospital</td>
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<td>PCBC</td>
<td>Pre-consultation business case</td>
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<td>PHE</td>
<td>Public Health England</td>
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<td>PSED</td>
<td>Public Sector Equality Duty</td>
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<td>QIPP</td>
<td>Quality, Innovation, Productivity and Prevention</td>
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<td>QOF</td>
<td>The Quality and Outcomes Framework</td>
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<td>SHMI</td>
<td>Summary Hospital Level Mortality Indicator</td>
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<td>STP</td>
<td>Sustainability and Transformation Partnership</td>
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<td>SUH</td>
<td>Southend University Hospital NHS Trust</td>
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<td>SUS</td>
<td>Secondary Uses Services</td>
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<td>TDA</td>
<td>Trust Development Agency</td>
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<td>UCC</td>
<td>Urgent Care Centre</td>
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<td>Abbreviation</td>
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<tr>
<td>UK</td>
<td>United Kingdom</td>
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<tr>
<td>UTC</td>
<td>Urgent Treatment Centre</td>
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<td>UTI</td>
<td>Urinary Tract Infection</td>
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<tr>
<td>WTE</td>
<td>Whole Time Equivalent</td>
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Foreword

The NHS in mid and south Essex is part of one of the best health systems in the world, but we do not consistently perform at that level. We do not reach the very best standards; we do not always achieve the best patient outcome and we could do better.

The Success Regime and subsequent Sustainability and Transformation Partnership have reset the system to achieve its potential. In less than twelve months, the three hospitals in Basildon, Chelmsford and Southend have established a single executive and a rapidly developing single support network. Five CCGs have begun to combine some of their commissioning resources and expertise, and streamlined decision making with the establishment of a joint committee. The system now has one predominant mental health provider and the three organisations providing community health to our populations are working much more closely together. With these system-wide approaches, barriers are slowly disappearing and people are talking about a once-in-a-career opportunity to create a world-class service for patients.

This business case is a critical and tangible step towards sustainable health and care for the people of mid and south Essex. While keeping our planned development of primary, community and social care clearly within view, we deal with the urgent need to redefine our future hospitals.

With three hospitals working as a group, it is possible to consolidate and strengthen specialist teams to improve care quality and outcomes; while at the same time ensuring effective and efficient local services for the communities around each hospital.

In this document, we show how we arrived at potential options for hospital reconfiguration and redesign, and what is needed to put these plans into action in a managed and safe way. We set out the case for change; show how local clinicians have joined forces to lead system-wide planning, based on clinical evidence and we demonstrate that public and patients have been involved in every decision-making stage, with more to follow.

The care model presented has been examined and assured several times during its development, notably in a series of detailed independent reviews by the East of England Clinical Senate. We have taken on board its recommendations and will continue to explore fully the implications of service change for local people.

This business case is critical in order to secure the investment needed to live well and manage long-term illness. It is urgent because acute services are overstretched and staff battle daily to deliver the quality of care that they believe in. It is compelling because there is significant potential to improve.
Executive Summary

Local health and social care organisations in mid and south Essex have come together as part of the STP – a national programme to improve health and social care.

There are many examples of excellent health and social care services in mid and south Essex, but local services are under pressure. Health outcomes are not consistently good in all parts of our community. Local services are struggling to stay within their means. We struggle to recruit enough appropriately qualified staff. This plan sets out the actions we intend to take to improve healthcare for the communities we serve in four main domains:

First of all, **to provide the highest possible quality of care across the patch within available resources:**

- Local health and care services are too fragmented. They do not provide consistently high-quality care for patients, for example those who are frail or approaching the end of their lives.
- In primary care, the level of patient satisfaction with GPs is below national average for all five CCGs. Across the patch, fewer patients than the national average rate the overall experience as “good” or “better”, and fewer patients are able to make an appointment when they try.
- In acute hospitals, key services are regularly falling short of important clinical quality and safety standards. For example in 16/17 all three Trusts significantly missed the national A&E target to see 95% of patients within 4 hours (Basildon 87%, Southend 83% and Mid Essex 81%) and patient surveys indicate lower levels of satisfaction than the national average
- National policy and standards set out challenging new quality and access targets, for 7-day services, cancer care, and mental health care, among others. Meanwhile, professional bodies (including Royal Colleges) have specified levels of staffing for safe, high-quality care. Without change, local services will struggle to meet these targets.

Secondly, **to meet rising non-elective demand:**

- A&E attendances are growing at double the national growth rate (3% vs. 6% in 2015-16). Unnecessary emergency admissions add to the pressure, with many patients being better suited to treatment through community care and primary care provision.
- However, neither acute nor primary services are currently configured to meet rising demand. If we do nothing, there is likely to be a shortfall of more than 300 beds by 2020-21.
Thirdly, to alleviate the pressure that workforce challenges are placing on services across the system.

- Mid and south Essex has more patients per GP than most of the other health authorities in England, largely owing to recruitment difficulties, and this number is set to rise. In the acute hospitals there are significant workforce shortages in medicine and nursing with high vacancy rates in some specialties.

- Relying on our ability to hire more staff is not a sustainable option, given local and national workforce shortages. The only solution is to adopt new ways of working, such as providing more care out of hospital, and widening the role of community health staff.

Lastly, to address the financial challenges:

- The annual financial deficit facing local commissioners and providers reached £99 million in 2016-17, and could increase to £532 million by 2021/22.

- To live within our means, we must look beyond the current configuration of services and find new, more economical ways of delivering high-quality services.

To address these various challenges, we need to adopt a new model of care for local health and social care services, and for acute care.

Our approach to local health and social care services are designed with two broad objectives in mind:

- Firstly, to build capacity outside the hospital to better support more complex care needs: releasing GP capacity through the use of other health and social care professionals and technology; organising care around natural communities (“localities”) – delivering more services at a local level

- Secondly, to manage demand for healthcare across primary, community and acute settings – via 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; and strengthening capacity in the urgent and emergency care pathway.

Adopting this model will reduce pressure on acute services and enable us to reconfigure our hospital services to provide safer, higher-quality care.

Our proposed new model for acute care will be based on the following:

- separating elective and non-elective care for high volume specialities.
  According to nationwide evidence, the separation of elective and non-elective care improves service reliability and efficiency, and leads to a better patient experience.
- **consolidating services.** Research shows that for many specialties, higher volumes of activity improve patient outcomes as a result of greater specialisation and 7 day senior cover. So where there is a clinical case, we will look to consolidate specialist activity across the three Acute Trusts.

The two models of care, for local health and social care, and for acute care are inextricably linked, of course, and reinforce each other. We cannot implement one without the other. Jointly, they provide a very promising opportunity to enhance the care provided to patients, and at the same time to shift local services to a sustainable position in respect of staff levels and cost.

Successful delivery of our plan will result in:

- **Improved quality and outcomes**
  - Centres of excellence with compliant rotas
  - Reductions in cancellations for planned surgery
  - Reduced variation across the hospital group

- **Increased capacity in out of hospital services**
  - Up to 24% of GP capacity freed up by:
    - Investment in new skills and a wider range of professionals
    - Increased emphasis on self-care and prevention
    - Harnessing innovation, including digital
  - Locality teams that integrate health, social care, public health and voluntary organisations

- **Reduced pressure on hospital services**
  - By 2021/22, compared with a ‘do nothing’ approach, there will be:
    - 14% fewer emergency admissions
    - 15% fewer A&E attendances
    - 35% fewer traditional outpatient appointments

- **Closing our financial gap**
  - Increased productivity across our hospitals, as a result of narrowing variation and separating and consolidating services
  - Delivery of £126m system savings

To enable us to deliver our programme, the system requires both non-recurrent and capital investment. We estimate that the acute reconfiguration identified in this case will require circa £118m of capital, and that pump priming capacity in services will require approximately £40m.
1. Purpose and scope of this document

1.1. Purpose

The purpose of this document is to set out the key elements of the mid and south Essex STP with a particular focus on the changes we propose to Local Health and Care and Acute services.

This document:

Sets out a clear case for change

- Based on the need to provide the highest possible standards of care and to improve outcomes; meet rising demand; respond to workforce challenges; and address financial pressures.

Describes key elements of mid and south Essex’s future model of care

- How our local health and care model will manage demand for healthcare and increase capacity in the community to support more complex care needs...
- …enabling our acute model to (i) improve emergency centres; (ii) separate elective and non-elective care; and (iii) consolidate some services in order to provide higher quality, safer, more efficient services

Provides detailed financial and clinical assurance

- Describing how the proposals maintain or enhance the quality of care, whilst addressing the financial challenges that commissioners and providers in mid and south Essex face
- Setting out the financial investments required to deliver the model; and the expected savings that will be delivered

Describes how we have involved key stakeholders, including the public, in the development of these plans

- Demonstrating that the public, and other key stakeholders, have informed and shaped these proposals and that we have acted on this feedback
- Setting out how we will continue to engage and consult with all stakeholders

Outlines how mid and south Essex will deliver these plans, if approval to move forward is received

- Including outlining implementation timelines and governance arrangements

1.2. Scope

With regard to the scope of this document, the following should be noted.
This document does not attempt to provide a full description of all services, or service improvement plans across mid and south Essex. For example, there are many initiatives ongoing where independencies are identified within this PCBC, but for which full detail is not provided, e.g.

- Individual organisational improvement plans not linked to the core financial bridge
- Initiatives delivered across a non-coterminous footprint for example, the implementation of the Essex Mental Health Strategic Review, which is being delivered across a larger footprint than the STP
- Initiatives managed through existing arrangements for which there is not clear benefit in bringing governance into the STP for example, Transforming Care for People with Learning Disability

This document does not represent a final or detailed delivery plan. This will be developed after consultation, taking into account further inputs from patients and other stakeholders, as well as other interdependencies such as the availability of capital.
2. Introduction and Context

About this section

This section considers the strategic setting for the pre-consultation business case. It reviews the progress to date in developing the Success Regime and STP, describes the structure of the healthcare system in the patch, and discusses trends in the health and wellbeing of the patch’s population.

2.1 Purpose of the pre-consultation business case (PCBC)

This PCBC considers proposed changes to health and care services in mid and south Essex. To make the case for commencing public consultation for the Success Regime (now referred to as the mid and south Essex STP), the document sets out the following:

- The clinical and financial case for change (Section 3)
- A vision for the future (Section 4)
- A future model of care for local health and care and in-hospital services (Sections 5 and 6)
- Strategic alignment of plans (Section 7)
- System-wide enablers and governance for clinical proposals (Section 8)
- How the proposals will help ensure financial sustainability (section 9)
- Clinical Assurance (Section 10)
- Assessment against the four test of reconfiguration (Section 11)
- Communications & Engagement (Section 12).
- Governance (Section 13)
- Implementation plan (Section 14)

2.2 Context of the Success Regime and STP

The *NHS Five Year Forward View* (FYFV) sets out the challenges facing health and care nationally, and shows how radical change is needed to sustain services into the future and improve care for patients. It is a blueprint for a crucial NHS effort to secure high quality, sustainable, joined up care. As part of this effort, a national Success Regime programme was initiated to improve health and social care where systems have financial deficits, issues of service quality, or both. The programme concentrates on certain areas of the country where there are deep rooted, systemic pressures.

In this context, the Essex Success Regime was selected by a committee of seven national regulatory bodies in June 2015 as one of three such programmes in the country. By the end of November, the diagnostic was completed and a decision was made to focus on mid and south Essex. Following a diagnostic phase, which ran from October to November 2015, the decision was taken to focus on mid and south Essex, which is accountable for approximately two-thirds of total spend on Clinical Commissioning Groups in Essex.

The Essex Success Regime was overseen by, and reported to, NHS England (NHSE) and NHS Improvement (NHSI) regional leads.

With the establishment of STPs across England in 2016 a decision was taken to embed the work of the Success Regime into the STP with the same footprint and governance processes in place.

2.3 The Success Regime Diagnostic

Following the launch of the Essex Success Regime in June 2015, a diagnostic review was carried out from 29 September to 2 November 2015. The review was a rapid five-week project to determine the Regime’s scope. It did not address the question of how to deliver the required change. The work involved more than 40 one-to-one stakeholder interviews and 187 total interactions, including those with patient representatives.

The review also included a systematic assessment of existing CCG and provider plans, supplemented by new data and analytics. Where possible, stakeholder perspectives were supported by data-driven evidence; where data was not available, stakeholder input was included as stand-alone evidence, subject to these provisos: it was reported or provided by more than one person, it was consistent with the fact-based narrative, and it was not undermined by any contrary opinions expressed in interviews.

The diagnostic concentrated on two questions:

(i) What are the key challenges (and their causes) faced by the Essex health economy?

(ii) What should the Success Regime focus on, given these key challenges?
The findings and recommendations of the diagnostic phase were endorsed by the tripartite Regional Directors (NHSE, TDA and Monitor, now NHSE and NHSI).

### 2.3.1 Key challenges

Four prominent themes were identified during the diagnostic phase. First, many of the challenges facing the Essex health and social care system are longstanding: they are pervasive issues that have been evident for many years and are intensifying. Secondly, the challenges are often system-wide, and can be seen across a range of organisations. Thirdly, there is a collaboration gap between organisations within the system, and that has inhibited collective action on improving performance. Lastly, there are many potential options for tackling the issues faced, so no “perfect answer” is likely to emerge; instead, what’s needed is a plan of constructive action that has the full support of stakeholders and will be implemented by all.

Against the backdrop of these thematic issues, the diagnostic review identified six key challenges for health and social care services across the patch. Specifically, Essex was found to have:

- **A clinically and economically disadvantaged acute footprint.** Essex is served by five small hospitals. On average, they have a higher proportion of non-elective work (32% of total trust income) than similar-sized hospitals outside of the patch (26% of income) and large multi-site / teaching hospitals (12% of income). Most services are provided at most of the sites, and there is a lower volume of elective and specialised work at each site. In addition, some of the sites are facing estate challenges.

- **Workforce and talent gaps.** There are gaps in many clinical rotas, especially A&E, where consultant cover is below the recommended levels across all five sites. There is difficulty in attracting talent into leadership roles. There is a capacity issue in primary care, coupled with an ageing GP workforce: that workforce declined by 1% in 2013/14. There are recruitment challenges in social care and community care.

- **A complicated commissioning landscape.** With seven CCGs, three upper-tier Local Authorities and more than 500 contracts, commissioning consumes a great deal of management time yet risks producing “more heat than light”.

- **Protracted decision-making.** Time and effort spent on decisions can be considerable, with decisions often re-opened – particularly in regard to strategic-service line changes.

- **Senior managerial / clinical leader capacity devoted excessively to operational needs.** In consequence, it is difficult for leaders to find the time to design and lead major change.

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1 Small being defined as £300 million income (smallest £200 million) in: Monitor. Facing the Future: Smaller Acute Providers. 2014.


• **Limited data usage and data sharing.** Commissioning plans are not always rooted in data-driven needs assessments; there are data gaps regarding outcomes as well as regarding the social-care expenditure on the CCG population.

2.3.2 **Root causes**

Essex’s pervasive, system-wide healthcare challenges can be attributed to several underlying factors. The recommendations of the diagnostic review address these root causes directly in order to drive long-term positive change. Six root causes were highlighted by the review:

• **The urban social geography of Essex.** All five acute hospitals serve towns of fewer than 180,000 residents, and have relatively low income levels (less than £300 million), which are associated with financial challenges. London acts as a magnet for all job types, with 140,000 people commuting out of Essex for work. Regarding healthcare workers specifically, London has an additional attraction, thanks to its salary weighting; and Essex lacks a natural academic “hub” for healthcare, so Addenbrooke’s and London act as pull factors.

• **National and local trends.** Essex has an ageing population: Between 2014 and 2016 the number of over 75 year olds grew by 2.3% vs the national average of 2.4%. National guidelines on safe care and seven-day working are driving greater staff needs and higher costs. The London job market has outperformed Essex over the last five years, with a 14% increase in all jobs vs. just 2% in Essex.

• **Rising demand in health and social care.** The number of emergency admissions in Essex hospitals grew by 6% from 2014/15 to 2015/16, vs. a national average of 3%. As a result of the ageing population, social spend is increasing rapidly. For example, between 2013 and 2015 Essex County Council recorded a 6.1% annual rise in spend on adult social care and a 4.9% rise in spend on domiciliary care and day spend.

• **A gap between actual and target funding for Essex.** For over a decade, now, on a range of formulae, the patch has failed to receive its target funding, though more recently it is heading towards the target.

• **Few coterminous boundaries.** Conurbations, acute catchment populations, and health and local-authority commissioners seldom coincide in their boundaries, so a larger number of stakeholders have to be involved in decision-making.

• **No overall Essex plan and few “givens” in regard to the acute footprint.** There is broad alignment on the need to concentrate clinical services and to apply hub-and-spoke models in the effort to create more robust clinical rotas, reduce agency needs, and drive better outcomes. However, as a result of strategy and legacy investments, the position is still that “every hospital has a reason to do everything”.

---

2.3.3 Diagnostic conclusion

Given the social geography of the county, the Success Regime opted to concentrate on the five CCGs and three acute hospital trusts of mid and south Essex. (See sub-section 2.5.) This area is largely self-contained, with 93% of local hospital trust activity coming from mid and south Essex patients. Further information on the diagnostic methodology and findings is available as required.

2.4 Goals of the mid and south Essex Success Regime and STP

There is a clear and urgent case for change in the mid and south Essex healthcare and social-care system. Following the diagnostic phase of the Success Regime, three goals were established to guide the programme.

To create and support the development of a transparent, internally consistent, whole-system plan:

- Enable organisations to deliver high quality care for patients and reduce local health inequalities
- Achieve financial balance by 2020/21, securing sustainable services for the future
- Address the root causes identified in the diagnostic
- Provide directional clarity to enable organisations to plan over the next five years

To establish a locally led and nationally supported programme to deliver the plan:

- Build and extend existing strategies / collaborations that are consistent with the FYFV
- Foster greater balance between system view and organisational view
- Increase the ability of leaders and workforce to make changes and develop other capabilities

To use NHSE and NHSI influence to remove barriers and accelerate delivery:

- Apply flexibility to business rules; give “permissions”
- Encourage a system approach, collaboration, and focus on the FYFV
- Bring national expertise and other forms of support to bear
- Enable greater flexibility in regard to national operational requirements
2.5 Health and social care services in mid and south Essex

The STP encompasses healthcare activity across mid and south Essex, with a population of 1.2 million.

**Figure 1: STP coverage area**


The following organisations are involved in the STP’s scope of work:

Five CCGs:
- Basildon and Brentwood CCG (B&B CCG)
- Castle Point and Rochford CCG (CP&R CCG)
- Mid Essex CCG (ME CCG)
- Southend CCG (SE CCG)
- Thurrock CCG (TCCG)

Three acute hospital trusts:
- Mid Essex Hospital Services NHS Trust (MEH)
- Basildon and Thurrock University Hospitals NHS Foundation Trust (BTUH)
- Southend University Hospital NHS Foundation Trust (SUH)

Three mental and community health providers and one ambulance service trust:
- Essex Partnership University NHS Foundation Trust
- North East London NHS Foundation Trust (NELFT)
- Provide
• East of England Ambulance Service NHS Trust (EEAST)

Three upper-tier Local Authorities:
• Essex County Council
• Southend-on-Sea Borough Council
• Thurrock Borough Council

In addition, there are a large number of voluntary, community and private-sector health and social care providers in the area. These organisations deliver services that are crucial to the wellbeing of the local population.

2.6 Population health and wellbeing

2.6.1 Demography

The mid and south Essex population is projected to grow by 136,000 residents by 2031, as a result of population growth and inward migration. At the same time, the age structure of the patch’s population is changing, with a notable increase expected in the proportion of people aged over 65. In 2016, 19.3% of the population in Essex were over 65, vs. 17.9% at the national level. “As for people aged 85 or more, the number will increase by 75%, from 30,000 in 2016 to 53,000 by 2031”

Figure 2: Essex population growth

Source: Essex County Council.

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The number of children in the patch is expected to grow approximately in line with the county’s general population, so the proportion of children should remain fairly constant up to 2031, at roughly the same level as England as a whole. The working-age population\(^8\) will decrease – from 57.4% in 2014 to 53.2% in 2031, some 1.4 percentage points below the national average. This lower level of working-age residents may reflect migration outwards as people seek work outside the area. The resulting decrease in the proportion of economically active people in the total population of Essex is expected to create increased demand for all public services in the county, and for health and social care in particular.\(^9\)

The mid and south Essex area encompasses considerable demographic diversity. It encompasses rural areas in the Dengie, affluent commuter towns like Chelmsford, more deprived urban areas such as Grays and Tilbury. This diversity is reflected across several factors; the median age in Maldon is 45, whereas for Thurrock it is 36, in Chelmsford and Southend it is the UK median of 40. In terms of ethnic diversity, the non-white British population ranges from 4.2% in Maldon, to over 20% in Southend East Central.\(^10\)

2.6.2 Income and deprivation

Essex-wide, the average gross disposable household income (GDHI) stands at £18,721, vs. a national average of £17,559. By contrast, the average GDHI in London is £22,516.\(^11\) According to the English Index of Multiple Deprivation (IMD), which ranks every small area in England according to a range of domains, Essex has some of the most affluent and some of England’s most deprived small areas.\(^12\)

Among the county’s most affluent areas are Brentwood and Chelmsford, and among its most deprived areas are Basildon and Southend. The most deprived areas have associated low levels of life expectancy, poor educational attainment levels, and higher social care and healthcare needs.

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\(^8\) Defined here as 20-65


\(^10\) ONS. UK Census data. 2011.

\(^11\) ONS. UK Census data. 2013.

\(^12\) Department for Communities and Local Government. The English Indices of Deprivation 2015.
Figure 3: Index of Multiple Deprivations (IMD) by small area in mid and south Essex

Child poverty levels also vary across Essex. Some 17.1% of all children in the county are living below the poverty line, vs. 19.6% in England as a whole; the rate is much higher in Basildon (24%) and Southend (28%).

Children from poorer backgrounds, the evidence shows, are more likely to suffer from accidental injury, infections, general ill health, anaemia, dental caries and teenage pregnancy. Moreover, families living in poverty are less likely to access health services and to benefit from health-promotion services and advice.

Although Southend includes some of the most deprived wards in the county, it performs well in terms of educational achievement, with 64% of students receiving 5 A*-Cs at GCSE, vs. 58% for the Essex County Council area and 52% in Thurrock, 52% in England as a whole. In terms of employment, the areas with the highest proportion of unemployment-benefits claimants are Southend and Thurrock, each at 1.9%, the lowest being Brentwood, at 0.6%; for the Essex County Council area, the figure is 1.3%, vs. 1.7% for England as a whole.

14 Department for Education. GCSE statistics 2014/15.
2.6.3 Life expectancy and disease prevalence

Overall life expectancy has been increasing across all areas of mid and south Essex. The life expectancy for Essex as a whole is at 80.3 years for men and 83.6 for women – higher than the national averages of 79.5 and 83.2 respectively. In Thurrock, however, life expectancy is lower than the national average in each case, being 79.3 for men and 82.6 for women. There is also great variation across mid and south Essex. For example, men in the 10% most deprived population in Thurrock have an average life expectancy of 74.1 years, vs. 83.2 for men in the least deprived 10% in Southend.16

The most common cause of death in Essex is cardiovascular disease, followed by cancer. Cardiovascular mortality for under-75s in Southend is 85.6 per 100,000 populations, and in Thurrock 88.8, both well above the national average of 75.7. However, the rate for the Essex County Council area is 64.2, significantly lower than average. The rate of smoking among adults in Thurrock, at 21.3%, is significantly higher than elsewhere in mid and south Essex (18.8% in Southend and 17.6% in Essex as a whole) and well above the national average of 16.9%. Infant mortality rates in Essex and Thurrock are below national average, and in Southend the rate matches the national average, at 4.0 per 1000 live births.

2.6.4 Conclusion

Overall, the population of Essex in recent decades has seen an improvement in life expectancy and a reduction in mortality rates for the most prevalent conditions, such as cancer and cardiovascular diseases. However, given the growing and rapidly ageing population, the outlook is for an increase rather than decrease in pressure on the health and social care system. In addition, health outcomes in Essex vary greatly owing to the large disparities in income and deprivation levels across the county. In view of these trends, the STP must develop a future model of care that addresses the changing nature of demand while maintaining accessibility of services for the patch’s entire population.

3. **Case for change**

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3.1 **Introduction**

The mid and south Essex success regime and subsequent STP identified four main drivers of change:

1. the need to provide the highest possible standards of care
2. the need to meet the rising demand (particularly non-elective demand)
3. the need to respond to workforce challenges
4. the need to address financial pressures
There is strong consensus across the patch about the case for change. In a workshop of the Senior Leadership Group - which included representatives from the acute services, primary care, social care, community health, and mental health – 97% of attendees agreed that there are convincing reasons to change the way we deliver services; the remaining 3% had no strong opinion.\(^{17}\)

The case for change that forms the basis of this section was considered by CCG and partner boards; subsequently, the fuller case was developed.

### 3.1.1 The need to provide the highest possible standards of care

While healthcare provision has improved significantly in mid and south Essex over recent years, a number of gaps persist. Figure 4 highlights some areas where outcomes in mid and south Essex are below national average, notably outcomes in primary care, end-of-life care, non-elective admissions to hospital, cancer statistics, and experience of maternity services.

#### Figure 4: Key health, quality and care indicators for mid and south Essex

<table>
<thead>
<tr>
<th>Metric</th>
<th>STP Position vs. national</th>
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<tbody>
<tr>
<td>People with LTC feeling supported to manage their condition</td>
<td>65.5%</td>
</tr>
<tr>
<td>AMR: Appropriate prescribing of antibiotics in primary care</td>
<td>1.16</td>
</tr>
<tr>
<td>AMR: Appropriate prescribing of broad spectrum antibiotics in primary care</td>
<td>10.4%</td>
</tr>
<tr>
<td>Quality of life of careers—health status score (EQ5D)</td>
<td>0.81</td>
</tr>
<tr>
<td>Maternal smoking at delivery</td>
<td>8.8%</td>
</tr>
<tr>
<td>% children aged 10–11 classified as overweight or obese</td>
<td>34.4%</td>
</tr>
<tr>
<td>Diabetes patients that have achieved all 3 of the NICE-recommended treatment targets</td>
<td>41.0%</td>
</tr>
<tr>
<td>People with diabetes diagnosed &lt;1 year who attend a structured education course</td>
<td>10.3%</td>
</tr>
<tr>
<td>Injuries from falls in people aged 65+ per 100,000 population</td>
<td>1912</td>
</tr>
<tr>
<td>Personal health budgets per 100,000 population (absolute number in brackets)</td>
<td>16.59 (196)</td>
</tr>
<tr>
<td>% deaths which take place in hospital</td>
<td>47.8%</td>
</tr>
<tr>
<td>Patient experience of GP services</td>
<td>77.6%</td>
</tr>
<tr>
<td>Primary care workforce - GPs and practice nurses per 1k population</td>
<td>6.55</td>
</tr>
<tr>
<td>Patients waiting &lt;18 weeks from referral to hospital treatment</td>
<td>10.4%</td>
</tr>
<tr>
<td>People eligible for standard NHS Continuing Healthcare per 50,000 population</td>
<td>64.09</td>
</tr>
<tr>
<td>% patients admitted, transferred or discharged from A&amp;E within 4h</td>
<td>60.5%</td>
</tr>
<tr>
<td>Ambulance waits: % of call A red 1 incidents responded to within 8 min.</td>
<td>64.6%</td>
</tr>
<tr>
<td>% children admitted, transferred or discharged from A&amp;U within 4h</td>
<td>64.6%</td>
</tr>
<tr>
<td>Delayed transfers of care due to NHS and Social Care per 100k population</td>
<td>9.08</td>
</tr>
<tr>
<td>Emergency bed days per 1,000 population</td>
<td>0.88</td>
</tr>
<tr>
<td>Emergency admissions for CACSC per 100k population</td>
<td>773</td>
</tr>
<tr>
<td>People w/urgent GP ref. having 1st definitive treatment for cancer w/in 62d of referral</td>
<td>73.6%</td>
</tr>
<tr>
<td>Cancer patient experience</td>
<td>88.8%</td>
</tr>
<tr>
<td>Improving Access to Psychological Therapies recovery rate</td>
<td>40.8%</td>
</tr>
<tr>
<td>People w/learning disability autism receiving specialist inpatient care per 1m populat.</td>
<td>30.00</td>
</tr>
<tr>
<td>Prop. of people with learning disability on GP register receiving annual health check</td>
<td>50.3%</td>
</tr>
<tr>
<td>Neonatal mortality and stillbirths per 1k births</td>
<td>6.96</td>
</tr>
<tr>
<td>Women’s experience of maternity services</td>
<td>79.2</td>
</tr>
<tr>
<td>Estimated diagnosis rate for people with dementia</td>
<td>62.6%</td>
</tr>
<tr>
<td>Emergency admissions for urgent care sensitive conditions per 100k population</td>
<td>573</td>
</tr>
</tbody>
</table>


This section concentrates on the quality, outcomes, and performance of health and social care services. Subsequent sections will deal with workforce challenges, rising demand, and financial issues.

### 3.1.2 Local health and care services

There are some excellent local health and social care services being delivered across mid and south Essex. For example, in 2016 Mid Essex CCG received an HSJ award for its continuing healthcare fast-track team, in recognition of its ability to rapidly assess patients who are at the end of life and to provide the care that they need. Similarly, in 2015 Castle Point and Rochford received national recognition, for its pioneering care-coordination service, which delivers care to vulnerable patients

\(^{17}\) Stakeholder Briefing, 13 July 2016.
who may be at risk of decline. NELFT has been shortlisted in the 2016 HSJ awards for the dementia crisis support team, a team based at Brentwood Community Hospital that provides support for people with dementia and their carers to avoid hospital admission.

However, there is much potential for reducing variation and ensuring that all residents can consistently access excellent local health and social care services, including general practice, community healthcare, rehabilitation and reablement, public-health initiatives and self-care.

**Primary care**

Primary care refers to services provided by GP practices, community pharmacies, dental practices and high street optometrists. For many people, primary care represents their first point of contact with the NHS, and around 90% of patient interaction is with the primary care services\(^\text{18}\). The majority of primary care services in mid and south Essex are of good quality: as of December 2016, nearly three-quarters of GP practices inspected by the Care Quality Commission received a rating of “Good” or better. However, 13 practices across the patch were rated as “inadequate” - 9% of all those inspected to date. This is a common theme across primary care that there are areas of excellent practice, but there remains too much variation in performance and outcomes between GP practices, and in the degree of integration between general practice and pharmacy, dental and optometry services.

Even where primary care is currently being delivered to high quality, services are facing strain due to workforce shortages and increasing demand. This problem is attributable to a range of factors, including an ageing population with more complex health conditions, and a lower-than-average number of GPs per head of population. And it is compounded by increasing population growth: local authority projections are that mid and south Essex will experience a demand of between 2,100 and 5,400 new dwellings per year between 2012 and 2037.\(^\text{19}\)

As a consequence of these pressures, the level of patient satisfaction with GPs is below national average for all five CCGs, though again there is much variation across individual GP practices. As Figure 5 shows, in nearly half of practices, fewer than 84% of patients rate the overall experience as “Good” or better, whereas in other practices, that rating is provided by more than 90% of patients.\(^\text{20}\) Access is also varied: nationally, 73% of patients are able to make an appointment when they try; in mid and south Essex, this figure varies between 68% and 72% depending on the CCG.\(^\text{21}\) For patients requesting a same-day appointment, the success rate is slightly lower in mid and south Essex than the national average: 37% vs. 38%.\(^\text{22}\) There is variance in the appointment systems within mid and south Essex: some but not all offer walk-in sessions, extended hours and email communication.

\(^\text{18}\) NHS Digital, [http://content.digital.nhs.uk/primary-care](http://content.digital.nhs.uk/primary-care)


Regarding performance on key outcomes in primary care, there is large variation across mid and south Essex, both within the patch and relative to the national average. A review of the admission rates for ambulatory-care sensitive conditions (ACSCs), such as asthma and chronic obstructive pulmonary disease (COPD) – a lens on the quality of preventative care in the community – shows that two of the five CCGs in mid and south Essex have higher admission rates than the national average.23

As Figure 6 indicates, there is often a wide gap between the highest- and lowest-performing CCGs for a range of similar metrics. In some instances, such as rates of avoidable emergency admissions, all CCGs perform better than the national average, though at different levels. For others, such as the proportion of patients who feel supported in managing their long-term conditions (LTCs), all CCGs are below national average.24 This particular indicator impacts on patient wellbeing: self-management is known to increase physical functioning, instil greater confidence, and reduce anxiety.25

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25 Challis et al. Self-Care and Case Management in long-term conditions. 2010.
Figure 6: Outcome metrics

Note: All metrics are directly standardised rates (DSR). Sources: Health and Social Care Information Centre. GP registered patient counts; Primary Care Mortality Database; ONS mid-year census-based England population estimates; NHS England. GP patient survey. HES.

There is also variability in the activity levels across mid and south Essex, some of which may be unwarranted and reflect differences in the quality of primary care provision. Across GP practices, elective admissions per capita showed a twenty-fold variation in 2015; and prescribing spend per patient showed a twenty-fold variation from the highest to the lowest practice. Across CCGs, there was a three-fold variation in emergency admissions per capita for certain ACSCs, such as ear, nose and throat infections and dental conditions in 2016.²⁶

Figure 7: Variation in elective admissions across mid and south Essex

Reflecting the challenges described above, the 2014 NHSE report\textsuperscript{27} concluded that the traditional model of primary care delivery in Essex is not sustainable, owing to:

- Variable quality of primary care, with differences in early diagnosis/interventions
- Lack of integration, with primary care services failing to provide a seamless experience for patients
- Increasing demands on health services, without new investment available
- An overloaded GP workforce
- Variable primary care estate, with lack of flexibility and incomplete utilisation
- Insufficient flexibility in the current model to adapt services for the most vulnerable in our community
- Changing population demographics

**Community, mental health and social care services**

Over the past five years, demand for social care services has been growing at an unsustainable rate of 5–10% a year. For example, looking at Essex County Council area, the number of people in need of care and support is projected to grow almost four-fold between 2013 and 2030 – from 35,000 to 137,000.\textsuperscript{28} Social care services are particularly affected by Essex’s demographic change. The number of over 85-year-olds in Essex is estimated to grow by over 60% from 2013 to 2025. Given that more than half of old persons’ social care services are used by people above 85 years of age (see

\textsuperscript{27} NHS England. Transforming Primary Care in Essex: The Heart of Patient Care. April 2014.

Figure 8), the expected growth is likely to pose a challenge to the current model of service delivery. In addition, the social care sector has been facing capacity and quality challenges in recent years. In Thurrock, for example, two of the four providers had to withdraw from work, one because of financial difficulties, and the other because of quality concerns.

**Figure 8: Social care service use of Essex's older persons' population (2014)**

![Pie chart showing social care service use by age group in 2014](image)

Source: Essex County Council.

Community and mental health providers have also been facing high pressure from rising demand. Provide a major community provider in mid and south Essex, reports that its caseload has been rising by 4% every year. And the number of referrals has risen by 13% from 2013 to 2016. For some services, the rise has been even sharper. For instance, adult diabetes referrals increased by 54% from August 2013 to July 2016 and the ambulance services provider reported an 18% year-on-year increase in the most serious calls from 2015/16. Mental health services in mid and south Essex have also struggled with the growing demand. The number of emergency admissions for dementia is telling: whereas the three trusts (BTUH, MEH, and SUH) jointly recorded about 700 emergency admissions in April 2013, that number almost doubled to 1300 in April 2016, just three years later.³⁰

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²⁹ “Red 1” and “Red 2” classified calls

Frailty and end-of-life care

Frail older people (over 75 years old) represent just 8% of the population in the patch but account for 39% of acute bed days and 35% of non-elective admissions.

Currently, outcomes are below national averages.

Figure 10: End of life metrics

Notes: 1“How would you rate his/her care in the last three months of life?” – % outstanding or excellent; 2“Were the carers given enough support by the healthcare team at time of death?” – % Yes / Definitely; Sources: Office for National Statistics; National Survey of Bereaved People (VOICES) 2011-13; National End of Life Care Intelligence Network; HSCIC.
Figure 10 shows that, for the majority of selected indicators, all CCGs are in the lowest two quartiles nationally. Almost half of end-of-life patients die in hospital, and patient assessments of care quality and support from clinical staff are both substantially below the national average.

**Patients' and carers' experience of care**

It is imperative that patients receive a quality experience of care. We know that the majority of patients are satisfied with their experience of care for example approximately three quarters of respondents to the annual GP patient survey would recommend their local practice to a friend. However, through our engagement with patients and carers, it is clear that there is more that can be done to improve the experience of care, as the following examples from feedback collected by HealthWatch Essex demonstrate:

Example 1: Dave, who cares for his daughter with a learning disability, was frustrated at having to repeat their story multiple times to multiple agencies. “Surely there must be a way of collating information previously provided or recorded centrally,” he says, “so that all teams can read and study the information in advance rather than just having to start afresh each time?”

Example 2: One woman said she has experienced mental health conditions since school and has used both in- and outpatient services for treatment. She voiced concerns over having received 13 different diagnoses from her community provider over the years, and having been prescribed lots of different medication. She felt there was no communication between services and that no one knew what was going on.

Example 3: Another woman was diagnosed with depression and experienced the mis-reporting of her notes and lack of communication between professionals. During her assessment she was addressed by the wrong name and in the follow-up letter most information was incorrect. For example, her GP documented the death of her mother when, in fact, her mother was still alive.

3.1.3 **Acute services**

The three hospitals in mid and south Essex evidence some excellent quality of care and patient safety. For example, Broomfield hospital is nationally renowned for the quality of its burns and plastic surgery services. Basildon and Thurrock University Hospital Foundation Trust has seen major reductions in its mortality rates – its Standardised Hospital Mortality Index score reduced from 108 to 92 between 2013/14 and 2015/16 (expected level is 100; lower is better). Southend University Hospital Foundation Trust has been designated a specialist centre for urological cancer, providing services across the county.

However, improvement is needed to attain the highest possible standards of care, and there is variation between the three trusts. Figure 11 highlights some of the key metrics and shows where the three trusts are below national average.

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31 HealthWatch Essex. 555 Neurology Project: Capturing the lived experience of people being diagnosed with a neurological condition in Essex. 2016.

32 HealthWatch Essex. 555 Capturing the lived experience of mental health service users in Essex. October 2014
Although the majority of local CCG patients needing acute care are treated in NHS hospitals within mid and south Essex, more than a quarter of those seeking elective (non-emergency) care choose to attend private hospitals or hospitals outside the patch\(^{33}\) in the belief that they can receive more convenient, quicker, or higher-quality care elsewhere.

This trend is particularly marked in elective orthopaedic services (see Figure 13) where 20–50% of CCG activity goes to private hospitals such as Spire and Ramsay. As well as suggesting that on-patch hospitals are not necessarily a patient’s first preference, this trend also points to a loss of potential income for the patch’s NHS hospitals. If those NHS hospitals could improve their performance, they could repatriate some of this activity, improve their financial position, and enable some services to run more efficiently by virtue of economies of scale.

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Figure 13: Patient flows between CCG and acute hospital for elective orthopaedics


Urgent and emergency care (UEC)

For the proportion of A&E patients seen within four hours, Mid Essex Hospitals is the lowest in mid and south Essex STP at 84% vs 90% nationally (and a national target of 95%) in March 2017.

Figure 14: A&E four-hour waiting times

Ambulance services

Nationally, the ambulance service has come under considerable pressure in recent years. In 2015, the East of England Ambulance Services’ three control rooms handled more 999 calls than ever before since its establishment in 2006, an indication of the year-on-year rise in demand on the service. At the same time, it has been experiencing workforce pressures, with an overall vacancy rate across patient transport services of more than 15% (60 WTE). The result has been an underperformance in service provision. In its inspection during August 2016, the Care Quality Commission (CQC) rated four out of five key indicators (safe, effective, caring, responsive, and well-led) as requiring improvement.

Among other findings, the CQC reported that it was failing to meet performance standards and targets for response to emergency calls. For instance, for Red 2 calls, the national target is 75%, and the trust fell short of that target on five occasions between July 2014 and January 2016. As of January 2017, the trust’s performance was ranked fourth out of ten among ambulance services in the NHS, with only 60% of responses meeting the target.

Given these pressures, the ambulance service is launching a new operating model that aims at providing safer, faster and better services through a region- and system-wide integrated approach. The idea is to integrate with the wider health service, including hospitals and community-based clinicians, to send more appropriate resources to patients, treat more patients within the community, and convey fewer patients to A&E. More specifically, the approach should stop 999 callers from “defaulting” so frequently into the emergency sector at high cost, and instead provides callers with better-targeted care pathways. In that way more resources would be available when and where required.

The Friends and Family Test reveals that respondents are notably less likely to recommend A&E services in mid and south Essex than the national average for trusts. In the March 2017 survey, 81% of local respondents stated they would recommend A&E services to friends and family vs 87% nationally. Although Southend is in line with national average at 87%, Mid Essex recorded significantly lower at 77%.

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35 Ambulance Systems Indicators January 2017

Strengths and weaknesses of the current urgent care system were identified in April 2016 via a workshop with service users, conducted as part of the options-development process. The two key performance metrics that emerged were communication and time to treatment; communication in particular is in need of improvement. The workshop also revealed a variation in performance: in some cases, the same aspect elicited both strong positive and strong negative feedback. The findings of the workshop are outlined in Figure 16 and Figure 17.

**Figure 16: Service user feedback**

Source: Service User Workshop. 28 April 2016.
Cancer

Ensuring swift access to cancer treatment is a local and national priority. Across the three local trusts, there is considerable variation in waiting times for both diagnostics and treatment (see Figure 18).

Figure 18: Cancer waiting times

<table>
<thead>
<tr>
<th>2 Week Cancer Waiting Time</th>
<th>2 Breast Week Cancer Waiting Time</th>
<th>One month (31 day) Diagnosis to first treatment wait</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>England</strong></td>
<td><strong>England</strong></td>
<td><strong>England</strong></td>
</tr>
<tr>
<td><strong>BTUHFT</strong></td>
<td><strong>BTUHFT</strong></td>
<td><strong>BTUHFT</strong></td>
</tr>
<tr>
<td>Q4</td>
<td>Q4</td>
<td>Q4</td>
</tr>
<tr>
<td><strong>90.1%</strong></td>
<td><strong>91.3%</strong></td>
<td><strong>95.4%</strong></td>
</tr>
<tr>
<td><strong>95.9%</strong></td>
<td><strong>93.5%</strong></td>
<td><strong>94.1%</strong></td>
</tr>
<tr>
<td><strong>96.4%</strong></td>
<td><strong>96.6%</strong></td>
<td><strong>92.7%</strong></td>
</tr>
<tr>
<td><strong>94.7%</strong></td>
<td><strong>92.9%</strong></td>
<td><strong>97.5%</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>31 day wait for second or subsequent treatment</th>
<th>31 day wait for second or subsequent treatment (drugs)</th>
<th>62-day wait for first treatment following referral from cancer screening service</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>England</strong></td>
<td><strong>England</strong></td>
<td><strong>England</strong></td>
</tr>
<tr>
<td><strong>BTUHFT</strong></td>
<td><strong>BTUHFT</strong></td>
<td><strong>BTUHFT</strong></td>
</tr>
<tr>
<td><strong>SUHFT</strong></td>
<td><strong>SUHFT</strong></td>
<td><strong>SUHFT</strong></td>
</tr>
<tr>
<td><strong>MEHT</strong></td>
<td><strong>MEHT</strong></td>
<td><strong>MEHT</strong></td>
</tr>
<tr>
<td><strong>95.5%</strong></td>
<td><strong>98.5%</strong></td>
<td><strong>95.4%</strong></td>
</tr>
<tr>
<td><strong>94.0%</strong></td>
<td><strong>98.7%</strong></td>
<td><strong>94.1%</strong></td>
</tr>
<tr>
<td><strong>92.7%</strong></td>
<td><strong>99.2%</strong></td>
<td><strong>92.7%</strong></td>
</tr>
<tr>
<td><strong>97.5%</strong></td>
<td><strong>99.9%</strong></td>
<td><strong>97.5%</strong></td>
</tr>
</tbody>
</table>

Source: Service User Workshop. 28 April 2016
Summary

Despite much good practice across mid and south Essex, the performance data suggests that some key services offered in an acute setting are falling short of top clinical quality and safety standards. More health and social care could be delivered in a local setting, and more work needs to be done to improve quality and reduce variation. Given that the highest standards of care are not being achieved in primary and secondary care, clinical leaders believe that change is required.

3.2 The need to meet the rising demand (particularly non-elective demand)

3.2.1 Increasing primary and community demand

All aspects of the health and care system are facing the challenge of increasing demand. As the population ages and more people live with complex long term conditions (such as diabetes and coronary heart disease), the demand for health and social care services is rising. Consider just one example: the number of people in residential homes increased nationally by 21% between 2005/6 and 2012/13. In addition, societal and policy changes have placed additional demands on local services. A familiar example is the increased burden on primary care resulting from the childhood immunisation programme and from the new requirements for medical notes for workplaces, schools and benefits. Nationally, the number of primary care consultations per person has recently been rising by more than 10% a year, with the largest increases being among infants (0–4 years of age) and elderly people (older than 85).

In addition, societal and policy changes have placed additional demands on local services. A familiar example is the increased burden on primary care resulting from the childhood immunisation programme and from the new requirements for medical notes for workplaces, schools and benefits. Nationally, the number of primary care consultations per person has recently been rising by more than 10% a year, with the largest increases being among infants (0–4 years of age) and elderly people (older than 85).

Other sorts of pressures are felt in surgeries; some 81% of GPs report a rise in complexity, and there is substantial need for same-day appointments to relieve urgent care pathways (two of the five CCGs have chronic-ACSC emergency admissions above the national average). GPs’ workloads are also set to increase in response to various other developments; notably, national policies to implement 7-day services, the Mental Health Taskforce, and the Cancer Taskforce Strategy.

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37 Age UK – Care in Crisis 2014


39 Ambulatory-care sensitive conditions
Primary and community health and care services have been unable to deal with all this additional demand. Accordingly, some of the demand has shifted on to the acute sector. Non-elective activity is increasing in mid and south Essex, and the three acute hospitals are struggling to cope with the growing demand. There is a clear need to alleviate the acute hospitals and prevent overcrowding.

### 3.2.2 Increasing non-elective demand

The data indicates that many of the people turning up at A&E do not need to be treated there and would be better served by community and primary services, if such services were available. As Figure 19 shows, 15-18% of A&E attendees were referred elsewhere, and 20-26% of A&E attendees were discharged without treatment. There are a number of reasons for increased attendances; evidence suggests that patients who are less satisfied with their primary care are more likely to attend A&E.

**Figure 19: Discharge location for A&E attendances**

![Discharge location for A&E attendances](image)


The impact on the patch’s three acute hospitals is shown by the four-hour-waiting-time performance, as discussed in the previous sub-section.

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As well as the increase in A&E attendances, there has also been an increase in emergency admissions. Historically, rates of non-elective admissions per head of population are lower in mid and south Essex than nationally. However, non-elective admissions constitute a high proportion of activity for the mid and south Essex Acute Trusts, accounting for 32% of their income, vs. 26% for similar-sized hospitals elsewhere in England and vs. 12% for selected large multi-site teaching hospitals in England. Furthermore, these non-elective admissions have been increasing in number. As shown in Figure 20, emergency admissions across the patch rose by 8% between 2013/14 and 2014/15 – twice the average national growth rate.

Figure 20: Non-elective demand

Note: Charts show emergency admissions to the three acute hospitals originating from all CCGs, including those outside Mid and south Essex. Growth rates shown are overall growth rates for the four years between 2012/13 and 2015/16.; Source: HES data 2012/13-2015/16

Some of these admissions were avoidable. In 2014/15, for every 100,000 population in mid and south Essex, there were 962 unnecessary emergency admissions for acute conditions – equivalent to 11.6% of total emergency admissions on patch.

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42 Hospital Episode Statistics. Accident and Emergency Attendances 2013–14

43 SUS data 2014/15, based on 8,300 admissions per 100,000 of population
This increase in non-elective demand growth is expected to continue. The UK population is projected to increase by 4.4 million in the next ten years. It is also projected to continue ageing, with the average (median) age rising from 40 years in 2014 to 40.9 years in mid-2024. By mid-2039 more than 1 in 12 of the population is likely to be aged 80 and over. As the very young and the elderly are the largest users of the healthcare services, the demand pressures will rise significantly. For example, 39% of acute bed days and 35% of non-elective admissions are accounted for by frail older people. This group represents just 8% of the older population. As the population ages, more and more people will have LTCs. Data clearly shows that the majority of people over 65 have two or more LTCs and are the most frequent users of our healthcare and social-care services, and that the majority of people over 75 have three or more LTCs.

Modelling the predicted increase in demand in mid and south Essex shows that neither acute nor primary services are currently configured to cope with the rising demand for healthcare. The do-nothing scenario produces a deficit of more than 200 beds in the acute sector by 2020/21.

Figure 21: Acute capacity modelling

<table>
<thead>
<tr>
<th>Projected 'do nothing' growth, pa</th>
<th>'Do Nothing' Bed Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-19</td>
<td>-0.40%</td>
</tr>
<tr>
<td>20-54</td>
<td>1.15%</td>
</tr>
<tr>
<td>55-74</td>
<td>4.54%</td>
</tr>
<tr>
<td>75-84</td>
<td>7.42%</td>
</tr>
<tr>
<td>85+</td>
<td>5.25%</td>
</tr>
<tr>
<td>Total</td>
<td>3.75%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>15/16</th>
<th>20/21</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elective</td>
<td>1,609</td>
</tr>
<tr>
<td>Non-elective</td>
<td>210</td>
</tr>
</tbody>
</table>

Notes: 1 including demographic and demand growth; 2 implied beds = # bed days / (365 * Utilisation rate). Utilisation rate = 96%; Source: Hospital Episode Statistics.; SR analysis.

3.2.3 Summary

Demand for healthcare services in the patch will rise over the coming decade. The acute hospitals are already struggling and are not equipped to cope with more activity. Again, primary and secondary care clinicians are united in the view that “no change” is not an option.

46 Department of Health. QIPP long term conditions.
3.3 The need to respond to workforce challenges

3.3.1 Local Health and Care

There are currently about 2,500 NHS vacancies across local health and social care services in mid and south Essex equivalent to 13% of the total workforce.\(^{48}\) In addition, up to one in five of the current workforce could retire by 2021. No quick fix is possible: there is not a sufficiently large pool of replacement staff available. Therefore, changes are needed to the way that we deliver care, if we are to make the most effective use of the entire healthcare and social-care workforce.

Pressure on primary care is evident. According to the 2015 BMA survey, the single greatest issue of concern to GPs and their staff is that of workload. The latest research, published in *The Lancet*, indicates an average increase in general practice workload of about 2.5% a year since 2007/8, taking into account both volume and acuity.\(^{49}\) Under the current model of care, the patch does not have the capacity to cope with the increased workload. The patients per GP ratio and patients per nurse ratio is 10% higher than the national average. This situation is forecast to worsen, because the area is among the worst in the country for staff due to retire in the next 5-10 years, an estimated 20% of practices have all their GPs aged over 54 years old. This is compounded by the existing difficulties in recruiting staff and the heavy use of locum staff, up to 20% in some areas\(^{51}\).

The community workforce too is facing various challenges, notably in recruiting adult mental health workers and learning disabilities nurses. The vacancy rate in community services as a whole is currently about 350 FTEs (12%), in the mental health services specifically it is about 360 FTEs (14%) and the ambulance staff have a gap of about 60 FTEs. Although the community sector is expected to gain additional staff in the next few years, there will still be a gap of 260 FTEs (9%) by 2021, according to the projections, with a gap of 100 FTEs (4%) for mental health services.

There are similar challenges in the social-care workforce. The estimated vacancy rate is 5.4% for the sector overall, and as high as 7.7% for domiciliary care services in particular. The rise in the national minimum wage has increased staff costs by 7.5%, and recruiting is arguably at its most difficult in a decade. Just under a third of all social-care workers were new to their role in the past 12 months – an estimated 372,000 people. Only 40% of these new workers were recruited from outside the adult social care sector. There is an estimated turnover rate of 25.4% across the whole sector, with domiciliary care services once again at the forefront: at 30.6%, its turnover rate is more than double that of staff in community care (14.6%).\(^{50}\)

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\(^{48}\) Health Education England.

\(^{49}\) General Practice Forward View.

\(^{51}\) HSCIC survey of Southend. September 2015

\(^{50}\) SkillsforCare. The state of the adult social care sector and workforce in England. March 2015.
In addition to the problem of unfilled vacancies and capacities, the workforce poses another challenge, according to local stakeholders – that of skills. In particular, there is an increasing need for “skilled generalists” – that is, staff with deep skills in a particular area and also broader skills needed for working in an integrated multi-disciplinary environment. The workforce’s overall skills mix will also need to change in order to conform to other major developments, such as new technology, Big Data, and the new ways of working. In sum, the following changes are likely to be needed:

- Up skilling of staff to take on additional roles, such as non-medical prescribers, specialist paramedic or community nurses specialising in / with greater care responsibilities for patients with LTGs
- Broadening the skill-sets of staff; for example, training healthcare workers to conduct basic social-care assessments, or training staff to use new technologies more effectively
- Investing in creating new roles, such as assistant practitioners, physicians’ assistants, community navigators or local healthcare data analysts

### 3.3.2 Acute hospitals

Across the acute hospitals, safe staffing levels are not being met. Since specialist resources are spread across all three hospital sites, it is even more difficult to have consultants present 7 days a week, 24 hours a day. So there could be less cover for those patients who become ill or sustain an injury at weekends or in the evening.

Similar difficulties apply to nursing staff. Figure 22 indicates current nursing practices across the three trusts and shows the number of unfilled slots.

#### Figure 22: Nursing rates across three acute trusts

<table>
<thead>
<tr>
<th>Metric</th>
<th>BTUHFT</th>
<th>MEHT</th>
<th>SUHFT</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of registered nurse day hours filled as planned</td>
<td>94%</td>
<td>92%</td>
<td>90%</td>
</tr>
<tr>
<td>% of unregistered care staff day hours filled as planned</td>
<td>90%</td>
<td>105%</td>
<td>115%</td>
</tr>
<tr>
<td>% of registered nurse night hours filled as planned</td>
<td>97%</td>
<td>99%</td>
<td>92%</td>
</tr>
<tr>
<td>% of unregistered care staff night hours filled as planned</td>
<td>98%</td>
<td>116%</td>
<td>119%</td>
</tr>
</tbody>
</table>


### 3.3.3 Summary

Simply hiring more staff is not a feasible solution. Locally and nationally, there is a shortage of key workforce groups, such as GPs.\(^ {51} \) so too with nurses and midwives, according to the Royal College of Nursing and CQC respectively.\(^ {52}, \(^ {53} \) and so too with

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\(^ {52} \) Staffing for older people’s wards

\(^ {53} \) CQC market report. Focus on maternity services
emergency medicine consultants, non-consultant anaesthetists, paediatricians, general surgeons and obstetricians and gynaecologists. There are two aspects to dealing with workforce shortages: reducing demand and increasing capacity. The best way to address both of these aspects is to develop new ways of working. For example, to increase the overall supply of local health and social care, community health staff will need to take on new roles, and will need new skills and training for that purpose. The same applies to other health professionals. Once again, “no change” is not an option: primary- and secondary-care clinicians are united in that view.

3.4 The need to address financial pressures

3.4.1 National context

Faced with growing demand from an ageing population and the need to comply with stricter standards, the NHS faces a likely funding shortfall of nearly £30 billion a year by 2020/21, unless it can find further efficiency improvements or increased funding.

The NHS Five Year Forward View confirms the need for nationwide action to manage demand, improve efficiency and address funding challenges, for the sake of maintaining comprehensive, high-quality NHS services. In particular, it calls for efficiency improvements to exceed the historic rate of 0.8% a year, and to reach 2–3% annually. To that end, each NHS Trust is obliged to support this national target through Cost Improvement Programmes (CIPs). In addition, the NHSE has challenged CCGs to lead the development of Quality, Innovation, Productivity and Prevention (QIPP) plans, in order to help achieve efficiency targets while also maintaining and improving quality.

3.4.2 Local funding

Collectively, CCGs across all of Essex have historically received less funding than their target allocation – a consistent picture across five funding regimes going back to 1999 (see Figure 23). In effect, this has meant year-on-year underfunding of investment into services. In 2016/17, the system funding shortfall for the CCGs in Mid and south Essex amounts to £9 million. This figure is set to reduce over time with system funding at target by 2019/20 albeit with variances within individual organisations still. In total, the cumulative gap between target funding and actual funding is in excess of £16 million for the period between 2016/17 and 2018/19.

---

54 United Kingdom Border Agency. Tier 2 shortage occupation list.
55 NHS. Five Year Forward View. October 2014.
56 And their equivalent previous bodies, such as PCTs
Figure 23: North and South Essex annual funding vs target allocation (1999-2016)


3.4.3 Current system financial position (2016/17)

The annual financial shortfall facing local commissioners and providers reached £99 million in 2016/17 in-year. Workforce expenditure represented the majority of provider spending, at 63% of the total for 2016/17.

Figure 24: Mid and south Essex financial position (£m), 2016/17

Source: Local Authority. Trust and CCG financials.2016/17.

57 Income categories: NHS England; Income for Specialised Services and General Practice; Private Sector; private income for acute and mental-health trusts; Non-clinical income: for acute and MH trusts; Local Authority: adult social care expenditure by Essex County Council, and Southend-on-Sea and Thurrock Borough Councils / unitary authorities
Acute trusts are responsible for most of the overall negative financial position. The 2016/17 system position was composed of a commissioner in-year deficit of £8.7 million, with an aggregate historic commissioner debt of £34m. There was a provider deficit of £89.9 million. MEH had the largest deficit of £36.7 million, with BTUH and SUH having deficits of £28.0 million and £21.2 million respectively.

3.4.4 Forecast system financial position (2021/22)

Looking ahead over the next five years, health commissioners and providers expect increased pressure on services as a result of growing demand due to both demographic and non-demographic trends in mid and south Essex.

There will also be an annual increase in income for commissioners (£280 million by 2020/21) and providers (£242 million), noting that the majority of provider income flows from local commissioners. However, it will be outpaced by the increase in demand and inflationary pressures, which is expected to create an extra £955 million in annual expenditure by 2021/22.

- For commissioners, expenditure is expected to grow by 5.9% a year to 2021/22, vs. annual income growth of 3.0%, although as mentioned above actual funding will still be substantially below target funding
- For providers, expenditure is expected to grow by 6.6% a year, vs. annual income growth of 4.3%

Overall, the financial shortfall affecting the patch’s healthcare system is expected to reach £532 million a year by 2021/22, in the absence of initiatives to reduce costs and/or increase income (the “do nothing” case, as shown in Figure 25).
Without intervention, the deficits for commissioners and providers are projected to reach £281 million and £251 million respectively by 2021/22 (excluding historic debt). There is clearly a strong financial case for change in mid and south Essex.

The deterioration in the system’s financial position is due largely to the funding needs of acute-care services. Acute care accounts for 44% of all additional spending by commissioners after 2016/17, with annual acute expenditure rising by £227 million to reach £1,061 million by 2021/22. On the provider side, acute trusts are forecast to reach an annual deficit of £208 million, with the remaining £43 million of deficit being attributable to other providers.

---

58 1. Demand growth pressure is the increased demand between the 2016/17 in-year position and the 2021/22 in-year position for services, based on demographic and non-demographic demand growth projections, in turn based on national and local projections per organisation; 2. Income uplift is the increase in allocations between the 2016/17 in-year position and the 2021/22 in-year position, based on projected allocations to trusts, CCGs and other NHS organisations. Source: STP submissions, Trust and CCG financials
3.4.5 Cost Improvement Programme (CIP) and Quality, Innovation, Productivity and Prevention (QIPP) delivery

Existing QIPP and CIP plans are not sufficient to close the deficit by 2021/22. Currently, QIPP schemes and acute CIPs are projected to save £135 million and £150 million in-year by 2021/22 respectively, with other organisation CIPs comprising £87 million. All in all, that leaves a gap of £82 million, as illustrated in Figure 27.
For commissioners, QIPP initiative savings, excluding QIPPs that impact on acute activity, will total £133 million annually by 2021/22 (Figure 28). This sum will not cover the commissioner deficit or repayment of debt. Although QIPP delivery in recent years has produced savings of 2.9% on average, such strong results are unlikely to continue, as the “quick wins” are exhausted: projections now are for an average saving of 1.7% of income per year.
Figure 28: Annual in-year commissioner QIPP projected savings (£m)

<table>
<thead>
<tr>
<th></th>
<th>Current CCG plans</th>
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<tr>
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<td>7.8</td>
<td>7.2</td>
<td>5.1</td>
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<tr>
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<td>2.0%</td>
<td>1.4%</td>
<td>2.6%</td>
</tr>
<tr>
<td>Castle Point &amp; Rochford</td>
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<td>8.0</td>
<td>9.4</td>
<td>8.8</td>
<td>13.3</td>
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<td>3.5%</td>
<td>4.0%</td>
<td>3.5%</td>
<td>5.3%</td>
</tr>
<tr>
<td>Mid Essex</td>
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<td>11.4</td>
<td>9.4</td>
<td>7.3</td>
<td>10.5</td>
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<tr>
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<td>2.0%</td>
<td>1.5%</td>
<td>2.1%</td>
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<tr>
<td>Southend</td>
<td>18.1</td>
<td>9.8</td>
<td>7.5</td>
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<td>9.3</td>
</tr>
<tr>
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<td>7.6%</td>
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<td>3.0%</td>
<td>1.6%</td>
<td>3.5%</td>
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<tr>
<td>Thurrock</td>
<td>7.6</td>
<td>8.1</td>
<td>5.4</td>
<td>5.1</td>
<td>5.1</td>
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<tr>
<td>% of income</td>
<td>3.7%</td>
<td>3.9%</td>
<td>2.5%</td>
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<td>2.2%</td>
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<tr>
<td>Adjustment to exclude CCG</td>
<td>(36.2)</td>
<td>(16.2)</td>
<td>(15.2)</td>
<td>(9.1)</td>
<td>(27.4)</td>
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<td>savings at expense of acutes</td>
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<tr>
<td>and other provisions</td>
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<tr>
<td>Net QIPP savings</td>
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<td>28.8</td>
<td>23.7</td>
<td>21.3</td>
<td>20.6</td>
</tr>
<tr>
<td>% of income</td>
<td>2.7%</td>
<td>1.9%</td>
<td>1.5%</td>
<td>1.3%</td>
<td>1.2%</td>
</tr>
<tr>
<td>Cumulative QIPP savings</td>
<td>40.1</td>
<td>68.9</td>
<td>92.6</td>
<td>113.9</td>
<td>134.5</td>
</tr>
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</table>

Source: CCG financials
For providers, forecast Acute CIP savings total £150 million by 2021/22 (Figure 29), short of the £208 million projected in-year deficit. Annual forecast in-year savings average 2.9% of income across acute trusts; again that shows a decline from recent levels, which average 3.5%.

**Figure 29: Annual in-year provider CIP savings projections (£m)**

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<tbody>
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<td>BTUH</td>
<td>15.3</td>
<td>10.0</td>
<td>8.7</td>
<td>8.7</td>
<td>9.7</td>
</tr>
<tr>
<td>% of income</td>
<td>4.6%</td>
<td>3.0%</td>
<td>2.6%</td>
<td>2.5%</td>
<td>2.6%</td>
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<tr>
<td>MEH</td>
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<tr>
<td>% of income</td>
<td>4.1%</td>
<td>3.3%</td>
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<td>2.6%</td>
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<tr>
<td>SUH</td>
<td>8.8</td>
<td>11.7</td>
<td>7.9</td>
<td>8.9</td>
<td>10.0</td>
</tr>
<tr>
<td>% of income</td>
<td>2.8%</td>
<td>3.6%</td>
<td>2.3%</td>
<td>2.4%</td>
<td>2.5%</td>
</tr>
<tr>
<td>Total in-year Acute Trust savings</td>
<td>37.4</td>
<td>32.4</td>
<td>24.7</td>
<td>26.3</td>
<td>29.2</td>
</tr>
<tr>
<td>% of income</td>
<td>3.8%</td>
<td>3.3%</td>
<td>2.4%</td>
<td>2.4%</td>
<td>2.6%</td>
</tr>
<tr>
<td>Total Acute Trust cumulative savings</td>
<td>37.4</td>
<td>69.8</td>
<td>94.5</td>
<td>120.8</td>
<td>150.1</td>
</tr>
</tbody>
</table>

Source: Trust financials
3.4.6 Sensitivity analysis

As mentioned, even once CIP and QIPP plans have been included, the annual healthcare-system deficit in mid and south Essex is £82 million by 2021/22, according to forecasts. The sensitivity analysis below (Figure 30) shows the range of alternative figures if either demand growth or savings programmes vary from current projections.

**Figure 30: Sensitivity analysis of system deficit to demand, CIP / QIPP assumptions**

| Aggregate Cost Improvement Programmes (CIP & QIPP) as % of Income | 
|---|---|---|---|---|---|---|---|
| 2.56% | 3.56% | 4.56% | 5.56% | 6.56% | 7.56% | 8.56% |
| 15.8% | 563 | 390 | 209 | 22 | -173 | -375 | -885 |
| 14.8% | 528 | 355 | 174 | -13 | -208 | -410 | -620 |
| 13.8% | 493 | 320 | 139 | -48 | -243 | -445 | -635 |
| 12.8% | 458 | 285 | 104 | -83 | -278 | -480 | -690 |
| 11.8% | 423 | 250 | 69 | -118 | -313 | -615 | -725 |
| 10.8% | 388 | 215 | 34 | -153 | -348 | -650 | -760 |
| 9.8% | 353 | 180 | -1 | -188 | -383 | -585 | -795 |
| 8.8% | 318 | 145 | -36 | -223 | -418 | -620 | -830 |

Source: SR Modelling.

3.4.7 Summary

CIP and QIPP projects are not sufficient to close the deficit gap. Without further change, the annual health system deficit will continue to increase, and will be £82 million by 2021/22, after CIPs and QIPPs are delivered.
4. **Our Vision: Working Together for Better Care**

We want the population of mid and south Essex to live longer, healthier and more independent lives. We want our population to *Live Well*.

To make this happen, we have commitment from partners across the system to ensure that our health and care services are organised in the most efficient way possible, so that we can achieve or exceed the outcomes nationally expected of the NHS. We will continue to develop a modern health and social-care system one that builds on the heritage of the NHS but is not afraid to embrace change wherever it benefits our local population.

This enhanced system will meet our four broad goals:

- To support people to manage their own health and wellbeing, by taking into account their individual health and social-care needs
- To create a workforce of the right size and capabilities, and enable all its members to carry out their duties in the best possible way
- To provide effective community-based care closer to people’s homes
- To organise our secondary care services in such a way as to provide acute specialist care of the highest standards

We want to help our population to create a resilient community that stays healthy for as long as possible. To do this, we will deliver a step change in our approach to prevention and self-care. People want to remain in control of their lives rather than being dependent on care. Our population will be supported to manage their own health, so that we meet their health care needs at the point of least acuity, supporting individuals with health conditions to remain independent for as long as possible. We know that people differ in their needs, so we will open new channels, online and offline, which offer greater choice in accessing healthcare support.

We will support our workforce, and enhance the care that they deliver, by providing the right training and tools for existing and new staff, so that they can deliver care in the most effective way possible. This means that we need to ensure we have the right staffing levels across the system; and that we remove barriers and seek out innovations to empower our staff. These changes will lead to better patient outcomes and patient experience, and greater job satisfaction for clinicians and other personnel. In line with the GP Forward View we are working to increase GP training places across the system. Anglia Ruskin University is planning to open a School of Medicine on the Chelmsford campus, bringing much needed focus and support to the medical workforce in mid and south Essex. Subject to GMC approvals processes, it is hoped that the School will take its first intake of students in September 2018. We are also running a successful EU GP recruitment programme.

We will release capacity in primary care so that GPs can do the job they are best at, supporting and co-ordinating care for those that need it most. We will maximise healthcare in the community, and closest to our population. This will produce not just better care but also greater convenience for our local population; and will have the further benefit of helping us to manage hospital demand more effectively. We will make sure that hospital and community-based services are more closely linked, so that the system works in an integrated way.
We will succeed in managing increasing demand on secondary care services by providing effective, proactive care and support to those who are the most vulnerable, and using technological solutions more effectively. We will reconfigure our services so as to meet best-practice standards in medicine and surgery and in access to them.

We have a duty to our local population to use our resources to deliver optimal services and produce optimal outcomes. If that sometimes requires us to take tough decisions, we are well prepared to work collectively across the system to take them.
5. Future Model of Care - Local Health and Care

About this section

This section sets out the future model of care for local health and care services, in other words those that are not-in-hospital. Our focus is on providing more effective community health and care services by:

1. managing demand for healthcare across primary, community and acute settings; and

2. building capacity outside the hospital to support more complex care needs.

Demand will be managed by making a step-change in Prevention, Early Intervention and Self Care; by identifying those at high risk, or rising risk, and managing their care more appropriately, by developing integrated pathways, including for Frail and End of Life patients and those with long-term conditions, and by strengthening capacity in community based urgent and emergency care.

We will build capacity outside the hospital by ensuring efficient use of primary care resources. We will do this by matching the skills of the wider primary care team to the needs of our patients and service users, and through exploiting the benefits of technology.

We will also organise health and care around natural communities (“localities”), which will enable collaboration between services and the ability to move some services that were historically delivered at acute hospitals, to a more local level. We describe the type of services that could be provided closer to home, reducing the need for our patients to travel to hospital for some outpatient, diagnostic and treatment services.

Our aim is to slow the growth in demand for secondary care, support greater resilience in primary and community care and enable the system to respond to demand in a more structured and proactive way.
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5.1 Introduction

“Local Health and Care” is a broad term used for referring to all the care and support that people receive outside of the acute hospital setting. Transformation of our local health and care services is an essential part of our overall vision. It will be supported by the delivery of the future hospital model, and in turn will facilitate the sustainable delivery of that model:

- Effective prevention and management of rising demand in the community will enable more specialist acute services to be consolidated and thereby offer the best quality of care.
- Acute reconfiguration and redesign, in turn, will facilitate more efficient provision of care and greater integration of pathways across the system, releasing finances to support the transformation and expansion of local health and care services.
Were we to make no changes to our system, our projections suggest that hospital demand could increase by 20% in both elective and non-elective areas over the period to 2020/21. With the changes described in this section, we aim to stem this growth such that elective and non-elective activity stays almost static across the period, coupled with the ambition to reduce the number of outpatient appointments delivered in a hospital setting (see section on Impact below)

Background

Pressure has been felt throughout the whole local health and care system. Locally there was a 15% increase in primary-care demand over the three years to 2014/15 – a period of flat NHS funding. Local Authority spending on adult social care has actually been cut during the past five years. Public funding to charities and voluntary-sector organisations has also been declining.

To date, the increasing pressure has been managed (with varying degrees of success) without any significant additional resources or changes in working practice. New technology has been introduced in limited ways and on a small scale.

The pressure on the existing workforce to manage the increasing demand is evident from the level of vacancies, sick leave, and reluctance of new staff to move into this sector. This puts even more strain on those dedicated people who continue to work to provide local health and care services. The current model is clearly not sustainable, but also offers many opportunities for improvement.

In order to fully deliver the local health and care model, our financial modelling has identified a potential reinvestment requirement of £17-20m per annum, which is a composite of costs associated with workforce, revenue associated with new estates and extended models of service delivery. It is recognised that it may be challenging to resource this requirement, but it is essential, otherwise the ability to move at pace will be compromised.

5.2 Key Objectives & Enablers

5.2.1 Our Vision

The mid and south Essex STP vision is to create and build upon an efficient, safe community-based system of care, centred on well supported practices working through localities in the most effective and affordable way, linked to and making optimal use of secondary care, and transforming the service with patient help and support.

Building on our development of localities, we describe the opportunities available to bring a range of services closer to home.

5.2.2 Our Three key Objectives

In order to bring care closer to home for our patients, the improved management of demand on our services, and support system change, our three key objectives are to:

1. Deliver an extensive self-care programme to empower patients to take responsibility for their own well-being.
2. Deliver a **comprehensive service redesign programme** that will support the “channel shift” of services, and associated funding, from secondary care towards provision in the community, supporting patients to access services closer to home.

3. Focus on improving **specialist pathways of care** (frailty, end of life, and long-term conditions) to manage demand on both community and secondary care services and enable patients to self-care, maintain their independence and live well.

### 5.2.3 Enablers

To support the delivery of the above objectives, we will:

- Increase capacity and improve efficiency through **Locality working**, enhancing collaboration across partners and developing locality based models and solutions.
- Develop a comprehensive **primary/community workforce programme**.
- Exploit the **benefits of IT/digitalisation** to support people with their health and care needs, reducing the need for some routine primary and secondary care appointments.
- Establish an STP wide primary and community **estates strategy** to support the creation of new models of care.
- Work collaboratively across the STP to develop **locality-based commissioning and contracting proposals**.

### 5.2.4 Measuring Success

We will measure our success through the following outcome metrics:

- Increased primary care workforce numbers, to include GP expansion targets set by NHS England.
- Uptake of training and education opportunities to upskill our existing workforce to work in different ways to deliver effective services in the community.
- Introduction of new and innovative roles to support local health and care services.
- Improved staff morale across primary and community service providers
- Improved patient experience of our services, reducing the need to travel to hospital for many outpatient and diagnostic services.
- Consistent risk stratification of patients, enabling the identification and proactive management of those considered “high risk”, and enhanced planning and support for those considered “rising risk”.
- Improved case management for frail and end of life patients, resulting in reduction of A&E attendances and non-elective admissions
- Improved management of long-term conditions, such that patients feel supported to manage their condition and their quality of life is maximised.
- Improved management of demand on services
• Creation of flexible new models of commissioning and contracting to enable integrated health and social care provision.
• System wide delivery of the Five Year Forward View requirements, including extended access, e-consultations and delivery of the ten high impact interventions.

5.2.5 Impact

Implementing our three key objectives will contribute towards the financial and activity bridge that predicts largely static growth over the period 2016/17-2021-22:

<table>
<thead>
<tr>
<th></th>
<th>Do Nothing</th>
<th>Implement Solutions</th>
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<tr>
<td>Outpatient *</td>
<td>1,212,439</td>
<td>1,510,168</td>
</tr>
<tr>
<td>Elective</td>
<td>141,643</td>
<td>173,511</td>
</tr>
<tr>
<td>Non-elective</td>
<td>109,066</td>
<td>126,608</td>
</tr>
<tr>
<td>A&amp;E Attendances</td>
<td>371,681</td>
<td>479,945</td>
</tr>
</tbody>
</table>

*this relates to activity within the acute setting. The 2021/22 solutions include 274k outpatient appointments delivered in alternative ways (e.g. closer to home, through digital channels)

5.3 Delivering Our Objectives

Objective 1: Self-Care

We are delivering an extensive self-care programme to empower patients to take responsibility for their own well-being. This will include formalising the use of patient navigation and triage with maximum use of IT tools, and through the STP Digital Board, we will ensure digital solutions are exploited to the full. The concept of “patient activation” is central, and will underpin our aim of encouraging individuals and communities to take responsibility for their own health, supported by a genuine partnership of local stakeholders.

The system is prioritising prevention, early intervention and self-care, working closely with our local authority and public health partners. There are four priorities for this approach:

• **A place-based approach.** Through our localities, we are engaging with a wide range of local stakeholders to jointly plan and implement initiatives on the specific health and wellbeing needs of their populations.

• **Evidence-based interventions.** We will use evidence-based interventions to target resources effectively.

• **Support for self-monitoring and self-care,** including the use of technology such as apps. Professionals with health-coaching skills will be available, where appropriate, to support those who need additional help.

• **“Making Every Contact Count”.** We commission directly and work with stakeholders to pursue the MECC agenda. This will include clear input into acute, community, and mental health service specifications, as well as support and training of frontline health and social care staff and VCS groups.
Our commitment to make prevention and early intervention a priority has seen the emergence of a number of local initiatives that improve health for the individual, and can lead to savings in the healthcare system. We will continue to work with our colleagues in Public Health across the three local authorities to support wider roll-out of these prevention programmes. Examples of our work in this area include:

- A successful bid for the STP to work with *Building Health Partnerships* Self Care Programme, which will support us in working with organisations to build trust and mutual understanding across patients, CCGs, HWBs, Local Authorities and local VCS organisations. The first project for this partnership is supporting patients with respiratory illness, with a focus on supporting patients to self-care.

- STP-wide focus on diabetes. There are various strands to this work, being taken forward by the Diabetes Forum – this includes take up of the National Diabetes Prevention Programme, with a focus on identifying patients at risk of developing diabetes and supporting them to reduce risk through lifestyle changes. The STP is also in receipt of diabetes transformation funding, helping us to reduce variation in patient access to NICE recommended treatment targets, increasing the uptake of structured education, and supporting improvements in inpatient care. We will benefit from working closely with the diabetes clinical network and utilising the quality improvement resources made available to the STP.

- Our community based musculoskeletal and pain services offer support to patients in life-style changes and self-care; these services are actively contributing to reducing demand on primary and secondary care services.

- Across our localities, we are starting to deploy care-coordinators and health trainers/coaches to support people in managing their own health, thus freeing time for clinicians to spend more time with those who need it. This includes support to carers, contracts with third sector and voluntary organisations, as well as the introduction of a single point for help and a dedicated care coordination digital and telephone support service.

- We continue to invest in and support the use of social prescribing to signpost patients, where appropriate, to alternative services to support their needs (see below).

**Objective 2: Service Redesign**

*We will deliver a comprehensive service redesign programme to complement the Acute Trust Reconfiguration.*

Redesigning our services will be critical to achieving care closer to home and supporting the acute hospital reconfiguration plans. In order to enable appropriate planning and care coordination across local health and care, we are using an approach called “population segmented management”.

An immediate benefit of this approach is the ability to plan and coordinate care effectively. Over time, this approach will enable us to identify, plan and deliver services that meet the patient at the lowest point of acuity, thus supporting self-care and independence.

Using a risk-stratification analysis, we have identified three broad population groups:
People who are Mostly Healthy
People who are Rising Risk
People who are High Risk

Additionally, two groups deserve particular attention, reflecting their distinctive circumstances:

- Children
- People in need of Urgent and Emergency Care

**Figure 31: Population segmented management**

Supporting the “Mostly healthy”

People in this group typically have straightforward needs. We will empower them to “live well”, managing their own health with support from digital technologies and the community and voluntary sector where appropriate.

Caring for individuals who have “Rising risk”

This group will typically have multiple and/or complex needs which require an integrated approach, increased use of multi-professional roles (e.g. nurses, AHPs, health trainers) and self-management. This group may benefit from the use of technology to better manage their own health and social-care. Integration with the wider social care, community care, the third sector and the use of social prescribing offers them more support.
Caring for patients who are “High risk”

This group typically have high health and social-care needs, and require intensive support.

New pathways of care will see primary care and the localities wrap services around these patients to support them to live as independently as possible. Personalised care planning, built around the wishes of the patient, and using an asset-based approach, will form the key elements of this pathway. Escalation and crisis plans will enable patients and their carers to manage their condition, and to know when and how to seek support from professionals. Schemes are already in place, building on nationally contracted programmes, to support enhanced case management both at practice and locality levels.

Figure 32: Illustrative Example: How care will be delivered to different population segments at locality level

Looking after our Children

The health needs of children are often very different to adults, and it is therefore important that children are able to access health and care professionals with specialist paediatric expertise. It is also important that children can access healthcare as close to home as possible, so as not to disrupt learning and education, particularly when they have a chronic, long term health condition.

Our approach to enhancing support for children involves five main elements:

- **Improving access to specialist advice**: This will be achieved via a combination of increasing access to GPs with a specialist interest in paediatrics, greater use of technology and, where applicable, enabling paediatric consultants to deliver more services in the community including, for example, outpatient appointments.
• **Pathway redesign**: We will explore opportunities to shift care provision into the community, including outpatient and follow-up appointments that would have historically taken place in a hospital setting.

• **Emotional health and well-being**: ensuring our children and young people have access to high quality mental health services.

• **Personalisation**: Through expanding our offer on personalised budgets, we will empower families and carers, particularly for those with longer-term health needs.

• **Co-ordinated support for vulnerable young people**: We will continue to work to ensure that the health needs of the most vulnerable young people are met in effective, co-ordinated ways. In particular, supporting the best possible health outcomes for the >1,500 looked after children across the STP, and through identifying and supporting young carers.

• **Promoting healthy lifestyles and behaviours**: We will focus on prevention to reduce the number of children who become overweight or obese e.g. by promoting targeted interventions to increase physical activity levels such as the "Daily Mile," where children run regularly in school, improving diet and delivering more effective education.

**Patients with Urgent Care Needs**

Urgent and Emergency Care (UEC) services in mid and South Essex are struggling to meet operational standards. The current model of service is complex, characterised by multiple routes of access, limited coordination, variable capacity, and restricted capacity in Primary Care for urgent appointments.

Our work on self-care and prevention, including education via means such as general public health messages and targeted local campaigns, will support our work in managing demand on the urgent care pathway.

For patients that do require access to urgent and emergency care, we will develop integrated pathways across the whole system that enable individuals to be cared for when needed in a coordinated way close to home. This includes delivery of extended access to primary care appointments, and innovative ways of supporting primary care to meet urgent care need (for example, one CCG has employed a paramedic to support triage of urgent demand as well as urgent home visits).

The NHS Five Year Forward View and Next Steps outline the redesign and integration of urgent and emergency care services to simplify the system, helping patients get the right care, at the right time, in the right place, and making more appropriate use of alternatives to higher acuity services such as ambulance and A&E.

The offer to the population of mid and south Essex is to have two simple entry points into UEC services:
111/Out of Hours

We are following the national vision where our Integrated Urgent Care service, supported by an Integrated Clinical Advice Service, will assess the needs of people and advise on the most appropriate course of action. We will achieve this through the procurement of a unified 111 and Out Of Hours Service, in line with new national standards. The new service, which will provide a fully integrated urgent care service, will go live in July 2018. The service will encourage organisations to collaborate to deliver high quality, clinical assessment, advice and treatment, to shared standards and processes, with clear accountability and leadership.

999 Ambulance

In line with the Five Year Forward View, the operational model changes that the ambulance service is setting out will drive our healthcare system to help patients get the right care, at the right time, making more appropriate use of existing services in primary, community and mental health care, thus reducing demand on ambulance and acute care services.

The ambulance service is fully engaged with the STP, and understands its role in supporting the UEC system. It is proposing to re-engineer its operational model to reduce inappropriate conveyance and truly deliver “right person, right place, right time” across the East of England.

Objective 3: Specialist Pathways

The STP has developed “blue prints” for integrated pathways for Frail and End of Life patients, that put individuals and their families / carers at the centre. We recognise that the complex nature of these conditions means that holistic care is essential to avoid unnecessary trips to A&E and hospital admissions.

We know that once elderly patients are admitted to hospital it can be difficult to get them back to their normal place of residence. Prolonged stays in bed can decondition frail patients quickly, often meaning that they never return to their previous level of capability. Consequently, they may require additional continuous care once discharged, and in some instances to residential or nursing care homes.

Frailty

Through the early work on the STP, clinicians and service users co-designed a frailty “blueprint”, describing the aspiration of the care and treatment of our frail, elderly population. The blueprint comprised 4 key elements:

- Identification and care planning
- Proactive care delivery
- Frailty Assessment Unit
- End of Life Planning

To date, all practices have undergone a process to identify patients, using the Electronic Frailty Index (or equivalent) tool. This has identified that 3% of the population is living with moderate and severe frailty. Localities are developing their multi-disciplinary teams, with a focus on the proactive assessment and review of frail patients, enabling proactive care.
planning and support. This is supported by changes to the GP contract.

Coordinated care, organised around localities, will ensure all professionals are working together with the common aim of enabling patients to retain their independence for as long as possible, while providing the right level of care and support where required. This includes a focus on the principle of “home first” – care to be provided in people's homes wherever safe and possible, as well as the appropriate use of “step up” community beds for periods of inpatient support, as well as “step down” reablement and community services to support people after a period of illness or ill health. This will contribute to our maintaining the level of non-elective admissions at 2016/17 levels.

We recognise that achieving these elements require contractual, clinical and cultural changes to the way in which care is commissioned and delivered. Our plans for 2018/19 include further enhancement of the MDT approach, consistent single point of access services across the STP and improved integration of physical and mental health, with social care, across our localities. We are also working closely with our care homes, employing various inputs to help care home staff to support patients in their place of residence and reduce A&E attendances – this includes training and education for care home staff, as well as regular clinical input from GPs and geriatricians.

Acute partners continue to work on further refinements to Frailty Assessment Units, to ensure a consistent approach and clear links with local services.

Across the STP new models of care are being developed to support the creation of integrated discharge teams and “Home to Assess” models, designed to support improved outcomes, reduced length of stay for our patients, preventing readmissions, and supporting them to regain/retain their independence.

End of Life

For those patients at end of life, excellent care coordination is critical.

We have developed action plans at locality level to enable delivery of the 6 key end of life ambitions, as described by the National Palliative and End of Life Care Partnership.

We have some extremely strong End of Life services in place across mid and south-Essex (two of our hospices have been rated as “outstanding” by the Care Quality Commission), and we have many innovative schemes in place, for example:

**OneResponse** - Operating 24 hours a day, 7 days a week, OneResponse is a coordinating service in south west Essex, offering support and advice for people with palliative care needs, or needing care at end of life. It is a central point of communication for patients, carers and family members as well as professionals.
Frailty and care home palliative support services to provide dedicated support to people living in our care and nursing homes. The aim is to prevent people being unnecessarily admitted to hospital – this includes training for care home staff. In south west Essex, the hospice is working with Basildon Hospital to conduct a follow-up clinical assessment for patients who have been discharged – this includes a “root cause analysis” to investigate reasons for hospital admissions to share learning and avoid, wherever possible, further admissions.

Bespoke training for health professionals - The mid and south Essex STP ran a short pilot, providing health professionals with training to help understand the vital role of hospice and palliative care, and to support professionals in having difficult conversations with patients and their carers. This scheme received excellent feedback. A bid has been made to the Health Foundation for funding to fully implement the pilot across the STP.

Our end of life plans for 2018/19 include:

- Ensuring a standardised approach to documentation and planning across the STP.
- Delivering a consistent approach to anticipatory management, including access to medicines 24/7
- Extending our successful training programme on “difficult conversations” to non-medical personnel (e.g. care home workers) to support advance care planning, enabling patients to receive care in their preferred place.
- Improved identification of patients at end of life across primary care, and in our hospitals, to ensure support is given where patients are “outlying” in specialty beds.
- Improvements to the children’s end of life pathway.

Long-term Conditions

While examining data from Right Care demonstrates areas of good practice in the management of long-term conditions across mid and south Essex, the data also provides pointers for areas where we could, as a system, make significant improvements for our patients. To this end, we are working with acute and community partners to redesign pathways and service offers for a number of conditions. In the first instance, we are focusing on:

- Respiratory
- Diabetes
- Cardiology
- Renal
- Neurology

These conditions/specialties have been chosen as they impact significantly on A&E attendance, non-elective admissions, and, in some cases, on our elective activity. They are also areas in which, across the STP, we have unwarranted variation in activity, access and outcomes for our population. We are clear that we have a “design once” principle for these conditions, where the high level pathway, and expected outcomes are designed centrally, ensuring:
• clear points of entry and exit to secondary care, consistent across the three acute hospitals.
• equity of access for patients across the STP
• best practice service delivery and outcomes
• sufficient flexibility for our localities to work creatively to deliver the required outcomes.
• Clear links to local health and care programmes; early identification, prevention, self-care and care planning/support, including crisis care.

5.4 Intended Impact

Reducing Outpatient Attendances

We are aiming to reduce outpatient attendances at our hospitals by c. 500,000 over the next 5 years (against the momentum case), and for some 270,000 such appointments to be provided in a different setting. This will be achieved through:

- Self-care – supporting patients to manage their condition and prevent exacerbation, reducing the need for primary or secondary care appointments
- Digital technology – through our digital work programme, we will exploit the opportunities of digital technology to provide non-face-to-face consultations – a number of practices are using e-consultation as a means of providing support and signposting to patients, reducing demand on services.
- Channel shift – providing outpatient care in a different setting – we have already implemented this for some conditions – for example, through community triage of MSK referrals and community dermatology services.

We continue to work closely with acute partners to identify high impact outpatient activity shifts that will be required to facilitate the acute service reconfiguration. We will be linking with localities, and ensuring strategic estates alignment, as well as robust digital/IT responses to enable this to happen.

Reducing A&E attendances and Non-elective admissions

Our aim is to contain growth in A&E attendances and non-elective admissions. To support this, we are working to design new integrated pathways of care for a number of conditions as described above. Our work to extend access to primary care during evenings and at weekends also supports the aim of reducing demand on secondary care.

We are linking closely with the developing acute ambulatory emergency care pathways to ensure consistent pathways into and out of hospital, reducing non-elective admissions and length of stay for those patients who need to be admitted.
5.5 Enablers

Enabler 1: Locality Working

In line with the Five Year Forward View, we are delivering an extensive engagement programme with general practice, in partnership with the wider health and social care communities, to increase capacity, improve efficiency and collaboration across partners and develop locality-based solutions.

The majority of health and social care service provision will be centred on natural communities, or **localities**, ideally for populations of 30,000+ – based on clusters of GP practices working together. We are forming 24 such localities, which will bring together physical and mental health, social care and third-sector services. These localities will ultimately be responsible for coordinating out-of-hospital care for the local population.

The locality approach is designed around the patient and local population needs. It includes patients in decision-making, and takes a preventative, integrated, and asset-based perspective in the delivery of care.

There will be a range of models employed across the STP, in some areas, this may result in the locality functioning as a unified group, managing a single budget to flex resources across services and to mobilise the workforce in innovative ways throughout the community.

The diagram (Figure 33) below provides an illustrative example of the key components of the future locality model of care for the STP (the workforce numbers are indicative)

**Figure 33: Future locality model of care (workforce numbers are illustrative)**
Services that could be provided via Localities

As Figure 33 outlines, working in localities will enable a range of services to be provided for the local population. In some areas, these services will be provided from a single physical location, or “hub”; in others, services may be provided in a coordinated way across the locality, working from different sites.

We are keen that a range of services historically delivered from hospital settings are transformed and delivered via alternative means. As well as our plans around self-care and prevention, we will also exploit what digital technologies can offer to support patients to self-care, and reduce, where safe and appropriate, the need to see a clinician face to face.

That said, we recognise that patients will be still need to access services directly, and, using our locality developments, we want to bring a number of services closer to the patient's home.

As part of the public consultation process, we will consult with local people about proposed changes to the services currently provided from Orsett Hospital. This forms part of our wish to provide more health and care services in the community, delivering high quality care to patients in modern and convenient settings.

Case Study: Locality Service Delivery

Orsett Hospital, located in Thurrock, is an aging facility and maintenance expenditure required to bring the building up to standard is in excess of £10m.

No inpatient services are provided at Orsett, all services are outpatient/day case based. The range of services currently provided includes:

- Audiology & ENT
- Haematology
- Orthopaedic clinics
- Pain and musculoskeletal services
- Phlebotomy
- Renal dialysis
- Rheumatology
- Surgical day unit
- Speech and language therapy
- X-ray
- Minor injuries unit
- Sexual health services
- Ophthalmology

Thurrock CCG and Thurrock Council have already consulted with local people on changes to the way in which health and care services are provided locally, with an emphasis on delivering care closer to where people live. Feedback strongly indicated that people welcomed the development of community-based facilities for health and care services.
The primary care transformation programme in the Thurrock and Basildon and Brentwood areas is proposing to deliver care from 7 community based locations; the table below indicates where the patient services currently delivered in Orsett Hospital could be provided:

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Purfleet IHLC</th>
<th>Thurrock IHLC</th>
<th>Corringham IHLC</th>
<th>Tilbury IHLC</th>
<th>Brentwood Community Hospital</th>
<th>Basildon Location</th>
<th>Billericay St Andrew’s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic Services (e.g. blood tests, ultrasound)</td>
<td>✔️</td>
<td>✔️</td>
<td></td>
<td>✔️</td>
<td></td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>General Outpatient Services (e.g. dermatology, ENT, respiratory)</td>
<td>✔️</td>
<td>✔️</td>
<td></td>
<td>✔️</td>
<td></td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Treatment Facilities (e.g. minor procedure rooms)</td>
<td>✔️</td>
<td>✔️</td>
<td></td>
<td>✔️</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Integrated Medical Centre

While we will be consulting primarily in one area of the STP on the changes to Orsett Hospital, the approach to what can be delivered closer to home, utilising existing and new estates and infrastructure, is one that can be adapted and adopted across the STP.

Figure 34: proposed change in the delivery of service provision shifting from acute to out of hospital.
Case Example: Our Localities

Twenty-four localities have been identified across mid and south Essex – each with very different characteristics:

- Populations range from c23,000 in Dengie to about 170,000 in Chelmsford
- Billericay is the least deprived locality in Mid and South Essex, with East Basildon the most deprived
- Most localities are urban in nature, but some, such as Dengie, are predominantly rural

Each locality has different opportunities and challenges. Some localities have strong and established integrated working, while some face serious challenges regarding availability of GPs. Those localities that have many care homes, or that have an acute hospital, face challenges that others do not.

Further information on our locality development can be found in Appendix 1

Delivering Localities

To help us drive forward change, and support locality development, we have defined levels of development and collaboration to describe how our localities are developing:

Figure 35: Levels of locality working

Transformation of primary care to occur through 4 levels

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Begin to release capacity and build locality identity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Informal collaboration</td>
</tr>
<tr>
<td></td>
<td>New ways of working with practices and other providers being established</td>
</tr>
<tr>
<td></td>
<td>Active evaluation of current provider and vulnerability</td>
</tr>
<tr>
<td></td>
<td>Reflection on current model of provision</td>
</tr>
<tr>
<td></td>
<td>Analysis of opportunities</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Level 2</th>
<th>Implement new ways of working, full capacity release</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Services beginning to be shared by practices within localities</td>
</tr>
<tr>
<td></td>
<td>7 day access to primary care</td>
</tr>
<tr>
<td></td>
<td>Shared estate, infrastructure, policies and operating procedures</td>
</tr>
<tr>
<td></td>
<td>Shared clinical processes and information</td>
</tr>
<tr>
<td></td>
<td>Variation between service provision being addressed</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Level 3</th>
<th>Provide greater array of services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The way patients access core primary care services within a locality has changed</td>
</tr>
<tr>
<td></td>
<td>Low level mental health services fully integrated within primary care pathways</td>
</tr>
<tr>
<td></td>
<td>LTC and urgent care delivered differently with MDTs and hub models</td>
</tr>
<tr>
<td></td>
<td>Community and Social Care services aligned to localities Single point of access</td>
</tr>
<tr>
<td></td>
<td>Services traditionally delivered in acute setting delivered in primary care localities</td>
</tr>
<tr>
<td></td>
<td>Voluntary sector embedded within primary care localities</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Level 4</th>
<th>Accountability for broader population health</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A complete transformation of primary care services has been completed with new model of care implemented</td>
</tr>
<tr>
<td></td>
<td>Wider delivery of non core</td>
</tr>
<tr>
<td></td>
<td>Integrated physical, mental health, primary care, social care, community care, and public health</td>
</tr>
<tr>
<td></td>
<td>Organisational form and structural change</td>
</tr>
<tr>
<td></td>
<td>Accountability shift to different organisations</td>
</tr>
<tr>
<td></td>
<td>MCP model or PAC model formed</td>
</tr>
<tr>
<td></td>
<td>Build out to encompass wider services: VCS, housing, employment...</td>
</tr>
</tbody>
</table>
Plans are in place across the STP to define, develop and support localities to move through these levels and offer a consistent set of services to our patient population. We will use GPFV transformation funding to support this work, but additional investment will be required in estates and workforce in order to bring further benefit. The high level timeline (at CCG level), is given below, some localities within each CCG will reach milestones earlier:

Creating capacity in primary care – using resources more efficiently

We know that nationally c 25% of GP consultations could be diverted to alternative channels. An audit of c.1, 400 GP consultations across three localities in the STP demonstrated that this national finding is applicable locally. See Figure 37.
Figure 36: Primary care audit across MSE

We will reduce the number of non-health-related consultations that GPs currently undertake (e.g. meeting DWP requirements, or providing work sick-notes). We will achieve this by enhancing the training of GP receptionists and practice nurses to support effective signposting.

A considerable amount of GP time is spent seeing patients who may not have a primary clinical need. Our Social Prescribing pilots are demonstrating real gains in reducing consultation time for such cases:

Note: 1. Avoidable includes consults that were classified as suitable for an alternative appointment, avoidable or no medical need; Audit included a mix of emergency and routine appointments 2. Others includes COPD team, dentist, dietician, hospice at home, midwife, optometrist and sexual health (each <1% share) 3. Includes fit notes and DWP req. Source: GP Forward View 2016 (Audit of ~5000 GP consultations); Audit of practices in three localities in M&SE, 2016 (~1400 consultations)
Case Summary Social Prescribing

- Basildon & Brentwood CCG is working in collaboration with local authority colleagues to pilot a social prescribing model, accessible via six of our GP practices, which collectively serve over 50,000 of our population. The social prescribing service has been developed in recognition of the fact that people often attend their Practice with problems that may not have a clinical presentation. Whilst there are often a range of services available, through local community and voluntary sector organisations that could provide valuable support in these situations, GPs and their teams may not be aware of which organisations these are, and how to contact them.

- To address this problem, the CCG has commissioned Basildon, Billericay & Wickford CVS to provide Social Prescribing Navigators who work with individuals, referred by members of the primary care teams in the pilot practices, to identify 3rd sector services that could be helpful, assist people to make contact with the selected organization and following up on patient progress where appropriate.

- In the last year, the Social Prescribing service has helped over 300 people to get support and advice, and the CCG will be working with the provider to expand access to our wider population during 2017.

- Social Prescribing services are now operating in all CCG areas.

Reducing the bureaucratic demands on Primary Care

We are working with our acute providers, in line with national contractual requirements, to reduce demand on GPs generated by acute hospitals – for example, in aligning Trust Access Policies, ensuring consistent use of E-referral services and ensuring timely access to advice and guidance services.

We are also working to reduce bureaucracy related to Primary Care payments – for example, through implementing a local QOF or CQUIN scheme for primary care.

Enabler 2: Develop a comprehensive primary/community workforce programme

A resilient and sustainable Primary Care base must be in place as the foundation for change. This needs to be achieved at a time when Primary Care is facing a workforce crisis nationally. As challenging as the national picture is, the local STP reality is worse, we have:

- An ageing GP workforce
- A high level of single-handed practices
- High workload levels
- Challenges in skill mix

A ‘do nothing’ scenario is not an option. The STP workforce strategy seeks to develop a primary care workforce that is able to deliver services and future models of care on a sustainable basis (see section 8 Enablers of Change).
This will be achieved with a strategic focus on recruiting, developing and educating a workforce that is competent to deliver whole person care that enhances patient self-management, with services and new roles that are enabling them as well as supporting their needs. We are supporting, extending and developing the primary care workforce through this significant change ensuring that all practices are able to support the overall STP vision of care. This change is based on strengthening a model not solely reliant on General Practitioners, but on a whole team approach incorporating and developing the skill sets of Allied Health Professionals.

Through our primary care workforce strategy, we have plans in place to enhance the skills of our existing workforce (e.g. offering training to create advanced nurse practitioners), as well as increase the workforce using innovative roles (e.g. clinical pharmacists working within localities, employing paramedics to support urgent care demand).

In terms of the medical workforce, we have a number of schemes in place. Anglia Ruskin University is planning, subject to final approvals, to open a School of Medicine in 2018 at its Chelmsford Campus. Having such a facility locally will assist with our workforce challenges over coming years as many students who study at the School will take up local placements and, once qualified, many may wish to stay in the area.

More imminently, the STP is on track to appoint 50 EU GPs over the next two years which should assist us in delivering the national FYFV target recruitment number for GPs which have been recently set for STPs.

The workforce strategy and delivery is overseen by the Primary Care Transformation and Development Group, a sub-group of the Local Workforce Action Board, and is supported by close working links with Health Education England.

**Enabler 3: IT & Digitalisation**

We will explore the use of IT/Digitalisation to reduce the need for routine primary care appointments through the development of new types of consultation including digital interaction with GPs outside of the surgery, offering remote consultations and using artificial intelligence where appropriate.

We will develop and deliver a digitally activated health and care system across greater Essex which will include out of hospital provision. The key areas of focus include:

- A data-enabled health and care delivery model
- A move towards population health management
- Activated citizens who use technology to maintain their own good health and well-being, self-care where possible, and manage their interventions with our services efficiently.

There are currently a number of work programmes underway with a focus on creation of e-consultations – practices are in the process of piloting different clinical IT systems.
In addition the system is exploring Virtualisation – to offer digital wrap-around Primary Care, so that patients can access clinical advice through text messages, health forums, or online consultation. The STP is progressing with the implementation of the local digital roadmap with a significant number of localities already offering e-consultations and exploring new models of access via technological solution.

**Enabler 4: - Estates Strategy**

We will establish an STP wide primary and community estates strategy to complement the creation of new models of care and respond to the Acute Trust reconfiguration.

The system successfully worked with the Department of Health to pilot its new approach to strategic estates planning – the Strategic Estates Planning and Implementation (SEPI) process.

See Chapter 8 Enablers of Change for further detail.

**Enabler 5: Primary Care at Scale**

The NHS Five Year Forward View and Next Steps publications described the movement towards integrated care, delivered through collaboration across health and care systems.

The system intends to progress New Models of Care to enable primary care to be delivered at scale.

Across the STP we are proactively supporting primary care development. Our Primary Care Leadership Group is exploring a number of options, including:

- **Creation of Super Practices** - typically run by a small group of elected or appointed partners. The GPC defines it as one GP practice covering a very large patient population, potentially in excess of 100,000, and which operates from a number of sites despite being a single organisation; and

- **Creation of Super Partnerships** - these are mergers of primary care practices on a larger scale, following developments around the country (for example, mergers of 5 to 20 practices have begun to take place – and in central Birmingham, a Super Partnership of just under 50 practices is forming).

We will examine these approaches and consider options for the STP.
6. Future Model of Care – Acute Care Proposals

About this section
This section describes the future model of care for the three hospitals within the mid and south Essex STP. It describes how this future model of care could be delivered across the three hospital sites and sets out the options for reconfiguration.

6.1 Introduction
The transformation of our acute hospital services will play a crucial role in realising the overall vision set out within this plan. Achieving this vision for acute hospitals will require the implementation of Local Health and Care plans to effectively manage demand. In turn, the reconfiguration of the hospitals will facilitate the more efficient delivery of care, and greater integration throughout the system – thereby releasing resources to support ongoing delivery of the new model of Local Health and Care.
As outlined in the case for change, the three hospitals in mid and south Essex all have examples of excellent care but there is significant variation across the Trusts. Improvement is needed to attain the highest possible standards and remove the variation between the three trusts and this will partially be achieved through standardisation of processes and real-time measurements.

The increasing numbers attending for emergency care, together with the gaps in the workforce, are stretching service delivery to – and sometimes beyond - its limits. Emergency care pathways are often overstretched, with all three Trusts struggling to consistently achieve the national A&E 4 hour standard.

As a result of the pressure on emergency care this has a knock-on effect on elective care, which can result in the cancellation of operations that cannot always be easily rebooked.

These pressures have an adverse effect on care delivery overall with all three hospitals struggling to achieve either emergency, elective or cancer access standards and a recognised need to improve patient experience; though two of the three hospitals have achieved a CQC rating of “good” overall, the third is rated as “requires improvement”.

We have developed plans to transform acute-care delivery – plans that we believe are capable of meeting best-practice standards, securing a more sustainable workforce, and ensuring access to high-quality acute care throughout mid and south Essex.

6.2 Our ambition and vision for acute services

6.2.1 Focus of this chapter: clinical reconfiguration

There are three main aspects to the transformation of acute hospital services:

1. Clinical reconfiguration
2. Clinical and corporate support services reconfiguration and redesign
3. Continuous improvement through standardisation and reduction in variation

The focus of this document is on aspect 1 – clinical reconfiguration – which is the area where public consultation is required.

6.2.2 Our vision for acute services

Our vision for the future of acute care in mid and south Essex covers five key areas:

- **Service offering.** We will improve current services, develop new services, and focus more sharply on innovation in hospital care. We also intend to build on the current centres of excellence across the three hospital sites, particularly focusing on:
  - The Essex Cardiothoracic Centre at Basildon Hospital.
  - The Cancer Centre at Southend Hospital.
  - The St Andrew’s Plastics and Burns Centre at Mid Essex.
- **Quality.** We aim to work in collaboration as a single network of care both across the three hospital sites and into the local health and care core offer, consolidating services where it makes sense to do so. This consolidation of services into centres of excellence will provide opportunities for increased sub-specialisation, group working and support, and make it possible to introduce greater innovation and new research and development opportunities.

- **Workforce.** The new system will help to create attractive and fulfilling working opportunities, with the flexibility for staff to work between different sites. By working at centres of excellence, staff will have greater opportunities to specialise and develop their careers. New roles will be created for nurses and other professionals; and the new system, working with deaneries and academic partners including ARU, supporting the introduction of a greater range of training opportunities for staff.

- **Financial sustainability.** The efficiencies gained through the new system and the attractiveness of the new clinical pathways and service models that will be introduced as part of this proposal will make more efficient use of staff time support recruitment and reduce the amount that trusts spend on agency support, and thereby support financial sustainability.

- **System working.** Hospitals will no longer work in isolation, and will therefore be able to manage demand more effectively. The site-specific front-ends will be enhanced through the establishment of the Urgent Treatment Centres (UTC) and Emergency Care Hubs, enabling staff to manage attendees more rapidly and avoid unnecessary admissions, supported by the local health and care offer. This will be supported through the implementation of a single, cross site, operational and clinical management model for cross site services and a single command centre which will support capacity management across all three sites, supported through the TeleTracking programme that the trusts have secured in partnership with NHS Improvement.

### 6.3 Approach to developing, evaluating and determining the preferred option

Figure 37 below outlines the approach which has been taken to support the determination of the preferred clinical service model across the three hospital sites. Well over 100 clinicians have been involved in this work to date.
The staged approach to development of the reconfigured model has been undertaken in the following steps:

1. **Initial option generation** was undertaken between March and September 2016 by around 70 clinicians and managers from across the three hospitals and the ambulance trust at a series of workshops (known as the Acute Leadership Group) and supported by focused sub-group meetings.

2. **Option testing and refinement** was then undertaken by more than 100 clinicians and professionals from across the health and social care sector and service user representatives, informed by a stage 1 clinical senate review. This recommended that two reconfiguration options (described further below) should go forward for consideration and pre-consultation engagement.

3. **Pre-consultation engagement** was undertaken through to summer 2017 with the public and clinical teams across the mid and south Essex health sector, as described further in the engagement section.

The sections below provide further description on the work undertaken at each stage of development of the clinical model.

6.3.1 **Stage 1 – Option generation and decision rules for reconfiguration and redesign**

The Acute Leadership Group held two workshops to agree its “decision rules”, i.e. its set of principles for reconfiguration and redesign. These rules were based on the case for change and national guidelines.
The Acute Leadership Group also agreed that reconfiguration alone will not be enough to realise the potential benefits, but that it is still essential for the ongoing enhancement of services. Individual disease pathways – for chronic obstructive pulmonary disease, for example – are currently undergoing redesign to improve care; this includes increasing the use of technology, changing the workforce model, and redirecting patient flows between primary, community, and acute services.

These decision rules are in line with the following specific aspirations, also identified by the Acute Leadership Group:

**Improving service reliability and efficiency through the separation of elective and non-elective care for specialities with a critical mass**

National guidance, including the Keogh, Willets and ‘Getting It Right First Time’ analysis has identified that for specialities with sufficient demand and staffing, the physical separation of elective and non-elective services can greatly enhance service reliability, seen across all aspects of hospital care including reduction in last-minute cancellations and greater standardisation and efficiency in the use of theatres which can be achieved through a more predictable workforce and better scheduling of senior clinician time.

**Improving outcomes and productivity through the consolidation of specialist services**

The ‘Getting It Right First Time (GIRT)’ analysis, alongside Briggs has identified that for patients that require specialist care secure better outcomes as a result of consolidation. This arises from patients having accesses to larger and more optimal specialist clinical teams and facilities which could not be replicated across three geographically close hospital sites.

There are already examples of this in mid and south Essex; for example, in cardiothoracic, plastic surgery and burns, and various cancer specialties, where there is established evidence base for better outcomes through consolidation. In the

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59 Briggs, 2012, Getting It Right First Time
Essex Cardiothoracic Centre our GIRT report from July 2017, we now see upper quartile outcomes being achieved for local people - risk-adjusted in hospital survival rate (98.44% against England’s 97.82%), and cancellations of procedure at half the national level (5.6% versus 11.2% for England).

In undertaking analysis of the available evidence base it has been determined that this principle takes precedence over the separation of elective and non-elective care in lower volume specialities, such as vascular surgery.

6.3.2 Stage 2 – Option testing and refinement

The mid and south Essex health economy has funding constraints on the relocation of equipment and the redesign of hospital sites. Various key services with high fixed costs were therefore identified as “givens”, i.e. fixed points for reconfiguration. These are set out in the figure below.

**Figure 39: “Givens” – out of scope services for reconfiguration**

<table>
<thead>
<tr>
<th>Given</th>
<th>Cost</th>
<th>Rationale</th>
</tr>
</thead>
</table>
| Plastic Surgery and Burns at MEH            | ~£98M (excl. land purchase costs) | • Cost of new build for designated specialist burns centre for East of England  
|                                            |                       | • Includes generic clinical accommodation comprising ITU, HDU, Theatres, recovery and ward space |
| Cardiothoracics at BTUH                    | ~£100M (excl. land purchase costs) | • Cost of new build CTC centre with capacity for provision of specialist care for all of Essex  
|                                            |                       | • Includes generic clinical accommodation associated with delivery of CTC services |
| Radiotherapy and Cancer Centre at SUH       | ~£92M (excl. land purchase costs) | • Cost of recreating SUH radiotherapy and cancer services at another site |

The choice of these “givens” was determined by two key factors: the financial impact of moving the services, and the clinical case for moving the services (and the effect on quality).

**Financial case** - the cost of relocating equipment and hospital sites is a key factor in any decision on acute reconfiguration. For example, the cost of moving and re-establishing the burns and plastics centre at Broomfield Hospital has been estimated at £98m. Given the limited capital available, such an expense is unrealistic, and accordingly those services will not be moved.

**Quality/clinical case** - moving hospital sites can, temporarily at least, have a negative impact on quality, while the workforce readjusts to a new working environment and style.
The givens were identified by clinical leaders in collaboration with financial leaders, and were tested under the direction of the Acute Leaders Group (ALG). Givens were based on national standards, local and regional reviews and programmes, and ALG advice, as outlined below.

Figure 40: "Givens" – consideration of site-specific locations of delivery models

<table>
<thead>
<tr>
<th>Given</th>
<th>Interdependency</th>
<th>Strength</th>
<th>Source</th>
<th>Implication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burns &amp; plastics @ MEHT</td>
<td>Burns units must have (amongst others) the following on the same site: urgent and emergency care, paediatric surgery, care of the elderly, radiology, general surgery</td>
<td>Strong</td>
<td>National Burn Care Standards</td>
<td>MEHT must be either specialist emergency centre or emergency centre with elective</td>
</tr>
<tr>
<td></td>
<td>Burns units must have paediatric medicine and paediatric surgery on the same site – specifically there must be 24h cover by a consultant paediatrician who can attend within 30 minutes and does not have responsibilities to other hospital sites</td>
<td>Strong</td>
<td>National Burn Care Standards</td>
<td>There must be general paediatric medicine at MEHT</td>
</tr>
<tr>
<td>CTC @ STUHFT</td>
<td>CTC – Vascular: NHS England service specification states that there needs to be a close relation between vascular services and cardiology, cardiac surgery services and whilst co-location is desirable it is not essential</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>CTC – Emergency: Vascular–Emergency–IR. CTC and emergency vascular have a shared interdependency for co-location with emergency IR</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Local vascular review states 24/7 co-location of emergency vascular with IR is essential (elective vascular can be located at other sites)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• London Health Programmes says cardiology and IR is absolutely dependent</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>24/7 emergency/IR service is likely to require consolidation to 1 site</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Currently, not able to provide 24/7 service at any site</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medium</td>
<td>NHS England service spec</td>
<td>STUHFT must be either specialist emergency centre or emergency centre with elective</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>CTC at STUHFT</td>
<td>Co-location of emergency vascular and emergency IR 24/7 services with CTC</td>
<td></td>
</tr>
<tr>
<td>Cancer centre</td>
<td>Complex cancer surgery will require intensive care unit. Options to deliver complex cancer surgery at different site to radiotherapy and other medical care</td>
<td>Strong</td>
<td>ALG</td>
<td>ITU at STUHFT, if complex cancer surgery delivered on site</td>
</tr>
<tr>
<td></td>
<td></td>
<td>re-location essential</td>
<td>Medium</td>
<td>re-location desirable</td>
</tr>
</tbody>
</table>

The givens were discussed and tested with a wide range of stakeholders, including the Systems Leaders Group, and at workshops and engagement events with service users. They are highlighted within the public discussion document.

The rationale for and logic behind the givens were reviewed by the Clinical Senate in October 2016. In its response, the Senate noted that:

“The STP does not have the luxury of being able to consider significant capital investment in their estates to facilitate service re-organisation and need to consider key fixed or relatively fixed assets in its forward planning. In addition, the local health system has identified three highly specialised units that would be particularly difficult to re-locate which they have described as their ‘givens’...In view of the lack of available capital investment and geographical factors, the reasoning behind the ‘givens’ these were better understood. The panel felt that of the three ‘givens’ the location of the Burns unit seemed perhaps the easiest to reconsider but it was also recognised that this service covered a large geographical area and access from the northern end of the East of England needed to be taken into account.”

6.3.3 Options appraisal

Process of the options appraisal

The options appraisal process scored the options against four criteria:

- Quality, outcomes and safety
- Sustainability of clinical workforce
- Access
- Efficiency and productivity

There were five key groups involved in the process (see Figure 42). Financial criteria (efficiency, productivity and capital requirements) were assessed and scored by the Financial Oversight Group. Non-financial criteria (quality, safety and outcomes; workforce sustainability and access) were initially assessed and scored by the Clinical Expert Panel and the Service User Panel, and subsequently by the Options Appraisal Group. All the findings were put before the programme board, which made the final decision on which option to recommend.

**Figure 41: An overview of the five options discussed**

<table>
<thead>
<tr>
<th>Option</th>
<th>BTUH</th>
<th>MEH</th>
<th>SUH</th>
</tr>
</thead>
<tbody>
<tr>
<td>1A</td>
<td>Essex Cardiovascular Centre Emergency centre MS Essex spec. emergency hospital MS Essex specialist obstetric centre</td>
<td>Plastics &amp; Burns Centre Emergency centre MS Essex elective surgical hospital MS Essex specialist obstetric centre MS Essex children’s centre</td>
<td>MS Essex Cancer Centre Emergency centre MS Essex elective surgical hospital</td>
</tr>
<tr>
<td>1B</td>
<td>Essex Cardiovascular Centre Emergency centre MS Essex elective surgical hospital</td>
<td>Plastics &amp; Burns Centre MS Essex spec. emergency hospital MS Essex specialist obstetric centre MS Essex children’s centre</td>
<td>MS Essex Cancer Centre Emergency centre MS Essex elective surgical hospital</td>
</tr>
<tr>
<td>1C</td>
<td>Essex Cardiovascular Centre Emergency centre MS Essex elective surgical hospital</td>
<td>Plastics &amp; Burns Centre Emergency centre Elective surgical hospital MS Essex children’s centre</td>
<td>MS Essex Cancer Centre Emergency centre MS Essex specialist obstetric centre</td>
</tr>
<tr>
<td>2A</td>
<td>Essex Cardiovascular Centre Emergency centre MS Essex spec. emergency hospital MS Essex specialist obstetric centre</td>
<td>Plastics &amp; Burns Centre Emergency centre MS Essex elective surgical hospital MS Essex specialist obstetric centre MS Essex children’s centre</td>
<td>MS Essex Cancer Centre Emergency centre Local emergency centre MS Essex elective surgical hospital</td>
</tr>
<tr>
<td>2B</td>
<td>Essex Cardiovascular Centre Emergency centre MS Essex elective surgical hospital</td>
<td>Plastics &amp; Burns Centre MS Essex spec. emergency hospital MS Essex specialist obstetric centre MS Essex children’s centre</td>
<td>MS Essex Cancer Centre Local emergency centre MS Essex elective surgical hospital</td>
</tr>
</tbody>
</table>

When assessing the overall criteria, participants on each of the assessment panels considered the supporting data on the sub-criteria for each of the five options outlined in Figure 41. Each of the overall criteria for each option was then rated on a scale of 1 to 5:

1. Strong evidence that the option would not achieve the desired result for the relevant criterion
2. Some evidence that the option would not achieve the desired result for the relevant criterion
3. The option would produce no predicted material change from the current model of care
4. Some evidence that the option would achieve the desired result for the relevant criterion
5. Strong evidence that the option would achieve the desired result for the relevant criterion
Further detail on the options appraisal process can be found in Appendix 12.

**Outcomes of the options appraisal**

The options appraisal process culminated in the following scores for each of the options, with raw scores being determined by the representatives listed above, and criteria then weighted as shown in the Figure below. The two options that were to be developed further, 1A and 2A, are highlighted in green.

**Figure 43: Raw scores for each option**

<table>
<thead>
<tr>
<th></th>
<th>Quality, outcomes, and safety</th>
<th>Workforce</th>
<th>Access</th>
<th>Productivity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Option 1A</strong> 3.5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Option 1B</strong> 2.9</td>
<td>3.0</td>
<td>2.8</td>
<td>2.6</td>
<td>4.0</td>
</tr>
<tr>
<td><strong>Option 1C</strong> 2.4</td>
<td>2.5</td>
<td>2.2</td>
<td>4.0</td>
<td></td>
</tr>
<tr>
<td><strong>Option 2A</strong> 4.0</td>
<td>4.0</td>
<td>3.3</td>
<td>5.0</td>
<td></td>
</tr>
<tr>
<td><strong>Option 2B</strong> 3.7</td>
<td>3.8</td>
<td>2.8</td>
<td>5.0</td>
<td></td>
</tr>
</tbody>
</table>
As shown in Figure 44, Option 2A was the preferred option after the voting and allocation, while Option 1A was the third most preferred overall and the most preferred of the three options that did not include an elective centre with local A&E. While the two options ranked similarly on Access, Option 2A scored substantially higher than 1A on the other three criteria.

In considering the results of the options appraisal, the STP Programme Board expressed a concern that the likely capital cost of option 2B was unrealistically high, as it involves extensive remodelling of the existing hospital infrastructure. In addition, the Board was mindful of the clearly expressed concerns in the South East of the patch over the future A&E model in the ‘yellow’ hospital configuration, and considered that given this context it would not be prudent to select either a single option (2A) or two options (2A and 2B) that only included a yellow hospital model in the South East of the footprint.

In March 2017, the STP Programme Board decided to take two models forward for further pre-consultation engagement – 2A and 1A. In reaching its conclusion, the Programme Board considered the results of the options appraisal, feedback from stakeholders such as HWBs and, critically, the likely capital cost of option 2B.

### 6.3.4 Pre-consultation engagement activities and refinement to establish the proposed model of care

Following the decision to move forward to further pre-consultation activities on options 1A and 2A, an extended period of pre-consultation engagement activities were undertaken with local communities as described within the Engagement section of this document.

Most feedback was supportive of the key elements and principles underpinning the proposed reconfiguration but several themes were identified which have been used to refined the proposed clinical model. These themes, alongside implications for the refined option are shown in figure 45 below.
Figure 45: Key feedback themes and implications for the proposed clinical model

The overriding feedback from pre-consultation engagement activities was the concerns regarding a reduction of access to emergency care and the additional travel time associated with moving to a new centre.

<table>
<thead>
<tr>
<th>Feedback on Options 1A and 2A</th>
<th>Implications for a revised option</th>
</tr>
</thead>
<tbody>
<tr>
<td>There should be 24/7 Consultant led A&amp;E at each site</td>
<td>Development of Treat and Transfer model of Care with local Trust transport</td>
</tr>
<tr>
<td>There should be Obstetric maternity presence at all sites 24/7</td>
<td>Cancer Centre to have 24/7 A&amp;E coverage and supporting services</td>
</tr>
<tr>
<td>There should be Paediatric A&amp;E presence at all sites 24/7</td>
<td>Only limited ambulance by-pass</td>
</tr>
<tr>
<td>We shouldn’t expect older people or children to have to travel away from their local hospital unless essential</td>
<td>Presumption that Frail and Paediatrics to stay local except highly complex cases</td>
</tr>
<tr>
<td>Ambulances should not automatically by-pass local hospitals except in highly specialist/complex cases with agreed pathways</td>
<td>Obstetric Maternity at all three sites</td>
</tr>
<tr>
<td>Ambulance service not resourced to implement new model</td>
<td></td>
</tr>
</tbody>
</table>

Following this feedback and the agreement of the implications for the proposed clinical model, revised clinical working groups were set up to refine the future service model across the three hospitals which was concluded in August 2017 and are outlined within section 6.4 below and in detail at Appendix 2.

6.4 Future Model of Care – An overview

6.4.1 Future Model of Care – the proposed clinical model

The core features of the proposed clinical model are shown in Figure 46 below; these retain the core underlying principles which were established initially by the Acute Leadership Group, alongside a number of key design features which have now been incorporated within the proposed option based on the themes that emerged through the pre-consultation engagement process.
Figure 46: underlying principles and key features of the preferred option

<table>
<thead>
<tr>
<th>Underlying principles</th>
<th>Key features</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>National guidance</strong></td>
<td>Specialist Cancer and Elective Hospital at Southend</td>
</tr>
<tr>
<td>Keogh-Willetts; NCEPOD</td>
<td>Consolidation of key inpatient services on single sites</td>
</tr>
<tr>
<td>Improve efficiency</td>
<td>Reconfiguration of Clinical Support Services to support new ways of working</td>
</tr>
<tr>
<td>Greater reliability</td>
<td>Potential Children’s Centre at MEHT in the longer term</td>
</tr>
<tr>
<td><strong>GIRFT</strong></td>
<td>Consolidation of specialist emergency activity at BTUH / MEHT</td>
</tr>
<tr>
<td><strong>NHSE Spec Comm</strong></td>
<td>Enhanced front door with significant investment in Ambulatory Care</td>
</tr>
<tr>
<td>Higher volumes / specialisation → improve outcomes</td>
<td>A single HASU, maintaining ASUs at each site and develop thrombectomy</td>
</tr>
<tr>
<td>Greater productivity</td>
<td></td>
</tr>
<tr>
<td><strong>Keogh Carter; Dalton</strong></td>
<td></td>
</tr>
<tr>
<td>Reduce variation across the three hospitals</td>
<td></td>
</tr>
<tr>
<td>Standardised pathways to deliver quality, efficient services</td>
<td></td>
</tr>
</tbody>
</table>


The key changes from options 1A and 2A resulting from the pre-consultation feedback and further detailed clinical work stream analysis are:

- All sites will have 24/7 consultant led emergency departments taking blue-light ambulances 24/7.
- There would be enhanced 24/7 specialist medical cover at Basildon Hospital, surgical cover at Broomfield Hospital and cancer care at Southend Hospital.
- A treat and transfer service would operate for patients with the most complex needs in defined speciality areas, including:
  - Cardiology, vascular, stroke and general surgery.
  - The delivery of inter-hospital transfers via a hospital run service to reduce pressure on blue light hospital services.
- The majority of paediatrics, women’s and older patients would be treated at their local hospital.
- Retention of the elective / emergency split remaining for simple, high volume specialities but not for complex specialist treatment, in line with the principles outlined at section 6.3.1.

This work has generated a set of detailed, speciality specific proposals which are outlined below and by speciality in Appendix 2.
In order to deliver this model there are fundamental enablers to secure the effective operation of the proposed clinical model:

- Firstly, the establishment of single clinical teams across all three sites (although we would generally expect no clinician to routinely work across more than two sites) under single clinical and managerial leadership which would begin to be established prior to the implementation of new clinical models to allow for standardisation in working practices and sub-pathway clinical redesign.

- Secondly the operation of a safe and effective treat and transfer service, as described below.

*Treat and transfer – how would it work?*

The treat and transfer service means that patients with more complex conditions will receive the first stage of their care in their local hospital. This may involve assessment, stabilisation and potentially some treatment (for example, thrombolysis for stroke patients with clots in their brain). If a patient has a condition that may benefit from more specialised care, senior clinicians within the Emergency Department, in collaboration with colleagues from the specialist centre, will discuss whether a patient is suitable for transfer.

Patients who may not be suitable for transfer may include those who are too ill to transfer safely, and young children or those who are very frail for whom any benefits of transfer are outweighed by the additional stress of moving hospitals. These patients will continue to receive care locally, with specialist input as required.

Patients who are suitable for transfer will be moved via hospital transport (including blue-light transport) to a specialist hospital. These sites will have full access to patient records, and will be prepared to receive patients and commence treatment as soon as possible. These specialist centres will benefit from greater specialist on-site staffing cover (including overnight and weekend cover) and specialist support services tailored to provide the best possible care for very sick patients.

In most cases, these patients would be expected to return back to their local hospital within 48-72 hours of transfer.

Treat and transfer is a model that is has been implemented at other trusts such as The Leeds Teaching Hospitals NHS Trust operating over two sites with different specialities with the only cross over being; Emergency Medicine, Anaesthetics, Obstetrics, Radiology. There is an extensive pre-operative triage and treat and transfer protocol in place.

It is important to note that in complex cases where patients are too sick to be transferred to another hospital, or require multi-speciality inpatient or surgical management arrangements would be in place for clinicians to be able to travel to the patient locally for their treatment.
6.4.2 The Emergency Care Hub

At the core of the in-hospital urgent and emergency care offer will be the creation of emergency care hubs at each of the three hospitals, fully integrated within the local health and care offer, aimed at providing better, faster and safer care for a majority of patients who need hospital treatment. This is summarised in Figure 47 below:

Figure 47: Emergency Care Hubs

<table>
<thead>
<tr>
<th>What are Emergency Care Hubs?</th>
<th>What is the evidence?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance</td>
<td>Improved flow at the Front Door can have a profound impact on patient outcomes:</td>
</tr>
<tr>
<td>Walk-ins</td>
<td>• Reducing ED crowding reduced 10-day mortality by ~30%†</td>
</tr>
<tr>
<td>GP Referral</td>
<td>• Early senior review reduced mortality by 27%² and shortens LOS by ~2-3 days²</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>• Placing patients into the right ward first time reduced mortality by 50%, reduced readmissions by 46% to 83%, and LOS by 2-4 days⁴</td>
</tr>
<tr>
<td>Home or Out-Patient</td>
<td>• Ambulatory emergency care is clinically safe with reduction in in-patient mortality of 1-6%⁵</td>
</tr>
<tr>
<td>Emergency Care Hubs</td>
<td>• Ambulatory care also reduces unnecessary overnight hospital stays and hospital inpatient bed days by 1.5 to 2.5 days⁵</td>
</tr>
</tbody>
</table>

A whole system approach which includes Medical Ambulatory Unit, Surgical Ambulatory Unit and Frailty Ambulatory Unit providing:
• GP streaming for all walk-ins
• Ambulatory care and short stay services
• Diagnostics, observation, treatment, and rehabilitation
• Standardised patient pathways following clear inclusion/exclusion criteria
• Consultant led service with quick decisions
• Dedicated discharge coordination


6.4.3 Proposed clinical model – the principal service changes

The proposed changes, for each service change area and a patient flow map has been developed and included at Appendix 2. A brief narrative description is provided of the proposed change and rationale. This is a focus on inpatient beds and if a service line is not described in this section then services will remain as currently organised.

Emergency Care (See Appendix 2 page 3)

In the current model, all three sites have 24/7 emergency departments with some specialist services going directly to specialist units e.g. Burns. However, a recent review has proposed increasing the number of services that are taken directly to specialist units.

Proposed changes would see all sites continuing to have 24/7 consultant led emergency departments taking blue-light ambulances 24/7 In addition, there will be enhanced 24/7 specialist medical cover at Basildon Hospital, surgical cover at Broomfield Hospital and cancer care at Southend Hospital to facilitate the operation of the Treat and Transfer service.
There will be 24/7 emergency departments in local areas to support and stabilise in case of emergency. However, in those cases where there is a benefit to patients, we propose to create differentiated inpatient pathways of care so that patients will receive more specialised treatment quicker, thereby supporting a quicker recovery.

Where patients are transferred to a specialist centre as described below, they will spend the minimum amount of time required in order to optimise their outcome with patients being transferred back to hospital or community services closer to home at the earliest opportunity for their recovery.

Hyper-acute stroke care (see Appendix 2 page 22)

Currently, all three hospitals offer stroke services on site. Patients suspected of having a stroke would be transferred to their local hospital, where they will have access to diagnostics and appropriate initial treatment such as thrombolysis within each of the three emergency departments.

Under the proposed changes, patients suspected of having a Stroke would still be seen in their local hospital, and would receive Thrombolysis locally. Complex cases will be transferred to a hyper-acute stroke unit at Basildon Hospital, for a period of intense support, usually the first ~72 hours. The rationale for this change is that evidence suggests that being able to access specialist intensive medical, therapy and nursing interventions should reduce morbidity following a patient suffering a stroke. By creating a single HASU we would be better able to provide the staffing levels required, and access to specialists needed to deliver excellent outcomes.

Following their intensive treatment within the HASU patients would be transferred to an Acute Stroke Unit at their local hospital or to a consistent set of community based early supported discharge services, based on patient need following their initial treatment.

Links to extended services will remain, for example, the delivery and expansion of the Thrombectomy service at Southend Hospital.

This model builds on strong national evidence that consolidating stroke care in HASU improves patient outcomes. This type of approach is already in place in Greater Manchester and London and has seen mortality and length of stay decrease by over 15%.

This model means that patients will not have to travel further than today to access immediate care including Thrombolysis, however some relatives and friends may need to travel further during the short period HASU stay but our assessment is the outcome gain expressed by improved morbidity and better outcomes for patients supports the proposed model for HASU care.

Cardiology (See Appendix 2 page 6)

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60 Saposnik et al, Neurology 2007
We are fortunate to have the Essex Regional Cardiothoracic Centre (CTC) based in Basildon. This centre provides acute care for the sickest Cardiology patients – including all patients with ST elevation Myocardial Infarctions. These patients are either taken directly to the CTC by ambulance or through a treat and transfer model from other hospitals.

After receiving immediate treatment, patients are discharged back to local hospitals. All three sites also offer emergency, non-complex elective and outpatient cardiology services.

Under the proposed clinical model we would propose that existing pathways to CTC such as non ST elevation, myocardial infarctions and life threatening arrhythmias who require a pacemaker would be accelerated, reducing the amount of time patients spend at their local hospital before being transferred, thereby reducing the overall length of time patients have to spend in hospital before receiving treatment, alongside improving their outcomes. Following their treatment and once stabilised patients would be transferred for any rehabilitation to their local hospital.

All sites will continue to offer short stay emergency cardiology care, including patients with Cardiac Chest Pain and Arrhythmia or conduction disorders.

Complex elective procedures, including Coronary Artery Bypass Graft and Percutaneous Coronary Intervention would also be delivered in the CTC.

There is strong clinical evidence that consolidation of Cardiology services can improve patient outcomes and this has been evidenced locally through the improvement in outcomes at the CTC.

**Respiratory (See Appendix 2 page 28)**

Currently all three hospitals provide routine elective and emergency care to patients and under the proposed clinical model the vast majority of patients will continue to be seen and treated locally, through the local health and care model. We expect that the enhancement of the local health and care model will result in a stabilisation of the demand on emergency respiratory services through the implementation of new models of care, such as the rollout of new self-management technologies.

Alongside the local health and care offer, the vast majority of emergency presentations will continue to be treated locally through Emergency Care Hubs, such as COPD.

However, for very complex patients such as those with pleural disease or severe pneumothoraces we would propose that following their initial assessment and treatment they would be transferred to a specialist acute respiratory unit at Basildon Hospital where staffing levels can be increased and improved specialist cover provided to provide better care and improve patient outcomes. This may include patients requiring non-invasive ventilation.

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61 Ross et al, NEJM 2010
Renal (see Appendix 2 page 24)

Emergency and elective services are currently offered at all three sites. Very complex work, such as renal transplantation is referred to specialist centres, such as the Royal London Hospital and Guy's hospital, with patients repatriated locally for follow up.

It is anticipated that the majority of renal patients would continue to access services at their local sites in the future model. This would include, for example, outpatient and short stay activity, including routine dialysis.

However, it is proposed that the establishment of an acute renal centre at Basildon Hospital which will enable patients with complex needs to benefit from being cared for with specialist care and would benefit from co-location with the proposed vascular centre described further below. By creating a single centre patients will have access to enhanced specialist cover, and allow for the investment in new facilities and technologies to provide better care and support better outcomes for those patients.

Patients who may benefit from an acute renal centre include unwell renal transplant patients; acute kidney injury patients requiring dialysis (including patients who had previously been in ITU) and renal biopsies. Patient requiring very specialist interventions will continue to be treated in London.

General Surgery: emergencies

All three sites currently offer a wide range of inpatient, outpatient and day case general surgery services, including upper GI, colorectal, breast and paediatric surgery.

Under the proposed clinical model, outpatient and day case services alongside initial emergency diagnosis and treatment and ambulatory care would continue to be provided at each hospital site, and would be increased through the implementation of the Emergency Care Hubs.

However, for complex inpatient emergency general surgery cases, such as exploratory laparotomies it is proposed that all cases are transferred to an emergency surgical service at MEHT. Currently approximately one patient /day at each site requires this intervention but there may be delays. It is proposed that physiologically stable patients requiring surgical intervention (e.g. perianal abscess, simple appendectomies), are treated locally. By creating a dedicated emergency surgical service at MEHT we can better organise services to create more dedicated theatre slots for emergency cases and bring together clinical teams to operate within these theatre slots, this would have the effect of rapidly decreasing the time patients would need to wait for emergency surgery from today. It is important that this complex surgery is performed by consultants with skills in general surgery who are supported by colleagues locally.

Surgery Elective

Breast

There are no plans to change the current breast surgery provision.
**ENT and OMFS**

There are no plans to change the current provision which is based at MEHT and supports all hospitals.

**Upper GI Surgery**

This service is already located at MEHT and supports all three hospitals. There are no plans to change this well-established service.

**Colorectal Surgery**

At present all three sites provide colorectal surgery but with a focus on cancer-related surgery at Southend Hospital.

It is proposed to maintain cancer related surgery at Southend Hospital and extend this to a specialist pelvic floor service, but with all other emergency and inpatient elective colorectal being undertaken at Broomfield Hospital in order to allow for the delivery of a 7/7 consultant led service for patients in mid and south Essex.

The changes in the surgical bed base across the three hospitals will be facilitate by consultant-led admission avoidance in the emergency hub, enhanced geriatric support to inpatient services and ring-fenced beds at MEHT to support the elective work. For both emergency and elective patients, once stabilised we would expect that patients would be transferred to their local hospital or a community rehabilitation pathway.

**Gynecology (See Appendix 2 page 17)**

Currently, emergency and routine Gynaecological services are offered on all sites. These include Early Pregnancy Assessment Units, and a range of clinics (e.g. Colposcopy clinics). Currently, Oncology patients are transferred from Basildon to Southend, although this arrangement is not in place with patients from Broomfield.

It is anticipated that routine outpatient, day case and short stay gynaecology services would remain local for both emergency and elective services.

It is proposed that for specialist elective and emergency patients who would need to stay in hospital for more than 48 hours, alongside oncology care will be provided at Southend Hospital.

There is good evidence that consolidating complex care, including cancer improves outcomes for patients. This is already partially in place across mid and south Essex, and would be extended under this model.

**Trauma and Orthopedics (see Appendix 2 page 31)**

All three sites currently offer a wide range of inpatient, outpatient and day case Trauma and Orthopaedic services.

Under the proposed clinical model, outpatient and day case services alongside initial emergency diagnosis and treatment, and ambulatory care would continue to be provided at each hospital site, and would be increased through the implementation of the Emergency Care Hubs.
However, for complex inpatient emergency trauma cases which at present may wait some time to receive treatment it is proposed that patients from south Essex would be transferred to an emergency trauma service at Basildon, whereas for mid Essex patients would be seen at an emergency trauma ward at Broomfield Hospital. By creating a dedicated emergency trauma service at Basildon we can better organise services to create more dedicated theatre slots for emergency cases and bring together clinical teams to operate within these theatre slots, this would have the effect of rapidly decreasing the time patients would need to wait for emergency surgery from today.

In order to free up the necessary beds and theatre time to allow for the introduction of very rapid access to emergency trauma surgery for inpatients we are proposing to bring together inpatient elective orthopaedic surgery at Southend Hospital and Braintree Community Hospital. Although patients would be provided with a choice of location, we would expect that most patients living in south Essex will elect to be treated at Southend Hospital and most people at mid Essex at Braintree. However, in some cases where patients from mid Essex may have complex needs or co-morbidities which require critical care these patients would be treated at Southend. As well as creating the capacity for the introduction of very rapid access for emergency inpatient trauma, this model for elective orthopaedics provides the advantage of increased numbers of ring fenced elective orthopaedic beds and theatre time, significantly reducing the risk of last minute cancellation and helping reduce waiting times for elective treatment.

Elderly patients presenting with a fractured neck of femur would be assessed and stabilised at their local hospitals. In most cases if an operation is required that would be performed locally to ensure that the correct consultant-led intervention occurs and post op care is maximised by local geriatricians. All three sites would follow common pathways for this important presentation.

For both emergency and elective patients, once stabilised we would expect that patients would be transferred to their local hospital or a community rehabilitation pathway.

There is good evidence that consolidating surgical procedures can improve outcomes for patients\(^\text{62}\). Improved outcomes typically include reducing complications and length of stay for patients receiving hip operations. This approach seeks to gain benefits of consolidation, whilst ensuring that there is appropriate access and volumes across all three sites to make staffing Rotas work effectively.

There are currently two major trauma networks in operation for the sites – Addenbrooke’s is the Major Trauma Centre for Broomfield, whilst Basildon and Southend are part of a Trauma network with The Royal London as the Major Trauma Centre, no changes are proposed to these models.

**Urology (see Appendix 2 page 35)**

Currently, emergency urology services are provided at all three hospital sites. Emergency patients are reviewed via A&E, and are referred for emergency surgery at the same site. Most elective surgery is currently provided on all sites.

\(^{62}\) NCBI Report, Nov 2010; Getting it right first time, March 2015
Under the proposed model, emergency patients will be assessed and receive initial treatment within the Emergency Department and the Emergency Care Hubs and for those with less complex conditions they will be treated at their local hospital, this will include conditions such as UTIs, Renal Colic and Haematuria.

For patients requiring complex inpatient surgery, following their initial diagnosis and treatment they would be transferred to a urology centre at Broomfield Hospital. Post-surgery, patients would be discharged, with follow up care being provided at their local hospital.

Patients too sick for transfer would be admitted to the local ITU/CCU, with urology in-reach available to these units.

In the case of elective services, complex elective surgery would also be consolidated at Broomfield Hospital and complex cancer surgery at Southend Hospital in order for patients to benefit from the concentration of expertise; this will include nephrectomy and pyeloplasty at Broomfield, and Radical Prostatectomy at Southend.

This approach should support enhanced patient outcomes: for example, there is clear clinical evidence that consolidation of complex Urology surgery (including Cancer surgery) can improve patient outcomes.

**Vascular**

Vascular outpatient, elective and emergency services are currently delivered across all three sites.

However, a review undertaken by NHS England based on best available evidence has proposed consolidating emergency and specialist elective inpatient treatment into a single vascular service in order to improve access to life saving surgery through the creation of centres which have a sustainable workforce which in turn can deliver rapid treatment for patients and improve outcomes.

The proposed clinical model is that all patients will continue be receive initial diagnosis and treatment at their local emergency department and the enhanced emergency hubs. All patients that require emergency surgery would be transferred to a 24/7 Emergency Vascular Centre at Basildon Hospital. Patients treated at the Emergency Centre would be repatriated to local hospitals for their ongoing care as soon as they are stable.

Due to the relatively low number of patients requiring emergency vascular surgery it is proposed that complex inpatient elective surgery would also be undertaken within the centre, including aorta-thoracic and abdominal surgery due to the benefits for patient outcomes of having the specialist workforce at one site, similar to the existing model for the Essex Cardio-thoracic Centre. Under this proposed model the service would operate 24/7 consultant cover with a rota of 1:6 or greater in line with national guidance.

The centre would also benefit from co-location with specialist renal, interventional radiology and cardio-thoracic services as described elsewhere within this section.
Outpatients and day surgery would be delivered locally under the proposed model; this would include lower limb, carotid and venous surgery.

**Obstetric Services**

All three sites have large obstetric led units. There are no current plans to consolidate services, however there will be opportunity for pathway re-design to allow some specialist services to brought together either in ante-natal provision or full complex deliveries requiring intensive support.

**Paediatric Services**

All three sites provide inpatient, outpatient and day-case facilities for children. Tertiary links are maintained with GOSH, Royal London and Addenbrooke’s with relevant facilities for safe emergency transfers.

It is proposed that paediatric ambulatory units are established at all sites, building on the BTUH model. This will reduce the need for inpatient beds as evidenced by an initial land sustained 20% reduction. Level 2 NICU services will be continued to support the obstetric services.

Over time it is hoped to consolidate elective beds at MEHT, initially for surgery, given the anaesthetic expertise at that site. There may be further opportunity to consolidate non-short stay inpatient beds at MEHT and the development of a regional hub.

6.4.4 Patients affected through the proposed clinical model and arrangements for elective patients and visitors

The total anticipated future volumes of elective and non-elective patients who will be seen at a different hospital site to present is shown in figure 48 below.

In summary the total number of emergency patients requiring treat and transfer is anticipated as 5,434 per year, which equates to c.15 patients per day.

**Figure 48: Estimated future numbers of patients being seen at a different hospital site to present post reconfiguration**

<table>
<thead>
<tr>
<th>From &gt; To</th>
<th>Elective / Emergency</th>
<th>Per day</th>
<th>Per week</th>
<th>Per month</th>
<th>Per Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Broomfield to Southend</td>
<td>Elective</td>
<td>1.3</td>
<td>9</td>
<td>40</td>
<td>474</td>
</tr>
<tr>
<td></td>
<td>Non Elective</td>
<td>0.4</td>
<td>3</td>
<td>12</td>
<td>139</td>
</tr>
<tr>
<td>Broomfield</td>
<td>Elective</td>
<td>0.7</td>
<td>5</td>
<td>22</td>
<td>269</td>
</tr>
<tr>
<td>From &gt; to</td>
<td>Elective / Non Elective</td>
<td>Per day</td>
<td>Per week</td>
<td>Per month</td>
<td>Per Year</td>
</tr>
<tr>
<td>-----------</td>
<td>-------------------------</td>
<td>---------</td>
<td>----------</td>
<td>-----------</td>
<td>----------</td>
</tr>
<tr>
<td>Basildon</td>
<td>Elective</td>
<td>2.3</td>
<td>16</td>
<td>69</td>
<td>832</td>
</tr>
<tr>
<td></td>
<td>Non Elective</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Southend</td>
<td>Elective</td>
<td>6.2</td>
<td>43</td>
<td>187</td>
<td>2,248</td>
</tr>
<tr>
<td>to Broomfield</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non Elective</td>
<td>5.0</td>
<td>35</td>
<td>152</td>
<td>1,818</td>
</tr>
<tr>
<td>Southend</td>
<td>Elective</td>
<td>0.4</td>
<td>3</td>
<td>12</td>
<td>147</td>
</tr>
<tr>
<td>to Basildon</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non Elective</td>
<td>3.3</td>
<td>23</td>
<td>100</td>
<td>1,194</td>
</tr>
<tr>
<td>Basildon</td>
<td>Elective</td>
<td>3.7</td>
<td>26</td>
<td>113</td>
<td>1,356</td>
</tr>
<tr>
<td>to Broomfield</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non Elective</td>
<td>3.7</td>
<td>26</td>
<td>112</td>
<td>1,344</td>
</tr>
<tr>
<td>Basildon</td>
<td>Elective</td>
<td>1.8</td>
<td>13</td>
<td>54</td>
<td>653</td>
</tr>
<tr>
<td>to Southend</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non Elective</td>
<td>0.3</td>
<td>2</td>
<td>9</td>
<td>107</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>29</td>
<td>203</td>
<td>882</td>
<td>10,581</td>
</tr>
</tbody>
</table>

**Transport options for elective patients and friends or relatives**

It is recognised that public transport provision is variable between the three hospital sites and therefore as part of the public consultation it is proposed that the trusts would operate a free shuttle bus service between the three hospitals. This would be based on the existing service already in operation in Northumbria between North Tyneside and Wansbeck hospitals and Northumbria Hospital.

Based on the indicative modelling the maximum elective patient demand will be around 9,761 total patients per year with provision being made within the financial model for a service which would provide up to 60,000 passenger journeys per year, providing sufficient allowance for relatives and visitors to patients. The service provision would be reviewed frequently to ensure that it meets patient need.

**6.4.5 Approach to service reconfiguration**

Within the Implementation section of this case we set out a number of go-live criteria in order to guide safe and structured implementation of new service models and the implementation of reconfigured services across the STP area.
As such, multi-stage phases approach to implementation of these service changes is expected which will need to be undertaken in tandem with the necessary capital infrastructure works in order to facilitate the new model of care.
7. **Strategic alignment of plans**

**About this section**

This section outlines how plans set out in the STP and this PCBC align with other work in mid and south Essex and beyond such as specialised commissioning, local authorities and neighbouring STPs.

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7. Strategic alignment of plans ........................................................................................................ 110

7.1 Alignment with other commissioners ...................................................................................... 110

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### 7.1 Alignment with other commissioners

#### NHS England

Apart from CCGs, the most significant commissioner of health services across the footprint is NHS England. Although NHS England commissions a wide range of services, two broad areas are of particular relevance to this PCBC: specialised and primary medical care.

**Specialised commissioning**

The future model of care set out in this PCBC has been developed alongside and in consultation with colleagues in specialised commissioning. There are currently three main areas where specialised commissioners have plans to make service change that could have a bearing on the proposals contained in this PCBC.

- Specialised urological cancer surgery
- Complex vascular surgery
- Location of a fixed site PET scanner for South Essex

How these three services align with the STP proposals is set out below in Figure 49.
In addition to the above, specialised commissioners are currently reviewing all flows into London to identify opportunities to repatriate work. Whilst this is at an early stage, this work aligns well with the proposals set out in this PCBC, which will result in additional acute capacity being created locally (and thus creating potential for repatriation), as well as consolidation of the some services.

Primary care (General Practice)

At present, the pattern of commissioning responsibility for primary care varies across the STP area, with NHS England having sole responsibility in some areas (e.g. Thurrock), full delegation to the local CCG in others (e.g. Castle Point and Rochford) and a joint commissioning model elsewhere (e.g. Mid Essex). CCGs are working with primary care and NHS England to consider delegated commissioning across the STP. This is viewed as a key enabler of the ‘Local Health and Care’ future model of care set out in this document.

The model of primary care that has been developed locally is well aligned with, and builds on, NHS England's GP Forward View. For example, both are supporting practices to work together and, where appropriate, come together either in federations or through mergers. Both include plans to increase the range of professionals and skill mix within practices, so that patients receive better access and GP time is released to focus on patients that need their skills and experience the most, such as frail older people or those with long term conditions.
Some of the key elements of the local primary care programme are:

1) **Contractual**

- Supporting practices to operate at scale
- Develop a framework for practice mergers to incentivise larger practices
- Implement an unplanned LES in place of the national DES
- Develop further a local QOF that better aligns with wider system objectives
- Develop a new model GP contract working across a number of practices within a locality

2) **Enablers**

The following enablers are also being developed as part of the Programme.

- Increase numbers of WTE GPs in line with the *GP Forward View* programme
- Increase the use of digital technology within primary care, as a means of improving inter-operability and releasing GP time
- Develop a framework for future primary care procurement with an emphasis on localities and sustainability
- Agree a set of outcome metrics that evidence change through transformation
- Develop a common approach to repeat prescribing and the role of community pharmacist
Local Authorities

Representatives from local authorities have been involved in developing the programme at every stage. This includes the overall governance, as set out in Section 13 of this PCBC, as well as in individual work streams such as frailty and end of life care. While not a major part of this pre-consultation business case, the STP is prioritising improvements to mental health care. This involves working with our communities to focus on prevention, early intervention, building resilience and emotional well-being, as well as working to ensure that anyone with a mental health need can access the right service at the right time. This is a whole system approach as identified through the Southend, Essex and Thurrock Mental Health and Wellbeing Strategy”.

In addition, there has been close liaison with all three Health and Wellbeing Board. This has included attendance at all meetings, as well as the establishment of a joint meeting between the Independent Chair of the STP and the three Chairs of the local Health and Wellbeing Boards.

As a result, there is a high degree of alignment between the plans set out on the STP and this PCBC and the strategies developed by the three Health and Wellbeing Boards.

Three examples of this alignment are highlighted below and, further details are in appendix 4.

1. Essex County Council identified ageing well and mental health as key priorities
   - JSNA and HWB Strategy prioritise optimising independence through prevention and early intervention in older people and people with mental health issues.
   - PCBC’s Future Model of Care includes prevention, early intervention and self-management with focus on older people and mental health, and the development of a consistent frailty pathway as a core element

2. Thurrock Council identified mental health as a key priority
   - JSNA and HWB Strategy prioritise mental health issues such as improvement in identification and treatment of depression in high-risk groups
   - PCBC’s Future Model of Local Health and Care includes prevention, early intervention and self-management with focus on mental health

3. Southend Borough Council prioritised action across the life course to ensure healthy ageing
   - JSNA and HWB Strategy prioritise joined up health and social care services, support for those with long term conditions and empowering people to be more in control of their own care
   - PCBC’s Future Model of Care uses an approach called ‘population-segmented management’ to ensure that people receive the most appropriate care, based on the specific needs of each group
Alignment with other STPs

While mid and south Essex is relatively self-contained (82% of activity from the 5 CCGs goes to mid and south Essex acute hospitals, 93% of activity at the 3 acute hospitals comes from mid and south Essex CCGs\(^{63}\)) any large scale reconfiguration in neighbouring STP areas could have an impact on patient flows. There are two neighbouring STPs where service change could impact the ability of mid and south Essex to deliver the Future Model of Care.

Most plans are in the relatively early stages of development. The October STP submissions include broad plans for potential acute reconfiguration but there are no specifics as yet. Conversations between mid and south Essex and neighbouring areas are ongoing and will be reviewed regularly to ensure any change in patient flows are taken into account.

Figure 50: Alignment of STP with neighbouring STP

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\(^{63}\) ESR Diagnostic Report. November 2015
8. **Enablers of change**

**About this section**

This section looks at the major enabling changes that must take place for the successful transformation of health services in mid and South Essex. The changes relate to the workforce, estates, and the functioning of IT and data.

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8.1 **Introduction**

For our vision for higher value, sustainable services across mid and south Essex to be realised, and for the proposed Model of Care to be implemented effectively, a number of system-wide enabling factors need to be in place. The success of the this transformation depends on attracting, keeping and developing a capable and fulfilled workforce, a more coordinated approach to utilising our estates, and better use of technology to share information and enable new forms of care. Innovations will be needed in each of these broad aspects.

This section describes the current status of the various enabling elements across the system, identifies the changes required by the Future Model of Care, and outlines the proposals for delivering these changes.

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8.2 **Workforce**

8.2.1 The current workforce gap and predicted future shortfall

8.2.2 Overarching principles

8.2.3 Greater flexibility and skills development

8.2.4 Training pipeline and leadership

8.2.5 Key priorities and next steps

8.3 **Estates**

8.3.1 The existing estate

8.3.2 The future estate requirement

8.3.3 Strategic Estates Planning and Implementation (SEPI)

8.3.4 Lead stakeholder roles and responsibilities

8.4 **Innovation and technology**

8.5 **Digital Essex 2020**

8.5.1 Empowered Population

8.5.2 Efficient Delivery

8.5.3 Actionable intelligence
8.2 Workforce

8.2.1 The current workforce gap and predicted future shortfall

People working locally in our system are facing a number of challenges in managing workload and helping to ensure we meet our patients’ needs for care. There are 2,500 NHS vacancies (a vacancy factor of 13%) across our STP partners, with a significant, 60 WTE gap in the ambulance service. This workforce gap may be compounded by the prospect of imminent retirements and loss of experienced staff (23% by 2021) as our more experienced workforce grows older, and at present an apparently shrinking pool of potential young employees in the region. Offering the 7-day service patients need may be hard to achieve in the longer-term if we are not able to recruit and retain the right workforce, and we evolve as employers and service providers to delivery care in new ways, with the right skills for the future.

Some of the staffing shortfall is made up through agency and bank staff. They account for 15% of the staff in post, which compares to a Midlands and East average of 11%. That solution is expensive; ranging from 8.6 to 9.5% of pay spend across the mid and South Essex hospitals alone; does not produce the same quality of care; and is still not sufficient for meeting the need. Our recent approach to developing the health and care workforce has been fragmented. Through the STP and working as a group and partnership, we will take a different approach to enhancing workforce productivity and revising the skill-mix of staff.

There is no simple solution to the workforce supply gap, which is manifest across most of England, but taking a system-wide, collective view and adopting innovative approaches to this challenge has been shown to make a positive impact on addressing this sustainably (as in example within the New Care Models programme and devolution areas). Through a range of targeted contributory approaches we can improve retention of the existing workforce as well as increase the supply route, through both pre-registration and other emerging routes into the system. In addition new roles and ways of working, pulling on a different pool of staff will increase the opportunity to bring a new workforce into health and social care.

The Next Steps for the Five Year Forward View, 2017, noted that “More people are training to join the NHS every year than are leaving it. Health Education England forecasts at least 25,000 to 50,000 net additional clinical staff could be available for NHS employment by 2020, partly depending on the NHS holding onto the staff it already has”. We must do more to retain our people and make sure they consider the NHS as somewhere they wish to spend their working lives.

Morale is low in many respects: for example, a recent BMA survey showed that over 60% of GPs are considering retiring early owing to workload pressures, and that almost 30% had thought about leaving the profession altogether. For current service models, the current supply of staff is simply insufficient, particularly of GPs, adult-mental-health nurses and learning-disability nurses, and A&E personnel.

The proposed model of care described here will change traditional boundaries and as services are coming together across the hospital sites; those delivering that care will need to work differently and in a more networked way. Clinical Leadership will be

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vital to the success of this model, as will empowering teams to act in the interests of patients and build trust between teams, including those outside of the NHS. More modern care and more holistic approaches (e.g. in localities across our community or in areas like frailty), will mean that professional roles will need to change, new skills will be needed, and we can learn from new workforce pioneers across the country in this regard.

Working as a hospital group and building on the NHS Improvement programmes Model hospital, Getting it Right First Time and the Carter Review data, we have an opportunity to look at our processes and systems for e-rostering and effective job planning to ensure right staffing at the right time, and most effective use of our talented workforce. There are plans to do support these improvements outlined elsewhere in this business case.

Greater opportunities will be available for training, for expansion of Allied Health Professional roles such as Advanced Nurse Practitioners and Physicians Associates to meet the growing demand. There is also opportunity to benefit from a more local workforce through “grow your own” education programmes for local people, adding skills to roles, the opportunity of the new apprenticeship levy, work-based learning, and rotational programmes. Developing the workforce and skills strategy to respond to this proposed model of care in hospital and in local settings, will require commitment, leadership and alignment of resources to be successful. We aim to achieve this by working together and with broader public sector partners within the STP.

8.2.2 Overarching principles

The proposed model of care involves a number of key work-streams that impact on the local workforce, including major clinical service reconfiguration and the transforming of primary care, community locality development and responding to the national priority for urgent and emergency care. Increasingly, organisations will concentrate on prevention of ill health and supporting rapid assessment and treatment closer to home, so the local workforce will have to respond differently to the needs of service users and their families, and will also have to be empowered and enabled to work across a range of care settings. This approach and cross-system working presents opportunities for staff to consider new and flexible roles, to extend their careers, return to practice, or move into training, education or even volunteering. We need to offer roles and working patterns that reflect how people live at different stages of life, and maximise the opportunity to provide non-financial benefits. We also need to think about opportunities to better harness the volunteer workforce and working with schools and higher education providers.

The table below shows the four proposed focus areas for developing our people and achieving workforce change:

1. Improve the training and supply pipeline: through provision of an attractive training offer, establishing supported rotational posts for newly qualified staff as well as development opportunities for the emerging talent within newly quality health professionals. Increasing the number of training placements, and consolidating services will also increase supply.
2. Establish flexible and sustainable working which will contribute to higher retention and improve staff satisfaction (e.g., by reviewing current flexible working arrangements, innovative new roles, taking the whole workforce – including the third sector – into account, and combining rotas)

3. Enable skills development through greater mobility; and create new roles so that staff can use their skill-sets to the full (e.g., prescribing roles for community nurses and pharmacists)

4. Develop strong clinical and professional leadership as part of national and local leadership programmes, at clinical team, site, organisation and system level.

**Figure 51: Routes to workforce change**

Section 1.2.3 considers the inter-relationship between flexibility and future skills requirement at a redesigned and reconfigured service level which will develop over the timeframe covered by this business case.

However, it is also recognised that regardless of service specific changes the system will require to increase the overall number of substantively employed staff in order to replace existing high cost agency and locum expenditure and to assist in tackling long standing quality concerns in services, therefore immediate steps are being taken with respect to the training pipeline and leadership activities which are considered within section 1.2.4.

**8.2.3 Greater flexibility and skills development**

The future predicated workforce demand is currently based on a steady state staffing model for clinical services, this steady state will clearly be affected by redesigned and reconfigured services which will identify how we can create services that encourage staff to work at the top of their licence and how we can substitute current work through the creation of new roles and through the use of technology to reduce the time spent on non-clinical activities.
In order to ensure that redesigned and reconfigured services deliver this change in workforce requirements our change management methodology (described further in the implementation section of this business case) has a number of stage gates through which projects under development are scrutinised and challenged from a number of aspects. Role design and anticipated workforce demand will be key considerations at gate 2 and pathway or service specific workforce supply plans will be considered at gate 3. The workforce considerations will be developed and worked through via the LWAB which is accountable to the STP Programme Board. A full Workforce Strategy will support and drive the progress of workforce plans. A summary diagram of the methodology is outlined below.

**Detailed project and improvement phases**

![Diagram]

### More flexible and sustainable working - focus on the ‘whole workforce’

The “true” local workforce engaged in healthcare and social-care-related activity is estimated to be twice the size of the NHS or Social Care workforce as traditionally measured. Going forward, the STP will focus on this larger “whole workforce”, including volunteers and carers, to facilitate and enhance the work of the regular workforce in meeting the needs of the local population.

The emerging work-streams here include:

- Resilience training: build a more resilient workforce to improve retention, reduce “change fatigue”, and revive enthusiasm; continue developing “rotational programmes” to produce more integrated working and support recruitment and retention of newly qualified and existing staff

- Integration: create the right HR environment to support opportunities to work across care settings in both health and social care, and for reducing hand-offs and improving quality

- A volunteer workforce: scope opportunities to enable our volunteers and carers to support service users and their families in promoting prevention and wellbeing
Skill development

The workforce skills mix can be divided into three levels: expert, intermediate, and basic. The current skills mix of our healthcare workforce is elliptical in shape, with a high number of registered professionals or workers at the “intermediate” skills level. There are shortages in the senior medical workforce, and the number of junior doctors is declining. So we have to plan for training that will fill the skills-mix gaps and address the changing needs of patients. Patients will need to understand the offer of these new roles. This requires a culture and expectation change that will be delivered through a robust, communication strategy with the support of patient communities and participation groups.

One promising option is to expand the role of support workers (the unregistered workforce) to take on more caring responsibilities, and to extend the range of their technical skills. In particular the new Nursing Associate role is a good example, and is currently being piloted on a national basis with some 2000 posts. They could then provide better support to the registered non-medical workforce, who could then in turn take on more advanced roles traditionally carried out by clinicians. There are existing examples of where this is already happening e.g., advanced nurse practitioners leading long term condition management with the support of existing specialist services such as podiatry. It is worth noting for the Mid and South Essex STP area, that Anglia Ruskin University is currently developing a new medical school due to commence in 2018/9 which will enhance local and regional supply into the future medical workforce in Essex.

Building and improving the capability of all existing staff groups will also ensure that they are equipped with the right skill set to deliver the best quality of care in their day-to-day jobs. It will enable the workforce to feel more fulfilled in their roles and support the clinical redesign of pathways. Evidence shows that empowering staff to make changes through a culture of continuous improvement results in improved patient safety and outcomes. Personalised, development plans and appraisal will ensure that staff are motivated to continue improving and to share best practice with colleagues.

The emerging work-streams here include:

- Enhanced use of assistant practitioners: develop assistant-practitioner roles to upskill the health and social care support workers
- Local Enterprise Partnerships skills strategy: influence Further Education provision and access further funding by engaging with the local enterprise partnership and their work in skills strategy and economic development
- Utilising the support workforce: develop the contribution of support workers to the system by enhancing the apprenticeship route and by building on existing networks, notably, the Essex excellence centre
- Adoption of new roles, such as physician associates and nursing associates
- Building and improving the capability of all existing staff groups
8.2.4 Training pipeline and leadership

The current workforce shortages across the mid and south Essex system mean that focused action is required now to increase workforce supply, particularly given the timeframes for the training of new staff and the need to improve the attractiveness of the NHS in mid and south Essex as a place to work.

Therefore priority focus is being placed on the construction of a training pipeline and targeted action to improve management and leadership, through which staff engagement and experience will improve.

*Improving workforce supply through the creation of a training pipeline and alignment of related activities across mid and south Essex*

Initial priority actions that are being taken to establish a training pipeline across mid and south Essex include:

- Capitalise on the opportunity the Comprehensive Spending Review brings in terms of increased pre-registration supply route for nursing and allied health professionals. Post CSR students now have access to student loans, which will allow the previously commissioned cap on training places to be lifted and numbers potentially increased.
- Maximising the use of the apprenticeship levy with the launch of apprenticeship programmes across the system in hospital, community and primary care settings and the development of a nurse apprenticeship programme for commencement during autumn 2017.
- The development of a ‘common offer’ to staff including preceptorships, rotations and continuing development opportunities and the development of ‘passporting’ arrangements to support staff who wish to move between sites as part of their career and personal development.
- Alignment of recruitment activities across the acute sector, utilising the opportunity presented by the new apprenticeship levy to increase supply over the medium term and reducing reliance international recruitment activities over this time period.

Further emerging work-streams have been identified which include:

- New education routes for non-medical students: provide work-based “grow your own” training programmes for nurses and AHPs
- The “branding” of health and social care as an employer of choice in Mid and South Essex
- An improved learning environment in service and an increase in placement capacity, through coaching and mentorship
- Establishing consistent terms and conditions for employment across the patch
Leadership

To narrow the workforce gap, our system requires high-quality clinical and strategic leadership at all levels. A current collaboration of organisations across Essex; the Essex Leadership Group, as well as the members of the Anglia Ruskin Health Partnership is currently involved in creating and implementing a range of programmes and experiential learning to develop system leaders by offering them rotations in different sectors and organisations within the system. The STP will draw on this work to shape the leadership work programme in mid and south Essex.

The LWAB for mid & south Essex will take a leading role, working with the system to implement the work-streams identified.

A key consideration within the leadership section is the roll out of a set of structured development arrangements to strengthen core management skills at every layer of the system alongside expanding improvement skills training to build a culture and ethos of continuous improvement across the sector. We are currently approaching this in two key ways:

- The development and launch of a pilot core leadership and management programme for line managers within Essex during 2017, focused on improving resilience, engagement with teams and providing foundation skills in quality improvement and project management.
- The development and launch of a suite of improvement and change management training across the system, initially beginning with the acute sector in 2017 based on learning from the existing improvement development offer in place across our system and learning from best practice such as the IHI.

It is considered essential that this training is applied to improve the learning experience; this application will be through staff working on projects associated with the STP to secure better buy in and better outcomes throughout this change process. We look forward to working more with the NHS Leadership Academy, our local AHSNs and other STP partners to provide innovative approaches to developing mid and South Essex’s leadership capacity.

8.2.5 Key priorities and next steps

The Local Workforce Action Board established in January 2017 is responsible for and accountable to the STP Programme Board and will on behalf of the Board progress the following key tasks:

- Develop a scenario based, high level workforce strategy that sets out the workforce implications of the SR/STP’s ambitions in terms of workforce type, numbers and skills, including leadership development;
- Develop a comprehensive baseline of NHS and care workforce within the SR/STP footprint and an overarching assessment of the key issues that the relevant labour markets(s) present.
- Develop a workforce transformation plan focused on what is needed to deliver the service ambitions in the SR/STP;
• Develop an action plan that proposes the necessary investment in workforce required to support SR/STP delivery, identifying sources of funds to enable its implementation. The LWAB has agreed four key priority areas to focus its initial work plan around which are; Supply (Recruitment and Retention), Primary Care, Leadership, and the Apprenticeship Levy.

8.3 Estates

8.3.1 The existing estate

Acute Hospitals

There are three major acute providers in the STP footprint:

• Basildon and Thurrock University Hospitals (BTUH) NHS Foundation Trust with its principle site at Basildon Hospital
• Mid Essex Hospital Services NHS Trust (MEH) with its principle site at Broomfield Hospital in Chelmsford
• Southend Hospital University NHS Foundation Trust (SHU), with its principle site at Southend Hospital

Community Hospitals and other assets

Across the CCGs and providers there are a significant number of facilities providing sub-acute, intermediate and other forms of community services. There is a significant variation in the specification, standard and age of these facilities; those key to current and future plans are shown in the appendix, summarised by CCG.

Primary Care

The Strategic Estates Plan of each CCG includes considerable detail on the primary care premises available within each area and for brevity is not included in this document.

8.3.2 The future estate requirement

In order to deliver the reconfiguration and service design changes outlined within this document it is recognised that a number of enabling changes are required to the composition of NHS estate across mid and south Essex.

The detailed estates requirements of this change have been outlined in detail within a Strategic Outline Case which has been developed based upon the proposed service model and reconfiguration model as set out within this document.

In summary, the future estate requirements break into two core themes of in-hospital and local health and care which are described further below.

In-hospital estate requirements

As per the proposed options for consultation the in-hospital estate requirements are based around the urgent and emergency care pathway based on the proposed model of care.
The current high level modelling and estate planning indicate that this will manifest as additional healthcare accommodation at new build asset totalling 6,650m² across the three acute sites, however the total scheme is a combination of new builds, disposals, refurbishments and remodelling across the three acute sites as detailed below:

<table>
<thead>
<tr>
<th></th>
<th>£m</th>
</tr>
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<tbody>
<tr>
<td>Basildon</td>
<td></td>
</tr>
<tr>
<td>Emergency Village</td>
<td>8.1</td>
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<tr>
<td>and associated enab</td>
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<td>ling projects</td>
<td></td>
</tr>
<tr>
<td>New theatre capacity</td>
<td>17.6</td>
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<tr>
<td>(inc. capacity from</td>
<td></td>
</tr>
<tr>
<td>Orsett)</td>
<td></td>
</tr>
<tr>
<td>Site infrastructure</td>
<td>4.6</td>
</tr>
<tr>
<td>costs</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>9.5</td>
</tr>
<tr>
<td>Broomfield</td>
<td></td>
</tr>
<tr>
<td>A&amp;E and critical care</td>
<td>7.3</td>
</tr>
<tr>
<td>capacity</td>
<td></td>
</tr>
<tr>
<td>Inpatient capacity</td>
<td>6.0</td>
</tr>
<tr>
<td>Repatriate daycase</td>
<td>4.0</td>
</tr>
<tr>
<td>facilities</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>2.0</td>
</tr>
<tr>
<td>Southend</td>
<td></td>
</tr>
<tr>
<td>New theatre capacity</td>
<td>10.0</td>
</tr>
<tr>
<td>Inpatient capacity</td>
<td>5.0</td>
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<tr>
<td>Linac bunkers for</td>
<td>8.0</td>
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<tr>
<td>cancer growth</td>
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<tr>
<td>Re-provided outpatient</td>
<td>6.5</td>
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<tr>
<td>space and ambulatory</td>
<td></td>
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<tr>
<td>capacity</td>
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<tr>
<td>Other</td>
<td>7.3</td>
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<tr>
<td>Site infrastructure</td>
<td>4.6</td>
</tr>
<tr>
<td>costs</td>
<td></td>
</tr>
<tr>
<td>System urgent care</td>
<td>7.3</td>
</tr>
<tr>
<td>centre capacity</td>
<td></td>
</tr>
<tr>
<td>Teletracking</td>
<td>6.7</td>
</tr>
<tr>
<td>Shared records</td>
<td>6.1</td>
</tr>
<tr>
<td>Contingency</td>
<td>10.0</td>
</tr>
<tr>
<td>Total (Gross before disposal receipts)</td>
<td>130.4</td>
</tr>
</tbody>
</table>

*£12m of capital receipts will also be factored into the bid (Orsett, Fossetts Farm)

**Local health and care estate requirements**

Work within the local health and care has two broad streams:

- The development of urgent care facilities co-located with the emergency departments at Basildon, Broomfield and Southend Hospitals.
- The establishment of locality/neighbourhood hubs to support the delivery of more care closer to home. This will involve the development of the physical estate across the mid and south Essex footprint.

### 8.3.3 Strategic Estates Planning and Implementation (SEPI)

Recognising that estates and infrastructure are key enablers to delivery of the aims of the STP in both the acute and local health and care sectors, STP partners have worked together to start to develop a joint approach to planning and implementation.

The STP was selected to work with the pilot phase of the new Strategic Estates and Planning Implementation (SEPI) team, set up following the Naylor review, which recommended that estates capabilities be strengthened through a national service providing property expertise and delivery support. The SEPI process aims to advise and support STPs to develop and successfully implement a comprehensive estates and infrastructure strategy.
An initial, system wide, workshop was held in September with the national SEPI team. Arising from this workshop are four key programmes of work that partners have agreed jointly to work upon in the coming months.

1. Accurate review and refresh of estates data (for both in- and out-of-hospital estates).

2. Take steps to establish a virtual Mid and South Essex STP Estates and Infrastructure Delivery Unit, to:
   
   a. Bring scarce estates and infrastructure expertise into a single team;
   b. Provide a mechanism to prioritise estates and infrastructure programmes across the system, recognising interdependencies
   c. Enable proper focus on benefits and return on investment for each programme, and understanding of the full resource requirements and costs.
   d. Provide expertise in accessing sources of funding and support for capital programmes.
   e. Form the local capital plan, which can be used to support local and central funding discussions.
   f. Bring clarity on governance arrangements across the system

3. Development, through the auspices of the Delivery unit, an STP Estates and Infrastructure Strategy.

4. Focused review and delivery of estates and infrastructure requirements of the acute reconfiguration to enable the changes proposed in the pre-consultation business case to take place (subject to the outcome of public consultation).
### Lead stakeholder roles and responsibilities

#### Implementation approach

A full implementation strategy is currently being worked up to understand the level of resourcing required to achieve this programme. At this stage it is envisaged that a central STP estates planning function is established to aid the clinical reconfiguration in line with the 5-year plan along with a strategic capital project delivery unit which would work alongside the trusts Change Management Office.

With regards to a procurement strategy it is envisaged that this would take the form of a partnering arrangement as this would provide the lowest level of risk to delivery of a multi-phased programme of capital works of this scale within the required timeframe. Both of these elements will be fully interrogated during the OBC stage.

#### Innovation and technology

We are committed to ensuring that innovation in health and care is integral to all that we do within our STP. Specifically, we want to ensure that innovation and technology are at the heart of our redesigned new models of care. Indeed, digital technology and innovation have been identified as critical enablers of system change by clinical leaders and frontline staff alike. These aims are entirely consistent with those set out in the 5YFV, the GPFV, the aims of NHS Digital and the ambitions of Making IT work, otherwise known as the Wachter Report.

Specifically, this programme aims to deliver in three main areas:
- Empowering our population – we want to ensure technology enables our population to take control of their own health and social care. This includes ensuring access to cutting edge technology to enable patients to remain independent in their own homes as well as empowering patient to manage their own conditions though the use of emerging health apps and wearable technology. Fundamental to an empowered population is accessible healthcare. Our citizens have told us that accessibility to health services is one of their key priorities.

- Efficient delivery – we want to ensure our workforce is empowered to deliver care as efficiently as possible. Be it mobile working, remote access, efficient equipment or virtualisation, we aim to ensure our STP is powered by the most efficient health and care technology available.

- Actionable intelligence – we are generating ever increasing amounts of health and social care data. We need to ensure this data is protected and secure, but more crucially, we aim to ensure this data is translated into actionable intelligence. We will explore the use of big data analysis; risk profiling, population health and machine learning to ensure the STP is using the data it generates for the benefits of our population.

We have a strong commitment from health and social care partners across the STP to oversee a significant transformation within Essex such that within the next 5 years, the mid and South Essex STP is seen as one of the most innovative within the country.

8.5 Digital Essex 2020

A group of senior leaders in technology from NHS and Local Authority organisations in Essex are working together to make best use of technology to drive changes that are needed in Health and Social Care services in the county. The group has recognised that there is a number of overlapping transformation initiatives at play in Essex, and a coordinated strategy is needed.

Also clear is that there are some big opportunities to use technology, in particular the new approaches and solutions referred to as ‘Digital’, to make a difference to the lives of patients and citizens and the jobs of care professionals, however up to now the county has failed to capture the full potential.

There is a need for an approach and plan which will speed-up the delivery of some technology foundations, while working out how the range of clinical and operational changes can be best supported through the use of Digital technology and transformation. The technology foundations will help to deliver some initial improvements, form a basis on which to build the Digital solutions as well as show people the ‘art of the possible’.

The group are consistent in their intention to make the Digital strategy an inclusive thing for all of the Essex population affected by it, with technologists, leaders, clinicians, patients, carers and citizen’s part of the process.
8.5.1 Empowered Population

The M&SE STP has a bold ambition to make Essex one of the most technologically enabled STPs within England within the next 5 years. This strategic vision is set out in the document *Digital Essex 2020*. However, it is important to note that in order to fully empower our populations to Live Well; we need to embrace all aspects of technology, not just those within the digital domain. In order to empower our population through technology we aim to significantly improve care in 3 broad domains;

- Digital Access Channels
- Assisted Living and Smart Technology
- Digital Apps and Wearables

**Digital Access Channels**

We are focussing on delivering digital access channels into both primary and secondary care. Our population have specifically identified access to services as a key priority, and the demand pressure on our GP appointments and outpatient appointments is greater than we have ever seen. We aim to create a *channel shift* to digital access channels. This might be via the form of text based consultations online, video consultations or, at the more extreme end of the spectrum, initial consultations powered by Artificial Intelligence (AI) machine learning. Ambitions in this area are significant and early indications suggest that up to 50% of outpatient appointments and 40% of GP appointments are amenable to channel shift. A number of companies are proving such solutions and several Vanguard sites have demonstrated the ambitions of the mid and South Essex STP are achievable.
Assisted Living and Smart Technology

The M&SE population is ageing. Additionally, we have a growing population who are living with conditions that limit their independence. Neurological conditions, MH conditions, physical disabilities and the challenges of old age all bring challenges to our population when it comes to remaining as independent as they are able. This situation is compounded by a challenged home care workforce within the STP.

We aim to ensure that we empower our population to remain as independent as possible by equipping our staff and patients with technology to enable independent living.

Smart technology is increasingly prevalent in the realm of health and social care. The internet of things and smart homes are enabling new ways of supporting patients to live safe, healthy lives, supported by health and social care professionals when required.

Self-Management Apps

With over 80% of the UK having access to a smartphone and 86% of the UK having access to the internet, the opportunity to use health apps and wearable technology is now a reality. Self-management apps can empower individuals to self-manage conditions in a way that has not previously been possible. By linking apps to wearable technology we can allow patients to monitor their conditions in new and innovative ways, ensuring quality and safety of care whilst decreasing costs and dependence on face to face health professional contact.

8.5.2 Efficient Delivery

Engagement with clinical and professional leaders and frontline staff has made it clear that our workforce does not feel enabled by technology to deliver care as efficiently as possible. Lack of access to electronic records, poor system interconnectivity, laborious sign-on processes and dated hardware are all frequently cited by frontline professionals as reasons for inefficient care delivery.

This view is supported by evidence showing both the multiplicity of clinical systems across the STP along with the relative digital immaturity of the system.
The M&SE STP aims to enable its workforce through technology to ensure they can deliver care as efficiently as possible.

A key step to achieving these aims is the delivery of a shared health and social care electronic patient record for the M&SE STP.

A commissioned market assessment has demonstrated that a shared care record would create a central, digital view of patient and care information accessible to multiple providers. As a technology enabler, the shared care record would support:
- The provision of higher quality care
- Integration of care across health and social care – including on particular pathways (such as end of life care)
- Delivery of more care in community settings (and associated workflow efficiencies and cost reductions)

Significant initial resource will focus on this fundamental building block that clinicians have identified as key to furthering digital efficiency within our STP.

8.5.3 Actionable intelligence

With ever increasing amounts of data generated by our health and social care systems, it is imperative we are able to translate this data into actionable intelligence that can empower clinicians, improve population health, stratify risk, predict trends and improve the quality and safety of the care we give to our populations.

The M&SE STP intends to revolutionise the way we use data. We will ensure all data held is safe and secure according to best practice IG principles. However, we want to make data more accessible than ever before enabling clinicians to deliver data-driven guidance and predictive analytics as well as feedback loops for risk stratification, proactive interventions and optimal population/patient management.

Thurrock CCG has undertaken an ambitious Integrated Data Project collaboratively with Local Authority partners. An integrated data is being developed that will help to drive the local care transformation process, enable The Council/CCG to understand their populations and service use, intervene earlier and more effectively preventing more costly interventions at a later date, reduce inefficiencies and inadequacies, and revise patient pathways by:

- Enabling the production of risk stratification models (i.e. to identify residents more likely to be at high risk of poor future outcomes based on trends and outcomes data)
- Enabling predictive / scenario modelling work (i.e. to apply current information on trends, needs and service usage to population projection data to forecast future demand to enable effective future planning)
- Enabling population segmentation (i.e. being able to identify sub-populations within Thurrock who share similar characteristics, needs and patterns of healthcare use in order to target interventions more appropriately)

The M&SE STP is investigating the opportunities to expand the Integrated Data Project to STP scale, though this will involve a more complex data-sharing agreement and IG given the complex nature of the STP.
9. Financial assurance

About this section

The section addresses the following questions for assurance purposes:

1. What is the financial impact of the STP?
2. What is the cost of implementing the STP?
3. Will the STP provide value for money?
4. What is the impact of commissioner savings on provider finances?

9.1 Introduction

As set out in NHS England’s guidance “Planning, assuring and delivering service change for patients”, it is essential that to put forward to options to the public that are sustainable in respect of services and in economic and financial terms.

Financial data was compiled and analysed locally and was signed off by the Financial Oversight Group – a group of directors and finance directors with representatives from the Acute Trusts and Local Health and Care core teams.

Specifically, this section is a summary of:

- The "do nothing" momentum case and impact of CIPs / QIPPs
- The impact of system transformation
- Potential risks associated with planned efficiency savings

A more detailed overview of the potential financial implications of the proposals being put forward can be found in the Financial Appendix (6).
9.2 Overview: system financial bridge

In 2016/17, the overall Health and Social Care income of mid and south Essex was £2,457 million. The NHS in the area ran at an in-year system deficit of £99 million, with 91% of this deficit attributable to providers. As shown in the Financial Case for Change (sub-section 2.5), the “do nothing” option, far from producing a financially sustainable health economy, will in fact lead to a deficit of £532 million for health by 2021/22.

Figure 55 below shows the summary financial bridge which gets the Mid & South Essex system to a break-even position by 2020/21. Details of the “Do nothing” case are included in the Financial Case for Change (sub-section 2.5). This section includes the financial impact of the proposals outlined in this PCBC and an assessment of the overall value for money. For full detail on all of the above, see Appendix 6.

Figure 55: Forecast financial system bridge 2021/22

9.3 Investments and value for money

To unlock further savings and return to full financial sustainability, £244m of capital investment will be required, £118m of which relates to the acute reconfiguration, and an additional £40m in support and transition costs has been assumed to be spent, allowing the system to reach a balanced position by the end of 2020/21.

These investments will be used for five main areas:

- Capital investments for acute reconfiguration
- Capital investment in local health and care infrastructure (which could be funded in several different ways)
• Investment in workforce to support GP capacity release, the upskilling of primary care, targeted new services in primary and community care, and leadership training and redundancies in the acute sector

• Investment in technology enablers, including apps and self-care technology, virtualisation and technology revenue costs

• Investment in change, including public culture change, change management coordination, IT infrastructure and patient engagement

The level of investment will ultimately determine the pace at which change will happen. As shown in Figure 56, pump priming compared to capital investment only would eliminate four years of deficits, freeing up £183m for the system

Figure 56: Impact of STP investments

<table>
<thead>
<tr>
<th>In-year deficit 2021/22 (£M)</th>
<th>NPV £</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do nothing post CIPs/QIPPs</td>
<td>n/a</td>
</tr>
<tr>
<td>Impact if Capital investment only (i.e. no pump priming available)</td>
<td>~£87m</td>
</tr>
<tr>
<td>Impact if pump priming available only (i.e. no capital available)</td>
<td>~£95m</td>
</tr>
<tr>
<td>Full SR with pump-priming</td>
<td>~£126m</td>
</tr>
</tbody>
</table>

In total, inclusive of internally-funded investments, £244m of capital investment and £40m of transition investments in addition to business as usual activity will be required.

65 The financial position for Mid and South Essex through to 2021/22 includes non-recurrent transitional expenditure of £40m. This impacts on the in-year deficits within the system in the short term, but is essential in order to achieve financial balance by 2020/21
9.4 Base case: momentum projections and the impact of CIPs and QIPPs

9.4.1 Momentum case: key drivers leading to unsustainability

Under the base case of care, momentum system income and expenditure is driven by the following:

- **Baseline deficit** – in 2016/17, a £99m system-wide, in-year, financial deficit for providers and commissioners
- **Momentum case** – expected uplift in commissioner allocation, change in demand and inflationary pressures, with a combination of demographic and non-demographic drivers of demand for health services (see section 1 of Figure 55)
- **Current CIP/QIPP plans** – CIPs are based operational plans, delivering a minimum 2% per annum efficiency requirements, and CCG QIPPs and other organisations' savings are based on their submissions (see section 3 of Figure 55, which excludes acute CIPs and QIPPs)

After organisation-focused CIPs and QIPPs, the system remains in a deficit of £82m – and therefore system-wide change, for which acute transformation is necessary, will be necessary to close the gap.

9.5 System transformation impact

System transformation is expected to deliver a total of £126m of in-year savings by 2021/22, through a combination of direct efficiency and pathway changes – across acute, community and primary care. The impact of these proposals has been modelled based on projected changes in activity and capacity requirements, and patient flows. These savings are outlined in sections 3 and 4 of the bridge in Figure 55. This allows for £44m of FYFV investments as well as bringing the health system back to financial balance.

The anticipated savings have been refined and agreed by the System Executive Group, and smaller groups have provided quality assurance on the viability of schemes with clinical input.

9.5.1 Direct efficiencies

There are a total of six principal initiatives which will contribute direct efficiencies to the system:

- Efficiency savings from the consolidation of services to one or two sites, ensuring the adoption of the most efficient model between the three sites
- Reduction in workforce and agency spend, through enhanced recruitment centres of excellence and joint rotas across sites
- Pan-trust initiatives relating to Clinical Support Services, including Radiology, Pathology, CSSD and Pharmacy
- Pan trusts initiatives relating to Corporate Support Services, including IT, Estates, HR, Finance
- Commissioner efficiencies through joint working initiatives
Rationalisation of the system

9.5.2 Pathway changes

There are six main initiatives enabling savings through pathway changes within the system:

- Acute CIps and QIPPs unlocked by system reconfiguration, overhead gain on growth and balance to achieve control totals
- Specialty Pathway Redesign: the reduction of Outpatient follow ups by moving to the community and using technology
- The proactive management of complex cohorts in integrated neighbourhood hubs, with an initial focus on frailty through identification and care planning, proactive care delivery, acute interface and coordinated End of Life services and pathway redesign – along with the improvement of self-management and MDTs for people with LTCs
- Common offer: the reduction and restriction of low value procedures in hospitals
- In Urgent Care, improved triage at Clinical Support Desk and on-scene to reduce the number of conveyances to A&E, with enhanced clinical capabilities in 111 and ambulance service
- Repatriation of profitable work from private providers and the delivery of profitable work currently done outside of Mid and South Essex

9.6 National schemes and other investments

Provision has been made for the following national schemes, as well as local investments, which will return the system to balance, from the surplus created by the impact of system transformation:

- Roll out of Seven Day Services through to 2019/2020
- Delivery of GP Forward View and Extended GP Access
- Increase in children and adolescent mental health services, and delivering access and wait targets for eating disorders services
- Implementation of the recommendations of the mental health taskforce
- Cancer taskforce strategy
- National maternity review
- Investment in preventing and tackling childhood obesity, improving diabetes diagnosis and care
- Local digital roadmaps for paper free at point of care and elective health records

9.7 Consolidated position

The impact of the initiatives listed above restores the system to in-year financial balance by 2020/21.
9.7.1 Income reduction for providers

As detailed in the Local Health and Care sub-section, we anticipate the following reductions relative to the momentum case: non-elective activity 14.0%, elective activity 18.0%, and outpatients 35.1%. As shown below, the result will be a £99m decrease in provider income against a momentum case of £236m increase.

The net effect would be, between 2016/17 and 2021/22, a net reduction in outpatient activity of 3.8% per annum, flat activity for elective and non-elective activity and a net growth of 1.9% per annum in A&E attendances.

Figure 57: Impact of savings on acute trusts

![Diagram showing the impact of savings on acute trusts. The diagram includes a bar chart and a commentary box. The commentary box states that a 'do nothing' increase in income of £236m is offset by £99m gross reduction income as a result of the LHC schemes. The spending is reduced as a result of the LHC schemes, with a provision made for standard costs which remain in the short to medium term. £35m of STF investments will also be required as part of the NHS Five Year Forward View, which will be funded through STF allocation advised for Mid and South Essex.]}
10. Clinical Assurance

About this section

This section describes the STP’s approach to clinical assurance. Proposals to date have been reviewed on several occasions by the Clinical Senate, and we plan a further review post consultation.

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10.1 Introduction

The mid and south Essex STP has tested its proposals for clinical reconfiguration in two main ways. The first was a series of clinical peer reviews, undertaken by the East of England Clinical Senate, and the second an independently commissioned academic review undertaken by the Eastern Academic Health Science Network. Both processes are outlined below with further detail provided in Appendix 10.

10.2 Reviews by the Clinical Senate

Twelve Clinical Senates were established across England in 2013 to bring together clinicians, healthcare and social-care professionals, patient and citizen representatives, and individuals from organisations involved in the commissioning and delivery of health and social care locally. The role of the Clinical Senate is to provide independent, strategic clinical advice and guidance to health commissioners and other stakeholders on healthcare decisions for the populations they represent.66

10.2.1 Summary of the Clinical Senate reviews

June 2016

In June 2016, a panel of the East of England Clinical Senate met to provide independent clinical advice on the initial proposals for the STP. The scope of the panel was: urgent and emergency care, women’s health, paediatrics, and elective and emergency surgery; in addition, the panel took into account the strong interdependencies between acute clinical reconfiguration and other initiatives in the overall programme, particularly the frailty pathway.

---

The Clinical Senate was asked to advise whether, “in the context of the case for change and national recommendations for care models, the emerging options for the reconfiguration of services between Mid Essex Hospital Trust, Southend University Hospital Foundation Trust and Basildon and Thurrock Universities Hospital Foundation Trust constitute reasonable proposals to improve clinical outcomes, ensure a sustainable workforce and improve efficiency and productivity”.

The Senate was broadly supportive of the programme’s emerging proposals. The panel acknowledged that the programme provided a real opportunity, possibly the only opportunity for many years, to make a real difference.

The panel recognised the scale of the challenge, and complimented the programme on the evidence provided and on the large amount of work that the team had undertaken in the time available. The panel felt that some of the proposals could be more radical, that in some areas there were other options worth considering, and that in some areas there was more work to do notably, more detailed activity and capacity modelling, a proper assessment of travel times, and a review of links between Acute and Local Health and Care work.

The detailed responses from the clinical senate were subsequently shared with the specialist clinical working groups. Each group considered the senate responses and in many cases refined and adapted proposals as a result.

October 2016

Following further revisions to the emerging clinical model a second panel of the Clinical Senate reviewed more detailed proposals in October 2016.

Key points made by the Senate in this second review included:

- The case for change was clear
- A clear challenge to the programme of consider being bolder, alongside a steer to reconsider the pace of progress with a view to taking more time
- Support for the direction of travel of consolidating and redesigning services
- Support for the principle centralising higher risk/lower volume emergency and elective services
- Support for the principle of establishing a high volume elective centre

September 2017

Following further refinement of the clinical model and, in particular, the development of the ‘triage, treat and transfer’ proposal (outlined in Section 6), the Clinical Senate was invited to undertake a further short review of the acute model prior to consultation. This review took place in mid-September 2017.

The Senate broadly endorsed the programme’s proposals, concluding that:
“the panel was supportive of the principles put forward underpinning the programme of change...the concept of the consolidation of certain specialist and complex services on to one or two sites to improve patient outcomes and ensure sustainability was supported, as was the associated need to develop systems to identify, treat and transfer...”

The Panel made a series of recommendations, which the programme is currently considering.

One area that the September 2017 panel did urge further work on was stroke services. In its report, the senate concluded that at the point of its review there was not enough evidence to include stroke services in the triage, treat and transfer model. The panel recommended that “thrombolysis should be delivered either at or in close proximity to the proposed hyper acute stroke unit”.

This differed from the locally proposed model, which would see all relevant patients receiving thrombolysis at their local hospital prior to transfer to the hyper acute stroke unit. Following the September Senate and in considering its recommendations, the programme gathered more evidence to inform its decision. This included:

- Seeking the advice of NHSE’s National Clinical Director
- Commissioning an independent literature review of the evidence of the two models of access (i.e. direct access to a HASU or local diagnosis and treatment followed by transfer)
- Reviewing other parts of the country that have adopted a similar model to that proposed by the STP.

**October 2017**

This additional evidence was then presented to a fourth Senate Panel which met in October 2017. This panel was focused entirely on the proposed stroke pathway.

In its report, the Senate concluded that in the light of the further evidence provided and the views of the National Clinical Director “the panel agreed that, subject to the recommendations of this panel and 18th September being actioned, the proposed three access point model would be likely to provide, at least in the short to medium term, a clinically safe and sustainable service”.

On the basis of the additional evidence gathered on stroke services and the Senate report, the programme concluded that only the proposed three access point model should be included in the consultation.

The October 2017 panel made further recommendations which the programme is currently considering.

**Further reviews**

The programme is planning a further clinical senate review, on the final post-consultation proposals following completion of public consultation and finalisation of the clinical reconfiguration preferred proposal. This is likely to be in March or April 2018.
10.2.2 Clinical review by the Eastern Academic Health Science Network

The Eastern Academic Health Science Network (EAHSN) was commissioned to assess the published evidence available on clinical outcomes, and to what extent they support the 5 options proposed for the options appraisal process. This review was performed independently of the STP.

Outcomes were assessed in two stages:

- **Stage 1: Published literature review**
  Reviewers searched ten bibliographic databases for research published between January 1990 and December 2016. This research was used to assess the likely impact of each reconfiguration option on clinical outcomes. This was weighted at 60%.

- **Stage 2: National guidance review**
  National guidance most pertinent to each of the proposed models was identified. The five options were evaluated against this guidance and the results of this stage were weighted at 40%.

Overall they judged that although there is limited research available regarding the exact model being proposed by the STP, there is evidence on component parts of models. They concluded that on balance all five of the acute options developed would likely improve patient outcomes.

Further detail is available in their report, which is available on request.
11. Assessment against the four tests of reconfiguration

About this section

This section outlines the assessment against the four tests of reconfiguration for clinical assurance, and the additional 'fifth test', introduced in March 2017. In addition this section refers to the Equality Impact Assessment and Privacy Impact Assessments which have been conducted.

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This chapter outlines the assessment against the four tests of reconfiguration for clinical assurance, and the additional ‘fifth test’, introduced in March 2017.

In 2010, the Government introduced four tests of service reconfiguration. These tests are “designed to build confidence within the service, with patients and communities.” The organisations involved in developing service change proposals are responsible for working together to show that the evidence in each test is convincing, and thereby to reassure themselves and their communities.

The four tests are for the proposed service changes to demonstrate evidence of:

- Strong public and patient engagement
- Consistency with current and prospective need for patient choice
- A clear clinical-evidence base
- GP Commissioner support for the proposals

The four tests have been applied throughout the pre-consultation phase, and will continue through the consultation and post-consultation phases of this programme. The following sections describe how the STP has engaged with a broad range of stakeholders to meet the four tests. Each section describes:

- The guidance
- The approach taken by mid and south Essex

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Future planned activities

11.1 Test 1 - Strong public and patient engagement

Guidance

Under the NHS Act 2006 (as amended by the Health and Social Care Act 2012), CCGs and NHS England must make arrangements to ensure that people who use, or may use, services are properly involved in the following:

- Planning the provision of services
- Developing and considering proposals for change in the way those services are provided
- Considering the NHS organisation’s decisions affecting the operation of services

Providers of NHS-funded services have a separate but similar legal duty, under Section 242 of the NHS Act 2016, to involve service users.

Guidance in “Planning and delivering service change for patients” states that engagement activity should be proactive and should reach out to local populations, engaging them in ways that are accessible and convenient for them. The approach should take account of the differing information and communication needs of the audiences, and their differing preferences. Communities should be actively involved as partners rather than as passive recipients.68

Approach taken by mid and south Essex

Public and patient involvement has been central to the approach taken in mid and south Essex, as set out in Chapter 12 of the PCBC and the governance of the Programme. A summary of the key approaches taken are set out below.

Over 100 pre-consultation engagement events

Between 1 March 2016 and end March 2017, the mid and south Essex STP has logged 103 engagement events with staff, public and patients. This is likely to increase by at least 30% by the time this business case is finalised.

A genuine influence on decision-making right from the start

Public and patients have engaged with the Success Regime/STP in four structured phases. This has ensured strong proactive engagement from the start and throughout the development of both the mid and south Essex Sustainability and Transformation Plan (STP) and the options for potential hospital reconfiguration.

The phases so far:

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Phase 1 (March-May 2016) - Early engagement in decision rules and criteria for decision making

Patients, carers, stakeholders and local people highlighted key issues that matter most to patients and families. This helped to agree planning principles and themes for appraisal criteria.

Phase 2 (June-August 2016) – Involvement in developing options

Patients, carers, stakeholders and local people had opportunities to discuss potential options for hospital reconfiguration and wider system changes. Common themes influenced the content of the STP and details of potential options for hospital reconfiguration. Specifically, service users helped to determine the design and weighting of the criteria used to assess the acute reconfiguration options.

Phase 3 (September 2016 – January 2017) - Engagement in wider STP and hospital service change

Building on the feedback from previous phases, local people gave their views on the case for change and emerging proposals. By this phase, we had arrived at five possible options for hospital reconfiguration and people were able to explore these in greater depth to identify potential implications for patients and families.

Phase 4 (February-March 2017) - Engagement on hospital options appraisal

The relationships and engagement structures built over the previous phases created informed service users, a manageable process and a level of mutual trust that enabled public and patient representatives to take a prominent role in the options appraisal process. Alongside three other panels of independent clinical experts, financial experts and system leaders, an expert panel of service users scored options and gave their views on the potential hospital reconfiguration. This subsequently influenced the pace and approach to planning, ensuring full consideration of issues raised by public, patients and frontline staff.

Phase 5 (April 2017-present) – Extended Engagement on hospital options appraisal

Following the options appraisal, there was a further period of engagement on the two models (2A and 1A) that scored most highly. This phase encompassed the public (including campaign groups), stakeholders (such as local MPs, HWBs and Councils) and clinicians from all sectors. This phase led directly to the amended proposals that are outlined in this PCBC, and the views received were a key factor in the decision taken to keep all three A&E departments operating largely as they do currently.
Checks and challenges by service users

A Service User Advisory Group (SUAG) is at the centre of the engagement programme, with around 60 active members drawn from patient and public engagement groups associated with all of the partner organisations. The chair of SUAG is a non-executive member of the Programme Board, ensuring strong links between the programme and service user representatives across mid and south Essex.

SUAG members are active in their communities and are able to hold the programme to account in terms of listening to local views. SUAG was directly involved in narrowing down the options for this business case and has identified for consideration many implications of potential change for patients and local people.

Coordinated, system-wide engagement

A working group involving all health and local authority partners is the delivery mechanism for communications and engagement. Reporting to the Programme Executive, it works within the governance structure of the STP and alongside all of the clinical working groups. It exchanges information and feedback regularly with organisational leaders, health and wellbeing boards, scrutiny committees, HealthWatch, MPs and a comprehensive network of patient reference groups, trust governors, service user groups and patient participation groups linked to GP practices.

This system-wide approach ensures that:

- Messages and methods are consistent and timely across the patch
- Planning benefits from existing patient and public engagement structures and from feedback from previous local engagement
- Engagement is embedded within the SR programme. Feedback is continually reviewed and has an influence on developing proposals.

Clinicians as engagement champions

The senior clinicians leading programme work streams have engaged with patients and public from the beginning. One of the earliest planning workshops brought clinicians and patients together to discuss and draw from their experiences.

In later stages, all main engagement workshops were led by a senior clinician, usually a medical director or chief nurse, supported by programme and communications leads and involving the relevant clinical commissioners in each locality.

Future planned activities

There will be another phase of pre-consultation engagement in June and July 2017, followed by a three-month public consultation in the autumn and further engagement in the final decision-making phase in early 2018.
The aim of phase 5 in June and July will be to engage people in the draft business case and development of the consultation plan. During this phase we will continue to extend our reach into local communities, working closely with SUAG, HealthWatch and other public representatives. This includes further work with vulnerable groups and young people.

SUAG plans to increase its activities to ensure service user involvement in the development of clinical pathways.

The consultation will include further public workshops and survey methods to maximise the benefits of genuine and meaningful insights.

### 11.2 Test 2 - Consistency with current and prospective need for patient choice

#### Guidance

The NHS Constitution outlines the right to informed choice on the following elements:

- The right to choose your GP practice
- The right to express a preference for seeing a particular doctor within your GP practice
- The right to make choices about your NHS care and to information to support these choices
- The right to choose the organisation that provides your NHS care when you are referred for your first outpatient appointments with a service led by a consultant

The Health and Social Care Act 2012 requires commissioners to ensure good practice and to promote and protect patient choice. Choice and competition are effective tools that a commissioner can use to improve services for patients.

In March 2013, NHS England and Monitor published a joint statement on choice and competition in commissioning clinical services in the NHS. According to the statement, it is for commissioners to decide how best to use choice and competition to improve the quality and efficiency of services, beyond the rights in the NHS Constitution. Commissioners need to make balanced judgments on a variety of factors, such as delivering care in a more integrated way, ensuring service sustainability, and determining whether there is a range of suitable providers.  

#### Approach taken by mid and south Essex

In the development of proposals locally, patient choice (to appropriate, high quality services) has been a key factor:

- One of the four criteria used for narrowing the options for acute service change was maintaining appropriate access to services for patients, relatives and staff. This criterion includes the impact of the proposals on patient travel times and the impact on patient choice (see Appendix 3)
A clinically-focused review panel assessed the impact of the proposals on each of the appraisal criteria, including patient choice. Each criterion was assigned a score between “−−” (strong negative impact) and “++” (strong positive impact), and the scores were combined to give an overall assessment of each proposal – an assessment that balances the need for appropriate patient choice with the need for safe and effective care. No option scored below neutral for patient choice.

An equality impact assessment was undertaken, to ensure that there will be equitable access for everyone and avoids inadvertently excluding any groups of people (on the basis of protected characteristics, for example).

Proposals were developed aimed at ensuring that services are locally accessible wherever possible and centralised where necessary. For example:

- Proposals include having paediatric assessment units at all sites, so that patients can access care at any one site.
- Each of the three hospitals will retain an obstetrician-led unit, alongside a midwife-led unit. While there will be some consolidation in the case of high-risk births, the majority of births will continue to be based at a local site.
- Day case elective services will be retained at all three sites.

### Assessment of impact of proposals on patient choice

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Description</th>
<th>Impact on patient choice</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Manage demand for healthcare</strong></td>
<td></td>
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</tbody>
</table>
| Prevention, Early Intervention and Self Care | • Individuals will be empowered to self-care and build healthy lifestyles
• Reduced demand on clinicians will make it easier for those most in need to access services | ✓ Type of care (Inc. self-care)
✓ Accessibility |
| Integrated pathways (Frailty, LTC) | • Patients will have more choice over who provides their care e.g., choosing to see a prescribing physiotherapists instead of a GP
• Clinicians will spend more time on the frail and patients with LTCs e.g., GPs able to offer more extended | ✓ Type of care (Inc. self-care)
✓ Accessibility |
## Local health and care led initiatives

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Description</th>
<th>Impact on patient choice</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Urgent and Emergency Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>appointments to frail patients</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• More patients will be supported to self-care and those in need will be supported by the correct clinicians e.g., triage by an suitable professional who can provide expert advice</td>
<td>✓ Type of care (Inc. self-care)</td>
</tr>
<tr>
<td></td>
<td>• Some patients may have to travel further to reach consolidated hubs</td>
<td>× Accessibility</td>
</tr>
<tr>
<td><strong>Primary care and localities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Patients will be offered integrated delivery of physical, mental health, primary care, social care, community care and public health, potentially delivered via a single physical or virtual hub</td>
<td>✓ Type of care (Inc. self-care)</td>
</tr>
<tr>
<td><strong>Specialist pathway redesign</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• A greater range of professionals will be involved in care delivery – e.g., community clinicians to set up infusions</td>
<td>✓ Type of care (Inc. self-care)</td>
</tr>
<tr>
<td></td>
<td>• Patients will be delivered care in a setting closer to them e.g., infusion clinics in the community</td>
<td>✓ Accessibility</td>
</tr>
<tr>
<td><strong>Consolidation of some sub-specialties and pathways</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Centers of excellence will achieve a greater consistency and quality of care</td>
<td>✓ Quality of care</td>
</tr>
<tr>
<td></td>
<td>• A small number of emergency patients will be transferred to a specialist center, after being triaged locally</td>
<td>× Accessibility</td>
</tr>
<tr>
<td></td>
<td>• Some patients will need to travel further for inpatient elective care</td>
<td>× Accessibility</td>
</tr>
</tbody>
</table>
### Local health and care led initiatives

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Description</th>
<th>Impact on patient choice</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>surgery</td>
<td></td>
</tr>
</tbody>
</table>

### Future planned activities

Patient choice will continue to be a focus for the programme, and to inform the programme’s proposals. The formal consultation will review the feedback from patients, public and clinicians, including feedback regarding the impact of the proposals on patient choice.

Once the final proposals have been agreed, reviewers will again assess the impact on patient choice, testing for any adverse effects and recommending any appropriate mitigating measures.

#### 11.3 Test 3 - A clear clinical-evidence base

**Guidance**

The objective of this test is to ensure that the service-change proposals are underpinned by a clear clinical-evidence base and align with up-to-date clinical guidelines and best practices.

**Approach taken by mid and south Essex**

Clinical leadership has been at the heart of the approach adopted in mid and south Essex, resulting in a strong focus on the evidence base underpinning the models of care proposed. Key developments have included:

- Proposals were developed by frontline clinicians. The Acute Leadership Group, together with clinical subgroups involving 60 clinicians from across the three acute trusts, developed the Future Model of Care for Acute services. For a detailed account of the clinically-led process, see Appendix 2.
- Proposals were assessed by the Clinical Senate on several occasions as an independent source of clinical advice. The conclusions of the Senate and our response to each of their recommendations can be found in Section 10 and Appendix 10.
- National guidance and recommendations from the Royal Colleges have been included in the proposal development process. The key elements of this guidance and the way it has been included in the proposals are attached at Appendix 3.
• Emerging proposals were tested and refined by a broad clinical and professional leadership group, including about 40 leaders from primary care, community services, mental health, public health and acute care. More details of the approach are set out at Appendix 2.

• Proposals have been developed in accordance with national policies and guidelines. The key aspects of national guidance considered, and how this has been reflected in the proposals, is outlined in section 6

• Case studies and benchmarks were consulted during the options-development phase. A group of about eight clinicians from the three acute trusts visited the specialist emergency hospital in Northumbria to examine new models of care. Details of this visit can be found in Appendix 2.

In addition to the above, the Programme commissioned an independent, external review of the five potential models of acute configuration against the existing clinical evidence base. This was conducted by the Eastern Academic Health Sciences Network (EAHSN). This review used a three stage methodology:

• Identification of academic studies that were relevant to the Mid and south Essex proposals
• Review of relevant national standards or guidelines (e.g. NHSE, Royal Colleges)
• Application of the evidence from stages one and two to the five specific proposals for acute reconfiguration

The independent report concluded that, based on the clinical evidence reviewed, all five options were likely to improve outcomes compared with the status quo. The report scored all five options on a ten point scale, where 5 was no improvement to current outcomes. The range of scoring for the five options was 6.3 to 7.4.

Future activities to maintain compliance

The proposals will continue to be clinically-led, and will include views from a wider group of clinicians during public consultation.

A third review of the final, post consultation, proposals for service reconfiguration by the Clinical senate is planned for late 2017/early 2018.

11.4 Test 4 – GP Commissioners support for the proposals

Guidance

All service change needs GP commissioner ownership, support and leadership (even if change is initiated by a provider or other organisation).

Commissioners have a duty to ensure that proposals meet certain conditions, including that they:

• Align with commissioning intentions and expenditure plans
• Will meet the current and future healthcare needs of the patients
- Will deliver high-quality care
- Will install services that have long-term sustainability

**Approach taken by mid and south Essex**

**Involvement in programme development**

The proposals for service change have been developed in concert with local commissioning organisations and GPs, and have broad support from partners from across the patch. Commissioning organisations have led much of the STP (in particular the Local Health and Care aspect) and have been involved in the Programme at a number of levels:

- The Chairs and Accountable Officers of all five CCGs have been members of the System Leadership Group, which steered and advised the programme in its early stages, and also have direct input to the STP Programme Board
- The Chairs and Accountable officers of the five CCGs form the core membership of the CCG Joint Committee
- The SRO for the Joint Committee and the Local Health and Care elements of the STP is also the Accountable Officer for Mid Essex CCG, and has ensured close liaison and joint working with the other Accountable Officers from the CCGs.
- GPs from across the patch have been involved in both the development of proposals (working alongside acute colleagues) and in the wider engagement on the programme (for example at primary care ‘shut down’ sessions)

**Leadership of key STP work streams**

CCG officers and GPs lead the development of most key STP proposals, and are fully involved in all of the project teams. For example:

- The locality development and primary care transformation work stream is led by the Accountable Officer of Castle Point and Rochford and Southend CCGs, with extensive input from all five CCGs.
- The frailty work stream is led by the Accountable Officer of Thurrock CCG.
- The Medical Director of Mid Essex CCG has been a member of the Acute Leadership Group, which has led the development of the hospital-reconfiguration options.
- Each of the five CCGs has engaged extensively with GPs in working with the STP and developing the options for change. For example, each locality has hosted open workshops, between local GPs and the Medical Director of the relevant acute trust, to discuss the details of the acute clinical model and the links with local health and social care.
**Decision making**

Each Governing Body formally discussed and accepted the case for change in mid-2016. An earlier draft of this PCBC was discussed by the Joint Committee of the CCGs in September 2017; this Committee agreed that it should go forward into the national assurance process.

**Future activities to maintain compliance**

The five CCGs in the STP are the owners of the programme proposals, and will lead the proposed public consultation in November 2017. Following consultation, decisions on service reconfiguration will be taken by the CCG Joint Committee in spring 2018.

**11.5 Test 5 – bed closures**

**Guidance**

In March 2017, NHS England published *Next Steps on the NHS Five Year Forward View*. This document introduced a ‘fifth test’ for proposed service reconfiguration:

*From 1 April 2017, NHS organisations will also have to show that proposals for significant bed closures, requiring formal public consultation, can meet one of three common sense conditions:*

- That sufficient alternative provision, such as increased GP or community services, is being put in place alongside or ahead of bed closures, and that the new workforce will be there to deliver it; and/or
- That specific new treatments or therapies, such as new anti-coagulation drugs used to treat strokes, will reduce specific categories of admissions; and/or
- Where a hospital has been using beds less efficiently than the national average, that it has a credible plan to improve performance without affecting patient care

**Approach taken by mid and south Essex**

The proposals developed across mid and south Essex include aspects of all three of the conditions set out above. For example, increasing capacity in primary care is at the heart of our local health and care proposals, and the consolidation of services will improve bed utilisation.

However, the proposals for acute reconfiguration involve consolidating and separating some services across the three sites, there are no plans to reduce the aggregate bed base across the STP footprint:
### Bed Model

<table>
<thead>
<tr>
<th>Site</th>
<th>Current bed base</th>
<th>Approximate Future bed base</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basildon</td>
<td>980</td>
<td>935</td>
</tr>
<tr>
<td>Mid Essex</td>
<td>829</td>
<td>921</td>
</tr>
<tr>
<td>Southend</td>
<td>817</td>
<td>829</td>
</tr>
<tr>
<td>Total</td>
<td>2626</td>
<td>2685</td>
</tr>
</tbody>
</table>

### Future planned activities

The STP bed model is being continually updated, and the position in relation to aggregate bed levels will be kept under review.

#### 11.6 Equality impact assessment

Public Bodies such as the NHS (both commissioners and providers) have a legal duty to eliminate unlawful discrimination, to advance equality of opportunity and to have particular regard to the impact of potential service changes on defined segments of the population – known as those with ‘protected characteristics’.

The main protected characteristics defined in legislation and national guidance are:

- Age
- Disability
- Sex
- Pregnancy
- Marital status
- Race
- Sexuality
- Religion
- Gender reassignment

In developing our proposals, the Programme conducted an initial Equality Impact Assessment to determine at a high level the main risks that the potential service changes set out in this PCBC might pose, and to develop initial thinking on possible mitigations. More detail on the approach taken is attached at Appendix 4.

The programme plans to refresh and expand the assessment as part of public consultation. The draft consultation plan includes activities to engage with a number of distinct groups (including those often referred to as hard to reach), which will provide an excellent opportunity for the programme to develop a deeper understanding of the potential impact of the proposed changes on those with protected characteristics.
The initial impact assessment conducted by the Programme involved an analysis of each of the main strands of potential service change and the possible impact against each of the protected characteristics outlined above. It was recognised in this initial assessment that the overall impact could be positive (in other words likely to reduce inequalities for people with some protected characteristics) as well as in some cases negative.

Bringing together the available evidence, an assessment was made on whether each potential change would likely have a high, medium or low impact:

<table>
<thead>
<tr>
<th></th>
<th>Age</th>
<th>Disability</th>
<th>Sex</th>
<th>Pregnancy</th>
<th>Marital status</th>
<th>Race</th>
<th>Sexuality</th>
<th>Religion</th>
<th>Gender reassignment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute reconfiguration</td>
<td>M/H</td>
<td>M</td>
<td>M</td>
<td>M</td>
<td>None</td>
<td>L</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Development of localities</td>
<td>M</td>
<td>M</td>
<td>L</td>
<td>M</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Pathway redesign (e.g. frailty)</td>
<td>None</td>
<td>M</td>
<td>None</td>
<td>L</td>
<td>None</td>
<td>L</td>
<td>None</td>
<td>L</td>
<td>None</td>
</tr>
<tr>
<td>Specialist pathways</td>
<td>L</td>
<td>L</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>111/OOH</td>
<td>M</td>
<td>M</td>
<td>None</td>
<td>L</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

The initial assessment was then tested with the Programme’s Clinical and professional Leaders’ Group, both to validate the analysis and begin to consider mitigations.

What is clear from this initial analysis is that the element of the programme that is likely to have the biggest impact – and therefore the biggest risk – on segments of the population with protected characteristics is the acute reconfiguration and, in particular, access.

Because a core element of the proposal is to consolidate some more specialist services on one or two sites, some people will have to travel further to access services. This has the potential to widen inequalities for some groups – for example those with a disability. For this reason, a key aspect of the additional work that will be undertaken during public consultation will focus on transport, and how the risks identified can be mitigated.

It was also noted, however, that some proposed changes have the potential to reduce inequalities. For example, developing locality hubs is likely to improve access to services, removing some barriers that currently exist.

It is anticipated that, at the conclusion of public consultation, a refreshed Impact Assessment will be produced and considered by the Joint.
11.7 Privacy impact assessment

The mid and south Essex STP has conducted an initial privacy impact assessment (PIA) review, and there are plans for further reviews and reassurance. The approach to the PIA has been based on NHS England’s guidance for new systems, as documented in “IG Requirements for New Processes, Services, Information Systems and Assets” and the “Information Commissioners Office guide for the application of Privacy Impact Assessment”, published in November 2015. The PIA working group has been broadly supportive of the programme, recognizing that it offers a real opportunity to make a difference. The group has proposed that implementation of the “privacy by design” concept could allow many of the identified risks to be addressed methodically during the design phase, rather than ad hoc after the solution has been implemented. Further work is planned for a number of aspects identified in the report, such as assessment of the “need to know” principle (see Annex 5 for fuller details).
12. **Strong public and patient engagement**

### About this section

This section describes how public and patient engagement influenced the business case and proposals for consultation. It covers the main actions taken by the mid and South Essex STP to embed and deliver public and patient engagement as part of the decision-making process; and summarises the plan for further public consultation.

“Views from Local People. Part 1 – Engagement in options for service change”, a more detailed report and engagement log is available in Appendix 7.

12. Strong public and patient engagement

12.1 Where we are now

The proposals in this business case and our wider plans as an STP are genuinely influenced by public and patient views. The outcome of over 100 stakeholder events in five distinct phases of engagement is a proposed transformation plan that is very different from the initial outline plan that we launched on 1 March 2016.

12.1.1 How our proposals changed as a result of input from stakeholders, staff and public:

<table>
<thead>
<tr>
<th>Some of the major changes in the emerging plan</th>
<th>Influences from engagement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greater emphasis on</td>
<td>Top theme from public feedback on the case for change –</td>
</tr>
</tbody>
</table>
| access to GP services and development of community services | **access to GP services**  
All workshops and discussions, including with hospital staff, repeatedly highlighted the importance of primary and community care. Feedback on the case for change identified access to GP services and development in community services as the two top priorities, with improvements in hospital services as 12th in a list of top 12 priorities for change.  
The Local Health and Care programme has increased in prominence since 1 March 2016. Each CCG has progressed with new locality models to increase capacity in primary care, and local developments to address complex care needs, frailty and end of life, for example. |
| Greater emphasis on mental health | **HWBs raised the profile of mental health**  
Mental health was explicitly excluded from the original outline plans as this was already in development in a separate programme. Strong representations from the Health and Wellbeing Boards and at discussion workshops have raised the profile of mental health as an integral part of new models of care in both community and hospital. The STP is prioritising improvements to mental health care. This involves working with our communities to focus on prevention, early intervention, building resilience and emotional well-being, as well as working to ensure that anyone with a mental health need can access the right service at the right time. This is a whole system approach as identified through the Southend, Essex and Thurrock Mental Health and Wellbeing Strategy. |
| Major change in the clinical model for access to hospital emergency care. | **Further engagement following options appraisal**  
In the fifth and final phase of engagement, following the options appraisal, we changed our thinking from a model where patients would access specialist emergency care at a single specialist emergency hospital to a model where the majority of patients would be treated initially at their local A&E and then, if needed, transferred by ambulance to a specialist service, which may be in another hospital.  
The feedback which led to this development came from several groups of stakeholders, including both professional and public voices. The influence was particularly strong from engagement that was embedded within the planning process and the options appraisal e.g. with the Acute Leaders Group. feedback from wider hospital staff, CCG clinical engagement, Service Users Advisory Group (SUAG), Health and Wellbeing Boards, Scrutiny Committees, HealthWatch bodies and liaison with local MPs. |

We have yet to fully test the level of consensus among public and patients, but feedback has:
highlighted themes from a service user and public perspective that contributed to framing the options for hospital reconfiguration, and subsequently modifying the preferred model.

identified key issues and implications for service users that will be considered in equality and risk management plans.

### 12.1.2 Summary of viewpoints on system change

<table>
<thead>
<tr>
<th>Viewpoints</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most people who participated in discussions agreed that the health and care system needs to change.</td>
<td>In addition to noting these views in meetings and group discussions, a simple survey showed that the vast majority of those involved in the September/October workshop programme said they agreed the need for change.</td>
</tr>
<tr>
<td>Feedback themes show a strong view that more should be available in primary and community care, including a shift from hospital to community.</td>
<td>From a survey of “your top three priorities for change”, there were twelve main categories, of which the following were the top three: 1. Access to GPs 2. Better access to community care 3. Prevention</td>
</tr>
<tr>
<td>Some people expressed the view that the strategy for change makes sense and that there are clear benefits to gain from consolidating some hospital services.</td>
<td>Not quantified, but stated in nearly every workshop and evident among representatives who have elected to be actively involved in the programme.</td>
</tr>
<tr>
<td>Some people accept that there are potential benefits in hospital reconfiguration, but would like further evidence to guarantee safety and improved care for patients.</td>
<td>This is a common theme, particularly in discussions with leading representatives, such as health and wellbeing boards, scrutiny committees and the STP Service Users Advisory Group (SUAG). We will continue to discuss planning details and clinical evidence with these groups through the consultation and continuing planning cycle. Feedback will further inform impact and risk assessments.</td>
</tr>
<tr>
<td>There are a number of campaign groups, some linked to political parties that have expressed their general opposition to STPs. To date, these groups have set up three petitions to “save our A&amp;E”.</td>
<td>These groups have raised concerns in their local communities, which are indicated in letters, emails and petition signatures. We will continue to publish the facts and correct misinformation in our responses to letters, via the STP website, in the local media and through our network of local groups.</td>
</tr>
<tr>
<td>A common theme from feedback from all groups of stakeholders throughout all our engagement activities was the</td>
<td>Even though the options appraisal process clearly identified preferred options for the potential hospital reconfiguration, there was</td>
</tr>
</tbody>
</table>
safety and effectiveness of emergency patients travelling by “blue light” ambulance directly to one hospital. Following the options appraisal process, for example, the service user’s panel perceived that the available clinical evidence was ambivalent, while senior hospital clinicians put forward an alternative approach. HealthWatch Essex was commissioned to complete a research project using a deliberative democracy approach, which investigated in further detail the concerns of local people regarding access to emergency care in light of the potential hospital reconfiguration. Further discussions with hospital staff, CCGs and local communities led to a change in thinking that was announced on 20 July 2017. The outcome from the HealthWatch Essex research project is included as part of Appendix 7, Views from Local People. Although this project reported its findings after the July announcements, it provides a deeper dive into the perceptions and concerns of our local public and patients.

12.2 Summary of approach

The Mid and South Essex STP ran the following five phases of engagement from March 2016 to July 2017:

- Phase 1 (March-May 2016) – Early engagement in decision rules and criteria
- Phase 2 (June-August 2016) – Involvement in developing options
- Phase 3 (September 2016-January 2017) – Engagement in STP and hospital service change
- Phase 4 (February-March 2017) – Engagement in options appraisal and subsequent modification of the preferred model for access to hospital services
- Phase 5 (April 2017 to present) – further engagement on the preferred options resulting from the options appraisal
The work to date lays the foundations for an annual cycle of engagement to support planning and delivery over the next four years and beyond.

12.3 Delivery and feedback

The resource to embed and support public and patient engagement is coordinated by an STP Communications and Engagement Group, which meets monthly and involves all STP partner organisations, including local authorities and HealthWatch. In addition, there is the Service Users Advisory Group (SUAG) which is drawn from public and patient representative groups associated with STP partner organisations, HealthWatch and the councils for voluntary services. The Communications and Engagement Group reports to the programme executive and informally to NHS England communications team. The SUAG Chair is a member of the programme board.

The Communications and Engagement Group has protocols for working with key messages, core narratives, presentation materials, coordinated distribution, enquiries and FOIs, horizon scanning and press and media liaison. It works very
closely with the Senior Responsible Officers, work stream leads and with clinical leads as key spokespeople.

There is a central public website with resources, updates and background information at www.successregimeessex.co.uk

12.3.1 Main channels for delivery

1. **Engagement at local level** supported by communications teams in each of the partner organisations
2. **Service user and stakeholder engagement within work streams** largely led by clinicians and work stream managers
3. **Action at STP level** led by a senior communications adviser reporting to the programme director and programme executive.
4. **External partners** – HealthWatch in Essex, Southend and Thurrock, key voluntary organisations, SUAG, HWBs and local MPs

**Figure 58: Main subjects for engagement**

| Overall plan under the Success Regime/STP, a vision of future health and care in terms of: 1. Your local services 2. Live well 3. In hospital |
| Focus on emerging options for the reconfiguration and redesign of hospital services, including post options appraisal |
| Engagement in specific workstreams for developing localities and primary care, frailty, end of life, mental health and self-care |

Early on in phase 1 of the engagement programme, health scrutiny and HealthWatch organisations held a conference for public and patient engagement groups involving some 70 public representatives. A report from the conference, subsequently endorsed by Essex HOSC, recommended numerous diverse methods to ensure meaningful engagement in the work of the STP.

The recommendations were incorporated into the communications and engagement strategy, and the table below shows the wide variety of methods we have used to reach different audiences.

**Figure 59: Highlights of activities**

*See also a detailed engagement log in Appendix 7*

<table>
<thead>
<tr>
<th>Phase 1 Early engagement in decision rules and criteria</th>
<th>March – May 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Launched SR plan publicly on 1 March 2016</td>
<td></td>
</tr>
<tr>
<td>• Continued distribution of stakeholder briefings and updates</td>
<td></td>
</tr>
<tr>
<td>• CCG and Trust Board discussions in public</td>
<td></td>
</tr>
<tr>
<td>• Continued stakeholder engagement with HWBs (jointly and separately), HOSCs and HealthWatch; all HWB and HOSC</td>
<td></td>
</tr>
</tbody>
</table>
meetings were held in public, and papers were available from the HWB and HOSC websites

- The three HealthWatch bodies and HOSCs held a conference for public representatives and patient participation groups on 18 April 2016
- Continued engagement with the local MPs and the Health Minister
- *In Your Shoes*, a structured engagement exercise involving service users and lead clinicians, conducted on 28 April 2016, enabled service users, though their stories and perspectives, to influence thinking on hospital reconfiguration from the outset.

### Phase 2: Involvement in developing options

**June – August 2016**

- Programme of service-user, staff and stakeholder workshops in July/August 2016, to inform the framing of options for consultation; the programme included:
  - 2 major stakeholder events – for board members, council leaders, chairs of HWBs, HealthWatch and senior teams of all partner
  - 6 service-user focus groups across Mid and South Essex
  - 8 staff workshops
- In addition to feedback on the overall plan, workshop participants gave views on options and weighting of criteria for options appraisal, which fed into the options shortlisting process.
- Production and wide distribution of core materials for engagement:
  - Continued progress updates for stakeholders
  - Publicity and invitation to get involved
  - Discussion document
  - Directions for use of Facebook and Twitter feeds
  - Key presentations, speaker support materials, lines to take and background Q&As
  - Content for blogs, intranets and newsletters
  - Supporting communications – podcasts, films (produced by HealthWatch Essex)
- CCG and trust boards continuing updates and discussions on STP plan – all boards discussed and provided feedback on the draft case for change
Continuing stakeholder engagement with HWBs jointly and separately, HOSCs and HealthWatch; all HWB and HOSC meetings were held in public and some resulted in published papers.

- Continuing engagement with MPs and Minister
- Continuing media liaison and coverage
- Launch of Service Users Advisory Group (SUAG) in August 2016

### Phase 3

**Engagement in STP and hospital service change**

**September 2016 – January 2017**

- Programme of 11 open public workshops across mid and south Essex
- Surveys and group discussions run by HealthWatch Thurrock with older people, stroke survivors, and people with COPD and with people on the high street.
- Special workshop for people with learning disabilities (in partnership with HealthWatch Thurrock)
- Staff workshops in all partner organizations
- Discussions with lead GPs and clinical commissioners in each CCG
- Discussions with district, borough councils and voluntary organizations in each CCG area
- Drama-style workshop on 22 September 2016 to gather input on the vision for future local health and care – localities, joined-up services, multidisciplinary teams, use of technology and shared records, and with a focus on prevention and early intervention.
- Podcasts on Frailty and End-of-Life care produced by HealthWatch Essex – useful for reaching an audience beyond those attending events, and also for engaging people with visual impairment.
- Films on Frailty and the STP overall plan – useful for reaching a wider audience than those attending events.
- Major stakeholder workshop on self-care and empowering of patients – held on 23 September 2016
- Survey of local primary care practices on transformation of primary care
- Major stakeholder workshop on Frailty and End of Life – held on 6 July 2016 with partner organizations and voluntary organizations
- Published STP in full and STP public summary on 23 November

Focus on emerging options for the reconfiguration and redesign of hospital services

Engagement in work-streams
### Phase 4 Options appraisal and further engagement

**February – July 2017**

- Discussion workshops with Service Users Advisory Group (SUAG) in February, March and June 2017.
- Special sessions with scrutiny committees and HWBs
- Continuing discussion events with HealthWatch, voluntary sector and community groups, including residents associations, district and borough councils, and advocates for vulnerable groups.
- Research project run by HealthWatch Essex, including a survey of patients in the three local A&Es.
- Review panel of service user representatives as one of four panels undertaking the options appraisal for potential hospital reconfiguration.

### Phase 5 Further engagement post options appraisal

**Apr 2017 to present**

- Discussions with key stakeholders including HWBs, council leaders, MPs, service providers and HealthWatch
- Further consideration by Service User Advisory Group
- Attendance at public meetings to discuss proposals

### 12.3.2 Phase 1 – Early engagement in decision rules and criteria

*See appendix 7 for further details of feedback*

Phase 1 covered the period between publishing an outline plan for system change on 1 March and the launch of clinical working groups.

The table below provides a high-level summary of early feedback from stakeholder organisations on the STP overall plan.

<table>
<thead>
<tr>
<th>Notable issues</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most partners were in agreement about the need for radical change and supported the direction of travel</td>
<td>Partnerships continued to strengthen through the System Leaders Group and engagement programme</td>
</tr>
<tr>
<td>NEP and SEPT sought SR’s endorsement of the mental-health review recommendations and the trust merger</td>
<td>The mental health review recommendations were incorporated into the STP</td>
</tr>
<tr>
<td>Most organisations discussed their need to be more involved in SR implementation</td>
<td>Organisations were represented across the work-streams.</td>
</tr>
<tr>
<td>Concerns were raised about the financial</td>
<td>Work continued on addressing these issues</td>
</tr>
</tbody>
</table>

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Within a range of public discussions, a structured engagement exercise called *In Your Shoes* brought together lead clinicians and patients and carers who had experienced hospital emergency care. Listening to patients’ stories and their views on what people want from emergency care services, the following were identified as the top three themes:

- Communication (strong emphasis on “listening”)
- Prevent A&E admissions (strong emphasis on access to GPs)
- Speed of access (included reference to same day investigations)

**Other common themes**

**Strengths to build on:**
- Competent staff – “*I felt confident in the people who treated me, they knew their job*”
- Quality of care and treatment
- Joined up services – “*Pre-hospital care was good and I was smoothly transferred from one hospital to another*”
- Patient and carers involvement and choice – “*They gave me the option for self-directed medication*”
- Support for carers and families – “*My brother felt supported by the palliative team caring for me*”

**Priorities for improvement:**
- Not being listened to and repeated questions
- Lack of communication (between teams and organisations)
- Lack of confidence in staff – “*Staff were too busy to do a complete assessment. I was worried things were missed.*”
- Families and carers not involved
- Lack of humanity – “*Some staff had an abrupt tone. They were not polite or friendly*”
Comparison of priorities between service users and clinicians

12.3.3 Phase 2 – Involvement in developing options

At this stage, prior to reaching conclusions about potential reconfiguration options, there was substantial agreement on the overall strategic direction. This was evident from a series of focus groups in July and August 2016 with local public patients and staff.

Summary of views on criteria for appraising options

<table>
<thead>
<tr>
<th>Considerations / criteria</th>
<th>Key issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical outcomes and patient safety</td>
<td>Consistent quality and the need for standardised pathways</td>
</tr>
<tr>
<td></td>
<td>Clear information for patients</td>
</tr>
<tr>
<td></td>
<td>Service users emphasise the importance of a good patient experience to aid recovery</td>
</tr>
<tr>
<td></td>
<td>Staff emphasise safety and clinical assurance in a potentially complex set of patient pathways e.g. clarity around managing multiple medical problems</td>
</tr>
<tr>
<td></td>
<td>Centralised specialist services made sense to some people, but many people felt the need for greater detail and evidence before reaching a view</td>
</tr>
<tr>
<td>Sustainable clinical workforce</td>
<td>Strong concerns about recruitment and retention and the impact of change</td>
</tr>
<tr>
<td></td>
<td>Incentives e.g. working environment, employment terms</td>
</tr>
<tr>
<td>Equal opportunities e.g. pay, training and development – joined up and shared development</td>
<td></td>
</tr>
<tr>
<td>Listen to and support for staff through change</td>
<td></td>
</tr>
<tr>
<td>Pressure on work / life balance</td>
<td></td>
</tr>
</tbody>
</table>

| **Efficiency and productivity** | Improve care for people at home and avoid emergencies |
| Data sharing and IT |
| Joined up services in the community |
| Potential costs of transport |
| Consider “did not attends” due to access difficulties |
| Adopt and spread innovation |
| Deal with prescribing costs and medicines waste |
| Raise taxes |

| **Access to services** | Transport to appointments in the community as well as hospital |
| Road infrastructure, parking and public transport – consider shuttle between sites and times of appointments |
| Ambulance and hospital transport |
| Support for carers at centers of excellence e.g. overnight accommodation |
| Patient information on where to go – e.g. to make better use of urgent care services |
| Older and vulnerable people need more person-to-person time, face greater challenges in travelling to services |

Many concerns were raised that patients and families might find it difficult to cope with the centralisation of some services. It is worth noting, however, that, during this phase, access was not the highest-scoring item in the exercise to weight criteria. Note too that staff and service users were broadly in agreement on the weighting of criteria: the charts below show the generally similar patterns of views.
12.3.4 Phase 3 – Engagement in STP and hospital service change

By September 2016, we had arrived at five possible options for hospital reconfiguration and were able to discuss these in a series of open public workshops, as well as in continuing sessions with stakeholders.

At the public workshops, people were asked whether they agreed or disagreed with the need for change and to state their top three priorities for change.

The following charts show a majority in agreement that the system needs to change:

Priorities for how the health and care system needs to change

The following lists the common themes in order of the number of times these issues were included in the feedback on top three priorities for improvement.
2. Better access to community care
3. Prevention
4. Staffing
5. Efficiency improvements
6. Increase in Government funding
7. Mental health
8. Integrated health and social care
9. Increase/improvement in social care
10. Education for the public on services
11. Discharge and care planning
12. Better hospital experience

appointments
2. Access to primary care and basic tests
3. Available health professionals
4. Local specialist services
5. Joined up care
6. Better social care
7. Funding
8. Transport
9. Personalised care
10. More time for patients

Issues and implications to be considered as part of decision-making

See appendix 7 for further details under each of the following themes.

The main themes in feedback from the autumn public workshops were as follows:

What matters to patients and carers, including choices

- Personalised and compassionate care
- Prevention through good community services
- Joined up services and development in the community
- Good quality care
- NHS funding

Issues for disadvantaged people and equality issues

- Support
- Mental health
- Equality

Transport and travel

- Transport challenges for patients
- Staff and internal transport issues
- Impact on efficiency

Advice on “making it work”

- IT and shared records
- Culture change
- Joined up services
- Improvements and development
• Workforce development
• Costs and savings

12.3.5 Phase 4 – Options appraisal and further engagement

Engagement in the options appraisal

The establishment of a Service Users Advisory Group (SUAG), drawn from the network of patient and public representatives across the STP, made it possible to involve fully a panel of service user representatives in the options appraisal itself.

The SUAG had recruited people with a keen interest in the future of health and care, who also had considerable experience of using services and had the time available to give detailed consideration to the evidence and issues.

SUAG set up a panel of 15 people, three from each CCG area and with a balance of locality and care group interests. The service users panel was one of four panels (the others being clinical experts, finance experts and system leaders).

There was an opportunity for a detailed briefing from subject matter experts prior to the appraisal day. Subsequently, the service user’s panel had access to the same data pack as all other panel members.

The panel reviewed the options against the agreed criteria and submitted a written report to the service leaders’ panel, which was included with the outcome of options appraisal for consideration by the STP Programme Board.

Outcome from the service users appraisal panel

In line with other appraisal panels, the service user panel scored option 2A the highest i.e. the option with maximum separation and consolidation of emergency care services.

However, it was noted that some panel members commented that the process had given insufficient time to digest the complexity of the evidence, which was one of the reasons for agreeing a further period of engagement and sense checking.

Further engagement

Following the options appraisal, local discussions became more focused on access to emergency care and a common concern as to whether or not a “blue light” ambulance journey to Basildon Hospital could be clinically assured.

Local concerns were articulated in the further work of HealthWatch Essex

The SUAG and others sought further details on the levels of service that would be available at each local A&E and which patients would be travelling direct to Basildon for life-saving emergency care. This will be addressed as part of the forthcoming public consultation.

At the same time, the emergency care clinicians and others, including CCG clinical chairs put forward a strong view of the benefits of a “treat and transfer” model.
12.3.6 Phase 5 – Further engagement

Engagement post options appraisal

Following the conclusion of the options appraisal and the decision by the programme board to further develop two options, a further round of engagement was undertaken. This focused on the two preferred models and, in particular, how access to services would work, particularly in an emergency.

This phase of engagement encompassed local stakeholders such as MPs, council leaders and members, members of the public and local clinicians.

A great deal of feedback was received on the future of the three A&E departments. There was widespread comment and some concern over proposals to change the way in which they operate (for example, some sites closing to ambulances overnight). A number of people and stakeholders were worried that the existing proposals did not strike the right balance between the benefits of consolidation (which were well understood) and increased travel times.

Following careful consideration of this feedback, the programme announced in July 2017 that it was going to amend its proposals, principally by largely retaining the current model of A&E, and developing a ‘triage, treat and transfer’ model for some pathways. These proposals are set out in section 6 of this business case.

12.4 Next phases - Overview of approach to consultation

There are three main objectives for engagement and consultation in 2017 that will support decision-making in 2018 and beyond.

1. To ensure public and stakeholder engagement in the strategic direction as set out in the STP plan – this is important as the context for service change decisions
2. To consult on specific service changes or first stages of change to be implemented from 2018/19.
3. To make further progress with continuing service user involvement and stakeholder engagement in planning and redesign of care pathways.

Further details are in the draft consultation document and consultation plan.

The main consultation document will include references to further information, such as clinical evidence, activity, financial data and links to other relevant consultations. All information will be easily accessible from the STP website.

12.4.1 Consultation period and activities

The period of consultation will run for a minimum of 12 weeks, to ensure sufficient time and opportunities for meaningful discussions.

The main activities will include:
• A widely published consultation document, with other versions and formats available on request

• Widely published shorter versions

• An online feedback questionnaire (printed version also available)

• Associated presentation materials and support information, such as material for newsletters, blogs, and social networking.

• A supporting publicity campaign, including engagement and special features with local and national media

• A distribution cascade, using all outlets offered by partner organisations within the STP, plus external partners and the Service Users Advisory Group

• Social networking to signpost to the main websites of all partners, alongside a suite of contextual materials, such as podcasts, films, presentations, and reports from previous engagement

• A programme of open public workshops, events and meetings to reach diverse audiences, and involving a range of techniques developed during the engagement phases

• Range of survey and discussion techniques through collaboration with HealthWatch and voluntary organisations e.g. street surveys, drop-ins, "chatterbox cab", podcasts and discussions with diverse and protected groups,

• A programme of consultation meetings for staff and stakeholders

• Coordinated handling of feedback, enquiries, FOI requests

12.4.2 Feedback analysis

The STP Programme Office will collate all feedback and prepare it for analysis by an independent review body.

A final report on the outcome of consultation will be prepared and presented to the CCG Joint Committee for consideration.

In preparing the outcome report for final consideration there will be a series of assurance checks by:

• STP Service Users Advisory Group

• The three health overview and scrutiny committees, with input from the three health and wellbeing boards

• The programme executive and programme board, with input from regulators.
13 Governance

About this section
This section sets out the governance arrangements within the STP area. It outlines the current approach, anticipated future developments and the broad approach to risk management across the footprint.

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13.1 STP wide arrangements

A range of statutory bodies commission or provide services within the STP footprint, including:

- Five CCGs
- Three acute providers
- Three providers of mental health and community services
- Three upper-tier local authorities
- One Ambulance Trust

Each of these has its own Board (or equivalent) to discharge its legal functions. In addition, some national bodies, such as NHS England and Public Health England, have an important role locally in service planning and/or delivery.

In order to develop and implement the STP on a system-wide – rather than organisational – basis, a set of governance arrangements has been developed to support local bodies and enable them to work together.
The current arrangements are set out below. The Programme Board, led by the Independent Chair, has overall responsibility for the STP and for working with partners across the footprint to oversee implementation. This Board is in turn accountable to NHSE and NHSI at Regional Level. The Board is supported by an Executive that oversees day-to-day delivery of the programme.

**Figure 61: STP programme governance**

The Programme Board draws its membership from across the STP footprint, including the two Senior Responsible Owners (see below), Medical Directors from both an acute and CCG setting, the three Directors of Adult Social Care, the Chief Executive of one of the three local HealthWatch organisations, a primary care representative, a community services and mental health representative and the Vice Chancellor of the University.

The Programme Board and the wider STP is supported by a small core team consisting of a Programme Director, Senior Communications advisor, Senior Programme Manager and administrative support.

The principal work streams of the STP are divided into “In Hospital” and “Local Health and Care”. Each of these elements of the Programme has a Senior Responsible Owner (SRO) who is accountable for delivery, as set out in other chapters.

The STP has a range of groups that support delivery, including:

- Service User Advisory Group – local residents, patients and carers, who act as a sounding board for the programme overall, as well as considering specific proposals.
• Primary Care Leadership Forum – bringing together local leaders from primary care to advise on the programme build capacity, offer development support and advise on the STP.

• Finance Oversight Group – chaired by the SROs and providing a forum for key cross system financial planning issues to be discussed and decisions taken.

• Clinical Cabinet – jointly chaired by the Medical Directors of the In-Hospital and Local Health & Care portfolios this forum has been established to ensure strategic clinical input to the STP providing clinical scrutiny and constructive appraisal of proposed service changes.

In addition, to ensure that there is close working between the Programme and all three local Health and Wellbeing Boards. This includes a bi-monthly working meeting between the Chairs of all three Boards and the Chair of the Programme Board, supported by senior officers from the STP and the Councils.

13.2 Hospital Group Model

The three hospitals within the footprint have for some time been working together as part of the STP, under a 'group model'. This forms a key element of the STP and will be central to ensuring there will be sustainable services locally.

Following a period of informal collaboration and joint working, the three Trusts have now formalised arrangements at a range of levels, including:

• The creation of a single Joint Working Board that provides the overarching governance for the hospital group, sets the strategic direction and holds the executive to account

• The appointment of a single Chief Executive as Accountable Officer for all three trusts (who also acts as the SRO for the In Hospital element of the STP), together with the appointment of managing directors to each of the three sites

• The establishment of the single executive team to drive delivery across the group and the STP

As part of this arrangement, the hospitals have created a contractual joint venture which will allow for consistent and joined up decision making which therefore removes the risk of service reconfiguration options being stifled by an individual trust due to the impact this may have on them financially.

It is believed that the development of the group model will harnesses the benefits of collaboration, while averting the disruption associated with a formal merger at this time, with questions of end state organisation form being considered once pathway design and reconfiguration has been completed.
13.3 CCG Joint Committee

The Success Regime/STP Implementation Plan (published in March 2016) included clear recognition that the five CCGs within the footprint needed to work more closely together in order to support joint working and streamline decision making. One aspect of the plan was an agreement to create an appropriate governance forum that would enable the five CCGs to come together to take relevant decisions once on an STP footprint.

Following extensive discussions with all five Governing Bodies in 2016 and the consideration of a range of options, a decision was taken in April 2017 to form a Joint Committee of the five CCGs. This Joint Committee is empowered to take binding decisions on behalf of all five CCGs.

CCGs have delegated a limited range of functions to the Joint Committee, including:

- Decisions on STP wide service configurations
- Leadership of relevant public consultations on significant service changes that affect the whole STP area
- Agreement of STP wide service restriction policies

The Joint Committee also has delegated responsibility for commissioning of some services in behalf of the five CCGs, including:

- Acute services (NHS and independent sector)
- NHS 111/OOH
- PTS
- Ambulance services

The Joint Committee will provide a single forum for all STP wide strategic decision making and will enable to CCGs to work more effectively with the hospital group.

The Joint Committee held its first meeting in public from July 2017.

13.4 Mental Health Trusts

As part of the STP’s wider ambition to reduce complexity and fragmentation in the local commissioning and provision landscape, the two main Mental Health providers (North Essex Partnership University FT and South Essex Partnership University FT) formally merged on 1 April 2017.

13.5 Approach to risk management

Risk management is being approached at three main levels: the organisational level, the project level, and the programme level.

13.5.1 Organisational

Each organisation within the STP has its own risk-management process in place. These processes will inform or be incorporated into a wider Board Assurance Framework or similar, which involve the following:
• a publicly available risk register, showing scored risks, risk owners, mitigating actions and timescales

• detailed scrutiny by the Audit Committee (or equivalent)

• an independent review by Internal and External Audit.

13.5.2 Programme

At the programme level, the STP Programme Board receives a monthly report on the risks that score highest, the “owner” of each risk, the review mechanism, and the mitigating actions being taken. Risks are identified from information provided by the project leads, as well as from programme-wide sources, such as those relating to communications or strategy.

13.5.3 Project

As part of the Programme, each project deploys a range of standard project-management tools, and applies a consistent methodology for identifying and mitigating risks. Each project owner is accountable for providing regular progress reports, including a risk summary, to the relevant SRO—as well as to the STP Programme Office.
14. **Implementation plan**

### About this section

The section discusses the implementation of the Future Model of Care. It sets out the different phases of and the timeline for implementation, reviews the main building blocks required for successful implementation, and outlines the risk factors and their mitigation.

14.1 **Introduction and timelines**

The purpose of this section is to set out the proposed approach to implementation across mid and south Essex of the transformation and change activities as outlined within this business case. It considers:

- The scope and structure of the change activities outlined within the case, and the agreed implementation ‘layers’ at regional and local levels.

- The approach to implementation, focusing on the implementation methodology which has been established and the governance and assurance approach prior to, during and post change implementation.

- The high level anticipated timeframes and identified service co-dependencies at service and system level which will need to be managed during this process.

The section finally considers the principal building blocks to support successful implementation and the currently identified risks associated with implementation of change across mid and south Essex.
14.1.1 Scope and Structure

The proposals set out within this business case fall within three portfolios of work and 8 programmes, as detailed below:

**Acute services portfolio:**
- Corporate and clinical support programme.
- Clinical redesign and reconfiguration programme.
- Local hospital site based change and transformation programme(s).

**Local health and care portfolio:**
- Acute work streams
- Primary Care & Localities
- Community pathways programme.
- Local CCG based change and enabler programmes.

**Joint Enabler portfolio:**
- Workforce programme.
- Infrastructure (principally technology and estates) programme.

For clarity, within this section we describe implementation at a number of levels, as outlined below:

- **Portfolios** of change activities organised on a pan-organisational level.
- **Programmes** of related change projects organised within each portfolio.
- **Projects** through which change activities are developed and implemented.
- **Work streams** within projects to support the organisation of complex projects where there is a number of delivery strands required.

Alongside this project, programme and portfolio organisation it has been identified that individual projects will fit within a certain implementation ‘layer’, described below:

- **Some initiatives will be planned and implemented once** – ensuring a consistent best practice approach.

- **Some initiatives will be planned once, but delivered multiple times** – for example, ensuring the best possible implementation of best practice pathways within each CCG area.

- **Some initiatives will be planned and delivered multiples times** – for example, each locality determining how they will engage with their local community sector services.
14.1.2 Approach - methodology

The overarching multi-phase approach which has been adopted across mid and south Essex to support the development of this case is outlined within figure 62 below; this section principally focuses on steps 4, 5 and 6.

Figure 62: Multi-phase approach

Upon approval of this business case it will initiate a series of projects within each programme. It has been agreed that the detailed project definition, implementation and transition methodology will combine best practice standards with respect to project management with the addition of an established improvement methodology to support service design and implementation. This approach is outlined within figure 63 below.

Figure 63: Detailed project and improvement phases
Of critical importance within this methodology is the establishment of multiple stage gate reviews of projects which have been based upon the OGC Gateway Review methodology with gateway 3 being the key point prior to implementation to ensure that critical criteria are met prior to a ‘go-live’ decision being made, an illustrative list of potential criteria at system and service/pathway level is outlined within the table below:

<table>
<thead>
<tr>
<th>System criteria</th>
<th>Service/pathway criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency ambulance services:</td>
<td></td>
</tr>
<tr>
<td>- Training</td>
<td>Workforce:</td>
</tr>
<tr>
<td>- Capability and capacity</td>
<td>- Capability and capacity</td>
</tr>
<tr>
<td>Treat and Transfer arrangements</td>
<td>Service demand levels</td>
</tr>
<tr>
<td>Patient and public transport</td>
<td>- Within specified range(s)</td>
</tr>
<tr>
<td></td>
<td>Estates capacity and provision</td>
</tr>
<tr>
<td></td>
<td>National/regional/local buys in to proposed service model including supportive peer review of service proposal.</td>
</tr>
</tbody>
</table>

### 14.1.3 Approach – governance

The system, portfolio, programme and project governance arrangements will mirror that of the overarching structure as outlined earlier within this section with decisions over ‘go-live’ being made at varying levels dependent on the nature, risk, size and interdependencies of the project under consideration. These groups are as follows:

- STP Programme Board.
- Acute Portfolio Group.
- Local Health and Care Portfolio Group.
- Individual programme boards.
- Individual project boards.

To support this, a standard set of documentation and reporting tools are under development to ensure consistency across all projects as outlined within this case, and more broadly across the system.

The hospital group has integrated project management offices within a single change management office as well as improvement and change management teams to better manage progress monitoring, ensuring consistent standards in planning and implementation, to support resourcing decisions and identify and support interdependencies between change projects covered by the acute services portfolio. A similar approach is under consideration between CCGs to support the implementation of the Local Health and Care Portfolio.
14.1.4 High-level timelines (overarching plan)

As outlined previously within this document, the various portfolios of change are interdependent and rely on one another for successful implementation. The mechanisms by which these dependencies will be identified and governed have been outlined above. Figure 64 provides the current indicative timeframe between 2018/19 and 2020/21 (subject to the outcome of the public consultation) for the establishment of the key components of the preferred clinical configuration option and how service capacity would be managed over this period of time.

**Figure 64: Indicative implementation dates (indicated by ‘x’)**

<table>
<thead>
<tr>
<th>Specialty</th>
<th>2018/19</th>
<th>2019/20</th>
<th>2020/21</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vascular – Emergency</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vascular – Elective</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hyper-acute stroke care</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Trauma</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Respiratory</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Cardiology</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Urology – Emergency</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urology – Elective non-cancer</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Orthopedics – Elective</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Gynaecology</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Emergency Care Hub</td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>
**Figure 65: Local Health & Care indicative implementation dates**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>All localities at Level 2</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All localities at Level 3</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All localities at Level 4</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care workforce model agreed</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Demand Management**

<table>
<thead>
<tr>
<th></th>
<th>2017/18</th>
<th>2018/19</th>
<th>2019/20</th>
<th>2020/21</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-care programme agreed</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extension of social prescribing</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Integrated urgent care service (111/OOH)</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>A&amp;E streaming</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient transformation*</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Pathway Redesign**

<table>
<thead>
<tr>
<th></th>
<th>2017/18</th>
<th>2018/19</th>
<th>2019/20</th>
<th>2020/21</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frailty blueprint delivered</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identification and care planning in place for high risk patients</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>End of life blueprint delivered</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enhancements to EoL Care</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Whole system Respiratory pathway launched</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Whole system Diabetes pathway launched</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Whole system Cardiology pathway launched</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whole system Renal pathway launched</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health FYFV implementation</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* full E-referral service implementation, including full use of advice and guidance, exploration of digital solutions, move of some hospital services to locality hubs where possible.

14.2 Building blocks for successful implementation

14.2.1 2017/18 activities

In order to be able to support the activities as outlined within the business case it has been identified that there are a number of key activities which will need to be undertaken over the course of 2017/18 to support the preferred service configuration options as outlined elsewhere within this case.

**Acute services portfolio:**

- Corporate and clinical support programme.
  - Development of target operating models and supporting transformation project plans for corporate and clinical support services alongside the implementation of phase 1 consolidation activities across these services during 2017/18.
- Clinical redesign and reconfiguration programme.
- Implementation of standardised pathways to support emergency care demand management, focused on strengthening ambulatory emergency care across medical and surgical pathways, particularly focusing on activities to create the emergency care hub at each hospital site.

- Development of the target end state clinical service model at a detailed level to support reconfiguration planning and implementation.

- Commence process and service harmonisation activities for those services within the first wave of reconfiguration to reduce variation and standardise working practices at each site.

- Local hospital site based change and transformation programme(s).
  - Reconciliation and alignment of local change and transformation projects alongside the corporate and clinical support programme and clinical redesign and reconfiguration programme.

Local health and care portfolio:

- Acute Interface programmes:
  - Joint work with the acute group to ensure out-of-hospital services is able to support clinical redesign and reconfiguration.

- Locality development programme.
  - Implementation of education and support programmes to foster the ability of individuals to self-care, linking with primary care, voluntary sector and public health programmes.
  - Pan-STP implementation of patient risk stratification at primary care level, providing appropriate levels of support and care planning to patients classed as “high risk”, “rising risk” and “mostly healthy”, with the intention of supporting care coordination, care close to home, prevention of A&E attendances and non-elective admissions.

  - Development of localities, groups of practices working together across a population base of c30-50k, enabling economies of scale to deliver an extended range of services to patients across the STP footprint,

  - Building capacity in primary care, identifying the appropriate workforce model to meet a range of care needs.

- Community Pathways:
  - Implementation of a range of consistent long-term conditions pathways to support reductions in non-elective admissions, effective functioning of ambulatory care pathways and improved outcomes for patients.
• Local CCG based change and enabler programme.
  o Development of a Joint Committee of the CCGs to provide a single commissioning decision-making forum and alignment of CCG functions.
• Specification of patient transport and ambulance transport requirements arising from clinical redesign and reconfiguration.
• Implementation of an STP-wide common offer/service restriction policy to ensure equity of access to treatment for STP the 1.2m population of mid and south-Essex.

Enabler portfolio:
• Workforce programme.
  o Development of a workforce strategy and plan to meet the future target operating model, including role design and supply plans (described further within section 8).
• Infrastructure (principally technology and estates) programme.
  o The development of technology and estates plans in support of the proposed service changes, and completion of the Strategic Outline Case for the resources required for these changes.

Other considerations
Alongside the enabling activities outlined above, the importance of establishing robust and consistent change management processes and support will be vital to the success of the service transformation as outlined within this case. Therefore, during 2017/18 the following supporting changes will be made:

- The establishment of common governance arrangements across portfolios programmes and projects.

- The creation of a single change management team for acute services, including change management support alongside a single project management office and the associated standardised change management methodology development and deployment.
14.2.2 Modelling and planning

The following provides an overview of the modelling and planning considerations which are being undertaken in respect to implementation.

- **System demand and capacity model** which will be used to establish go-live criteria and to support the development of infrastructure and workforce plans.

- **Financial model** which will be used to establish affordability envelopes for future transformed services. It is intended throughout the time period covered by this case that the service change pipeline will be used to provide a further level of detail and assurance regarding the deliverability of the savings plans as set out in the financial bridge.

14.2.3 Success factors

A number of success factors underlie the successful implementation of the Future Model of Care.

- Public engagement, support for change and involvement in service design.

- Workforce engagement, support and enablement.

- Embedding innovation within future service models and the flexibility to adapt the future model of care to future demands.

- High quality and consistent change management support and assurance.

14.3 Implementation risks and mitigation

Robust risk management is a key element of the delivery of any change project or activity, the table below outlines some of the key strategic risks that have been identified with respect to the implementation of service change and the current mitigating actions that are in place to resolve these.

<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>Failure to implement change due to poor change management delivery.</td>
<td>4</td>
<td>3</td>
<td>AR</td>
<td>Establishment of best practice portfolio, programme and project delivery arrangements.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Roll out of training and support for people involved in designing and</td>
</tr>
</tbody>
</table>

Figure 66: Risks and mitigation
<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>Financial</td>
<td>Failure to deliver savings as identified within the financial bridge.</td>
<td>4</td>
<td>3</td>
<td>AR</td>
<td>Implementing service change.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Securing specialised support in those projects and programmes where a capability or capacity skill gap is identified.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Creating a single change management function to support change.</td>
</tr>
<tr>
<td></td>
<td>Unable to fund capital requirements of service change</td>
<td>4</td>
<td>3</td>
<td>AR</td>
<td>Establishment of service/pathway specific financial envelopes for future service models.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Development of further savings schemes for implementation over the life of the change activities.</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>Completion of the Strategic Outline Case.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Review opportunities to generate capital receipts across system to support capital developments.</td>
</tr>
<tr>
<td>Joint decision making</td>
<td>Failure to agree detailed service change proposals, or common cross</td>
<td>4</td>
<td>3</td>
<td>AR</td>
<td>Public consultations to be held regularly</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Public feedback to be considered in improving programme implementation</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Creation of joint committee of CCGs to support decision making.</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>Ongoing engagement</td>
</tr>
<tr>
<td>Risk Description</td>
<td>Impact</td>
<td>Likelihood</td>
<td>RAG</td>
<td>Mitigation</td>
<td></td>
</tr>
<tr>
<td>---------------------------------------------------------------------------------</td>
<td>--------</td>
<td>------------</td>
<td>-----</td>
<td>---------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>System pathways of care.</td>
<td>5</td>
<td>3</td>
<td>AR</td>
<td>Staff involvement in redesign proposals.</td>
<td></td>
</tr>
<tr>
<td>Lack of staff support for the Future Model of Care; reluctance to change</td>
<td></td>
<td></td>
<td></td>
<td>Involvement of relevant professional bodies in development and assurance of new models of care.</td>
<td></td>
</tr>
<tr>
<td>Inability or unwillingness of system partners to implement changes as required by the new models of care resulting in failure to secure benefits of service change.</td>
<td>4</td>
<td>3</td>
<td>AR</td>
<td>Involvement of system partners in redesign proposals.</td>
<td></td>
</tr>
</tbody>
</table>
This is a confidential document for discussion purposes and any application for disclosure under the Freedom of Information Act 2000 should be considered against the potential exemptions contained in s.22 (Information intended for future publication), s.36 (Prejudice to effective conduct of public affairs) and s.43 (Commercial Interests). Prior to any disclosure under the FOI the parties should discuss the potential impact of releasing such information as is requested.

The options set out in this document are for discussion purposes. The involved NHS bodies understand and will comply with their statutory obligations when seeking to make decisions that will have an impact on the provision of care services. The options set out do not represent a commitment to any particular course of action on the part of the organisations involved but instead act as a catalyst for continuing discussion.