For planning purposes only

NHS

Mid and South Essex Success Regime

A programme to sustain services and improve care

STP - Local Health and Care Annex

21 October 2016

About these materials

These materials provide further detail about the local health and care model

Specifically, they cover:

1. **Core model**

2. **Activity shifts**
   - Locality activity and savings targets

3. **Locality Deep Dives**
   - Locality context and plans – summary
   - Key gaps required to deliver the model of care
   - Investments to deliver the model of care

4. **Delivery**

Appendix
- Supporting material

Executive Summary (1/2)

The Local Health and Care model has two goals: (i) manage demand; (ii) build capacity

- Manage demand for healthcare across primary, community and acute settings
- Build capacity outside the hospital to support more complex care needs

The are four key elements of the model:

- Delivering a step change in Prevention, Early Intervention and Self Care
- Releasing General Practitioner capacity
- Organising care around natural communities ("localities")
- Developing integrated pathways for services that impact the acutes – esp. Frail and End of Life patients

Delivering this model will achieve £53M in net system savings by 2020-21 (vs momentum)[1]

- Primarily driven through a ~13% reduction in A&E attendances and 10% reduction in NEL vs momentum[2]
- Five key schemes to deliver the activity reductions include Frailty / EOL; LTC; Specialty Pathway Redesign; Urgent and Emergency Care; Common Offer[1]

Locality targets are being developed for the three locality-based initiatives (Frail/EOL; LTC; Specialist Pathway)

- Calculated in relation to CCG distance to peers and relative performance of locality vs peers
- E.g. NEL reductions: greatest reductions vs momentum in Corringham (-15%); lowest in Prosper (-5%)

Note: Locality target setting methodology currently being refined

1. Common Offer only refers to Common Offer initiatives impacting acute hospitals
2. Deep dives being undertaken on initiative activity assumptions – subject to further refinement ahead of final STP submission

Executive Summary (2/2)

The delivery of the model will differ across localities due to local circumstances, for example:

- **Rayleigh** building on strong foundation of primary care and established joint working with social care – seeking to move towards MCP-type model with locality-based MDTs
- **Tilbury** facing challenges in PC – focussing on vertical collaboration with Community Services / ASC rather than horizontal collaboration between GP practices. Model based around new integrated hub with practice-based MDTs focussing on LTCs

Future locality models estimated to require ~£35-45M in pump-prime funding; plus ~£20-£25M in capital

- Funding to cover four key areas: workforce; change management; IT enablers; estates
- Expectation that majority of investments will be self-funding within 12 months

Note: Investment figures to be finalised and subject to refinement

Proposed delivery includes phased approaches at three levels: Locality, Pathway and System-wide

1. **Locality** – accelerating more advanced localities to end-state; use 'pull-through' for subsequent waves
2. **Pathway** – start with 1 LTC and wave 1 of specialty pathways (that don't require consultation)
3. **System-wide** – e.g. common IT enablers (shared care record)

1

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

The challenge

Primary care is under pressure: rising workload...

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

...with significant workforce challenges

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

Urgent and emergency care pathway also under strain

- Rising demand for A&E services (previous two years growing above national average at c. 4%)
- Complex system with little coordination or PC capacity for emergency appointments

GP and 5YFV[4] encourage move towards a larger footprint with greater integration between practices...

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

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

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

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

Two objectives to address the challenge

1 Manage demand

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

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

2 Build capacity

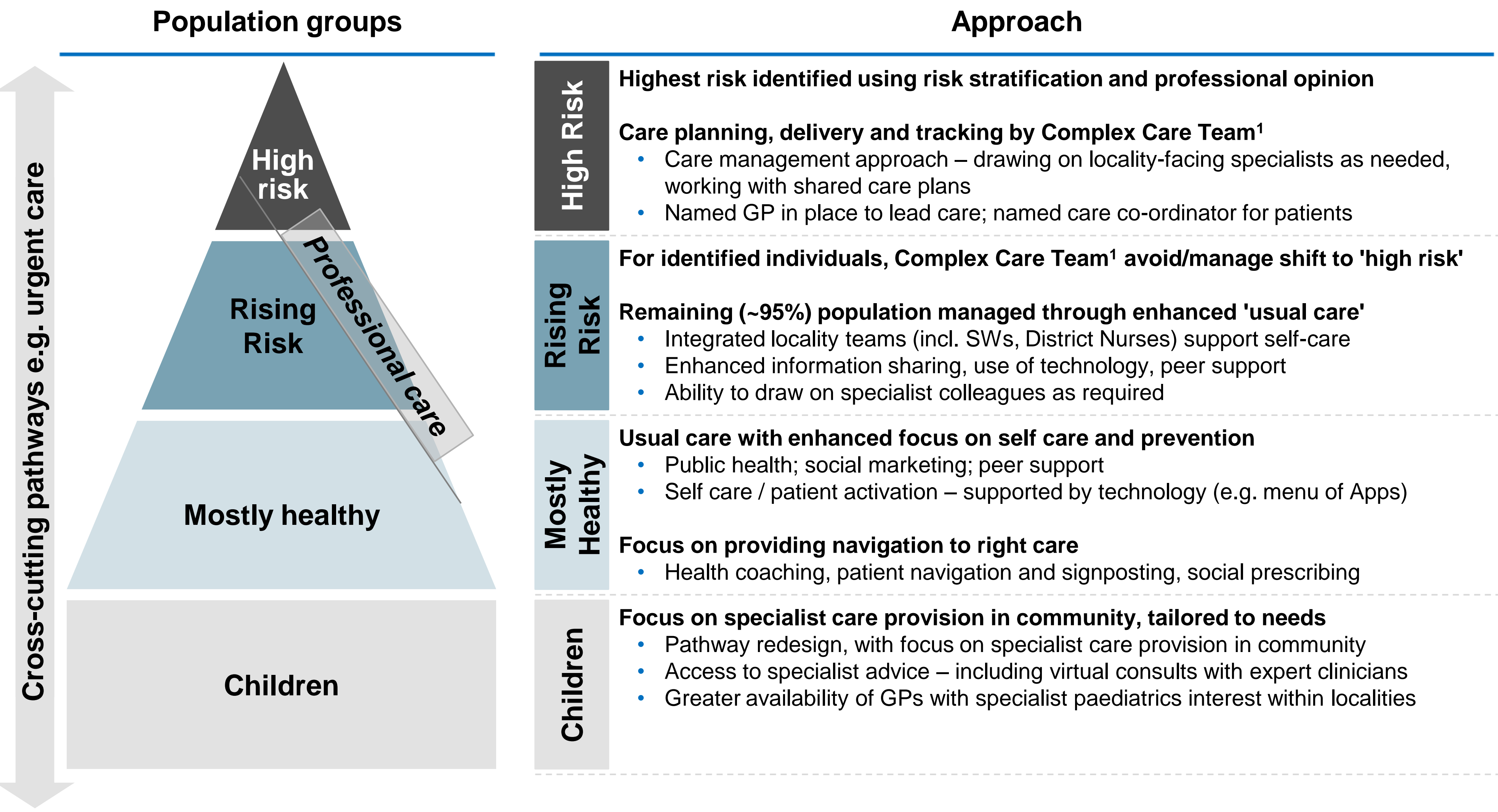
Build capacity outside the hospital to support more complex care needs, by:

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

1. Five Year Forward View (2015) and GP Forward View (2016) 2. Ambulatory care sensitive conditions 3. HEE, STP workforce intelligence (2016) 4. Five year forward view

1

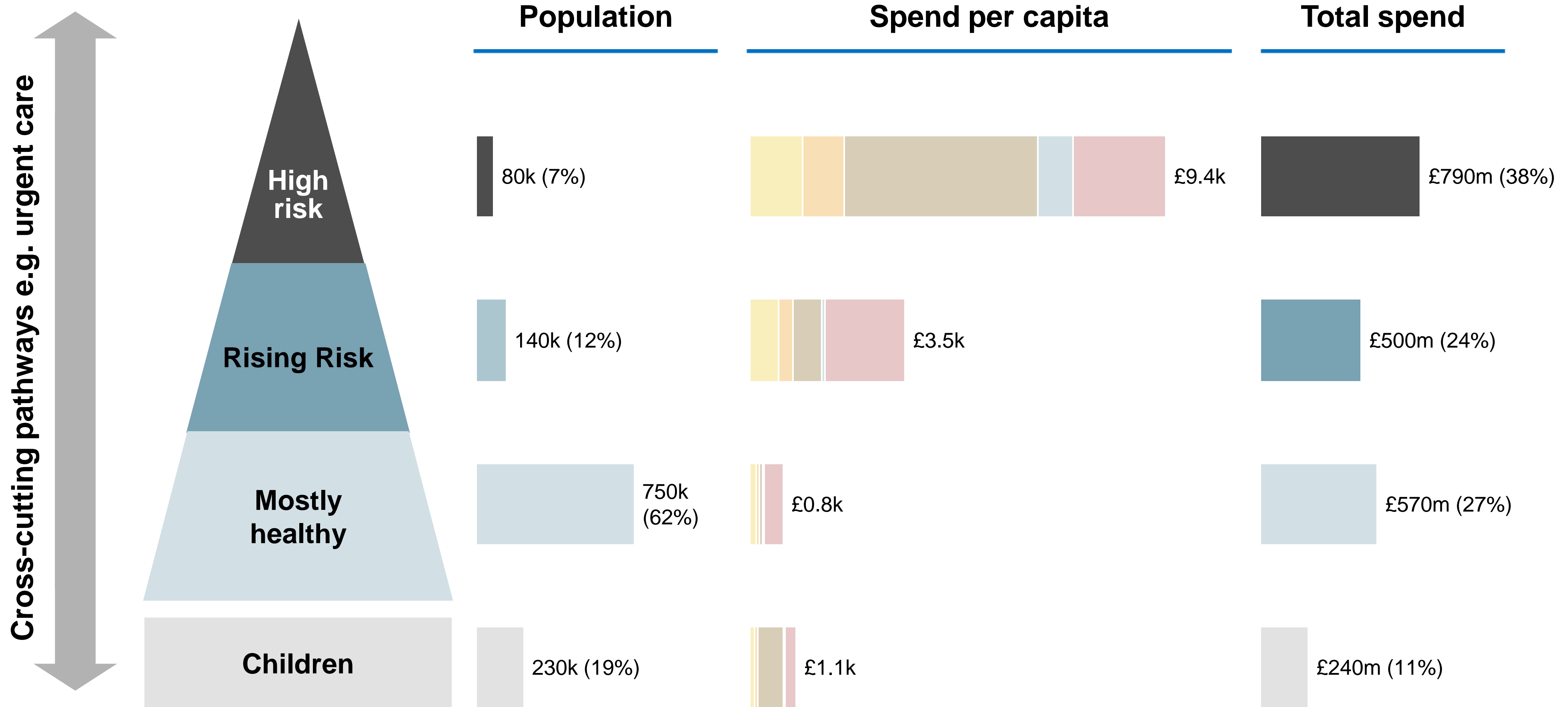
Approach to delivery in M&SE will be based around population segmented management



1. Or equivalent locality based multi-professional MDT delivering proactive caseload management 2. All changes based on 'do nothing' scenarios, all by 2020/21,

1

Population breakdown for Mid and South Essex



Primary: Primary care and prescribing
Social: Social care and public health
Community: Community health services and continuing care
Mental health: Mental health services
Acute: A&E, inpatient admissions, maternity admissions and outpatient appointments

Total spend[1] : £2.1B
Population: 1.2M
Spend/capita: £1.7k

1. Excludes CCG administration, other CCG expenditure and specialised commissioning spend Note. Numbers may not sum because of rounding. High risk includes mostly frail patients with LTCs and disability; Rising risk includes elderly patients with fewer morbidities and younger patients with a few morbidities; Mostly healthy includes adults with few morbidities
Source: Monitor spend estimating tool; MedeAnalytics; STP June 2016 submission; HSCIC GP Registered population for July 2016; BCG analysis.

1

Care will be adjusted according to need: illustrative example

A locality population of ~50,000 will have approximately:

- ~ 2,500 **high risk** with 'complex needs' – e.g. Frail, EOL, in Care Homes etc
- ~ 12,000 **rising risk** – e.g. poorly controlled LTC
- ~ 35,500 **mostly healthy**

High risk

2x cohorts of ~700
- Highest risk / least stable
- E.g. Frail / EOL

Identified using risk stratification and professional opinion

Care planning, co-ordination, delivery and tracking by Complex Care Team[1]
- Intensive care management approach – drawing on locality-facing specialists as needed

Dynamic approach – service users discharged to usual care

More stable high risk patients managed through usual care

Rising risk

1x cohort of ~800
- Unstable population with highest risk of entering 'complex' category

Care planning, co-ordination, delivery and tracking by Complex Care Team[1]

Remaining (~95%) population managed through usual care
- Best practice standard approach
- Integrated locality delivery teams (incl. SWs, District Nurses...)
- Supported by enhanced information sharing etc.

Ability to draw on Complex Care Team colleagues as required

Mostly healthy

Usual care with enhanced focus on self care and prevention
- Public health
- Self care
- Community empowerment
- Social marketing

Focus on providing navigation to right care
- Health coaching, patient navigation, community activation

Maximising independent living opportunities through self-management a key element also of high and rising risk

1. Or equivalent locality based multi-professional MDT delivering proactive caseload management

1

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

See section 3 for locality deep dives

Core elements of the locality vision

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

The delivery of care in a locality will reflect local population needs

Illustrative view of archetype features and impact on locality management

See section 3 for locality deep dives

		Urban affluent *16 localities*[1]	Urban deprived *8 localities*	Rural *2 localities*
Typical features	Ageing population	Median age of 40 Likely mixed young and old population in urban deprived areas (→)	Median age of 43 Likely mixed young and old population in urban deprived areas (→)	Median age of 48 Increased likelihood of older population in rural areas (↗)
	Level of deprivation	Typically wealthier urban areas (↘)	Typically poorer and more deprived urban areas (↗)	Mixed population with mixed levels of affluence (→)
	Access to services	Easy access to healthcare for patients; most being close GP to practices (↗)	Easy access to healthcare for patients; most being close to GP practices (↗)	GP practices located far from many patients homes (↘)
Approach for archetype within each pop. segment	High Risk	• Enhanced care home support • Centralised clinical triage	• Upskilled primary care professionals to provide frailty services	• More frailty services • MH: Dementia care
	Rising Risk	• Upskilled primary care professionals to support LTC management	• More mental health professionals • Social prescribing to support rising risk cohort	• Potential for virtual consultations to support rising risk cohort
	Mostly healthy	• Local menu of Apps/IT to support self-care • Care navigators to assist access to 3rd sector support	• Public engagement to promote self-management/culture change	
	Children (0-15 yrs old)			

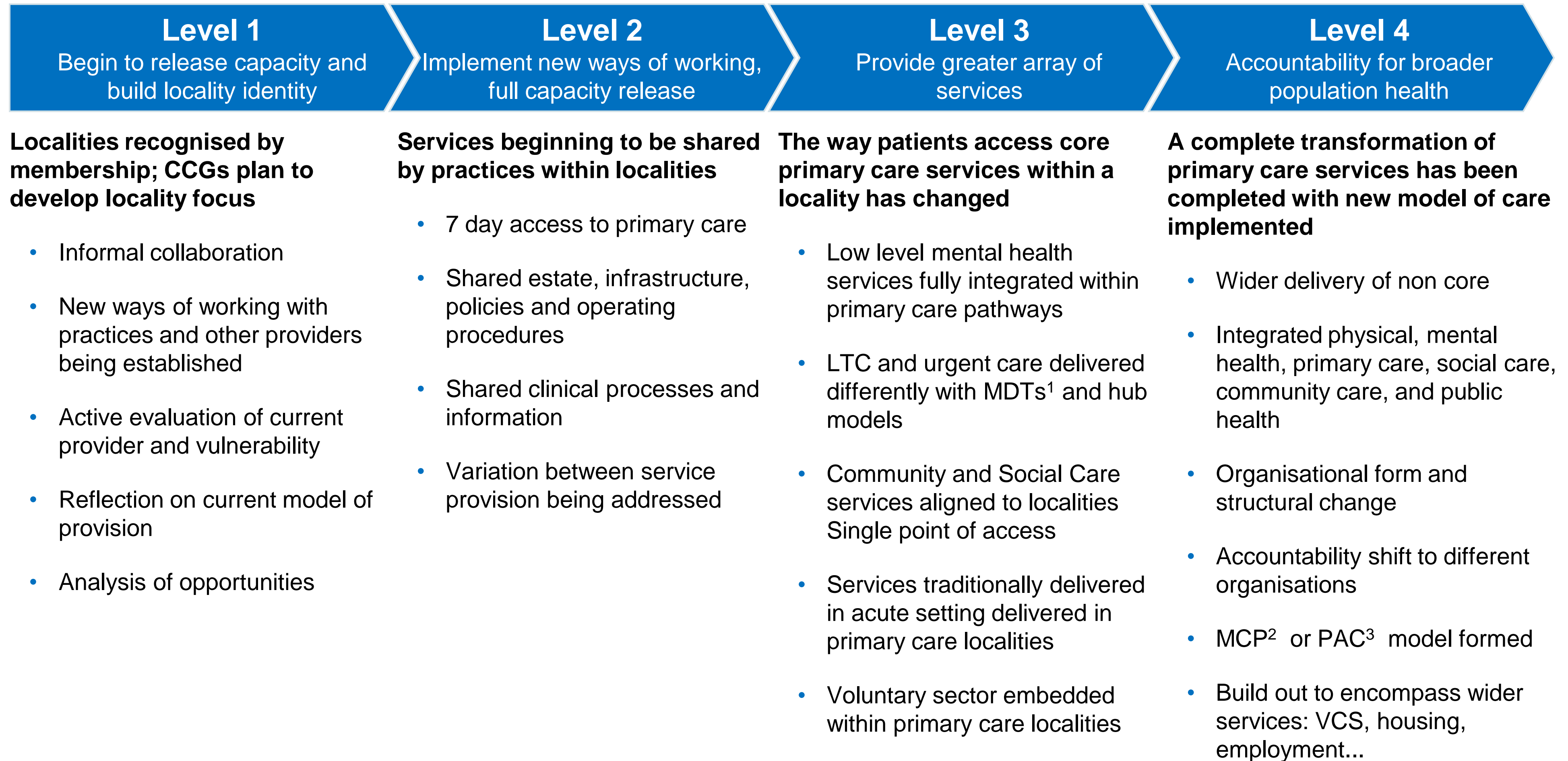
1. 'Affluent' localities are defined as being below the England average Index of Multiple Deprivation score (2015) of 22, deprived localities are above 22

Source: HSCIC GP registered population

1

Transformation of primary care to occur through 4 levels

See section 3 for locality deep dives



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

2

Delivering the model will result in a reduction in acute A&E and IP activity, and shifts of OP from acute to community settings

Preliminary – to be refined

	Acute				OPs
Metric	**A&E**	**Elective IP**	**Elective DC**	**Non-elec IP**	**Elective OP**
Unit	Att.	Adm.	Adm.	Adm.	App.
Assumed momentum growth rate per year	2.3%	3.3%	3.3%	2.3%	3.3%
Modeled Change (%) from 2015/16	-2.47%	13.60%	9.30%	1.14%	-1.44%
Modeled change (%) from momentum	-12.95%	-3.42%	-7.08%	-9.73%	-16.21%

Note: includes mix of absolute reductions and appointments that will need to be re-provisioned in the community

~£53.3M in system savings

2

Figures per 18th October

Five initiatives are central to delivering these activity reductions

Preliminary – to be refined

Local Health and Care SR initiatives are expected to contribute to up to £53.3m in system savings by 2020/21, with hospital reconfiguration and redesign as an important enabler

Initiative	Description	NET
Complex care	• Frailty and EOL: Proactively manage complex cohorts in integrated neighbourhood hubs; Initial focus on frailty (>75s) through identification & care planning, proactive care delivery, acute interface (FAU[1] and D2A[2]) , and coordinated EoL services and end of life (EoL[3]) pathway redesign to keep bed days flat • Long term conditions: Improve self-management and MDTs	£7.4m
Specialty pathway redesign	• Reduce outpatient FUs by moving to community and using technology	£23.8m
Common Offer in-hospital	• Reduce and restrict low value procedures in hospitals	£7.5m
System-wide transformation	• Savings from estates and commissioner efficiencies	£9.6m
Urgent care	• Improved triage in the Clinical Support Desk and on-scene to reduce the number of conveyances to A&E, with enhanced clinical capabilities in 111 and ambulance service	£5.0m
Total		**£53.3m**

Savings are expected to be realised by acutes via a reduction of outsourcing due to better capacity management and, in the longer term, capacity efficiency and rationalisation

Note: savings are net

2

Figures per 18th October

Local Health and Care: detailed impact on activity by 2020/21

Preliminary – to be refined

Segment	Metric	Acute: A&E	Acute: Elective IP	Acute: Elective DC	Acute: Non-elec IP	OPs: Elective OP
Frailty and EoL	*Change (%) from 2015/16*				4.39%	
	Change (%) from momentum				-6.83%	
Long-term conditions	*Change (%) from 2015/16*				8.8%	11.9%
	Change (%) from momentum				-2.9%	-4.86%
Specialty pathway redesign	*Change (%) from 2015/16*		13.6%	8.2%		4.29%
	Change (%) from momentum		-3.4%	-3.4%		-11.34%
Urgent care	*Change (%) from 2015/16*	-2.47%				
	Change (%) from momentum	-12.95%				
Common offer	*Change (%) from 2015/16*			4.1%		
	Change (%) from momentum			-7.1%		
Total	***Momentum change (%) from 2015/16***	**12.0%**	**17.6%**	**17.6%**	**12.0%**	**17.6%**
	Total (%) change from 2015/16	**-2.47%**	**13.6%**	**9.3%**	**1.14%**	**-1.44%**

1. Activity per year, except prescribing spend which is £m per year.2. Some activities extrapolated from 2014/15 data.3. Includes common offer savings for outpatient appointments.4. Includes common offer and complex care demand mgmt. savings for prescribing. 5. Includes complex care demand mgmt. savings for CHC
Source: HES, HSCIC, EEAST MDS, NHSE Statistics, local clinician interviews

2

System wide targets for three initiatives will be broken down to a locality level

Preliminary – to be refined

	1 Frailty and EOL	2 Long term conditions	3 Specialist pathway redesign	Total
Initial assumptions	**Frailty:** Reduce 75-85 age band NEL admissions by 11% **Care homes:** Reduce 75-85 age band NEL admissions by 2%. Reduce prescribing spend by 15% **Die Well:** Reduce 85+ age band admissions by 40%. Reduce prescribing spend by 15% **Discharge:** Cheaper provision of CHC in community	**LTC – NELs:** Reduce NEL admissions for 45 – 75 age band by 13% **LTC – OPs:** Reduce first OP interaction by 5%, Move 40% of patients to digital solution in selected specialities	**Pain:** Create community cognitive-pain services and consolidate acute pain services **Infusions:** move infusion clinics out of acutes **Neuro-rehab:** move to lower cost settings **Other OPs:** Shift to digital solutions in OPs **Self-Care:** Use virtual tools and patient mobilisation to reduce ELs *workstream in early stages*	
Gross savings	**£26.3M**	**£20.0M**	**£65.4M**	**£111.7M**
Invest	**£14.5M**	**£10.8M**	**£21.6M**	**£46.9M**
Acute stranded cost	**£6.9M**	**£6.8M**	**£20.5M**	**£34.5M**
Net savings	**£4.9M**	**£2.4M**	**£23.8M**	**£31.1M**
Activity shift (2020/21)	**8K NEL admissions fewer**	**3.4K NEL admissions fewer** **129K OP appointments fewer**	**296K OP appointments fewer**	

1. Assumes that 70% of OP FUs in this age group are for LTCs; assumes that 70% of all OP attendances are FUs
Note: Investment and net savings are to be refined on a locality level; Numbers may not sum because of rounding
Source: MedeAnalytics, Complex savings methodology deck (Jun 2016), SR initiatives model (v9); SR assumptions

2

Locality targets for Frailty and Long Term Conditions: NELs

Preliminary – targets to be confirmed

CCG		Locality	Pop	NELs 2015/16	NELs 2020/21E	NELs target 2020/21	Reduction in NELs vs. 2015/16	Reduction in NELS vs. 2020/21E	Gross savings 2020/21 (£)
Mid Essex	1	Braintree	60K	5.7K	6.3K	5.9K	-260 (-5%)	355 (6%)	£1.0M
	2	Witham	30K	2.7K	3.0K	2.6K	85 (3%)	382 (13%)	£1.1M
	3	Chelmsford 1	47K	3.8K	4.2K	3.9K	-78 (-2%)	330 (8%)	£1.0M
	4	Chelmsford 2	51K	4.3K	4.7K	4.3K	-92 (-2%)	325 (7%)	£0.9M
	5	Colne Valley	46K	3.8K	4.3K	4.0K	-124 (-3%)	291 (7%)	£0.8M
	6	Dengie	23K	1.8K	2.1K	1.8K	48 (3%)	259 (13%)	£0.7M
	7	Prosper	70K	5.4K	6.0K	5.8K	-319 (-6%)	286 (5%)	£0.8M
	8	Maldon	33K	2.7K	3.0K	2.7K	-10 (0%)	292 (10%)	£0.9M
	9	Woodham	22K	1.5K	1.7K	1.5K	33 (2%)	193 (11%)	£0.5M
B&B	10	Billericay	40K	2.6K	2.9K	2.5K	55 (2%)	389 (13%)	£1.1M
	11	Brentwood	78K	5.9K	6.7K	6.2K	-259 (-4%)	490 (7%)	£1.5M
	12	East Basildon	61K	5.4K	6.0K	5.3K	140 (3%)	688 (12%)	£2.0M
	13	Wickford	38K	2.9K	3.3K	2.8K	82 (3%)	433 (13%)	£1.3M
	14	West Basildon	59K	4.7K	5.2K	4.7K	40 (1%)	515 (10%)	£1.5M
TH	15	Grays	72K	4.5K	4.9K	4.5K	25 (1%)	458 (9%)	£1.3M
	16	Ockendon	37K	2.6K	2.8K	2.4K	117 (5%)	355 (13%)	£0.9M
	17	Tilbury	37K	2.8K	3.0K	2.6K	121 (4%)	389 (13%)	£1.0M
	18	Corringham	26K	1.9K	2.1K	1.8K	110 (6%)	315 (15%)	£0.8M
CP&R	19	Rochford	51K	4.8K	5.3K	4.7K	92 (2%)	653 (12%)	£1.9M
	20	Rayleigh	43K	3.6K	4.0K	3.5K	96 (3%)	555 (14%)	£1.6M
	21	B&H	49K	4.5K	5.2K	4.4K	117 (3%)	734 (14%)	£2.2M
	22	Canvey Island	42K	4.1K	4.6K	4.0K	126 (3%)	600 (13%)	£1.7M
SE	23	Southend E	36K	3.5K	3.9K	3.4K	138 (4%)	530 (14%)	£1.5M
	24	Southend EC	58K	6.1K	6.7K	6.2K	-63 (-1%)	569 (8%)	£1.6M
	25	Southend W	56K	5.7K	6.4K	5.9K	-221 (-4%)	507 (8%)	£1.5M
	26	Southend WC	35K	3.5K	4.0K	3.5K	31 (1%)	509 (13%)	£1.5M
		Total	**1.2M**	**101K**	**112K**	**101K**	**31 (0%)**	**11K (10%)**	**£33M**

Gross savings includes forecast cost reductions from reduced prescribing spend and cheaper CHC provision in the community

Note: Total SR activity target allocated to CCGs based on their distance to peer average. CCG target is then allocated to localities based on their performance relative to other localities within CCG
Activity growth rates for 'Well' categories from financial bridge assumptions deck. Note numbers may not sum because of rounding
Source: MedeAnalytics, Q4FY2014/15 to Q3FY2015/16, HSCIC GP pop Jul 16, Rightcare peers, Oct 2016

2

Locality targets for LTCs and Specialist Pathway: OPs

Preliminary – targets to be confirmed

CCG		Locality	Pop	OPs 2015/16	OPs 2020/21E	OPs target 2020/21	Reduction in OPs vs. 2015/16	Reduction in OPs vs. 2020/21E	Gross savings 2020/21 (£)
Mid Essex	1	Braintree	60K	125K	147K	124K	1k (1%)	23k (16%)	£4.3M
Mid Essex	2	Witham	30K	56K	66K	54K	2k (3%)	11.5k (18%)	£2.1M
Mid Essex	3	Chelmsford 1	47K	87K	102K	85K	1k (2%)	16.7k (16%)	£3.1M
Mid Essex	4	Chelmsford 2	51K	94K	110K	92K	1k (1%)	17.8k (16%)	£3.3M
Mid Essex	5	Colne Valley	46K	90K	106K	88K	1k (2%)	17.3k (16%)	£3.2M
Mid Essex	6	Dengie	23K	45K	53K	44K	2k (4%)	9.6k (18%)	£1.8M
Mid Essex	7	Prosper	70K	126K	149K	126K	1k (1%)	23.1k (16%)	£4.3M
Mid Essex	8	Maldon	33K	63K	74K	62K	2k (3%)	12.9k (17%)	£2.4M
Mid Essex	9	Woodham	22K	38K	45K	37K	1k (4%)	8.1k (18%)	£1.5M
B&B	10	Billericay	40K	68K	80K	65K	2k (4%)	14.3k (18%)	£2.7M
B&B	11	Brentwood	78K	150K	176K	146K	3k (2%)	29.7k (17%)	£5.5M
B&B	12	East Basildon	61K	103K	121K	100K	3k (3%)	21.4k (18%)	£4.M
B&B	13	Wickford	38K	69K	81K	66K	2k (4%)	14.6k (18%)	£2.7M
B&B	14	West Basildon	59K	96K	113K	93K	3k (3%)	20.2k (18%)	£3.8M
TH	15	Grays	72K	109K	128K	107K	2k (2%)	21.5k (17%)	£4.M
TH	16	Ockendon	37K	61K	71K	58K	2k (4%)	12.8k (18%)	£2.4M
TH	17	Tilbury	37K	62K	73K	59K	2k (4%)	13.1k (18%)	£2.4M
TH	18	Corringham	26K	43K	51K	42K	2k (4%)	9.2k (18%)	£1.7M
CP&R	19	Rochford	51K	94K	110K	90K	3k (4%)	19.9k (18%)	£3.7M
CP&R	20	Rayleigh	43K	69K	81K	67K	2k (4%)	14.6k (18%)	£2.7M
CP&R	21	B&H	49K	89K	104K	86K	3k (4%)	18.8k (18%)	£3.5M
CP&R	22	Canvey Island	42K	79K	92K	76K	3k (4%)	16.6k (18%)	£3.1M
SE	23	Southend E	36K	65K	76K	65K	0k (0%)	11.8k (15%)	£2.2M
SE	24	Southend EC	58K	105K	124K	105K	0k (0%)	18.3k (15%)	£3.4M
SE	25	Southend W	56K	104K	122K	104K	0k (0%)	18.1k (15%)	£3.4M
SE	26	Southend WC	35K	55K	65K	55K	0k (0%)	10k (15%)	£1.9M
		Total	**1.2M**	**2.1M**	**2.5M**	**2.1M**	**47k (2%)**	**425K (17%)**	**£79M**

Gross savings includes forecast cost reductions from reduced prescribing spend, virtualisation, increased self-care and cheaper provision of services in community

Significant reinvestment required to deliver these savings

Note: Total SR activity target allocated to CCGs based on their distance to peer average. CCG target is then allocated to localities based on their performance relative to other localities within CCG
Activity growth rates of 3.3% assumed as per NHSE guidance. Note numbers may not sum because of rounding
Source: MedeAnalytics, Q4FY2014/15 to Q3FY2015/16, HSCIC GP pop Jul 16, Rightcare peers, Oct 2016

3

Locality deep dives: reflecting their different starting points, priorities for each locality will differ

Emerging draft

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

1. Southend East Central locality

3

Progress in developing locality models

Preliminary view – to be refined

		Rayleigh *Urban Affluent*	Brentwood *Urban Affluent*	Southend EC *Urban Deprived*	Tilbury *Urban Deprived*	Dengie *Rural*
Enablers	Workforce capacity (Patients per GP)	2	3	3	1	1
	GP Practice collaboration	2	3	2	2	1
	Joint working with SC/CH	3	2	2	3	1
	Shared information and intelligence	3	3	3	*TBC*	2
	Risk-strat. management	4	3	3	2	2
Outcomes	Frailty (High Risk)	*Level 3*	*Level 2*	*Level 2*	*Level 2*	*Level 1*
	LTCs (Rising Risk)	*Level 1*	*Level 1*	*Level 1*	*Level 1*	*Level 1*
	Rest of Population (Low Risk)	*Level 1*	*Level 1*	*Level 1*	*Level 1*	*Level 1*

More advanced 4 3 2 1 Less advanced

Source: BCG preliminary assessment based on locality visits and desk research

3

Back up: scoring criteria I/II

Enablers	1	2	3	4
Workforce capacity (Patients per GP)	>3000	2600 - 3000	2100 - 2600	<2100
GP Practice collaboration	No professional collaboration	Co-operative, interest in collaboration	Regular locality meetings	Joint working
Joint working with SC/MH	Irregular, collaboration, low trust	Limited collaboration e.g. occasional MDTs	Regular, functioning MDTs	Locality teams, named practice SW
Shared information and intelligence	None	Full integration to NHS111	All on interoperable system	Sharing information with community care
Risk-strat. management	None	Risk stratification tool available	Practice based MDTs	Locality based MDTs driven by risk strat. tool

For level descriptions please see page 8

3

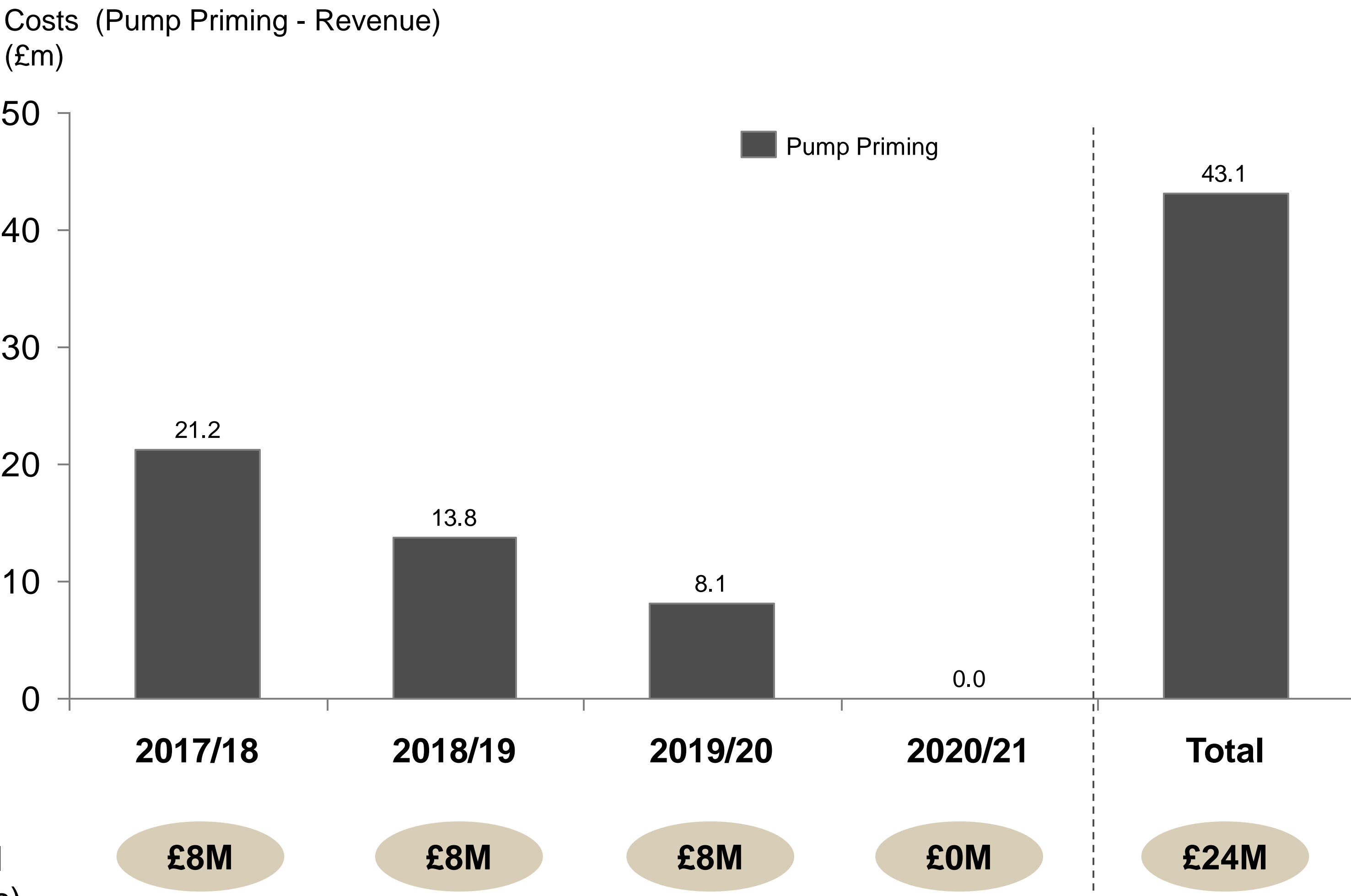
Delivering locality working: key gaps to realise

Investment	Scale	Illustrative Example
Workforce • Frontline capacity • Frontline training • Back-office	Locality (although consolidation of 'need' at SR level to engage with HEE and others)	• **Health and care professionals t**o support GP capacity release (e.g. AHPs, Social Care, MH, third sector etc) • Training of **independent prescribing** nurses, physios, optometrists • Delivery of **new services** to address frail / LTC (e.g. rapid response, SPA) • Training health professionals to undertake initial social care assessments, LTC management etc. • Development of **data-analytics** capability within a locality
Change capacity and skills • Leadership development • Change management	Common approaches across SR Delivery tailored to locality	• Potential roll-out of **leadership development** programme currently delivered to health and social care leaders in Southend • Project and **change management r**esource to drive change within a locality
IT enablers for capacity release • Triage / risk stratification • Apps • Virtualisation • Data sharing	Potentially common SR systems – with locality tailoring	• **Telephone / on-line triage** systems to support channel shift of patients from GPs to other appropriate professionals (E.g. College Health – Thurrock) • **Digital signposting** mechanism to direct patients to most appropriate Apps / digital resources • **Virtualisation** – e.g. consultations, health advice etc. • **Shared care records**
Capital investment • To support enhancement of estate	Locality-specific	• Development of **locality hub facilities**

3

Investments to deliver local health and care model centred around change management, capital, technology and workforce

Preliminary view – to be refined



Note: Not all costs require new funds; Change management includes project management and leadership development; technology enablers such as IT infrastructure, virtualisation, apps and self-care technology, workforce includes costs of additional AHPs, up-skill training, back-office support staff and targeted new services e.g., care home support
Source: BCG analysis, preliminary view 1 Includes £1m 'mix' for years 1 and 2

3

Pump priming required to deliver Local Health and Care model

Preliminary view of forthcoming PCBC investment case – to be refined

Highly provisional – subject to refinement

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

Note: Recurrent costs are expected to become self-funding

1. Represents costs which are expected to become self-funding from released costs e.g., through fewer NELs 2. Represents costs each less than £1m p.a.

3

Summary of workforce implications of investments

Initial view – subject to further refinement

Highly provisional – subject to refinement

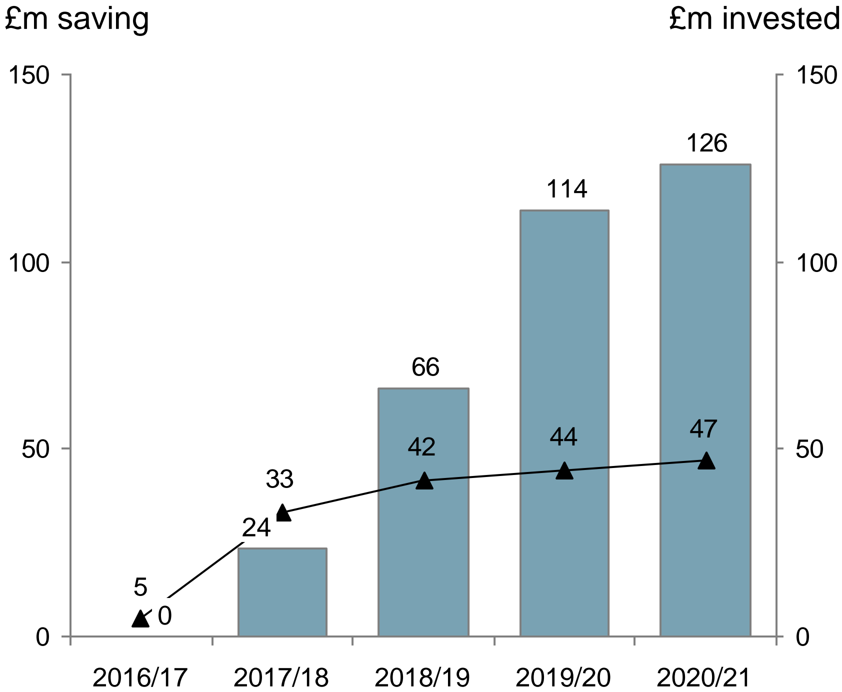
	Description	2020/21 Additional FTE	2020/21 Up-skilled workforce	Investment 2017/18 (£m)	Investment 2018/19 (£m)	Investment 2019/20 (£m)	Investment 2020/21 (£m)
Pump priming[1]	Workforce changes to support GP capacity release	+40 Nurses/HCAs[1] +40 Therapists[1] +26 MH therapists[1]	• Non-medical prescriber training for nurses and AHPs • Training for nurses to deliver enhanced role e.g., in LTC	6.2	3.6		
	Up-skilling Primary Care		• Train ~52 GPwSI[3] based on need in locality	2.6	1.0	0.5	
	Targeted new services	+12 Nurses/HCAs[1] +12 Therapists[1] +8 Care co-ordinators[1]	• +8 GP MDT leads[4], enabled by capacity release • Training to support technology adoption to facilitate new service delivery	2.4	2.4		
	Social prescribing pilots		• Train ~180 care navigators[5] from existing workforce	0.4			
	Locality back-office support	+13 Support/admin[2]		0.3	0.3		
	Change Management	+~26 Project managers[3]		1.0	1.0		
	Training to up-skill existing workforce		• +26 non-medical prescribers	1.0			
	Total	**~180 FTE**	**Phased over 3 years**	**£14M**	**£8M**	**£0.5M**	

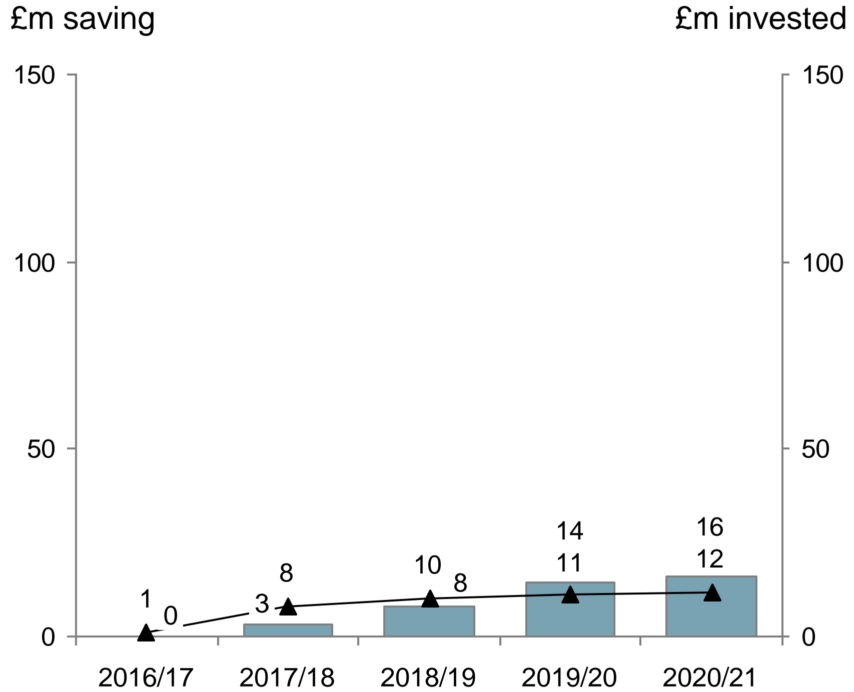
1. Assumes initial cost of £50K per FTE 2. Assumes initial cost of ~£20K per FTE 3. Assumes initial cost of ~£80K per FTE 4. Assumes cost of ~£60K per lead 5. Assumes cost of ~£2K per navigator

4

Phasing of funding: full investment required to deliver full forecast benefits by 2020/21

Highly preliminary projection





Investment
Forecast saving

Source: Financial analysis based on SR investment model

Initial view on phasing

Proposed approach is to plan delivery in three ways:

(i) Locality: accelerate implementation within more mature localities to get to end state; use a 'pull-through' approach to support acceleration of subsequent waves of localities (e.g. second key people from other localities in to accelerators to upskill others)

(ii) Pathway: design and implement single pathways across the system; starting with a single LTC (COPD) and first wave of specialty pathways. Following waves delivered through a programme of system-wide pathway redesign

(iii) System-wide: implement system enablers to free up capacity and support change (e.g. delivery of system-wide enabler initiatives such as shared care record)

Locality implementation: phasing

Draft – subject to refinement

Timeline: 2016/17, 2017/18, 2018/19, 2019/20, 2020/21 (Q1 Q2 Q3 Q4 each year)

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

▲ - Investment required

How we will deliver the local health and care model

The local health and care model is to be implemented by each CCG individually, and tailored to local needs and conditions based on the core Success Regime model

- CCGs will receive individual local health and care activity and financial targets aligned with their operational plans
- The Success Regime team will play a policy and coordination role amongst the CCGs

The Success Regime team will function as the interface between CCGs and the Acute Trusts

- Elements requiring a standard approach that interact with hospitals will be managed centrally

Appendix: Supporting Materials

Backup: Primary care audit – alternative channels

	Alternative channel	Description
1	Alternative professional	Patients who could alternatively have seen another professional (e.g. nurses, health care assistants, physiotherapists, pharmacists, counsellors...)
2	Virtual consultations	Patients who could have been seen via telephone or live stream ('Skype' style) with a clinician based elsewhere
3	Virtual other	Patients who could have had their issue resolved through other virtual services such as text chat with a clinician
4	Non-health related	Patients whose primary need is to serve requirements of other organisations (e.g. DWP, schools, work sick notes etc)
5	Acute hospital generated	Patients whose attendance is hospital driven – e.g. recommended consultant prescriptions; re-referral for a missed outpatient appointment
6	Self-care	Patients who have minor ailments that could be self-diagnosed or self-managed e.g. via a pharmacy
7	Social prescribing	Patients who have social-welfare needs that could be managed through signposting to community providers
8	Care home support:	Care home residents whose GP appointment could have been avoided through proactive management e.g., through the use of care home nurse practitioners to manage their needs in the home