Reconfiguration of hospital services

A programme to sustain services and improve care

Local Health & Care

7 November 2017

About these materials

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

Specifically, they cover:

Vision

Locality Working

Managing demand

Releasing capacity

Investment & Impacts

Supporting Materials

Executive Summary (1/3)

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 in line with the GP Forward View.

The are three key objectives :

- Deliver an extensive **Self-Care** programme and focus on **Prevention** and **Early Intervention**
- Deliver a comprehensive **service redesign** programme to support the appropriate shift of activity and funding from secondary care to alternative settings
- Focus on **integrated specialist pathways of care** - initially focussing on **Frail** and **End of Life** patients and those living with **long term conditions**

In order to deliver this, we have four key enablers:

- **Locality working** – improving capacity and efficiency in primary care, including the delivery of locality based commissioning and contracting proposals
- **Workforce** - Developing a comprehensive primary and community workforce programme
- **IT/Digitalisation** – exploring the benefits of IT/digital channels to reduce need for face to face appointments
- **Estates** – using our estates effectively to deliver the changes across the system

Delivering this model will help to enable £126M in net system savings by 2021-22 (vs momentum)[1]

- Primarily driven through a reduction in activity of between 14% and 18% in all areas vs momentum[2]
- Five key schemes to deliver the activity reductions include Frailty, EOL, LTC pathway redesign, Urgent and Emergency Care and Common Offer[1]

1. Common Offer only refers to Common Offer initiatives impacting acute hospitals
2. Deep dives being undertaken on initiative activity assumptions

Executive Summary (2/3)

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 ~£8M in pump-prime funding; plus ~£77M in capital

- Funding to cover four key areas: Locality development; Workforce; IT/Digital enablers; Estates
- Expectation that majority of investments will be self-funding within 12 months

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

1. **Locality** – accelerating more advanced localities to end-state (level 4); use 'pull-through' for subsequent waves, releasing time to care.
2. **Pathway redesign** – Working through frailty, end of life pathways, as well as redesigning a number of long-term condition pathways
3. **System-wide** – eg. common IT/Digital enablers (shared care record), system wide Estates wide programme

Executive Summary (3/3)

Impact:

Combined, the above objectives will contribute towards the financial and activity bridge that predicts largely static growth over the period 2016/17-2021-22:

	Do Nothing			Implement Solutions		
	2016/17 Activity	2021/22 activity	Growth %	2021/22 Activity	Net Impact (Activity)	Growth (%)
Outpatient *	1,212,439	1,510,168	24.6%	979,654	- 232,785	-19.2%
Elective	141,643	173,511	22.5%	142,265	622	0.4%
Non-elective	109,066	126,608	16.1%	108,886	- 180	-0.2%
A&E Attendances	371,681	479,945	29.1%	407,368	35,687	9.6%

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

Vision

What local health and care transformation will mean for patients

- **Alternative means to access primary care information**
- **Wider range of professionals providing advice and care to patients**
- **Longer consultations for those patients who need it**
- **Greater range of services delivered at a local level**
- **Best practice case management of patients that require multi-professional input**
- **More resilient, educated communities equipped to manage their own health**

Consistent high quality delivery of health and care no matter where you live in Mid and South Essex

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

Core elements of the locality vision

1	**General practice will form the heart of the locality**	• General practice will act as a key hub, providing a new offer for patients to access the care and support they need • To enable this, resources will be invested to grow capacity in the community, enabling some services to 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, physiotherapists, community and mental health nurses, occupational therapists, pharmacists and the voluntary sector • Care will be delivered by multidisciplinary teams (MDTs) who will plan care, help patients to self-manage and support prevention. These MDTs will focus on those with the most complex needs • Social care will be integrated e.g., by locating a social care professionals within GP practices or hubs • Integrated pathways across the whole system will 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 • A proportion of outpatient hospital consultations will shift to localities, delivering care to patients in a more convenient and suitable setting
4	**Wider healthcare workforce will be developed**	• We will enhance the GP workforce, through recruitment as well as returner and retention programmes. • We are developing a different workforce mix will be in place –new roles will be introduced, the 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**	• Patients will be empowered to use local resources to help them self-care and take responsibility for prevention eg. through developing and promoting patient community networks, use of technology, etc. • While localities will provide a common offer to all patients, individual localities may have a different emphasis, reflecting the needs of that area eg. a locality with a large number of care homes will provide enhanced support for frail and elderly patients, such as targeted care home support

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. 6%)
- Complex system with little coordination or primary care capacity for emergency appointments

GP and 5YFV[1] encourage move towards a larger footprint with greater integration between practices...

- Fragmented care: ~181 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 support independent and 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 and those with long-term conditions 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**.
- Optimising **mental health,** new pathways

2 **Build capacity**

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

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

Locality Working

Building Capacity Through Locality Working: Transformation care to occur through 4 levels

In order to track delivery, we have defined 4 levels of transformation, describing collaboration and joint working. The levels are not mutually exclusive

Level 1	Level 2	Level 3	Level 4
Begin to release capacity and build locality identity	Implement new ways of working, full capacity release	Provide greater array of services	Accountability for broader population health
Localities recognised by membership; CCGs plan to develop locality focus	**Services beginning to be shared by practices within localities**	**The way patients access core primary care services within a locality has changed**	**A complete transformation of primary care services has been completed with new model of care implemented**
• Informal collaboration • New ways of working with practices and other providers being established • Active evaluation of current provider and vulnerability • Reflection on current model of provision • Analysis of opportunities	• 7 day access to primary care • Shared estate, infrastructure, policies and operating procedures • Shared clinical processes and information • Variation between service provision being addressed	• Low level mental health services fully integrated within primary care pathways • LTC and urgent care delivered differently with MDTs[1] and hub models • Community and Social Care services aligned to localities Single point of access • Services traditionally delivered in acute setting delivered in primary care localities • Voluntary sector embedded within primary care localities	• Wider delivery of non core • Integrated physical, mental health, primary care, social care, community care, and public health • Organisational form and structural change • Accountability shift to different organisations • MCP[2] or PAC[3] model formed • Build out to encompass wider services: VCS, housing, employment...

Detailed plans are in place at CCG level to deliver these levels of collaboration, with shared learning across localities, allowing a “pull-through” method to ensure delivery

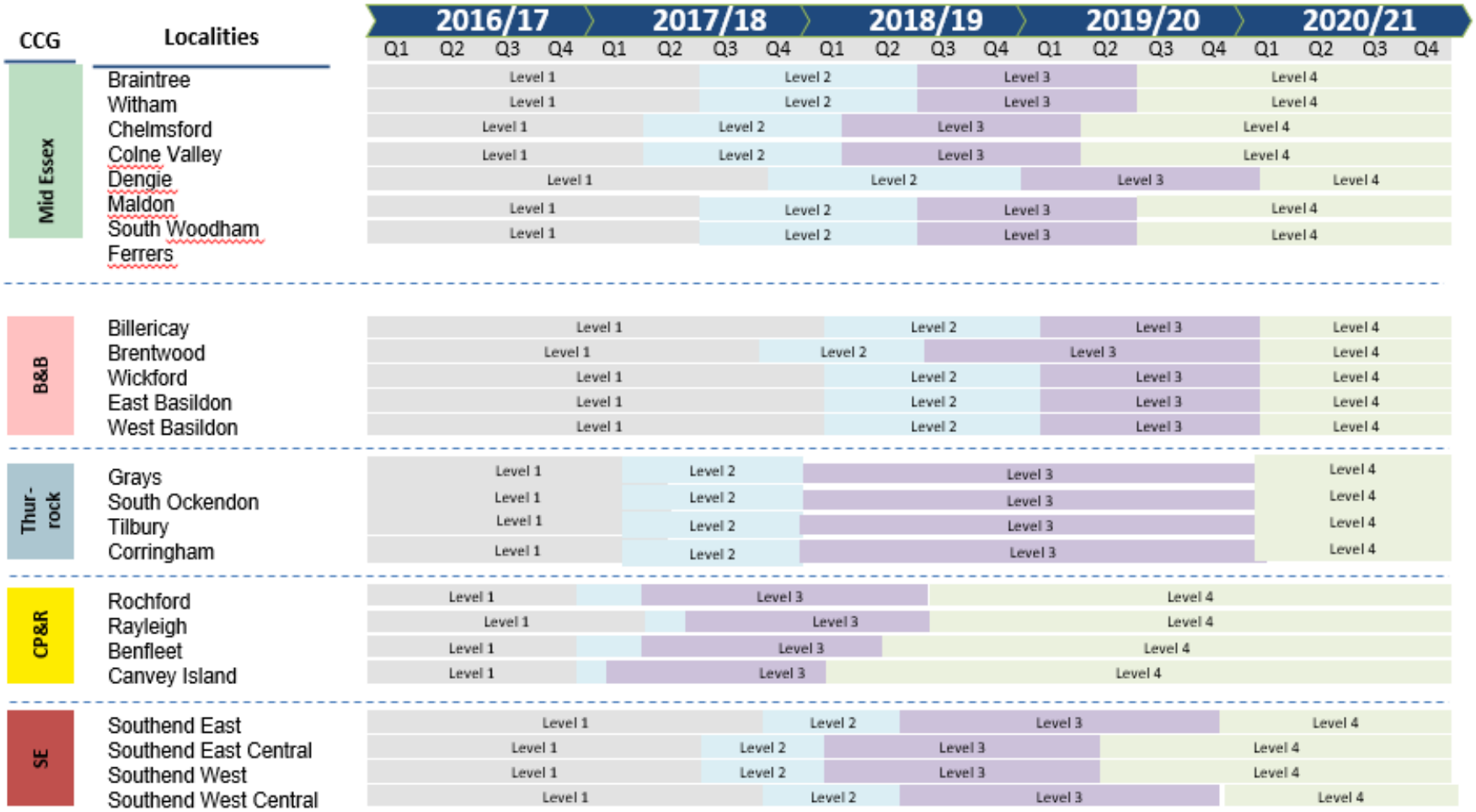
1. Multidisciplinary teams 2. Multispecialty community provider 3. Primary and acute care system 4. Voluntary and community sector

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

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

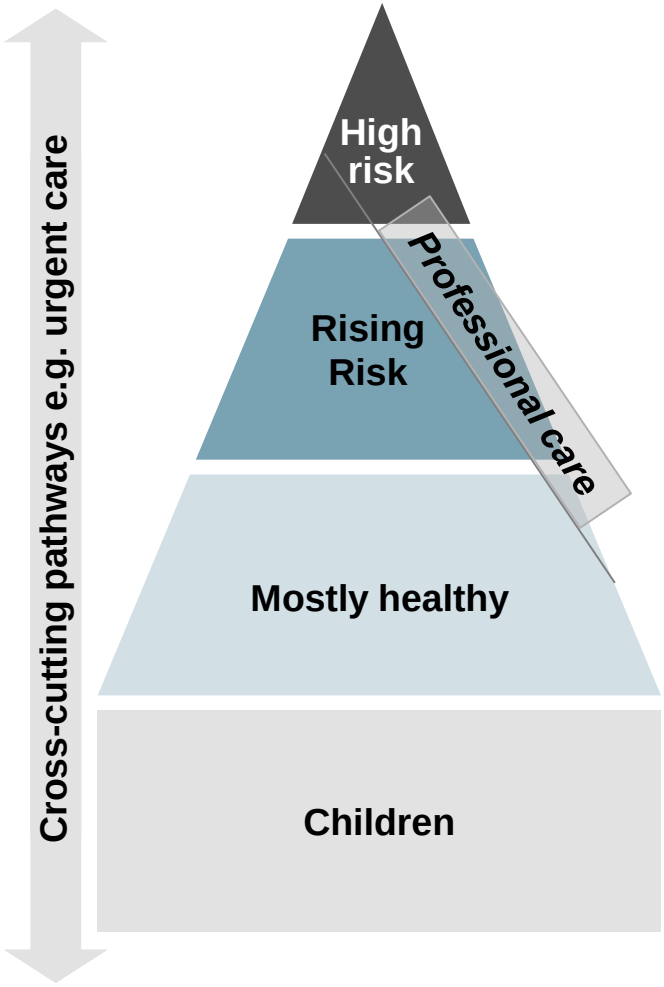
1. Southend East Central locality

Locality Implementation: Phasing



Managing Demand – Proactive Care

Approach to delivery will be based around population segmented management



Approach

High Risk

Highest risk identified using risk stratification and professional opinion

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

- Care management approach – drawing on locality-facing specialists as needed, working with shared care plans
- Named GP in place to lead care; named care co-ordinator for patients

Rising Risk

For identified individuals, Complex Care Team[1] avoid/manage shift to 'high risk'

Remaining (~95%) population managed through enhanced 'usual care'

- Integrated locality teams (incl. SWs, District Nurses) support self-care
- Enhanced information sharing, use of technology, peer support
- Ability to draw on specialist colleagues as required

Mostly Healthy

Usual care with enhanced focus on self care and prevention

- Public health; social marketing; peer support
- Self care / patient activation – supported by technology (e.g. menu of Apps)

Focus on providing navigation to right care

- Health coaching, patient navigation and signposting, social prescribing

Children

Focus on specialist care provision in community, tailored to needs

- Pathway redesign, with focus on specialist care provision in community
- Access to specialist advice – including virtual consults with expert clinicians
- Greater availability of GPs with specialist paediatrics interest within localities

Local health and care SR savings[2]:	£26m

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

Care will be adjusted according to need: illustrative example

Based on the population segmented management approach, 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**
- They might be cared for like this:

High risk

2x cohorts of ~700, identified using risk stratification and professional opinion

- Highest risk / least stable
- E.g. Frail / EOL

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 (c. 1,100) 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

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

Illustrative view of archetype features and impact on locality management

		Urban affluent *14 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		• Enhanced care home support • Centralised clinical triage	• Upskilled primary care professionals to provide frailty services	• More frailty services • MH: Dementia care
		• 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
		• 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	

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

Locality deep dives: lighthouse working now taking place, with focus on two localities

	South Woodham Ferrers	Benfleet
Context		
	Small locality with pop ~22K, four practices taking on an extra 1500 patients each due to a practice closure. A GP group close to retirement age. Plans to move three practices into a single locality hub, co-located with some community services within the next 18 months driving the need for change in their models of working Currently no joint working or commissioning; practice-based MDTs and minimal integration with other services and professionals Outcomes generally good, however in the elderly, particularly NELs and readmissions higher than CCG average	Medium sized locality with 7 practices with a history of collaborative working. Won Challenge Fund grant to commission an ECP, ANP and pharmacist to work full time across the locality. Already commissioning a Care Co service providing services in the community for frail and complex patients: currently being extended Able to refer patients to a CCG-commissioned weekend hub: SystemOne records accessible GPs committed to increased collaborative working through an Enhanced Access Hub
Approach		
	Locality identified rising risk patients with long term conditions (LTCs) as a key issue. • Modelled a locality-based MDT model with specialist input for LTC patients through a One Stop Shop • Includes opportunity for clinical services to be delivered locally eg diabetic foot clinics for most at risk patients Locality-based MDT with consistent risk stratification will see changing cohort of top 2% most complex patients including the very frail and EOL Committed to integration of care records on SystemOne Initiatives for self care agreed • Practice staff to train as Connect Well volunteers • PPGs to lead on promoting self care/peer support groups Agreed to integrate back office functions, outsource functions eg payroll and recruit apprentice and doctors assistant for admin tasks	Enhanced Access hub will be a physical hub with core team of GP and ANP and allied health professionals • See up to 20% GP patients if non-urgent and if could be seen by an AHP • Triage coordinated by a central management system with trained triage staff and may be a combination or phone, online and virtual triage Fully integrated IT systems across the locality and community services Opportunity to expand the hub to include additional services e.g. specialist nurse clinics, phlebotomy, anticoagulation Opportunities for locality GPs to work more or less in the hub, focusing on triage, acute care and/or specialist interests • Increased flexibility working hours, attracting trainees

Delivering locality working: key gaps to realise

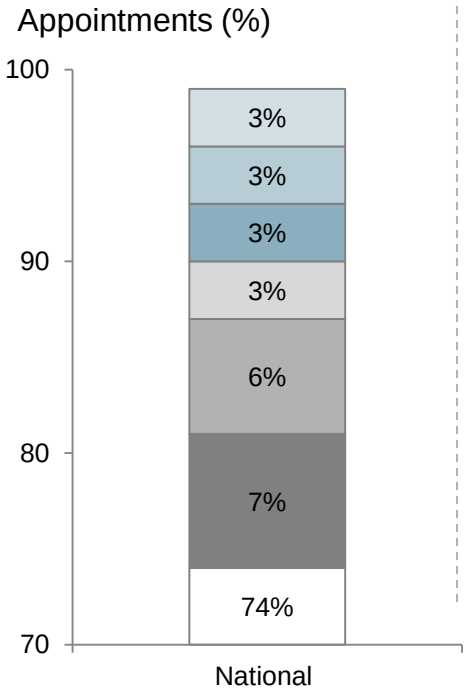
Investment	Scale	Actions Required	Managed Through
Workforce • Frontline capacity • Frontline training • Back-office	Locality (although consolidation of 'need' at SR level to engage with HEE and others)	• **Health and care professionals t**o support GP capacity release (e.g. AHPs, Social Care, MH, third 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	STP Workforce Groups
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	STP Primary Care Leadership Forum
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 • **Digital signposting** mechanism to direct patients to most appropriate Apps / digital resources • **Virtualisation** – e.g. consultations, health advice etc. • **Shared care records**	STP Digital Board
Capital investment • To support enhancement of estate	Locality-specific	• Development of **locality hub facilities**	STP Strategic Estates & Infrastructure Delivery Unit

Releasing Capacity

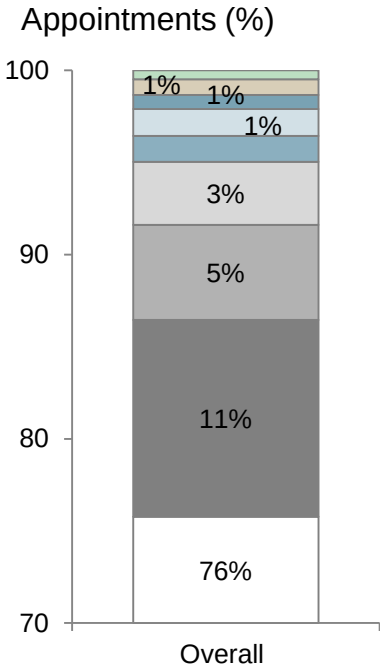
Time to Care: A quarter of GP consultations could be avoided

Audit of GP practices across five localities in Mid and South Essex

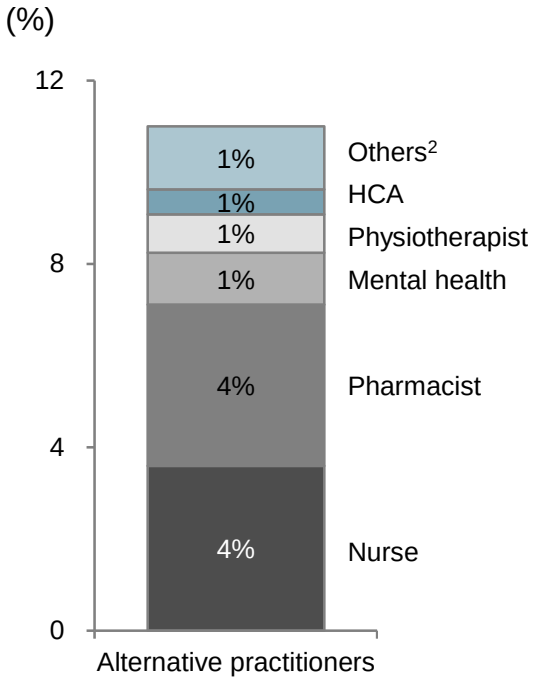
Nationally, 26% avoidable



Mid and South Essex, 24% avoidable[1], 11% could be diverted to alternative practitioners …



… mostly nurses and pharmacists



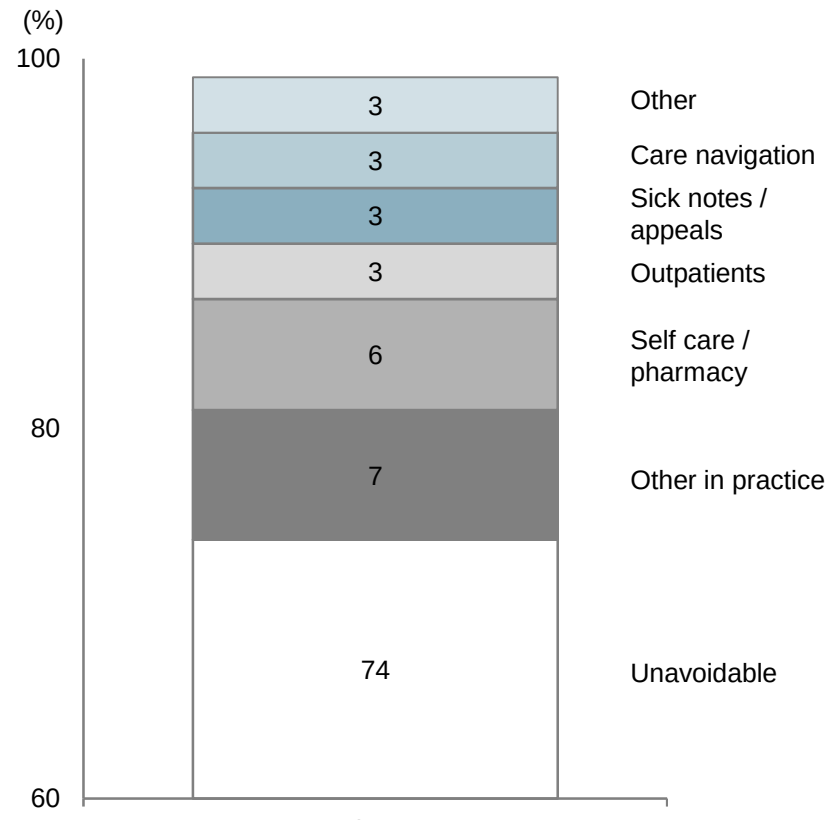
Care home spt. | Non-health related[3] | Social prescribing | Virtualisation | Unavoidable

Acute hosp. gen. | Self-care | Other - could avoid or no medical need | Alternative practitioners

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

Releasing General Practitioner capacity: what this means in practice

More than a quarter of current GP appointments are considered to be avoidable



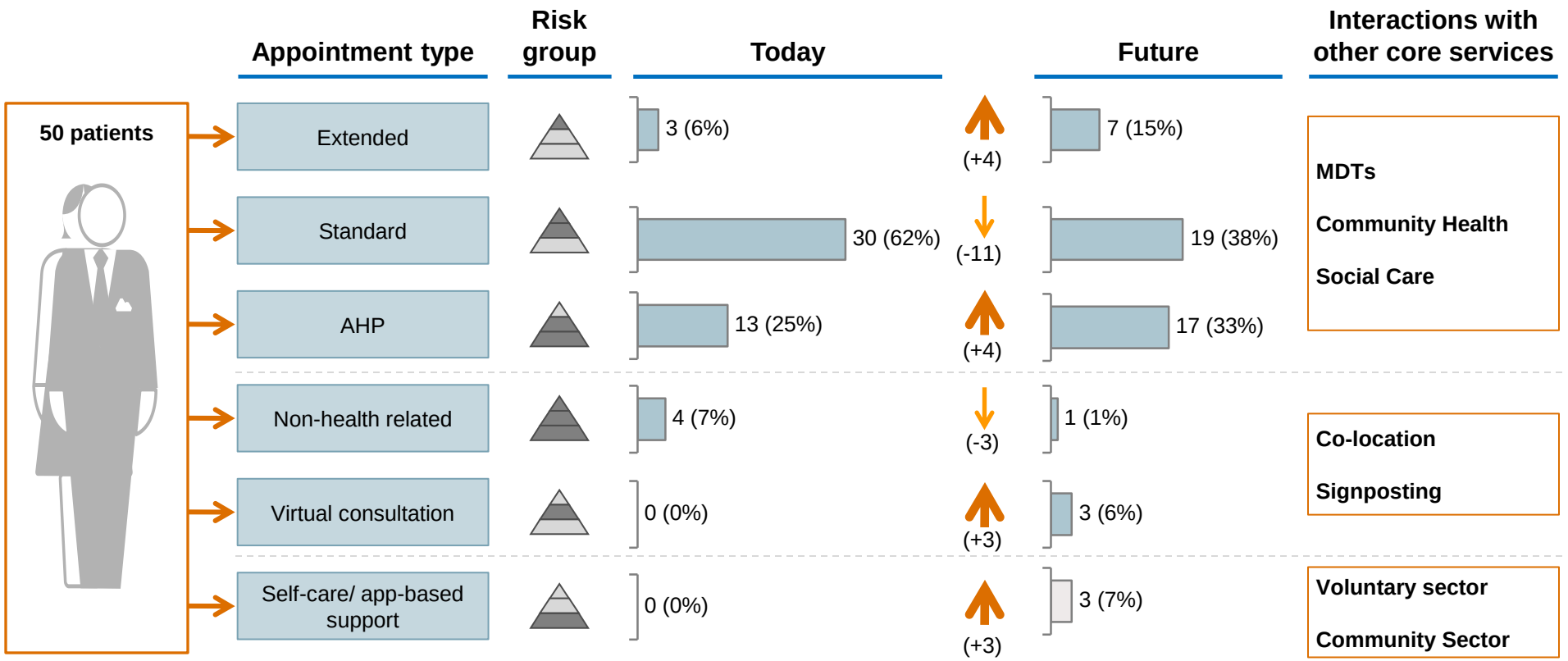
Interventions can release GP capacity

1. **Virtualisation**
   Virtual consultations; online advice
2. **Care Home support**
   Care home nurse practitioners
3. **Reduction in non-health related consultations**
   DWP; Schools; Sicknotes etc
4. **Acute hospital generated demand**
   e.g. Outpatients; consultant prescribing
5. **Self care / Self management**
   Including pharmacy
6. **Social prescribing**
   e.g. VCS support
7. **Increased utilisation of Alternative Practitioners**
   e.g. Independent Prescribers, Social Workers
8. **Reduction in PC Bureaucracy**
   Payments

Source: GP Forward View 2016; Making Time in Primary Care

Potential GP appointment channel shift (Illustrative example)

Analysis based on primary care audit in five localities



Non-appointment workload

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

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

Investments & Impact

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

	Acute			OPs
Metric	**A&E**	**Elective IP & DC**	**Non-elec IP**	**Elective OP**
Unit	Att.	Adm.	Adm.	App.
Assumed momentum growth rate per year	5.8%	4.5%	3.2%	4.9%
Modeled Change (%) from 2016/17	1.9%	0.1%	0.0%	-3.8%
Modeled change (%) from momentum	-3,9%	-4.40%	-3.2%	-8.8%

~£26M in system savings

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

Note: Percentage changes are approximately equal for both financial and activity shifts

Local Health and Care: detailed impact on activity by 2021/22

Initiative		Accident & Emergency	Elective IP	Elective DC	Non-elective IP	Elective OP
	Momentum change (%) from 2016/17	**29.1%**	**22.5%**	**22.5%**	**16.1%**	**24.6%**
Spec. pathway redesign	Change (%) from momentum		-11.3%			-11.1%
Frailty and EoL (Complex)	Change (%) from momentum				-3.7%	
LTCs (Complex)	Change (%) from momentum				-6.7%	-0.5%
Common offer	Change (%) from momentum			-4.4%		
Urgent care	Change (%) from momentum	-10.0%				
Total	**Net change from 2016/7**	**19.1%**	**11.2%**	**18.1%**	**5.7%**	**12.9%**

Figures exclude the impact of CCG and specialised commissioning QIPP initiatives

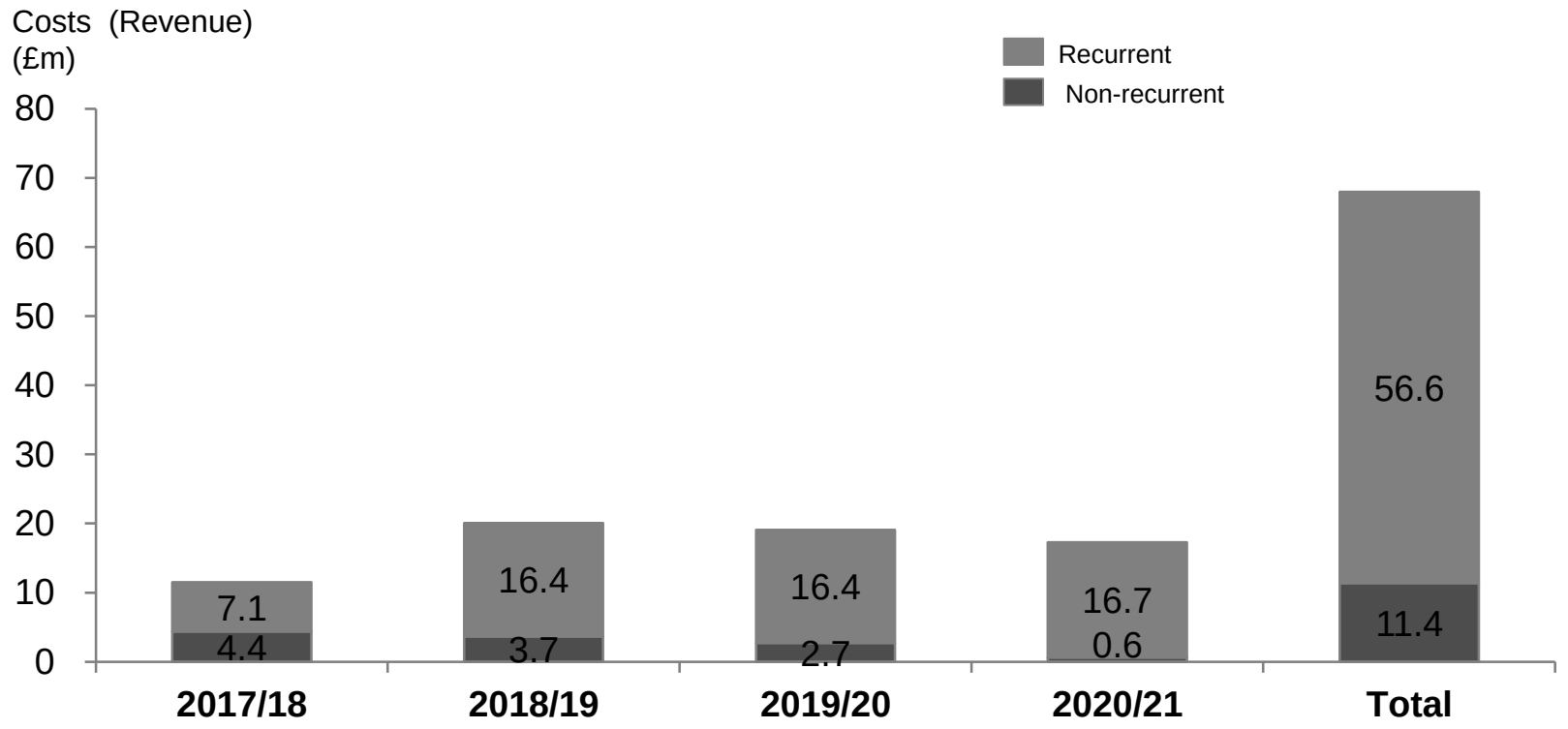
System Savings & Investment for Three Initiatives

	1 Frailty and EOL	2 Long term conditions	3 Specialist pathway redesign	Total
Initial assumptions	**Frailty:** Reduce 75-85 age band NEL admissions by **15%** **Care homes:** Reduce 75-85 age band NEL admissions by **2%.** Reduce prescribing spend by **15%** **Die Well:** Reduce 85+ age band admissions by **15%.** Reduce prescribing spend by **15%** **Discharge:** Cheaper provision of CHC in community	**LTC – NELs:** Reduce NEL admissions for 45 – 75 age band by **40%** **LTC – OPs:** Reduce OP for 45 – 75 age band by **33%**	**Elective:** Provide **31%** of outpatients in alternative setting. **Specialist:** Provide specialist outpatient appointments into community	
Gross savings	£18.9M	£24.0M	£39.8M	£82.7M
Invest	£10.8M	£12.0M	£28.6M	£51.4M
Net Commissioner savings	£8.1M	£12.0M	£11.2M	£31.3M
Activity shift (2020/21)	**8.6K NEL admissions fewer**	**12.8K NEL admissions fewer** **301K OP appointments fewer**	**130K OP appointments fewer**	

Note: Investment and net savings are to be refined on a locality level; Numbers may not sum because of rounding
Source: MedeAnalytics, Not in Hospital Schemes Solutions model.

Investments into new models of primary care to deliver local health and care programmes

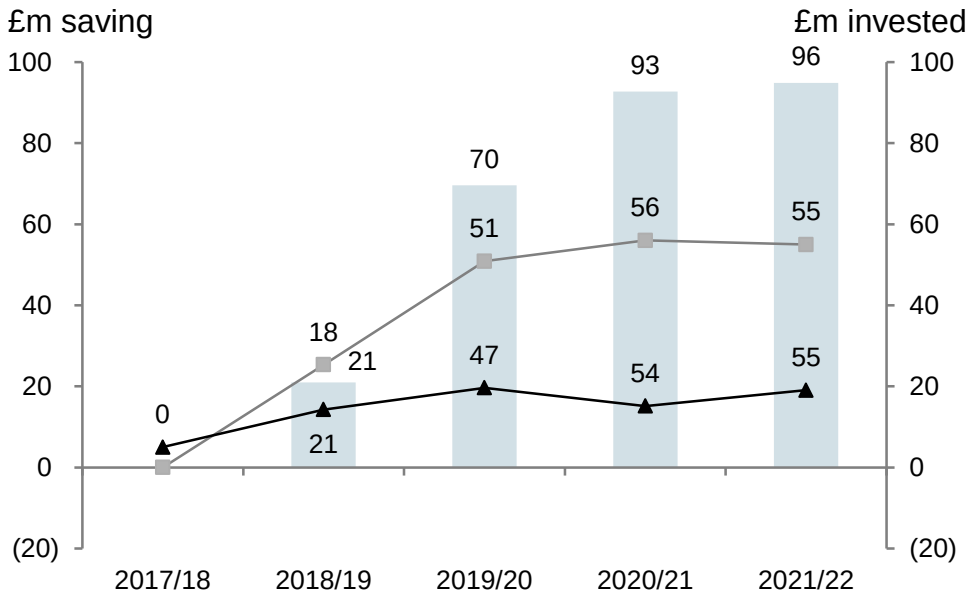
Investments centred around change management, capital, technology and workforce for new models of care



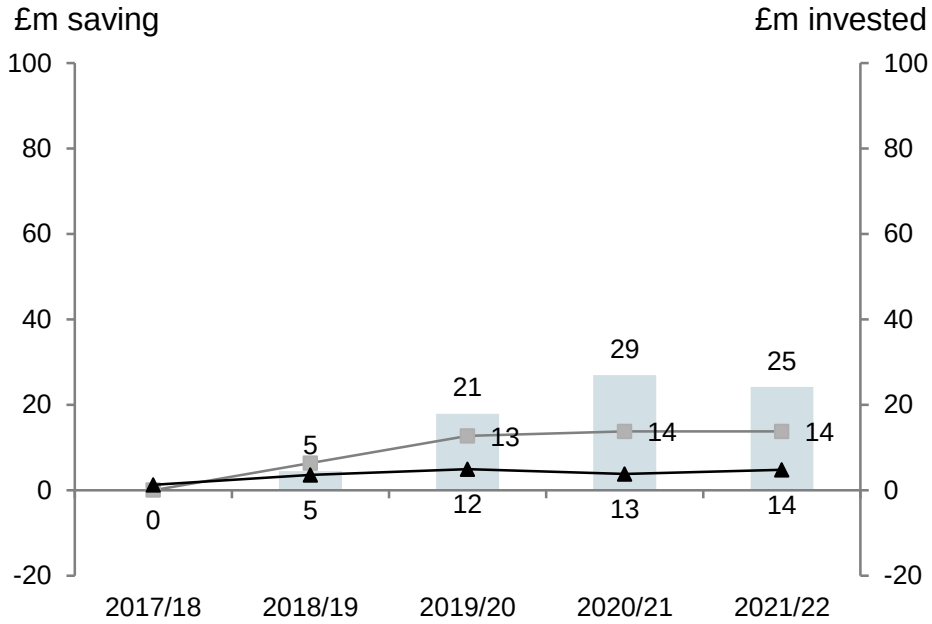
Note: Not all costs require new funds; Change management includes project management and leadership development; technology enablers such as IT infrastructure, virtualisation, apps and self-care technology, workforce includes costs of additional AHPs, up-skill training, back-office support staff and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

Phasing of funding: full cost of new service delivery (including investment in primary and community services) required to deliver full forecast benefits by 2021/22

Target scenario:
Full investment releases full savings



Alternative scenario:
25% investments release 12.5% savings[1]



Investment
Forecast saving

1 – reduced savings where initiatives have investment requirements.

Source: Financial analysis based on SR investment model

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

Backup: Peer comparison by CCG

	45 – 74 NEL admissions per 1000 pop		75-84 NEL admissions per 1000 pop		85+ NEL admissions per 1000 pop	
	CCG	Peer group average	CCG	Peer group average	CCG	Peer group average
Mid-Essex	76	80	248	261	540	543
Basildon & Brentwood	74	89	271	275	574	574
Thurrock	75	90	276	286	539	582
Castle Point & Rochford	85	88	289	268	640	551
Southend	104	118	312	338	624	658

Source: MedeAnalytics Q4FY15/16 to Q3FY16/17; Rightcare peers, December 2016

Locality targets for Frailty and Long Term Conditions: NELs (Illustrative example)

	CCG	Locality	Pop	NELs 2015/16	NELs 2020/21 "Do Nothing	NELs target 2020/21	Change in NELs Target 2020/21 vs. 2015/16	Change in NELs Target 2020/21 vs 2020/21 E Do Nothing	Gross savings 2020/21 (£)
1	Mid Essex	Braintree	60K	5.7K	6.3K	5.9K	262 (5%)	-352 (-6%)	£0.8M
2	Mid Essex	Witham	30K	2.7K	3.0K	2.6K	-83 (-3%)	-379 (-13%)	£0.9M
3	Mid Essex	Chelmsford	168K	13K	15K	14K	496 4%)	-934 (-6%)	£2.1M
4	Mid Essex	Colne Valley	46K	3.8K	4.3K	4.0K	126 (3%)	-289 (-7%)	£0.6M
5	Mid Essex	Dengie	23K	1.8K	2.1K	1.8K	-46 (-3%)	-257 (-13%)	£0.6M
6	Mid Essex	Maldon	33K	2.7K	3.0K	2.7K	12 (0%)	-290 (-10%)	£0.7M
7	Mid Essex	Woodham	22K	1.5K	1.7K	1.5K	-32 (-2%)	-192 (-11%)	£0.4M
8	B&B	Billericay	40K	2.6K	2.9K	2.5K	-53 (-2%)	-387 (-13%)	£0.9M
9	B&B	Brentwood	78K	5.9K	6.7K	6.2K	262 (4%)	-486 (-7%)	£1.1M
10	B&B	East Basildon	61K	5.4K	6.0K	5.3K	-136 (-3%)	-684 (-11%)	£1.5M
11	B&B	Wickford	38K	2.9K	3.3K	2.9K	-80 (-3%)	-431 (-13%)	£1.0M
12	B&B	West Basildon	59K	4.7K	5.2K	4.7K	-37 (-1%)	-512 (-10%)	£1.1M
13	TH	Grays	72K	4.5K	4.9K	4.5K	-22 (0%)	-454 (-9%)	£1.0M
14	TH	Ockendon	37K	2.6K	2.8K	2.4K	-114 (-4%)	-353 (-13%)	£0.8M
15	TH	Tilbury	37K	2.8K	3.0K	2.6K	-118 (-4%)	-386 (-13%)	£0.8M
16	TH	Corringham	26K	1.9K	2.1K	1.8K	-110 (-6%)	-315 (-15%)	£0.7M
17	CP&R	Rochford	51K	4.8K	5.3K	4.7K	-89 (-2%)	-650 (-12%)	£1.4M
18	CP&R	Rayleigh	43K	3.6K	4.0K	3.5K	-93 (-3%)	-552 (-14%)	£1.2M
19	CP&R	B&H	49K	4.5K	5.2K	4.4K	-114 (-3%)	-731 (-14%)	£1.7M
20	CP&R	Canvey Island	42K	4.1K	4.6K	4.0K	-123 (-3%)	-596 (-13%)	£1.3M
21	SE	Southend E	36K	3.5K	3.9K	3.4K	-134 (-4%)	-526 (-13%)	£1.2M
22	SE	Southend EC	58K	6.1K	6.7K	6.2K	68 (1%)	-565 (-8%)	£1.3M
23	SE	Southend W	56K	5.7K	6.4K	5.9K	225 (4%)	-503 (-8%)	£1.1M
24	SE	Southend WC	35K	3.5K	4.0K	3.5K	-28 (-1%)	-505 (-13%)	£1.1M
		Total	**1.2M**	**101K**	**112K**	**101K**	**39 (0%)**	**-11K (10%)**	**£25M**

Note: Activity growth rates from Out of Hospital Solutions Model ; Locality targets allocated on basis of population and activity levels vs. peers from system-wide targets
Source: MedeAnalytics, Q4FY2014/15 to Q3FY2015/16, HSCIC GP pop Jul 16, Complex Savings Methodology deck, Commissioning for Value similar 10 CCG, Financial Bridge Assumptions deck

Locality targets for LTCs and Specialist Pathway: Ops (Illustrative example)

CCG		Locality	Pop	OPs 2015/16	OPs 2020/21" Do Nothing	OPs Target 2020/21	Change in OPs Target 2020/21 vs. 2015/16	Change in OPs Target 2020/21 vs 2020/21 E Do Nothing	Gross savings 2020/21 (£)
Mid Essex	2	Braintree	60K	125K	145K	122K	-3k (-2%)	-23k (-16%)	£2.2M
	3	Witham	30K	56K	64K	52K	-3k (-6%)	-12k (-19%)	£1.2M
	4	Chelmsford	168K	307K	355K	301K	-5k (-2%)	-54k (-15%)	£5.2M
	5	Colne Valley	46K	90K	104K	88K	-2k (-2%)	-16k (-15%)	£1.5M
	6	Dengie	23K	45K	52K	42K	-4k (-8%)	-11k (-20%)	£1.M
	7	Maldon	33K	63K	73K	59K	-4k (-7%)	-14k (-19%)	£1.4M
	8	Woodham	22K	38K	45K	37K	-2k (-4%)	-8k (-17%)	£.7M
B&B	9	Billericay	40K	68K	78K	62K	-5k (-8%)	-16k (-20%)	£1.5M
	10	Brentwood	78K	150K	173K	143K	-6k (-4%)	-30k (-17%)	£2.9M
	11	East Basildon	61K	103K	119K	97K	-6k (-6%)	-23k (-19%)	£2.2M
	12	Wickford	38K	69K	80K	64K	-5k (-8%)	-16k (-20%)	£1.6M
	13	West Basildon	59K	96K	111K	90K	-6k (-7%)	-21k (-19%)	£2.1M
TH	14	Grays	72K	109K	126K	105K	-4k (-4%)	-21k (-17%)	£2.1M
	15	Ockendon	37K	61K	70K	56K	-5k (-8%)	-14k (-20%)	£1.4M
	16	Tilbury	37K	62K	71K	57K	-5k (-8%)	-15k (-20%)	£1.4M
	17	Corringham	26K	43K	50K	40K	-3k (-8%)	-10k (-20%)	£1.M
CP&R	18	Rochford	51K	94K	109K	86K	-7k (-8%)	-22k (-20%)	£2.1M
	19	Rayleigh	43K	69K	80K	64K	-5k (-8%)	-16k (-20%)	£1.6M
	20	B&H	49K	89K	103K	82K	-7k (-8%)	-21k (-20%)	£2.M
	21	Canvey Island	42K	79K	91K	72K	-6k (-8%)	-19k (-20%)	£1.8M
SE	23	Southend E	36K	65K	75K	65K	0k (-0%)	-11k (-14%)	£1.M
	24	Southend EC	58K	105K	122K	106K	1k (1%)	-16k (-13%)	£1.5M
		Southend W	56K	104K	120K	104K	1k (1%)	-16k (-13%)	£1.5M
		Southend WC	35K	55K	64K	55K	0k (0%)	-9k (-14%)	£.9M
		Total	**1.2M**	**2.4M**	**2.8M**	**2.35M**	**-93k (-4%)**	**-431K (-15%)**	**£42M**

Gross savings will require significant re-investment to provide services in the community

Note: - Activity growth rates from Out of Hospital Solutions Model; Locality targets allocated on basis of population and activity levels vs. peers from system-wide targets

Source: Mediganalytics, Q4FY2014/15 to Q3FY2015/16, HSCIC GP pop Jul 15, Complex Savings Methodology deck, Commissioning for Value similar 10 CCGs, Financial Bridge Assumptions deck