For planning purposes only

Mid and South Essex Success Regime

A programme to sustain services and improve care

STP submission

June 30th 2016

Contents

Executive summary (I/II)

The STP for Mid and South Essex is focused on four key priorities with the aim of closing health, quality and financial gaps, achieving long term sustainability, and reducing health inequalities across the patch

- In line with the Five Year, GP and Mental Health Forward Views
- Expanding on existing local initiatives...
- ...and work mobilised as part of the Essex Success Regime and Mental Health Strategic Review

1 Build stronger health and care localities, with reconfigured primary care delivering a broader range of integrated services

- Achieve 'Level 4' across all 26 localities within 4 years: reconfigured practices to deliver redesigned services previously provided in acute and specialised trusts; underpinned by a multi-disciplinary, redefined workforce model, including integration with social care

2 Ease pressure on the non elective pathway and reduce inappropriate admissions into the acutes

- Supported by stronger localities; with better prevention; redesigned complex care pathways across health and social care; re-commissioned ambulance service focussing on hear and treat/see and treat; and a recommissioned 111-OoH service

3 Reconfigure the acute footprint to address quality, financial and workforce challenges – in line with national guidance

- Implement Willetts Urgent Care recommendations[2] and designate A&Es to address rota gaps and agency spend
- Achieve greater separation of elective and non elective care in line with Briggs[3] to improve elective experience and improve efficiency
- Increase service consolidation in line with Keogh[4] to improve outcomes and increase productivity

4 Optimise mental health care: integrated, joined up services across sectors

- Redesign pathways clarifying what can be delivered locally, integrating with community, health, public and social care, linked to housing
- Consolidate between the two mental health trusts to improve specialised care, with co-commissioning for specialised and tertiary services
- Improve and integrate the dementia care pathway between health, mental health and social care

Core to these priorities and the STP programme is the redesign of all pathways within a fixed financial envelope

1. EEAST: East of England Ambulance Service NHS Trust 2. Willetts: https://www.england.nhs.uk/tag/urgent-and-emergency-care-review/ 3. Briggs: www.gettingitrightfirsttime.com/report
4. Keogh: www.nhs.uk/NHSEngland/bruce-keogh-review/Pages/published-reports.aspx

Executive summary (II/II)

In addition to the four key priorities, the system continues to drive specific programmes of work around learning disabilities, prevention, cancer and maternity care as well as social care

- These are also summarised in this document

System change is being supported by a simplified commissioning and provider landscape

- An acute group model across the three hospitals
- Joint decision making across the five CCGs
- A consistent service offer: service restrictions (e.g. gluten-free food) and access to services in line with existing policies (e.g. orthopaedic procedures)

The STP footprint is also driving innovation around key enablers

- IT and data; workforce; estates

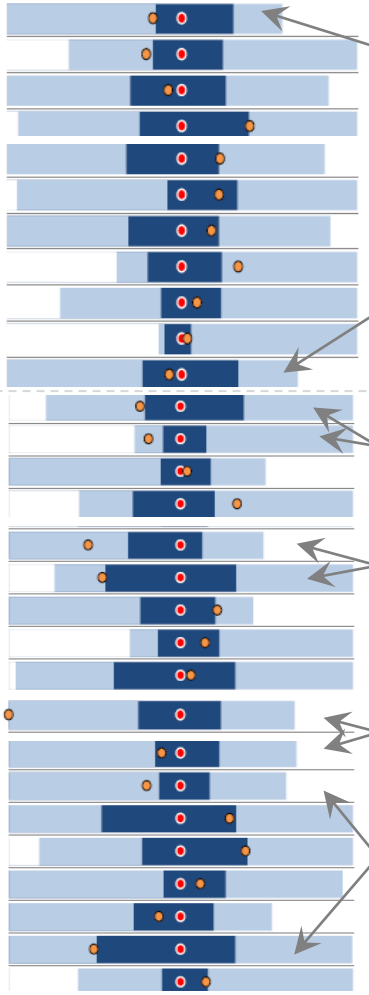
The Success Regime area has one of the most significant structural health economy deficits across the NHS. If Mid & South Essex does not implement a significant transformation, it faces a £630m health and care challenge deficit by 2020/21

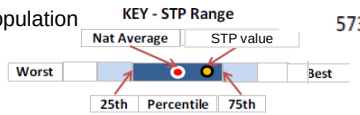
The local system has formulated a plan which, if successful, will enable us to reach financial surplus by 2021 within health. It should be noted that:

- There are not yet firm plans in place for colleagues in social care to get to overall balance
- The solutions identified in this plan are currently being worked up in more detail and tested; for the plans to be fully implemented at the pace described may require access to capital and non-recurrent support - this will be confirmed in the Pre Consultation Business Case
- CIPs and QIPPs in the outer years of the plan have been modelled based on previous delivery; these will need to be worked up into firm plans
- To deliver the surplus, the key risks highlighted in this document need to be successfully mitigated

1. This includes £59m accelerated and stranded costs

Recap of starting point: health, quality and care gaps

	Metric	STP	Position vs. national	Comments
Health	People with a long-term condition feeling supported to manage their condition	65.5%		Priority 1: localities and primary care (Level 3 – MDTs for complex conditions)
	Anti-microbial resistance: Appropriate prescribing of antibiotics in primary care	1.16		
	Anti-microbial resistance: Appropriate prescribing of broad spectrum antibiotics in primary care	10.4%		
	Quality of life of carers - health status score (EQ5D)	0.81		
	Maternal smoking at delivery	8.8%		
	% children aged 10-11 classified as overweight or obese	31.8%		
	Diabetes patients that have achieved all three of the NICE-recommended treatment targets	41.0%		
	People with diabetes diagnosed less than a year who attend a structured education course	10.3%		
	Injuries from falls in people aged 65 and over per 100,000 population	1912		Priority 2: non elective pathway (EoL and frailty workstream)
	Personal health budgets per 100,000 population (absolute number in brackets)	16.32 (196)		
	% deaths which take place in hospital	47.8%		
Quality and care	Patient experience of GP services	71.0%		Priority 1: localities and primary care (Levels 1-4, new workforce model)
	Primary care workforce - GPs and practice nurses per 1,000 population	0.55		
	Patients waiting 18 weeks or less from referral to hospital treatment	92.4%		
	People eligible for standard NHS Continuing Healthcare per 50,000 population	64.09		
	% patients admitted, transferred or discharged from A&E within 4 hours	80.5%		Priority 2: non elective pathway and Priority 3: acute reconfiguration
	Ambulance waits - % of cat A red 1 incidents responded to within 8 minutes	64.6%		
	Delayed transfers of care attributable to the NHS and Social Care per 100,000 population	9.08		
	Emergency bed days per 1,000 population	0.86		
	Emergency admissions for chronic ambulatory care sensitive conditions per 100,000 population	773		
	People with urgent GP referral having 1st definitive treatment for cancer within 62 days of referral	73.6%		Priority 3: acute reconfiguration (cancer consolidation / network approach)
	Cancer patient experience	0.88		
	Improving Access to Psychological Therapies recovery rate	40.8%		
	People with a learning disability and/or autism receiving specialist inpatient care per million population	35.00		Priority 4: mental health (integration with localities) and frailty pathway redesign
	Proportion of people with a learning disability on the GP register receiving an annual heath check	55.3%		
	Neonatal mortality and stillbirths per 1,000 births	6.96		
	Women's experience of maternity services	79.2		
	Estimated diagnosis rate for people with dementia	62.6%		
	Emergency admissions for urgent care sensitive conditions per 100,000 population	573		



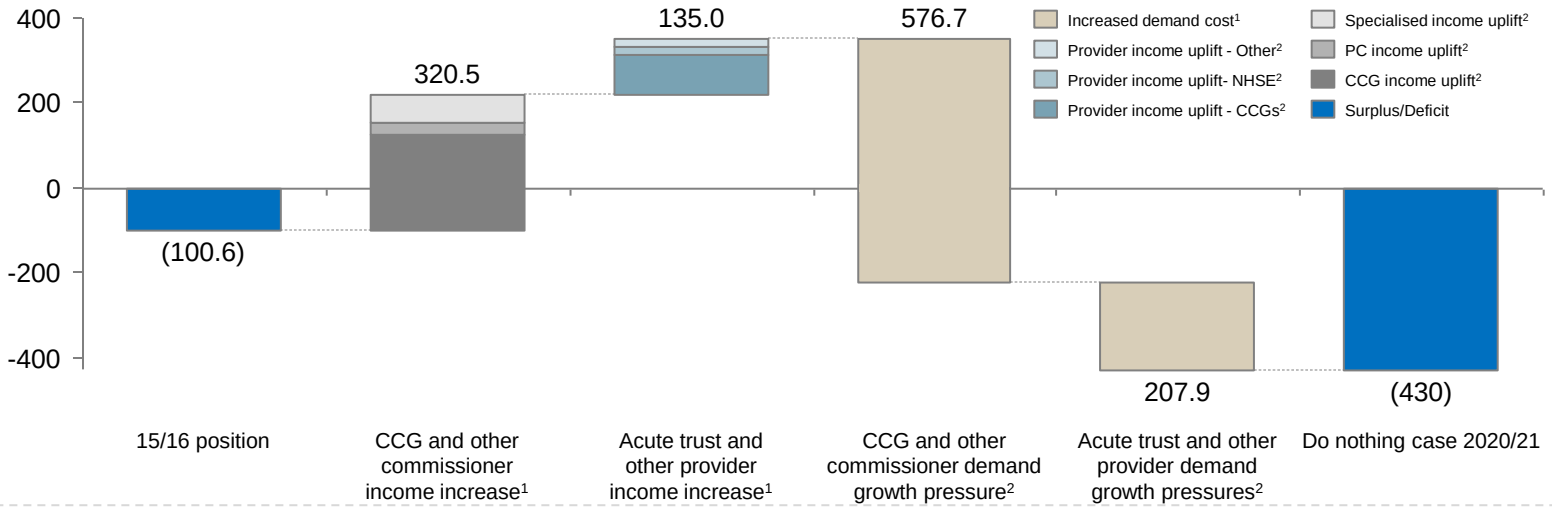
Note different time periods for each metric

Recap of starting point: financial gaps

See page 34 for details on planned savings

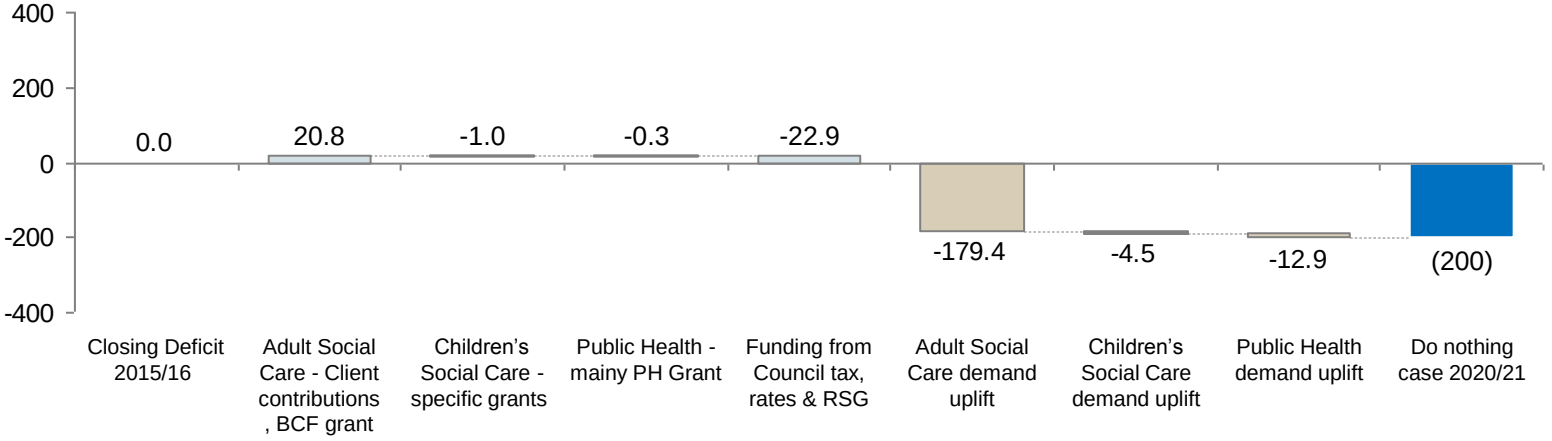
Health

Deficit breakdown in 2020/21, £m



Social care

Deficit breakdown in 2020/21, £m



Note: SR uplifts displayed as mid-points of possible range;
1. Demand growth pressure is the increased demand between 2015/16 in-year position and 2020/21 in-year position for services based on demographic and non-demographic demand growth projections based on national and local projections per organisation 2. Income uplift is the increase in allocations between 2015/16 in-year position and 2020/21 in-year position based on projected allocations to trusts, CCGs and other NHS organisations Source: Financial model, SR workstreams, Local Authority, Trust and CCG financials

Transformation schemes and solutions for each priority

Priority ❶: localities and primary care

Context and goals

Context

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

- GP FTEs projected to fall from 595 to 578 FTEs by 18/19[3]; challenges recruiting to vacancies; high locum spend
- 0.55 GPs/practice nurses per 1,000 population, compared to a national average of 0.69 – bottom quartile

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

- ~160 independent GP practices operating across Mid and South Essex with fragmented care delivery
- Positive impact of integration already seen locally, e.g. Tilbury (see case study page 9)

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

- Redesigned workforce with GPs taking on different roles: some concentrating on the to highest risk patients others overseeing the rising risk patients ...
- ...and overseeing a team of integrated professionals providing timely interventions to reduce admissions and prevent ill health

Goals

All localities across the STP footprint to reach Level 4 by 2019/20

- By 2017/18, all localities to reach Level 3
- By 2019/20, all localities to reach Level 4

Level 1 — **Practices functioning collaboratively and working towards consistency within localities**

Level 2 — **Practices co-operating to share core/ enhanced GP services and deliver single pathways across the locality**

- E.g. 7 day access to GP services, minor surgery

Level 3 — **Practices within a locality aligning to absorb services outside the core GP contract and evolving closer relationships**

- Single point of access, increased practice mergers, services traditionally delivered in hospital delivered in locality

Level 4 — **Full scale transformation including accountability for wider determinants of health/ MCP[5] model**

1. Five Year Forward View (2015) and GP Forward View (2016) 2. Ambulatory care sensitive conditions 3. Based on extrapolation of current trend of GP workforce decline (~1% per year), HSCIC Census September 2014 4. Five year forward view 5. Multispecialty community provider

Process and next steps

Process to date

Within the STP footprint, 26 primary care localities have been established, each with population of ~40-50k

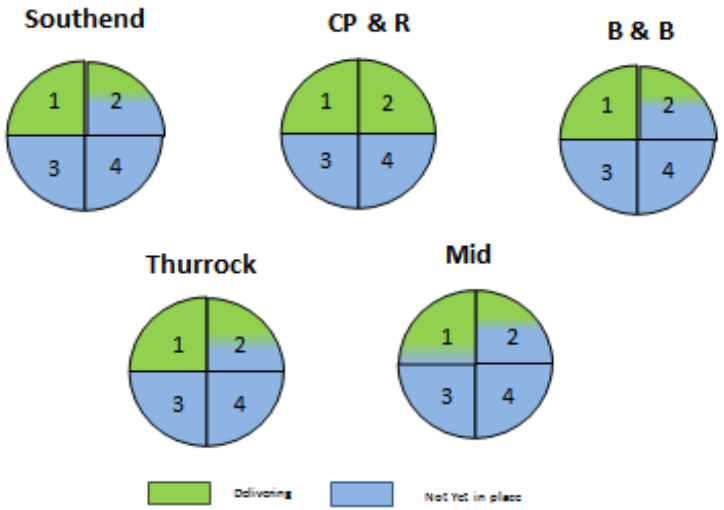
Each locality and CCG is at a different starting point

- Pace of change differs depending on local circumstances

A small, central team has been established to provide oversight, co-ordination, and share best practices to drive forward primary care transformation rapidly

- Led by Ian Stidston, see page 24

Locality baseline by level and CCG:



1. Quality outcomes framework

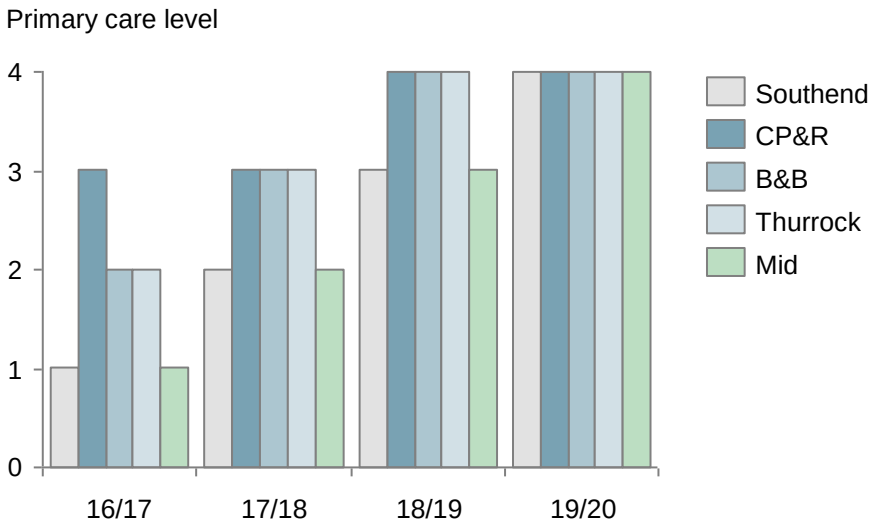
Next steps / ambition for pace of change

8 Task and Finish Groups are underway to address different aspects of transformation

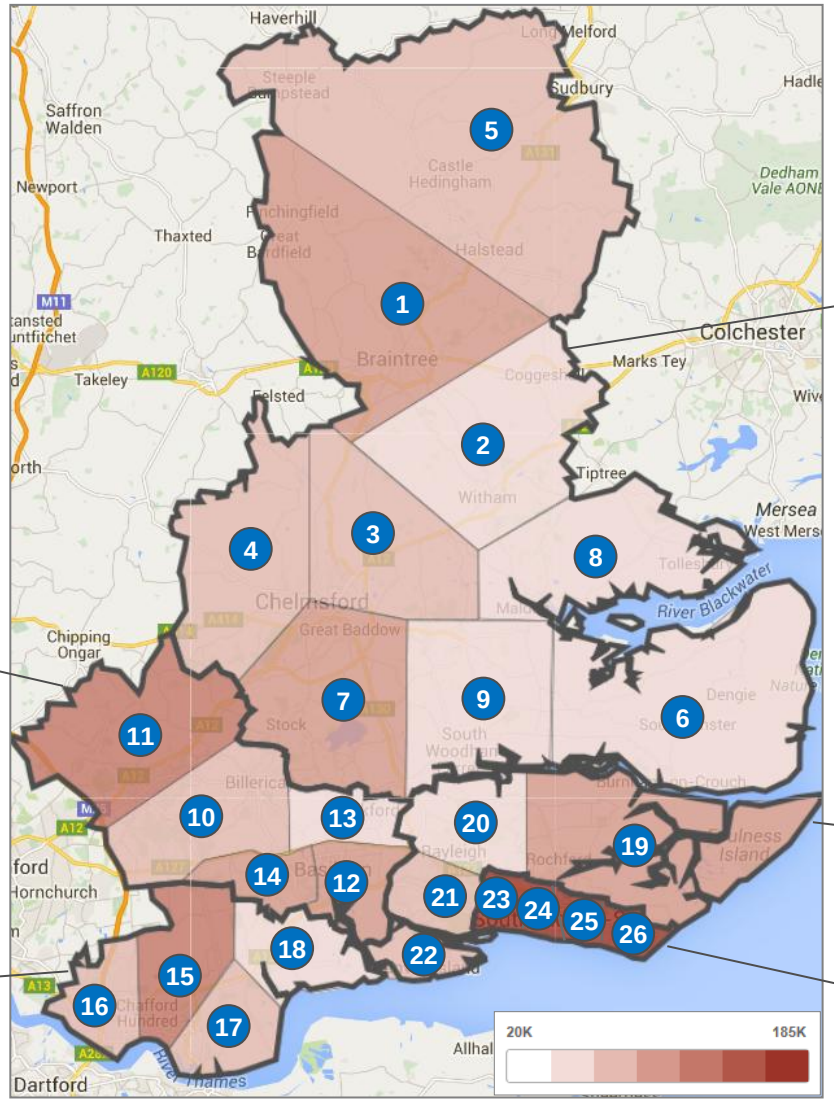
- E.g. Locality contracts; Local QOF[1] ; Practice Merger Incentive scheme

By the end of 16/17, the aim is for all localities aside from Southend and Mid Essex to have reached Level 2

Current ambition – pace of change of primary care transformation



Overview of localities



CCG		Locality	Pop'n (k)	# GP practices
Mid Essex	1	Braintree	64	5
	2	Witham	29	5
	3	Chelmsford 1	45	7
	4	Chelmsford 2	49	4
	5	Colne Valley	45	8
	6	Dengie	23	5
	7	Prosper	63	6
	8	Maldon	32	3
	9	South Woodham	22	5
B&B	10	Billericay	40	7
	11	Brentwood	77	8
	12	East Basildon	60	14
	13	Wickford	34	5
	14	West Basildon	57	9
Thurrock	15	Grays	70	12
	16	South Ockendon	35	6
	17	Tilbury	38	9
	18	Corringham	26	6
CP&R	19	Rochford	58	7
	20	Rayleigh	34	4
	21	Benfleet & Hadleigh	46	7
	22	Canvey Island	42	8
SE	23	Southend West	39	8
	24	Southend West Central	52	11
	25	Southend East Central	34	8
	26	Southend East	41	8

Note: Clusters have been identified for illustrative purposes and do not represent real or intended neighbourhoods; total Southend population represented by map shading (as opposed to split across 4 localities)
Source: BCG analysis of GP patient list size data (HSCIC October 2015)

Transformation of primary care to occur through 4 levels

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

1. Multidisciplinary teams 2. Multispecialty community provider 3. Primary accountable contractor 4. Voluntary and community sector

Case study: Tilbury

Context and case for change

Significant shortage of GPs in Tilbury with challenges recruiting to vacancies

- Each GP is responsible for ~2.5x more patients than the England average of 1.3k/GP
- Last year, there were only 8.5 full time GPs in Tilbury

Death rates are higher than the England average, and a Tilbury baby is predicted to die 10 years earlier than a baby from neighbouring Orsett

- If death rates were the same as the England average
  - 43 fewer people would die before 75
  - 16 fewer people would die of heart attack or stroke before 75
  - 13 fewer people would die of cancer before 75

New centre to deliver integrated care (Level 3)

Move to a more joined up, integrated approach to care coordination and planning to help support service users

- Model of care based on local patient needs
- Locality based and delivered through MDTs[1] by fully integrated health and social care teams delivering coordinated care closer to home at Integrated Healthy Living Centre

New centre plans to tackle the root causes of bad health and wellbeing, as well as provide clinical support, to provide a truly integrated community service

- Housing, benefit, and parenting advice will be available, in addition to employment support and children's centres

Frail and complex patients are also to be better managed in the community through effective MDTs[1] , better coordinated care plans and shared escalation plans

- Ensure people don't end up in the hospital unless they need to be there

1. Multidisciplinary teams

Case study: Castle Point and Rochford

Context and case for change

There are currently 26 individual practices within CP&R of varying size

The population which they serve is projected to undergo a significant rise in frail elderly

Current community services are inconsistent and unaligned in supporting primary care proactively managing patients

- This creates fragmentation across care pathway, leading to poorer outcomes and a worse experience for patients
- Moreover, there are significant workforce benefits to consolidation, with ability to implement new models of care around a multi-disciplinary team in line with progression from Levels 1 to 4

Enhancing Primary Care Capacity

The CCG is under going a programme of incremental changes to enhance the primary care offer in the locality, and begin the alignment of community services around groups of GP practices

Commissioning of Primary Care at Scale
Through the local GP Federation CP&R have commissioned weekend access to planned appointments from two hubs, accessible by all patients registered at practices that are members of the federation achieving elements of Level 2 primary care services

Commissioning Care Co-ordination Services to support practices with their complex patients
All practices can refer complex patients to the local care co-ordination service who support these patients in care planning on behalf of the practice. Neighbourhood MDT's[1] , led by a named GP, support the management of complex patients. Delivering neighbourhood level primary care support.

Investing in Primary Care
The pressures primary care face from Care Homes has been recognised, with investment made in primary care to deliver an improved offer to this patient group.

1. Multidisciplinary teams

Priority ❷: ease pressure on the non-elective pathway

Context and goals

Context

39% of acute bed days and 35% of non-elective admissions are accounted for by frail older people (>75s)

- This group represents just 8% of the population
- Growing trend, as the number of frail older people increases
- Please refer to Page 10 for CPR example

Rapidly rising demand on acutes for non-elective care, with projected 7.1% growth in next 3 years

- 4% rise in admissions over last 2 years, with associated operational pressures: STP falls in bottom quartile nationally with 81% of A&E patients seen within 4hours compared to national average of 95%

'Do nothing' scenario would lead to need for 150 additional beds within acute sector by 2018/19

Aspirations to improve care has been limited by fragmented approach within system

- Limited focus on proactive, preventative services
- Lack of incentives across the system for services to work together to deliver seamless care and support
- Difficulty in sharing patient information

Goals

Primary goal is to keep non-elective bed days flat by 2018/19 when compared to 2015/16

Initial focus on frailty (>75s) and end of life (EoL[1]) pathway redesign to keep bed days flat

- Integrated care: locality based, integrated primary, social and community care for the frail population
- Care home residents: lead provider model for integrated community services
- EoL[1]: co-ordinated services with shared care records and complex care registers
- Pre and post hospital: support at home including discharge-to-assess (D2A[2]) and redesigned step-up

Wider plans impacting all non elective admissions and other complex cohorts (e.g. diabetes, COPD[3]) are also underway

- LTCs: integrated complex care and increases community outpatient care (see also priority 1)
- Re-commissioned ambulance service focusing on hear and treat/see and treat
- NHS 111/00H: increase calls and reduce inappropriate transfers
- 24/7 mental health crisis: increased access (see also priority 4)
- Emergency paeds and dental: improved system responses to reduce acute demand
- Optimise opportunities to increase and maintain evidence based preventative interventions including around CVD[4] , alcohol, falls, and smoking

1. End of life 2. Discharge to assess 3. Chronic obstructive pulmonary disease 4. Cardiovascular disease

Activity view of pathway

Reducing admissions…

Frailty

- Provide integrated primary and community care for the frail population

Care Homes

- Develop lead provider model for integrated community services for care home residents

Die Well

- Develop co-ordinated EoL[1] services with shared care records and complex care registers

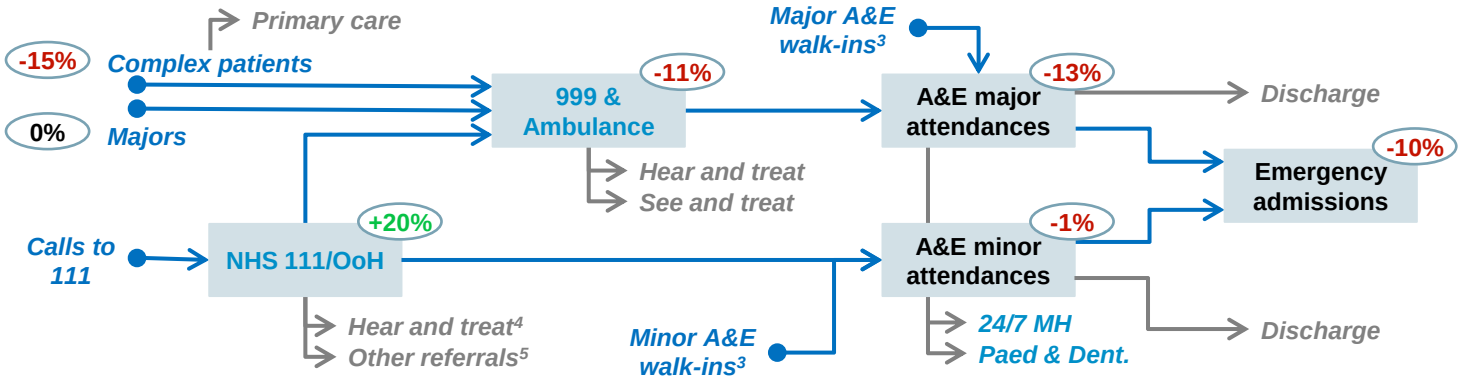
LTCs

- Provide integrated complex care & redesign LTC outpatient care in the community

…& more rapid discharge

Discharge

- Support at home following discharge incl. D2A[2] and redesigned step up



NHS-111/OoH

- Increase publicity for NHS 111
- Expand clinical triage capabilities with broader range of clinicians
- Improve algorithm to avoid unnecessary referrals to 999 and A&E

999 & Ambulance

- Expand clinical support desk (CSD), with broader range of clinicians to reduce ambulance dispatches
- Improve paramedic capabilities to treat on the scene
- Optimise process for paramedics to seek telephone advice

24/7 Mental Health

- Increase access to and capacity in 24/7 mental health crisis services

Paeds & Dentistry

- Improve system response to surges in emergency paediatric demand
- Improve emergency dental capacity and availability to avoid A&E and inpatient activity

1. End of life 2. Discharge to assess 3. Includes GP referrals 4. Includes calls ended before triage and hear and treat 5. Primary care and other services 6. Change if initiatives delivered in 2015/16
Source: CCG financial plans 2015/16; Hospital episode statistics 2014/14, HSCIC; NHSE Statistics; NHS 111 Situation Report 22/11/2015; BCG local clinician interviews

Priority 2

Frailty: overview of process to date and next steps

Aim is to keep non-elective bed days flat by 2018/19 when compared to 2015/16

Overview of process

15% increase expected in >75 non elective admissions over the next 3 years

- Given this projected increase in demand, frailty has been identified as an initial focus area

Key levers identified through national best practice, leading to development of "strawman" models of potential patient care pathways within Mid and South Essex

- 4 working groups, led by clinicians, have been focussing on different elements of the overall pathway

Need to ensure pathways have common interface with acutes

- When 3 acutes reconfigured, processes in and out of hospital need to be standardised
- Local variations on pathways outside of hospital needed to ensure needs of local population are met

Groups are also developing outcomes for each part of the pathway, and aligning KPIs to each to measure outcomes

Broader Complex Care Leaders Group established to test and challenge group output

Engagement planned with public and wider organisations to obtain feedback on outcomes

4 clinician led groups include: identification and care planning; proactive care delivery; frailty assessment units (FAUs); end of life

Next steps

Q2 16	Q3 16	Q4 16
• Develop outline / strawman • Develop outcomes • Understand gaps to current service • Proposals for double running costs/capita	• Public and staff engagement on proposals • Development of more detailed blueprints • Commissioners realign services/commission additional services (dependent upon funding) • Locality dashboard in use to monitor activity	• Where possible realigned services live in time for winter (e.g. frailty assessment units - FAUs) • Where additional funding received commissioner proposals put in place • Monitoring of KPIs to know if actions making an impact

Ambition to achieve complete transformation of how care for people living with frailty provided

- Evidence from the Vanguards (Salford, Sunderland, Morecambe Bay) points to system integration and partnership working towards a new model of care (5YFV[1])
- Accountability for broader population health is most effective delivery mechanism

Thurrock CCG is already exploring possibility of forming an Accountable Care Partnership (ACP) for this group

- In line with Priority 1 (localities and primary care), particularly Level 4

1. Five year forward view

Priority ❸: acute reconfiguration

Context and goals

Context

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

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

This is leading to increasing operational and financial pressures

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

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

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

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

- There are no deviations from national guidance (Willetts; Briggs; Cumberledge; etc.) at this point

Goals

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

1. Five year forward view
Source: The Nuffield Trust. The reconfiguration of clinical services. What is the evidence? November 2014

Overview of process to date – and next steps

Process to date: Steps 1-4

A seven step approach is being followed that builds advocacy for the model with a small group of front line clinical leaders...

- With the supporting facts and data they need to be advocates

... then builds support through clinical then broader professional groups, whilst identifying second order implications and interdependencies

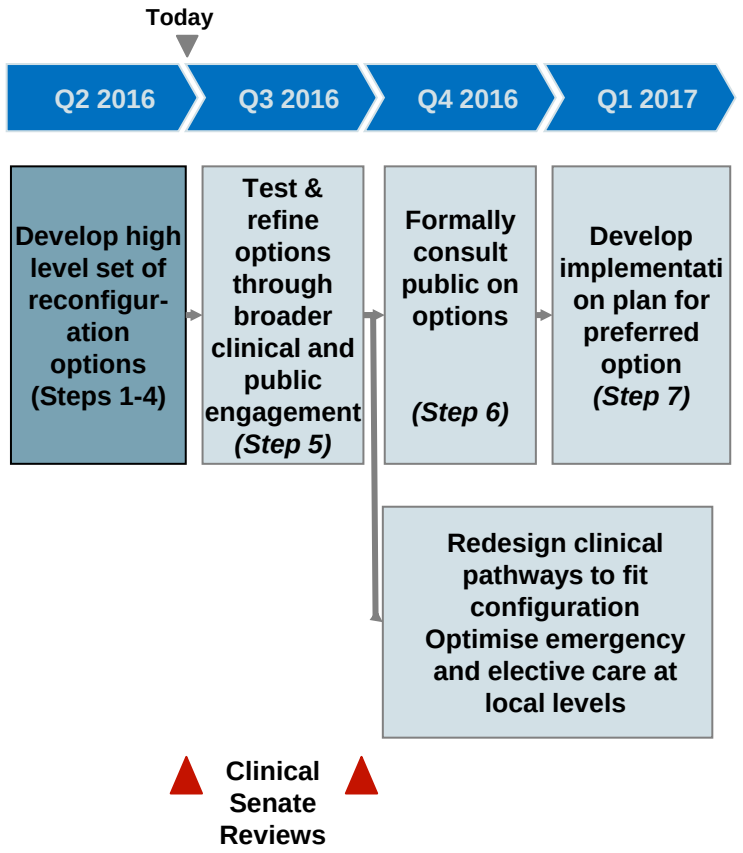
Step 1: Create high-level blue print
- Frame opportunity and set initial targets
- Identified via 1:1 interviews supported by analysis

Step 2: Refine blue print with core clinical leads
- Build out proposal with data and clinical perspective, including delivery plan
- Developed with Medical Directors from each acute Trust and Mid Essex CCG; 10 meetings (Dec-Mar)

Step 3: Test and refine with core clinical group
- Refined by Acute Leadership Group of ~40 clinical /managerial leads from each acute Trust; 4 meetings (Apr-May)
- Co-design (~30 service users) of assessment criteria

Step 4: Test with broader group
- Clinical and Professional leadership Group of ~30 multidisciplinary staff across acutes, primary care, social care, mental health and public (Apr-May)
- Test with clinical senate for external sense-check

Next steps: Steps 5-7



Priority 3

We have agreed an approach to clinical service change

Criteria to be met

Clinical outcomes and patient safety
- Meet national recommendations e.g. Willetts, Cumberlege
- ... and move towards best practice quality standards e.g. Royal Colleges, safe staffing, safety outcomes, 7 day working

Sustainable clinical workforce
- Move towards best practice and improve training opportunities e.g. Royal Colleges.
- Improve quality of working life for all staff

Efficiency and productivity
- Deliver services at lower cost where possible

Access
- Maintain appropriate access to services for patients, relatives and workforce

Interdependencies
- Maintain appropriate clinical adjacencies

Capacity
- No new builds

Givens

Maintain "givens" (high-cost fixed services), as plan to deliver within 2 years
- ...so, no major new builds, use existing infrastructure with refits

The identified givens are:
- Plastics and burns at Broomfield Hospital
- Cardiothoracics at Basildon Hospital
- Radiotherapy / cancer centre at Southend Hospital

Sequenced approach to service design

1. Decide services to move to the community: releases capacity in the acutes (commissioner led workstream)
2. Designate Emergency Hospital Centres (EHC) and adjacent services: starting point due to Willetts's directive
3. Decide location of paediatrics: emergency element needs to align with EHC designation
4. Decide location of women's services: emergency element needs to align with EHC designation
5. Consolidate and separate elective surgery: need EHC designation to proceed

Other specialties will be located according to capacity constraints and clinical adjacencies

Major decision

Emerging narrative

Overall narrative

Effective system interventions will be put in place to stop the rise in non-elective admissions

All three hospital sites will still provide services for the majority of local patient visits ...

... including access to emergency care; maternity services (either OLU[1] or MLU[2]), selected medical admissions and step down beds, diagnostics and outpatients

In addition, centres of excellence likely to be established:

- A specialised emergency centre will receive life threatening emergencies, and will be able to offer an enhanced service (e.g. higher levels of consultant presence; more rapid access to diagnostics and interventions)
- Elective surgical centre(s) could treat patients in dedicated theatres and inpatient facilities to ensure better outcomes and a more reliable and efficient service
- An obstetric unit will be established to deal with high risk deliveries, concentrating experience and expertise
- Childrens centre(s) will be established for inpatient paediatrics

Preliminary options
Example – emergency care

	Site A	Site B	Site C
"As is"	Specialised emergency centre	Specialised emergency centre	Specialised emergency centre
Option 1	Specialised emergency centre	24/7 selective ED	24/7 selective ED
Option 2	Specialised emergency centre + / - urgent care centre	24/7 selective ED + / - urgent care centre	24/7 selective ED + / - urgent care centre
Option 3	Specialised emergency centre + / - urgent care centre	24/7 selective ED + / - urgent care centre	Urgent care centre
Option 4	Specialised emergency centre + / - urgent care centre	Urgent care centre	Urgent care centre

1. Obstetrics led unit 2. Midwifery led unit Note: Specialised emergency centre: accepts all patients, with specialised services; for a population of 1-5m, supported by acute medical and surgical specialties. 24/7 selective ED: treats majority of patients arriving at front door, includes consultant supervision (available within 30 mins), contain some facilities and beds to admit and investigate patient's illnesses and injuries. Urgent care centre: receives patient referrals if within agreed protocols and pathways of care, staffed by multidisciplinary teams including at least one registered healthcare practitioner

Priority ❹: mental health

Overview of mental health and dementia

Mental health

Good progress has already been made in CAMHS, where services have been re-commissioned across the system

Nonetheless, certain challenges remain within system

- Increasing support according to specific needs
- Essex remains to be an outlier, with higher than average rates of suicide

The Essex Mental Health Strategic Review was conducted between June and September 2015

- Commissioned jointly by the 7 CCGs across Essex, Essex County Council, the 2 unitary authorities, and both providers

The review outlined a shared, Essex-wide strategy around commissioning and provision of mental health (MH) services, and made a number of recommendations:

- A requirement to conduct needs assessments based on robust data and clinical input
- Based on this, a review of the funding allocations across MH to ensure these are in line with greatest need
- SEPT and NEP to consider their organisational futures together, with potential merger and a single commissioning arrangement from April 2017
- Which services would be provided pan-Essex by specialised trusts vs. which could be integrated locally
- Change to model of care and delivery, outside of secondary care, as well and taking into account link to physical health

A pan Essex AO-level steering group, led by North East Essex CCG (Sam Hepplewhite) is overseeing implementation

- Carol Anderson is the lead accountable on behalf of the STP footprint

Dementia

The system is looking improve the care and support provided to people with dementia and their cares, in line with the Dementia Implementation Plan

As part of this, there is a need to improve the dementia diagnosis rate

- Currently below national average at 62.6%

The system is taking an integrated approach to planning, commissioning and service delivery with local authority adult social care services

- Also significant overlap with mental health, frailty, primary care and locality work, social care, public health, ...

Priorities will reflect needs identified from the joint strategic work on planning future dementia services including:

- Improving access to diagnosis within primary care
- Improving access to specialised diagnostic services for more complex cases within secondary care
- Re-designing pathways in partnership with carers and families
- Support for carers
- Jointly commissioning with social care
- Using both national and co-produced local metrics to assess outcomes

Pathway redesign across mental health

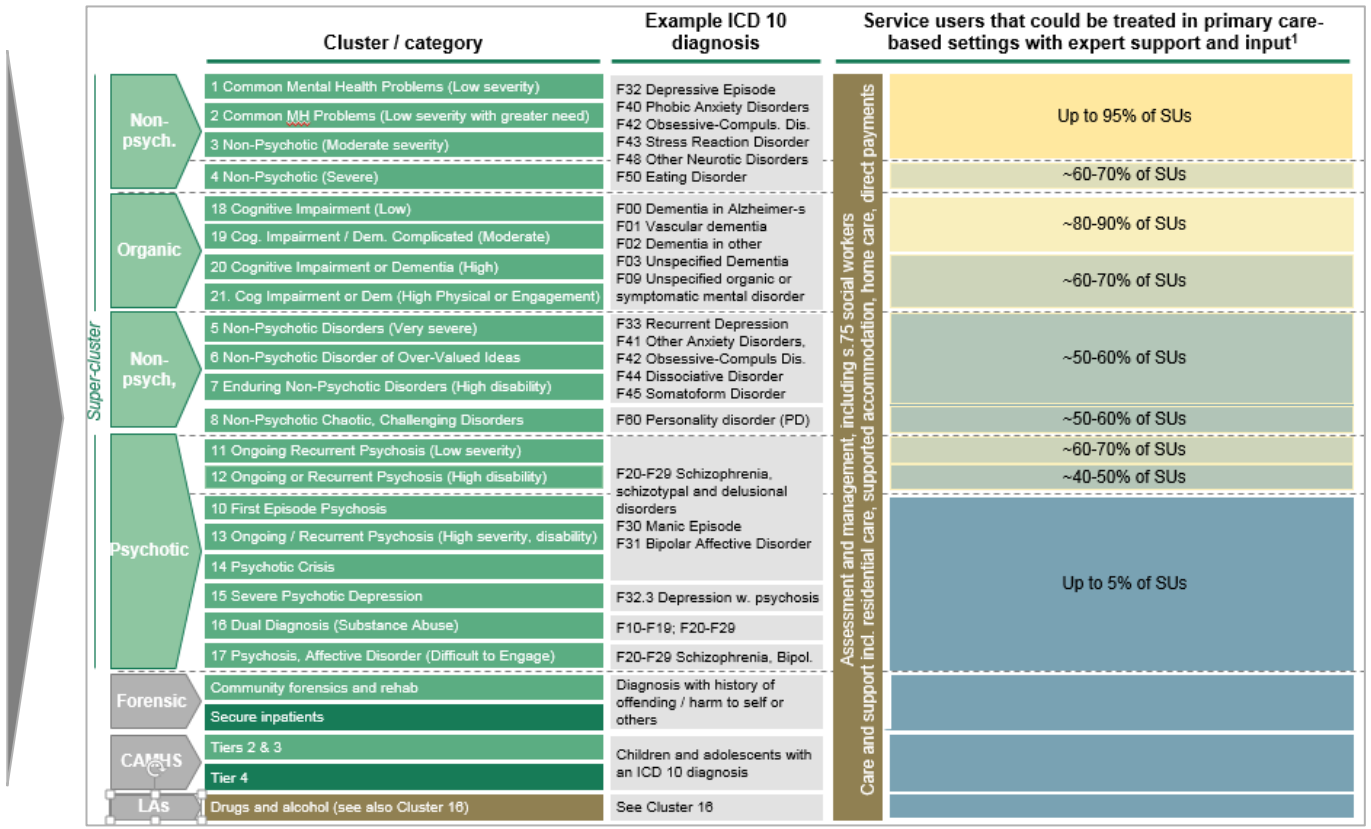
The Essex Mental Health Strategic review identified services which could be more appropriately be provided integrated in a locality setting alongside social, primary, and health care

- Services identified in conjunction with clinicians and service users

Work is underway to redesign the pathways to ensure appropriate specialised support and escalation mechanisms in place in localities

- For example, rapid referral; 24/7 access to specialised care; outreach CPN[2] support; ...

The service users that could potentially be managed in localities and primary care settings are shown below, and include a high proportion of dementia clusters 18-19 (mild and moderate cognitive impairment)



1. Each segment is heterogeneous in terms of diagnoses, severity, and service user (SU) needs: this view will need refining and working through with clinicians. Shared care refers to care shared with a specialised provider. 2. Community psychiatric nurse Notes: This is not a comprehensive view of services; intended for illustration purposes only; excludes some specialised care e.g. peri-natal, eating disorders, adult ADHD which may also be given a Cluster diagnosis; picture is emerging and is based on latest available views.
Source: Stakeholder interviews; Expert interviews

Pathway redesign underpins transformation plans

Acutes

From June to October:

- **Four teams have been set up to look at site level optimisation and redesign (paeds, surgery, womens and acute and emergency medicine)**
  - supported by data and analytics
- **Initial focus will be on the development of site based services**
  - including surgical assessment unit, paediatric assessment unit, midwife led delivery unit, frailty unit
- **Two additional teams will look to optimise performance of current assets**
  - demand management, flow management

From October:

- **6-8 cross Essex pathway groups will finalise clinical strategy, configure regional flows and develop the site level protocols and infrastructure to support new pathways**
  - includes out of hospital representation

Not in hospital

A team is looking across the patch at service redesign for selected specialties

- Led by Dan Doherty; SRO Caroline Rassell

7 specialties have been prioritised for initial review, based on either clinical or financial need

Pain	Address Pregabalin prescriptions; single hub for pain; community based pain management
Dermatology	Open up AQP[1] reprocurement more widely across STP; benchmark best practices internally across AQPs[1]
Neuro rehab	Optimise pathways for those patients requiring complex neuro-rehabilitation. Significant opportunity to reduce length of stay
Neurology	Improve pathway to reduce number of follow-ups and investigations
Rheumatology	(Infusions): liberate acute capacity by proving common day therapy infusions in community
Ophthalmology	Address current quality challenges
Acute paediatrics	Improve shared care pathways between community and acute paediatric teams to reduce duplication and improve patient experience

1. Any qualified provider

System change supported by a simplified landscape

Core focus: deliver at pace to ensure secure sustainable services in line with the 5YFV[1] time frame

Acutes – Group model

Three DGHs – with duplication of services, and all struggling operationally and financially

Establishing a group model with single clinical and support teams

.... and setting up a legal framework to be able to transact business in a joined up way with commissioners and regulators

CCGs – Joint decision making

Complex commissioning landscape – lack of collaboration

- >300 contracts; >100 providers
- Contracting for activity – not outcomes

Chairs actively exploring joint decision making approach

Initial focus: development of an acute joint commissioning function ...

... with ambition to develop joint UEC, LTC, Frailty, PC, Enablers and specialty teams

This will enable the development of lead providers across the STP footprint

Consistent offer

Currently – variability in the services offered across CCGs

- Complexity for providers limiting ability to deliver

Building alignment across CCGs to implement a 'Consistent Offer'[2]

... with standardised service restriction policies (SRPs)

Step 1 (this year) is to robustly implement across all service restriction policies already in place in at least 1 CCG

Step 2 will be to incorporate additional service restrictions

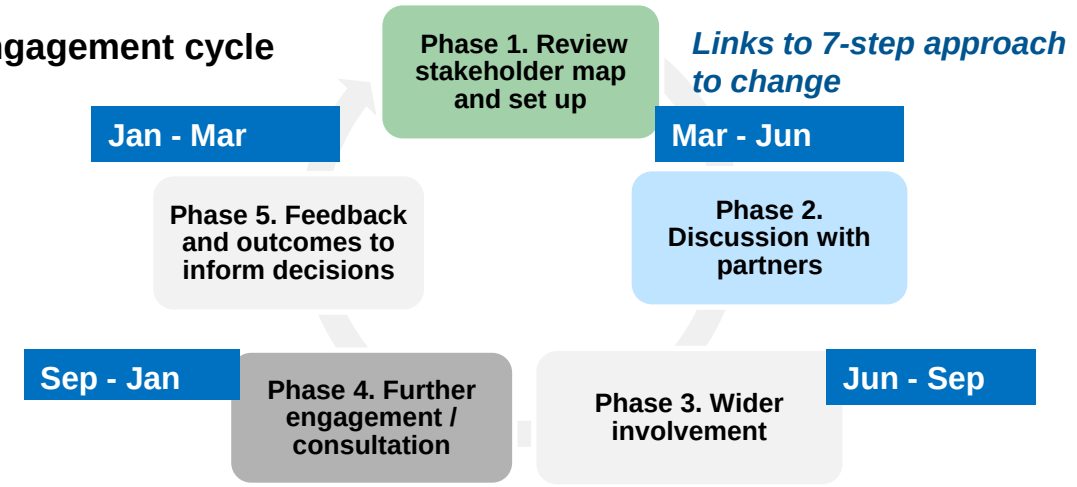
1. Five year forward view. 2. nclude some restrictions, e.g. gluten free food; and some restricted access in line with existing policies, e.g. orthopaedic procedures

Key to success is strong engagement with patients, carers, staff and the public

Aims

- Help build public awareness
- Provide channel for all perspectives to inform decisions
- Strengthen stakeholder relationships to ensure smooth change process
- Promote behaviour and culture change in patients and public to support sustainability
- Fulfil statutory duties

Engagement cycle



Links to 7-step approach to change

Summary of deliverables

- **Coordinated information package** on whole STP/SR - discussion document, support materials, summaries, website, dates of events, social networking
- **Targeted engagement within specific workstreams**
- **Local & STP-wide stakeholder engagement in overall plans**
- **Range of methods** – workshops, meetings, media and digital e.g. podcast debates, online and face to face surveys, focus groups, “on-the-street” e.g. “chatterbox cab”, “In Your Shoes”, “deliberative democracy approach” for reconfiguration
- **Consultation document and programme, when required**
- **Engagement logs, feedback analysis and summary**

Delivery channels

- STP Communications lead
- System-wide Communications and Engagement Group and workstream comms leads – protocols, templates, partnership support
- Service User Forum - advice on process and link to networks
- Independent partners HOSC, Healthwatch – additional programme
- Working groups for in hospital, out of hospital, mental health and LD

Summary of overall STP solutions and accountabilities

STP overview and named leads

Addressing the '10 questions' and key accountabilities

Governance Anita Donley

2 **Engagement** Wendy Smith

1 **Prevention**

Prevention
Mike Gogarty

3 **Improving general practice**

Localities
Ian Stidston

GP / PC
Ian Stidston

4 **New models of care / service redesign**

Complex conditions; frailty
Mandy Ansell

Ambulance
Melanie Craig

111-OoH
Robert Shaw

Acutes
Caroline Rassell

6 **2020 priorities:**

Mental health: *Carol Anderson*
Learning disabilities: *Mark Tebbs; Simon Leftley*
Dementia: *Carol Anderson*
Cancer: *John Leslie*
Maternity: *Lisa Allen and Jane Foster Taylor*

Mid Essex localities: health and social care

CP&R localities: health and social care

B&B localities: health and social care

Southend localities: health and social care

Thurrock localities: health and social care

Social care Sheila Norris

5 7 **Quality and safety; performance against targets (**system wide)

8 **Innovation, enablers (IT, data, care records, estates)**
Caroline Rassell, with Margaret Hathaway (LDR)

9 **Workforce**
Caroline Rassell; Louise Kitley

10 **System (health and care) model: income, costs, capital, activity, demand** Jason Skinner, Mike Foster

x Question number

Summary (I/III)

	Prevention	Localities	Primary care	Complex: Frailty	999-ambulance
Summary	Focus includes local capability and cultural change through use of MECC[1] approach and addressing lifestyle and broader determinates across the whole system. Target and coordinated approach to focus on vulnerable groups to avoid hospital admissions	Supporting transformation of primary care services by strengthening locality capabilities to offer an expanded array of services on a larger footprint	Four levels of primary care transformation underway Level 1: practices collaborating Level 2: practices sharing services, shared pathways Level 3: reconfiguration to offer a wider array of services Level 4: New model of primary care	Over 75s represent 39% of non-elective acute bed days. Frailty programme looking at four areas identification and care planning; proactive care delivery; acute interface; EoL[2] . Read out end June with current baseline, best practice framework, service for FAUs[3]	Recommission: focus on H&T[5] and S&T[6] Underpinned by staffing changes, expanded clinical support desk, and improved capabilities to treat on the scene. Will also help address performance versus percentage category A red 1 incidents responded to within 8 minutes
STP lead	**Mike Gogarty, Caroline Rassell**	**Ian Stidston**	**Ian Stidston**	**Mandy Ansell**	**Melanie Craig**
Overall priorities/ deliverables	1. Deliver local public health priorities eg MH, obesity, school readiness 2. Ensure we maintain face to face services eg sexual health, substance misuse, 0–19 3. Work with NHS to deliver invest to save around LTC and frailty	All localities to reach Level 4 by 2019/20 1. Primary care (wider than GP) consultations increase by 2,600 2. Average face to face consultation time increased from 12-15 mins 3. Increased GP time on telephone consultation 6-12% 4. Reduced admin time 11-5% 5. OPD appointment delivered in community from acute setting 250k 6. Reduction in OP volume in acute setting -25% 7. Patient experience of primary care +5%		1. Keep bed days flat through identification & care planning, proactive care delivery, acute interface (FAU[3] and D2A[4]) , and coordinated EoL[2] services	1. Increase hear and treat/see and treat, with fewer conveyances through new paramedic staffing structure and expanded clinical support desk 2. Establish STP locality arrangements 3. Deliver the recovery trajectory in RAP[7]
Support for STP priorities	Priority 1: localities and primary care Priority 2: non elective pathway	Priority 1: localities and primary care Priority 2: non elective pathway	Priority 1: localities and primary care Priority 2: non elective pathway	Priority 2: non elective pathway Priority 4: mental health (dementia)	Priority 2: non elective pathway Priority 3: reconfiguration of acutes

1. Make every contact count 2. End of fife 3. Frailty assessment units 4. Discharge to assess 5. Hear and treat 6. See and treat 7. Rapid access programme

Summary (II/III)

	111-OoH	Acutes	Mental health	LD	Dementia
Summary	Commission an optimised 111—OoH service that will reduce inappropriate transfers and will keep activity out of the localities. Underpinned by publicity to increase use; supported by an expanded clinical hub; and with ability to handover directly to out of hospital teams	Establish acute hospitals under a single group model: with single teams and functions, reconfigured and redesigned services, designated A&Es, Separated elective care, consolidated services, improvement of outcomes, rotas and productivity	Essex Mental Health Review recommended review of Essex-wide needs, with bottom up assessment to review funding allocation, followed by phased re-commissioning of services Also made recommendations around MH services for local integration.	Transforming Care Partnership project aims to address disparities in health for people with LD; strengthen community-based support to reduce admissions to LD inpatient services; manage demand to the acutes; re-procure specialist LD health provision across Essex; and ensure personalised care/use of budgets	Core to frailty workstream, and to integrated approach to service delivery with adult social care services. Priorities include approving access to diagnosis within primary care and re-designing pathways in partnership with carers and families
STP lead	**Robert Shaw**	**Caroline Rassell**	**Carol Anderson**	**Mark Tebbs, Simon Leftley**	**Carol Anderson**
Overall priorities/ deliverables	1. Re-commission service with enhanced hub to provide triage for 30% of callers to 111 2. Operators able to directly handover to OoH services/ book PC[1] 3. Reduction in referrals to 999 by 10% (versus momentum)	1. Establish group model across three acutes 2. Reconfigure and redesign clinical services 3. Consolidate back office and clinical support services	1. Community and primary care provision to promote early detection and intervention 2. Crisis care—in line with Willet model, building a sustainable model of 24/7 liaison psychiatry 3. Reduce suicide/ self harm *Note: priorities cover all ages (incl. CAMHS)*	1. Joint commissioning across TCP 2. Reduce inpatient beds from 73 to 46 within three years 3. LD health checks and support within primary care and localities to reduce health inequalities	1. Maintain 2/3 diagnosis rate, particularly in primary care 2. Provide post-diagnostic support to reduce NEL activity; work with voluntary services to support patients and carers in own home 3. Carers support and involvementt—roll out Thurrock model across Essex
Support for STP priorities	Priority 2: non elective pathway Priority 3: reconfiguration of acutes	Priority 2: non elective pathway Priority 3: reconfiguration of acutes	Priority 1: localities and primary care Priority 2: non elective pathway Priority 4: mental health	Priority 1: localities and primary care	Priority 1: localities and primary care Priority 2: non elective pathway Priority 4: mental health

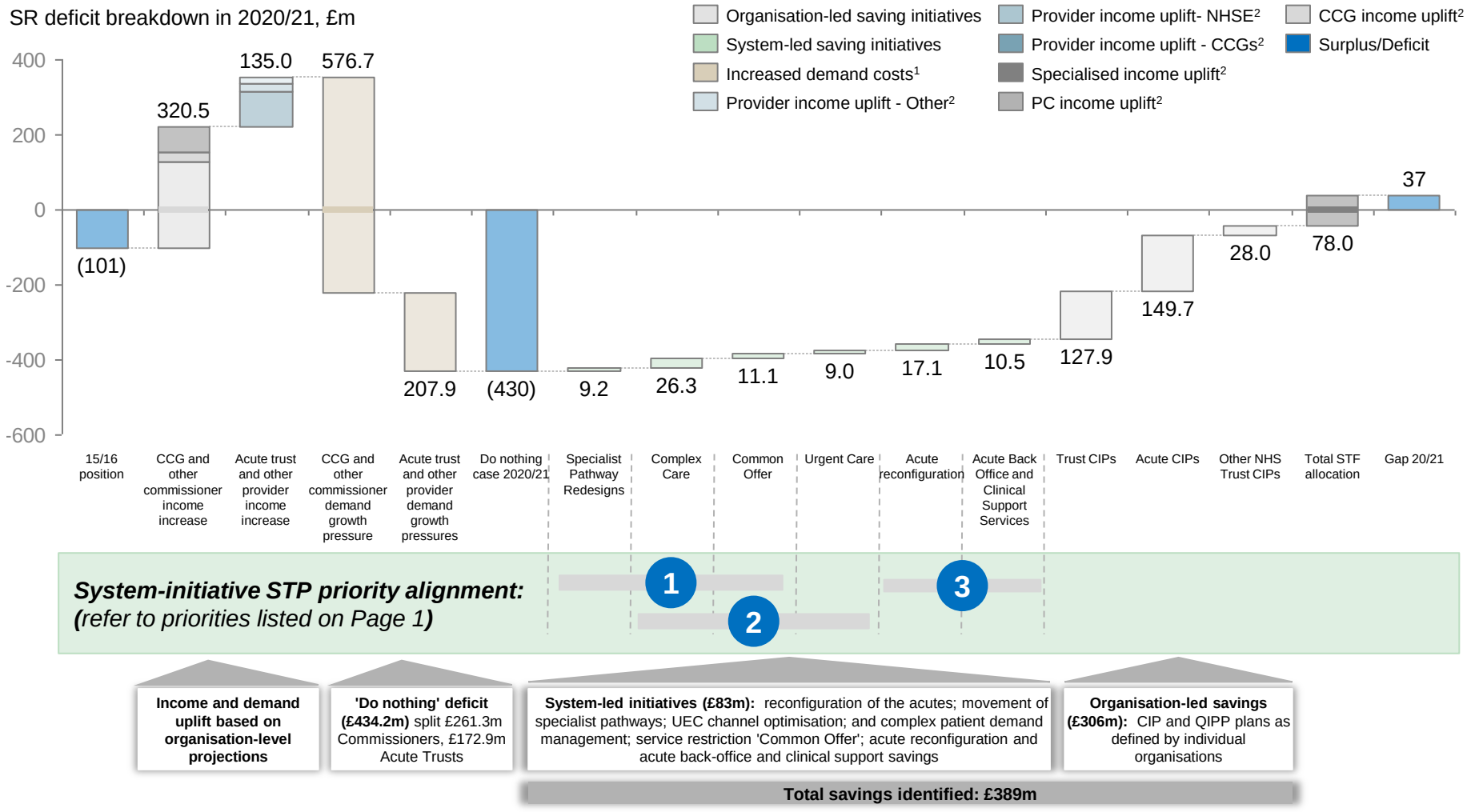
1. Primary care

Summary (III/III)

	Cancer	Maternity	Social care
Summary	Bring cancer care closer to home, improving experience (STP region just below national average) and decongesting acutes. Priorities include resolving demand and capacity issues for treatment, and consistent delivery of cancer standards	Deliver high quality and safe services in line with national guidance (Cumberledge). Offer a choice of type and place of maternity care and birth, and develop personal of budgets Key starting point will be receipt of Essex Maternity Capacity Plan, which will provide data platform from which to build resilience across ESR footprint	Co-ordinated, person-centric approach to enable independence, supporting people to live at home with appropriate level of support Mechanisms include collaborative case finding, identifying those at risk, care co-ordination with GP practices and MDT, and support for carers
STP lead	**John Leslie**	**Lisa Allen; Jane Foster Taylor**	**Sheila Norris; Sharon Holden; Emma Sanford**
Overall priorities/ deliverables	1. Improve early identification and diagnosis through increased diagnostic capabilities in primary care 2. Improved post-treatment support in localities—working with Macmillan and other VCS organisations 3. Focus on skin cancer	1. Reconfiguration of maternity services (as part of acute reconfiguration) 2. More births in the community with greater patient choice	1. Early intervention and prevention through collaboration 2. Co-ordination with MDTs around GP practices 3. Support for carers, including tackling capacity issues
Support for STP priorities	Priority 1: localities and primary care Priority 2: non elective pathway	Priority 3: reconfiguration of acutes	Priority 1: localities and primary care

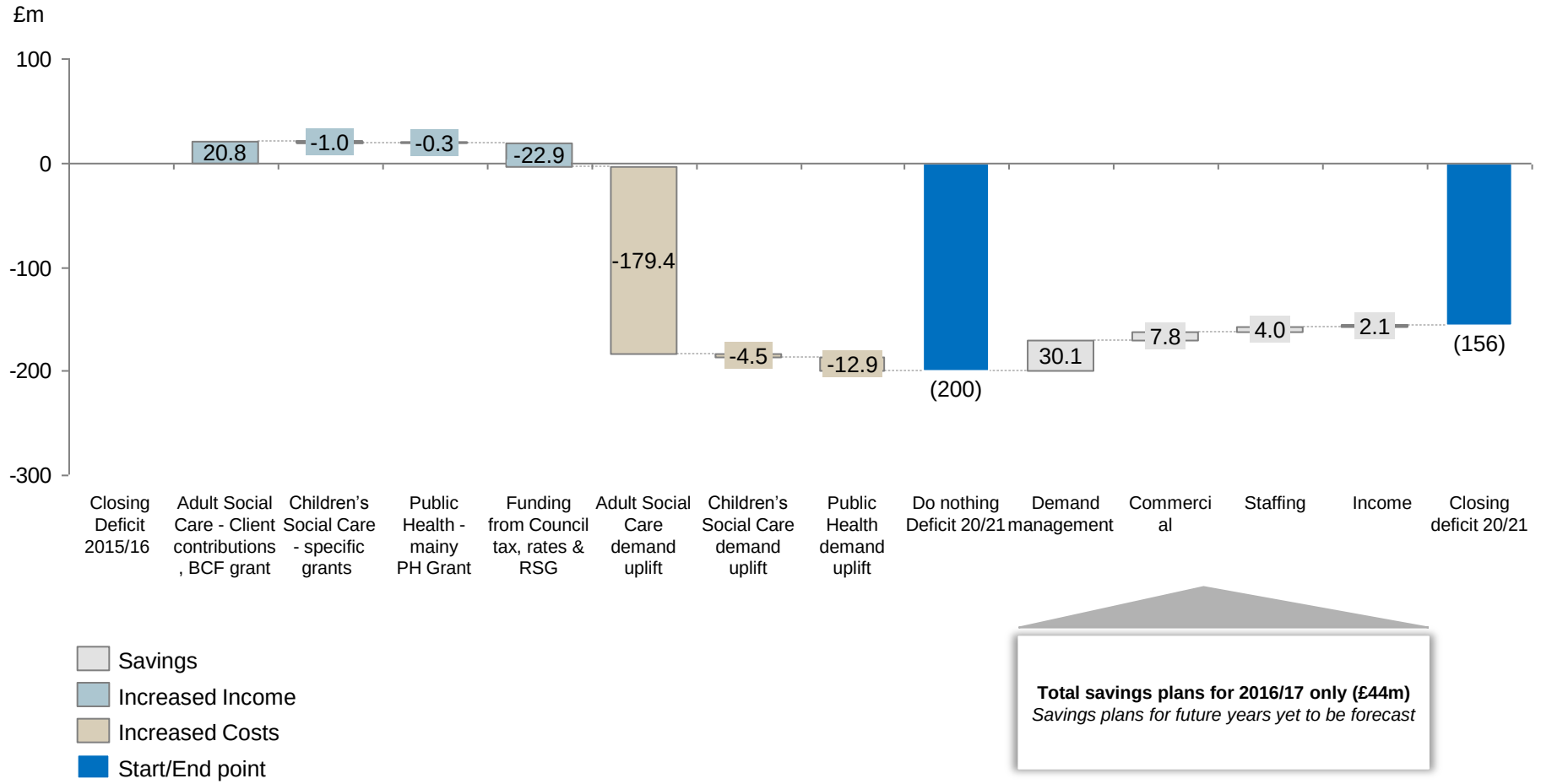
Financial impact

Health system financial bridge 2015/16 to in-year position 2020/21



1. Demand growth pressure is the increased demand between 2015/16 in-year position and 2020/21 in-year position for services based on demographic and non-demographic demand growth projections based on national and local projections per organisation 2. Income uplift is the increase in allocations between 2015/16 in-year position and 2020/21 in-year position based on projected allocations to trusts, CCGs and other NHS organisations Source: Financial model, SR workstreams, Trust and CCG financials

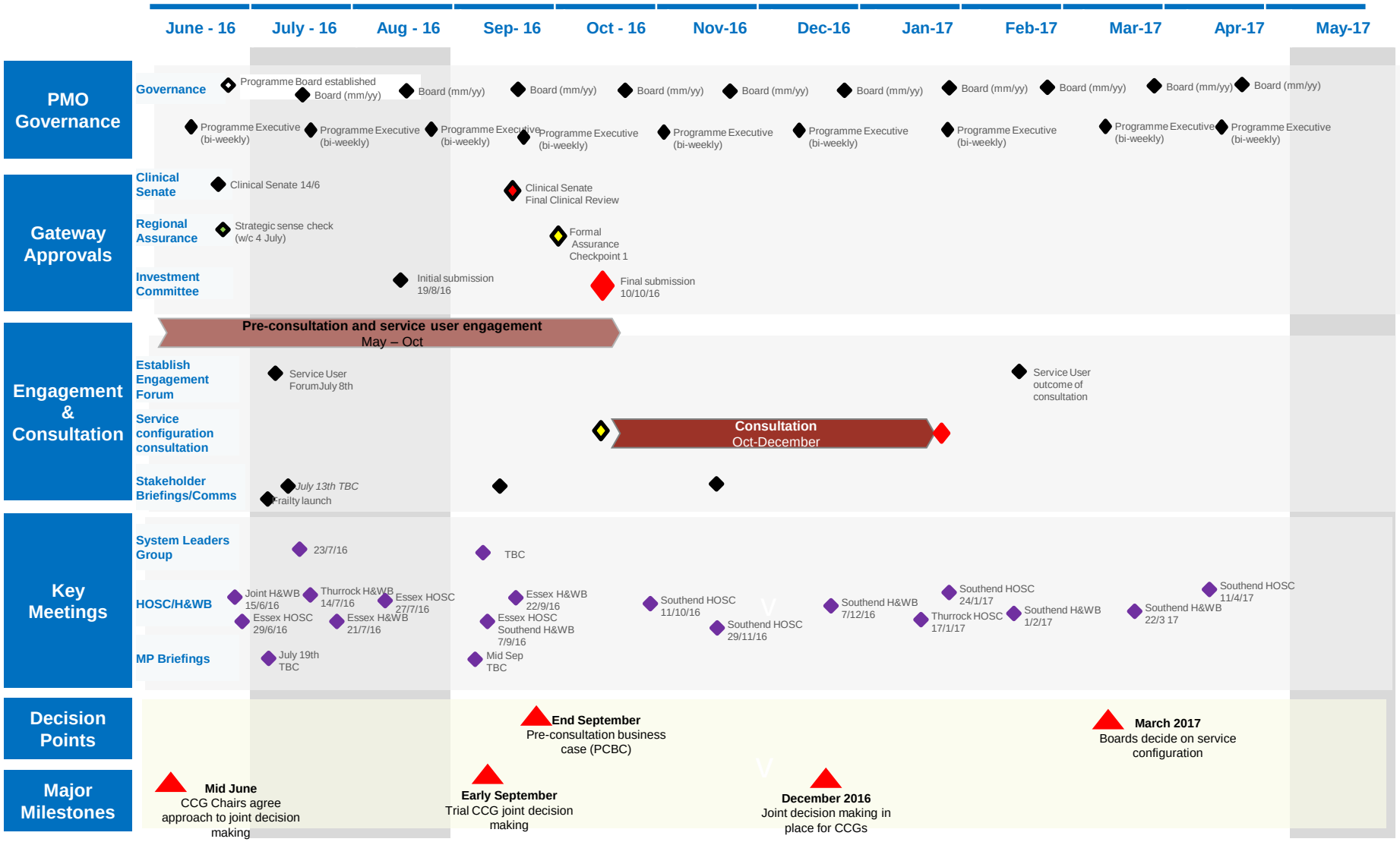
Local Authority financial bridge 2015/16 to in-year position 2020/21



Notes: 1. Council tax increases of 1.99% are included for all three local authorities in 2016/17 and for the two subsequent years for Southend and Thurrock. The County Council has made no assumption about council tax increases for 2017/18 onwards. 2. Social Care precept increase of 2% is included for all authorities in 2016/17 only 3. ECC social care costs are apportioned to Success Regime area on basis of DH Relative needs formula used in BCF calculations. 4. The three authorities have included anticipated increases in Better Care Fund income as per government illustrations and national guidance. 5. For the three authorities combined the overall momentum deficit across all services is £330m, of which £131.1m has been attributed to social care on the Success Regime footprint for the purposes of this exercise.

Delivery: implementation plan and risks

Overview of major milestones



Risks and mitigations

Risk	Description	Mitigation
Delivery	• Limited experience with large scale transformative change of an entire system to result in joint decision making • Lack of redesign skills – need to be able to design care pathways to cope with clinical and organisational needs	• Success Regime infrastructure and support • Partnerships with external organisations (e.g. UCLP for leadership training)
Financial	• Savings opportunities identified may deliver less than anticipated • Significant change requires capital – investment capital may not be available nationally, or access to funding may be unavailable	• Validate assumptions made in savings calculations • Understand specific risks behind each initiative to create detailed mitigation plans (see next page) • Plan around funding schedule
Workforce	• Low level of GPs per head in STP area • Recruiting appropriately skilled staff • Retention of staff during reorganisation: within localities, and acute sites • Maintaining continued involvement and support of staff	• Strengthen localities, encouraging greater integration between local practices • Redesign workforce with GPs taking on different roles • Ensure pro-active work around recruiting and availability of training programmes for staff • Clearly articulated benefits case for end goal; with comprehensive engagement plan • Comprehensive engagement plan with clinical staff throughout process
Political	• Political support for proposed solutions	• Ongoing active engagement strategy: with regular update of emerging solutions
Regulatory	• Disagreement between regulatory bodies around key proposals • Sufficient support from national bodies	• Communication strategy with regulators (see governance section) • Clarity around the "ask", and strong communication on support required
Public	• Widespread public support for the proposed solutions	• Public consultation to be held
Clinical support	• Clinical support for proposals	• Clinically led engagement process – coproduction of solutions