Mid and South Essex
Success Regime

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A programme to sustain services and improve care

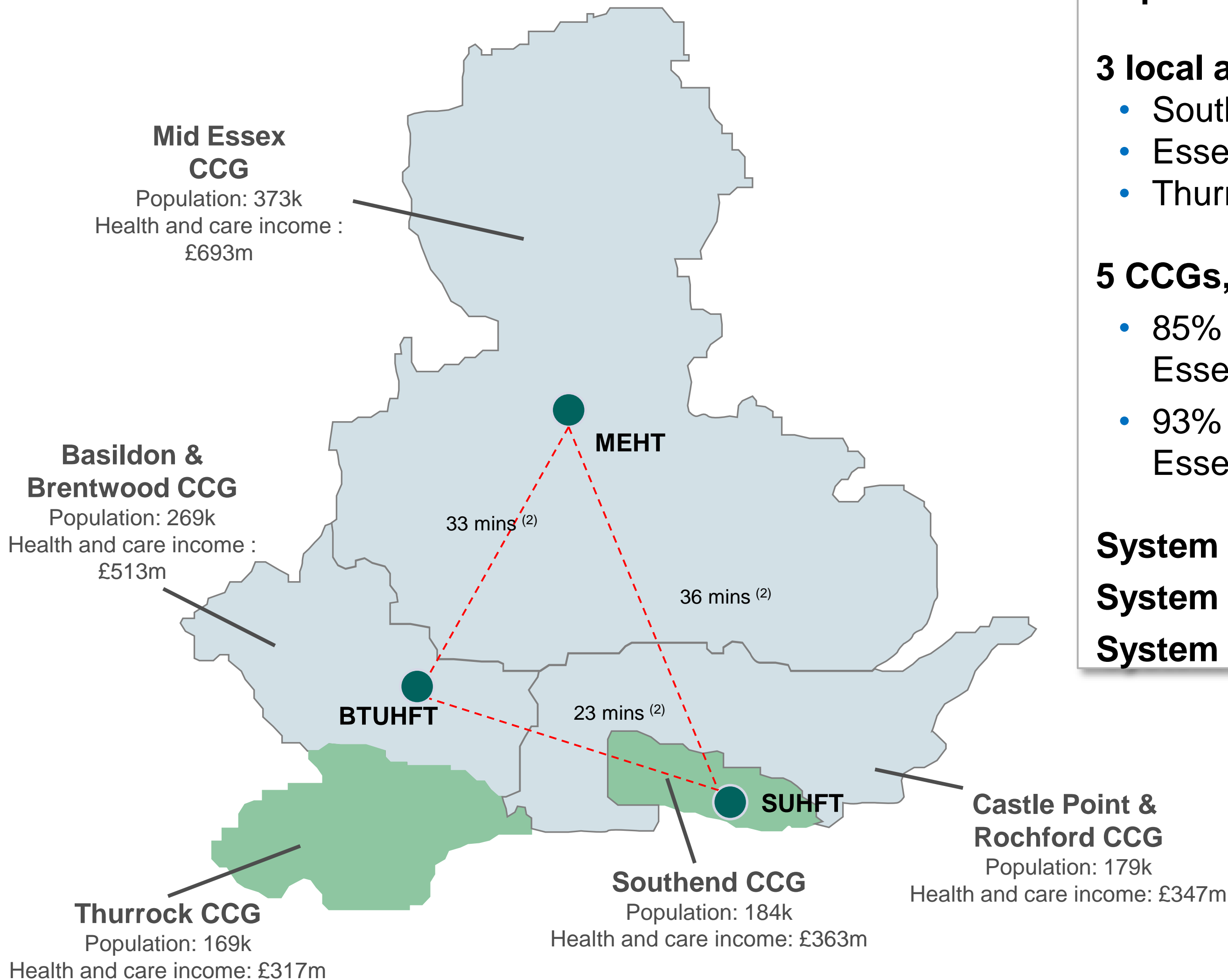
Progress update

21 July 2016

What's in this briefing

- **Overview**
- **The plan in summary**
- Snapshots of some of the main work streams
  - **Prevention**
  - ***Your local services*** **- Joined up health and care in 26 localities**
  - ***Live well*** **– Care closer to you to stay healthy and avoid hospital**
  - ***In hospital*** **– Hospitals working better as a group**
- **Timescales and next steps**

Overview – the planning "footprint"



Population: 1,175k[1]

3 local authorities:
- Southend Borough Council
- Essex County Council;
- Thurrock Borough Council

5 CCGs, 3 Acute trusts
- 85% of acute activity from 5 CCGs remains in Essex NHS trusts
- 93% of local trust activity is from Mid and South Essex patients

System health and care income 15/16[3]: £2,233m
System health and care exp. 15/16[3]: £2,327m
System health deficit 15/16[4]: £94m

Note: all financials are 2015/16 estimates: Version 13,12th Feb modelling assumptions
1. Population based on 14/15
2. Travel times without traffic from google (Jan 16)
3. Includes estimate of social care expenditure (based on 14/15 report) related to health and CCG mental health expenditure
4. Deficit relates to health only

Overview

<table>
<tr><th>Sustainability & Transformation Plan (STP)</th><th>Success Regime</th></tr>
<tr><td colspan="2">• Part of the NHS Five Year Forward View
• Five year plan to secure sustainable, high quality, joined-up care through transformation
• Mid and South Essex “footprint”</td></tr>
<tr><td>Some specific characteristics

• Whole system, all aspects of care
• Incorporates and links to other plans and STPs e.g. some plans Essex-wide
• About partnership and planning</td><td>Some specific characteristics

• One of only three in country
• Focus on highest priorities for change
• Management support to speed up pace
• Financial support including bridging over period of change</td></tr>
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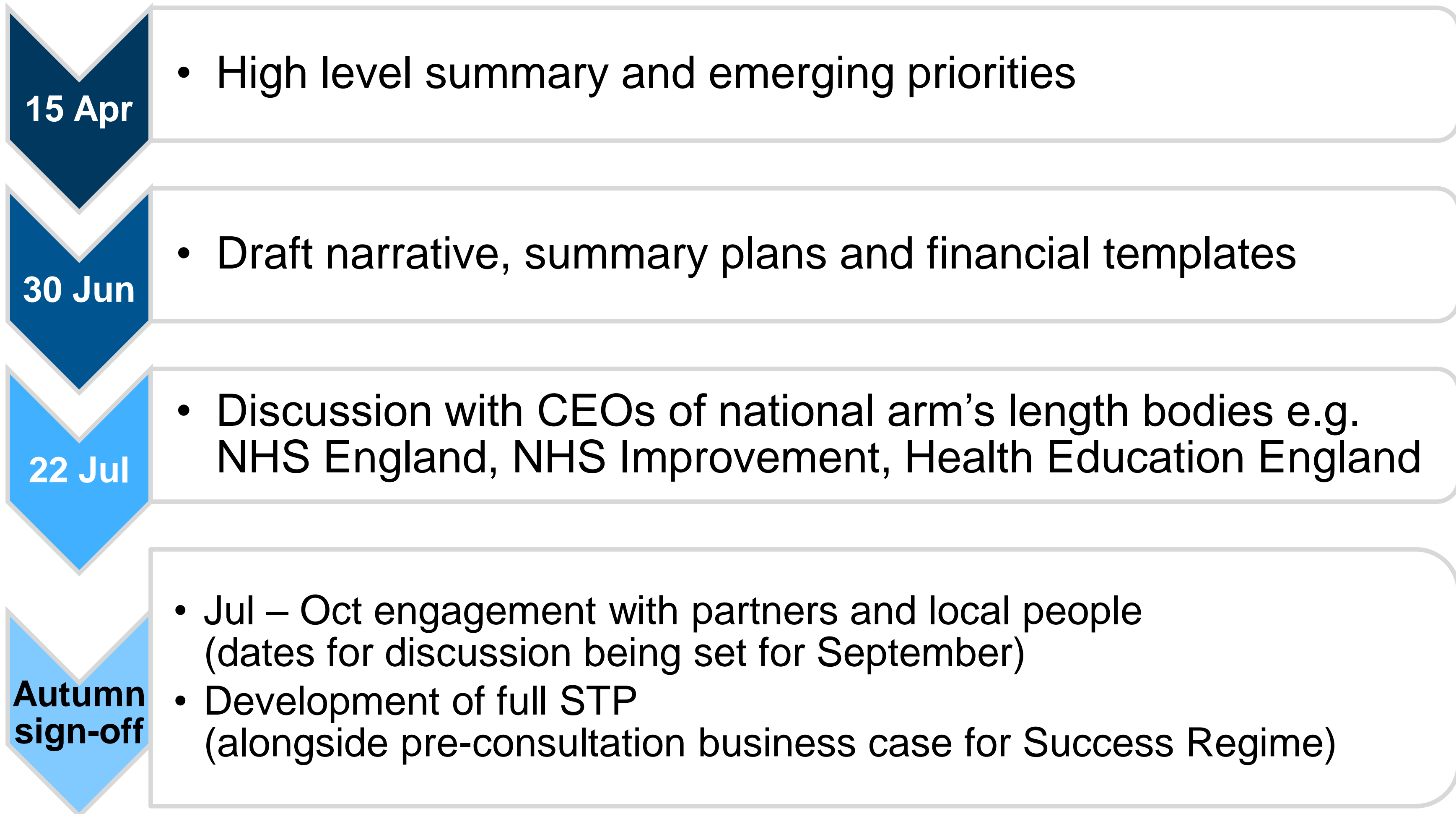
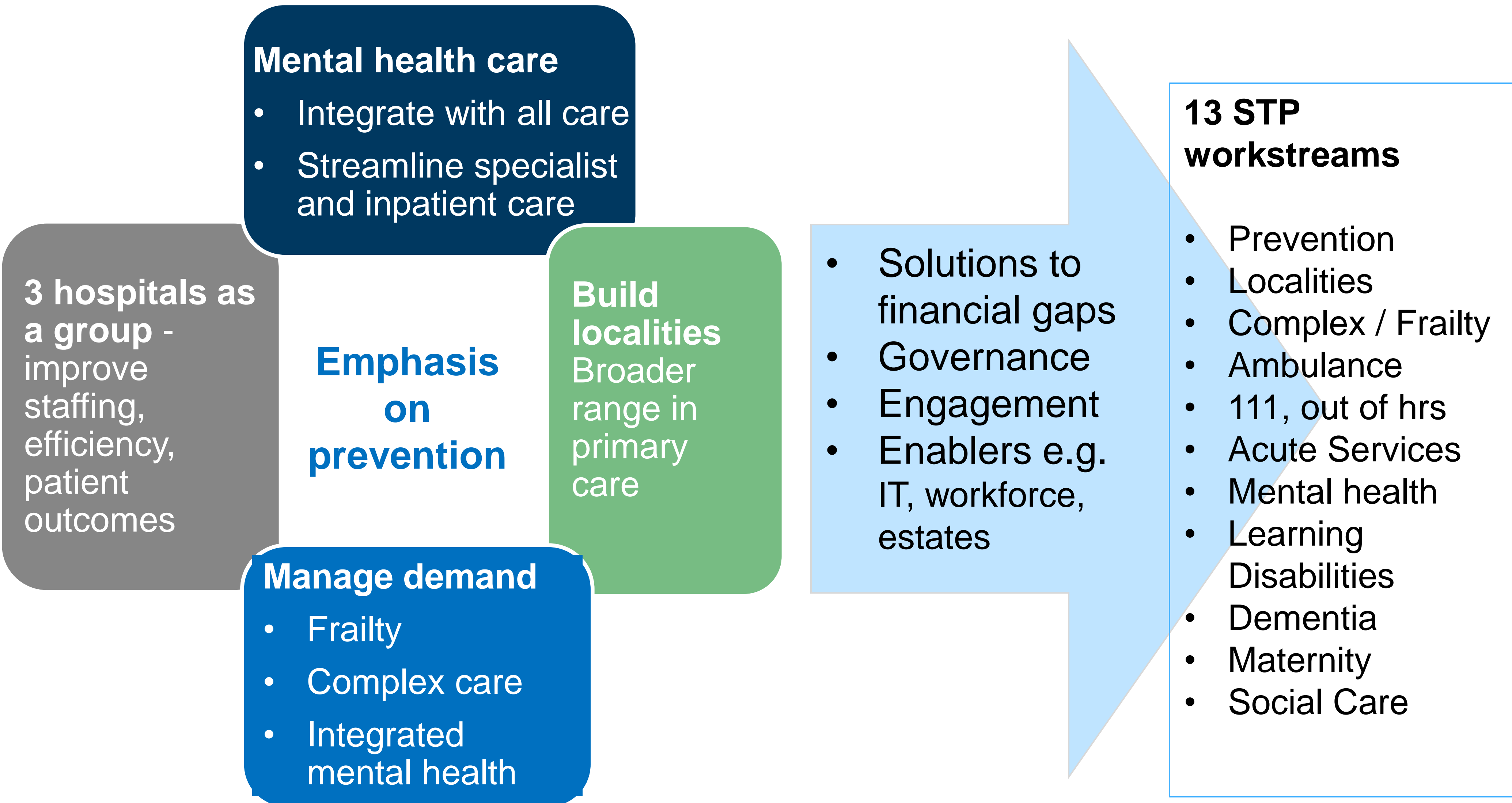
Sustainability and Transformation Plan (STP)



The STP in summary



Prevention

Main strategic points

- New public health strategies
- *Making Every Contact Count* across all public services, including schools – lifestyle change
- More systematic e.g.
  - Health checks
  - Alcohol and substance misuse
  - Falls prevention
- Improve risk prediction, early intervention, crisis management and contingency planning

Aims

- Deliver local priorities e.g. mental health, obesity, school readiness
- Maintain face to face services e.g. sexual health, substance misuse, 0-19 years
- Invest in support for people with long term conditions / frailty

Priorities

- Face to face services
- Health and care partnerships for "invest to save" interventions to reduce hospital admissions e.g. for falls, cardiovascular, alcohol

Your local services – joined up health & care in 26 localities

Main strategic points

- 26 localities - 40-50,000 people
- New style of primary care - GP, community, mental health and social care – **not just GP**
- Collaboration with local authority (e.g. housing) and voluntary services
- Better information - high risk, rising risk and healthy patients
- Consistency across CCGs

Phases of transformation

Level 1 Practices working collaboratively

Level 2 Practices sharing services

Level 3 New services that would previously have been delivered from hospital (or we never had before)

Level 4 Health and care as one, greater range of professionals and support

Live well – care closer to you to stay well & avoid hospital

Main strategic points

- More emphasis on prevention – strengthening resilience – support individuals and communities
  Live Well
- Early identification, risk stratification
- Coordination with urgent care services – 111, out of hours
- Holistic patient-centred care – proactive, closer to home, personalised, planned
- Integrated multidisciplinary support
- Better use of technology, innovation
- Developing future workforce

Focus on frailty and end of life

Identification and care planning

- Risk stratification
- Mutli-disciplinary teams
- Holistic care plans
- Information sharing

Interface between community and hospital

- Blueprint for Frailty Assessment Units
- Integrated frailty assessment team
- Mental health reviews within 4 hrs
- Dementia support specialists
- Discharge to Assess
- Reablement at home

Proactive care delivery

- Out of hospital services
- Single point of access
- Health and social care integration
- Care homes service development
- Falls services
- Coordination with 111 and ambulance

End of life

- Blueprint for end of life care
- Identification and care planning
- System-wide education
- Outcomes aligned to 6 national ambitions
- Raising public awareness

In hospital – hospitals working better as a group

Main strategic points

- Hospital group model for 3 acute hospitals
- Shared corporate office and clinical support functions
- Reconfiguration to improve staffing levels and patient care:
    - Designation for emergency care, one centre for specialised emergency care
    - Separation of planned and emergency surgery
    - Potential for other centres of excellence

Developing options for “in hospital”

Current process

- Acute Leaders Group (around 60 clinicians) considering evidence and possibilities
- Wider groups giving feedback and input to options appraisal
- 12 corporate office and 9 clinical support workstreams in progress

Sequenced approach to decision-making

- Working with community on new models of care
  - Shift services to community settings
  - New pathways to manage demand (link to localities and frailty)
  - Create new capacity and clinical expertise
- Consider possibilities for emergency care to meet national guidance
- Separate elective surgery to improve flow, avoid cancellations
- Identify services to consolidate and specialise
- Redesign pathways and internal services to improve patient flow
- Test options for public consultation

Emergency care designation

Emergency care centre	Emergency care centre with specialised services
Treats majority of patients	Accepts all patients
Refers life-threatening emergencies to specialised centre for surgery or medical treatment	May receive direct from ambulance for life-threatening emergencies (bypassing other sites)
24/7 access to diagnostics	24/7 rapid access to high tech diagnostics and interventional radiology

- **Specialised model already in practice with Cardiothoracic Centre at Basildon, Burns at Broomfield, Trauma centres in London, Cancer and Radiotherapy in Southend**

Decision rules for reconfiguration and redesign

Reconfiguration

1. The needs of the patient come first
2. Only do it (i.e. implement a new care model) if it is safe
3. Ensure if there is no rationale for service change, then it should not change
4. Deliver in two years: maintain "givens" (high-cost fixed services), no major new builds, use existing infrastructure with refits
5. Split elective and non elective work
6. Consolidate services where the increased volume will improve outcomes
7. The local site should be gateway to all hospital services: Maintain core local services, and links to all sites

Redesign

1. Design along pathways: any service that can be delivered more efficiently and effectively out of hospital, should move
2. All changes should be implemented with measures that allow their impact to be assessed objectively
3. Apply common standards at all sites: measure to ensure the same processes and outcomes
4. All designs / pathways should focus on creating simplicity for patients and referring doctors
5. All staff should be working to the top of their skill set – don't use a doctor where an allied health professional can do it
6. Don't make staff / patients travel when there's a technological solution e.g. telemedicine; remote monitoring; community access to specialist advice
7. Prioritise: initially focus redesign on bigger services / those with lots of interdependencies

Timescales and next steps to consultation

Dates	Action
May/June	• Workstreams mobilised
July - Sept	• Develop emerging options • Wider engagement
Aug	• Further testing and refinement of options • Preparation of “pre-consultation business case”
Sep/Oct	• Further engagement • Feedback analysis and input to pre-consultation business case (PCBC)
Oct/Nov	• National and local assurance prior to consultation • Prep for consultation