Mid and South Essex Success Regime

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A programme to sustain services and improve care

Overview for discussion and feedback

Updated 12 May 2016

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Part 1 - overview

- Background to the Success Regime
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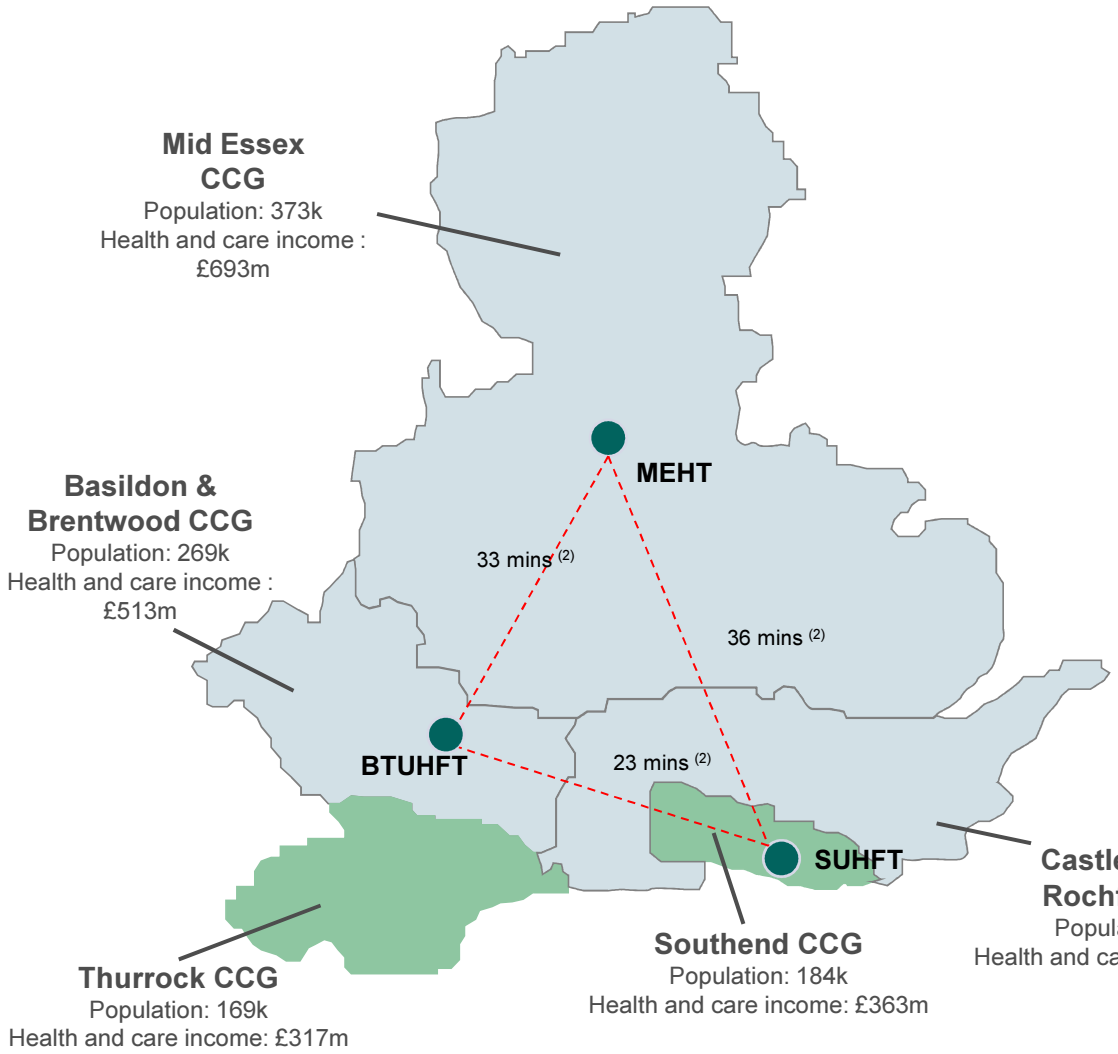
Background to the Success Regime

- Part of the *NHS Five Year Forward View*
  - Sustainability and transformation
  - Accelerate pace of change
  - 1 of 3 Success Regimes (others in Devon and Cumbria)
- Overseen by national organisations:
  - NHS England
  - NHS Improvement
- Management support / help to unblock barriers to change
- Clinicians will drive change together with local people

Action to date

Action	Dates
Announced	June 2015
Diagnostic phase	October – November 2015
First phase of planning	November 2015 – February 2016
Published overview	1 March 2016
Discussion phase	March – June 2016
Mobilisation of working groups	March – June 2016

The challenge (1/3)



Population: 1,175k[1]

3 local authorities:

- Essex; Southend; Thurrock

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

The challenge (2/3)

Key challenges

1. **Clinically and economically disadvantaged hospitals**
2. **Workforce and talent gaps**
   - Rota gaps (e.g. A&E); GP capacity
3. **Complicated commissioning landscape**
   - 5 CCGs; 3 LAs; >300 contracts
4. **Limited data usage and data sharing**
5. **Time and effort spent on decision-making can be protracted**
6. **Senior managerial and clinical leader capacity focused on operational imperatives**

Root causes

Urban social geography of Essex

National and local trends

Distance between actual and target funding for Essex

Rising demand in health and social care

Few co-terminous boundaries

No overall Essex plan and few 'givens' around acute footprint

1. Based on Version 7 January, 15th financial modelling

The challenge (3/3)

2015/16 financial position for the NHS - currently estimated as an in-year deficit of £94m[1]

If we took no action, that in-year system deficit increases each year by between £35-44m

- Income each year does not cover the effects of rising demand and inflation

Need to make recurrent savings of around £70-£80m a year to be in balance in 18/19

- Requires a total saving of around £94m
- Plus a further £35-44m saving each year to meet new growth in demand and rising costs

Working with local authorities on social care position

1. Version 13 of modelling, February 12th
2. Individual acute trust deficits do not sum to the total acute trust deficit due rounding
3. Acute demand growth of 3% based on weighted average of 2.3% for non-elective and 3.3% for elective demand - based on January 2016 NHSE guidance

Six main areas for change

1. **Address clinical and financial sustainability of local hospitals**
   - Increasingly collaborate and share services across three sites
   - Potential savings in back office and clinical support services
2. **Accelerate plans for changes in urgent and emergency care**
   - Meet national recommendations
   - Further develop urgent care in communities
   - Identify options for improving sustainability of emergency and planned care
3. **Join up community based services**
   - Integrate GP, social care, mental health and community services around defined localities or hubs
4. **Simplify commissioning, reduce workload & duplication**
   - Reduce number of contracts (currently over 300)
   - Commissioning on wider scale
5. **Develop a flexible workforce**
6. **Better data sharing**

Benefits

Clinical

- Improved staffing levels
- Care consistency through joint teams
- Meeting/exceeding standards
- Fewer “crisis” events

Workforce

- Attractive roles / responsibilities
- Skills development
- Career progression
- Flexibility to adapt to change
- Satisfaction of better outcomes

Patients

- Care closer to home
- Joined up and personalised care
- Focus on prevention / early intervention
- Higher quality / safer care
- Better outcomes

Part 2 – Broad components of the plan

- **Local health and care overview**
  - Joined up services around localities
  - Better management of urgent care
  - Simplified commissioning

- **Hospital collaboration**
  - Significant step towards single teams
  - Principles for clinical redesign

Local health and care overview

1 **Build strong localities: that can deliver more integrated services**

- Build on existing CCG plans and bring more care closer to home,

2 **Better management of urgent and emergency care**

- Focus on people at risk of admission, assessment and early treatment for frail and older people

3 **Simplify commissioning**

- Reduce duplication – *'do once not five times where possible'*

Joined up services around localities

New model of integrated out of hospital care

- Based around clusters of GP practices
- Populations of 40-50,000 people
- Co-location where feasible
- Integrate GP, community, mental health and social services
- Stronger links with 111 and GP Out of Hours
- Focus on prevention and those with greatest needs (e.g. frail older population)
- Focal point for voluntary services
- Enable stronger links with other public services e.g. housing

Better management of urgent care

National recommendations include:

- Active management of those at risk of admissions
- Develop frailty assessment units
- Improve clinical triage: 111-OoH; 999
- Consistent health and social care support for frail elderly leaving hospital
- Consider 24/7 mental health crisis service
- Designation for specialist emergency care

Simplified commissioning

Five CCGs to work collaboratively with agreed leads for services

- Aim to reduce bureaucracy, focus on developing services

Simplify contracts by commissioning services around population groups - lead provider to coordinate delivery

- Reduce from around 300 to around 50 contracts

Develop a 'consistent and common offer'

- Supports commissioning across the five CCG populations
- Focus on priority needs with potential to reduce activity that has limited clinical benefit

Hospital collaboration

All acutes realise the need for close 'working together'

- Builds upon existing collaborative activities

Take a significant step towards single teams

- clinical teams, clinical support and back office functions

Benefits of this closer working will enable:

- Evidence-based clinical processes to improve outcomes and reduce costs
- Optimal service arrangements across sites
- Shared expertise and development of sub-specialisation
- Scale advantages and reduction of duplication

The three acute boards have established a joint committee

Principles for clinical redesign

1. **Start from a patient and service user perspective**

2. **Avoid moving or replicating high fixed cost services**
   - Maintain some "givens"

3. **Ensure deliverability by 2017**
   - No major new builds, use of existing infrastructure

4. **Ensure clear rationale for any service redesign**

5. **Design along pathways**
   - Move care between hospital and community, and increase integration

Work led by clinicians, with input from staff, patients and service users, and the public

Making change possible

IT

Create a shared care record across the SR patch which provides real-time cross-sector access – for example, NHS 111 able access to primary care GP records

Data

Create a system-wide patient and service user dataset to track SR targets and enable deeper insights to support delivery of care

Estates

Explore the potential to take a different approach to estates to support new models of care and release value

Workforce

Support workstream initiatives to realise plans, e.g.

- Develop an Improvement Academy to empower and equip clinicians around pathway redesign
- Enabling primary care to create new roles for other professionals to free GP capacity

Part 3 – Next steps, involvement and consultation

Timeline	Action
1 March – end May	• Discussions with local bodies, boards, including discussions on service user involvement • Set up of Service User / Carer Forum • Service users / carers start join up with workstreams
May - Aug	• Next phase of discussions in more detail • Service users / carers actively involved with workstreams
Aug – Sept	• Emerging options for consultation • Refine and test options
Oct - Dec	• Start of public consultation
Jan – Mar 2017	• Outcomes and decisions • Plan for implementation • Plan for continued service user / carer involvement