Mid and South Essex Success Regime

A programme to sustain services and improve care

Operational Briefing

Tuesday 1 March, 2016

Overview: Success Regime (SR)

SR and diagnosis

SR launched in June 2015

Diagnostic phase ran October to November 2015

Two core recommendations:

- Mid and South Essex as the geographic scope of SR
- Six core areas to address

Implementation planning

Ran end November 2015 – mid February 2016

Goal to create an integrated, internally consistent whole system plan for Mid and South Essex…

...which will put the system back into balance in 18/19...

....and enable local organisations to deliver high quality care and address local inequalities

Moving forward

Period for discussion and feedback

Align SR plans with 16/17 operational plans

Align clinical priorities between CCGs and providers on service redesign

Identify and 'formally' kick off appropriately resourced workstreams…

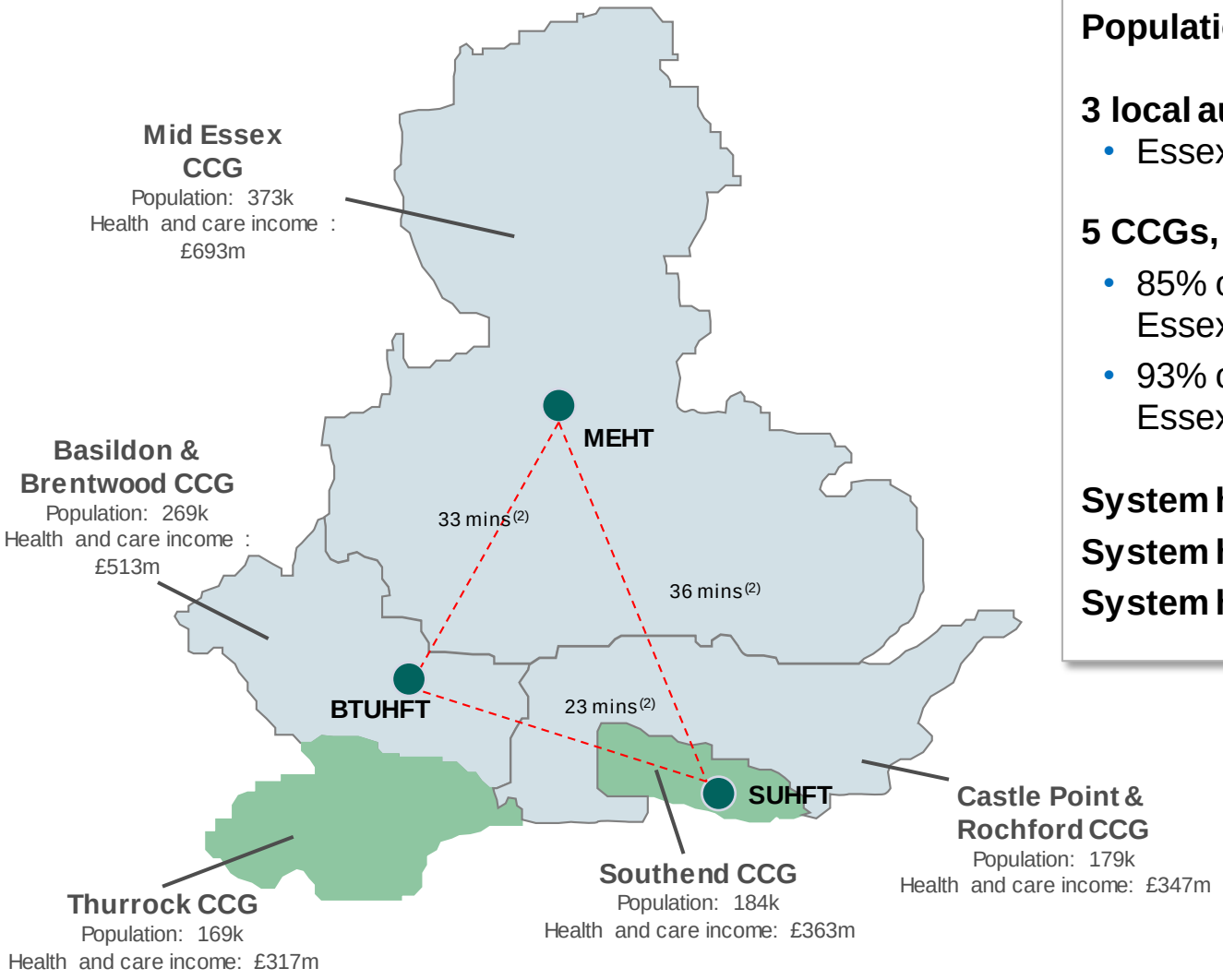
...working to clear objectives, scope and milestones, with aim of delivering significant changes in 16/17

Who has been involved: broad engagement across multiple settings

- Regional Directors: 6 meetings
- Senior Leadership Group: 4 meetings
- Acute Trust CEOs: 6 meetings
- CCG Accountable Officers: 8 meetings
- Acute Chairs: 4 meetings
- CCG chairs: 4 meetings
- CPLG: 2 meetings
- Directors of Finance: 10 meetings
- Medical Directors: 10 meetings
- SR workstreams: ~50 meetings

Plus hundreds of 1:1 discussions across the patch

Key facts about Mid and South Essex



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

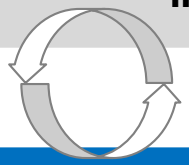
Note: all financials are 2015/16 estimates: Version 13, 12th Feb modelling assumptions

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

Recap: challenges and root causes

Key challenges

1. **Clinically and economically disadvantaged acute footprint**
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, with decisions often re-opened**
6. **Senior managerial and clinical leader capacity focused on operational imperatives**



Root causes

Urban social geography of Essex

Population health inequalities

Rising demand in health and social care

National and local trends

Few co-terminous boundaries

Distance between actual and target funding for Essex

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

Overview: diagnostic recommended six areas of focus

1. **Correct the clinical and financial disadvantage of the acutes**
2. **Create / accelerate UEC plan based on national recommendations**
3. **Accelerate existing strategies for primary, community and social care integration**
4. **Simplify commissioning and reduce workload and duplication**
5. **Enable greater flexibility of workforce across organisations**
6. **Raise level of data availability and data sharing**

Enablers

SR goals

1 Create and support the development of a transparent, internally consistent, whole system plan to:

- Enable organisations to deliver high quality care for patients and reduce local health inequalities
- Put the system into financial balance in 18/19; secure sustainable services for the future
- Address root causes identified in the diagnostic
- Provide directional clarity to enable organisations to plan over next 2-3 years

2 Establish a locally led and nationally supported programme to deliver the plan

- Build and extend existing strategies and collaborations which are consistent with 5YFV
- Foster greater balance between system view and organisational view
- Incorporate building change and other capabilities in leaders and workforce

3 Use tripartite oversight to unblock barriers to enable delivery at pace

- Apply flexibility to business rules; give 'permissions'
- Encourage a system approach, collaboration, and focus on 5YFV
- Bring national expertise and other forms of support to bear
- Enable headroom for change from national operational requirements

Proposed model of care

Models of care described in this plan are consistent with the 5YFV...

...and are largely an acceleration of many of the existing provider and commissioner strategies

1. **Deliver more services or parts of pathways out of hospital where appropriate, and closer to home**
2. **Drive greater integration at locality level of primary care, community care, mental health, social care, public health and the voluntary sector to deliver services better aligned to local need**
3. **Reconfigure the acute hospitals to ensure delivery of core acute services at each site, yet greater concentration of more specialist care, and greater separation of non-elective and elective care to improve operations**

Key components: 'at a glance'

Recommendations from the diagnostic	Key components of the plan
1 Correct the clinical and financial disadvantage of the acutes	Group model with single clinical and support teams; service reconfiguration to support improved quality and clinical staffing levels
2 Create / accelerate UEC plan based on national recommendations	Whole pathway plan including proactive management for complex cohorts, stronger clinical triage in 111-OoH-999
3 Accelerate existing strategies for primary, community and social care integration	Build strong localities able to deliver greater number of integrated services, closer to patients, with general practice at the core
4a Simplify commissioning	Create a consistent and common offer, agree 'committee in common' approach
4b Create management and clinical capacity by reducing workload and duplication	Reduce duplication, the number of contracts, clarify commissioning teams and look for ways to reduce 'bureaucracy'

Enablers: high level objectives

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

- In line with Five Year Forward View requirements

Data

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

- For example, locality-level dashboards with baseline, outcomes and targets

Estates

Explore the potential to take a different approach to estates, including enhanced utilisation of core estate to support new models of care, and value released out of non-core sites through sale, remodelling, innovative financing

Workforce

Support to workstream initiatives to realise plans, e.g.

- Development of an Improvement Academy for the acutes at Group level to empower and equip clinicians around pathway redesign
- Enabling primary care to create new roles for other professionals to free GP capacity

Size of the challenge

The 2015/16 position for the system is currently an in-year deficit of £94m[1]

- £92m of which sits in the acute trusts: £43m MEHT; £32m BTUFT; £18m SUHFT[2]

Each year, the in-year system deficit increases by between £35-44m

- Annual system income driven predominantly by CCG allocations of between 2-5%…
- …which do not compensate for the effect of demand growth and inflation
  - acute demand growth ~3%[3]
  - other demand growth (e.g. primary care, mental health, prescribing) between 2-7%
  - inflation 2-3%

System needs to make recurrent savings of ~£70-£80m a year to be in balance in 18/19

- Requires a total saving of ~£94m (i.e. ~£30-£35m each year) to correct current in-year deficit
- Plus a further £35-44m saving each year to meet new growth in demand and rising costs

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

Size of the challenge:
Momentum case income vs expenditure by year

Version 13, February 12th

	15/16	Change in 16/17	Change in 17/18	Change in 18/19	18/19 momentum case
Income	**£1,837m**	**£76m**	**£57m**	**£61m**	**£2,031m**
Expenditure	**(£1,931m)**	**(£112m)**	**(£99m)**	**(£105m)**	**(£2,247m)**
Net deficit change each year	**(£94m)**	**(£35m)**	**(£42m)**	**(£44m)**	**(£216m)**
Total in-year deficit	**(£94m)**	**(£130m)**	**(£172m)**	**(£216m)**	

Source: Financial model

Potential savings identified to date

Version 13, February 12th

Cost reduction — £27m

Clinical services — £17m
- Reconfigure around hub and spoke, reduce agency spend

Clinical support and back office — £10m
- Drive efficiency through better resource management

Shift activity to lower cost settings — £18m

Unplanned — £9m
- Improve out of hospital triage to reduce A&E attendances

Planned — £9m
- Shift follow-up outpatients into community to reduce volume

Demand management — £44m

Complex care management — £25m
- Increase active mgmt. of complex cohorts to reduce non-elective admissions

Common offer — £19m
- Create consistent service offering across SR

£125m

CIPs — £64m
- Acute CIPs

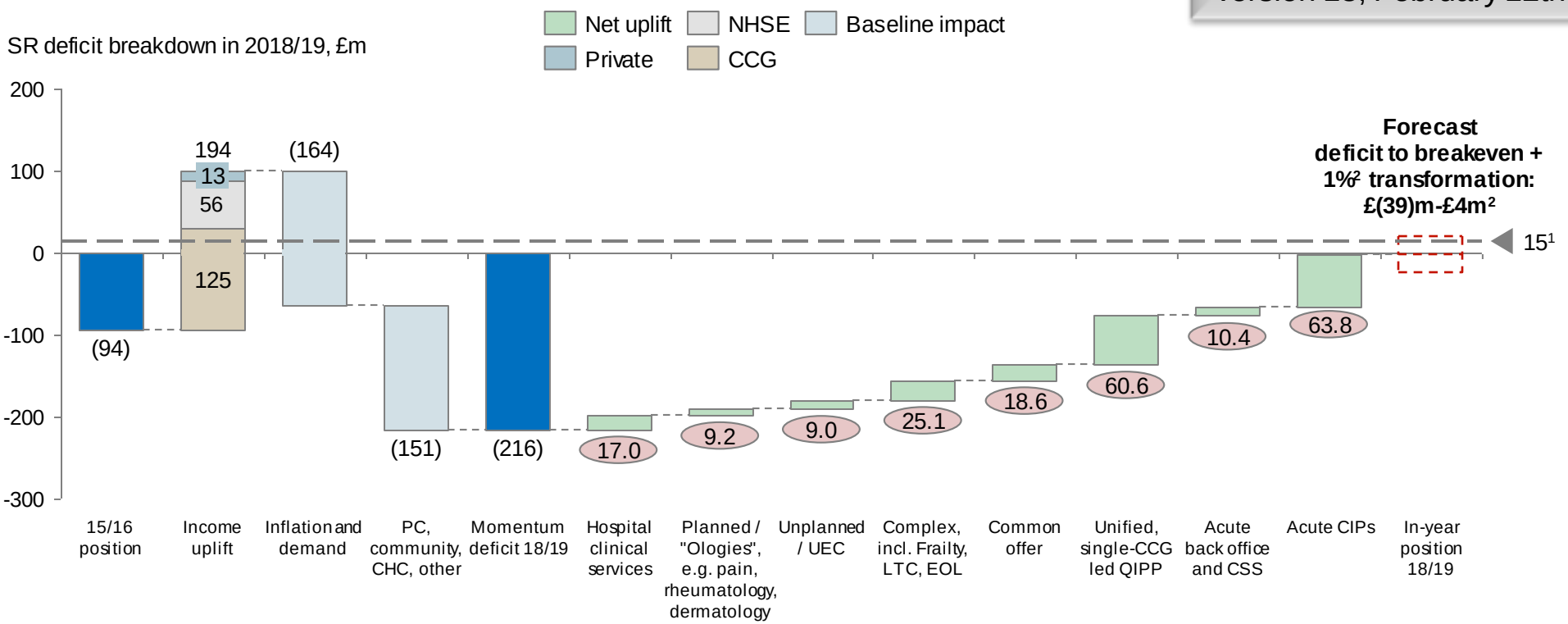
QIPP — £61m
- Joined-up CCG QIPP plan, e.g. prescribing; CHC

Source: Financial model, SR workstreams

System bridge

2015/16 to in-year position 2018/19

Version 13, February 12th



Acute deficit £92m ((BTUFT: £32m, MEHT: £43m, SUFT: £18m); CCG deficit £2m

CCG allocations corrected for GP IT, ETO, CAMHS

Acute demand 3.3% elective, 2.3% NEL based on Jan 16 NHSE

Includes net expenditure out of Essex

Redesign of clinical services (£60.3m): reconfiguration of the acutes; movement of selected pathways out of hospital ("ologies"); UEC channel optimisation; and complex patient demand management

Simplification of commissioning (£79.2m): "common Offer", unified single-CCG led QIPP plan

Removal of fixed costs (£74.2m): acute back-office and clinical support savings; acute CIPs

Stretch of existing initiatives; estates; redesign with top down view; and review of areas not yet assessed

Total savings identified: £213.7m

Moving forward: next two months

Discussion and feedback from boards, governing bodies and local partner organisations

Engage with and gather inputs from national experts, local clinicians, service users and local communities

Align SR plans with 16/17 operational plans

Align clinical priorities between CCGs and providers on service redesign sequence

Adjust the programme governance to the implementation phase

Start mobilisation and create implementation teams

Draft key milestones (I)

Key Milestone	Date	Following actions
SR operational briefing circulated	1st March	Start of discussions with Boards and Governing Bodies which runs to 2nd May
Align SR plan for 16/17 with operational targets	Early April	Align plans and targets (e.g. for QIPP / CIP) based on agreed contracts
Programme governance in place for next phase	April	Formal 'launch' of work streams with agreed deliverables, milestones, dates and teams
Refine SR plan to include Board feedback	Mid May	Confirm full clinical redesign programme for hospital, out of hospital and urgent care services
Proposed options for key services changes identified	End May	Start of patient, clinical and staff engagement on potential service changes and implications

Draft key milestones (II)

Key Milestone	Date	Following actions
Acute Boards agree 'Committee in Common'	End May	Programme governance adjusted to account for Committees in Common • SROs to lead joint working
CCG Governing bodies agree 'Committee in Common'	End June	
End of engagement on development of options	Early Sept	Refinement of options based on input from patient, clinical and staff engagement
Start of public consultation	Late Sept	Formal public consultation around key services changes
End of public consultation	Late Dec	Finalisation of clinical service changes and implementation timelines

Local health and care overview: three goals

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

- Build on and extend existing CCG plans, bring more care closer to home, including shared care with acute, community, social care and specialist providers

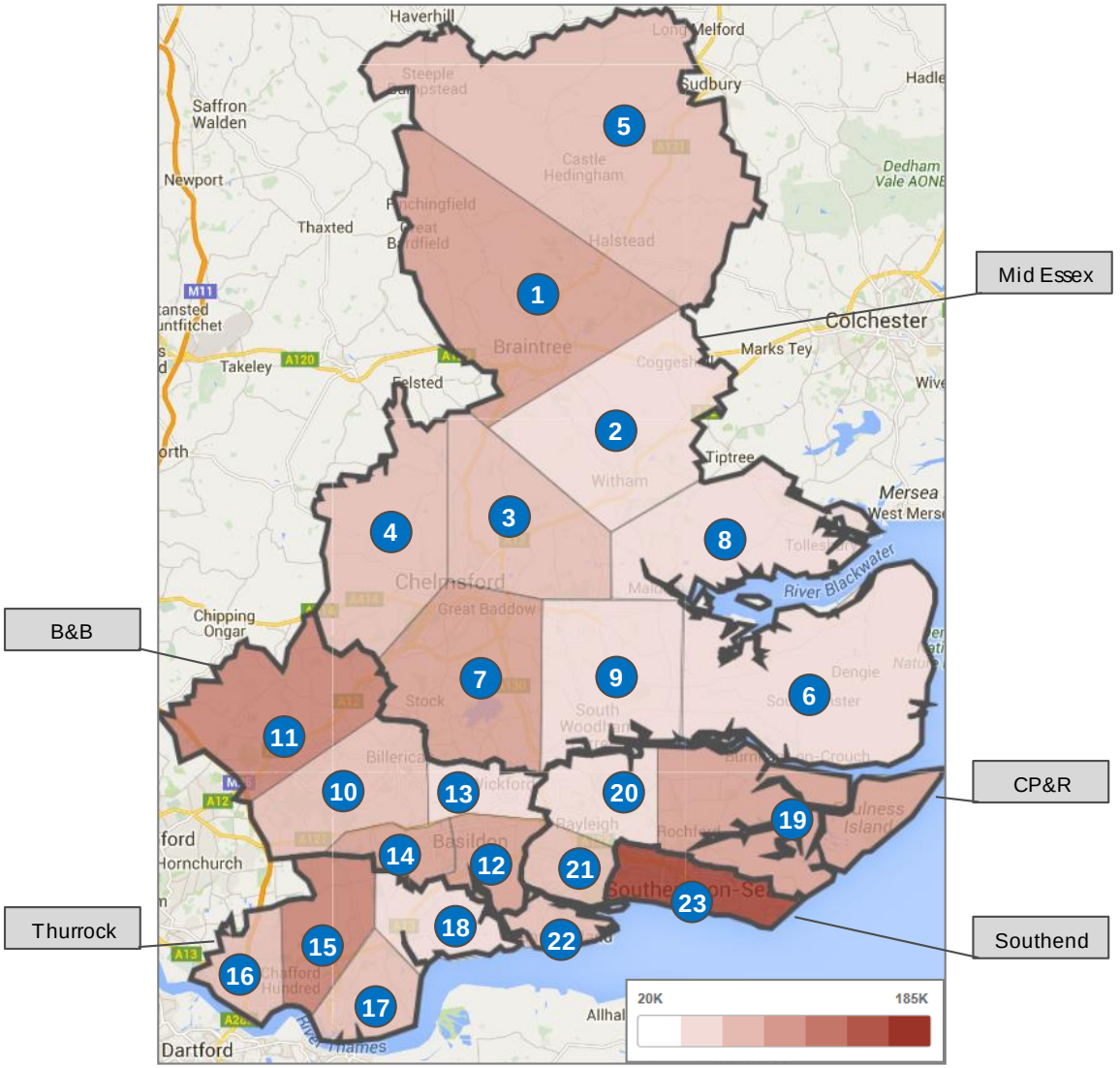
2 **Better management of whole non-elective care pathway based on national guidelines / Willetts recommendations**

- From focus on those at risk of admission, to better triage, to consistent approach to assessment of frail elderly and if they are admitted, to getting them home quickly

3 **Simplify commissioning and create a consistent and common offer**

- Reduce duplication – *'do once not five times where possible'* - and provide a consistent service offer

Potential localities



CCG		Neighbourhood	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	185	35

Note: Clusters have been identified for illustrative purposes and do not represent real or intended neighbourhoods. Source: BCG analysis of GP patient list size data (HSCIC October 2015)

Build strong localities: levels

Level 1: Increase capacity of primary care to meet rising demand by

- GPs focusing on complex cohorts with extended consultations
- Increase number of consultations offered including use of other allied primary care clinicians
- Work to meet national access requirements

Level 2: Accelerate implementing MDT[1] approach and supporting services in primary care

- Reduce non-elective admissions for complex patients (EoL, frailty) and those at high risk

Level 3: Expand services in primary care setting to meet needs of complex conditions

- Outpatient services for specific specialities[2] out of the acutes ("ologies")
- Mental Health for selected service users out of specialist trusts[3]

Level 4: Each locality to become accountable for wider determinants of health and wellbeing

- Integrated physical, mental health, primary care, social care, community care, and public health
- Outcomes-based contracts delivered through MSCPs[4] with leader provider model
- Build out to encompass wider services: VCS, housing, employment, social prescribing

1. Multi-disciplinary team 2. Initial priorities specialities are dermatology, rheumatology, neurology, ophthalmology and pain
3. A per 2015 Strategic Review, e.g. 95% of service users in Clusters 1-3; up to 40% in Cluster 4 4. Multi-speciality community providers

Better management of whole unplanned care pathway

Integrate key components of the national recommendations including:

- A&E designation
- 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

Simplify commissioning and create a consistent, common offer

Simplify commissioning

Commission at SR level or above where appropriate
- Acutes, 999, specialised MH, ...

Move to lead provider and outcomes focused contracts
- eg EOL

Reduce complexity
- e.g. simplified contractual arrangements

Consistent and common offer

Common offer
- Consistent access, reduce variation (eg elective referrals)
- Common (aligned) service offers

'Committee in Common'

Agree 'committee in common' for CCGs
- Enable change at pace

Acutes: working together

All acutes realise the need for close 'working together'

- Part of solving for the clinical and financial disadvantages of the footprint...
- ...and builds off existing collaborative activities

As part of the Success Regime, plan is to take a significant step

- Progressively move towards single teams, common processes, shared platforms
  - clinical teams, in clinical support and back office functions

Benefits of this closer working will be to enable:

- Evidence-based clinical operating processes to improve outcomes and reduce costs
- Optimal service arrangements across sites and service planning over a larger portfolio
- Sharing of expertise and development of sub-specialisation (eg radiology and pathology)
- Scale advantages and reduction of duplication in back office

The three acute boards are considering proposal for a 'group model' that leverages a 'committee in common' in the first instance

- To move at pace, and to balance any financial asymmetry as change is implemented

Acute clinical redesign: update on emerging thinking

Services in the acutes to be redesigned to address both clinical and financial challenges

- Improving safety and quality by consolidating rotas
- Meeting national guidelines, e.g. separation of elective and non elective care
- Addressing high fixed costs

Clinical services will be more joined up, with joint teams, single platforms, common platforms

- Better opportunities for career progression, training and development, and potentially new roles

This thinking builds upon and extends existing collaborations including:

- Acute Care Collaboration
- Joint ventures on pathology, pharmacy

Principles for 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 with refits

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

- If no clear rationale, then no change

5 **Design along pathways**

- Move care between hospital and community, and increase integrated working

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

Recap: key steps for clinical service redesign

Initial ideas — 1

Identify potential for change, frame opportunity and set initial targets

Refine options and phasing — 2

Refine high level options

- Core group of 3-5 frontline clinical staff
- Facts and data, clinical perspective, path forward
- Start wider discussions with staff and local people

← Currently at Step 2

3

Core clinical group to test proposal (+/- options) with frontline working groups

- Broader set of clinical leaders related to pathway being redesigned
- Core group working up weekly: further facts and data
- Service user involvement with working groups

← PEx sign off proposal & target

← Narrative to governing bodies

Pre consultation engagement — 4

Test proposals

- Broad set of multidisciplinary staff across acutes, PC, SC, MH, public health

← Sign off by governing bodies

5

- Feedback to staff and local people
- Further patients and public engagement to develop options for consultation

Consultation — 6

Undertake formal public consultation

Implement-ation plan — 7

Translate refined proposal into implementation plan