Recap on current position

Mid and South Essex
Success Regime

Dr Celia Skinner, Chief Medical Officer, Hospital Services
Ian Stidston, Accountable Officer, CP&R / Southend CCGs

6 April 2017

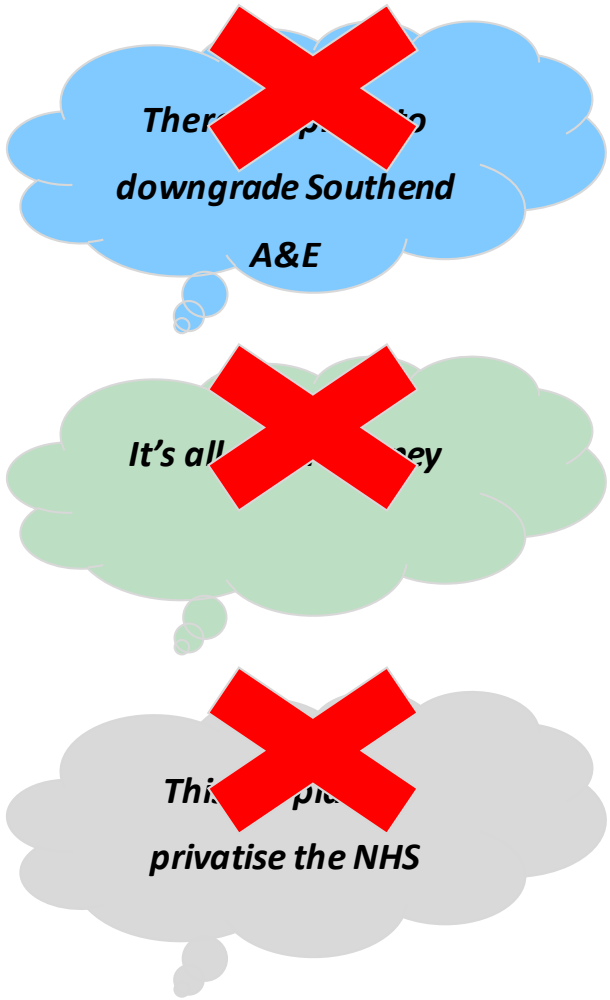
Three popular MYTHS

There are plans to downgrade Southend A&E

It's all about saving money

This is a plan to privatise the NHS

Three popular MYTHS



- Building a new network of emergency care
- Local A&E and assessment units for older people, children and surgical assessment - **much more than minor injuries**

- Investment and capital are part of plan
- Biggest driver - **best use of workforce**

- Main aim - to create a **sustainable NHS**

Recap on current challenges

- **Rising demands overstretching health and care services**
  - 81% GPs seeing patients with more complex conditions – **diabetes, COPD, dementia**
  - 18% rise in 2016/17 in ambulances for serious emergencies
  - Rise in A&E attendances since 2012:

National average	Mid and South Essex
1.6%	4.6%

- **Traditional style workforce is unsustainable**
  - Recruitment challenges for Essex in both health and care – **currently over 2,000 vacancies in NHS**
  - GPs and nurses reaching retiring age
  - Modern standards require hospital specialists 24/7

Local feedback on what needs to change

Top 12 common views about what needs to improve

1. Access to GPs
2. Better access to community care
3. Prevention
4. Staffing
5. Efficiency improvements
6. Increase in Government funding
7. Mental health
8. Integrated health and social care
9. Increase/improvement in social care
10. Education for the public on services
11. Discharge and care planning
12. Better hospital experience

Recap on the vision

Our untapped potential in the community

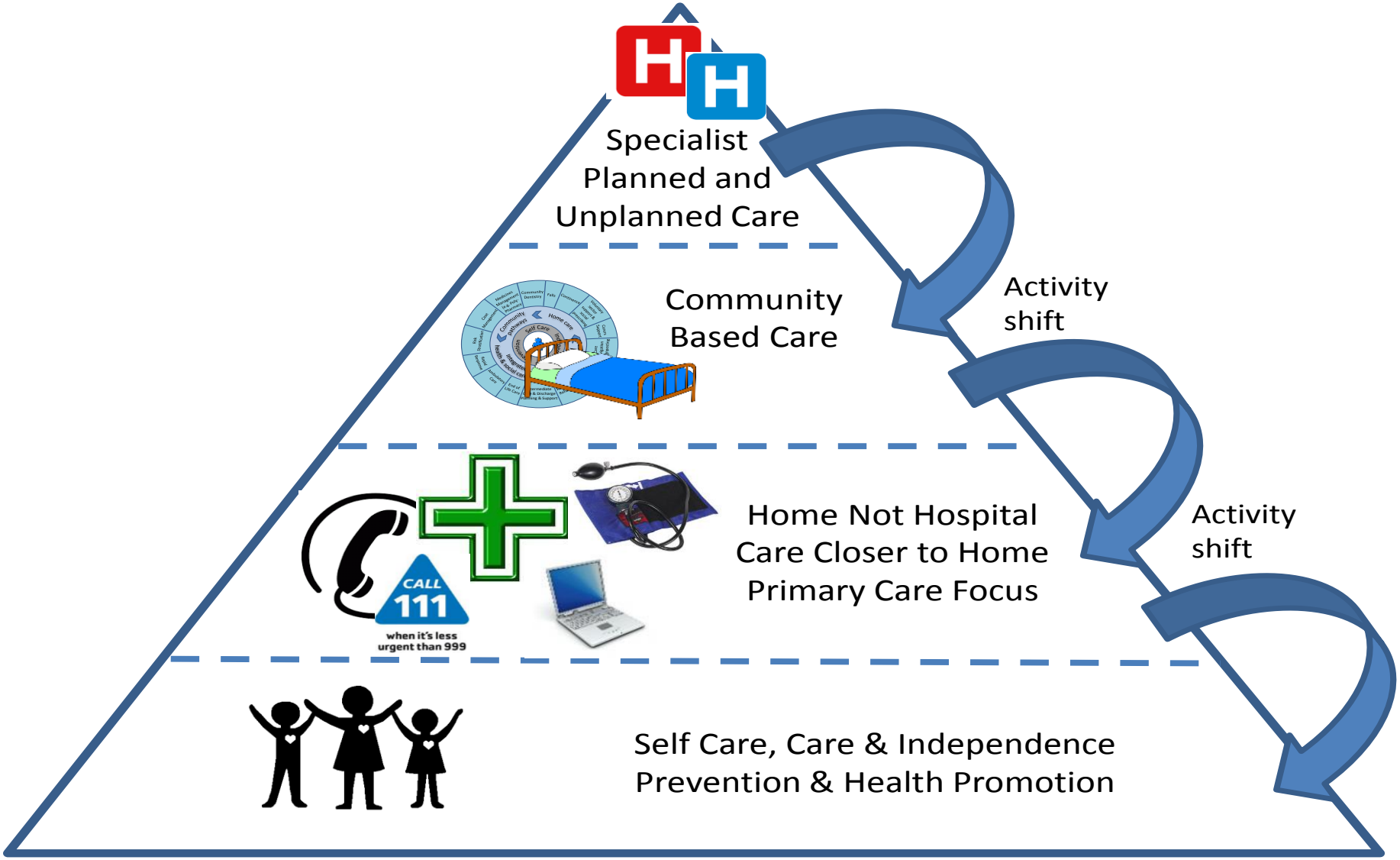
Bigger emphasis on prevention

- Campaigns and information for self-care
- New technology and support tools
- Joined up patient information and access to care record
- Partnership with vol sector and community services

Earlier treatment to avoid illness and hospital stays

- New practitioners and ways of working – not always a GP
- Joined up services linked to GP hubs – wider range of services “out of hospital”
- Co-ordinated network of emergency care – 111, out of hours, rapid response teams
- Early intervention with joined up care

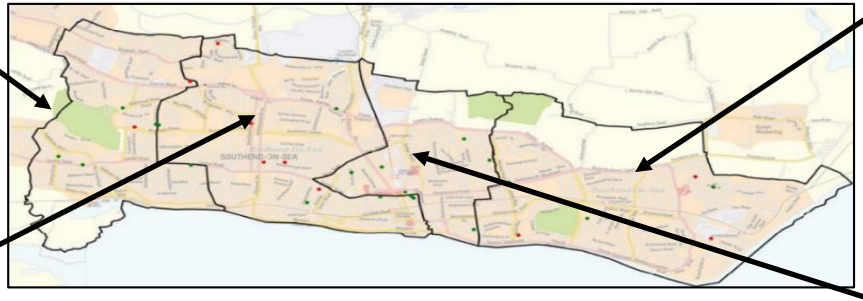
Delivering care to population segments



Southend localities overview

West Locality	List Size
Krishnan A C & Partner	4,955
Malik SA	3,413
Dr Sathanandans Practice	3,379
Eastwood Group Practice	11,745
Highlands Surgery	11,393
The Leigh Surgery	1,854
Family Healthcare Practice	17,717
The Pall Mall Surgery	2,027
Total	56,483

East Locality	List Size
Dr Dhillon's Surgery	2,340
Shoebury Health Centre	7,088
North Shoebury Surgery	3,465
Dr Mario & Partners Surgery	3,782
Dr Marasco Surgery	2,443
Shaftesbury Avenue Practice	6,764
The Thorpe Bay Surgery	2,939
Central Surgery	7,671
Total	36,492

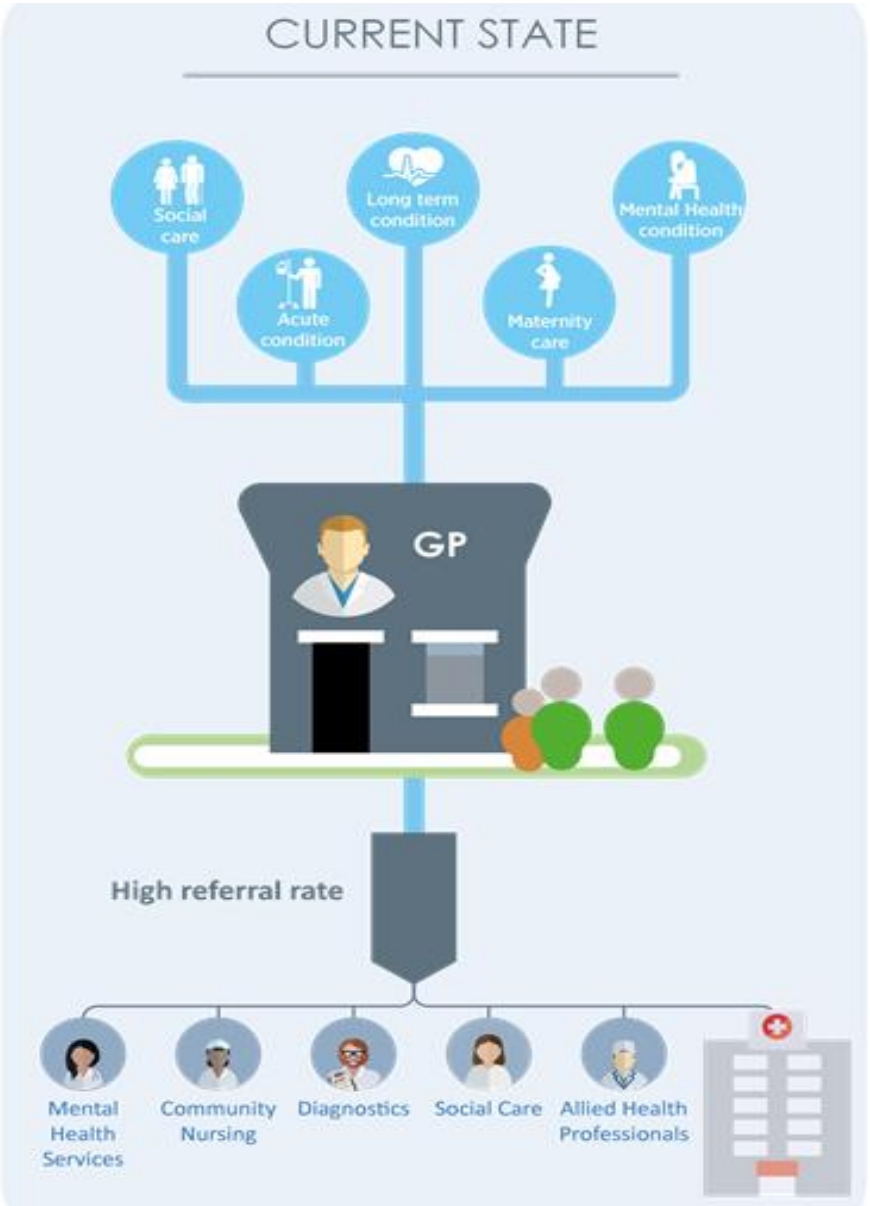


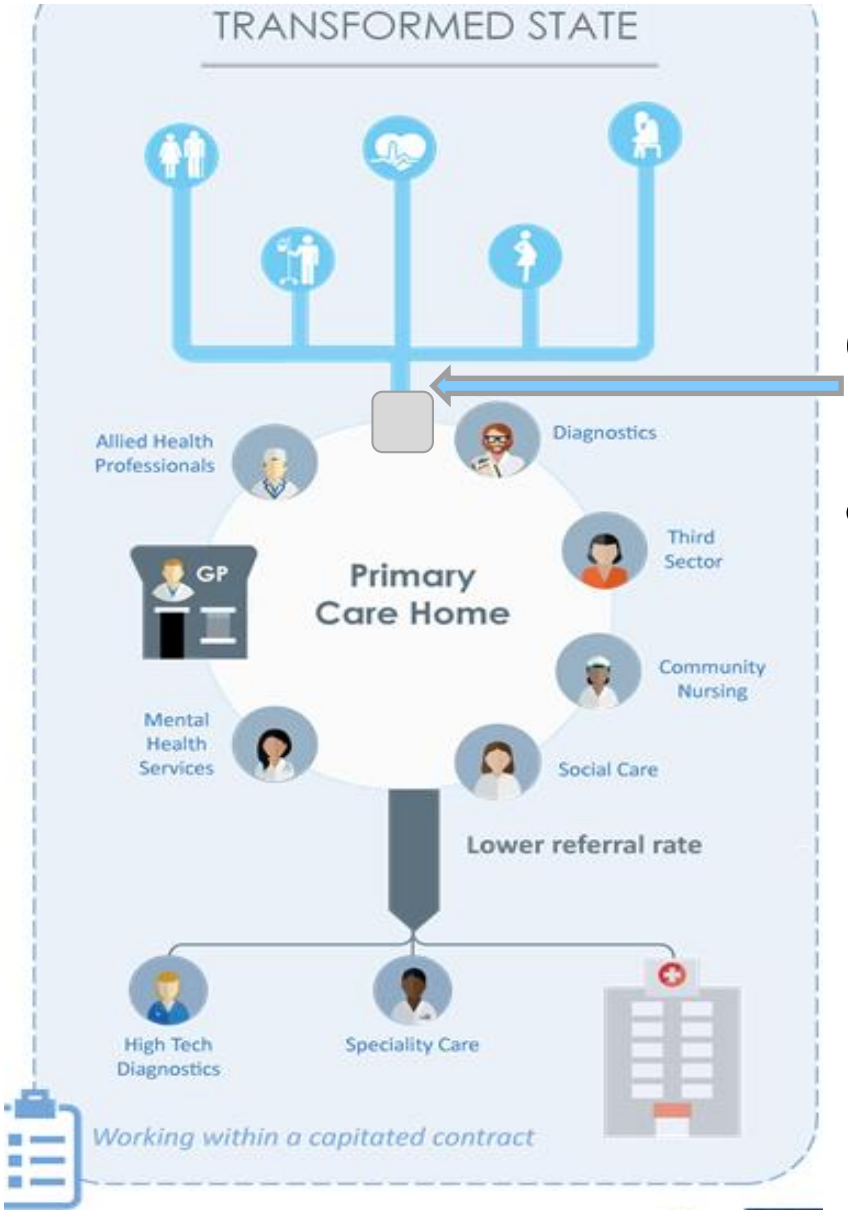
West Central Locality	List Size
Scott Park Surgery	2,689
Sooriakumaran V & Partner	4,432
Southbourne Grove Surgery	3,331
Dr Bekas Medical Centre	1,619
Valkyrie Surgery	16,271
Southend Medical Centre	4,609
Victoria Surgery & SAS	325
Total	33,276

East Central Locality	List Size
Dr L Vashist Surgery	2,996
North Avenue Surgery	2,424
St Luke's Health Centre	6,220
West Road Surgery	7,976
Central Surgery	5,059
New Westborough Road Surgery	3,524
Queensway Medical Centre	20,823
Carnarvon Medical Centre	6,407
The Practice Northumberland Avenue	5,009
Total	60,438

Source data – 01.01.2017

Building capacity in your local services





Central point of access

Complex Care Initiative

Aims

Work with practices to deliver :

- **Risk stratification:** identify most complex /at risk patients
- **Complex Care:** Multi-disciplinary team with single care plan
- **Case Management:** review and implement plan

Outcomes

- **Where appropriate, complex patients stay within their own home, with support to stay healthy and independent for as long as possible**
- **Relieve pressures on primary care by reducing need for multiple appointments/follow ups**
- **Reduce A&E attendances and hospital admission**

Our future hospitals – rationale for change

The challenge

Sustain high quality care and safety
- Recruit and retain clinical workforce
- Create centres of excellence

Meet rising demands
- Improve flow of patients
- Reduce operational and financial pressures

Meet national standards
- Adopt best practice
- Maintain senior medical cover 24/7

Addressing the challenge

1 Redesignate emergency centres
- 24/7 specialist cover - improve rotas with larger teams
- Reduce agency staff

2 Separate planned from emergency
- Improve patient experience – reduce cancelled operations
- Improve efficiency and throughput

3 Consolidate services
- Better outcomes from higher volumes
- Reduce length of stay – treat more people

Our future hospitals – what stays local

No change for existing centres of excellence

- Cancer and Radiotherapy at Southend
- Cardiothoracic Centre, Basildon – life-saving heart and lung treatments
- Plastic Surgery and Burns Centre at Broomfield in Chelmsford

Services that would be provided at local sites

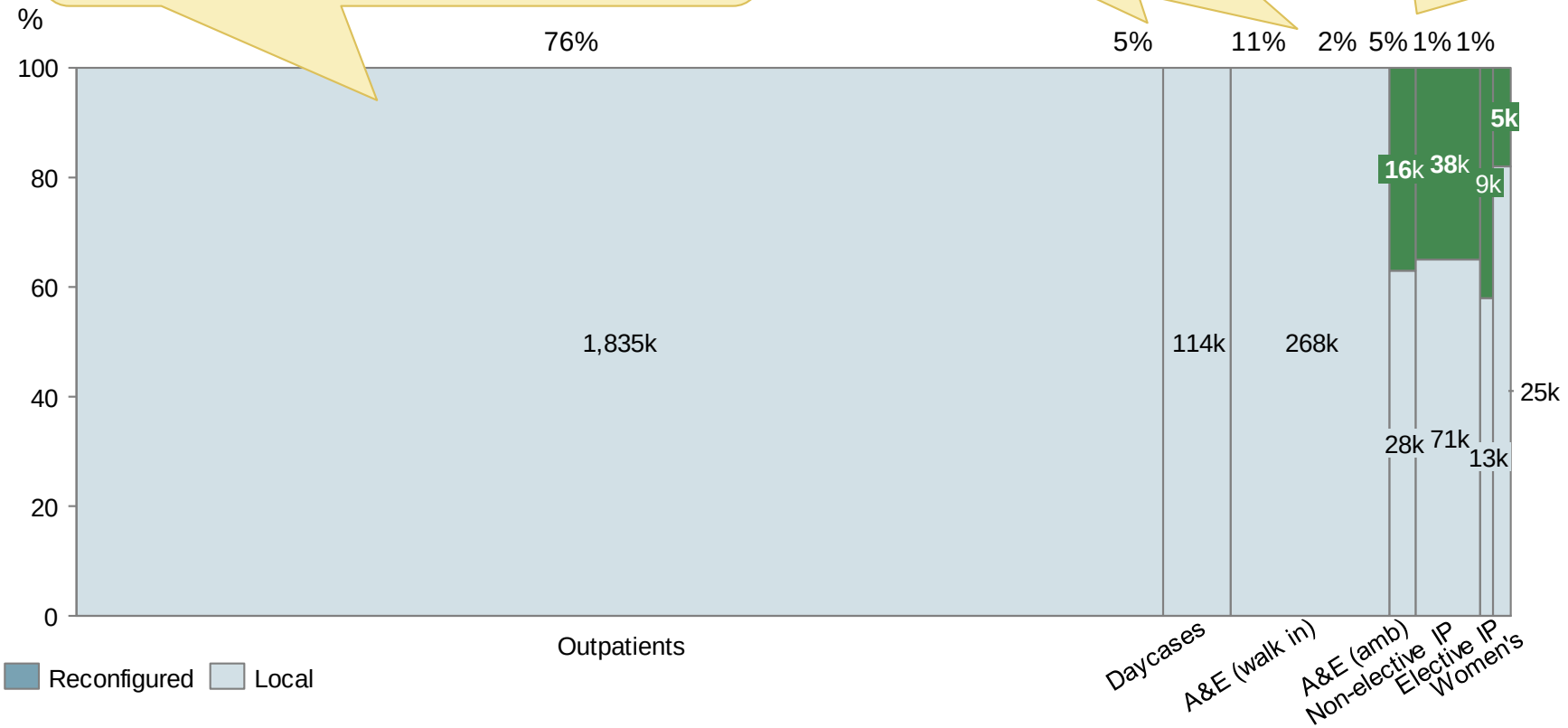
- **A&E at all three sites for walk-in and ambulances**
- **Surgical assessment unit**
- **Frailty assessment unit**
- **Children's assessment unit**
- **Outpatient clinics**
- **Day surgery**
- **Midwife-led maternity unit and obstetrician cover**
- **Step down beds for after surgery or specialist care**

Our future hospitals - majority stays local

Outpatients appointments represent three quarters of hospital visits – all of these would stay local

All day cases stay local, and walk-ins continue to go to their local A&E, 24/7

Majority (66%) of visits for specialist services stay local



~95% of all visits to stay local, including all A&E walk-ins

Note: local defined as staying at current hospital. Outpatients defined as all booked outpatient appointments at the three trusts, and includes patients from other CCG catchments. Source: HES A&E, inpatients and outpatients data, 15/16. 1. Modelling assumes that 20% of walk-ins closer to the non-SEHC sites will go straight to the SEHC

Our future hospitals – possible options

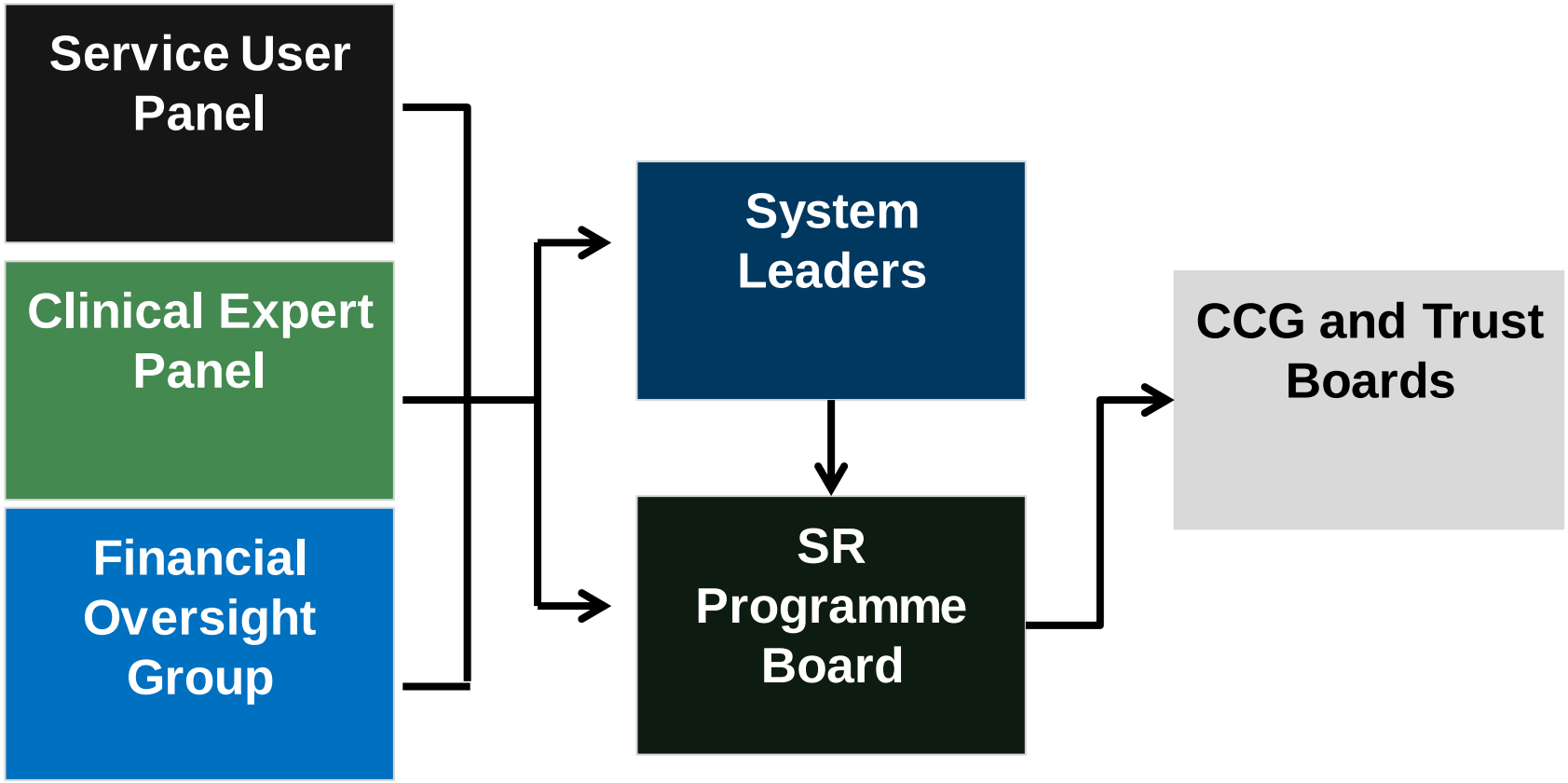
Option	Basildon	Broomfield	Southend
1A	Essex Cardiothoracic Centre H Specialist emergency hospital Specialist obstetric centre	Plastics & Burns Centre Emergency centre H Elective surgery Children's centre	Cancer Centre H Emergency centre Elective surgery
1B	Essex Cardiothoracic Centre H Emergency centre Elective surgery	Plastics & Burns Centre H Specialist emergency hospital Specialist obstetric centre Children's centre	Cancer Centre H Emergency centre Elective surgery
1C	Essex Cardiothoracic Centre H Emergency centre Elective surgery	Plastics & Burns Centre H Emergency centre Elective surgery Children's centre	H Cancer Centre Specialist emergency hospital Specialist obstetric centre
2A	Essex Cardiothoracic Centre H Specialist emergency hospital Specialist obstetric centre	Plastics & Burns Centre H Emergency centre Elective surgery Children's centre	H Cancer Centre Local emergency centre Centre for planned care
2B	Essex Cardiothoracic Centre H Emergency centre Elective surgery	Plastics & Burns Centre H Specialist emergency hospital Specialist obstetric centre Children's centre	H Cancer Centre Local emergency centre Centre for planned care

Narrowing down using four main criteria

Criteria	Description	Weighting	
1	**Quality, outcomes, and safety** • Meet national recommendations (e.g. Willetts, Cumberlege), move towards best practice quality standards (e.g. Royal Colleges), meet safety standards, optimise patient experience, reduce variation in provision	**35%[1]**	**Scored by main group**
2	**Sustainability of clinical workforce** • Move to best practice workforce standards, ease recruitment and retention, improve training opportunities (e.g. Royal Colleges), quality of working life for all staff	**25%**	
3	**Access** • Maintain appropriate access and choice for patients, relatives and workforce	**22%**	
4	**Efficiency and productivity**	**18%**	**Scored by FOG[2]**

1. In line with staff and other key stakeholders, service users viewed quality, safety, and outcomes as the highest priority. 2. FOG = Financial Oversight Group – meeting on 21/02 to score this criterion.

Options appraisal panels



Supporting evidence and information

Criteria	Key sources of evidence and information
Quality, safety, and outcomes	• Clinical Senate reports • Independent review by Eastern Academic Health Science Network • Evidence on correlation between volumes and outcomes • Information on impact of travel times on outcomes • Evidence on impact of separation of emergency from planned • Evidence from patient surveys
Sustainability of workforce	• Evidence from the clinical sub groups on workforce and ability to meet standards in emergency, paediatrics, maternity, surgery • Evidence from staff surveys

Access	• Information on likely impact of:
	  • Ambulance travel times
	  • Travel times by car
	  • Travel times by public transport and possible mitigations

Productivity and efficiency	• Information on the likely savings including:
	  • Improved productivity (e.g. reduced length of stay)
	  • Economies of scale
	  • Reduction in reliance on agency expenditure
	  • Repatriation (e.g. patients going into London to come back to Essex)

Narrowing down options – overall pattern

Panels	1A	1B	1C	2A	2B
Service user representatives	3.53	3.53	3.19	3.81	3.59
Clinical experts	3.40	3.40	2.14	4.18	4.18
System leaders	3.40	3.02	2.68	4.02	3.74

Required capital investment

	Quality, outcomes, and safety	Workforce	Access	Efficiency and productivity	Total score	Normalized score (High score = 100)	Capital req. (£M)	Value for money score[1]
Option 1A	1.22	0.76	0.70	0.72	3.40	84.52	**78**	**1.08**
Option 1B	1.02	0.71	0.57	0.72	3.02	75.02	**106**	**0.71**
Option 1C	0.86	0.62	0.49	0.72	2.68	66.77	**92**	**0.73**
Option 2A	1.41	0.99	0.72	0.90	4.02	100.0	**91**	**1.10**
Option 2B	1.28	0.94	0.61	0.90	3.74	92.99	**114**	**0.82**
Weight	**35%**	**25%**	**22%**	**18%**				

1. Value for money (calculated as normalized score / capital requirement)

Narrowing down options – current thinking

Option 2A received the highest score by all panels

	Basildon	Broomfield	Southend
2A	H Essex Cardiothoracic Centre Specialist emergency hospital Specialist obstetric centre	H Plastics & Burns Centre Emergency centre Elective surgery Children's centre	H Cancer Centre Local emergency centre Centre for planned care

Option 1A was highest scoring of model 1

1A	H Essex Cardiothoracic Centre Specialist emergency hospital Specialist obstetric centre	H Plastics & Burns Centre Emergency centre Elective surgery Children's centre	H Cancer Centre Emergency centre Elective surgery

- **This is not a decision and does not rule out other options or variations at this stage**

Current position

- **STP summary and full documents published 23 Nov**
  - Please visit www.successregimeessex.co.uk
- **Further development within Success Regime workstreams – data gathering, developing patient pathways**
- **Finalise business case for approval later this year**
- **Continuing engagement with local people**
  - Further engagement with community groups
  - Service Users Advisory Group
  - Consultation later in 2017

Five key things to take away

1. A&E would continue at all three sites for vast majority of patients

2. Over 90% of local patients would be cared for at your local hospital

3. For most serious and life-threatening cases, national evidence tells us we could save more lives with a specialist emergency hospital

4. With one hospital concentrating on major emergencies, the other two have more space and specialists for planned operations

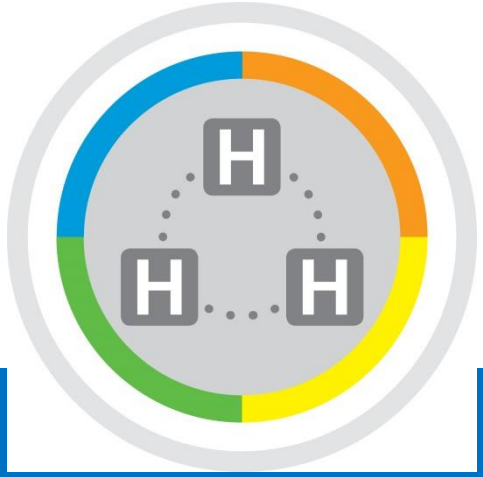
5. **We have the opportunity to create one of the largest most successful hospital services in the country**

Mid and South Essex
Success Regime

What are your thoughts?

Mid and South Essex
Success Regime

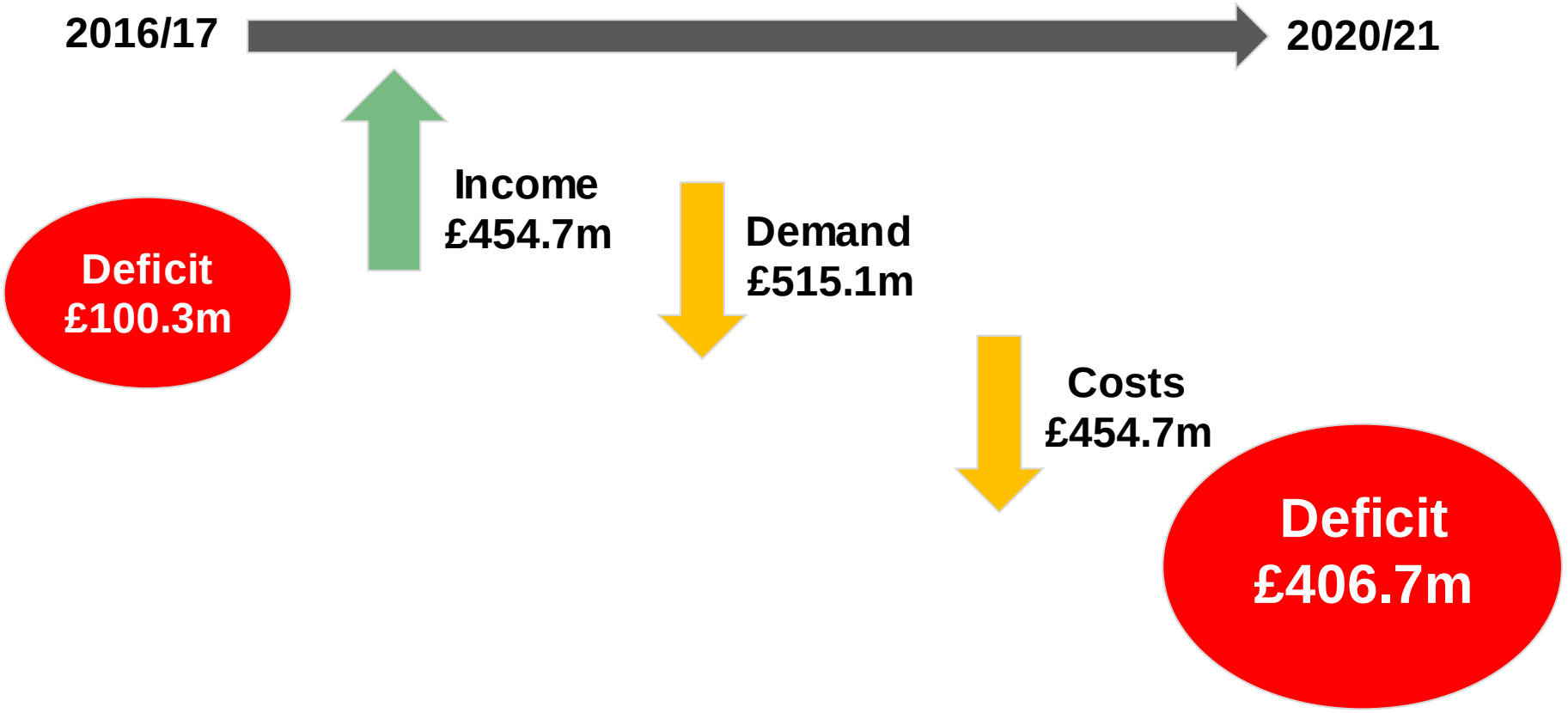
Back up slides if needed



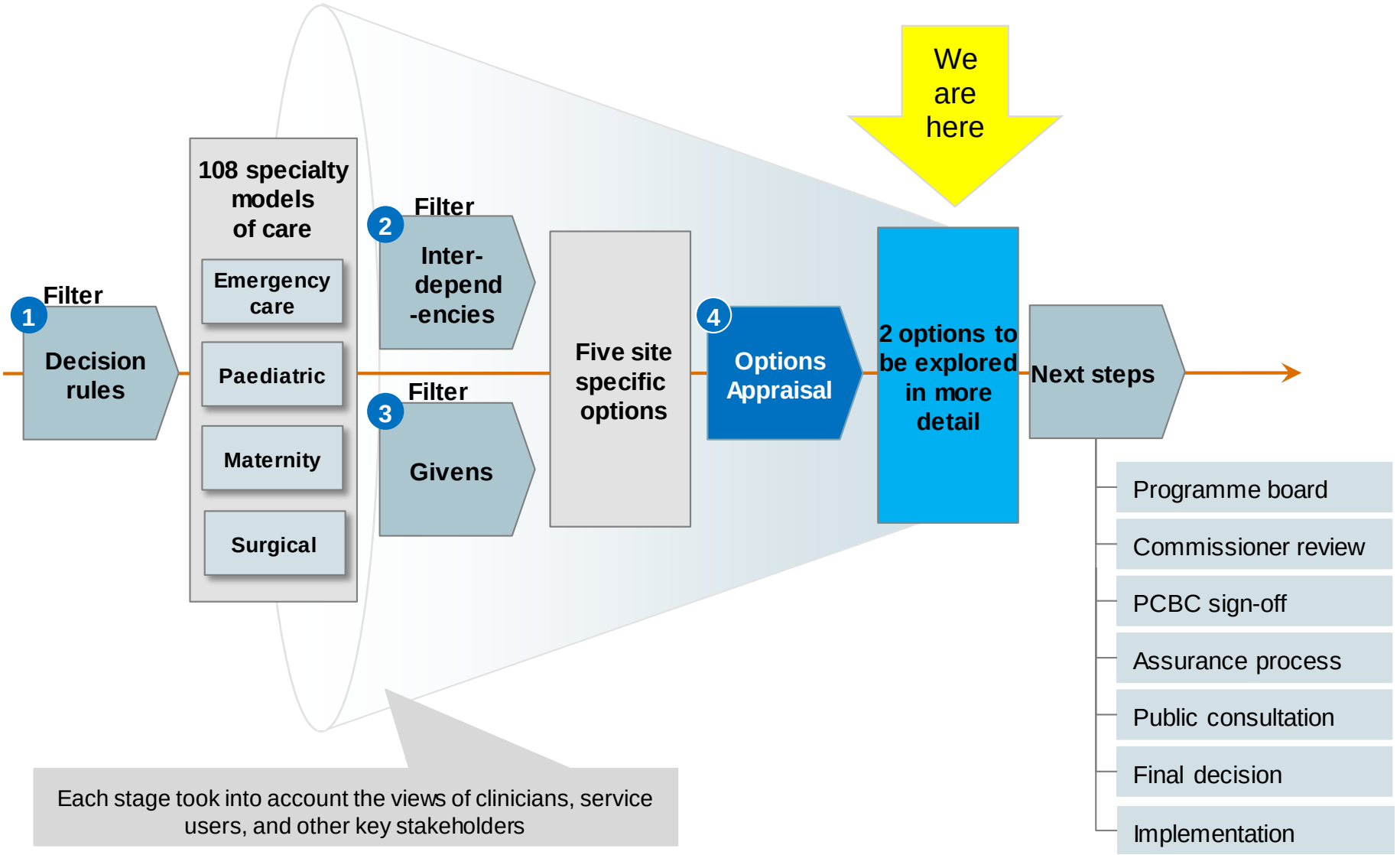
Why health and care needs to change

- **Fragmented system, over-reliant on hospitals is unaffordable**

Future deficit if we did nothing to change over next 5 yrs



How we developed the five options and where we are now



Access – the tests

What the professionals are looking for

Sub-criteria	Tests
Minimum emergency travel time	• Will it ensure most patients (>95%) are within 30 mins of specialist emergency hospital by blue-light?
Travel times for patients and carers	• Will it provide reasonable access to services for patients, families and carers?
Access to high quality out of hours services	• Will it increase access to high quality services at evenings and weekends (e.g. staffing out of hours)? • Will it maintain out of hours services?
Improve access to range of specialist services	• Will it increase specialty services?

What service users are looking for

- Consider roads, parking and public transport
- Improve patient information on where to go, what to do
- Support carers at specialist centres

Access: “blue light” travel time within 45 mins

Option	Journey		Avg. affected ambulances/day	Current time (min-max)		Additional time		% within 30 mins		% within 35 mins		% within 45 mins	
	From (catchment)	*To*[1]		*Peak*	*Off-peak*	*Peak*	*Off-peak*	*Peak*	*Off-peak*	*Peak*	*Off-peak*	*Peak*	*Off-peak*
1A	SUHFT	BTUHFT	32	~8 m (2–23 min)	~7 m (2–23 min)	~+14 m (+2–18 min)	~+12 m (+1–15 min)	96%	96%	96%	100%	100%	100%
	MEHT	BTUHFT	21	~13 m (3–22 min)	~11 m (3–20min)	~+14 m (+2–23 min)	~+10m (+2–18 min)	78%	92%	97%	100%	100%	100%
1B	SUHFT	MEHT	32	~8 m (2–23min)	~7 m (2 – 23min)	~+25 m (+9–31 min)	~+21 m (+7–26 min)	30%	70%	67%	93%	100%	100%
	BTUHFT	MEHT	15	~13 m (7–31 min)	~11 m (6–27 min)	~+11 m (+2–17 min)	~+10 m (+0–14 min)	93%	93%	93%	100%	100%	100%
1C	MEHT	SUHFT	16	~14 m (3–22min)	~11 m (3 –20min)	~+14 m (+8–27 min)	~+11 m (+5–21 min)	62%	95%	100%	100%	100%	100%
	BTUHFT	SUHFT	23	~10 m (1–31 min)	~9 m (1–27 min)	~+9 m (+3–21 min)	~+7 m (+0–15 min)	96%	98%	100%	100%	100%	100%
2A	SUHFT	BTUHFT	58	~8 m (2–23min)	~7 m (2–23min)	~+14 m (+2–18 min)	~+12 m (+1–15 min)	96%	96%	96%	100%	100%	100%
	MEHT	BTUHFT	22	~13 m (3–22 min)	~11 m (3–20 min)	~+14 m (+2–23 min)	~+10 m (+2–18 min)	78%	92%	97%	100%	100%	100%
2B	SUHFT	BTUHFT	27	~8 m (2–23min)	~7 m (2 – 23min)	~+14 m (+2–18 min)	~+12 m (+1–15 min)	96%	96%	96%	100%	100%	100%
	SUHFT	MEHT	32	~8 m (2–23min)	~7 m (2 – 23min)	~+25 m (+9–31 min)	~+21 m (+7–26 min)	30%	70%	67%	93%	100%	100%
	BTUHFT	MEHT	15	~13 m (7–31 min)	~11 m (6–27 min)	~+11 m (+2–17 min)	~+10 m (+0–14 min)	93%	93%	93%	100%	100%	100%

Note: assumes blue light travel time is 33% faster than car travel times. Median and range for current journey.
Methodology: Using Google Maps API, 4 different departure times (8:30, 13:00, 17:00, 21:00) were used to simulate journeys over 3 days, including the weekend, to find ranges & averages. Source: Google Maps API SR A&E model

Specialist emergency hospital
Emergency hospital with elective

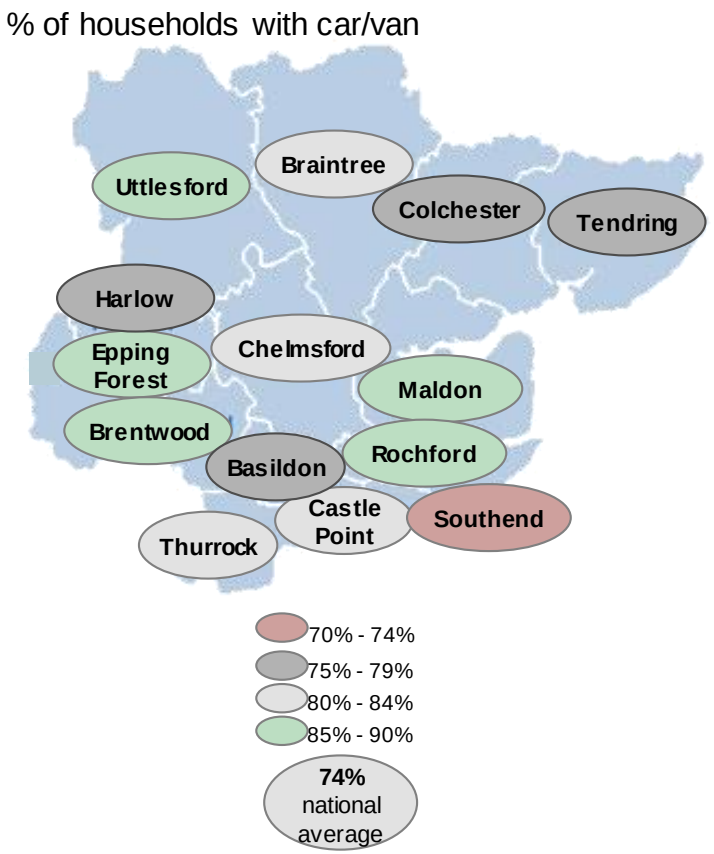
Access: 80% car journeys within 45 mins
(Not including parking)

Option	Population within 30 min		Population within 35 min		Population within 45 min	
	Off-peak	Peak	Off-peak	Peak	Off-peak	Peak
Current	95%	92%	98%	98%	100%	100%
1 A H H H	77%	60%	88%	73%	96%	91%
1 B H H H	61%	49%	78%	58%	92%	82%
1 C H H H	79%	54%	92%	77%	99%	92%
2 A H H H	77%	60%	88%	73%	96%	91%
2 B H H H	61%	49%	78%	58%	92%	82%

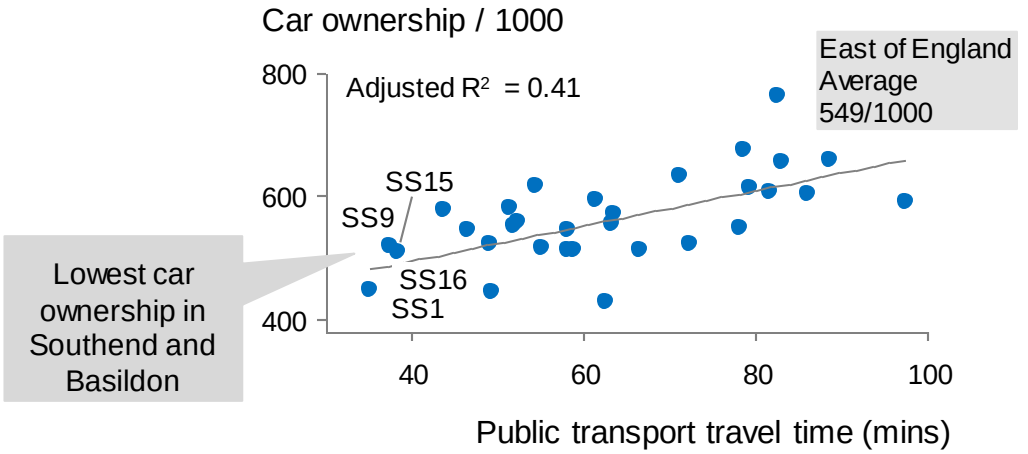
Assumption: people will travel to their closest open hospital
Source: BCG Geoanalytics

Access: Car ownership across the area

In general, high level of car ownership across the region...



... with lower car ownership districts closer to hospital via public transport[1]



SR is working to address remaining concerns over increased public transport travel times

- Need to address potential disadvantages of minority who face long distances by public transport
- Need to address potential issues for protected groups

Impact assessments in progress to identify mitigation and support for patients, relatives, and carers

- Includes working with local authorities, voluntary sector, and service users

1. $p < 0.05$, n = 33/37. 4 outliers (bottom and top 5%) were excluded from analysis; un-cleaned data also yielded significant association ($p < 0.05$). Travel time for each district calculated as the average of travel times to closest two sites. Source: Public transport travel times based on average of simulated journeys at 8:30AM and 1:00 PM, collected from Google Maps API in November 2016; DVLA vehicle licensing statistics, July – Sept 2016, DoT vehicle licensing statistics Q3 2016; ONS statistics, Southend-on-sea borough council

Estimated increase in use of public transport

Preliminary view – being refined by public transport work stream

Patient visits

	From Basildon area to MEH	From Basildon area to SUH	From Mid Essex area to BTUH	From Mid Essex area to SUH	From Southend area to BUHFT	From Southend area to MEH	Visits per day
1A	~2	~2	~1	~0	~1	~1	**~7**
1B	~1	~0	~2	~2	~0	~2	**~7**
1C	~0	~1	~0	~1	~3	~4	**~9**
2A	~0	~4	~1	~0	~3	~0	**~8**
2B	~1	~0	~0	~4	~0	~3	**~8**

Family & friend visits

	From Basildon area to MEH	From Basildon area to SUH	From Mid Essex area to BTUH	From Mid Essex area to SUH	From Southend area to BUHFT	From Southend area to MEH	Visits per day
1A	~5	~4	~5	~0	~10	~3	**~27**
1B	~9	~1	~4	~5	~0	~12	**~31**
1C	~2	~8	~0	~5	~7	~9	**~31**
2A	~1	~8	~5	~0	~31	~2	**~47**
2B	~9	~1	~0	~9	~0	~32	**~51**

Initial findings

Suggests small increase of patients on public transport

- Partially driven by all daycases and outpatient procedures remaining local

Larger nos. of additional relatives may need public transport

- Visits for both elective and non-elective in-patients

Greater impact for option 2B

- 8 additional patients/day
- 51 additional relatives/day

Impact of staff travel on public transport currently being estimated

Source: Inpatients beds model, ONS car ownership. Assumptions; each patient would be visited by two relatives; 5% of non-car owning non-elective patients would require public transportation, since most would be covered by relatives and patient transport services. Number of elective patients using public transport calculated using local car non-ownership statistics

Access – Further work in progress

Transport project team assessing impacts

- Data analysis by specialty and age
- Range of assumptions
  - Car ownership, inter-site shuttle, subsidised public transport
  - Contracts for patient transport
  - Patient choice
  - Access to other hospitals outside mid and south Essex

Essex Transport Integration Programme - transport between hospital sites

- Potential to decrease vehicle congestion at hospital sites with additional bus routes
- Major towns where hospitals are located are largely well-served

Reviewing wider strategic plans for road infrastructure - part of Essex Traffic Management Strategy