Mid and South Essex
Sustainability and Transformation Partnership (STP)

Your care in the best place

At home, in your community and in our hospitals

Joint Health Overview and Scrutiny Committee, 30 August 2018

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Purpose

1. Decision-making
2. Implementation process
3. Transport
4. Workforce
5. Capital works
6. Primary care strategy
7. Next steps

Decision-making

- CCG Joint Committee supported all 19 recommendations within the decision-making business case.
- Recommendations included key enablers (as highlighted by the JHOSCs recommendations):
  - Clinical transport
  - Patient, family and carer transport
- … and also included mechanisms to ensure effective oversight of implementation:
  - Implementation Oversight Group
  - “People’s Panel” to provide an independent view on matters relating to the relocation of services from Orsett.
  - Continued engagement with partners

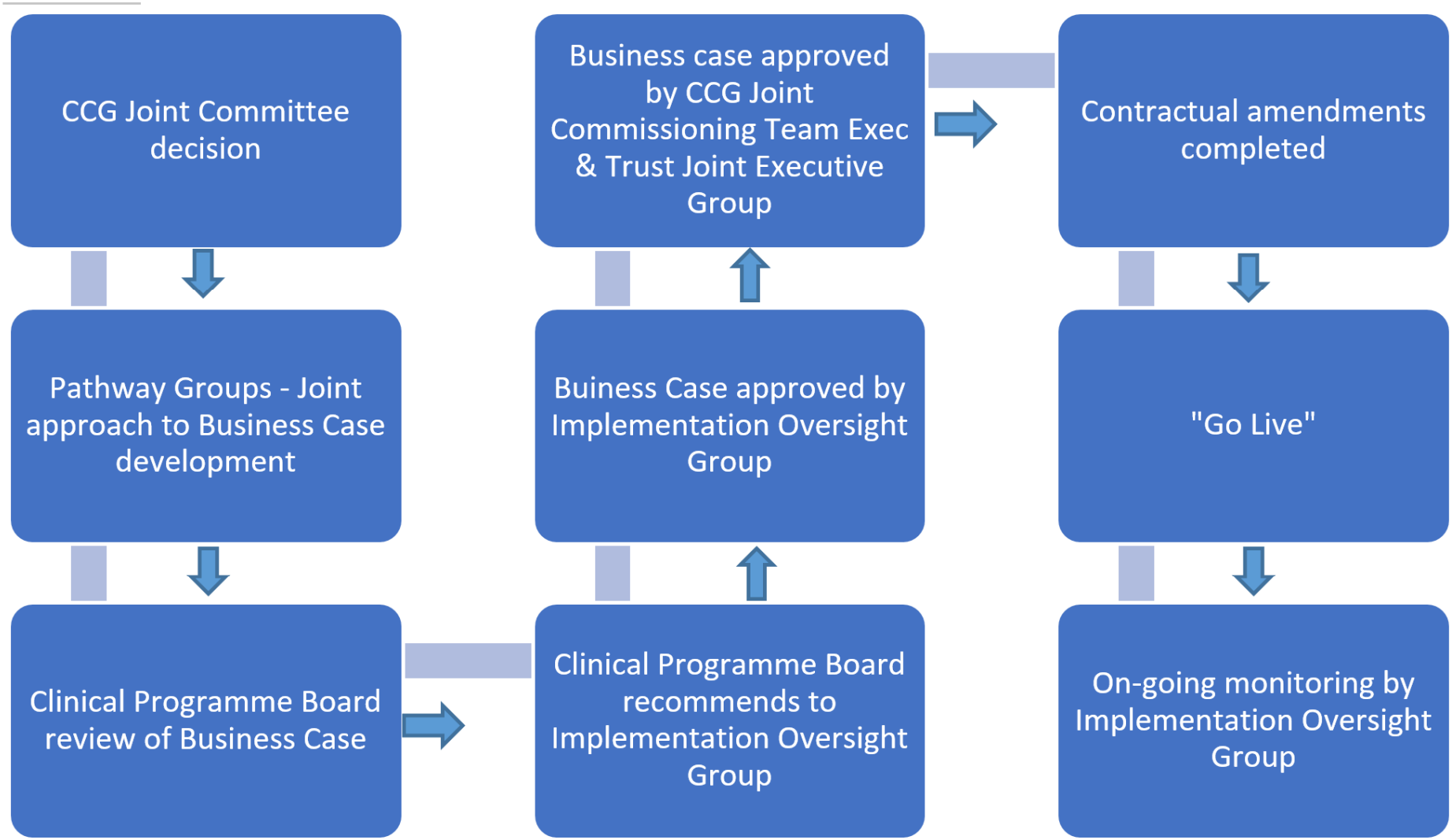
Communication of decision making

- Social media continues to be used extensively as recommended by JHOSC including live Tweets throughout decision making meeting as recommendations discussed
- As live recording broadcast distributed via web and social media (Facebook and Twitter) the same day and boosted subsequently
- Summary of recommendations and decision made sent to JHOSC and extensive stakeholder list the same day
- Letter and summary sent to all groups and individuals who wrote or emailed their feedback during the consultation period.
- Press release issued on day and broadcast and print interviews undertaken both on day and subsequently
- Summary A5 and shorter three fold leaflet summary leaflets produced and distributed via CCG and hospital trust networks
- Targeted full page newspaper ads in Thurrock, alongside suite of materials specifically on Orsett including blog, video and posters

Implementation Process

- Pathways to commence implementation in 2018/19:
  - Continued improvements to A&E departments
  - Acceleration of ambulatory care pathways for surgery, medicine and older people.
- Implementation will be dependent on a clear set of ‘go-live’ criteria such as having sufficient staff and capacity (e.g. beds) to be able to safely implement the change, particularly over winter. Described further during this section.

Implementation Oversight



Pathway Groups

- **Responsibility: Pathway development**
- Clinically-led with programme management support (Trust)
- Comprises providers, commissioners & service users
- Co-production of pathway, service specification, outcome measures, business case (including finance and activity framework) and implementation plan.

- **Outcome:**
  - Recommend business case and implementation plan to Clinical Programme Board ⇒

Clinical Programme Board

- **Responsibility: Clinical sense check of business case**
- Chaired by Trust CMO
- Comprises provider and commissioner clinicians
- Reviews business case and implementation plan and ability to "go live":
  - workforce
  - leadership
  - clinical governance processes
  - interdependencies

- **Outcome**
- Recommend business case and implementation plan to Implementation Oversight Group ⇒
- OR
- Recommend that business case and implementation plan goes back to Pathway Group for further work ⇐

Implementation Oversight Group

- **Responsibility: Receives business cases recommended by Clinical Programme Board**
- Independently chaired. Membership given below.
- Reviews recommendation from Clinical Programme Board and checks that:
  - Clinical and operational leadership in place
  - Enabling/inter-dependent activities identified
  - Outcome measures defined
  - Recommendations from CCG Joint Committee are met
  - Discharge and repatriation pathways identified
  - Financial, contractual requirements met. See Appendix 1

- **Outcome:**
- Recommend "go live" and inform relevant governance processes (CCG Joint Committee, Joint Working Board, etc)
- OR

Escalation point:
CEO Acute Hospitals
Lead AO for Joint Committee

Implementation Oversight Group

- Membership:
  - Independent Chair
  - CCG Joint Committee (AO and Chair)
  - CCG Joint Commissioning Team (Head of Governance)
  - CCG Lay representative
  - Acute Trust Executive
  - Acute Trust Non-executive representative
  - Patient representative
  - Other colleagues as required
- Role and remit:
  - Receive business cases and implementation plans that have been:
    - Co-produced by clinicians, Trust service leads and commissioners
    - Assured by the Clinical Programme Board
  - Consider requirements of the CCG Joint Committee (equality and health inequality assessments)
  - Ensure enabling/co-dependent infrastructure is in place
  - Ensure that all necessary steps have been taken and make a decision to support the pathway to “go live”.

Implementation Oversight Group - Checklist

- Checklist developed to support IOG work:
  - Business case and implementation plan meets provider and commissioner requirements
  - Clinical Programme Board support for the pathway change
  - Clinical and operational leadership articulated
  - Workforce model articulated and achievable
  - Enabling/interdependent activities identified and factored into pathway change
  - Patient-centred outcome measures identified
  - Clear quality and KPIs identified and means to measure and report against these
  - Model reflects mitigations identified from CCG EHIIAs
  - Discharge and repatriation pathways defined
  - Financial and contractual agreements in place to facilitate the change
  - Necessary infrastructure in place (eg transport)*
  - Clear plan for communication and engagement with GPs and other clinical professionals defined
  - Clear plan for communication and engagement with patients and service users

*Where implementation of a specific pathway change can be achieved but full implementation of an interdependent recommendation is not achievable at the same time, the IOG will need to be assured that robust interim solutions are in place to ensure patients are treated safely and appropriately.

Implementation Oversight Group (cont../)

- IOG will communicate its decisions to:
  - CCG Joint Committee
  - Acute Trust Joint Working Board
  - STP Board
  - Key stakeholders
  - Patients and service users

- IOG has a role in on-going monitoring:
  - Once implementation has occurred, there will be review points at timed intervals (3 6 and 12 months) to ensure compliance with CCG Joint Committee decision-making
  - After which pathway moves to “business as usual” monitoring processes.

- Where the IOG cannot reach a decision on whether a particular pathway is ready to “go live”, it will escalate to the Lead AO for the Joint Committee and the CEO of the Acute Hospitals for resolution.

Relocation of Services from Orsett

- CCG Joint Committee approved the relocation of services from Orsett Hospital to new centres in Thurrock, and new and existing centres in Basildon and Brentwood. This relocation of services would enable the Orsett site to close.
- No closure will occur until all services have been appropriately re-located.
- Discussions with Healthwatch Thurrock identified a need for on-going engagement with residents on the service changes.
- The CCG Joint Committee approved the establishment of a “People’s Panel” to provide independent view on service relocation.
- This is being established currently with Healthwatch Thurrock with links to STP Service User Advisory Group
- Members will be representative of groups within the community

Aims of the People's Panel

- To seek and represent the views of the wider community in relation the relocation of services provided at Orsett

- To review wider community and stakeholder engagement plans related to service change ensuring any information produced is easily understandable and clear before being shared with the wider public

- To review service related information to ensure any potential impact on the local community and/or protected groups have been recognised and reasonable steps put in place to seek to mitigate that impact.

- To ensure protected and other 'seldom heard' groups are given appropriately tailored opportunities to shape future services

- To bring any local issues that may have some bearing on the implementation of plans to the attention of the group.

- To assist in how the evaluation of redesigned services can be measured from a user perspective

Clinical Transport (Treat & Transfer)

- In response to the JHOSCs recommendation for further detail on the treat and transfer model, it had an extensive briefing on proposals for clinical transport at its informal meeting on 19th July 2018.

- As we work through the detail of the phased implementation of clinical reconfiguration we are creating the capacity requirement for the treat and transfer model over the next 3 to 5 years.

- Initially we are exploring an option for a pilot treat and transfer service which would allow us to refine our model and which would be flexible enough to increase capacity over time as reconfiguration is implemented.

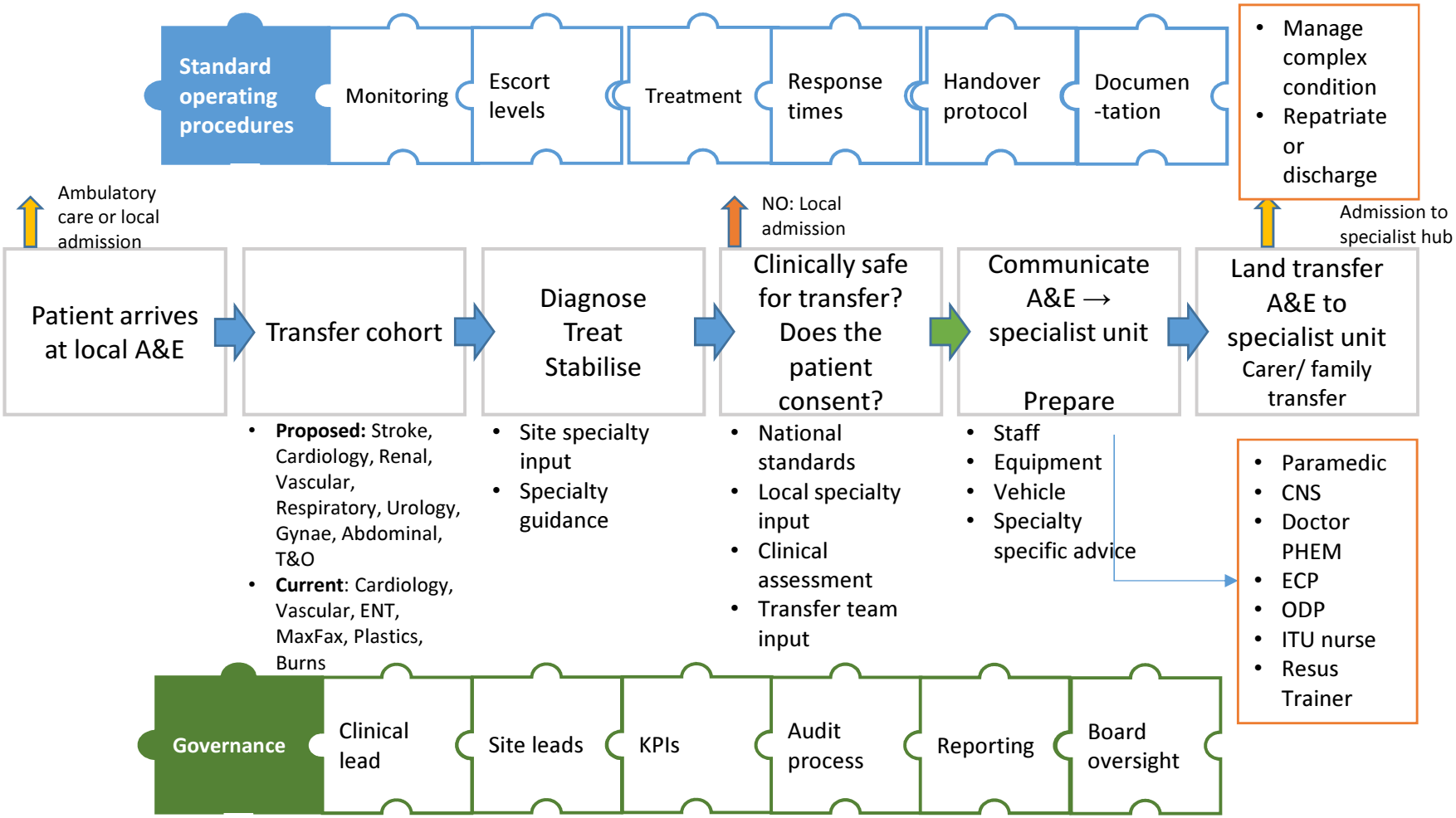
Clinical Transport (Treat & Transfer)

- Existing transfers of patients between mid and south Essex's acute hospitals are believed to be at least 14 per day; this is primarily cardiology, burns, maxillofacial, burns and ENT patients
- The 15 anticipated additional patients being transferred would increase the total number to 29
- Existing models of inter-hospital transfer have been reviewed – including Northumbria, London, Staffordshire, Cumbria, the Pennines and West Yorkshire. These processes have been running for a number of years and have been carried out safely
- An initial 24-hour audit of new transfer numbers has been undertaken. A further two-week audit has now been planned.
- A planning group has been established to identify the best option for the provision of this service.
- Commissioners and leadership of the trusts will require full assurance about the plans for any transfer service, the equipment, processes, vehicles and workforce for its safe implementation before any changes are put into practice

Categorisation of Patients

Green	No level of medical oversight required during inter-hospital transport. An example might be a patient with a laceration involving tendon disruption but not vessel injury. This patient could travel in a private car companied by a friend or relative as driver, in a taxi or on a hospital PTS vehicle which is purely for transport with no medical capability or equipment.
Yellow	This patient will travel in a fully equipped ambulance staffed by professionals with the appropriate skill set. An example could be a patient who has a fracture requiring intervention at the trauma unit and who is not anticipated to deteriorate from a cardio-respiratory perspective on route but may require analgesia and may have had initial IV analgesia in the presenting A&E.
Orange	This patient will travel in a fully equipped ambulance with an appropriately skilled paramedic. An example patient would be as given above, but who required IV analgesia en-route.
Red	This patient will travel in a fully equipped ambulance where at least one of the crew is trained to paramedic level, and an extra health care professional accompanies the patient who can manage infusion pumps and invasive monitoring. This could be, depending on patient need, a specialist nurse/ operating department technician/ resus training officer or equivalent/a training doctor of the appropriate clinical speciality (all with appropriate transfer training).
Black	This patient will travel in a fully equipped ambulance where the ambulance crew are at a level where at least one is at paramedic level and an extra healthcare professional accompanies the patient who can manage development of anticipated instability during transfer such as Airway/CVS/CNS compromise. This could be a Pre-Hospital Emergency Medical Doctor, or appropriate specialist consultant.

The treat and transfer model



Patient, Family & Carer Transport

- Recap: Transport Working Group established during the consultation; chaired by a representative of the STP Service User Advisory Group.

- The Transport working Group has met 3 times and has its next meeting in September.
- An hierarchical approach has been agreed:

    - Promote the use of public transport options to try to reduce reliance on car usage.
    - Make best use of existing public transport facilities wherever possible – including engagement with commercial and non-commercial transport operators to alter services to accommodate changing travel patterns.
    - Promote and use existing infrastructure, eg park and ride schemes
    - Ensure users have clear and easily accessible information about public transport options to encourage uptake.

- DMBC identified four priorities relating to:
    - Urban areas
    - Rural areas
    - Enhancing information on public transport options
    - Standardising staff travel and transport options

Urban Areas

Maximising the use of existing services:

- Detailed review, with transport planners and service users, of existing transport links, and opportunities to enhance access between urban centres and hospital sites.
- Working with ECC Integrated Passenger Transport Unit to engage with transport operators to look at the amendment of existing routes. We are currently exploring any opportunities there may be for amendments to the following routes:
  - Southend <> Broomfield : X30 and 3
  - Southend <> Basildon: 25
  - Broomfield <> Basildon: 100 and/or 10 / X10
- Meetings established with transport providers
- **Transport Working Group to assist with discussions.**

Introduction of a Shuttle Service

- Where existing public transport services are unable to facilitate improved access between hospital sites, consider development of a shuttle service to run between the three hospitals (with extension to some community hospitals).
- Hospitals are currently commencing an inter-hospital transfer service for equipment. If shuttle services were required, the intention would be to augment and extend these services to enable transport of patients and families
- **The Transport Working Group will assist the Trusts in developing operational arrangements (eg. operating hours, development of clear information).**

Rural Areas

Improve accessibility for people who live in smaller towns and villages

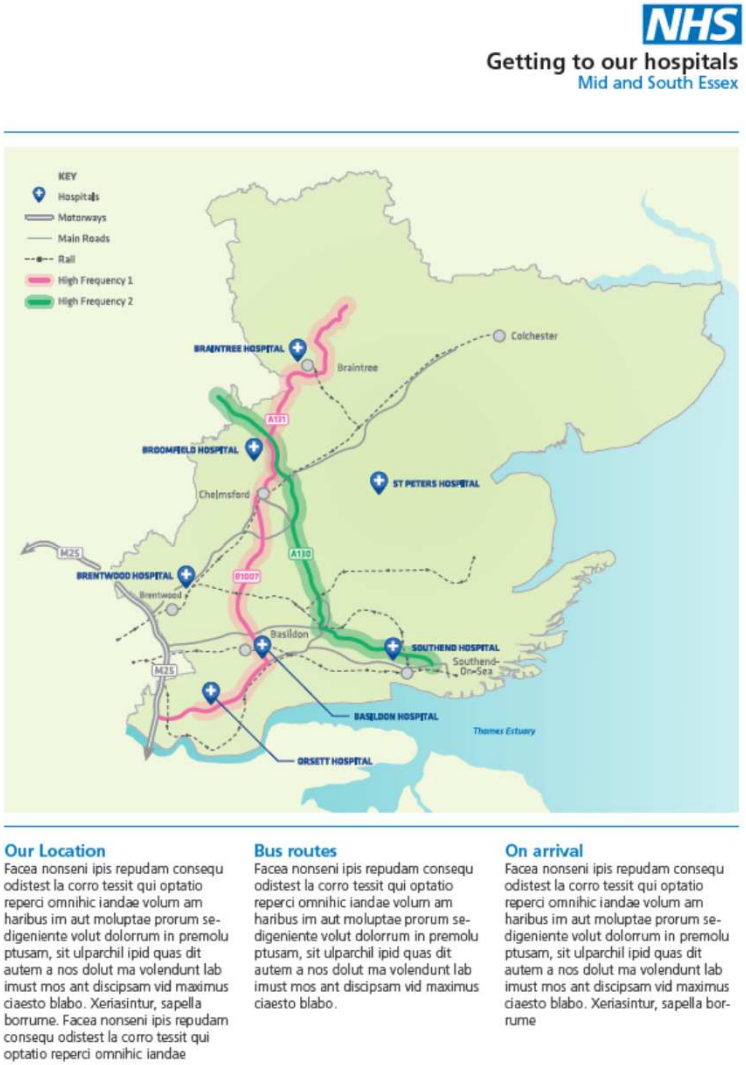
Expansion of existing volunteer driver schemes:

- Agreement to support expansion of existing Care Cars service operating at Southend Hospital.
- Mobilisation likely to be phased, initially to cover Mid Essex and then Basildon and Thurrock due to capacity within the volunteering and third sector teams at each trust.
- Working through implementation plan to confirm likely start date of the expanded service.

Improving Information on Transport Options

Provide better information for patients, families, carers and staff

- Aim to increase uptake of public transport options to reduce burden on car parking at hospital sites
- Transport Working Group session in September to review existing information on public transport between hospital sites with the aim of making this accurate and accessible.
- To include:
  - Review of information currently given by hospitals (both on-line and through written correspondence/information).
  - Provision of maps showing transport links



Staff Transport

Implement a common approach to staff transport across the three hospitals

- To include:
  - Standardising policies and procedures with respect to staff transport with an emphasis to encourage switches away from driving to work.

  - Consider:
    - Pool cars for staff which need to travel regularly during the day.
    - Promotion of car / lift sharing schemes.
    - Improvement of cycle infrastructure.

- The hospitals are shortly commencing the inter-hospital transport service for equipment, with a view that this service could be augmented to allow for staff transfer.

- Estates master planning underway for all three main hospital sites; this work will include how best to establish the necessary infrastructure for cycling and car/lift sharing.

Preparatory capital works

- Next stage of capital release application proceeding, alongside detailed estates strategy across the three trusts.

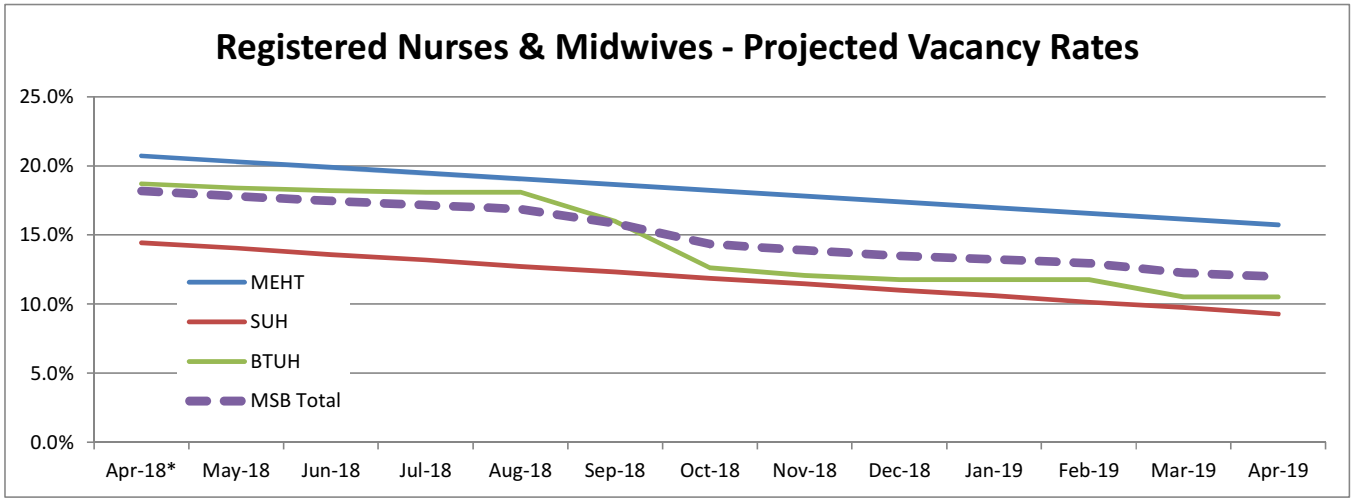
- Focus also remains on delivering immediate term actions to improve facilities and improve hospital resilience including:
  - A&E expansion at Southend (as per artists impression, above)
  - CT scanner replacement, alongside preparatory work for interventional radiology and EBUS at Basildon
  - MRI scanner replacement at Broomfield

Workforce (hospital services)

Hospital services

- A single workforce strategy has now been agreed across the three trusts, this includes action to:
  - Standardise policies, procedures and recruitment activities across the hospitals.
  - Establish rotational roles across sites and/or between different service areas.
  - New return to practice and ‘stay campaign’ for those who have retired or are shortly to due to retire.
  - Use of the nurse apprenticeship pathway to increase ‘home grown’ talent.

- Agreed trajectories for vacancy reduction for nursing and midwifery posts through to April 2019 shown below:



Workforce (hospital services)

Focus on apprenticeships

- As an example of the work going on across the three hospitals to resolve workforce shortages is the significant focus is being placed on the use of apprenticeships and in particular the nursing apprenticeship pathway from qualification as a Healthcare Assistant through to Registered Nurse, recruited from our local communities.

	Healthcare Support Worker Apprentices	Assistant Practitioner Apprentices	Nurse Degree 'top up' Apprentices	Total
	12-18 months	24 months	20 months	56–62 months
Broomfield	23	17	4	**44**
Southend	14	14	5	**33**
Basildon	21	18	16	**55**
Total active	**58**	**49**	**25**	**132**
Planned starts during September and October 2018	*86*	*47*	*22*	***155***
Active + Planned	**144**	**96**	**47**	**430**

Nurse apprenticeship pathway

Primary Care Strategy – Summary

The primary care strategy has now been finalised:

- Signed off by all five CCG Boards in public in June
- Endorsed by both LMCs
- Discussed with STP Board, HWBs, HOSCs and practices
- Endorsed by the CCG Joint Committee

CCG have developed detailed local implementation and investment plans, signed off by Boards

The recurrent investment required to implement the strategy (£28.7m) has been assured by NHSE, and sources of funding identified

If fully implemented, the strategy will close the gap between demand and capacity by 2020/21

The Primary Care Programme Board and sub-groups mobilised in August

We are working with the NHS England national team on:

- A finance ‘experiment’ which seeks to pool a range of budgets and delegate decision making about their deployment to the Programme Board
- Opportunities to support ‘leading edge’ localities that are ready move at pace

Next steps

Mid-September **Sept-December** **November**

Pathway implementation processes