Mid and South Essex
Success Regime

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STP and Success Regime

A programme to sustain services and improve care

Southend-on sea Borough Council – People Scrutiny Committee

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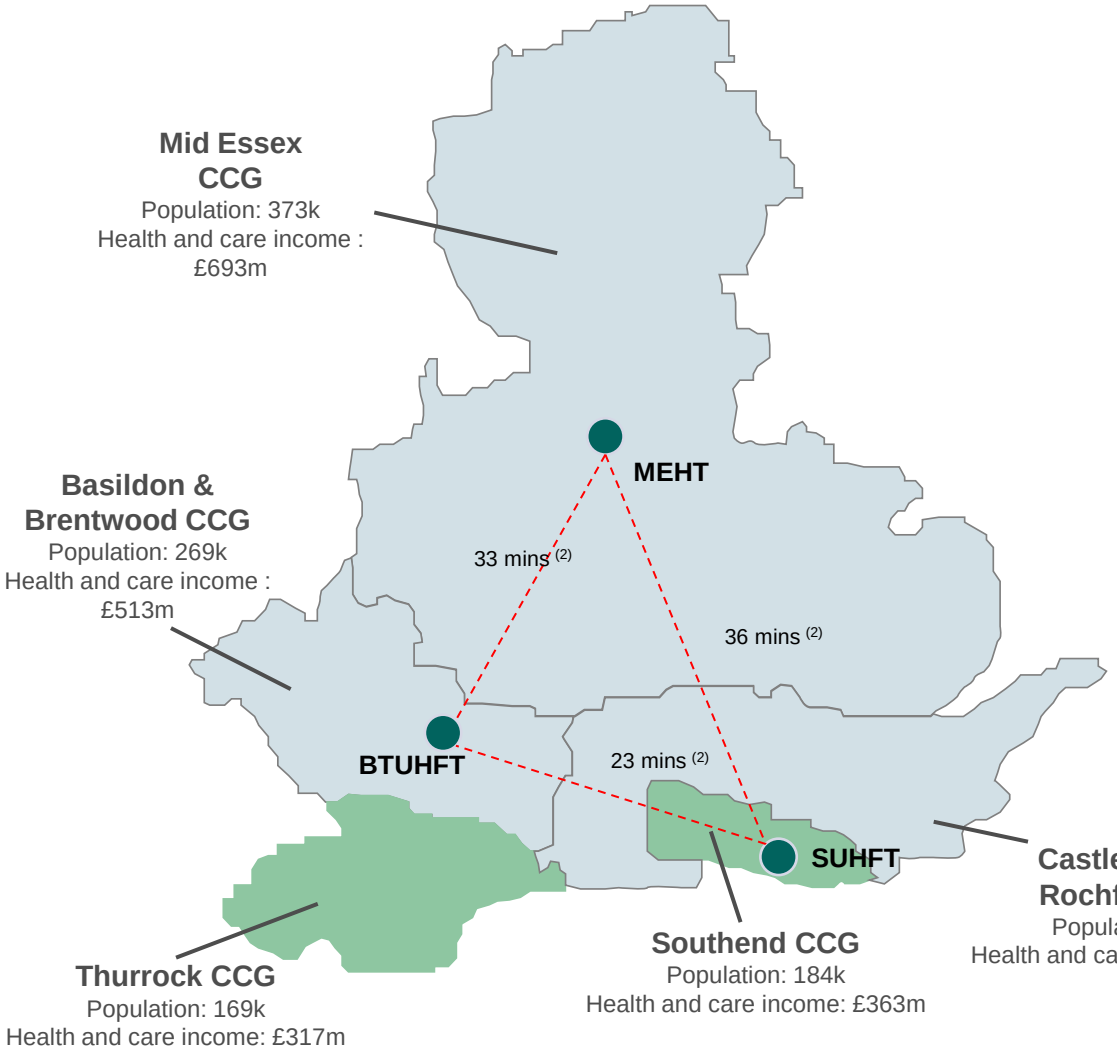
What's in this briefing

- **Introduction and overview**
- **Sustainability and Transformation Plan (STP)**
- Snapshots of some of the main work streams
  - **Prevention**
  - **Localities and primary care**
  - **Complex patients, frailty**
  - **Acute**
- **Timescales and next steps**

Introduction and overview

Sustainability and Transformation Plan	Success Regime
• Part of the NHS Five Year Forward View • Five year plan to secure sustainable, high quality, joined-up care – transformation • Mid and South Essex footprint	
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	**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

The 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

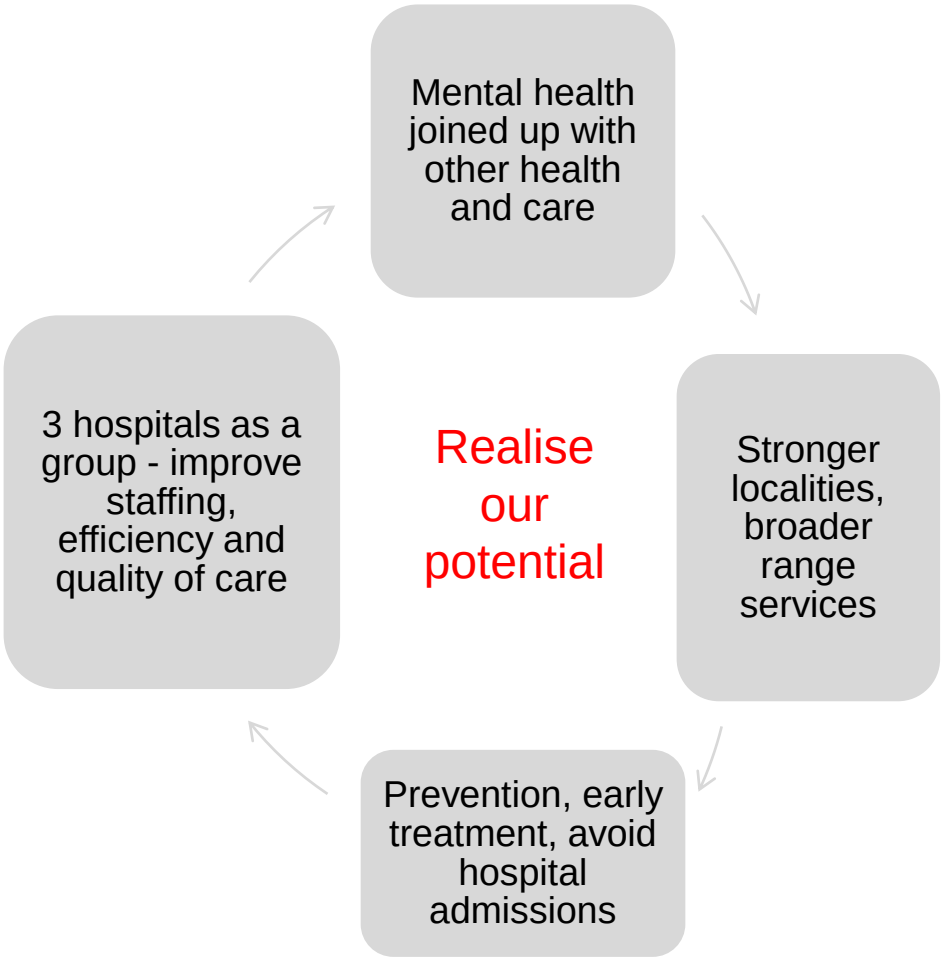
System health and care income 15/16[3]: £2,233m

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

STP in summary



- Solutions to financial gaps
- Governance
- Engagement
- Enablers – IT, workforce, estates

13 Work Streams

- Prevention
- Localities
- Complex: Frailty
- Ambulance
- 111 7 Out of Hours
- Acute Services
- Mental health
- Learning Disabilities
- Dementia
- Maternity
- Social Care

Prevention

Main strategic points

- New public health strategies across Essex, Southend and Thurrock
- *Making Every Contact Count* across all public services, including schools – lifestyle change
- Make public health interventions more systematic e.g.:
  - Health checks
  - Alcohol and substance misuse strategies
  - 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
- 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, cardio vascular, alcohol

Localities and primary care

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

The journey of primary care 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

What does this mean for Southend

Context and case for change

Currently 35 practices in four localities:

- 8 practices in Southend West
- 11 practices in Southend West Central
- 8 practices in Southend East Central
- 9 practices in Southend East

Growing population, more people over 75 with complex needs, high level of care homes

High demand for mental health, drug and alcohol services

- Reduce fragmentation
- Multi-disciplinary team
- Improve workforce capacity, capability
- Improve patient outcomes & experience

Enhancing capacity

Incremental change to develop primary care and align community services around groups of GP practices

Investing in Primary Care

- Improving services to people in care homes
- Enhancing range of same-day services

Improving network of urgent and emergency care

- Improvements in 111
- Ambulance doing more than just transport

1. Multidisciplinary teams

Complex patients, long term conditions, frailty

Main strategic points

- Greater emphasis on prevention – strengthening resilience – support for individuals and communities (*Live Well*)
- Early identification and care planning
- Risk stratification
- Coordination with urgent care services – 111, out of hours
- Proactive care closer to home, personalised approach and plan
- Integrated multidisciplinary support
- Holistic patient-centred care
- Better use of technology / innovation
- Developing future workforce

Frailty and End of Life work in progress

Identification and care planning

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

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

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

End of life

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

Acutes

Main strategic points

- Hospital group model for 3 acutes
- Shared back office and clinical support functions
- Reconfiguration to improve staffing levels and patient care:
  - Designation for emergency care with specialised services
  - Separation of planned and emergency operations

Current process

- Acute Leaders Group developing options for reconfiguration
- 12 back office and 9 clinical support workstreams in progress

Acutes

Sequenced approach to decision-making

- Working with community to develop new models of care – manage demand on hospitals
- Considering options for specialised emergency care designation
- Separating elective surgery to avoid disruption and cancellations
- Identifying potential to consolidate specialised expertise
- Redesign pathways and internal services to improve patient flow
- Test options for public consultation

Acutes - Designation

Emergency care at all sites	Emergency care with specialised services
Treats majority of patients	Accepts all patients
Refers life-threatening emergencies to specialist 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

- Model already in practice with Cardiothoracic centre at Basildon, Burns at Broomfield, Trauma centre at Addenbrooke's

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) • Prep for consultation
Oct/Nov	• National and local assurance prior to consultation • Start of consultation
Jan - Mar 2017	• Outcome, decision-making business case and assurance process