Mid and South Essex
Success Regime

Mid and South Essex Success Regime

Pre-consultation business case

The Case For Change

About this document

The pre-consultation business case seeks permission to commence public consultation for the transformation of health and care across Mid and South Essex. It is to be submitted to NHS England in November.

The pre-consultation business case includes

- The clinical and financial case for change
- A future model of care and how this has been developed
- An outline of system wise enablers and governance for clinical proposals
- An overview of engagement to date and consultation plans

This document covers the clinical and financial case for change. This extract from the draft pre-consultation business case is for approval by the Boards of each statutory organisation involved. It includes a 2 page summary and the full case for change.

It is a work in progress and the Boards will be asked to approve the full pre-consultation business case in October.

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Executive Summary

The Mid and South Essex Success Regime is part of a national programme initiated to improve health and care where systems are managing financial deficits, issues of service quality, or both. It concentrates on certain areas of the country where there are deep-rooted, systemic pressures. The Success Regime aims to:

- Create and support the development of a transparent, internally consistent, whole system plan to deliver high quality care for patients, reduce local health inequalities, and achieve financial balance by 2020-21;
- Establish a locally led and nationally supported programme to deliver the plan;
- Use NHSE and NHSI oversight to unblock barriers to enable delivery at pace

In recent years, Essex has seen higher life expectancy and reduced mortality rates for key conditions. However, an ageing population is placing pressure on the system, and health outcomes are notably worse for those at lower income and higher deprivation levels. This pre-consultation business case identifies four drivers of change that must and will be addressed by the Success Regime.

Firstly, the **highest possible standards of care must be provided across the patch**:

- Out of hospital services are fragmented: primary care has numerous independent practices with limited integration; EoL care is covered by 15 separate contracts. Access is below national levels in primary and EoL care. Quality of life for adults with LTCs varies widely, and the majority of EoL outcomes are below national averages;
- In acute hospitals, key services are falling short of some clinical quality and safety standards. Only 81% of A&E patients are seen within 4 hours (95% national target), with patient surveys indicating lower levels of satisfaction than nationally.
- Local clinicians have conclusively affirmed a compelling case for change across a range of services.

Secondly**, rising non-elective demand must be met**:

- Non-elective attendances are growing at double the national growth rate (8% versus 4% in 2014-15). Unnecessary emergency admissions add further pressure, and could be more suitably treated through community and primary care provision;
- However, neither acute nor primary services are currently configured to meet rising demand. The do nothing scenario leads to a need for 300 additional beds by 2020-21.

Thirdly, **workforce challenges are placing pressure on services across the system.**

- In primary care, the patch ranks in the bottom quartile for GPs/practice nurses coverage, driven by recruiting challenges and high locum spend. In acute hospitals, safe staffing levels are not being met, in particular for A&E where the three trusts average only half of the recommended cover of 10 FTEs;
- Hiring more staff is not a sustainable option given local and national workforce shortages. These can only be met by new ways of working, such as delivering more care out of hospital with new roles required for community health staff.

Lastly**, financial pressures need to be addressed**.

- The annual financial challenge facing local commissioners and providers reached £101 million in 2015-16, and is forecast to increase to £430 million a year by 2020. Increasing financial pressure in funding and delivering acute care services drives much of the deterioration in the system position;
- Identified CIP and QIPP savings would reduce the 2020/21 deficit to £124 million; to achieve balance, initiatives must look beyond the existing configuration of services and find new ways to deliver high quality care at lower cost.

Evidence on health outcomes, patient, family and clinician surveys, and financial and estate projections under a 'do nothing' scenario indicate a compelling case for change through the Success Regime. The pre-consultation business case outlines four implications.

Build stronger localities to deliver a broader range of primary and community services

- Rising non-elective demand and variation in quality across the patch indicates that more care needs to be delivered in primary and community settings or in a person's own home;
- Providing care closer to home can improve patient outcomes, particularly in the case of clinically stable elderly patients, rehabilitation and reablement, and reduce costs;
- NHSE encourages moving towards a larger footprint with greater integration of practices (>30k patients) to increase range and continuity of services, productivity, access to specialist care and longer patient consultations.

Reduce the number of non-elective admissions into acute hospitals

- Rising non-elective demand places immediate pressure on the acute hospitals and wider urgent care network;
- The Urgent and Emergency Care Review recommended extending urgent care services outside of hospital to manage demand. Evidence indicates that early senior consultations improves outcomes and reduces LOS, hospitalisation rates and cost.
- The Urgent and Emergency Care Review recommends centralising specialist care, maximising survival and recovery rates for serious and life-threatening emergencies. Getting patients into the right ward first time also reduces mortality, harm and LOS.

Reconfigure acute services

- Financial, workforce and quality concerns indicate a need to reconfigure the acutes;
- Evidence suggests that consolidation and associated higher volume of procedures can improve health outcomes for certain key conditions, while reducing costs through greater efficiency and productivity. It can also improve reliability by standardising protocols for treatments and pathways, and workforce needs by reducing duplication and increasing productivity.

Redesign clinical pathways

- Post reconfiguration, clinical pathways will need to be redesigned to reduce duplication, ease patient flows and improve quality of patient care. this includes changing how a pathway is managed by acute, primary and community providers, maximising the use of technology and innovation and changing the workforce model

Mid and South Essex
Success Regime

The Case For Change

Extract from PCBC

Version 1.3 [9/8/16]

WORK IN PROGRESS

Contents

2.1 Introduction

The NHS Five Year Forward View sets out the challenges facing health and care nationally and how radical change is needed to sustain services into the future and improve care for patients. It is a blueprint for the NHS to take decisive steps to secure high quality, sustainable, joined up care. As part of this a national Success Regime programme was initiated to improve health and care where systems are managing financial deficits, issues of service quality, or both. It concentrates on certain areas of the country where there are deep rooted systemic pressures.

Within this context, the Essex Success Regime was selected by a committee of seven national regulatory bodies and announced in June 2015 as one of three such programmes in the country. The Success Regime has three core goals:

- Create and support the development of a transparent, internally consistent, whole system plan
- Establish a locally led and nationally supported programme to deliver the plan
- Use NHS England and NHS Improvement to unblock barriers to enable delivery at pace

A diagnostic phase which ran from October to November 2015, identified key challenges and root causes. This has now been developed into a full case for change.

There are four main drivers of change:

1) the need to provide the highest possible standards of care;
2) the need to meet the rising non-elective demand;
3) the need to respond to workforce challenges;
4) the need to address financial pressures.

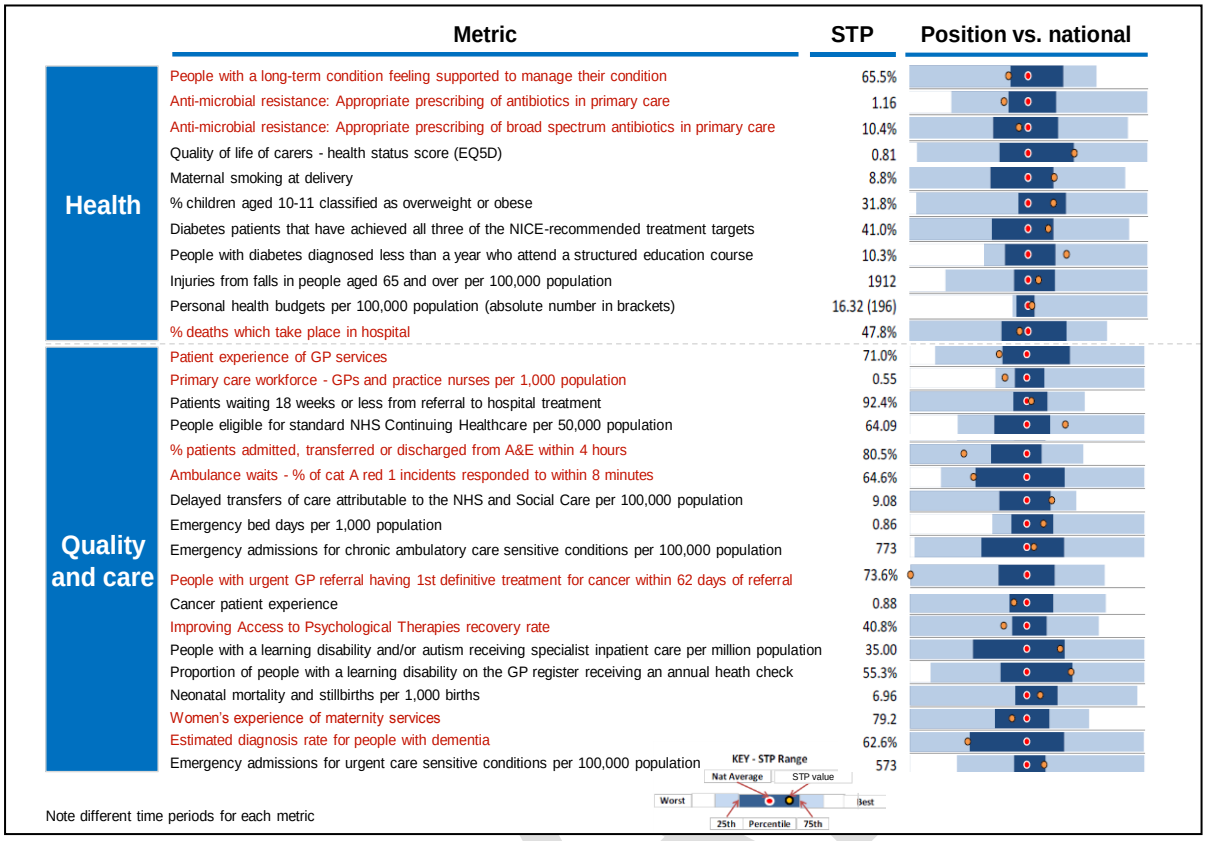
There is strong consensus on patch about the case for change. In a workshop of the Senior Leadership Group which includes representatives from the acutes, primary care, social care, community, mental health, 97% of attendees agreed that there are convincing reasons to change the way we deliver services. 3% had no strong opinion[1].

2.1. The need to provide the highest possible standards of care

While provision of healthcare has improved significantly over the recent years there are still a number of health, quality and care gaps that exist in Mid and South Essex. Figure 1 highlights some areas where Mid and South Essex is below national average. Key areas are primary care, end of life care, non-elective admissions to hospital, cancer statistics and experience of maternity services.

[1] Stakeholder Briefing. 13th July 2016

Figure 1: Key health, quality and care indicators, Mid and South Essex



Source: Five Year Forward View – STP footprint analysis pack for Mid and South Essex. April 2016

This section focuses on the performance of health and care services. Workforce challenges, pressures from increasing demand and financial issues are covered in other sections.

2.1.1. Out of hospital services

There are examples of excellent out of hospital services being delivered across Mid and South Essex but there is significant scope for reducing variation and ensuring that all residents have access to consistently excellent out of hospital services, including general practice, community healthcare, rehabilitation and reablement, public health initiatives and self care.

Primary care

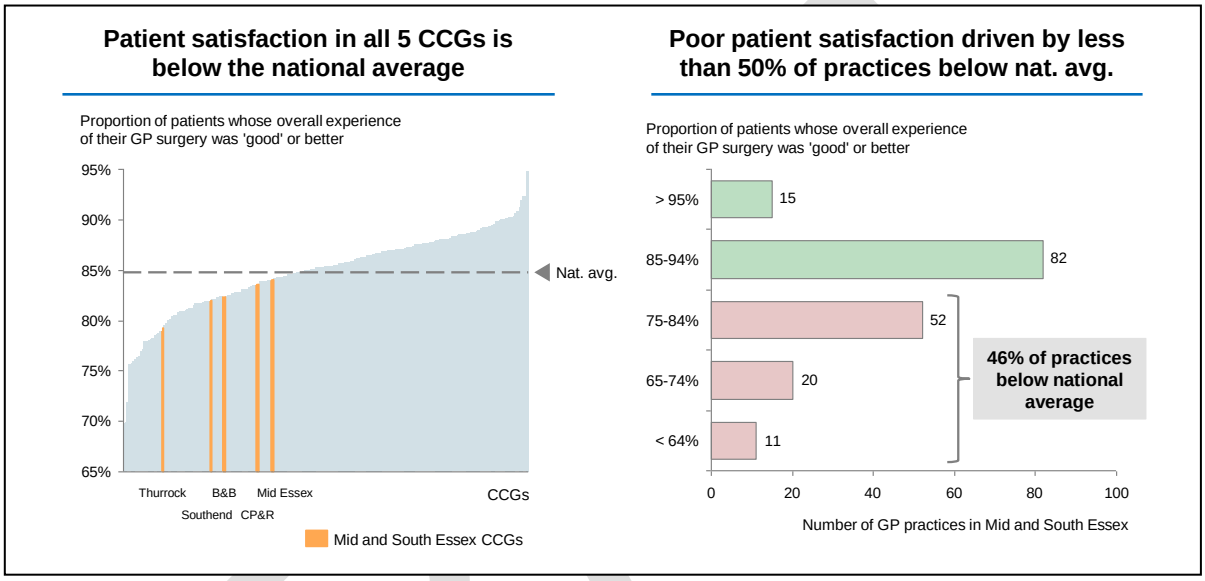
Primary care refers to services provided by GP practices, community pharmacies, dental practices and high street optometrists. As many people's first point of contact with the NHS around 90% of patient interaction is within primary care services[2]. In Mid and South Essex significant variation in performance between GP practices and varying levels of integration between GP, pharmacy, dental and optometry.

[2] HSCIC: http://www.hscic.gov.uk/primary-care

Patient satisfaction for all 5 CCGs is below national average but this hides significant variation. As shown in Figure 2 this is driven by just 46% of practices have a patient satisfaction of less than 84% [rating overall experience good or better]. [3]

Access is also varied. Nationally 73% of people are able to get an appointment to see or speak to someone, in Mid and South Essex this varies between 68% and 72% depending on the CCG. [4] For same day appointments 37% of people in Mid and South Essex are able to make an appointment versus the national average of 38%[5]. There is also little consistency in appointment systems. Some offer walk in sessions, extended hours and/or email communication whilst others only offer some of these.

Figure 2: Patient satisfaction

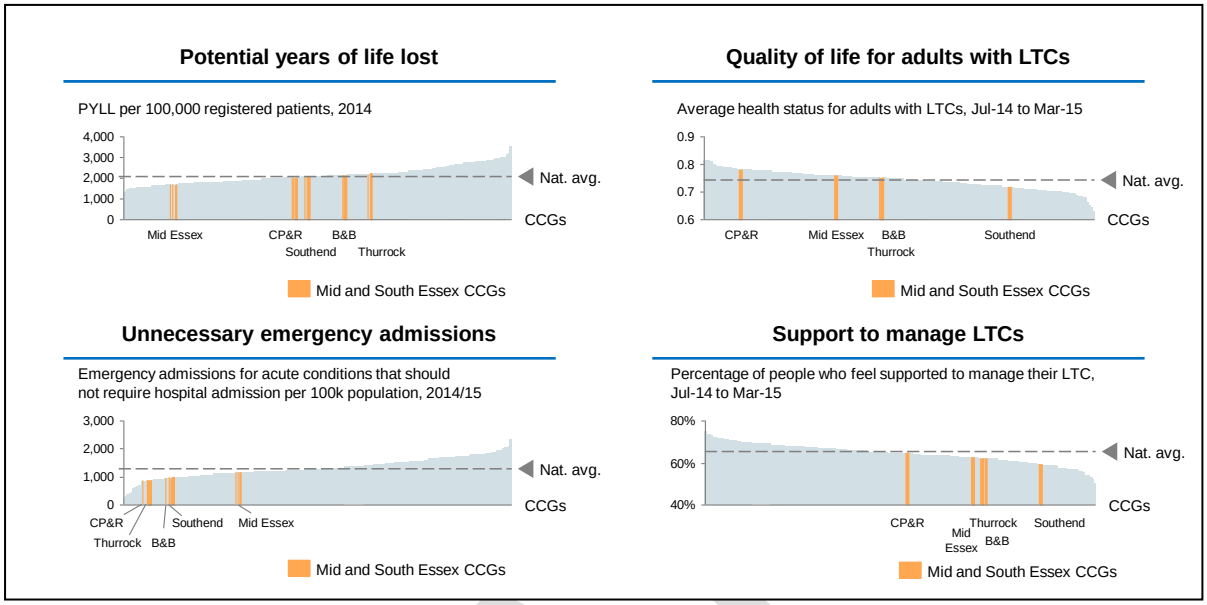


Source: GP patient survey. January 2016 publication

There is large variation in performance on key outcomes in primary care. A review of the admission rates for ambulatory care sensitive conditions such as asthma and Chronic Obstructive Pulmonary Disease (COPD), a lens on the quality of preventative care in the community, shows that 2 out of 5 CCGs in Mid and South Essex have higher admission rates than national average[6]. Figure 3 outlines some additional key outcomes, indicating a large gap between the highest and lowest performing CCG for a range of metrics. The proportion of patients who feel supported to manage their long term conditions is below national average in all CCGs.[7] This impacts patient outcomes as it is known that self management can increase physical function, instil greater confidence and reduce anxiety.[8]

[3] GP patient survey, January 2016 publication
[4] GP patient survey. July 2016 publication
[5] GP patient survey, July 2016 publication
[6] STP Submission, July 2016
[7] GP patient survey, July 2016 publication
[8] Challis Hughes Bezines Reilly Abell Steward (2010) Self Care an Case Management in long term conditions

Figure 3: Outcomes metrics



Note: All metrics as directly standardised rates (DSR); Source: All via HSCIC: GP registered patient counts from NHAIS; Primary Care Mortality Database; ONS mid-year census based England population estimates; GP patient survey; HES

A 2014 NHSE report[9] affirmed that the traditional model of primary care delivery in Essex is not sustainable due to:

- Variable quality of primary care, with early diagnosis/interventions differing;
- Lack of integration: primary care services do not provide a seamless experience for patients;
- Increasing demands on health services but no new available investment;
- An overloaded GP workforce;
- Variable primary care estate: lacking flexibility, not being fully utilised;
- The current model not being flexible enough to adapt services for the most vulnerable in our community;
- Changing population demographics.

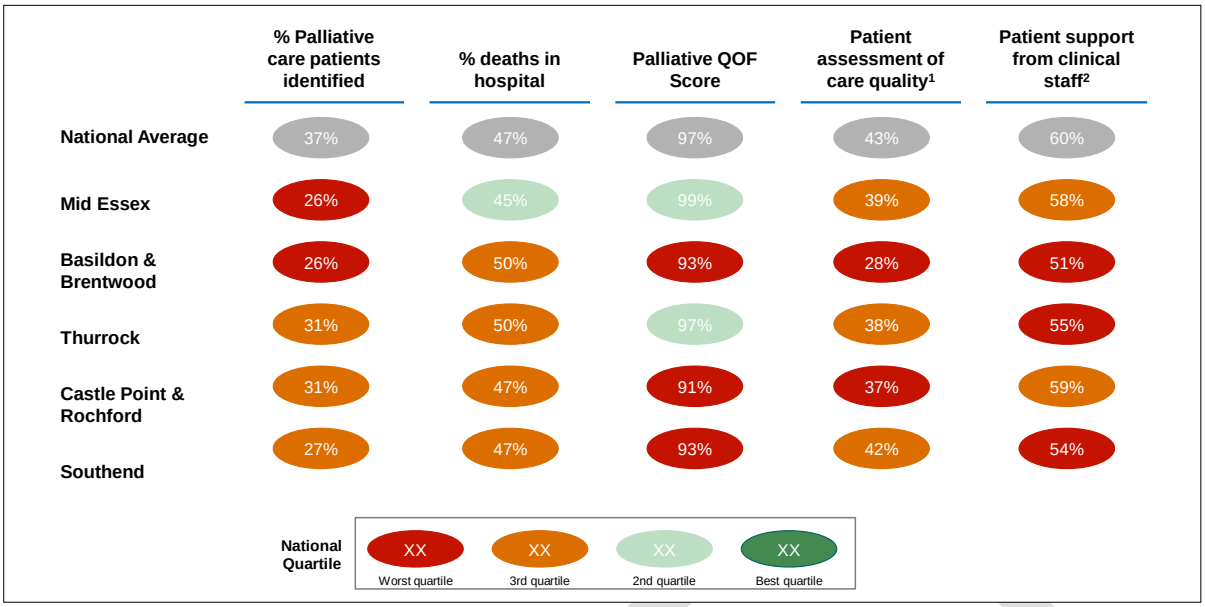
Frailty and End of life care

Frail older people (over 75 years old) represents just 8% of the population but accounts for 39% of acute bed days and 35% of non elective admissions.

Currently, outcomes are below national averages. Figure 4 indicates that, for the majority of selected indicators, all CCGs are in the bottom two quartiles nationally. Almost half of end of life patients die in hospital, and patient assessments of care quality and support from clinical staff are both substantially below the national average.

[9] Transforming Primary Care in Essex: The Heart of Patient Care, NHS England, April 2014

Figure 4: End of life metrics



1. Voices Survey 2011-13: "How would you rate his/her care in the last three months of life?" - % outstanding or excellent; 2: Voices Survey 2011-2013: Were the carers given enough support by the healthcare team at time of death? - % Yes / Definitely; Source: Voices Survey 2011-13; National End of Life Care Intelligence Network; ONS; HSCIC

2.1.2. In hospital services

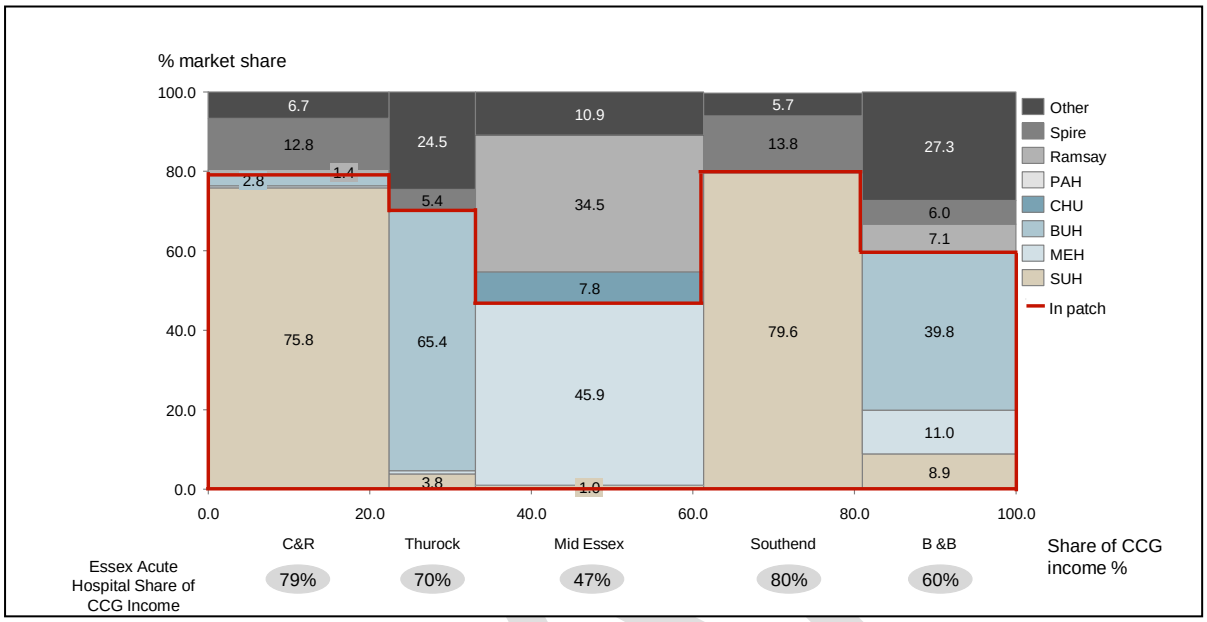
There are examples of excellent quality of care and patient safety across the three hospitals in Mid and South Essex, but there is also variation between the three trusts and improvement is needed to provide the highest possible standards of care. Figure 5 highlights some of the key metrics and where the three trusts are below national average.

Figure 5: Acute metrics

Metric	BTUHFT	MEHT	SUHFT	Nat. average	Source
Referral to Treatment Time	90.7%	92.3%	91.0%	91.8%	NHS England May 2016
Percentage of patients not treated within 28 days of a cancelled operation	0%	5%	12%	6%	NHS England Q3 2015-16
SHMI	0.92	1.06	1.09	1.00	HSCIC April 15 – Mar 16
Delayed Transfers of Care	290	432	359	N/A	NHS England Jan 2016
CQC Rating	Good	Req Impr	Req Impr	N/A	NHS Choices Aug 2016
Recommended by staff	83%	81%	72%	N/A	NHS Choices Aug 2016
Patients assessed for blood clots	99.5%	97.6%	96.5%	N/A	NHS Choices Aug 2016
Complaints about hospital care	46.8/10,000	44.1/10,000	27.7/10,000	N/A	NHS Choices Aug 2016
% of patients being treated for a bed sore	2.7%	3.96%	3.59%	N/A	NHS Choices Aug 2016
Friends and Family Test	95%	92%	91%	N/A	NHS Choices Aug 2016
Infection control and cleanliness	Among the best	Among the worst	Among the worst	N/A	NHS Choices Aug 2016
Mortality rate	As expected	As expected	Worse than expected	N/A	NHS Choices Aug 2016

The hospitals of Mid and South Essex lose a significant proportion of activity to private providers, with 6% of elective volume from local CCGs going to hospitals outside the SR[10]. This is particularly visible in orthopaedics (see Figure 6) where between 20-50% of activity goes outside Mid and South Essex to private hospital such as Spire and Ramsay. An improvement in performance could repatriate some of this activity back onto the patch.

Figure 6: Patient flows between CCG and acute hospital for elective orthopaedics



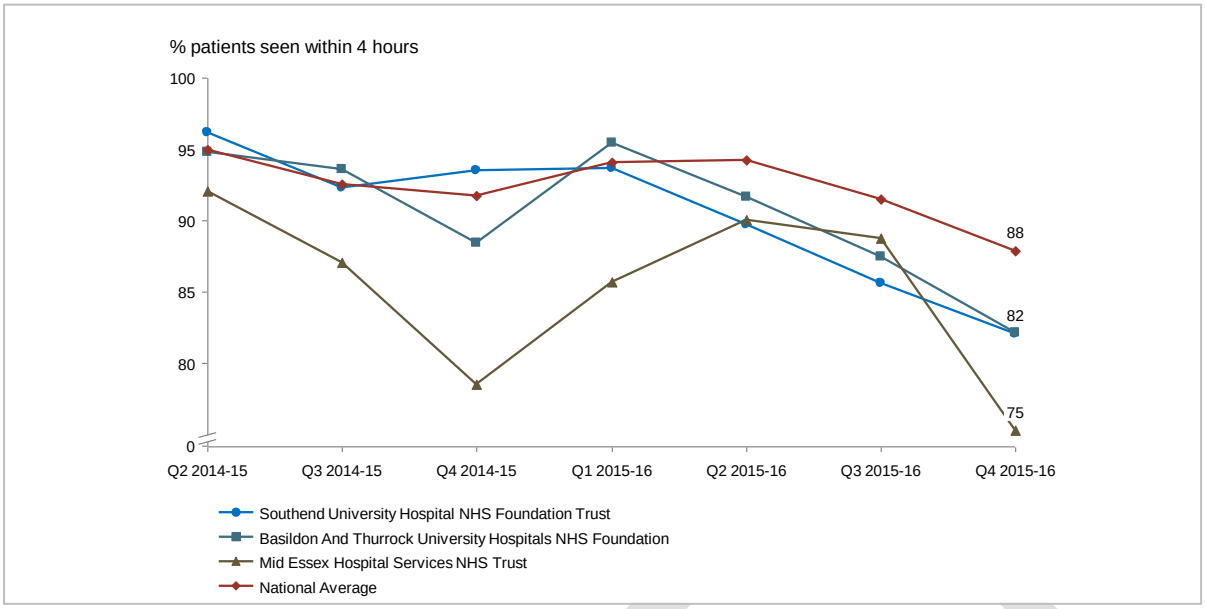
Source: CHKS July 2014 – June 2015

Urgent and emergency care

A particular area where there is significant variation is in urgent and emergency services. The patch falls in the bottom quartile nationally with 81% of A&E patients seen within 4 hours compared to a national target of 95%.[11] Figure 7 shows how this is declining over time. Evidence suggests an increase in patient mortality associated with emergency department overcrowding. [12]

[10] CHKS July 2014 – June 2015
[11] NHS Statistics Quarterly, Q4 2015-16, aggregated Mid and South Essex score
[12] MJA 2006 184:213-216

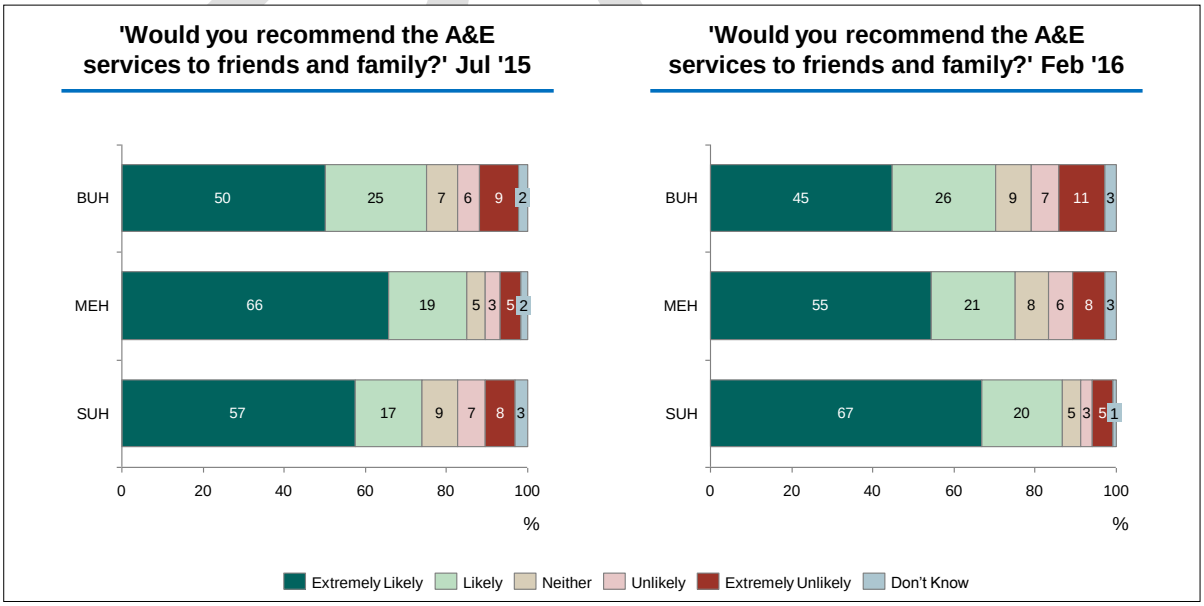
Figure 7: A&E 4 hour waiting times



Source: NHS Statistics Quarterly, 2014 – 2015, 2015-2016. NHS England

The Friends and Family Test reveals that respondents are notably less likely to recommend A&E services in Mid and South Essex than the national average for trusts. In the July 2015 survey, 77% of local respondents stated they would recommend A&E services to friends and family in comparison to 88% nationally. While Southend improved from a 74% recommendation rate in July 2015 to 87% recommendation rate in February 2016, both Mid Essex and Basildon showed a decline in recommendation rate.

Figure 8: Friends and Family Test



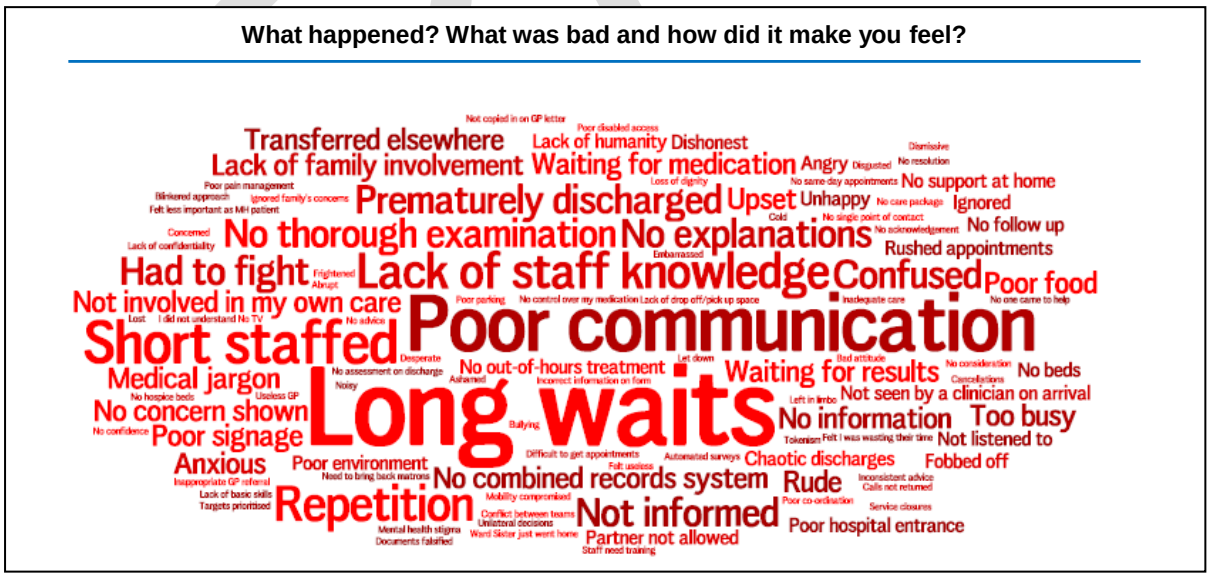
Source: https://www.england.nhs.uk/ourwork/pe/fft/friends-and-family-test-data/fft-data-historic/

An April 2016 workshop with service users run as part of the options development process helped to identify the strengths and weaknesses with the current urgent care system. Communication and time to treatment were noted as key metrics of performance, with communication in particular being identified as an area that needs to be improved. A variation in performance was also evident. There was some considerable positive and negative feedback on the same aspect of user experience in some cases. The findings of the workshop are outlined in Figure 9 and 10.

Figure 9: Service user feedback

Source: Service User Workshop, 28th April 2016

Figure 10: Service user feedback

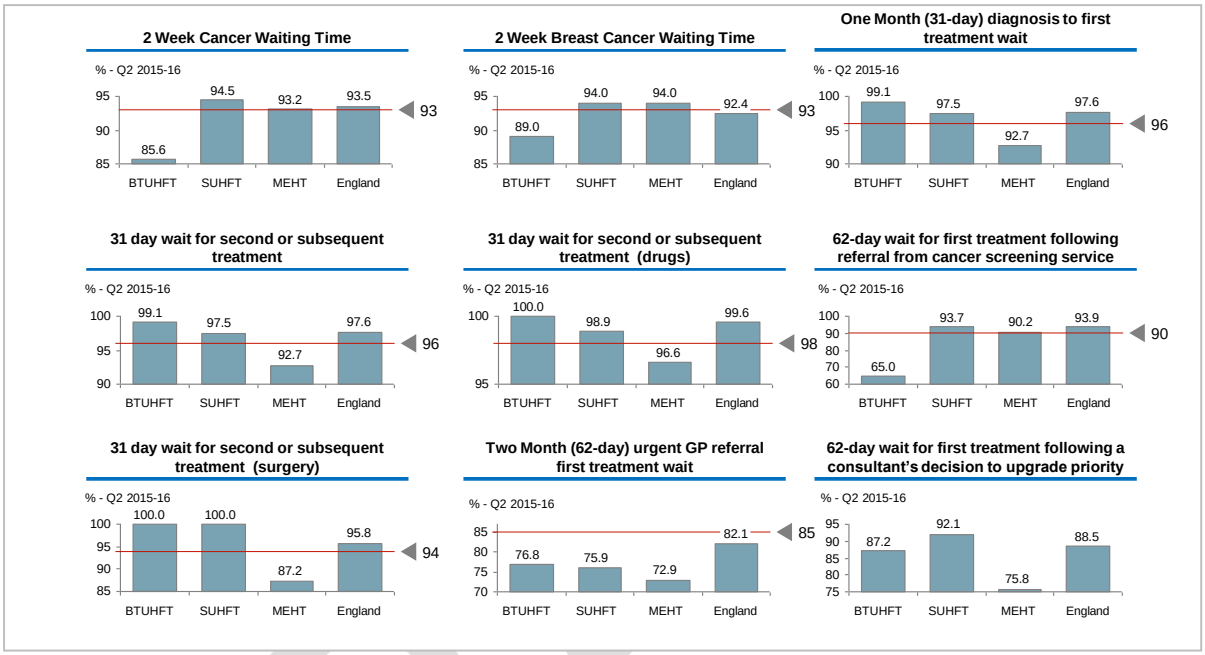


Source: Service User Workshop, 28th April 2016

Cancer

Another area where improvement is needed is for Cancer waiting times. Across the three trusts there is significant variation in waiting times for both diagnostics and treatment (See Figure 11)

Figure 11: Cancer waiting times



Source: NHS England Statistics

2.1.3. Conclusion

Reviews of performance data demonstrated that key services delivered in an acute setting are falling short of some clinical quality and safety standards. More care needs to be delivered in an out of hospital setting and more work needs to be done to improve quality, and reduce variation. Given that the highest standards of care are not being achieved primary and secondary care clinicians are united in the view that "no change" is not an option.

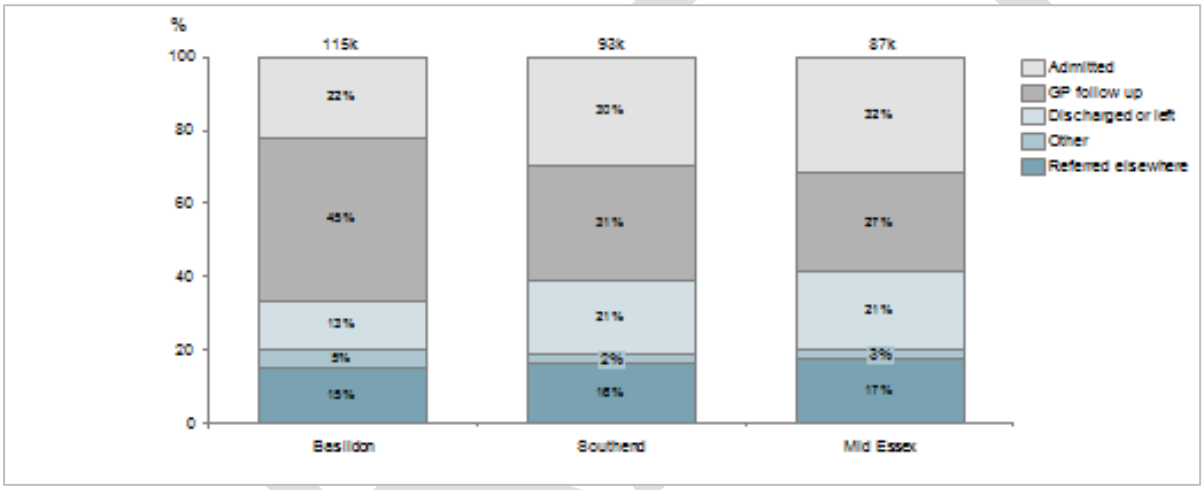
2.2. The need to meet the rising non-elective demand

2.2.1. Increasing non-elective demand

Non elective activity is growing in Mid and South Essex and the three acute hospitals are struggling to cope with the increased demand. There is a clear need to unblock the acute hospitals and prevent overcrowding.

The data shows that a proportion of people turning up at A&E do not necessarily need to be treated there and could be better served by community and primary services, if such services were available. As Figure 12 shows between 15-17% of A&E attendances were referred elsewhere and between 13% and 21% of A&E attendances were discharged without treatment.
There are a number of reasons for increased attendances, some evidence suggests that patients who are less satisfied with their primary care are more likely to attend A&E.[13]

Figure 12: Discharge location for A&E attendances



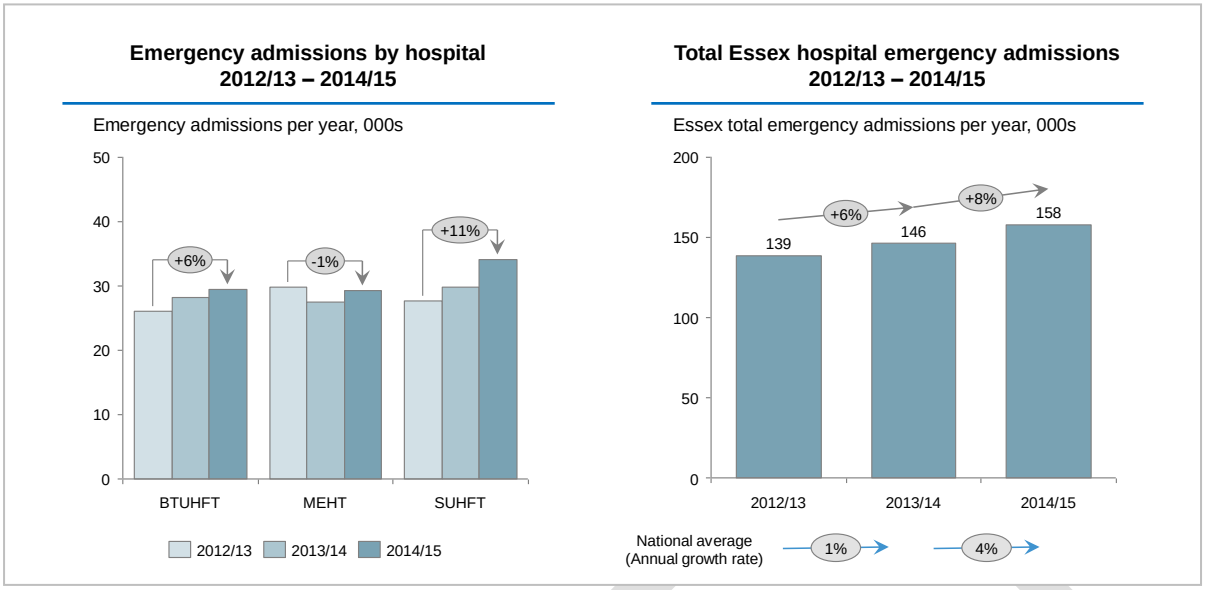
Source: HES A&E data 2014/15

The impact on the three acute hospitals is shown by the 4 hour waiting time performance – as discussed in the previous section.

As well as increased A&E attendances there are also increased emergency admissions. Non-elective admissions are already a high proportion of activity for the Mid and South Essex Acute Trusts. They account for 32% of income for the three trusts versus 26% for other similar sized hospitals outside of Essex and versus 12% for selected large multi site teaching hospitals.[14] Non elective admissions are growing. Emergency admissions across Mid and South Essex grew 8% between 2013-14 and 2014-15, 4% faster than national average, with over 295,000 attendances reported in 2014-15.[15]

[13] Urgent and Emergency Care Review End of Phase 1 Report. Appendix 1 – Revised evidence base from the urgent and emergency care review NHS England. November 2013
[14] SR Diagnostic Report November 2015
[15] HES Accident and Emergency Attendances 2013-14

Figure 13: Non-elective demand



Note: Charts show emergency admissions from all CCGs, including those outside Essex. Growth rates shown are annual growth rates between 2012/13 and 2014/15. Source: A&E Attendances and Emergency Admissions. NHSE Statistics

Some of these admissions were avoidable. In 2014/15, for every 100,000 population in Mid and South Essex there were 962 unnecessary emergency admissions for acute conditions. Nationally, up to 1 million emergency admissions per year are avoidable.[16]

It is expected that this non elective demand growth will continue. The UK population is projected to increase by 4.4 million in the next 10 years. It is projected to continue ageing, with the average (median) age rising from 40 years in 2014 to 40.9 years in mid 2024. By mid-2039 more than 1 in 12 of the population is projected to be aged 80 and over.[17] As the very young and the elderly are the largest users of the healthcare services, the demand pressures will rise significantly. For example, 39% of acute bed days and 35% of non-elective admissions are accounted for by frail older people. This group represents just 8% of the older population.[18] As the population ages, more and more people will have long term conditions. Data clearly shows that the majority of people over 65 have two or more long term conditions and are the most frequent users of our health and social care services and the majority of people over 75 have three or more long term conditions.[19]

Modelling of the predicted increase in demand shows that neither acute nor primary services are currently configured to cope with rising demand for healthcare. The do nothing scenario would lead to a need for >300 additional beds in the acute sector by 20-21.[20] (see Figure 14)

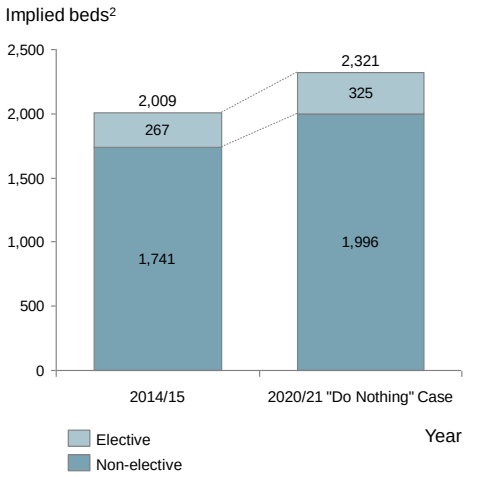
[16] Urgent and Emergency Care Review. End of Phase 1 Report, Appendix 1 – Revised evidence base from the URgent and Emergency Care Review. NHS England. November 2013
[17] ONS. 2014 based statistical bulletin. 29th October 2015
[18] HES 2014-15
[19] QIPP long term conditions. department of health.
[20] NHS Success Regime Capacity Modelling

Figure 14: Acute capacity modelling

Projected momentum case growth[1]

	Age	Assumed CAGR 14/15 – 20/21
Elective	**0-19**	2.32%
	20-54	1.26%
	55-74	3.21%
	75-84	5.65%
	85+	7.38%
	Total	**3.32%**
Non-elective	**0-19**	0.72%
	20-54	-0.33%
	55-74	1.61%
	75-84	4.06%
	85+	5.79%
	Total	**2.30%**

"Do Nothing" bed requirements, 2020-21



1. Including demographic and demand growth 2. Implied beds = # bed days / (365 * Utilisation rate). Utilisation rate = 89%
Source: HES data, SR analysis

Source: HES data, SR analysis

2.2.2. Conclusion

Demand for healthcare services in the Area will rise over the coming decade. The acute hospitals are already struggling (as seen in performance section) and are not equipped to cope with more activity. Primary and secondary care clinicians are united in the view that "no change" is not an option.

2.3. The need to respond to workforce challenges

2.3.1. Out of hospital

Pressure on primary care is evident. Workload was identified by the 2015 BMA survey as the single biggest issue of concern to GPs and their staff. Latest research, published in the Lancet, suggests that there has been an average increase in workload in general practice of around 2.5% a year since 2007/8, taking into account both volume and acuity.[21] GP FTEs are projected to fall from 595 to 578 by 2018-19 but there are already challenges recruiting to vacancies and high locum spend. There are 0.55 GPs/practice nurses per 10,000 population compared to a national average of 0.69. This puts Mid and South Essex in the bottom quartile.

2.3.2. In hospital

Across the acute hospitals, safe staffing levels are not being met. Figure 15 outlines current staffing levels against best practice for a number of specialties.

Figure 15: Workforce data vs national standards for three acute hospitals

Specialty	Recommended consultant cover (Guidance)	Recommended WTE cover[1]	Current staffing levels (WTE)[2]		
			MEHT[10]	BTUHFT[11]	SUHFT[12]
A&E	Consultant presence in ED 16 hours a day, 7 days a week as a minimum in all EDs. [2]	10+[3]	4.0 / 10.0	6.0 / 10.0	6.0 / 8.0
Maternity	168 hours per week consultant presence.[4] Should be aspired to in all maternity units regardless of size.[5]	10-12[6]	8.0 / 9.9	10.0 / 10.9	7.9 / 9.9
Emergency Surgery	Emergency admissions should be seen by a consultant in 12 hours[7] Cover extended day working, 7 days a week[8]	8-10	10.0 / 10.0	11.9 / 13.1	8.5 / 8.4
Paediatrics	Consultant present/available during peak emergency attendance & admission. [9]	8-10	7.7 / 9.2	12.0 / 14.7	10.0 / 12.0

Actual / Planned

Source: Internal workforce data

Spreading specialist resources across all three hospital sites makes it difficult for each hospital to ensure that consultants are present to deliver and direct care seven days a week, 24 hours a day. This can mean there is less cover for those patients who become ill or sustain an injury at weekends or in the evening.

While the workforce shortfalls described above are focused on consultant staff it is representative of the difficulties faced in recruiting and retaining skilled medical staff across all grades. Agency and locum spend in the trusts (10%) is higher than national average (5%). In total, agency spend in 2014-15 was £14m for Mid Essex Hospital Trust, £14m for Southend University Hospital Trust and £15m for Basildon and Thurrock University Hospital Trust.

[21] General Practice Forward View

It also applies to nursing staff. Figure 16 outlines current nursing practices across the three trusts and the number of unfilled slots.

Figure 16: Nursing rates across acute trusts

Metric	BTUHFT	MEHT	SUHFT	Source
% of registered nurse day hours filled as planned	94%	92%	90%	NHS Choices, Aug 2016
% of unregistered care staff day hours filled as planned	90%	105%	115%	NHS Choices, Aug 2016
% of registered nurse night hours filled as planned	97%	99%	92%	NHS Choices, Aug 2016
% of unregistered care staff night hours filled as planned	98%	116%	119%	NHS Choices, Aug 2016

2.3.3. Conclusion

Hiring more staff is not a sustainable option. Locally and nationally there is a shortage of key workforce groups such as Emergency Medicine consultants. Non consultant anaesthetists, paediatricians, general surgeons and obstetricians and gynaecologists are all on the national shortage occupation list.[22] Shortages in nurses and midwives have also been reported by the Royal College of Nursing and CQC respectively[2324].

It is expected that workforce shortages can only be met by new ways of working. For example for more care to be delivered out of hospital new roles will be required for community health staff. Health professionals are likely to need new skills and training in order to take on their new role. Therefore, primary and secondary care clinicians are united in the view that "no change" is not an option.

[22] United Kingdom Border Agency. Tier 2 shortage occupation lits.
[23] Staffing for older peoples wards
[24] CQC our market report. focus on maternity services

2.4. The need to address financial pressures

2.4.1. National context

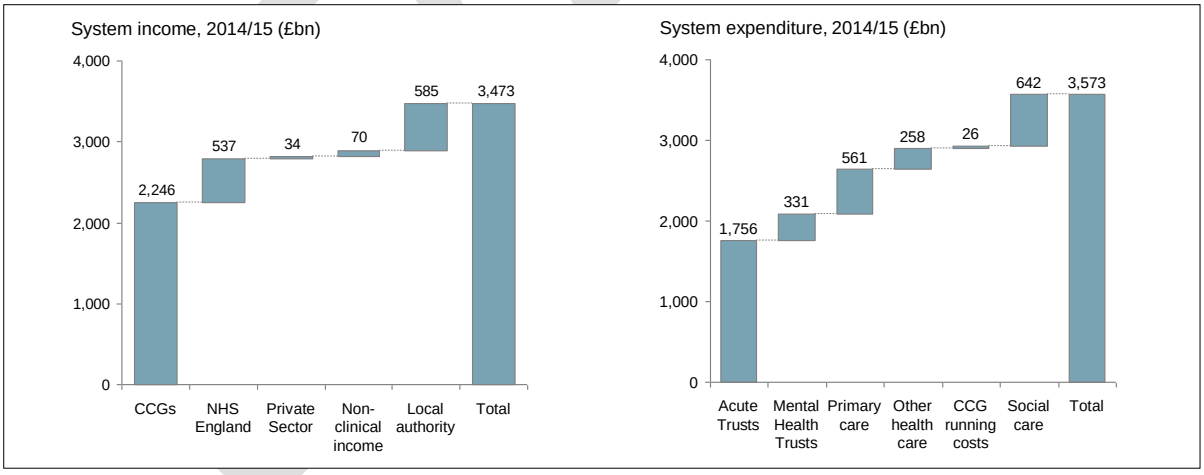
Faced with growing demand as a result of a growing an ageing population as well as new technologies and improved care, the NHS is projected to have a funding shortfall of nearly £30 billion a year by 2020-21 if not met by further annual efficiency improvements or growth in real terms funding[25].

The NHS Five Year Forward View affirms that action needs to be taken nationally to manage demand, improve efficiency and address funding if comprehensive, high quality NHS services are to be sustained. It calls for efficiency improvements in particular to exceed the long run rate of 0.8% a year, and instead reach 2 – 3% annually. Within this context, each NHS trust is required to support this national target through Cost Improvement Programmes (CIPs). In addition, the Department of Health has challenged CCGs to lead development of Quality, Innovation, Productivity and Prevention (QIPP) plans to help achieve efficiency targets whilst maintaining and improving quality.

2.4.2. Current system financial position (2015-16)

The annual financial challenge facing local commissioners and providers reached £101 million in 2015-16. Total income of £3,473 million was more than offset by expenditure of £3,573 million (Figure 15), with CCGs as the main source of income (65%) and acute trusts accounting for the largest proportion of total system expenditure (49%). Workforce expenditure represented the majority of provider spending at 62% of the total for 2015-16.

Figure 157: Mid and South Essex financial position[26] (£m), 2015-16



Source: Local Authority, Trust and CCG financials

The 2015-16 system position was composed of a commissioner deficit of £2.9 million and a provider deficit of £97.7 million. Acute trusts drive most of the overall negative financial position; MEHT ran a deficit of £46.2 million, while BTUHFT and SUHFT recorded £31.7 million and £19.5 million deficits respectively.

[25] NHS Five Year Forward View, October 2014
[26] Income categories: NHS England: Income for Specialised Services and General Practice; Private Sector: private income for acute and MH trusts; Non-clinical income: for acute and MH trusts; Local authority: adult social care expenditure by Essex County Council, Southend –on-Sea and Thurrock unitary authorities.

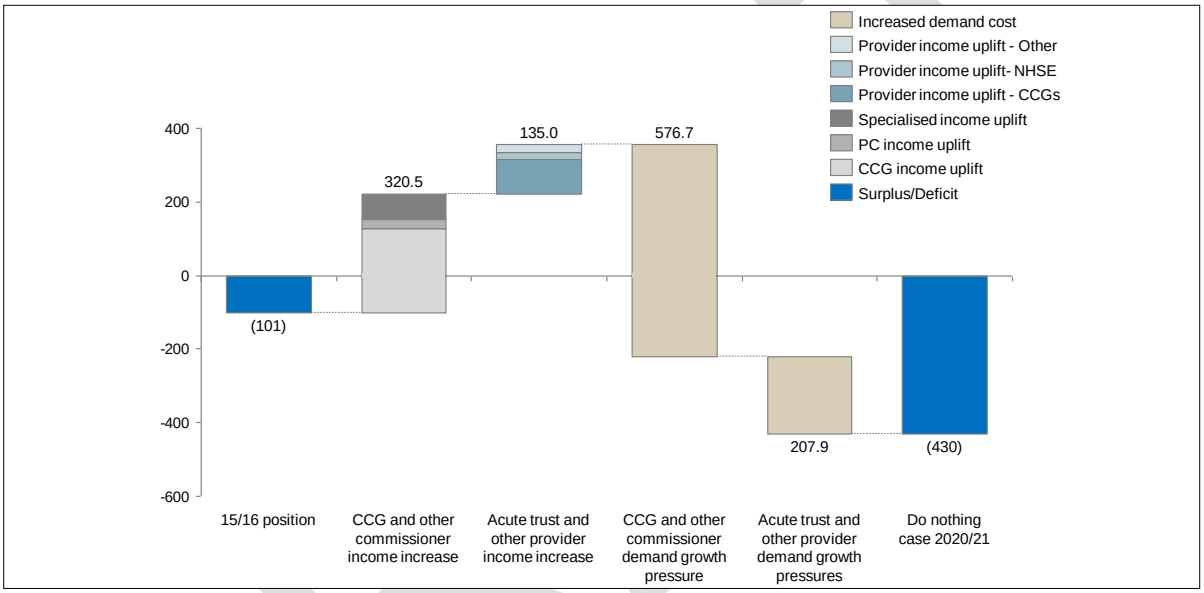
2.4.3. Forecast system financial position (2020-21)

Looking ahead over the next five years, health commissioners and providers are projected to face significant pressure from growing demand for services as a result of both demographic and non-demographic trends in Mid and South Essex.

As a result, demand growth pressures are expected to lead to £785 million in additional expenditures per year by 2020-21. While commissioner and provider incomes are expected to increase by £321 million and £135 million respectively, the financial challenge faced by the patch's healthcare system is forecast to increase to £430 million a year by 2020-21 in the absence of initiatives to reduce costs and/or increase income (the 'do nothing' case,

Figure).

Figure 18: System deficit breakdown in 'do nothing' case[27] (£m), 2020-21



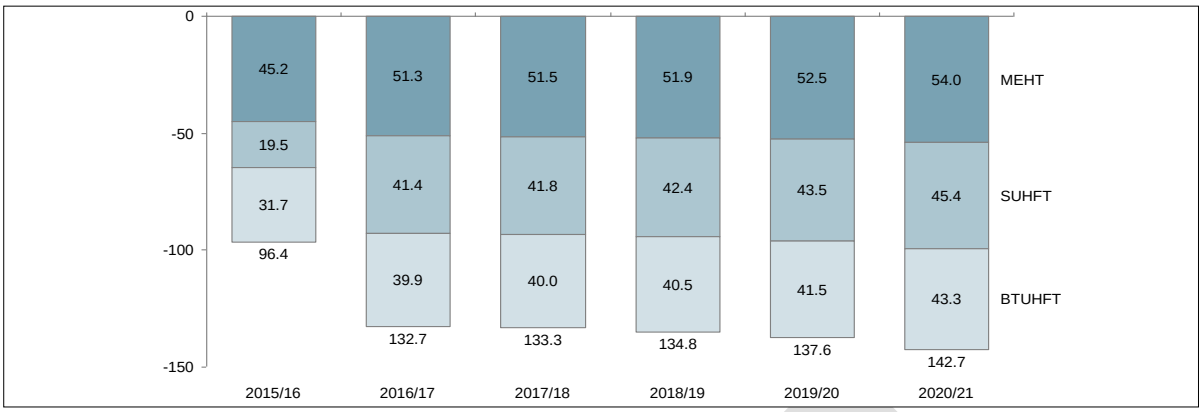
Source: Financial model, Local Authority, Trust and CCG financials

The magnitude of the financial challenge under the 'do nothing' scenario highlights the strong financial case for change in Mid and South Essex. Without intervention, the deficits for commissioners and providers are projected to reach £259 million and £170 million respectively. While commissioner income is expected to grow by an average of 3.4% per annum to 2020-21, expenditure is set to increase by 5.8% annually over the same period. Similarly, while provider incomes are expected to grow by 2.2% a year until 2020-21, expenditure growth will outstrip this at 3.2% a year.

Increasing financial pressure in funding and delivering acute care services drives much of the deterioration in the system position. Acute care accounts for 41% of all additional spending by commissioners after 2015-16, with acute expenditure increasing by £255 million to £1,050 million by 2020-21. On the provider side, acute trusts are forecast to reach an annual deficit of £143 million by 2020-21 (Figure gure 19), 84% of the total provider deficit position.

[27] Demand growth pressure is the increased demand between 2015-16 in-year position and 2020-21 in-year position for services based on demographic and non-demographic demand growth projections based on national and local projections per organisation; Income uplift is the increase in allocations between 2015-16 in-year position and 2020-21 in-year position based on projected allocations to trusts, CCGs and other NHS organisations Source: Financial model, Trust and CCG financials

Figure 19: Financial deficit across acute trusts (£m), 2015-16 to 2020-21

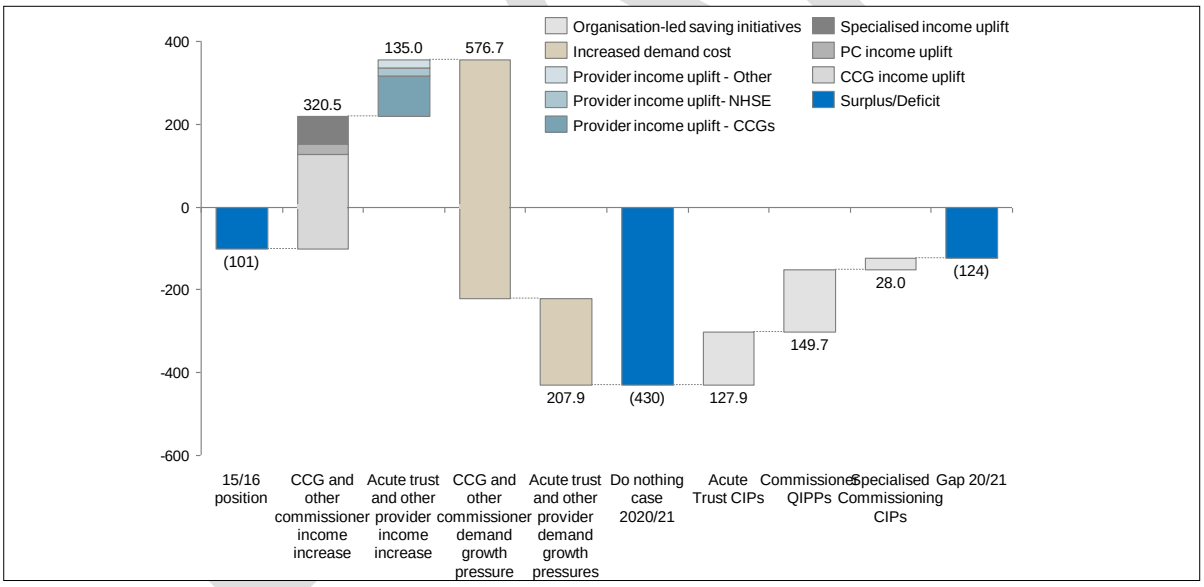


Source: Financial model, Trust and CCG financials

2.4.4. CIP and QIPP delivery

In order to achieve internal balance by 2020-21, commissioners and providers would have to reduce total expenditures by a compound annual rate of 2.4% and 2.6% respectively. While organisation-led savings plans are currently in place, Figure 20 illustrates that the system remains in deficit even once accounting for these adjustments. The overall system deficit is projected to stand at £124 million a year by 2020-21, equivalent to 3.7% of total annual income.

Figure 2016: System deficit breakdown with projected savings plans (£m), 2020-21



Source: Financial model, Trust and CCG financials; CIP and QIPP projections as per current provider and commissioner plans

For commissioners, planned improvements are set out in each CCG's Quality, Innovation, Productivity and Prevention (QIPP) initiative. Assuming delivery is achieved in line with each CCG's plan, commissioners in Mid and South Essex aim to reduce costs by £150 million a year by 2020-21 (Figure). Average in-year savings of 1.5% of CCG and commissioner income are not of the required level to plug the £259 million commissioner deficit in 2020-21. QIPP delivery in recent years has averaged 2.4% of CCG income annually.

Figure 21: Annual in-year commissioner QIPP savings (£m), actual and projected

	Current CCG plans				
	2016-17	**2017-18**	**2018-19**	**2019-20**	**2020-21**
Basildon & Brentwood	7.9	-	-	0.8	0.8
% of income	*1.8%*	*0.0%*	*0.0%*	*0.2%*	*0.2%*
Castle Point & Rochford	8.3	4.3	5.6	8.3	14.3
% of income	*2.9%*	*1.5%*	*1.9%*	*2.7%*	*4.4%*
Mid Essex	13.8	2.2	7.0	8.5	9.0
% of income	*2.4%*	*0.4%*	*1.2%*	*1.4%*	*1.4%*
Southend	6.4	2.5	3.2	4.4	5.0
% of income	*2.1%*	*0.8%*	*1.0%*	*1.3%*	*1.4%*
Thurrock	6.4	2.3	2.3	2.5	2.7
% of income	*2.4%*	*0.9%*	*0.8%*	*0.9%*	*0.9%*
CCGs, total in-year	**42.7**	**11.4**	**18.1**	**24.5**	**31.7**
% of income	*3.0%*	*0.8%*	*1.2%*	*1.6%*	*2.0%*
Other providers + adjustment, total in-year	4.8	6.4	0.1	1.2	8.6
Commissioners, total in-year savings	**47.5**	**17.8**	**18.2**	**25.7**	**40.3**
Commissioners, total combined savings	**47.5**	**65.3**	**83.5**	**109.2**	**149.5**

Source: CCG financials; adjusted in line with additional social care pressures (BCF) as identified by local authorities

For providers, forecast Cost Improvement Programme (CIP) savings total £156 million a year by 2020-21 (Figure 22), short of the £170 million projected in-year deficit. Annual forecast in-year savings average 2.6% of income across all providers (2.2% for acute trusts), which is lower than recent CIP delivery performance of 3.5%.

Figure 22: Annual in-year provider CIP savings (£m), acute trusts, actual / projected

	Current trust plans				
	2016-17	**2017-18**	**2018-19**	**2019-20**	**2020-21**
BTUHFT	12.7	9.4	9.4	9.4	9.4
% of income	*4.1%*	*3.0%*	*2.9%*	*2.8%*	*2.7%*
MEHT	10.6	7.9	7.9	7.9	7.9
% of income	*3.6%*	*2.6%*	*2.5%*	*2.4%*	*2.3%*
SUHFT	9.0	6.7	6.7	6.7	6.7
% of income	*3.1%*	*2.2%*	*2.1%*	*2.1%*	*2.0%*
Acute trusts, total in-year	**32.3**	**23.9**	**23.9**	**23.9**	**23.9**
% of income	*2.9%*	*2.1%*	*2.0%*	*2.0%*	*1.9%*
Other providers, total in-year	9.6	5.0	4.6	4.3	4.5
Providers, total in-year savings	**41.9**	**28.9**	**28.5**	**28.2**	**28.4**
Providers, total combined savings	**41.9**	**70.8**	**99.3**	**127.5**	**155.9**

Source: Trust financials

2.4.5. Sensitivity analysis

As discussed in the previous section, the healthcare system deficit in Mid and South Essex is forecast to increase to £124 million by 2020-21. A number of underlying assumptions are made in this analysis. Firstly it is assumed that CCG and other commissioner QIPP initiatives will achieve average in-year cost reductions worth 1.5% of income while provider CIP plans will achieve average in-year reductions equivalent to 2.6% of total income (2.2% for acute trusts).

Secondly, it is assumed that commissioner expenditures grow by a compound annual rate of 5.8% and provider expenditures by 3.2% annually; this is driven in part by rising acute and mental health expenditure, growing at 5.3% a year. Figure23 illustrates the sensitivity of deficit projections to differing levels of demand growth pressure as well as CIP and QIPP delivery.

Figure 23: Sensitivity analysis of system deficit to demand, CIP / QIPP assumptions

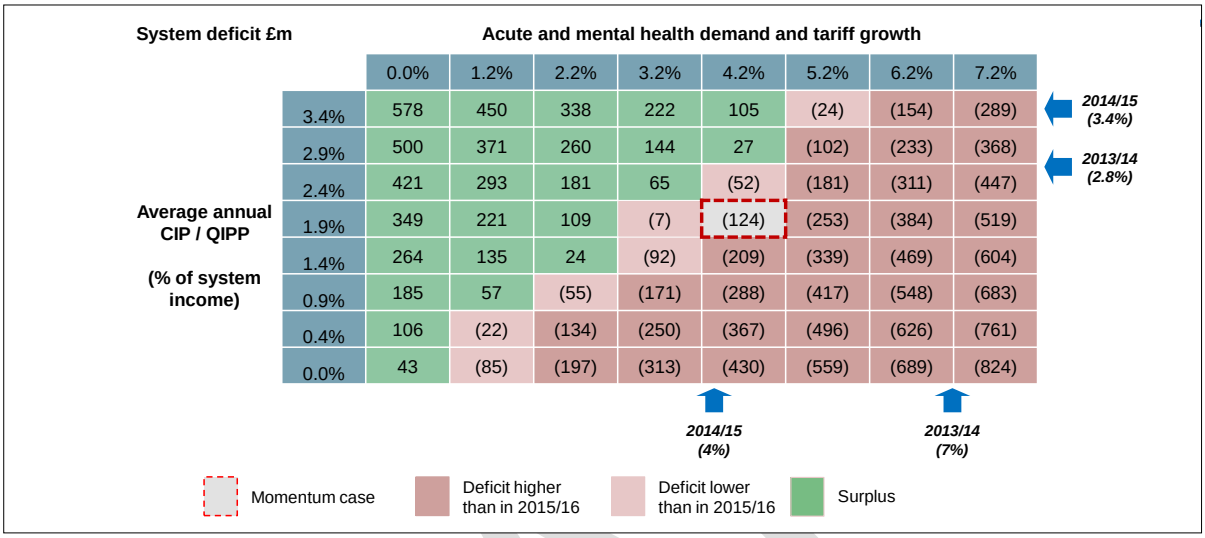
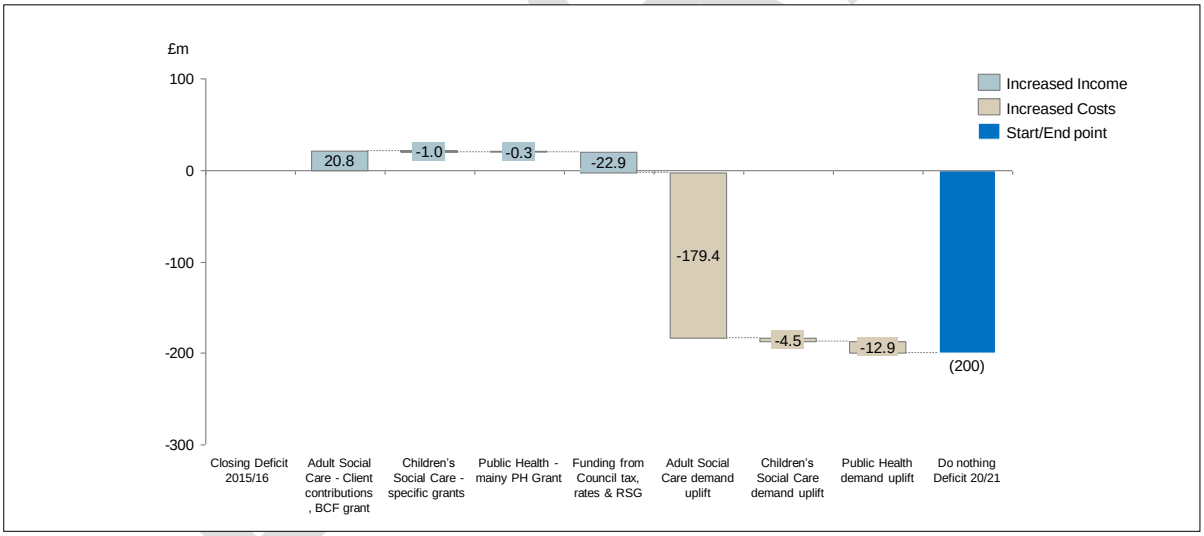


Figure 174: Local Authority financial bridge 2015-16 to in-year position 2020-21[28]



Source: Local authorities; Note: Local authority 'do nothing scenario' for 2015/16 takes 2015/16 expenditure and then apportions the £44m of savings on a pro-rata basis to adult SC, children SC and public health for each following year as these savings are assumed to be recurrent

[28] Notes: Council tax increases of 1.99% are included for all three local authorities in 2016/17 and for the two subsequent years for Southend and Thurrock. The County Council has made no assumption about council tax increases for 2017/18 onwards; Social Care precept increase of 2% is included for all authorities in 2016/17 only; ECC social care costs are apportioned to Success Regime area on basis of DH Relative needs formula used in BCF calculations; The three authorities have included anticipated increases in Better Care Fund income as per government illustrations and national guidance; For the three authorities combined the overall momentum deficit across all services is £330m, of which £131.1m has been attributed to social care on the Success Regime footprint for the purposes of this exercise.

2.4.6. Conclusion

CIP and QIPP projects are not sufficient to close the deficit gap. Without change, the deficit will continue to increase to £430m.

2.5. Implications of the case for change

Mid and South Essex requires a whole system leadership commitment to the reduction of unplanned admissions to hospitals and other care institutions alongside a transformation of primary and acute services that deliver outcomes.

2.5.1. Build stronger localities delivering a broader range of primary and community services

The rising demand for non-elective care and variation in quality across the patch indicates that more care needs to be delivered in primary and community settings or in a person's own home. The primary care capabilities therefore need to be strengthened in Mid and South Essex.

It is acknowledged that providing more care closer to home can improve patient outcomes and reduce costs. There are numerous academic studies that have supported this. In a randomised trial for elderly patients with a medical event (e.g. stroke or COPD) who are clinically stable and do not require diagnostic or specialist input, it was found that those who received hospital care at home have a significantly lower mortality rate at six months after the medical event and report higher levels of satisfaction. It can also reduce the cost of care provision. The same trial concluded that the cost of delivering hospital care at home was lower than the cost of admission to an acute care hospital ward.[29] Another study showed that users of community health centres, when compared to non-users had lower A&E attendances and admission rates, and when admitted into hospital had lower length of stay.[30]

Moving care closer to home can also improve outcomes from rehabilitation and reablement. A study showed that people with chronic pulmonary disease have more effective rehabilitation in an out of hospital setting. [31]

The General Practice Forward View and the Five Year Forward View encourage a move towards a larger footprint with greater integration of practices in order to provide a greater range of services. The Five Year Forward View encourages GP practices to form federations, networks or single organisations covering >30k patients.[32] There is evidence that larger size practices can deliver greater productivity, better access to specialist care, longer patient consultations and provider greater continuity of care, providing an effective patient per GP rate is held.[33] For example the quality of referrals for cardiovascular disease as measured by the Quality and Outcomes Framework increased for practices with larger list size and higher cardiovascular disease caseloads. This is because the greater number of similar patients seen by a GP increases their ability to identify need and refer to specialist care at the most clinically appropriate sites.[34]

[29] Shepperd S, Doll H, Angus R, Clarke M, Illffe S, Kalra L, Ricauda N, Tibaldi V, Wilson A (2009a) Avoiding hospital admission through provision of hospital care at home a systematic review and meta-analysis of individual patient data. Canadian Medical Association Journal, vol180, no 2, pp 175 – 182
[30] Alabama Primary Health Care Association (2012) Cost savings associated with the use of community health centres
[31] Man et al. Community Pulmonary Rehabilitation after hospitalisation for acute exacerbations of COPD. BMJ. 2004 329:1209
[32] FYFV government statement 4th October 2015.
[33] Campbell JL 2001. Practice size: impact on consultation length, workload and patient assessment of care. British Journal of General Practice. 51 (469) 644-50
[34] Saxena S et al. 2007. PRactice size, caseload, deprivation and quality of care of patients with coronary heart disease, hypertension and stroke in primary care. National Cross Sectional Study. BMC Health Services Research

The Five Year Forward View also supports a redesigned workforce with GPs taking on different roles: some concentrating on the highest risk patients, others overseeing the rising risk patients.

2.5.2. Reduce the number of non-elective admissions into acute hospitals

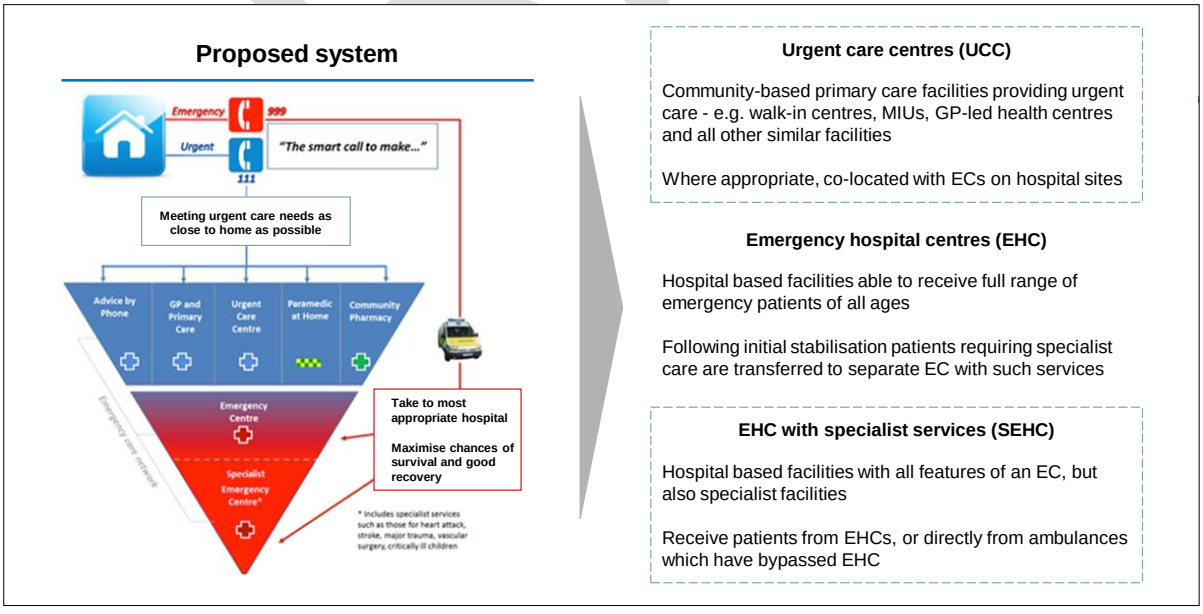
The rising demand for non-elective admissions means there is an immediate need to relieve pressure in the urgent and emergency care system. The do nothing scenario would lead to a need for 150 additional beds in the acute sector by 18-19.

The Urgent and Emergency Care Review has recommended extending urgent care services outside of hospital to manage demand. This is supported by studies which show that seeing a senior clinician early improves outcomes and reduces length of stay, hospitalisation rates and cost.[35] The Urgent and Emergency Care Review also recommends centralising specialist care. This can maximise survival and recovery rates for serious and life-threatening emergencies. The volume effect has shown to be more important that getting to the closest hospital in the case of strokes, major trauma and STEMI.[36] Getting patients into the right ward first time also reduces mortality, harm and length of stay.[37]

With one million avoidable emergency admissions per year, the redesignation of urgent and emergency care (UEC) services can manage demand and improve patient outcomes by (i) meeting urgent care needs as close to home as possible, while (ii) maximizing survival and recovery rates for serious and life threatening emergencies through hospitals with specialist facilities.

In the review, NHS England proposes a new system for UEC as outlined in Figure25 with three entry points for patients with UEC needs.

Figure 25: Structure of new UEC system envisaged by NHS England



Source: adapted from Urgent and Emergency Care Review Phase I, NHS England, November 2013

[35] The benefits of consultant delivered care. Academy of Medical Royal Colleges. January 2012
[36] Evidence from London CVA concentration into hyperacute centres
[37] Impact on patients, hospitals and healthcare systems. Dan Beckett, May 2014

2.5.3. Reconfigure acute services

The financial pressures in the acutes, workforce capacity issues and variation in quality of care indicates the need to reconfigure acute services.

The unacceptable variation in the quality of care is in part because our hospitals are all delivering similar services. This means that the hospitals only care for a very small number of patients with life threatening illnesses or that specialist care is split between many sites.

Consolidation can improve health outcomes and reduce costs through a number of mechanisms:

- **Increased productivity**: focused approach to care delivery with dedicated specialists and facilities. This can lead to measurably reductions in unit cost, while improving condition and procedure specific outcomes (e.g. bundles);

- **Increased efficiency** through better utilisation of existing facilities and labour by concentrating key services as well as better equipped and concentrated support functions; this results in lower variable costs per patient, better supply / demand matching, and less redundancy in system services;

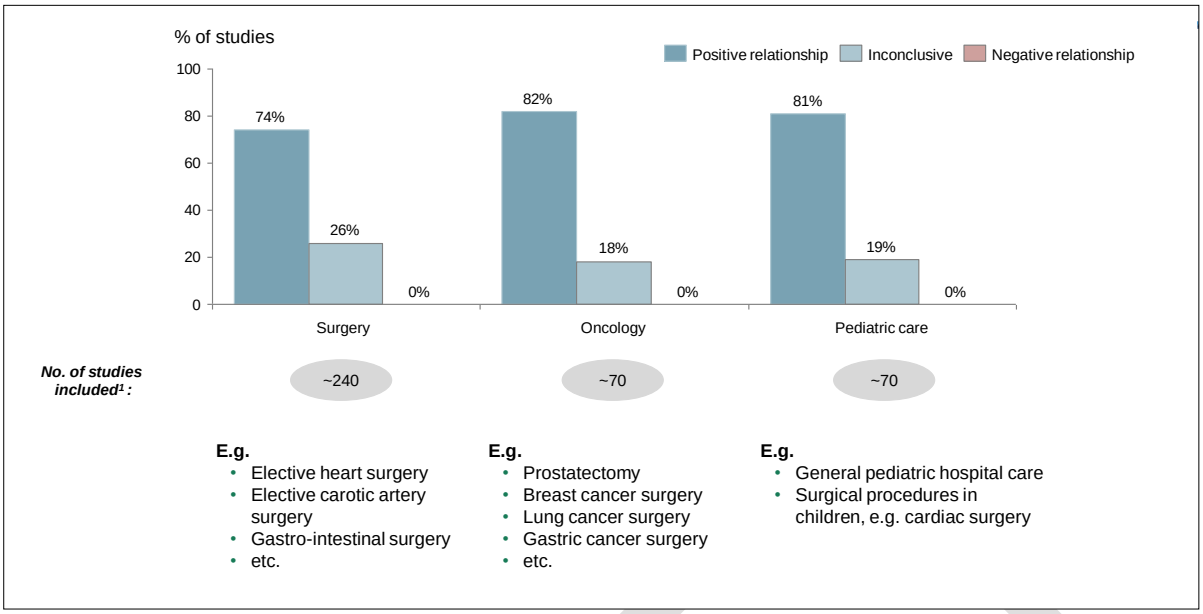
- **Improved quality of care:** there is a strong evidence base (see below) for volume / outcome relationship for certain conditions, in environments designed around the needs of particular patient groups; a wide portfolio of treatment options provided and maintained can better match individual patient needs; this results in better diagnosis and management, increased survival and recovery opportunities, and a continuous learning cycle for medical and surgical staff;

- **Increased reliability** through generating standardised protocols for treatments and pathways across the NHS; this decreases practice variation while allowing a more predictable patient flow;

- **Workforce sustainability** through achievement of sustainable rotas, in line with national best practice; There may be unnecessary duplication of effort. For example, all three hospitals run an emergency surgery out of hours rota for a few cases of emergency surgery overnight. Consolidation can ensure the most efficient use of this resource.

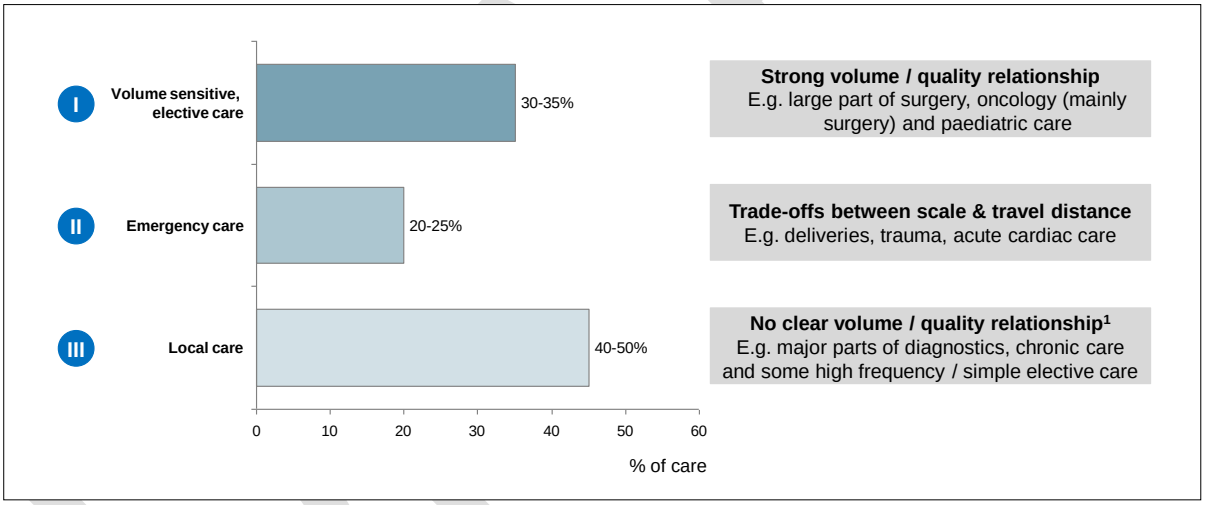
There is a strong body of empirical evidence to support the relationship between patient volume and quality of care in acute services. In a meta-study analysis of research in to the relationship between volume and quality of care, 70-80% of studies found a positive relationship while none show the opposite for surgery, oncology and paediatric care.

Figure 186: Quality and volume relationship, meta-study analysis



Source: Meta-studies: 1. Chowdhury et al. (2007); 2. Halm et al. (2002) (together ~280 studies included for surgery, onco and ped. care) and >100 other studies (of which ~65 related to ped. care)

Figure 19: Quality and volume relationship, meta-study analysis



2.5.4. Redesign clinical pathways around outcomes

Individual disease pathways (stroke, CHF, etc) will need to be redesigned ot better improve care. This would include increasing the use of technology, altering the workforce model to ensure patients are treated by the right person at the right time and redirecting patient flows across primary, community and acute services.