Health Overview and Scrutiny Committee

11:00	Wednesday, 08 February 2017	Committee Room 1, County Hall, Chelmsford, Essex

PLEASE NOTE THERE WILL BE A PRIVATE BRIEFING AND PRE-MEETING FOR ALL HOSC MEMBERS COMMENCING AT 9:30 IN COMMITTEE ROOM 6

Quorum: 4
Membership:

Councillor J Reeves	Chairman
Councillor D Blackwell	
Councillor K Bobbin	
Councillor J Chandler	
Councillor P Channer	
Councillor M Fisher	
Councillor R Gadsby	
Councillor K Gibbs	
Councillor D Harris	Vice-Chairman
Councillor R Howard	
Councillor A Naylor	
Councillor A Wood	Vice-Chairman

Co-opted Non-voting members: Chelmsford City Councillor M Sismey
Harlow District Councillor W Forman
Uttlesford District Councillor S Harris

For information about the meeting please ask for:
Graham Hughes, Scrutiny Officer
Fiona Lancaster, Committee Officer
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www.essex.gov.uk/scrutiny

Essex County Council

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Part 1

(During consideration of these items the meeting is likely to be open to the press and public)

		Pages
1	**Apologies and Substitution Notices** The Scrutiny Officer to report receipt (if any).	
2	**Declarations of Interest** To note any declarations of interest to be made by Members in accordance with the Members' Code of Conduct.	
3	**Minutes** To approve the minutes of the meeting held on Wednesday 11 January 2017.	5 - 12
4	**Questions from the Public** A period of up to 15 minutes will be allowed for members of the public to ask questions or make representations on any item on the agenda for this meeting. On arrival, and before the start of the meeting, please register with the Committee Officer.	
5	**Mental Health - merger of Trusts and strategic oversight** To consider the report (HOSC/08/17) and accompanying three appendices.	13 - 36
6	**Update on the Urgent Care Review engagement by the North East Essex Clinical Commissioning Group (CCG)** To consider the report (HOSC/09/17).	37 - 44
	***** LUNCH BREAK [APPROX 12.30 - 1.45 PM]**	
7	**Princess Alexandra Hospital, Harlow - regulatory concerns** To consider the report (HOSC/10/17) and accompanying appendices.	45 - 84
8	**General update** To consider the report (HOSC/11/17) and accompanying appendix.	85 - 88
9	**Work programme** To consider the report (HOSC/12/17).	89 - 92

10 Date of Next Meeting

To note that the next meeting will be held at 10.30 am on Monday 20 March 2017, in Committee Room 1, County Hall.

11 Urgent Business

To consider any matter which in the opinion of the Chairman should be considered in public by reason of special circumstances (to be specified) as a matter of urgency.

Exempt Items

(During consideration of these items the meeting is not likely to be open to the press and public)

To consider whether the press and public should be excluded from the meeting during consideration of an agenda item on the grounds that it involves the likely disclosure of exempt information as specified in Part I of Schedule 12A of the Local Government Act 1972 or it being confidential for the purposes of Section 100A(2) of that Act.

In each case, Members are asked to decide whether, in all the circumstances, the public interest in maintaining the exemption (and discussing the matter in private) outweighs the public interest in disclosing the information.

12 Urgent Exempt Business

To consider in private any other matter which in the opinion of the Chairman should be considered by reason of special circumstances (to be specified) as a matter of urgency.

Minutes of the meeting of the Health Overview and Scrutiny Committee, held in Committee Room 1 County Hall, Chelmsford, Essex on Wednesday, 11 January 2017

Present:
County Councillors present:

J Reeves (Chairman)
D Blackwell
K Bobbin
J Chandler
P Channer
M Fisher
R Gadsby
K Gibbs
D Harris (Vice-Chairman)
R Howard
K Twitchen (substitute)
A Wood (Vice-Chairman)

Borough/District Councillors present: M Sismey (Chelmsford City Councillor), W Forman (Harlow District Councillor)

Also in attendance:
County Councillors A Browne (Cabinet Member for Communities and Corporate), M Maddocks (Deputy Cabinet Member for Adults and Children) and C Sargeant
David Sollis (Healthwatch Essex observer)
Barbara Herts, Director for Commissioning Mental Health

The following Officers were present in support throughout the meeting:
Graham Hughes, Scrutiny Officer
Fiona Lancaster, Committee Officer

1 Apologies and Substitution Notices

Apologies for absence had been received from County Councillor A Naylor (substituted by Councillor K Twitchen), and Uttlesford District Councillor S Harris.

2 Declarations of Interest

Councillor A Wood declared a personal interest as a Governor of the North Essex Partnership University NHS Foundation Trust (NEPFT).

Harlow District Councillor W Forman declared a personal interest as a Registered Nurse, employed by Princess Alexandra Hospital, Harlow.

Councillor P Channer declared a personal interest as a member of the Maldon Community Services and Community Hospital Project Board.

David Sollis, Healthwatch Essex observer, declared a personal interest in agenda items 5 (Sustainability and Transformation Plans) and 6 (Mental Health) due to Healthwatch Essex involvement with both issues.

3 Minutes

The minutes of the meeting of the Health Overview and Scrutiny Committee held on 9 November 2016 were approved as a correct record and signed by the

Chairman.

4 Questions from the Public

There were no questions.

5 Sustainability and Transformation Plans - Strategic overview

The Committee considered a report (HOSC/01/17) on the responses received from each of the three Sustainability and Transformation Plans (STPs) impacting on Essex in response to questions from the HOSC, and the further development of the STPs.

The following were in attendance to participate in a question and answer session:

- Andrew Pike, NHS England
- Nick Hulme, Suffolk and North East Essex STP Lead
- Dr Anita Donley, Independent Chair, Mid and South Essex STP
- Andrew Vowles, Programme Director, Mid and South Essex STP
- Steve Peacock, Programme Manager, Hertfordshire and West Essex STP
- Andrew Geldard, West Essex CCG

Andrew Pike introduced the item and commented that there was no intention to have any further re-writes of the published STPs. Activity plans had now been agreed with the CCGs and they were ready to start the delivery phase of the plans. Operational plans for 2018/19 were also being drawn up. Members noted that the NHS was setting up a Capital Priority Process to enable a more efficient use of funds.

During the discussion the following was acknowledged, highlighted or questioned:

Finance and Capacity:

- NHS England and NHS Improvement had set budget control totals for 2017/18;
- The significant debts sat in the acute trusts. Deficits were likely to continue for the time being, and the long-term intention was that historic debts would be repaid. Each organisation had a 6% improvement/resource gain target comprising 4% cost improvements and 2% real terms demographic growth;
- Each organisation was responsible for its own resources/financial governance, and funds were intended to be used for Essex residents. There could be some spending across county borders because of the location of the service;
- Planning was based on restricting future demand growth both at A&E and in urgent care to 1% per annum and elective demand growth to 2%. This would be very challenging given the current levels of demand growth;
- Each STP incorporated mental health, but the extra national funding was not ring- fenced within individual CCG budgets. It was envisaged that the planned single commissioning structure for mental health would preserve

investment in this area;

- NHS England had established a ***Parity of Esteem*** Programme in order to focus effort and resources on improving clinical services and health outcomes - the organisations all need to meet these requirements;
- Members considered whether the financial plans were achievable and how patient experience improvements would be measured. The three STP Leads indicated that they were confident with their approach to deliver the plans by 2021. Doing nothing was not an option; residents need to be offered alternatives for 'out of hospital' care and there is a new focus on the routes into healthcare to alleviate the day to day pressure on A&E admissions;
- The involvement of Primary Care with the STPs and the shortage of GPs in the country. Members noted that NHS England had additional funds to support a European Induction Scheme which would help address the gap of doctors in the short term;
- Members noted that cost recovery on decisions such as charging for missed appointments were made at a national level;

Joint Working:

- Discussions on issues regarding finance were challenging for the three local STP Leads;
- More dialogue was needed with their wider partners. There was a determination to work more closely with local government and the NHS organisations going forward;
- Financial challenges needed to be addressed at a system rather than organisational level and focus on prevention and early interventions. However, each organisation would retain sovereignty and remain responsible for its own resources;
- A new Board, to be chaired by Dr Anita Donley, would include Chief Executives from local councils. Healthwatch and the local Health and Wellbeing Boards would also be involved;
- Members questioned if, and how, mental health experts would be involved in the STPs;

New Models of Care and Quality of Services:

- Members discussed what would be done to avoid a postcode lottery for the availability of services across the county, and on waiting times to access these;
- The likelihood that residents would have to travel further for care if services were merged, and whether risk assessments on the detrimental impact of travel on patients and staff was being assessed;
- The Leads confirmed that all Consultations would include a risk assessment and the Care Quality Commission would continue with its oversight role. Any reconfiguration of services, and their expected benefits, would need to be evidenced and communicated to residents;
- The continued pressures on A&Es. The potential impact of closing for example the Minor Injury Unity in Tendring on A&E admissions and residents access to care and the need to better signpost patients to the

most appropriate care;
- The need for the STP Leads to be aware of any other potential changes in services being considered by the CCGs/Commissioners. It was important that individual organisational planning also aligned with the STPs;
- The potential impact of the new Garden Towns had been taken into account;
- Greater collaboration and efficiencies between GP practices;

Engagement and Consultation:

- The different methods used to communicate and engage with residents to enable them to comment on proposals. Members noted that Anglia Ruskin University was now going to be involved;
- The need for consistency on how Consultations were carried out;
- Planned Consultation dates had not yet been set, but a range of planned discussion meetings for the Mid and South Essex could be provided, and they envisaged consulting in the second quarter of 2017. It was expected that the North East and West Essex would be consulting in the autumn;
- Whether the whole STP project was achievable in five years;
- The preference at this point to continue discussions with individual scrutiny committees rather than a joint committee.

The Committee **agreed**:

a) To provide HOSC with the schedule of (pre-consultation) Mid and South Essex discussion meetings (Andrew Pike/Andrew Vowles).

b) To provide HOSC with more information on STP engagement and collaboration (Dr Tom Nutt, Chief Executive, Healthwatch Essex, to attend a future HOSC meeting).

c) Andrew Pike/team to liaise with the Scrutiny Officer to plan attendance at a future HOSC meeting to report on Consultations - avoiding the pre-election period.

6 Mental Health - Lead Commissioning arrangements

The Committee considered a report (HOSC/02/17) from the current Lead Commissioners of mental health services to discuss the future arrangements of commissioning in Essex.

Sam Hepplewhite, Chief Officer, North East Essex Clinical Commissioning Group (CCG), Barbara Herts, Director for Commissioning Mental Health, Essex County Council, and Dr Caroline Dollery, a GP in Danbury Medical Centre and Chairman, NHS Mid Essex Clinical Commissioning Group (CCG), were in attendance to participate in a question and answer session.

During the discussion the following was acknowledged, highlighted or questioned:

- The agreement from the seven CCGs and the three local authorities in

Essex to commission mental health services on an all age basis, and the commitment to have one integrated provider plan;
- The plan to have joint commissioning posts across health and social care for mental health;
- The plan to commission services in an integrated way across Essex would be pursued, regardless of the outcome of the proposed merger between the two Mental Health Trusts in Essex;
- The Mental Health Strategic Forum would enable the best arrangements to be achieved as senior representatives from the seven CCGs and three Essex local authorities were involved;
- There needed to be a shift in focus to early intervention and prevention support services;
- Members expressed some concern regarding the number of CCGs involved and the possible breakdown of the approach. In response, the Chief Officer explained that there would be a separation of contracts, whereby the mental health contract would be with NEPFT and the South Essex Partnership University NHS Foundation Trust (SEPT) only. The SEPT provision of community services would be separate;
- The involvement of the Lead Commissioners with the development of the Mid and South Essex, North East Essex and Suffolk and West Essex and Hertfordshire STPs;
- How the all age plan would be achieved with the current separate arrangements with children and adult services. A number of models exist on how this could be achieved and which involve patients, families and Healthwatch;
- The 'lived experience' feedback had helped to shape the direction of the mental health strategy;
- The involvement and support for Chris Butler, interim Chief Executive of NEPFT, in continuing to help develop the strategy;
- The opportunities to bid for additional funding for mental health provision could be improved if there was one approach to commissioning.

The report was otherwise **noted**.

The Chairman thanked the contributors for their attendance and input on this item.

7 Suicide Prevention Strategy

The Committee considered a report (HOSC/03/17) on the development of a Suicide Prevention Strategy by Essex County Council's Public Health team.

Maggie Pacini, Public Health Consultant, Essex County Council and Dr Caroline Dollery, a GP in Danbury Medical Centre and Chairman, NHS Mid Essex Clinical Commissioning Group (CCG), were both in attendance to participate in a question and answer session and to seek the Committee's comments on the draft strategy document.

During the discussion the following was acknowledged, highlighted or questioned:

- There had been 394 reported deaths by suicide in the last three years, and the number of incidents in Essex was higher than the regional average. The majority of suicides occurred in people not under the care of local services;
- The Committee noted some of the everyday triggers that can lead to suicide, and the most common means and locations of death;
- Southend, Essex and Thurrock Councils had agreed to take the approach of 'Zero Suicide' as the key driver for transformational change. There was some concern that this approach could be perceived as a performance rather than aspirational target for organisations;
- Six key areas had been identified for action to support the delivery of the approach;
- A stakeholder event would be held in February, and the Public Health team intended to submit a draft strategy to the March meeting of the Essex Health and Wellbeing Board;
- Due to the complexity of the suicide prevention agenda across Essex and of partner agencies the setting up of a Prevention Group was not recommended;
- In response to a question on how the implementation of the strategy would be monitored, the Committee noted that actions would be owned by the responsible organisations and a nominated champion for each group, with annual oversight by the Essex Health and Wellbeing Board. There would not be a specific project or prevention Board - instead it was proposed to use existing forums;
- The challenge of preventing suicides if unable to identify those at risk;
- The role schools, employers, job centres and GPs for example have to play in helping with individuals wellbeing;
- The negative effect of debt on people's wellbeing and the help available at Citizens Advice Bureau;
- Members questioned how those who are unable to cope know where to find help, and expressed concern about how suicide is reported in the media. A range of solutions was needed to publicise the range of help available, and Cambridge and Peterborough Councils were leading on some positive work in this area;
- How suicides were recorded by the Coroner's Office and whether the data has been underestimated;
- How to tackle social isolation and other vulnerable groups such as the homeless. There could also be links between autism and suicidal tendancies.

The report was otherwise **noted**.

The Chairman thanked the contributors for their attendance and they left the meeting at this point.

8 North Essex Partnership University NHS Foundation Trust (NEPFT) - Care Quality Commission Inspection report

The Committee **noted** a report (HOSC/04/17) from the Scrutiny Officer which provided an update on the latest Care Quality Commission (CQC) Inspection

report for the North Essex Partnership Trust stating that the Trust overall *required improvement.*

The Committee **agreed** that the report would be considered at its next meeting, as senior NEPFT representatives were already due to attend to update the Committee on the Essex Mental Health Trust merger plans.

9 Mid Essex Hospital Trust - Care Quality Commission Inspection report

The Committee **noted** a report (HOSC/05/17) from the Scrutiny Officer which provided an update on the latest Care Quality Commission (CQC) inspection report on Broomfield Hospital, published on 1 December 2016.

The Committee welcomed the improvement in rating for the Mid Essex Hospital Trust.

10 General update

The Committee **noted** a report (HOSC/06/17) from the Scrutiny Officer outlining updates on local health news, primary care service changes and variations, and forthcoming meeting dates for 2017 public meetings.

Councillor Wood undertook to update the Committee at the next meeting on his continuing discussions with Colchester Hospital regarding its decision to stop providing birthing services at the Fryatt Hospital, Harwich, from 1 April 2017.

11 Work programme

The Committee considered a report (HOSC/07/17) from the Scrutiny Officer setting out the Committee's work programme scheduled for the remainder of the 2016/17 municipal year.

The Scrutiny Officer advised the Committee that due to the high volume of business it was likely that an all day meeting would be needed on 8 February.

The Committee **agreed** that the Consultation relating to Minor Injury services in North East Essex would be included in the 2017/18 work programme.

The report was otherwise **noted.**

12 Date of Next Meeting

The Committee **noted** that the next meeting would take place at **10.30 am on Wednesday 8 February 2017**, in Committee Room 1 at County Hall (preceded by a private pre-meeting for Members only at 9.30 am). Members were advised that this would be an all day meeting. **[Afternote: the February meeting will now start at 11.00 am].**

The Scrutiny Officer confirmed that the joint Essex and Hertfordshire HOSC site visit to the Princess Alexandra Hospital was taking place on Monday 16 January

2017, and that he would be confirming the arrangements shortly.

A list of proposed meeting dates for the 2017-18 municipal year had been circulated in advance of the meeting by email and was received by the Committee.

HOSC meeting dates 2017-18:

- Wednesday 7 June 2017
- Wednesday 5 July 2017
- Wednesday 26 July 2017
- Wednesday 13 September 2017
- Wednesday 11 October 2017
- Wednesday 8 November 2017
- Wednesday 13 December 2017
- Wednesday 10 January 2018
- Wednesday 7 February 2018
- Wednesday 7 March 2018
- Wednesday 18 April 2018

There being no further business the meeting closed at 13.56 pm.

Chairman

AGENDA ITEM 5

HOSC/08/17

Committee Health Overview and Scrutiny

Date 8 February 2017

Report by Graham Hughes, Scrutiny Officer
Contact details: graham.hughes@essex.gov.uk Tel: 03301 34574

Mental Health – merger of Trusts and strategic oversight

North Essex Partnership Foundation Trust and South Essex Partnership Trust, and Lead Commissioners for north and south Essex, have been requested to attend the 8th February 2017 meeting of the Committee to discuss current performance issues and preparations for the proposed merger of the two providers.

The following reports are attached:

1. North East Essex Clinical Commissioning Group (as Lead Commissioner for adult mental health services in north Essex); **Appendix A**
2. Castle Point and Rochford Clinical Commissioning Group (as Lead Commissioner for adult mental health services in south Essex); **Appendix B**
3. Joint provider report from North Essex Partnership Foundation Trust and South Essex Partnership Trust. **Appendix C**

Advance questions (derived from a private HOSC session) were submitted to the Lead Commissioners and the providers to provide answers for inclusion in their respective reports. Those questions were as follows:

Lead Commissioners:

1. How do you determine the KPIs you use to monitor Provider performance and help to improve patience experience? Do you still think they are appropriate?
2. What measures are you asking Providers to have in place to ensure timely assessments? Please confirm current waiting times and do you think current waiting times for assessments are satisfactory at present?
3. What measures are you asking Providers to have in place to ensure timely access to talking therapies? Please confirm current waiting times and do you think current waiting times are satisfactory at present?
4. What is Plan B if the merger does not go ahead? What contingency planning at a system level is in place?

Cont 1/2….

Cont 2/2…

Providers:

1. There should be a brief update on current merger status and provisional timetable together with planned engagement with stakeholders.
2. What actions are you taking before and during the merger process to ensure that service performance is protected and that patience experience is not sacrificed?
3. Please outline actions you are taking to improve patient access to services after the merger is in place.
4. Will differences in service quality and access across the county be 'ironed-out' post-merger i..e a common service offer? If so, how?
5. How will you ensure good social care is also offered for MH patients after the merger, particularly bearing in mind the different staff structures at NEPFT and SEPT at the moment?
6. Please indicate how you are implementing NICE Guidance on Self-Harm.

Action required:

The Committee is asked to consider the information provided by the Lead Commissioners and providers in response to the advance questions submitted to them by the HOSC and to seek further assurance on arrangements for the merger and actions to improve performance.

North East Essex
Clinical Commissioning Group

Report to Essex Health Overview and Scrutiny Committee

Meeting Date: 8th February 2017

FOR INFORMATION

Report Title: Mental Health Update Report

Presented by: Lisa Llewelyn, Director of Nursing and Clinical Quality

There are two main providers for the provision of adult mental health care across North Essex:

- **North Essex Partnership Foundation Trust (NEP)**

NEP is the main provider of secondary specialist Mental Health services for Adults and Older adult across North Essex. While NEP cares for the majority of patients in the community, some people need in-patient care. This can be for a short period of intensive care, longer recovery, or people with advanced dementia. NEP also provides dedicated liaison psychiatry services to the Acute Hospitals in north Essex and staff a Street Triage service in conjunction with Essex police.

- **Hertfordshire Partnership Foundation Trust (HPFT)**

HPFT is the main provider of Primary Care Psychological Therapies to all adults across North Essex. The service is based on the National Institute for Health and Care Excellence recommended evidence-based psychological therapies and is part of an integrated pathway for people with common mental health disorders. Core interventions provided are orientated around Cognitive Behavioural Therapies, Counselling, and Interpersonal Therapies

How do you determine the KPIs you use to monitor Provider performance and help to improve patience experience? Do you still think they are appropriate?

For both providers, there are a number of ways that the performance of our providers is monitored:

1) **Nationally mandated Operational Standards and Quality Requirements.**

The Operational Standards and Quality Requirements are nationally-mandated standards set out by NHS England, with the Operational Standards derived specifically from the NHS Constitution. The objective of these is to ensure that service users receive a quality service. Namely, one that is safe, effective and provides a good patient experience. These are aligned to the regulatory standards as set out by the Care Quality Commission. All providers are

expected to achieve all of the Operational Standards and National Quality Requirements which relate to the commissioned services.

2) Locally agreed Quality Requirements

As with the National Quality Standards, the objective of these is to ensure that service users receive a quality service, namely one that is safe, effective and provides a good patient experience. However, these Quality Requirements are agreed locally and represent particular areas of risk that the CCG require assurance over from the provider. These take into account the needs of the local population, system partners and other stakeholders and should be both clinically appropriate and realistically achievable.

3) Commissioning for Quality and Innovation indicators (CQUIN)

The CQUIN scheme is the national NHS quality incentive scheme. The scheme is intended to deliver clinical quality improvements and drive transformational change. The current CQUIN indicators are designed to support the ambitions of the Five Year Forward View and directly link to the NHS Mandate. There are 5 Clinical quality and transformational indicators which aim to improve the quality and outcomes for patients including reducing health inequalities, encourage collaboration across different providers and improve the working lives of NHS staff.

4) Locally set KPIs

These KPIs monitor specific areas of performance across different areas of identified risk. Achievement thresholds are set with reference back to past performance and (if appropriate) national or local guidance. As with the local Quality Standards, these KPIs are agreed locally and represent particular areas of risk that the CCG require assurance over from the provider, taking into account past performance and the needs of the local population/system partners/ other local stakeholders. These areas of risk (and examples of KPIs) are:

Access to services (Both, Nationally mandated KPI for HPFT)
Recovery (Nationally mandated KPI for HPFT)
Reliable improvement (HPFT)
Care Programme Approach and Care plans (NEP)
Inpatient Care and Discharge (NEP)
Demographics *(Both)*
Quality and Safety *(Both)*

The various measures described above are all embedded within the contract for services held between commissioners and providers. As such, there is contractual recourse for non-performance, including both financial and non-financial penalties. The on-going appropriateness of all ***local*** performance measures are considered at regular intervals, with the main conduit being the monthly contract management meetings with both providers. Any new areas of focus (based on service developments, regulatory changes, population need) are formally agreed by commissioner and provider. The appropriateness of these measures have been assessed as part of the recently-concluded contract negotiation process with NEP and the on-going contract negotiations with HPFT.

What measures are you asking Providers to have in place to ensure timely assessments? Please confirm current waiting times and do you think current waiting times for assessments are satisfactory at present?

NB: This section focuses on the contract with NEP as the talking therapies provided by HPFT are dealt with in the next section.

A proportion of NEP patients initially enter NEP care in a Mental Health crisis. The performance measures in this area are focused around patient access to NEP whilst patients are in a crisis and the performance of the services supporting them. Assessments are performed within these crisis pathways; however we do not monitor the timing of that separate part of the pathway. Rather our KPIs focus on other risk areas of the pathway in which the assessments take place.

Performance measures that are monitored include:

- Percentage of inpatient admissions that have been gate kept by the Crisis Resolution/Home Treatment (CRHT) Team
- Number of inpatient admissions that have been gate kept by the Crisis Resolution/Home Treatment (CRHT) Team
- Percentage of patients seen by psychiatric liaison service within 4 hours of referral
- Total number of client assessments undertaken by A&E Psychiatric Liaison Team(s)
- Number of client assessments undertaken in A&E Department(s)
- Number of client assessments undertaken in Acute Ward(s)
- Total number of unique clients assessed
- Number of clients seen within one hour of A&E referral
- Percentage of clients seen within one hour of A&E referral - within operating hours (09.00 to 00.00 seven days a week)
- Number of breaches attributable to MH and the reason(s) for these
- Number of 'Potential' A&E breaches avoided
- More than 50% of people experiencing a first episode of Psychosis will be treated with a NICE approved care package within two weeks of referral

Performance against these measures for the entirety of the 16/17 is included in Appendix 1. and displays that performance around these measures is satisfactory at present. For patients that do not enter NEP in a crisis (i.e. through a GP referral route) there is not a nationally mandated or local KPI covering the waiting times to assessment. The quality requirements within the contract enable commissioners to assess this within the context of the ***quality*** of the service i.e. one that is safe, effective and provides a good experience.

NEP also provide Memory Clinic services as part of the Dementia diagnosis pathway for North Essex. These patients **are** referred in to NEP. Contractual KPIs are being introduced in 2017/19, however we currently monitor the performance of the Memory clinic to gain assurance over the ability to achieve the governments stated Dementia 2020 ambition of *"An expectation that the national average for an initial assessment should be six weeks following a referral from a GP".*

Current waiting times to assessment across North Essex (as at Dec 16) are 5.46 weeks (area specific performance is listed below), in line with the ambition above:

Average waiting time to Assessment (weeks)	Oct	Nov	Dec
Mid	5.65	3.78	4.63
North East	4.81	5.20	5.64
West	5.70	4.60	6.68

What measures are you asking Providers to have in place to ensure timely access to talking therapies? Please confirm current waiting times and do you think current waiting times are satisfactory at present?

Access

The NHS 5YFV sets a targeted increase in Access to psychological therapies so that by 2020/21 at least 25% of people with common mental health conditions will access services each year. Two thirds of the additional people receiving services will have co-morbid physical and mental health conditions (Long Term Condition) or persistent medically unexplained symptoms (MUS). Currently Access is set at 15% of the local prevalence who will enter treatment per annum. Performance against this target as at Dec 16 is listed below:

		Q1	Q2	Q3	Q4	Cumulative YTD	Target
West	Actual	1,114	1,128	1,280		3,522	4,933
West	Percentage of prevalence	3.39%	3.43%	3.89%		10.71%	15%
Mid	Actual	1,271	1,253	1,139		3,663	5,890
Mid	Percentage of prevalence	3.24%	3.19%	2.90%		9.33%	15%
North East	Actual	1,298	1,326	1,336		3,960	5,327
North East	Percentage of prevalence	3.66%	3.73%	3.76%		11.15%	15%

Both North East Essex and West Essex are expected to achieve their end of year targets of 15% of prevalence entering treatment. The Mid Essex IAPT service is currently behind target, and is not expected to meet target for 16/17. Commissioners continue to work closely with providers to maximise the impact of the services going forward.

Assessment

HPFT are expected to undertake a Patient Assessment within 14 days of the patient being referred to the service. Providers will ensure that patient treatment (1st treatment) will commence within 14 days of the completion of the assessment. In the majority of cases the assessment and 1st treatment session are delivered at the same time, with the majority of people being booked in for their assessment/1st treatment within 4 weeks of receipt of referral by the service. A small number of clients wait longer than 4 weeks (see table below) however this is often through patient choice or contact issues.

CCG Area	Q3 16/17 – Referrals received	Number who waited over 6 weeks for assessment
West Essex	1460	6
Mid Essex	1523	31
North East Essex	1757	11

Waiting times to 1st Treatment

In parallel with increased access numbers, IAPT services will maintain and develop quality in services; including meeting existing access and recovery standards so that 75% of people access treatment within 6 weeks, 95% within 18 weeks; and at least 50% achieve recovery across the adult age group. Performance as at Dec 16 is detailed below:

CCG Area	75% access to 1st treatment within 6 weeks	95% access to 1st treatment within 18 weeks
West Essex	97.7%	99.7%
Mid Essex	94.5%	99.6%
North East Essex	98.1%	100%

Waiting Times to 2nd/subsequent treatment

Whilst there is no national or local KPI in place at the moment it would be true to say that IAPT services across North Essex are not currently performing to commissioning expectations and we are actively working with our providers both contractually and on a number of initiatives to reduce these waiting times. The table below shows the number of people waiting over 18 weeks for 2nd /subsequent treatment as at end December 2016:

CCG Area	Number of people waiting over 18 weeks for 2nd/ subsequent treatments as at 31.12.16
West Essex	77
Mid Essex	267
North East Essex	107

For patients waiting for their choice of 2nd/subsequent treatment, regular contact is made to access risk and if necessary clients can be fast tracked into treatment. We are currently negotiating a local KPI for time to 2nd/subsequent treatment for inclusion in the 2017/18 contract with our providers.

What is Plan B if the merger does not go ahead? What contingency planning at a system level is in place?

It is the intention for NEP and SEPT to merge into one Trust from 1st April 2017. This continues to go through the relevant governance processes within the Trust and NHS hierarchy. At this stage we have received no indication that it will not proceed. However, to protect against this likelihood, the signed contract for 17/19 between North commissioners and NEP is structured **as if** the merger does **not** proceed. If the merger proceeds, this contract will be novated across to the merged body. This guarantees that in either circumstance (be it through a single or merged entity) the services currently provided by NEP will continue to be provided to the North Essex population.

NHS

North East Essex
Clinical Commissioning Group

Appendix 1

	Indicator		Target	Line No	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	2016/17 Year to Date*
Access to Services	Percentage of inpatient admissions that have been gate kept by the Crisis Resolution/Home Treatment (CRHT) Team		95%	D1	97.56%	97.06%	96.49%	98.46%	100.00%	97.75%	98.53%	96.81%	98.70%				98.28%
	Number of inpatient admissions that have been gate kept by the Crisis Resolution/Home Treatment (CRHT) Team		—	D2	80	66	55	64	71	87	67	91	76				745
	Percentage of patients seen by psychiatric liaison service within 4 hours of referral		95%	D3	99.53%	99.08%	99.18%	97.20%	98.92%	98.39%	98.50%	98.59%	98.83%				98.64%
	Total number of client assessments undertaken by A&E Psychiatric Liaison Team(s)		—	D4	400	485	389	194	421	482	451	423	340				3585
	Number of client assessments undertaken in A&E Department(s)	A	—	D5							267	283	256				806
	Number of client assessments undertaken in Acute Ward(s)	B	—	D6							184	140	84				
	Total number of unique clients assessed		—	D7							429	378	326				1133
	Number of clients seen within one hour of A&E referral		—	D8							181	187	204				572
	Percentage of clients seen within one hour of A&E referral - within operating hours (09.00 to 00.00 seven days a week)		50%	D9							67.79%	66.08%	79.69%				70.97%
	Number of breaches attributable to MH and the reason(s) for these*		—	D10		3	2	8	3	2	4	2	3				27
	Number of 'Potential' A&E breaches avoided**		—	D11							39	29	33				101
	More than 50% of people experiencing a first episode of Psychosis will be treated with a NICE approved care package within two weeks of referral		50%	D15	45.45%	80.00%	87.50%	88.89%	70.00%	63.00%	53.00%	78.00%	66.67%				72.50%

NHS
Castle Point and Rochford
Clinical Commissioning Group

Report to Essex Health Overview and Scrutiny Committee

Meeting Date: 30th January 2017

Report Title: Mental Health Update Report

Presented by: Sipho Mlambo, Senior Commissioning Manager Mental Health

Introduction:

This briefing is a response to the following four questions raised by HOSC members relating to mental health provider performance:

1. How do you determine the KPIs you use to monitor Provider performance and help to improve patience experience? Do you still think they are appropriate?
2. What measures are you asking Providers to have in place to ensure timely assessments? Please confirm current waiting times and do you think current waiting times for assessments are satisfactory at present?
3. What measures are you asking Providers to have in place to ensure timely access to talking therapies? Please confirm current waiting times and do you think current waiting times are satisfactory at present?
4. What is Plan B if the merger does not go ahead? What contingency planning at a system level is in place?

1. Mental Health KPIs - How they are Determined and their appropriateness

The SEPT mental health contract is divided into a number of specific services, each with its own specification outlining what the service should provide and how it should provide it. The KPIs are designed to ensure that each of those services is delivering safe and effective treatment and care. The KPIs will also need to take into account any nationally laid out targets that have been set out by NHS-England.

The current KPIs are focused on the right and appropriate areas of measurement. These measures span various aspects of treatment and care, for example; care planning, waiting times and data quality, to name a few. However, in some instances, the construct of the measures may need reviewing.

The KPIs are a mixture of process driven measures and service outputs, not many are set out as outcomes. There is a national move towards more outcome based performance management and monitoring in mental health. In South Essex a significant piece of work is being undertaken to change the way we contract from the current measures to measures that tell us more about impact and benefit to patients and the system rather than processes that are adhered to. This is being undertaken through work on developing outcome based commissioning in mental health. South Essex is seen to be an early adopter and a leader in this field.

2. Measures to Ensure Timely Assessments (Including Waiting Times)

It is critical that patients are quickly assessed to determine the level of their need and the type of treatment that they require. Timely assessments mean that patients are more likely to begin the right treatment sooner.

Timely access to services is identified as a key factor in supporting patients with mental health difficulties. Patients with timely access to services are likely to do better than those with long waits. There are a number of targets (mainly waiting times that look at access to mental health services). The main gateway into secondary mental health services is via the single point of contact (SPOC) which operates within the First Response Team (FRT).

Assessment for FRT

In quarter 3 the Trust narrowly missed the assessment target related to crisis referrals seen within 24 hours with an overall figure of 94.87% against a target of 95%. The performance against the target for routine referrals is very poor at 27.3% (year to date) against a target of 95%.

This has been raised at performance meetings and the Trust has been required to carry out an audit to find out why the performance is so low against this measure.

Service	Quality requirement	Threshold			Oct	Nov	Dec	YTD
First Response	% Crisis (FRT) referral processed and refer notified of outcome within 4hrs	95%	<95%	95%	100.00%	100.00%	100.00%	100.00%
First Response	% Crisis (FRT) referral seen within 24hrs	95%	<95%	95%	89.19%	95.73%	95.12%	94.87%
First Response	% Routine (FRT) seen within 14 days	95%	<95%	95%	22.82%	23.05%	13.71%	27.30%

Other Waiting time Measures include:

- Assessment for IAPT (Therapy for You)
- Assessment for Early Intervention Program (EIP)
- Memory service assessments
- RAID (Psychiatric Liaison services) assessments

Performance against the measures

Service	Quality requirement	Threshold			Oct	Nov	Dec
IAPT	(The proportion of people that wait 6 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period)	75%	<75%	75%	98.66%	97.90%	98.40%
IAPT	The percentage of Service Users referred to an IAPT programme who are treated within 18 weeks of referral (The proportion of people that wait 18 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period)	95%	95%	>95%	100.00%	100.00%	100.00%
MAS Service	Total Number waiting over 30 working days (6 weeks) from receipt of referral to assessment	0	>0	0	3	1	4
MAS Service	Total number waiting over 6 weeks from assessment to diagnosis appointment	0	>0	0	117 (40)	99(25)	118(33)
Raid	A & E liaison assessment to be carried out within a maximum of one hour of referral 95% of referrals	95%	<95%	95%	85.13%	90.33%	95.75%
Raid	Emergency Ward liaison assessment within a maximum of 1 hour from referral 95% of referrals	95%	<95%	95%	100.00%	90.91%	100.00%
Raid	Urgent ward liaison assessment within a maximum of four hours of referral 95% of referrals	95%	<95%	95%	97.40%	97.62%	100.00%
Raid	Routine ward liaison assessment within a maximum of 48 hours of referrals	95%	<95%	95%	100.00%	100.00%	100.00%

As outlined above most of the key measures relating to access are showing that the trust is performing at or near the target. The main exception relates to the memory assessment service. Commissioners are working closely with SEPT to better understand the reason for this low performance. This includes exception reporting on breaches which are then scrutinised by commissioners.

3. Access to Talking Therapies (IAPT)

Currently our waits for IAPT meet the national requirement. However it is important to note that the national waiting time target for IAPT is concentrated on first treatment appointments. There is a large waiting list for second and subsequent appoints to IAPT. We are working closely with SEPT to address this and have agreed additional investment into the service to address capacity issues and improve the flow of patients through the service.

In addition to the issue of the large waiting list for IAPT. SEPT is currently failing to meet the national annual access target for IAPT which is 15% (which equates to 3.75% per quarter). For Caste Point and Rochford CCG quarter 1 performance sits at 3.46% and quarter 2 performance sits at 3.19%. For Basildon and Brentwood CCG the quarter 1 performance sits at 3.45% and the quarter 2

performance sits at 3.24% %. For Southend CCG the quarter 1 performance sits at 4.14% and quarter 2 performance sits at 3.47%, currently Southend CCG is the only CCG meeting the access target. There is an action plan to improve performance which is reviewed in the monthly IAPT performance meeting.

In order to achieve better access and flow through the service with reduced waits we are requiring the provider to change the current service model to maximise the impact of the additional resources going into the service. These requirements have been written into contract and are contractually binding and include the following:

- Ensuring that the service offer is clearly framed in a stepped care model
- Moving the provision hub premises wherever feasible
- Carry out a specific waiting list clearance exercise
- Working with the CCG to agree referral protocol for GPs

Measures to ensure timely Assessments

All these measures have clear contractual targets which are reported either monthly or quarterly. The monthly and quarterly reports are viewed in our local clinical quality review group (CQRG) monitoring meetings and in our local contract technical review group (CTRG) meetings. The remit of both meetings is to scrutinise the performance looking at implications for patient experience and quality of the service from a CQRG perspective and looking at technical aspects including systems and reporting through CTRG. Both meetings are able to consider escalation and the application of contract levers where necessary. In the past this has included:

- Issue of contract performance notices
- Escalation to senior executives or SEPT's Chief Executive Officer
- Requirement for recovery action plans
- Application of financial penalties

4. Contingency Plans if the merger does not go ahead

If the merger is not successful then the current arrangements would continue. Commissioners in South Essex would continue working with SEPT within the current contract to ensure that the population of Essex get high quality mental health care from this specialist provider. It is also important to state that the ambitions for system change that are expressed in the draft Essex Thurrock and Southend Mental health strategy will still from the basis to drive system transformation and improvement in South Essex.

Essex County Council Health Overview & Scrutiny Committee
Wednesday 08 February 2017

Update Report on Proposed Merger of NEP and SEPT

This report updates the Essex County Council Health Overview & Scrutiny Committee (Essex HOSC) with the progress of the proposed merger between North Essex Partnership University NHSFT (NEP) and South Essex Partnership NHSFT (SEPT). This paper builds upon the report given at the meeting of 15 September 2016, in which the HOSC noted the progress with the proposed merger and agreed to invite the Trusts to provide a further update early in 2017.

Summary

The Trusts first approached the idea of a formal merger in September 2015, in response to regional plans for the future. The strategic rationale for a proposed merger remains strong with the publication of the four Sustainability and Transformation Plans (STPs) which affect the proposed new Trust and the Essex Mental Health Strategy.

The Outline Business Case, competition reviews and the due diligence exercise confirmed that a proposed merger is a feasible and deliverable proposition. The Full Business Case (FBC) defines and describes the benefits of the proposed merger and details how it will be implemented fully. This was agreed by both Trust Boards in November 2016 and submitted to NHS Improvement (NHSI), our regulator, in early December 2016 – as advised by CEO letter to HOSC Chair that same month.

Engagement with a range of stakeholders, specifically staff at both Trusts and service users and carers via a proposed merger stakeholder reference group, has continued throughout the process.

Current merger status

The Trust Boards received and approved a Full Business Case for the merger at their meetings on 30th November 2016. Following some final comments and additions this was submitted to NHSI on 5th December 2016.

This triggered the NHSI assessment process. Following authorisation from the Trust Boards of both NEP and SEPT in November 2016 the draft Full Business Case and draft Post Transaction Integration Plan was submitted to NHS Improvement's Provider Assessment team.

The assessment process is fully described in the Transactions Guidance at pp35 to 57 available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/417799/Transactions_guidance_2015_FINAL.pdf .

In summary, the process focuses on four areas:

- **Strategy:** Is there a clear strategic rationale for the transaction and does the board have the capability, capacity and experience to deliver the strategy?
- **Finance:** Does the transaction result in an entity that is financially viable?
- **Quality:** Is quality maintained or improved as a result of the transaction?
- **Transaction execution:** Does the trust have the ability to execute the transaction successfully?

The assessment takes the form of a review of various background evidence used to write the business case and integration plans; meetings with Interim Executive Directors and other staff members to understand, assess and challenge the assumptions used in the business case; and finally a meeting with the Interim Board and NHSI Executives to summarise the findings of the assessment and challenge any outstanding areas of concern. This final meeting is scheduled for the week commencing 20th February 2017.

In parallel, Grant Thornton (NEP's current external auditors and appointed as Reporting Accountants for the merger by both Boards) have begun their assessment of the transaction to allow them to provide each Board with an independent expert opinion regarding:

- proposed financial reporting procedures
- proposed quality governance procedures
- integration planning

The opinion is given on a Board Memorandum that covers each of the topics above that is to be presented to the NEP and SEPT Boards at the end of February.

The formal audit opinion of Grant Thornton is shared with NHSI and NHSI's Provider Assessment Committee give the overall transaction a risk rating. This is expected the week ending 17th March 2017. This allows both Trust Boards to then re-affirm their commitment to the merger and ask their respective Council of Governors to vote that the transaction has been carried out properly.

Once the vote is confirmed the Trusts sign a legally binding merger agreement and formally apply for a merger to NHSI. In turn NHSI agree a Grant of Merger that will dissolve NEP and SEPT on 31st March 2017 and create Essex Partnership University NHS Foundation Trust on 1st April 2017. All the assets and liabilities of NEP and SEPT legally transfer to EPUT at the stroke of midnight 31st March 2017.

Planned engagement with stakeholders.

The Trusts have established a Stakeholder Reference Group of service users, carers and Healthwatch Mental Health Ambassadors. This group is chaired by a service user. It is an active and engaging group. Members are keen to develop it themselves and, at the next meeting, will be debating draft Terms of Reference developed by a member. The group is being engaged by the Trusts' clinical leaders on the emerging clinical model from the design stage onwards. Anyone interested in the proposed clinical model is invited, via Trusts' websites and public meetings, to join the group.

A major public meeting was held at the end of January 2017 in Brentwood. Attendees were able to meet the Interim Board of the proposed new Trust and ask questions related to the merger plans and the proposed new organisation. It was a lively and very well attended meeting. People who were unable to attend had the opportunity to send in questions in advance. These were read out and answered on the night. All the questions and answers from the event are being published on both Trusts' websites. In addition, both Trusts have held or are holding public meetings in their localities for people to ask questions directly about the merger proposals.

In the summer, many staff took part in focus groups to discuss the Trusts' current cultures. Following on from these, joint workshops for staff were run, along with surveys for staff and service users and carers, to engage everyone in co-producing the proposed new organisation's vison and values. The outcomes were that the vision 'Working to improve lives' and the values 'Open, Compassionate and Empowering' were agreed. These are values that staff in the proposed new organisation, including the Interim Trust Board, will be expected by colleagues and people who use the proposed new Trust's services to demonstrate in every contact they make at work. Also, they will be part of the proposed new Trust's processes such as recruitment, supervision and appraisal of staff.

The Consultants and other clinical and social care leaders from both current Trusts have been meeting together to help shape the proposed future Trust. Their discussions have included the principles for the emerging proposed new Essex-wide integrated health and social care model for mental health services for adults and older people. The proposed model is being co-produced with a range of stakeholders including staff, commissioners, service users and carers. Progress to date is being shared with the East of England Clinical Senate in February 2017.

The CEOs of both Trusts have provided other key stakeholders with written updates at key points in the merger process, including MPs, Local Authorities, NHS partners, Healthwatches and HOSCs. The Trusts have attended HOSC meetings in Essex, Thurrock and Southend to present to members on the merger proposals and have provided detailed merger progress updates which have been published on Council websites. A merger update is discussed at every public meeting of each Trust Board and published on the Trusts' websites. A "Proposed Trust Prospectus" has been published on both Trusts' websites and made available at public meetings.

Provisional timetable

Since September 2016, the key dates for the proposed merger have not changed very much and the merger remains in line for completion by 31st March 2017. The main milestones since submission of the FBC are shown below. It is recognised that the deadlines remain subject to change as the process is not entirely within the Trusts' control.

Planned Timetable for Merger

Action	Planned Date	Responsible Body
Engagement with stakeholders (staff, service users, commissioners) to develop FBC	Ongoing	Merger Project Team
Appointment of Interim Board for the merged organisation	10 Nov 2016 Completed	SEPT Board NEP Board
FBC for merger received by Trust Boards for approval to submit to NHSI	30 Nov 2016	SEPT Trust Board NEP Trust Board
Appointment of Grant Thornton as external advisors to provide an independent audit opinion to both Boards on the merger transaction; their audit opinion is shared with NHSI	30 Nov 2016 to 24 Feb 2017	SEPT Trust Board NEP Trust Board
NHSI reviews FBC, tests assumptions with external advisors, meets the Interim Board for a challenge session, gives the merger transaction a risk rating	5 Dec 2016 to 16 March 2017	NHSI
Membership of NEP and SEPT invited to be members of new Trust. This is an "opt out" process with membership continuing to EPUT unless indicated otherwise.	w/c 13 Feb 2017	SEPT Council of Governors NEP Council of Governors
NHSI Provider Assessment Committee considers the merger transaction and offers the Trust Boards a risk rating (red/amber/green)	16 March 2017	NHSI
Trust Boards consider risk rating and re-affirms commitment to merger and approves amended FBC	w/c 20 March 2017	SEPT Trust Board NEP Trust Board
Council of Governors approve transaction amended in light of NHSI risk rating. Councils are voting to confirm that the Boards of Directors have: • been thorough and comprehensive in reaching its proposal (that is, has undertaken proper due diligence)	w/c 20 March 2017	SEPT Council of Governors NEP Council of Governors

• obtained and considered the interests of trust members and the public as part of the decision-making process		
NHSI complete Transfer Order and approve application for authorisation of new merged Trust – Essex Partnership University NHSFT (EPUT)	30 March 2017	NHSI
EPUT comes into being and all assets are transferred	1 April 2017	Interim Board of Directors
New Council of Governors elected from membership and appointed, new Chair and Non-Executive Directors appointed, confirmation of CEO and Executive Directors posts and formal creation of substantive Board of Directors	Sept 2017	Board of Directors of EPUT
Benefits review to ensure early merger benefits have been realised/are on plan to be realised and move to "business as usual" for the new Trust	Oct 2017	Board of Directors and Council of Governors of EPUT

What actions are you taking before and during the merger process to ensure that service performance is protected and that patience experience is not sacrificed?

Both Trusts have undertaken a comprehensive due diligence process to understand each other's' operations and clinical strengths and weaknesses. We used our CQC inspection information, reports and action plans to inform this due diligence. We used our own staff to make the assessment but asked PricewaterhouseCoopers (PwC) to provide and external quality assurance report to both Trust Boards that the process had been thorough and comprehensive. Their report was submitted to Trust Boards in July, with follow up recommendations in October and the Trusts confirmed in November that all recommendations had been completed. PwC confirmed that the process undertaken "has been robust" and in line with guidance issued by NHSI.

The due diligence has helped us to populate a risk register that ensures that the most significant operational risks are managed transparently across both Trusts. Although the formal process of due diligence has now concluded, the Trusts' teams at all levels continue to work on integration plans and share information and risks with each other.

One of our key risks, identified early, was that the uncertainty of the merger may cause some staff to leave, or to make filling posts generally difficult. The two Trusts have made arrangements to share staff to provide cover for vacant posts. At the moment, Andy Brogan, SEPT's Executive Director of Nursing and Deputy Chief Executive, is covering the NEP Director of Operations post; SEPT's Chief

Pharmacist is covering the NEP position following the departure of NEP's postholder; SEPT's Director of IT is covering the NEP Head of IT post after the Interim NEP contract holder finished their assignment and several members of the SEPT IT Team are supporting the NEP IT team in general. Not only does this help set up the merged teams in EPUT, it also ensures operational continuity.

As we get closer to the actual date of the proposed merger – from about mid-March – and for a month afterwards, we will use a system of daily "sitreps" from the clinical and operational areas to ensure we identify any issues early. A "sitrep" is short for Situation Report and is a rapid assessment submitted each day to the Executive Management Team. The report covers, for example, staffing levels, bed capacity, caseloads for community teams, reported incidents and near-misses. This is routine management information for managing operational risk, but it will be submitted directly to Executive Directors on a daily basis to allow them to assess whether any issues are directly related to merger, or whether they are the normal operational issues that arise every day.

Finally, the changes for the proposed merger must be set in context of the overall transaction. There will be no significant changes to the clinical services brought about by the merger until the new clinical model is agreed with commissioners, service users and other stakeholders. This is scheduled for Quarter 3 of 2017/18 – from about October 2017. Until we have agreement on the new service model and any changes to service configuration – which will mean seeking the support of all three HOSCs, Essex Healthwatch, service users and the public in general including, potentially, formal consultation – the services continue to be commissioned and delivered much as they are now. In the first year, changes will be incremental and have been agreed as part of our contracts with commissioners for 2017/18.

The first year changes are in corporate services – creating a single Board, ensuring that corporate support services such as IT and estates are working together as a single team, reducing our overall corporate costs by approximately 15%. This allows a solid foundation for EPUT to work with commissioners and stakeholders to plan and deliver truly transformational clinical change from 2018/19 and beyond.

Please outline actions you are taking to improve patient access to services after the merger is in place.

As explained above, the common service offer is really defined in the proposed new integrated health and social care clinical model that is being co-produced with commissioners, service users and stakeholders at present. We are asking the East of England Clinical Senate for a review of the proposed model on 6th February as part of our process of ensuring that the model delivers best practice in clinical and social care. Once we have broad agreement from the commissioners and stakeholders helping us create this model we would expect to, around October 2017, launch an engagement exercise to explain the new service model and what this would mean for service users and the public in general.

We anticipate that there will be significant service changes – both in the way a service is delivered and, in some cases, from where it is delivered. We anticipate we will need to undertake a formal public consultation exercise and we have scheduled for the time period of October 2017 to March 2018. Having heard the views of the public and stakeholders, and after making any necessary adjustments to our plans, we will be in a position to start to implement a new model from April 2018.

It is important though to recognise that the proposed new Trust is only one half of the equation. A common service offer depends as much on those commissioning services as it does on those delivering the service. An Essex-wide mental health strategy, reflected in the three STP footprints covering Essex, is essential to ensure there is a common service for the population of Essex, whether they are based in Essex County Council areas or Thurrock or Southend on Sea local authorities' areas. We would expect that commissioners will define some services, for example in patient services, at an Essex county level and would want and expect the same service everywhere. However, we know that the needs of the population we serve is not the same across the whole county and so we also expect some local variations to services.

Will differences in service quality and access across the county be 'ironed-out' post-merger i.e. a common service offer? If so, how?

Differences in access will be answered largely by the commissioning process outlined above. If commissioners specify local variations for a service there will potentially be differences in access. We would highlight commissioned differences and their consequence to commissioners and stakeholders prior to agreeing to deliver the revised clinical model.

Quality, however, is a different issue. It is absolutely our aim to ensure that service quality is uniformly excellent throughout all the services that EPUT offers in all locations.

We have a three-tiered approach to addressing quality issues. Firstly, we must ensure that legacy quality issues are fully resolved. Both NEP and SEPT had a CQC inspection in autumn 2015 and both Trusts have been working through their agreed action plans with the CQC to address any issues that were found.

SEPT's management reported to its Board in October 2016 that all actions had now been completed and implemented a two stage test of assurance and audit to confirm that all actions, as recommended by and agreed with the CQC, had now been completed.

NEP's action plan was more far reaching and the NEP management team continues to report the progress of the recommended action plan to its Board each month. As part of the agreement between the two Trusts to merge, as well as its commitment to the CQC and NHSI, NEP will complete its action plan by 31st March 2017.

Our second approach is to ensure that the processes and policies that govern quality within EPUT are established and in place from Day 1. Clear plans are in place to establish harmonised processes that are most crucial; for example, adverse and serious incident reporting; complaints handling and safe staffing management. We will run other processes in parallel until full harmonisation has taken place in a managed and safe way during the first 12 months post transaction.

A policies workstream for the merger is in place and has established a clear plan and schedule for policy / procedure harmonisation and communication of these to staff. This approach will provide a robust framework within which staff will operate within the new organisation from day 1 onwards, as well as appropriate controls in terms of policy development and implementation. These plans and this approach form a key part of the assessment by both NHSI and Grant Thornton as to whether the transaction is being managed well. All staff will be communicated with in the middle of March to provide them effectively with a “New Trust Guide”, giving them clear notification on what will change on Day 1 and what remains the same.

Of course policies and procedures are only as good as the people who implement them. The third important part of our approach to ensuring quality is improved under EPUT is a comprehensive organisational development programme. This has begun pre-merger and includes engagement with staff and stakeholders regarding the new Trust’s agreed objectives and key performance indicators and continues with a £500k investment in a full organisational development programme in the first year of the Trust to invest in the culture, training and development of all staff.

How will you ensure good social care is also offered for MH patients after the merger, particularly bearing in mind the different staff structures at NEPFT and SEPT at the moment?

Both Trusts have well-established partnership relationships with Essex County Council and it is anticipated that the proposed merged Trust will continue to build on the strengths of these partnerships. The two existing 5 year Section 75 Partnership Agreements for the two separate geographical areas will continue to be in place on 1st April 2017 and, therefore, also the current employment arrangements for social care staff. Going forward (2017/18), the new merged Trust will be working with Essex County Council on a review of Social Care and the Section 75 Partnership Agreements. This is in line with social care commissioning timelines.

It is expected that on day 1 of the new organisation it will be ‘business as usual’ for front-line social care delivery and that, for example, a service user in Harlow will continue to have the same access to a personal budget as a service user in Basildon.

As Partnership Trusts, we recognise the need for strong and consistent social care leadership within the new merged organisation to ensure the continued delivery of the Section 75 KPIs and the development of a service model that embraces recovery

and social inclusion. We will continue to provide this leadership through a structure that recognises and reflects the significance and voice of our Local Authority partners, while also meeting the requirements of operational management.

The NEP and SEPT social care leadership teams started to meet jointly from January 2017 to share learning and identify areas of strengths, as well as potential 'gaps' within social care service delivery. The social care leadership teams are committed to the further development of social work in the merged organisation using a strengths-based approach that focuses on creating sustainable models of service user-centred care, placing the service user at the heart of service delivery.

In addition to the good structural and professional synergy that already exists, the benefits of shared expertise and management across a new merged organisation aims to improve the access to specialist and, in some cases, award-winning services such as the Essex-wide Employment Services, Family Group Conference Adult Mental Health Service, Open Arts, and Your Health, Your Life carers' courses.

Some changes have already been implemented, and these have been driven by ECC mental health commissioners. The Trusts' Associate Directors for Social Care have been working with ECC mental health commissioners on the establishment and pathways to the new Mental Health Care and Assessment Team (MHCAT). This ECC-managed service was launched in mid-Essex on 25/01/2017 and is planned to be rolled out across Essex. This MHCAT supports the merged Trust's emerging integrated clinical model and will be providing social care services for people with mental health needs whose health needs are managed within primary care.

The AMHP service will continue to be operationally managed by the two existing AMHP Hubs – one in the south, based at Basildon Mental Health Unit and one for the North, based in mid-Essex. The AMHP forums across the whole of Essex will be joined up to maximise on professional expertise and support. During 2017/18, the merged organisation will work with ECC commissioners on the development of a centralised AMHP service.

Please indicate how you are implementing NICE Guidance on Self-Harm.

SEPT undertake baseline compliance reviews on all NICE guidance as it is published and have policies on suicide prevention and self-harm aligned to the NICE guidance. As part of their Sign up to Safety programme, SEPT has a suicide prevention workstream which identifies audits to be undertaken within their clinical audit programme covering risk management and care plans after an incident of self-harm. During 2017, re-audits will be carried out to ensure that any learning and the new suicide prevention training has been embedded and, therefore, shown a continual improvement.

Nice Guidelines gap analysis is a process NEP undertakes to measure the quality of the care the Trust offers and to assess whether it is line with current NICE guidance as evidence based. It allows the Trust to compare its performance against a standard to see how it is doing and identify opportunities for improvement. Changes can then be made, followed by further audits to see if these changes have been successful. NEP also has a suicide prevention workstream as part of their Sign Up to Safety Programme.

SEPT are rolling out further specialist suicide prevention training from Connecting with People. Connecting with People is accredited by the Royal College of Psychiatrists. They have a variety of modules available of which the Trust has purchased three; Suicide Awareness, Suicide Response Part 1 and Suicide Response Part 2. The training is based on evidence from people who have survived serious suicide attempts and now work in the field of prevention. It comes from the premises that people at the point of taking their lives are ambivalent and, actually, do not want to die. They do, however, want their distress to end.

NEP runs a two day Storm training. This is a package designed to help clinicians build on existing skills and to develop more comprehensive and robust risk assessment and risk management strategies, with the aim of minimising the risk of suicide and self-harm for service users. The course covers the following:

- Understanding self-harm and suicide
- Assessment of risk
- Immediate safety planning
- Problem solving
- Future safety planning
- Self-injury mitigation

EPUT will continue to review all NICE guidance and compliance to the guidance. EPUT will continue to roll out staff training, take the Sign Up to Safety workstream forward and undertake further clinical audits to monitor the effectiveness of the proposed new Trust's approach.

Acronyms used in report:

AMHP	Approved Mental Health Professional
CEO	Chief Executive Officer
CQC	Care Quality Commission
ECC	Essex County Council
EPUT	Essex Partnership University NHS Foundation Trust *(proposed new Trust)*
FBC	Full Business Case
HOSC	Health Overview and Scrutiny Committee
IT	Information Technology
KPIs	Key Performance Indicators
MH	Mental health
MHCAT	Mental Health Care and Assessment Team
MPs	Members of Parliament
NEP	North Essex Partnership University NHS Foundation Trust
NHS	National Health Service
NHSFT	NHS Foundation Trust
NHSI	NHS Improvement
NICE	National Institute of Clinical Excellence
PwC	PricewaterhouseCoopers
SEPT	South Essex Partnership University NHS Foundation Trust
STPs	Sustainability & Transformation Plans

Further reading

NHSI have published a literature review of how mergers can be made to work better for patients. This has helped inform the two Trust Boards in terms of planning for the merger and is helpful background reading for anyone interested in the merger transaction. It can accessed at https://improvement.nhs.uk/resources/how-make-nhs-mergers-work-better-patients/

Report prepared on behalf of:

Sally Morris, Chief Executive, SEPT and Christopher Butler, Interim Chief Executive, NEP

North East Essex
Clinical Commissioning Group

AGENDA ITEM 6

HOSC/09/17

BRIEFING FOR THE HEALTH AND OVERVIEW SCRUTINY COMMITTEE

Subject – An update on the Urgent Care Review engagement by the North East Essex Clinical Commissioning Group (CCG)

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1. Summary

1.1 This paper provides an overview for the Health and Overview Scrutiny Committee (HOSC) on how public and stakeholder engagement activities are progressing in relation to the CCG's Urgent Care review.

2. Key points to note

2.1 Key points to note are as follows:

- 1,491 responses received to date (correct as at 31 January 2017) with a target originally suggested by HOSC of 1,500 responses;
- CCG representatives have had a total of 1,489 face to face contact with members of the public since 1 January;
- The CCG is half way through this engagement exercise;
- The CCG is engaging with the public, support groups and stakeholders on four potential approaches relating to the way services might be provided in the future;
- There has, and continues to be, a significant amount of local interest amongst local people, political leaders and the media as expected;
- No decision has been made – the CCG's board will make its decision during its May meeting based on feedback, on the evaluation and on the full business cases for each of the options which will be completed over the next few weeks.

3. Background

3.1 As part of the Five Year Forward View, the NHS is taking action to review urgent and emergency care services across the country. The aim is to take the pressure off A&E and emergency departments and meet the increasing healthcare needs of the population.

3.2 Across north east Essex, the CCG is seeking views on the Walk in Centre at Colchester and the minor injury units at Clacton and Harwich. We want to provide services so that they are simpler for patients or carers to access as well as reduce any instances of waste or duplication. In addition, contracts between the CCG and the providers of these services are due for renewal in March 2018, so this provides an opportunity for clinicians to determine if these services are meeting local needs.

4. Our approach

4.1 To further understand the local need for out of hospital urgent care services, the CCG undertook a listening exercise during September and October 2016 with service users and the wider public. This assisted the CCG to develop four potential approaches.

4.2 Following feedback from the Chair and the two Vice Chairs of the Health and Overview Scrutiny Committee (HOSC), it was agreed that the CCG should undertake a period of engagement lasting eight weeks. This approach was formally signed off by the CCG during the previous Board meeting held on 29 November 2016. As a result, the engagement commenced on Wednesday 4 January 2017 and is due to finish on Wednesday 1 March 2017.

5. Potential approaches

5.1 The CCG is seeking views on four potential approaches:

1) To continue to commission a Walk in Centre service in Colchester and Minor Injury Units at Clacton and Harwich.
2) To stop providing the Walk in Centre and Minor Injury Unit services. Patients would be required to contact NHS 111. They would be directed by NHS 111 to their local GP, Out of Hours GP or encouraged to self-care (helping people to look after themselves).
3) The establishment of a minor injury service - This proposal would see the establishment of a minor injury service which would see and treat a range of minor injuries, from fractures, wounds requiring stitching to infected bites, taking the pressure off A&E. This service would have sites in Colchester and Tendring - dependent on where there is greatest need.
4) Other views and ideas from members of the public.

5.2 Respondents are being asked to complete an online questionnaire available on the CCG's website which seeks to establish people's preferred approach. Completed and submitted questionnaires are sent directly to an academic researcher at the University of East Anglia who is conducting our independent analysis. Hard copy questionnaires are also available from public or support group meetings that CCG representatives attend as well as by phone from the CCG.

6. Key progress to date

6.1 To date, the CCG has:

- attended seven support group meetings and held eight of its own public meetings across Colchester and Tendring;
- written a one page advertorial that has been published in the Gazette series newspapers over a three week period. This has promoted our public meetings, the reasons for the engagement as well as background information;
- produced editorial that gave details of the CCG's engagement activities and the purpose of the review which appeared in the Colchester United Football Club Home match programme (28 January);
- included an advertisement editorial in the local Your Life magazine that was issued to thousands of households across the Colchester and Tendring areas;
- issued four social media messages each week that have promoted the engagement. These have been shared by partners to their respective followers.
- responded to correspondence from all four MPs and several members of the public via letter and through social media channels;
- delivered presentations and answered questions during well attended CCG led public engagement events – held across Colchester and Tendring areas – during weekdays, evenings and weekends. Each has been led by CCG clinicians;

- engaged with some local councillors to increase their support and understanding;
- challenged instances of misreporting and the use of the CCG's corporate logo on politically generated material;
- organised a stand, which has been displayed at Colchester Library, that featured posters and copies of the questionnaire for the public;
- handed out posters and flyers in busy town centre, supermarket and train station areas;
- issued posters and flyers to the CCG's healthcare providers for onward cascade to their patients and service users;
- received high levels of support from partner organisations, in particular the Community Voluntary Services Tendring, which has supported the facilitation of a presentation at a recent Network Breakfast meeting as well as featured details of our engagement in its weekly news briefing. This has reached around 200 support groups across the Tendring area.

Support groups attended (up to 30 January)
Since 4 January, the CCG has had representation at the below support groups:

Date	Location	Attendance numbers
9 January	Parkinsons UK Clacton & District Branch, Holland on Sea	25
11 January	Alzheimers Society Tendring, Clacton	40
16 January	Friendship & Bereavement Café, Harwich	25
18 January	New Mum's and Toddler group, Colchester	15
20 January	Breathe Easy, Colchester	18
24 January	Copford Mother and Baby group	40
24 January	Action on Hearing Loss Drop-In, Clacton	Our attendance was cancelled
25 January	Macular Disease Society, Clacton	Our attendance was cancelled
27 January	Headway Essex, Colchester	12
31 January – 10am	Friendship & Bereavement Café, Jaywick	Yet to take place
8 February – 2pm	BME Older People's Group, Colchester	
8 February – 2pm	Local Health Matters meeting, Harwich	
9 February – 1.45pm	Colchester Deaf Club	
9 February – 2.15pm	Practice Managers meeting, Colchester	
9 February – 7pm	Younger Persons Dementia Group	
15 February – 10am	The Flamingo Restaurant, Holland	
17 February – 3pm	Colchester Pensioner's Action Group	
22 February – 2pm	Local Health Matters meeting, Colchester	
28 February –	Epilepsy Action Tendring Drop-In,	

11am	Clacton	

CCG public meetings
Since 4 January, the CCG has held the following public meetings:

Date	Location	Attendance numbers
5 January	Jaywick Sands Happy Club	80
10 January	CSVT, Clacton	51
10 January	Postgraduate Medical Centre, Colchester	30
14 January	Great Clacton Residents Association, Great Clacton Community Centre	50
17 January	Electric Palace Cinema, Harwich	105
20 January – 12.30pm	Tendring District Council, Weeley	50
21 January – 11am	Lion Walk United Reformed Church	84
27 January – 12.30pm	Colchester Institute	0
30 January – 1.30pm	Holland Residents Association, Holland Public Hall	205
3 February – 2pm	St. Paul's Church Hall, Clacton	
4 February – 11am	Electric Palace Cinema, Harwich	
11 February – 11am	CVST, Clacton	
11 February – 2pm	The Columbine Centre, Walton	
17 February – 2pm	Electric Palace Cinema, Harwich	
21 February – 7pm	CVST, Clacton	

7. Promotion of the engagement

7.1 Promotion of the CCG's Urgent Care review started before Christmas in an effort to increase awareness of the engagement exercise. A full page advertorial, which ran for two weeks before the engagement started, was published promoting the events and the case for the proposed change. The CCG also took out a third week during January. All costs associated with this advertising were negotiated at a heavily reduced rate. This was supported through a programme of proactive media coverage.

8. Publicising the engagement

8.1 The engagement has been publicised through a number of ways - more details are included later within this paper:

a) Repeated newspaper advertising;
b) Supported media coverage and radio interviews;
c) Widespread use of social media, promoting the questionnaire and events through our Twitter and Facebook channels;
d) Attended a variety of network/support group meetings. Many chairs or organisers of these groups and meetings also conducted some awareness raising to their own members;

e) Press releases were issued to the local media as well as uploaded to the CCG's website;
f) Posters and leaflets were distributed and displayed within prominent locations across north east Essex including libraries, supermarkets, voluntary and community centres, train station distribution;
g) Regular reminders issued through the weekly newsletters of the Community Voluntary Services (Colchester and Tendring).

9. Themes so far

9.1 The following key themes have been raised during public meetings:

- Concerns about GP recruitment;
- Concerns about transportation and costs associated with getting to and from Colchester Hospital;
- General concern about the lack of health services in Clacton and that many services have already been taken away from the town;
- Concerns of accessing GP services;
- Concerns around infrastructure and whether the local NHS has considered the high number of new houses that are planned for Clacton and other areas across Tendring;
- Concerns about no provision within Harwich;
- Better use of the Fryatt Hospital in Harwich.

10. Further engagement achieved to date

10.1 The CCG has been engaging with the public, distributing flyers and questionnaires in an effort to raise awareness of the engagement exercise. We have been to the following places of high footfall:

Date	Location	Approximate number of public engaged with
4 January	Aldi, Clacton	120
5 January	Iceland, Harwich	50
5 January	Asda, Harwich	60
11 January	Aldi, Lexden	60
11 January	Aldi, Cowdray Avenue	50
11 January	Waitrose, Colchester	40
12 January	Colchester Train Station	400

10.2 There has been engagement with local councillors to ensure they were made aware of engagement activities. These councillors have been helpful in supporting the CCG raise awareness of our engagement and the review to local people.

10.3 A display of the review has been set up at Colchester Library which can be viewed by the general public up to 29 January.

11. Press coverage (up to 18 January 2017)

11.1 This review and engagement has received much coverage in the local media. This coverage has been mostly factual with comment columns encouraging people to have their say through our questionnaire. See below list of coverage:

Date	Publication	Headline
25 November	Essex County Standard	Health bosses to shake up urgent care to take pressure off A&E Walk-in centre could be expanded under new plan
25 November	Colchester Gazette	Three minor injury units under threat in review
25 November	Colchester Gazette Online	Minor injury units under threat in review
25 November	Colchester Gazette	We need more services not less (Comment)
25 November	Maldon and Burnham Standard Online	Walk-in centre at Turner Road, Colchester and minor injury units at Clacton and Harwich placed under threat in review
26 November	Colchester Gazette Online	Walk in centre and minor injury units placed under threat in review
26 November	Harwich and Manningtree Standard Online	Minor injury unit at Dovercourt's Fryatt Hospital faces closure threat
28 November	East Anglian Daily Times Online	Two-tier health system fears in Essex if minor injuries units in Clacton and Harwich close
15 December	Colchester and Clacton Gazettes	Fighting for services – Councillor Andy Wood's petition
16 December	Colchester Gazette Online	Residents urged to speak out over proposal to shut minor injuries unit
20 December	BBC Essex	Pre-recorded interview with the CCG's Clinical Director about the review
21 December	East Anglian Daily Times Online	Views wanted on plans which could see minor injury units closed in north Essex
23 December	Harwich and Manningtree Standard – advertorial	Public asked to share views on the future of minor injury units and walk in centre across Colchester and Tendring
23 December	Essex County Standard - advertorial	Public asked to share views on the future of minor injury units and walk in centre across Colchester and Tendring
23 December	Colchester Gazette – advertorial	Public asked to share views on the future of minor injury units and walk in centre across Colchester and Tendring
23 December	Harwich and Manningtree Standard	Patients can have say over future of unit
23 December	Essex TV Online	Colchester public asked to share views on the future of minor injury units and walk in centres
28 December	Colchester Gazette Online	Patients urged to have their say over future of minor injury units
29 December	Clacton and Frinton Gazette – advertorial	Public asked to share views on the future of minor injury units and walk in centre across Colchester and Tendring
30 December	Essex County Standard – advertorial	Public asked to share views on the future of minor injury units and walk in centre across Colchester and Tendring
30 December	Colchester Gazette - advertorial	Public asked to share views on the future of minor injury units and walk in centre across Colchester and Tendring
4 January	Clacton and Frinton	Patients urged to have their say over plans that

	Gazette	could see minor injury units in Clacton and Harwich axed
4 January	Harwich and Manningtree Standard	Patients urged to have their say over plans that could see minor injury units in Clacton and Harwich axed
5 January	Colchester Gazette	Have your say on minor injury units
5 January	Clacton and Frinton Gazette	Future of hospital services considered
5 January	Clacton and Frinton Gazette	Consultation over scrapping of minor injury units
5 January	Clacton and Frinton Gazette	Minor Injury idea just beggars belief
5 January	Colchester Gazette	This is no one's fault but action is needed (Comment)
6 January	Harwich and Manningtree Standard	Have your say on future on minor injury units
6 January	Harwich and Manningtree Standard	Make sure you have your say on our unit's future
10 January	Colchester Gazette	Walk-in units meeting
12 January	Clacton and Frinton Gazette – advertorial	Public asked to share views on the future of minor injury units and walk in centre across Colchester and Tendring
13 January	Colchester Gazette Online	MP: 'Don't close our walk in centres- it will pile pressure on A&E'
13 January	Harwich and Manningtree Standard - advertorial	Public asked to share views on the future of minor injury units and walk in centre across Colchester and Tendring
13 January	Essex County Standard – advertorial	Public asked to share views on the future of minor injury units and walk in centre across Colchester and Tendring
16 January	Colchester Gazette	Quince: Fight to save our walk-in centres

Social Media

- We have issued several social media messages which have focused on encouraging people to have their say on the review, linking to the online questionnaire and highlighting dates for the CCG's public meetings. These posts have been widely shared by other users and forwarded to their followers.
- The organiser of the Jaywick Sands Happy Club, Danny Sloggett, posted a video on Facebook and Twitter on 2 January which received over 10,000 views. Following the public meeting, a further video was produced which included a brief interview with the CCG's Head of Communications and Public Engagement. This was shared to Mr Sloggett's followers.
- There has been much social media activity from local councillors and a group lobby groups calling for the MIU to be saved. Three online petitions have been established. A page called *Save our NHS Clacton/Tendring locality* has been established by 38 degrees which is attracting many signatures.

Distribution of flyers and posters

In addition to the public, posters and flyers have been sent to the following outlets across north east Essex:

- All CCG stakeholders and providers such as ACE, CHUFT, Care UK, EEAST, Vivo Support, Open Road (SOS bus), Healthwatch Essex, CVST and CCVS
- All NEE Care Homes
- All NEE Pharmacies
- All NEE schools and local colleges

- Charities
- Churches
- Cinemas
- Citizen Advice Bureaus
- Councils / Parish Councils / District Councils
- Golf Clubs
- Health Forum members
- Leisure Centres such as Leisure World Colchester, Harwich Sports Centre, Weston Stadium Football Club
- Libraries
- Mother & Baby Groups
- North East Essex GPs
- Play Centres
- Restaurants, cafes and tearooms
- Shopping Centres / Supermarkets
- Social Clubs
- Sports Centres
- Toy Shops
- Transport companies such as bus and train stations and taxi companies

Further advertisement
Colchester United Football Club – We also had editorial included in the club's home game programme (on 28 January). This included details of the engagement, its purpose and how to provide feedback.

Your Life – We will be advertising the urgent care review in the Your Life magazine. This free magazine is distributed to neighbourhoods across north east Essex – it is due to be distributed on 28 January 2017.

ENDS

HOSC/10/16

Committee Health Overview and Scrutiny

Date 8 February 2017

PRINCESS ALEXANDRA HOSPITAL (HARLOW)

Report by Graham Hughes, Scrutiny Officer
Contact details: graham.hughes@essex.gov.uk Tel: 03301 34574

Background

On 19 October 2016, the CQC published an inspection report on PAH. The CQC have rated PAH as inadequate overall due to significant concerns in safety, responsiveness and leadership, and commented that they view that there is an apparent disconnect between the trust board leadership level and the ward level.

The CQC's full inspection report is available from the following link - https://www.cqc.org.uk/sites/default/files/new_reports/AAAF6797.pdf. The Letter from the Chief Inspector of Hospitals, which summarises the report, is attached as Appendix 1.

In consultation between the HOSC Chairman and the Herts HOSC Chairman, a joint approach on reviewing proposed improvement actions being taken by PAH (and this was endorsed at the November 2016 meeting of the HOSC). Accordingly, representatives from both HOSCs attended a preparatory site visit at PAH in January 2017 and Herts HOSC have been invited to send representatives to join the Essex HOSC today for this agenda item.

The following advance questions were developed during a private session at the PAH site visit and the PAH response to these is attached as Appendix 2. Further information provided by PAH is attached as Appendices 3 and 4.

1. Please provide a copy of your current CQC Improvement Plan (is there a summary version?)
   – please briefly explain the verification process to determine the status of an action to be taken and if an action has been completed – e.g. does the CQC counter-verify?

2. How is PAH working with partners to improve links to services in the community to help relieve pressure on the hospital? e.g. alternative locations for blood tests and other straightforward tests, greater use of primary care etc?

3. Bearing in mind some of the regulatory criticism is around not being able to meet current demand, can any actions be taken to increase capacity?

4. The CQC specifically made reference to capacity pressures had led to patients sometimes not being placed in the most appropriate ward for their particular condition/treatment.

    - What risks to patient care does this create?
    - What is PAH doing to mitigate and minimise this risk going forward?

5. What resources do you provide for the Patient Panel and other patient feedback mechanisms? Are you satisfied that you have sufficient patient feedback mechanisms in place to allow patients to easily feedback their experience?

6. What are the financial consequences to the Trust of addressing the issues raised by the CQC and implementing improvements? - Are there any compensating revenue generating opportunities identified by the Trust?

Action required:

To consider the responses received to the advance questions, and other evidence, and to seek assurance on improvement actions being taken.

APPENDIX 1

CQC Overall rating for PAH - **Inadequate**
Are services at this trust safe? **Inadequate**
Are services at this trust effective? **Requires improvement**
Are services at this trust caring? **Good**
Are services at this trust responsive? **Inadequate**
Are services at this trust well-led? **Inadequate**

Letter from the Chief Inspector of Hospitals (dated 16 October 2016)

We carried out a comprehensive inspection on 28 and 29 June 2016 as part of our regular inspection programme. This inspection was carried out as a comprehensive follow up inspection to assess if improvements have been made in all core services since our last inspection in July 2015.

The Princess Alexandra Hospital NHS Trust is located in Harlow, Essex and is a 460 bedded District General Hospital providing a comprehensive range of safe and reliable acute and specialist services to a local population of 350,000 people. The trust has 5 sites; Princess Alexandra Hospital, St Margaret's Hospital, Herts and Essex Hospital, Cheshunt Community Hospital and Rectory Lane Clinic. At our inspection on 28 and 29 June 2016, we inspected The Princess Alexandra Hospital. On our unannounced inspection on 2 and 5 July 2016, we inspected The Princess Alexandra Hospital. We reviewed the service provided at the Rectory Lane Clinic and found that this location did not require registration. The trust informed us that they would be applying to remove this location.

During this inspection, we found that there had been deterioration in the quality of services provided since our previous inspection in 2015. There was a lack of management oversight and lack of understanding of the detail of issues which we observed. We found that the trust had significant capacity issues and was having to reassess bed capacity at least three times a day. This pressure on beds meant that patients were allocated the next available bed rather than being treated on a ward specifically for their condition. We found that staff shortages meant that wards were struggling to cope with the numbers of patients and that staff were moved from one ward to cover staff shortages on others. The trust sees on average around 350 patients a day in its emergency department (ED).
We have rated the Princess Alexandra Hospital location as inadequate overall due to significant concerns in safety, responsiveness and leadership, with an apparent disconnect between the trust board leadership level and the ward level. It was evident that the trust leaders were not aware of many of the concerns we identified through this inspection. However, we found that the staff were very caring in all areas. We have rated the maternity and gynaecology service as outstanding overall.

Our key findings were as follows:
• Shortages of staff across disciplines coupled with increased capacity meant that services did not always protect patients from avoidable harm, impacted upon seven day provision of services and meant that patients were not always treated in wards that specialised in the care their condition.
• The disconnect between ward staff and the matron level had improved, however some cultural issues remained at this level which required further work.

• The relationship between staff and the site management team had improved, though this was still work in progress and the trust acknowledged further work was required here.
• Agency staff did not always receive appropriate orientation, or have their competency checks undertaken for IV care for patients on individual wards. This had improved by the time our unannounced inspection concluded.
• The storage, administration and safety of medication was not always monitored and effective.
• Information flows and how information was shared to trust staff were not robust. This meant that staff were not always communicated to in the most effective ways.
• The staff provided good care despite nursing shortages.
• There were poor cultural behaviours noted in some areas, with some wards not declaring how many staff or beds they had overnight to try and ease the workloads. This was a result of constant pressure on the service activities.
• The mortuary fridges had deteriorated since our last inspection and were no longer fit for purpose. These were replaced during our unannounced inspection to ensure they provided an appropriate environment for patients.
• Across surgery, there were notable delays in answering call bells on surgical wards including Kingsmoor and Saunders ward.

Gynaecology inpatient care had not improved, but declined, since our previous inspection. The inpatient gynaecology service, which was operated through surgery, was not responsive to the needs of women.

We saw several areas of outstanding practice including:
• The ward manager for the Dolphin children's ward had significantly improved the ward and performance of children's services since our last inspection
• The tissue viability nurse in theatres produced models of pressure ulcers to support the education and prevention of pressure ulcer development in theatres. This also helped to increase reporting.
• The improvement and dedication to resolve the backlog and issues within outpatients was outstanding.
• The advanced nurse practitioner groups within the emergency department were an outstanding team, who worked to develop themselves to improve care for their patients.
• The gynaecology early pregnancy unit and termination services was outstanding and provided a very responsive service which met the needs of women.
• The outcomes for women in the maternity service were outstanding and comparable with units in the top quartile of all England trusts.
• MSSA rates reported at the trust placed them in the top quartile of the country.
• The permanent staff who worked within women's services were passionate, dedicated and determined to deliver the best care possible for women and were outstanding individuals.
• The lead nurse for dementia was innovative in their strategy to improve the care for people living with dementia.

However, there were also areas of poor practice where the trust needs to make improvements. Importantly, the trust must:
• Ensure that fit and proper persons processes are ratified, assessed and embedded across the trust board and throughout the employment processes for the trust.
• Ensure that the risk management processes, including board assurance processes, are reviewed urgently to enable improved management of risk from ward to board.

• Ensure that safeguarding children's processes are improved urgently and that learning from previous incidents is shared.
• Ensure that staff are provided with appraisals, that are valuable and benefit staff development.
• Improve mandatory training rates, particularly around (but not exclusive to) safeguarding children level 3, moving and handling, and hospital life support.
• Ensure that trust staff are knowledgeable and provide care and treatment that follows the requirements of the Mental Capacity Act 2005.

These are the areas the trust should improve on:
• Review the priority improvement programme to ensure that the mortuary is refurbished.
• Review the cleaning schedules for the public areas throughout the hospital, and review the disposal of rubbish arrangements from the portering area to reduce the impacts of waste build up.
• Review the processes of how ward to board escalation is embedded to ensure that all concerns are captured where possible.

As a result of the findings from this inspection I have recommended to NHS Improvement that the trust be placed into special measures. It is hoped that the trust will make significant improvements through receipt of support from the special measures regime prior to our next inspection.

Professor Sir Mike Richards
Chief Inspector of Hospitals

The NHS Choices website allows patients and service users to rate their experience of NHS providers and to leave comments. The link below takes you to the part of the site that receives comments and ratings on Princess Alexandra Hospital.

http://www.nhs.uk/Services/hospitals/ReviewsAndRatings/DefaultView.aspx?id=RQWG0

INTRODUCTION

The Princess Alexandra Hospital NHS Trust Chief Executive Officer and Chief Nurse will be attending the Essex Health Overview and Scrutiny Committee (HOSC) on February 8th 2017. The following questions have been submitted and responses will be attached to the published meeting agenda.

1. **Please provide a copy of your current CQC Improvement plan (summary version)**
   See separate submission.

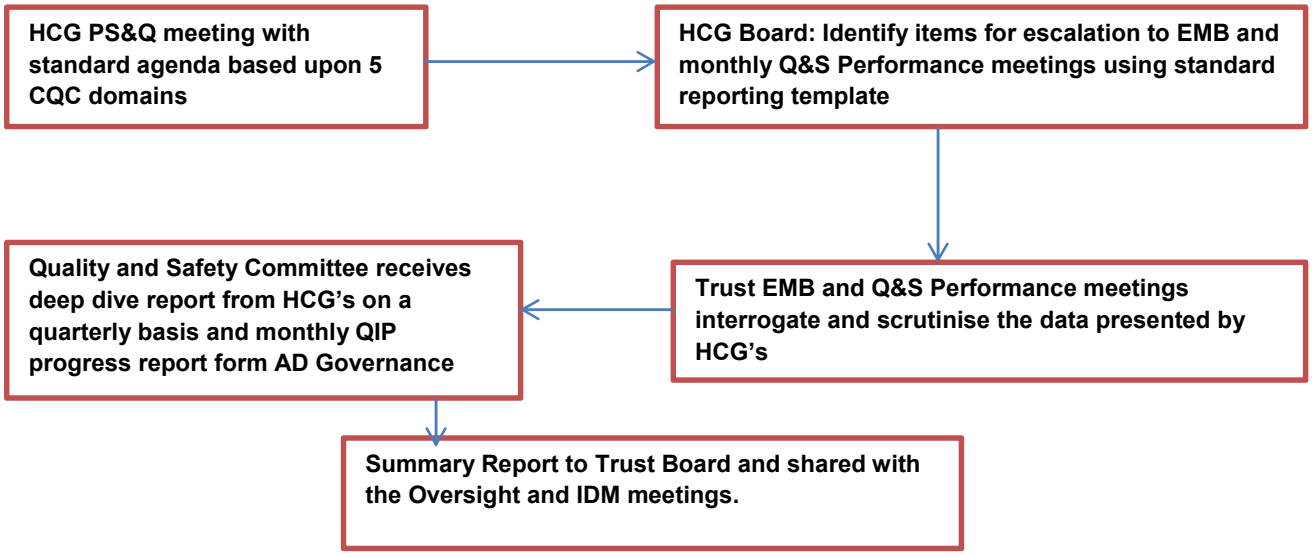
1.b Please briefly explain the verification process to determine the status of an action to be taken and if an action has been completed e.g. does the CQC counter-verify?

Once an action to address a recommendation, issue or concern has been entered onto the Improvement plan, its progress is rated (see table 1).

Table 1: Status rating scale

Key	
B	Desired outcome achieved
G	Actions and outcomes on track
AG	Actions in place. Progress requires external engagement
A	Actions commenced
RA	Actions identified not yet initiated
R	Scoping commenced. Awaiting progress

The formal process for monitoring progress is described in the flow chart below. In addition, the Trust undertakes fortnightly quality inspections in the clinical areas to assess compliance with agreed standards in line with CQC regulations. The output from the inspections is shared with the clinical teams to support their actions in the improvement plan.



2. **How is PAH working with partners to improve links to services in the community to help relieve pressures in the hospital? E.g. alternative locations for blood tests and other straightforward tests, greater use of primary care etc.**
    - Multi-agency colleagues are members of the Oversight Committee chaired by NHS Improvement (NHSI) to oversee progress against the Quality Improvement plan.
    - There is a multi-agency Local Delivery Board whose responsibility is to identify ways of enhancing patient flow in and out of the hospital.
    - We are working with community providers and General Practitioners (GP's) on the development of GP Network Neighbourhoods. These enable provision of a out of hours appointments across a range of locations in the network. Currently this model is being rolled out across Harlow.
    - The hospital has access to GP surgery appointment slots to stream people away from ED both in the networks and individual GP practices.
    - We have a single point of access contact line for community providers to assist with directing patients to the most appropriate non hospital service.
    - The West Essex CCG is promoting the use of a telephone app (MIDAS); this health care direction service is available to both the general public and to healthcare providers. It signposts the user to the most appropriate service in the locality.
    - In July 2016 we introduced an Integrated Hospital Discharge Service which includes representation from County councils, Mental Health Trust, Community Trust and the hospital to support earlier discharge from hospital.

3. **Bearing in mind some of the regulatory criticism is around not being able to meet current demand; can any actions be taken to increase capacity?**
    - In December the Trust reconfigured the adult inpatient ward facilities; this included opening a refurbished ward area and moving the planned orthopaedic surgical service. In doing this we were able to release 12 inpatient beds for use by emergency patients.
    - Work is being completed to optimise the scheduling of planned surgical workload so that the risk of cancelled operations is minimised.
    - The Trust is currently refurbishing a 26 bed facility (Gibberd ward) aiming to be available by March 2016. We are working with community colleagues; our aim is to facilitate provision of a transitional care area for people who no longer require hospital admission but are waiting to move to an appropriate community service.
    - The Trust launched a rapid improvement project on 16th January 2017; Red to Green Bed Days is a visual management system to assist in the identification of wasted time in a patient's journey through the hospital. The approach is about reducing internal and external delays.

4. **The CQC specifically made reference to capacity pressures had led to patients sometimes not being placed in the most appropriate ward for their particular condition/treatment.**
    - **What risks to patient care does this create?** Care and treatment interventions will be provided to the patient regardless of their whereabouts. However, accessing the correct clinical teams in a timely way may delay discharge form hospital. There are clinical risks associated with avoidable increases in length of stay including exposure

to hospital associated infections and loss of independence leading to reduced mobility and reliance upon assistance from care providers.

- **What is PAH doing to mitigate and minimise the risk going forward?** The Trust has a programmed of work called Transforming our Care; there are 5 work streams focused upon ensuring that the patient is accessing the most appropriate pathway:
    - Patient at Home
    - Complex care
    - Speciality pathway
    - Frailty
    - 48 hours length of stay

  In essence the programme is about streaming the patient to the right pathway, first time every time.

Success so far includes:

- Creation of 31 internal professional standards which underpin the way we work.
- The launch of SAFER in June 2016; this is a process for optimising patient safety through a structured ward round and reassessment. Thereby triggering timely interventions and discharge for the patient.
- The development of a business case to provide a new 2 storey facility adjacent to the Emergency Department. The facility will provide a fit for purpose assessment unit and a short stay ward (48 hours).

5. What resources do you provide for the Patient Panel and other patient feedback mechanisms?

Leadership/ Material and Human Resources

- An open door to speak to the Chief Nurse and Deputy Chief Executive, Professor Nancy Fontaine, the CEO Phil Morley and the Chair
- Regular meetings with the Chief Nurse and Chief Executive.
- Autonomy and flexibility to function within the organisation for the purpose improving patient experience.
- Day to day support from the Voluntary Services Manager and Associate Director for Patient Engagement.
- Meeting space to run at least 12 meetings per year
- The whole of the Patient Experience Team is dedicated to gathering feedback from patients and this is a group of 6.75 WTE staff

Financial Resource

- The Patient Panel are allocated an annual budget of £5.6k
- The Patient Experience Team have a total annual budget of £16.9k which includes patient feedback as well as a newly developed budget for electronic feedback of £90k
- Fundraising capacity and sufficient autonomy to raise funds from funding and grant-making bodies.

5.b Are you satisfied that you have sufficient patient feedback mechanisms in place to allow patients to easily feedback their experience?

The Trust has embedded a patient feedback culture in every service and healthcare group in the last 3 years taking the number of PALS cases from 2558 in 2012-13 to 5065 in 2015-16.

Effective feedback mechanisms are seen as fundamental indicators of quality and transparency in our services by leaders of services throughout the organisation. One key gap remains and that is that we need to bring this process forward into the present day and so are in the process of procuring a service to gain electronic feedback

We are never satisfied that we have done enough, the evidence continues to accumulate that people remain afraid to complain. According to a Health Watch England report in 2014, nationally:

- Six in ten people do not complain because they are worried it will adversely affect their treatment
- Of those who do complain, a third say doing so actually affected the care they received
- People are most reluctant to complain about senior figures

This is why we have introduced changes which have directly impacted on these issues, for example:

- Patient Panel members are involved in responding to complaints and reviewing them
- Ward level surgeries take place so patients and carers can meet senior staff to ask questions
- A "meet-first" policy to receiving concerns and complaints, face to face with senior staff
- A face to face meeting to explain a response to a concern or complaint including the CEO
- Multi-disciplinary team meetings which can include the family

This is not an exhaustive list because we believe this is a journey, not an endpoint, a journey of continuous improvement.

Our collective goal for the process is that our organisational culture is one where we always listen, always hear and always respond, in an effective and timely way. We believe that we can never say we have reached our goal and we do not believe any achievements to date can allow us to be complacent about this, considering how poorly complaint and feedback processes are perceived nationally as is evidenced above.

6. **What are the financial consequences to the Trust of addressing the issues raised by the CQC and implementing improvements? Are there any compensating revenue generating opportunities identified by the Trust?**

As a consequence of being placed in Special measures, the Trust has access to funding via NHSI specifically to support the actions required to improve. The Trust is also allocated an Improvement Director (ID) whose role it is to support the organisation on their improvement journey. One of the responsibilities of the ID is to access funding on behalf of the Trust. This funding is available on an annual basis and because PAH went in to special measures half way through the year the Trust can only access 6 months' worth of the funding. The Improvement Director worked with the Executive team to identify the areas which needed additional financial support. A business case was submitted to NHSI in December 2016 which was successful.

In addition to this the Trust has been asked to identify any additional spending it has incurred as a result of the Inadequate rating from CQC. Issues such as refurbishment of the Mortuary which

was identified by the CQC as a must do falls into this category. Regular dialogue is held between the Trust and NHSI about these issues.

The Trust has not identified any compensating revenue generating opportunities.

Thematic Summary of the Quality Improvement Plan with Progress (23 January 2017)

Areas for improvement	KPI	M. 8 RAG	M. 9 RAG	Progress	Risk
OUR PEOPLE					
Life support training	≥95% by 30 November 2017	G	A	51% in December 2016. Training capacity in place to achieve KPI. Attendance in December dropped in line with anticipated challenges associated with bank holidays. Behind agreed trajectory for month 9 Data issues as described in Mandatory training section. Manual validation in progress.	Non Attendance Informatics
Improved appraisals	≥95% by October 2017. Dec.16 Trajectory - 60%	G	G	Achieved Trust wide 62% Appraisal Rate. This is above trajectory. Critical Care Unit - 83% compliant, an improvement from the last reported figure of 79%. ED is at 100%	
Mandatory Training	≥95% by October 2017 Dec.16 Trajectory – 75	G	A	Combined Total Compliance Achieved 73% for the core subjects. This is 2% below trajectory. Data issues remain combined with December being a peak Holiday period. Issues uploading the revised data onto the Electronic Staff record (ESR) and the Oracle Learning management (OLM) system are being addressed by IBM.	Informatics
Improved RN staffing	Incremental reduction of Registered Nurse vacancy rates to achieve ≤10% by 2020	AG	AG	RN/ RM vacancy rate 16% (June 2016 =20.35%) Turn over 19% (June 2016= 20.46%) Recruitment pipeline includes 200 international nurses (17 pre-reg nurses currently at PAH). 33 international nurses are expected in next 3 months. Retention plans in place	Turnover Waiting impact of retention actions
Compliance with MCA		G	G	New MCA paperwork in place, all band 6/7 to receive training. Staff booked on MCA2 Adult Safeguarding Training sessions Evaluation/ survey of all trained staff in February 2017 Adult Safeguarding Peer Review March 2017	
Staffing levels in Resus ED		A	A	Bespoke recruitment for ED Nurses & Doctors continues with 8 middle grade doctors recruited and due to start in January 2017.	Workload tempting staff to other services; Patient at Home
Supervisory time for nursing leads		G	G	All job plans have been revised and will be assessed to ensure supervisory time is included.	
GETTING THE BASICS RIGHT					
Checking emergency equipment	Consistent 100% compliance by 31 March 2017	G	G	Improved compliance; Standardised resuscitation trolleys to minimise variation in checks	Performance management
Monitoring of fridge temperatures	Consistent 100% compliance by 31 March 2017	G	G	Continued trend of improved compliance	Performance management

Improved record keeping in critical care	To meet national standards	G	G	Minimum standards reasserted; consultant dashboard introduced and monitored by lead clinician.	
Timing of ward rounds and timely discharges	Elimination of avoidable evening discharges	A	A	SAFER discharge bundle rolled out. Red to Green process for ward rounds launched	System wide collaborative work required for success
Organise patient records to support pathways		A	A		
PATIENT FOCUS					
Safeguarding processes	Training ≥95% by 31 March 2017 Compliance with process.	G	G	Training capacity adjusted to meet KPI. Audit impact of training taking place.	Informatics Release of staff to attend
Gynaecology service improvement	i)≥95% designated staff trained/ competent in gynae procedures ii) ≥95% of gynae women allocated beds appropriate to their care	G	G	Competency booklet produced. New Doctors commencing in January and February. Dedicated area for female surgery which will include gynaecology patients identified.	
Improvements in end of life care	i) 100% of EOL patients discharged to preferred place of death within 12 hours of decision 31 October 2018 ii) Achieve fully funded and recruited specialist palliative care team iii) Ceilings of care included in healthcare record by 31 Dec 2017	AG	AG	Fast Track and Rapid Discharge Home to Die process drafted and with stakeholders. Business case completed to identify workforce requirements to augment service.	Hard to recruit to posts. Reliant upon whole health and social care economy to resolve
Identify trends and learn from complaints and incidents in EOL care		G	G	Review of all incidents and complaints related to end of life care now taking place by specialist team; initiating actions and sharing the learning.	
Reduce impact of SSA breaches in HDU and use of PACU	All level 0 and level 1 patients discharged within four hours of decision	AG	AG	Standard operating procedure in place to optimise the privacy and dignity of patients no longer requiring critical care, awaiting transfer to a general ward.	HDU Environment and hospital capacity require system side actions
ED Improvement - Ambulance triage, handover and assessment	Patients arriving by ambulance are offloaded and assessed within 15 minutes of arrival with trajectory for reducing the	G	G	Ambulance assessment checklist introduced – 100% compliance with the checklist achieved in December.	

	number of 30 minute and >1 hour delays.				
Response rates to call bells in ED		A	A	Reviewing standard for response times. Creating an observation of practice audit with support from Patient Panel.	
Centralise appointment booking		A	A	Benchmarking with other organisations is in progress.	
Reduce number of cancelled operations		A	A		
Critical care improvement in MDT working/ M&M Meetings		G	G	Twice weekly M&M taking place. Revised template for documentation in place.	
Reduce number of delayed discharges form critical care		AG	AG		
INFRASTRUCTURE					
Future sustainability of maternity services		AG	AG		
Mortuary refurbishment	Compliance with HTA requirements	AG	G	Positive Draft HTA Report received for factual accuracy by 20th Jan 17.	
GOVERNANCE, RISK MANAGEMENT AND MAKING INFORMED DECISIONS					
Improve governance and risk management arrangements		A	G	Risk Management Group commenced. Strategy updated ahead of schedule.	
Share the learning from complaints		A	A		
Ratify and embed Fit and Proper persons Process		G	G	Policy written undergoing peer review. Expected to be ratified by January 2017. Internal Audit review of process in the pipeline	
Update Trust policies and guidelines		A	A	Corporate document tracker in place	

The Princess Alexandra Hospital NHS
NHS Trust

Essex and Hertfordshire HOSC February 8th 2017

Phil Morley, Chief Executive

Nancy Fontaine, Deputy Chief Executive and Chief Nurse

Our time is precious

AIMS

- Response to the Chief Inspector of Hospitals' inspection findings and recommendations
- Update on progress with quality improvements
- To demonstrate governance and oversight of learning, monitoring and sustaining improvements

Themes

- Our people
  - Training: mandatory, resuscitation, mental capacity assessment
  - Appraisal
  - Nurse staffing levels
- Getting the basics right
  - Emergency equipment checks
  - Monitoring of drug fridge temperatures
  - Timely ward rounds
  - Timely discharge form hospital
  - Improved recordkeeping
- Patient Focus
  - Ambulance triage and handover
  - Safeguarding processes
  - Response rate to patient call bells
  - Improve end of life care
  - Critical care: MDT working, timely discharge, same sex accommodation
- Infrastructure
  - Mortuary refurbishment
  - Future sustainability of maternity services
- Governance
  - Policies and guidelines including Fit and proper Persons Process
  - Governance and risk management arrangements
  - Sharing the learning from complaints

In terms of Outcomes for Patients

1. Mortality
2. Harm Caused
3. Infection Control
4. Complaints
5. Patient Satisfaction

Top quartile performance across England

Overall Rating and Recommendations

Overall rating for this hospital	Inadequate
Urgent and emergency services	Inadequate
Medical care (including older people's care)	Requires improvement
Surgery	Requires improvement
Critical care	Inadequate
Maternity and gynaecology	Outstanding
Services for children and young people	Requires improvement
End of life care	Inadequate
Outpatients and diagnostic imaging	Good

- 16 must do's
- 22 should do's

PAHT CQC ratings: Comparison

The Princess Alexandra Hospital NHS Trust

July 2015 ratings

Overall	Safe	Effective	Caring	Responsive	Well led
U&E Care		Good	Good	Requires improvement	
Medical			Good	Requires improvement	
Surgery		Good	Good	Requires improvement	
Critical care	Good	Good	Good	Requires improvement	
Mat & Gynae	Good	Good	Out-standing	Good	
Child & young people			Good	Requires improvement	
End of Life care			Good	Good	
OP and imaging		Not rated	Good		

June 2016 ratings

Overall	Safe	Effective	Caring	Responsive	Well led
U&E Care				Inadequate	
Medical				Requires improvement	
Surgery				Requires improvement	
Critical care				Inadequate	
Mat & Gynae			Out-standing		
Child & young people					
End of Life care				Inadequate	
OP and imaging		Inspected but not rated			

PAHT CQC ratings: Comparison

The Princess Alexandra Hospital NHS Trust

July 2015 ratings

Overall	Safe	Effective	Caring	Responsive	Well led
U&E Care		Good	Good	Requires improvement	
Medical			Good	Requires improvement	
Surgery		Good	Good	Requires improvement	
Critical care	Good	Good	Good	Requires improvement	
Mat & Gynae	Good	Good	Out-standing	Good	
Child & young people			Good	Requires improvement	
End of Life care			Good	Good	
OP and imaging		Not rated	Good		

June 2016 ratings

Overall	Safe	Effective	Caring	Responsive	Well led
U&E Care				Inadequate	
Medical				Requires improvement	
Surgery				Requires improvement	
Critical care				Inadequate	
Mat & Gynae			Out-standing		
Child & young people					
End of Life care				Inadequate	
OP and imaging		Inspected but not rated			

Board Reflections on Report

- We celebrate with our workforce and service users the achievements of our maternity services rated ‘outstanding’
- We are pleased to see the recognition of the passion and commitment of our staff reflected in the ‘GOOD’ rating for *CARING*
- We are pleased to see the recognition of improvements in Outpatient services
- We recognise the scale and pace of the change that is required and we are committed to improvement

CQC recommendations Progress

The Princess Alexandra Hospital NHS Trust

Actions to address concerns identified and initiated:

Key	
B	**Desired outcome achieved**
G	**Actions and outcomes on track**
AG	**Actions in place. Progress requires external engagement**
A	**Actions commenced**
RA	**Actions identified not yet initiated**
R	**Scoping commenced. Awaiting progress**

Oct 2016 RAG	**1**		**24**		**3**		**1**	
Nov 2016 RAG	**0**		**9**		**6**		**14**	
Dec 2016 RAG	**0**		**10**		**5**		**14**	

Monitoring Process

- Fortnightly inspections scrutinising all quality standards across the Trust
- Executive team working closely with NHS Improvement
- Improvement Director allocated to the Trust from NHSI
- NHSI regional team oversee the implementation and progress of Improvement plan
- Monthly multi agency Oversight meetings chaired by NHSI to oversee the delivery of the quality Improvement plan across the health economy

Meeting current demand

The Princess Alexandra Hospital NHS
NHS Trust

BBC NEWS

7 June 2016 | UK

Bed-blocking delays may continue 'up to five years'

Delays in releasing elderly patients from hospital could continue for up to five years, NHS England boss Simon Stevens has warned.

NHS Trusts most affected by bed-blocking

Delayed transfers saw nearly 12 days lost per 100 beds in one hospital

Mail Online News

No free beds in 15 hospitals: Doctor say they are close to meltdown as figures show one health centre had no spare capacity for 27 days

- Princess Alexandra in Harlow, Essex, did not have a single bed free for 27 days

Princess Alexandra continues to be on "high alert" over A and E pressures

Date posted: 09-01-2017

Monday January 9th

PRINCESS Alexandra Hospital (PAH) in Harlow has made an appeal to residents as pressures continue to mount on it's services.

HarlowStar

Princess Alexandra Hospital A&E under 'intense' pressure

By **Harlow Star** | Posted: November 22, 2016

Ambulances were diverted from Princess Alexandra Hospital due to overcrowding

By **William_Mata1** | Posted: January 09, 2017

Meeting current demand

Transforming Our Care

The Princess Alexandra Hospital NHS Trust

Specialty

Getting the right patient, to the right place/team – first time

Improving performance against internal professional standards

Enabler

Frailty

Multi-disciplinary team providing safe, timely, compassionate care for frail older people using an integrated care pathway

Develop and implement a new way for the hospital to operate, that is person and place centered

Increasing assessment and short stay outside of the Emergency Department (A&E). Plans include the development of an Urgent Care Centre and expanded EAU.

Short Stay

Patient at Home

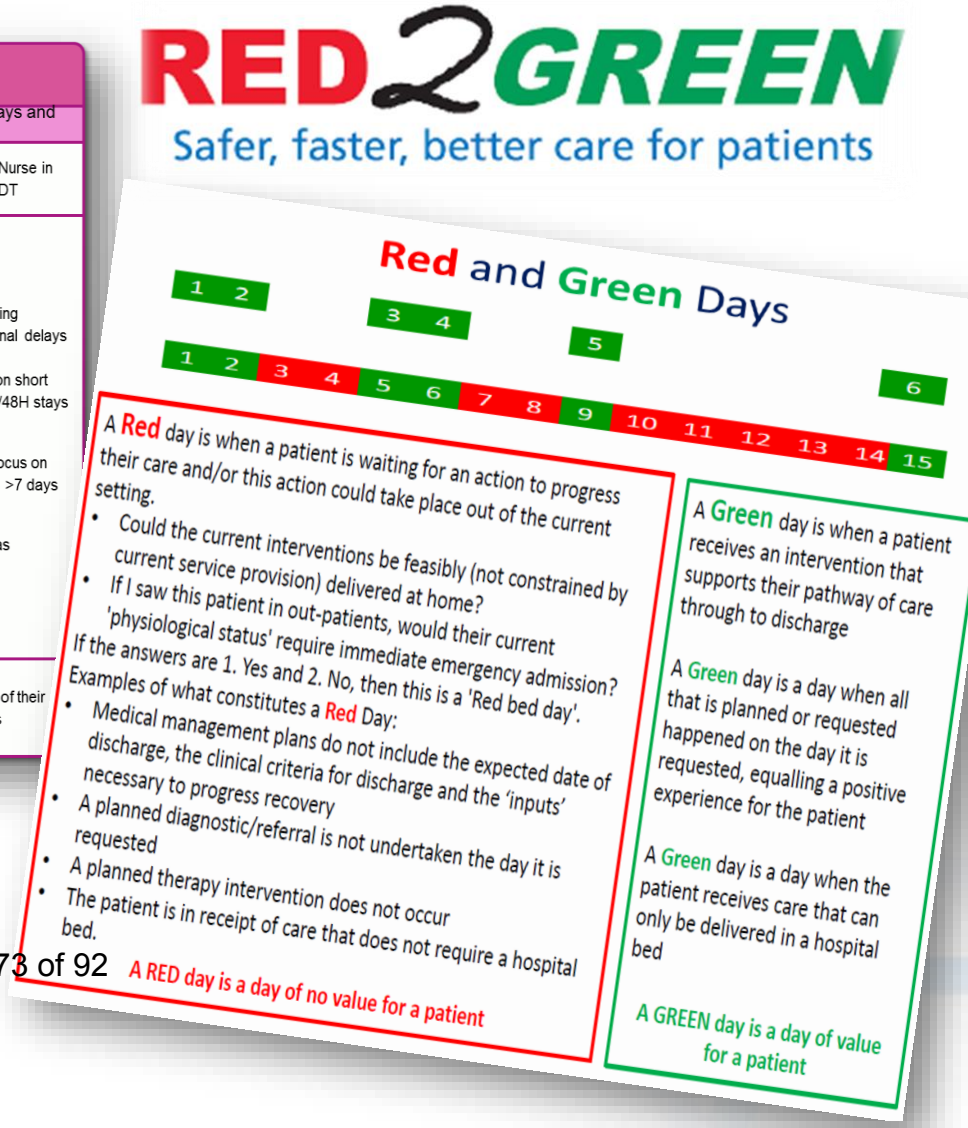
Providing acute healthcare in our patient's home

Meeting current demand

The Princess Alexandra Hospital NHS Trust

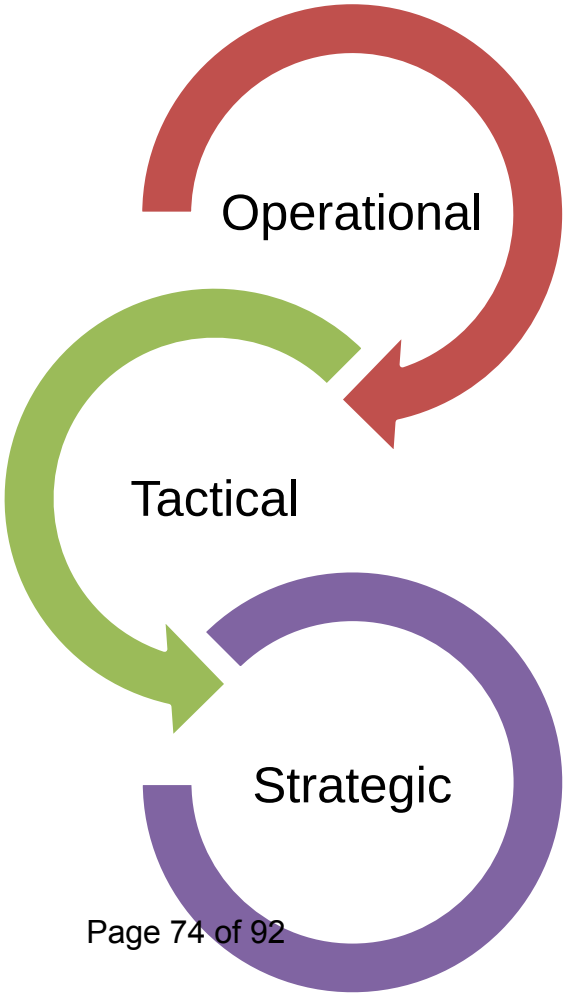
SAFER Patient Flow Bundle & R2G

S	A	F	E	R
Senior Review	**Anticipate**	**Flow**	**Earlier** discharges	**React** to delays and waits
Consultant/SpR with Nurse in Charge	Patient, Consultant/SpR, Nurse in Charge, Wider MDT	Consultant/SpR, Nurse in Charge, Wider MDT	Consultant/SpR, Nurse in Charge, Wider MDT	Consultant/SpR, Nurse in Charge, Wider MDT
Daily Senior Review at board round Nurse in charge present at ward and board round Review before 10am:- 1. Sick & unstable patients 2. Patients able to be discharged today/tomorrow* Allocate/action (TTAs & Discharge Summary in real time on board/ward round) to ↑ am discharges Review, confirm and communicate medically fit date (MFD) Ensure every patient has a clear management plan	Inform patient/carer of EDD Daily communication with patient/family and wider MDT re MFD Timely submission of discharge planning documentation to facilitate discharge on MFD ***Anticipate tomorrows discharge patients:-*** TTAs and discharge summary prepared by 3pm day before Transport booked day before Discharge lounge booked day before	Specialty/Health Group management:- anticipate patient population/demand Early placement of patients from ED and assessment areas into speciality beds Awareness and plan for elective demand for today/tomorrow Be ready to accept patients from 10am	***TTOs, AVS & discharge summary written day before:-*** Maximise discharges by midday Focus on "check-out time 10am" Use discharge lounges ***TTAs, AVS & discharge summary not written day before:-*** Escalate TTOs and discharge summary (with aim to discharge later) Escalate to Senior team (Supervisory Ward Sister/ Manager of the Week) issues that may inhibit discharge later	Focus on unblocking internal and external delays Increased focus on short stay patients <24/48H stays Increased MDT focus on long stay patients >7 days Early escalation as appropriate
All orders for sick/unstable & dischargeable patients to be placed in real time during ward rounds		Speciality teams to pull speciality patients into their speciality beds from outlying areas	TTAs completed as soon as appropriate/possible after discharge decision made	Speciality review of their long LOS patients



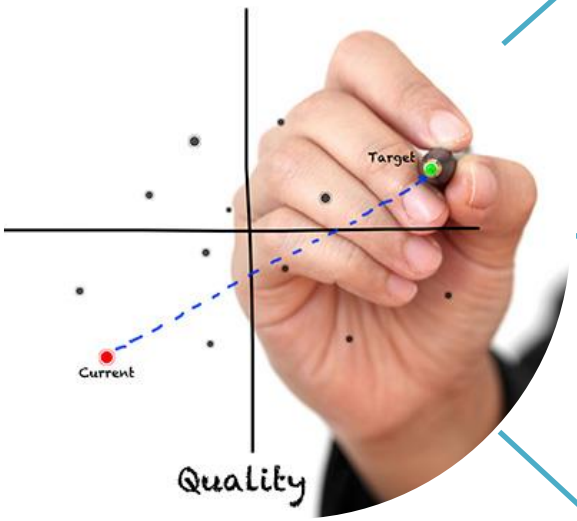
Our time is precious

Our Approach to Quality



Quality First – “Our Time is Precious”

Quality First means…



Safety

Experience

Outcomes

Our time is precious

A new Future

What will it take?

New Harlow, New Hospital, New Hope

40,000-80,000 new houses

New Motorway Junction

Public Health England

Health and Social Care campus

Move to a new site

Integrated models of care

Left shift of patients

New roles and contracts of employment

Population Health management

The Five Key Jigsaw Pieces

PAH Strategy

- Vertical
- Horizontal
- Lateral
- Clinical Services
- Place

Shaping the Future

The Princess Alexandra Hospital NHS Trust

Vertical

- Integrated Primary, Community, Social and Acute Care
- Reducing hospital activity by 20%

Horizontal

- Preferred partner status
- Protecting Fragile services

Lateral

- Bigger footprint, sustainable Acute care
- Population health, ACOs, STPs

Clinical Services

Five year strategy for each service

Place

- Right location, right clinical adjacencies, right partnerships
- Fit for long term future

The Vital Elements

A New Paradigm

Integrated Approach

Clinical Leadership

Workforce

Our time is precious

Issues

- Transport and Infrastructure
- Impact of Residential and Care Homes
- Staff fatigue
- Domestic Violence
- Geography – Geopolitical isolation
- Capital Resource

Support required

- Affordable housing and key worker homes
- Land Issues, preferred site decisions
- Strong neighbourhood teams based around Primary Care
- Social Nudging
- Joined up scrutiny and support
- Funding the Future

HOSC/11/17

Committee Health Overview and Scrutiny

Date 8 February 2017

GENERAL UPDATE

Report by Graham Hughes, Scrutiny Officer
Contact details: graham.hughes@essex.gov.uk Tel: 03301 34574

This report is in two parts – Part 1 provides general local health issues and items of interest. Part 2 relates to variations and changes to services that the HOSC has been notified of, usually relating to primary care.

Recommendation: To note the updates in Part 1 and Part 2 below:

(i) LOCAL HEALTH NEWS

Mid and South Essex Success Regime

On 23 January the Mid and South Essex Success Regime published two independent clinical reviews of their emerging plans to reconfigure the three main hospitals in Basildon, Chelmsford and Southend. The reports were prepared by the East of England Clinical Senate following detailed reviews which took place in June and October 2016. The Clinical Senate's final report of October 2016 supports the principle of having a designated specialist emergency hospital for more challenging and complex emergency work. It also supports the principle of having a centre of excellence for planned care. The review panel also felt that the potential hospital changes could be *"bolder with greater potential benefits if there was less focus on continuing to provide virtually all current services on all three sites."* However, the review panel urged caution around the pace of change recommending that quality and safety of services is paramount and the need for long-term sustainable services should take priority over speed. Next steps in February and March will narrow down the hospital reconfiguration possibilities to one or two preferred options that will then be the basis for a detailed business case to be reviewed by national bodies before public consultation later in 2017

Health bodies - Public meetings 2017

A list of forthcoming meeting dates for CCGs, Acute Trusts and Essex Mental Health Services is attached for your information (**Appendix 1**). If members attend any of these meetings can they please feed-back to the HOSC any significant or topical issues that may be of interest to the wider committee membership.

Local Clinical Commissioning Groups – news

Web addresses

http://www.basildonandbrentwoodccg.nhs.uk/news

http://castlepointandrochfordccg.nhs.uk/news-a-events

http://www.midessexccg.nhs.uk/news-events
http://www.neessexccg.nhs.uk/News%20and%20Events/News/Current%20News.html

http://www.westessexccg.nhs.uk/news

Southend CCG

Melanie Craig is leaving her role as Chief Officer of NHS Southend CCG to take up a new role as Accountable Officer at NHS Great Yarmouth and Waveney CCG. Melanie leaves the CCG on 2 February and Ian Stidston has been appointed joint Accountable Officer for both Southend CCG and Castle Point & Rochford CCG for the next six months. He will start this new joint role on 6 February and will manage both CCGs until permanent arrangements have been confirmed for Southend.

(ii) SERVICE CHANGES AND VARIATIONS (including consultations)

Primary care

A proposal to close one of the two Swanwood Partnership sites in Wickford is awaiting further patient engagement. The partnership currently delivers services from two sites which are 0.5 miles apart and the proposal under consideration is to close one site and consolidate services for the current registered patient lists for both sites at just one site in future

Essex Clinical Commissioning Groups - Board Meeting dates 2017

Date	Time	Location	Event
23 March 2017	13:15	The Board Room Phoenix Place Basildon SS14 3HG	Basildon and Brentwood CCG
30 March 2017	14:00	Audley Mills Education Centre 57 Eastwood Road Rayleigh SS6 7JF	Castle Point and Rochford CCG
30 March 2017	13:30	Witham Community Association Spring Lodge Community Centre Powers Hall End Witham CM8 2HE	Mid Essex CCG
28 March 2017	14:30	The McGrigor Hall Fourth Avenue Frinton CO13 9EB	North East Essex CCG
30 March 2017	9:30	Council Chamber Uttlesford District Council Offices Saffron Walden	West Essex CCG

Acute Trusts – Board of Directors Meeting dates 2017

Date	Time	Location	Event
8 February 2017	14:30	The Essex Cardiothoracic Centre Rooms 4/5 Basildon and Thurrock Hospital	Basildon and Thurrock University Hospitals NHS Foundation Trust – Board of Directors meeting
28 February 2017	13:30	Postgraduate Medical Centre, Colchester General Hospital	Colchester Hospital University NHS Foundation Trust – Board of Directors meeting
25 April 2017	13:30	Postgraduate Medical Centre, Colchester General Hospital	Colchester Hospital University NHS Foundation Trust – Board of Directors meeting

Date	Time	Location	Event
6 February 2017	13:30	Lecture Theatre 1 Medical Academic Unit (MAU) Broomfield Hospital Court Road Broomfield CM1 7ET	Mid Essex Hospital Services NHS Trust – Trust Board/Board of Directors meetings
1 February 2017 5 April 2017	9.30 9.30	The Boardroom Education Centre 2nd floor Southend Hospital The Boardroom Education Centre 2nd floor Southend Hospital	Southend University Hospital NHS Foundation Trust – Trust Board meetings Southend University Hospital NHS Foundation Trust – Trust Board meetings
25 May 2017 (now bi-monthly meetings)	All day	Trust Board Room (Lower Ground Floor) The Princess Alexandra Hospital Hamstel Road Harlow	The Princess Alexandra Hospital NHS Trust – Trust Board meetings

Essex Mental Health Services - Meeting dates 2017

Date	Time	Location	Event
Not currently available	Not currently available	Stapleford House 103 Stapleford Close Chelmsford CM2 0QX	North Essex Partnership University NHS Foundation Trust – Public Board Meeting
22 February 2017	10.30	Training Room 1 The Lodge Runwell Chase Wickford SS11 7XX	South Essex Partnership University NHS Foundation Trust – Board of Directors Meeting

NOTE:

Agendas are normally published one week before public meetings. Please check the time and venues on individual websites in case there have been any changes.

AGENDA ITEM 9

HOSC/12/17

Committee Health Overview and Scrutiny

Date 8 February 2017

Report by: Graham Hughes, Scrutiny Officer

Work Programme 2016/17

Purpose of report

The purpose of this report is to consider the work scheduled for the remainder of the municipal year (overleaf) which has been prepared in consultation with the HOSC Chairman and Vice Chairmen. It is suggested that, with the restricted pre-election period for the county council elections starting at the end of March 2017, the Committee should aim to conclude its current work activity by, or at, its 20 March 2017 meeting.

Similarly, Task and Finish Group and Joint Committee activity will also need to finish (or be adjourned until after the county elections) by March 2017.

Action required by the Committee at this meeting:

To consider and agree the remaining proposed work programme prior to the restricted pre-election period;

HEALTH OVERVIEW & SCRUTINY COMMITTEE – WORK PROGRAMME SNAPSHOT AS AT 31 JANUARY 2017:

Current scheduled work (in Full Committee)	**Current work (in Task and Finish Group, Joint Committee or similar)**
Transformation of Services: strategic review of all 3 Sustainability and Transformation Plans impacting Essex – patient engagement (Tom Nutt, Healthwatch) **(March 2017)**	*Joint Committee - Urological Cancer Surgery proposals* (with Southend and Thurrock) – one further meeting expected to monitor implementation of Joint Committee recommendations from last September.
Transformation of Services: written update on the Colchester & Ipswich Hospitals strategic partnership /relocation of Essex County Hospital services **(March)**	*Joint Committee - PET CT Scanner for south Essex proposal* (with Southend) – subject to Secretary of State referral.
Autism – written update from commissioners and providers on diagnostic pathway **(March 2017)**	*Mental Health Services for children and young people* (Southend-on-Sea Borough Council representatives also on the group) – to finish review in February and report to the March full HOSC.
Task & Finish Group - Mental health services for children & young people – final report **(March 2017)**	*Transformation of Services* –specific work streams under Sustainability and Transformation Plan for North East Essex and Suffolk *(Joint Committee with Suffolk)* - one public meeting in March prior to restricted pre-election period and will then reconvene later in the year.
Obesity Issues in Essex - Scrutiny Report – Implementation review **(March 2017)**	East of England Ambulance Service – regulatory concerns *(Regional HOSC Chairs forum)* - likely to not reconvene until after May elections.