Essex County Council

Health Overview Policy and Scrutiny Committee

10:30	Wednesday, 09 October 2019	Committee Room 1, County Hall, Chelmsford, CM1 1QH

For information about the meeting please ask for:
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1	**Private Pre-Meeting, HOPSC Members Only** To be held at 09:30am in Committee Room 6, County Hall.	
2	**Membership, Apologies, Substitutions and Declarations of Interest**	4 - 4
3	**Minutes**	5 - 9
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	**Dementia Community Support**	10 - 19
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11 Date of Next Meeting

To note that the next committee activity day is scheduled for 09:30am on Wednesday 6 November 2019, in Committee Room 6, County Hall. Scheduled activity dates may be a private committee session, meeting in public, briefing, site visit, etc. - format and timing to be confirmed nearer the time.

12 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)

The following items of business have not been published on the grounds that they involve the likely disclosure of exempt information falling within Part I of Schedule 12A of the Local Government Act 1972. Members are asked to consider whether or not the press and public should be excluded during the consideration of these items. If so it will be necessary for the meeting to pass a formal resolution:

That the press and public are excluded from the meeting during the consideration of the remaining items of business on the grounds that they involve the likely disclosure of exempt information falling within Schedule 12A to the Local Government Act 1972, the specific paragraph(s) of Schedule 12A engaged being set out in the report or appendix relating to that item of business.

13 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.

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Agenda item 2

Committee: Health Overview Policy and Scrutiny Committee

Enquiries to: Graham Hughes, Senior Democratic Services Officer

Membership, Apologies, Substitutions and Declarations of Interest

Recommendations:

To note

1. Membership as shown below
2. Apologies and substitutions
3. Declarations of interest to be made by Members in accordance with the Members' Code of Conduct

Membership
(Quorum: 4)

Councillor J Reeves	Chairman
Councillor A Brown	
Councillor J Chandler	
Councillor B Egan	Vice-Chairman
Councillor R Gadsby	
Councillor D Harris	
Councillor J Lumley	
Councillor B Massey	
Councillor M McEwen	
Councillor J Moran	
Councillor A Wood	Vice-Chairman

Minutes of the meeting of the Health Overview Policy and Scrutiny Committee held in Committee Room 1, County Hall, Chelmsford, CM1 1QH at 10.15am on Wednesday 4 September 2019

Present:
County Councillors

Councillor Reeves (Chairman)	Councillor Massey
Councillor Wood	Councillor Harris
Councillor Egan	Councillor Moran
Councillor Chandler	Councillor Brown
Councillor McEwen	

Graham Hughes - Senior Democratic Services Officer

Andrew Seaman – Democratic Services Officer

Meeting started at 10:22

Membership, Apologies, Substitutions and Declarations of Interest

Apologies had been received from Councillors Lumley, Gadsby, Edwards and Hannah Fletcher from Health Watch Essex.

Councillor Wood had been voted as Vice-Chairman
Councillor Sergeant had stepped down as Councillor.

The following Councillors declared an interest:

(i) Councillor Egan – Code interest. Her cousin is Managing Director of Basildon and Thurrock University Hospital Trust – however, she believed that this did not prejudice her consideration of the public interest and that she was able to speak and vote on the matters on the agenda.
(ii) Councillor Wood – Governor of EPUT
(iii) Councillor Brown – Son is cardiovascular Surgeon at Southend

1. Appointment of Vice-Chairman

The Chairman advised the Committee that Colin Sargeant had stood down as councillor and thanked him for his service on the committee and it was agreed that a letter to that effect would be sent to him. The Chairman then invited nominations for Vice-Chairman, Councillor Egan proposed Councillor Wood, seconded by Councillor Harris. With no other nomination Councillor Wood was appointed as Vice-Chairman.

2. Minutes

The Minutes of the meeting of the Health Overview Policy and Scrutiny Committee (HOPSC) held on 4 July 2019 were approved as a correct record and were signed by the Chairman.

3. Questions from the Public

There were no questions from the public

4. Mid & South Essex Hospitals – Cardiology Clinical Reconfiguration

The Committee considered report **HOPSC/29/19**. The following joined the meeting and at the invitation of the Chairman, introduced the item.

Mid & South Essex University Hospitals Group:

Tom Abell – Deputy Chief Executive
Dr Stuart Harris – Group Clinical Director, Cardiovascular
Dan Turner – Head of Integrated Care

During discussion the following points were highlighted and/or acknowledged:

(i) It was noted that the last few winters had been quite difficult, and preparations had been made to increase capacity at all three hospitals.

(ii) Aim would be to transport coronary patients directly to Basildon as opposed to being treated at Broomfield, after stabilisation.

(iii) There were ongoing discussions between health organisations, local government and bus companies to further support people visiting patients.

(iv) The number of patients needing transferring was relatively small (2 to 3 patients needed to be transferred a day, 921 a year). Improving the car parking issue at Basildon was to benefit the patient transfer changes but was also to improve the day to day operations.

(v) There was an aim of working with Basildon Borough Council to identify staff parking opportunities within the town centre.

(vi) It was noted that there were ongoing discussions to find opportunities for patient and visitor transport.

(vii) It was noted that NICE guidelines suggested that better outcomes were achieved if clinical interventions were made within 72 hours for all cases.

(viii) Urgent pacemakers were an area that could be improved.

(ix) There was continued focus on minimising admissions.

(x) Weekends were a challenge; the new process would allow cardiologists to be available at weekends. Though this was temporary, it was noted that should this be effective a review would take place to consider if it should continue.

(xi) There would be evaluations to take the positives from the temporary measures and apply them in future planning.

(xii) Hospitals would become more specialised in certain clinical disciplines. Basildon cardio, Southend cancer, Broomfield complex inpatient surgery. was the target model. Currently, it was a challenge to provide all these specialisations at all three

(xiii) Hospitals continue the same bed model at an assumed rate of 95% occupancy; therefore, should any spikes occur this would dampen that effect.

(xiv) It was noted that South and Mid Essex Hospitals were in communications with other Hospitals in order to share knowledge and best practice.

(xv) The hospitals intended to increase the use of 'virtual beds' to relieve hospital beds. This was where patients are transferred home but still not signed off from the hospital. These are patients who need minor treatment.

(xvi) The average length of stay for this cohort of patients was anticipated to be between 4.5 day to 6.5 days.

Conclusion:
The Chairman thanked the witnesses for attending and the HOPSC support the proposed changes. It was agreed:

- That the witnesses would come back March/April to debrief on the pilot.
- Further information to be provided on transport arrangements.
- A separate update to be planned to discuss STP plans.

The witnesses then left the meeting.

Adjourned – 11:09
Restarted 11:15

5. Public Health Update

The Committee considered the report **(HOPSC/30/19)** the paper specially addressed issues raised by the HOPSC in advance**.** The following joined the meeting and, at the invitation of the Chairman, introduced the item.

Essex County Council:

Dr Mike Gogarty – Director of Wellbeing, Public Health, and Communities

During discussion the following points were highlighted and/or acknowledged:

(i) It was noted that ECC continued to receive the same level of public health grant from national government.

(ii) Various public health initiatives were outlined and that the 'Live Well' scheme was highlighted to have worked well.

(iii) The biggest challenge was providing better education opportunities to children to improve health and wellbeing.

(iv) Loneliness in the elderly community was an issue. It was noted that loneliness in younger people was being dealt with in a similar way to elderly.

(v) It was noted that there was a possibility that parishes could be involved in tackling loneliness. They had been implementations to introduce roles at a localised level.

(vi) An updated deprivation index would be released in October, Tendring and Colchester was likely to decline. The profile of the Tendring mental health hub needs improvement.

(vii) Saw a decline in school readiness.

(viii) Colchester, Basildon and Tendring –national grant funding was received by Active Essex. – active aging was a target; infrastructure changes and cultural changes need to be made. Target was to get those inactive people active.

(ix) Compared to northern and metropolitan authorities Essex seems poorly funded per person, Suffolk and Hertfordshire were similar in terms of funding per person. Though this may look different when needs are considered.

Conclusion:
The Chairman thanked Dr Gogarty for attending and the HOPSC support the proposed changes. The chairman request that Dr Gogarty returned to present the deprivation index later in the year.

6. Chairman's Report

The report **(HOPSC/31/19)** was noted, there were no questions.

7. Member Updates

The report **(HOPSC/32/19)** was considered and noted.

Councillor Brown – JHOSC, noted a lack of representation from west Suffolk.

Councillor Wood – ESNEFT, Updated members on the most recent meeting he attended, including improved vacancy rates and reduced agency costs.

8. Work Programme

The committee noted and considered report **(HOPSC/33/19).**

Amendments would need to be made to reflect the updates requested in item 4.

9. Date of next meeting

The committee noted that the next committee activity day was scheduled for 09:30 on Wednesday 9 October 2019.

10. Urgent Business

There being no further business the meeting closed at 12:08

Chairman

AGENDA ITEM 5

HOPSC/34/19

Committee Report to Health Overview Policy and Scrutiny Committee

Date 9 October 2019

SOUTH EAST ESSEX CLINICAL COMMISSIONING GROUPS (CASTLE POINT & ROCHFORD CCG AND SOUTHEND CCG)

Report by Jo Dickinson, Locality Development Manager (Dementia lead SEE CCGs), Southend Borough Council

Contact details: Jo.Dickinson@southend.gov.uk Tel: 01702 534689

Recommendation: The Proposed Implementation of a Dementia Community Support Model
Part 1 (Public Agenda Item)

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1 Purpose of Report

The purpose of the report is to provide the Committee with:

1.1 An update on the issues and paper submitted to the Health Overview Policy and Scrutiny Committee on 10th October 2018 proposing the closure of Maple ward; and

1.2 Share details of the newly approved Dementia Community Support Model in the south east.

2 Recommendations

2.1 To note the update and share their views on the newly approved Dementia Community Support model.

2.2 To note the details of the dementia community model which is a permanent move and aims to go live April 2020;

2.3 To note the reduction in the ring fenced step up and step down beds in Clifton Lodge and Rawreth Court from ten to four. The number of beds available across both facilities remains the same; there is no overall reduction.

2.4 To note the CCG commitment to regular review of the bed base to see if there is further scope for reduction or increase due to work with community providers to offer a clinically suitable alternative.

3 Background & Context

3.1 In October 2018, the Committee considered and agreed the following:

(i) The proposed creation of additional Adult Mental Health ‘inpatient beds’ and associated temporary ward moves

(ii) The proposed temporary relocation of Cumberlege Intermediate Care

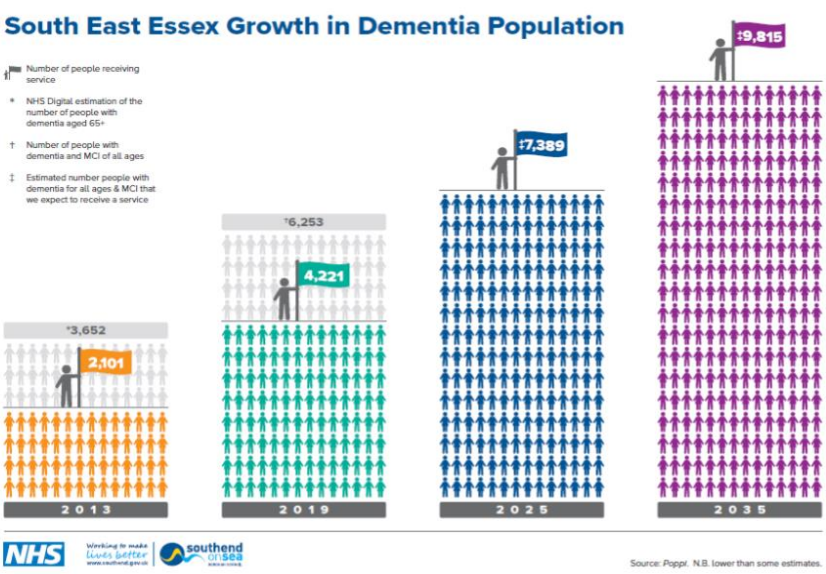
Centre (CICC) to facilitate the St. Lukes Primary Care Centre Development

AGREED: Whilst some members felt there could have been better foresight and planning to avoid the urgency of the proposals, the Committee supported the proposals to facilitate the continued development of the St Lukes Primary Care Centre and supported the request to defer formal consultation until proposals for a permanent move for the CICC was available next year.

3.2 The decision was therefore that Maple Ward would be closed - a 24 bedded organic assessment unit in Southend that was running at half occupancy. Dr Jose Garcia was asked to chair a clinical group to look at: the current dementia offer; identify the requirements of a new wraparound model to ensure robust community support to the person with dementia and their carer and to identify any gaps in knowledge and data.

3.3 As well as a commitment to develop a robust community model there was also a commitment to offer 10 beds (from the totality of 70 across Clifton and Rawreth) in Clifton and Rawreth (five in each) exclusively to the south east as step up/step down beds. The aim being to prevent as many people from the south east as possible being detained in Thurrock Meadowview ward. The beds have had a low occupancy rate overall since Maple Ward closed; one person has moved to Meadowview at the family's request because of their local connection to Thurrock and twelve other people have not needed to be assessed and detained in Meadowview due to the use of the step up beds.

3.4 The infographic below shows the rise in people with Dementia in South East Essex over the next 15 years. The person standing on top represents the current service. As shown, if the number of people with dementia rises as expected, the current service will not be able to safely manage and support the number of people with dementia. The growth numbers indicate that the number of people with dementia is likely to increase up to 4 times the current rate. The business case introduces a smarter model with a more diverse range of skilled staff which will enable the service to safely support the increase in demand for the service at a lower cost.



3.5 The above is also inextricably linked to two other pieces of work:

- The requirement to develop St Luke's primary care centre through NHS England capital funding (circa 1.5m).
- The requirement to address pressures on adult mental health beds across south Essex and the impact this is having on both their treatment and wellbeing.
- Updates on all can be found in section 4.

4 Update

Detail from paper to Scrutiny & Council in October 2018	Update
Facilitate the improvement of St Luke's Primary Care Centre. Thus enhancing facilities and access to primary care in Southend. Opportunity to increase the current list size by approx. 4,000 patients from its current 6000 to 10000.	All is going ahead and work currently taking place. Plan for a new GP surgery to be operating from the new site in Feb 2020.
Move intermediate care beds from CICC to Maple ward at Rochford hospital. This will increase the capacity for intermediate care provision from 16-22 beds across south east Essex.	Increased capacity is very helpful and being utilised. Facility is modern, bigger and can accommodate bariatric patients (the former CICC site could not do this).
Move existing south east Essex dementia care assessment beds from Maple ward to Meadowview Ward at Thurrock Community Hospital in Grays. As these patients have an urgent need for specialist assessment and treatment they need to be formally detained under the Mental Health Act, and that means they need to be Admitted to hospital (and not any other such facility such as nursing or care home).	There has been a considerable reduction in the numbers of people that have needed to access dementia assessment beds over the previous eleven months compared to numbers that were detained on Maple ward. The numbers that have been prevented using the beds across the south east in Meadowview is 19 over the 11 month period. This has been due to the use of the step up beds available in Clifton and Rawreth and gatekeeping by the Dementia Intensive Support Team. Further information about the proposed Dementia Community Support model can be found in section 5 of the report.

5 Proposed Dementia Community Support Model:

5.1 As a system we are driving through changes that put the person and their families at the centre of their care. The premise is wellbeing and living longer and more fulfilling lives in the community for as long as possible. We want to manage rising risk, take a preventative approach and avoid crisis by deploying resources pro-actively. The desire includes the mobilisation of all the assets at our disposal

(within Local Authorities, Health and 3rd Sector) which can be used to engage communities and empower a supportive functionality.

5.2 The opportunity to test in the south east arose in November 2018 due to a requirement to reconfigure dementia inpatient beds in order to provide additional mental health beds. A small augmentation to the South East Essex Dementia Intensive Support Service, alongside operationalising the proposed integrated model and new ways of working resulted in significant reduction in admission to dementia beds.

5.3 The new model is a culmination of work that has been taking place in the south east as well as the clinical group chaired by Dr Garcia. The south east has a good reputation for dementia services. This began with a series of public and stakeholder consultation engagement events; followed by system checks such as EQUIP, clinical tasking of diagnosis, running the Dementia Quality Toolkit (DQT) in practices; plus a number of test and learns of different scale and magnitude. Examples can be found on page 7 of the business case.

5.4 During the last nine months the Dementia Intensive Support Team (DIST) have developed a strong working relationship with Day Assessment Unit (DAU) and SWIFT (physical health community support team) to help support the admission avoidance process.

5.5 The new model in the south east comprises of the following principles:

5.5.1 Easy access, no wrong door approach to our service, pre, peri and post diagnosis through to end of life.

5.5.2 The service wraps around people living with dementia and their carers, empowering and enabling them to live the life they would like with their diagnosis.

5.5.3 The service is driven by and directly influenced by the voices, experiences and opinions of people with dementia and their carers.

5.5.4 The emphasis is on identifying rising risk and enhancing positive risk taking rather than reacting to a crisis response. This compliments the strength based approach that we promote as a team.

5.5.5 Services are responsive, appropriate, integrated with whole locality systems and provide right care, right place and right time interventions and support.

5.5.6 Where inpatient care is required that it is planned, purposeful of optimal length and has clear value to the person admitted.

The Dementia Community Support Model:

5.5.7 **The Locality Teams** are aligned with each of the eight localities and nine Primary Care Networks. The locality team are the point of contact for the GP's, Practice staff and patients. All members of the locality team will have access to the same patient record system as GP's and the other services that wraparound the patient,

and all will be able to input into and update the dementia care plan. We aspire to work with PCN's as they develop to explore how they can complement the dementia locality offer. It is envisaged both will work closely together. On completion of a home assessment the locality team will bring the patient to MDT where further assessments and tests can be undertaken. After this the opportunity to discuss the diagnosis will be offered.

5.5.8 **Care Home Team** A Dementia Nurse Specialist leads in the care home team offering expert advice and supports the GP when diagnosing. Registered nurses can offer training and support to care home staff on site which will enable understanding of their clients; understand a response appropriately that can be challenging and identify rising risk. This will help reduce A&E visits and support the movement between care homes to enable people with dementia to have the best and most appropriate care. They will help develop care home multi-disciplinary team meetings with their dementia expertise and pick up a diagnosis of Mild Cognitive Impairment (this converts to a dementia diagnose in 1 in 3 cases). The Speech and Language Therapist supports care home staff with training on Dysphagia and practical help to improve the care for residents who need support and a swallowing/dysphagia plan to help them to live independently for longer. Locality Dementia Navigators also support the home to achieve dementia friendly accreditation and continue to support the care home staff with basic dementia training and education around environments and offering peer support for resident's families.

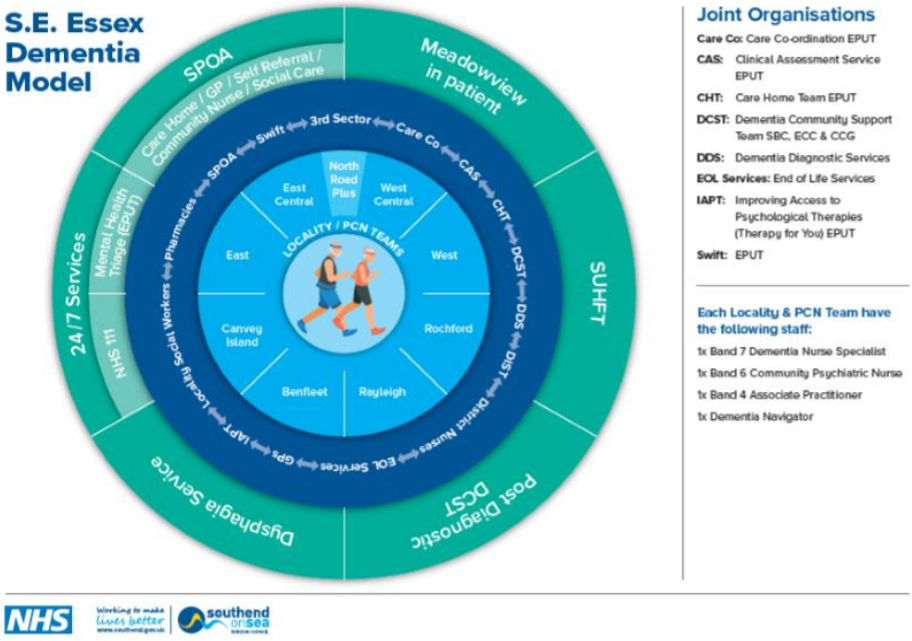
5.5.9 **Clinical Assessment Service** Offering a specialist assessment service for older adults not previously known to Mental Health services. It is an intermediate service that gives a greater level of clinical expertise in assessing a patient. This expertise ensures that individuals are referred efficiently and effectively into the most appropriate onward care pathway, including consultant lead secondary care services. The service consists of a Mental Health Nurse Practitioner, Community Mental Health Nurse and Community Support Workers to support comprehensive assessment and appropriate support in completing actions identified in assessment.

5.5.10 **SPOA (Single Point of Access)** Staffed with a Dementia (Mental Health) Nurse Specialist and an Associate Practitioner, this will provide a single access point to community dementia and older adult mental health services, triaging and passing to the appropriate team/team member. They will also offer advice and support to other professionals in SPOA in providing appropriate MDT responses to referrals.

5.5.11 **The Dementia Intensive Support Team (DIST)** work jointly with community health services, mental health, primary care, the acute trust and other agencies (including social services and ambulance services) to reduce unplanned emergency admissions to acute hospitals. The service operates from a community base but link directly with Southend University Hospital (SUHFT) A&E Department, DAU (Day Assessment Unit) and SPOA (Single Point of Access). The interventions offered by the Service are aimed at managing pre crisis and

enabling people with dementia and their carers to be supported in the community to avoid an unnecessary admission. Should people with dementia be admitted to SUHFT the service will support/facilitate early than usual discharge where able. The Dementia Navigator is also a part of the team, within SUHFT, attending board rounds and ensuring carer / family support is place where requested and onward referrals to the community Dementia Navigators are completed, ensuring a smooth transition between inpatient stay and community residence.

5.5.12 The visual below shows the narrative of the new model in an easy to understand diagram.



6 Financial

6.1 The funding for the new Dementia Community Model has been clinically approved at the CCG's Joint Clinical Executive Committee and at both Southend and Castle Point and Rochford Governing Body meetings. The model will be implemented from April 2020.

6.2 Pooled funding will also be explored with system partners.

6.3 There is an expectation that the model will save costs across the system and over the next six months, before implementation, we will identify practice level activity and associated costs to baseline these figures. Numbers will be baselined across localities/Primary Care Networks.

7 Clifton and Rawreth Lodge Beds

7.1 Five beds have been made available at Clifton Lodge (and the same at Rawreth Court). This was an assurance given to Full council in Southend in November 2018. These beds have been ring fenced for south east patients as long as they are needed. They were intended to have two different uses:

Step Up - ability for people to use the Clifton/Rawreth beds as an opportunity to avoid assessment at Meadowview. A short stay that can monitor/treat behaviour that challenges/ meds review and carer respite. Plus assess if a longer stay is needed in a regular bed.

Step down - at the point at which patients can appropriately have their mental health act section removed they can be transferred to Clifton Lodge/Rawreth Court for any on-going treatment, monitoring and discharge planning.

7.2 The beds in Clifton and Rawreth have been very helpful as they have supported patients to have short term interventions that have enabled them to step up so they do not require use of the detention beds in Meadowview.

7.3 The number of ring fenced beds required in the south east moving forward can be reduced from ten to four. There have been, on average, 2, 3 or 4 used in any given month. This number will be reviewed on a regular basis to ensure the bed numbers meet the needs of the population. The first review will take place in six months and then regular quartlery reviews will take place from April 2020 when the new community model is introduced within the system.

7.4 The introduction of the new community model will enable people to have the right care and support in the community and the care home team will ensure that the person is getting the right level of support in their care home and are appropriately placed.

8 Reasons for Recommendations

8.1 There are many reasons why an enhanced community model is paramount, which include:

- Being able to pro-actively review patients so people with rising risk are monitored and not just those with the highest need.
- Growth of number of people likely to have a dementia diagnosis in the south east over the next 15 years.
- Supporting the integrated care plan; Co-ordinator of care role and regular dementia reviews.
- Increased risk of crisis, hospital admission (both acute and mental health) increased CHC funding, increased care home and care package usage.
- Increased carer stress due to reduced support and understanding of their unique role.

9 Workforce - Dementia Community Support Model

9.1 The south east Essex dementia teams have always had passionate and committed staff who are loyal. The team has consistently been fully staffed and whenever vacancies are advertised strong applications are received. The model we are planning to implement is innovative and cutting edge and national award finalists. Staff will be working with people in a preventative way which affords people a better quality of life in their community. We are assured that workforce will not be a risk that will prevent the new model being implemented and delivering the benefits as planned.

10 Consultation

10.1 There has been consultation over the last few years with public, patients and stakeholders regarding clinical and community services..

11 Outcomes/Benefits

11.1 The expected benefits of the new model are as follows:

- Introduction of an integrated care plan, incorporating both dementia and frailty that can be viewed and used across services and systems on SystmOne.
- Locality teams that align to Primary Care Network's to offer bespoke support to primary care.
- Locality teams will support rising risk and have integrated pathways with DAU, SWIFT and Complex Care Coordination.
- Locality teams will offer 'lifelong' support, advice and review; and are able to take the care coordination role.
- Reduced GP workload as less appointments are taken up by people living with dementia and their carers in GP surgeries and more people are seen by the dementia locality team.
- Better links to social care and ability for dementia nurses to implement packages of care.
- A better quality service for people with dementia that ensures they do not have to repeatedly tell their story and that there are fewer hand offs.

- Greater level of personalised support, advice and health promotion to carers.
- More support to care homes and GPs via a care home team.
- Reduced memory assessment pathway by introducing diagnostic phasing over a range of entry points to enable a better fast track diagnostic offer that enables quicker access to post diagnostic support.
- Established links to frailty.
- Delirium recognised, identified and treated faster.
- A 'watch and see' approach to Mild Cognitive Impairment (one third of cases converts to dementia) that ensures no one falls through the net.

12 Test and Learns

12.1 A number of test and learns have been tried across the system to test the new model and ways of working. They have proved successful and have been scaled up. Details of the test and learns can be found on page 7 of the business case.

13 Testimonial

13.1 *'We as a family have found the DIST team to be a amazing help to us, before they were involved in the care of my mum we were struggling to know what way to turn we had been to many appointments at the doctors and Private hospital appointments to try and get some help and get our foot on the ladder so to speak but had had no luck it was just taking so long and to be honest they won't very helpful.*
My mum had been confused and very aggressive for quite some time but we felt like it was getting worse and something needed to be done.
We've never had to deal with I'll health or doctors in the past so this was all new to us and very daunting.
Out of desperation and a last resort I ask for help on our local Facebook page as the situation was getting worse, and straight away Diane's name was being put forward. I texted her that evening and within minutes she was in contact with me and the ball was rolling.
Within days she was at my parents house having a meeting and sorting out a bad situation, and from that point on we've had so much help and support mum is on mediation now and although the situation will never get any better it's under control with the help of the DIST team (Tony and Diane).
I fill that they have become friends and I fill that I could call them at any time day or night and they would be there for my me, my mum or my family.
My mum was very nervous about seeing someone and facing the problems she has but she is so at ease with Tony and Diane especially Tony she has taken a liking to him and trusts what he tells her.
The DIST team have become a very important part of our life and we don't know where we would be without there care and support we are eternally grateful they go above and beyond and really do actually care.
Thank you so much.'

14 Legal Implications

14.1 None at this stage.

15 Equality & Diversity

15.1 An Equality Impact and Quality Impact assessment have been carried out.

16 Background Papers

The following papers have been considered and are included in the business case:

- Essex County Council Public Consultation
- South East Essex Locality Strategy
- 2050 and Transforming Together (one sider)
- Southend 2050 Roadmap summary
- Southend 2050 Five Year Road Map to 2023
- Wraparound Support Scenarios
- SEEMS slides
- Care Home Toolkit
- Dementia Friendly Primary Care Practice
- Domiciliary Care Food and Fluid Flow Chart
- Domiciliary Care Personal Care Flow Chart
- Domiciliary Care Toolkit
- Dementia Integrated Care Plan

HOPSC/35/19

Committee Health Overview Policy and Scrutiny

Date 9 October 2019

NORTH EAST ESSEX CCG – CONTRACT OVERSIGHT

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

Action required:

To consider:

(i) the attached report from North East Essex CCG on their contract oversight processes and monitoring;
(ii) any further reassurances or information required;
(iii) any common issues or challenges that may be extrapolated to other Essex CCGs.

Background

The HOSC Chairman and Lead Members have requested that the North East Essex CCG update the Committee on its contract oversight processes in light of the early cessation of certain contracts and have asked that the CCG repsonds to a number of advance questions as set out overleaf.

In February 2019 the HOSC were updated by North East Essex CCG on a number of issues including discussion about care navigation systems in primary care, using the GP surgeries operated by Anglian Community Enterprise around the Clacton Area as a case study. A link to the meeting papers for that discussion is here - HOSC 6 Feb 2019 - meeting papers. A number of concerns had been raised locally about the operation of the ACE care navigation system which had prompted the HOSC session in February and further questions were asked (as recorded in the minutes of that meeting).

At the end of July 2019 One to One Midwives contract for the North East Essex area was terminated and links to some media coverage relating to that follow.
https://www.esneft.nhs.uk/maternity-services-for-north-east-essex/
https://www.essexlive.news/news/one-one-midwifes-pregnant-women-3151562
http://essexbaby.co.uk/one-one-midwives-coming-essex/

Both the above contracts are referenced in the attached update from the CCG **(Appendix 1)** together (in a further appendix) with an update of the Care Closer to Home contract **(Appendix 2).**

Cont overleaf…..

The HOSC Chairman and Lead Members have specifically asked that the CCG address the following advance questions:

- What governance processes are in place for contract oversight?
- How is contract performance monitored to ensure quality and consistency of service? (e.g. Contractual provisions, commissioner/provider meetings, patient feedback and responding to issues raised etc).
- Using them as Case studies – what Lessons have been learnt from particular contracts (e.g. ACE, One to One Midwives, Care Closer to Home contracts)?
- Are you currently reviewing any of your current contracts (e.g. Care Closer to home)
- What system learning is there for lessons learnt from other CCGs and how share learning and info with them?
- Are any changes planned to modelling of future services?
- As there are differences between Essex and Suffolk commissioning models (e.g. community services and the care closer to home contract) - which is better and is any alignment between the two planned for the future particularly as a result of ICS strategies/plans?

APPENDIX 1

Report title: NEE CCG contract oversight

Report to: Essex Health Overview Policy and Scrutiny Committee (HOSC)

Report by: North East Essex CCG

Date: 9th October 2019

Background:

North East Essex CCG (NEECCG) has been asked to share an update on its contract oversight processes in light of the early cessation of three contracts. This paper sets out the contract assurance processes used by North East Essex CCG.

Key lines of enquiry:

1. What governance processes are in place for contract oversight?

At the outset of any commissioning exercise the CCG establishes the initial governance processes ahead of the formal contracting phase to ensure that the services commissioned are fit for purpose. This includes conducting a rigorous due diligence process as part of any procurement to ensure that providers meet sufficient quality, performance and finance standards before any contract is awarded. The CCG has also put in place additional assurance measures as a prerequisite for contract awards to protect public funds wherever possible; this includes agreeing parent company guarantees. Once a contract is awarded this is then subject to the contract oversight governance processes as set out below.

2. How is contract performance monitored to ensure quality and consistency of service? (e.g. Contractual provisions, commissioner/provider meetings, patient feedback and responding to issues raised etc).

The NHS Standard Contract is mandated by NHS England for use by commissioners for all contracts for healthcare services other than primary care services. As part of the governance framework this contract provides, the CCG has in place contract and quality review meetings with its providers to ensure that contract performance is regularly monitored. The meetings discuss a range of performance measures including key performance indicators, patient experience and feedback, patient safety issues and finance and activity trends. The contract meetings are managed by a matrix team of subject matter experts who attend and or inform the key lines of enquires for those meetings to ensure that any performance matters are challenged and addressed.

In addition to contract review meetings the contracts provide additional mechanisms to allow the commissioner to hold the provider to account, including Contract Performance Notices. Such notices provide an additional legal framework for compelling performance to be remedied and may result in financial sanctions where this is not achieved within an agreed timeframe.

The primary care contracts for the delivery of GP services have a different contract structure. However still provide the ability to manage the contracts via contract review meetings and using performance metrics. This ability is more overt within the APMS contracts (Alternative Provider Medical Services) than the General and Personal Medical Services (GMS and PMS),

which have less scope for local measures and do not compel reporting to the commissioner in the way an APMS contract does. The majority of GP contracts in North East Essex are GMS contracts.

3. Using them as Case studies – what Lessons have been learnt from particular contracts (e.g. ACE, One to One Midwives, Care Closer to Home contracts)?

ACE- Anglian Community Enterprise was awarded an APMS contract for Caradoc Surgery in 2016 by NHS England following a competitive procurement process. This was prior to NEECCG taking on delegated commissioning responsibility. In terms of learning therefore this is more focussed on the contract management post April 2017 when the CCG took on its delegated commissioner role.

Formal monthly contract meetings were held with the aim of detecting and managing any performance concerns. The NHS England contract had no specific KPIs which made the contract monitoring more challenging as there were no local performance metrics and limited reporting. As a result all future contracts have included performance metrics to provide early warning signals that performance may not be up to standard.

Most issues raised by patients related to the GP access Hub, which was the central appointment booking function for both Caradoc and the three other GP practices operated by ACE under a different contract arrangement.

The appointment of a new Accountable Officer has changed the approach to the contract management. Once serious concerns were detected and evidenced the CCG took decisive action to terminate the contract. The access issues relating to the GP Hub were subject to an improvement plan which was regularly scrutinised and monitored at Executive level. However ACE also faced considerable workforce challenges in recruiting to the practice, despite the use of different incentives. This recruitment deficit has been resolved by the Caretaker provider.

The CCG are aware via its recent due diligence process to appoint a caretaker provider for Caradoc Surgery that the primary care landscape has changed and there is now a more active market of interested providers amongst existing primary care providers and the emerging Primary Care Networks (PCNs). This is in vast contrast to market two to three years ago where there was limited interest in the GP contracts in North East Essex.

The CCG is currently working with ACE and local Clacton practices to agree by December the future leadership arrangements for the other three practices currently run by ACE.

One to One Midwives – NEECCG had a non-contract activity arrangement with One to One Midwives. Non-contract- activity or NCA is the term used to describe NHS-funded services delivered to a patient by a provider which does not hold a direct contract with that CCG but does with another CCG.

The One to One model was designed to offer choice to women about how and where they give birth. The Suffolk and North East Essex Integrated Care System (ICS) has recently produced a strategic maternity plan across Suffolk and NEE, which has been developed with system partners and is designed to deliver the national strategy for better births and offer a continuity of midwife model. This national model of care replicates the One to One Midwives model but on a larger and more sustainable scale. On that basis the CCG had not formalised its commissioning arrangement with One to One Midwives as its longer term strategy was to develop an ICS level model. The commissioners in North West England had also developed

strategies with their local acute trusts to transform their maternity services and as such had made the decision to serve notice on the One to One Midwives contract at the end of its contract term and re-tender the service. It is believed that this decision may have been the major factor affecting the sustainability of the service as this contract was the provider's only guaranteed source of income. The arrangement with North East Essex was commissioned without the guarantee of any activity or income, in a similar way to the any qualified provider contracts. The CCG does not believe the service was sustainable in Essex without the guarantee of the activity in the North West and therefore there was little mitigation the CCG could undertake to prevent the liquidation of the company.

4. Are you currently reviewing any of your current contracts (e.g. Care Closer to home)

All contracts are reviewed on a regular basis as part of the contract monitoring and in some cases annual negotiation processes. NHS England updates its terms and conditions annually and as part of the agreement of these new terms with providers, the key local provisions are also reviewed and potentially re-negotiated. This applies most pertinently to the key performance indicators, reporting requirements and service specifications. This ensures contracts are still fit for purpose and delivering the expected outcomes for the local population. However such reviews are not usually with the intent of terminating a contract.

The CCG is currently taking a more detailed joint review of the Care Closer to Home contract with ACE at the mid-point of the 7 year contract term. This is one of the CCGs contracts with a longer duration and at the time was an innovative prime contractor model that had not been used widely in the NHS. On that basis it was felt to be important to undertake a view of the contract's successes and challenges from both the commissioner and provider perspective to obtain shared learning and ensure that the contract remains sustainable for both parties.

5. What system learning is there for lessons learnt from other CCGs and how share learning and info with them?

The lead commissioner for the One to One Midwives contract was the Wirral CCG who has acted on behalf of the associate commissioners and NEECCG as a commissioner under a non-contract-activity (NCA) arrangement. NEECCG has been in active contact with the North West commissioners as part of the shared root cause analysis and learning. The lessons learned which are still in progress, will then be shared with the other commissioners across the Suffolk and North East Essex system. The commissioners in the North West, as the lead commissioners, are also expected to share their findings more widely.

The CCG has also used the NHS England Integrated Support and Assurance Process (ISAP) guidance, which is designed to provide an assurance process for novel or complex contracts, to risk assess it commissioning approaches. This guidance was developed nationally to provide the learning gained from the collapse of NHS contracts, including the Circle contract held by Cambridgeshire & Peterborough CCG.

6. Are any changes planned to modelling of future services?

The CCG undertakes an option appraisal before each major commissioning exercise to determine the appropriate commissioning model. This balances the risks and benefits of each model before a final decision is made. The CCG has commissioned a number of outcomes based contracts based on its Care Closer to Home strategy. However it has evaluated this approach and has recently opted for different models depending on the type of service, the value of the contract and the market interest. This has allowed for more successful tailored commissioning solutions that are sustainable for both the commissioner and the provider. The

NHS Long Term Plan also indicates that a change in procurement approach is being considered in regards to health services which may limit the need to seek extensive competition. The CCG is already working with its procurement advisors to develop its Alliance commissioning principles which reflect this guidance with the aim of reducing unnecessary and fragmented pathways and providing more integrated care solutions with its system partners.

7. **As there are differences between Essex and Suffolk commissioning models (e.g. community services and the care closer to home contract) - which is better and is any alignment between the two planned for the future particularly as a result of ICS strategies/plans?**

Suffolk was a pioneer in developing guaranteed income contracts with their acute Trusts, to ensure financial matters were concluded at the start of the year and therefore enable energy to be focused on transformation of services. North East Essex has also adopted this contractual approach with their acute provider. Suffolk has also pioneered the development of Alliances, built around working with local NHS and local government providers. They have successfully transformed community services through an Alliance of the two acute Trusts, the County Council and the CCGs. They are currently focusing on Mental Health services. The North East Essex Alliance is developing very positively and a review is underway concerning the Community Services contract.

APPENDIX 2

Care Closer to Home Review

20 September 2019

Background

- **November 2014:** CC2H Business Case designed to 'transform the delivery of physical, mental health and social care services across North East Essex over the next 7 to 10 years'
- **March 2015:** NEECCG and ECC commence procurement to co-commission the 7-10 year CC2H contract
- **April 2016:** 7(+3) year £240m (*over 7 yrs*) contract awarded to Anglian Community Enterprise (ACE) CIC
- **Summer 2019:** Tripartite agreement to review the 'fitness for purpose' of the CC2H contract, as currently cast

Rationale for Review

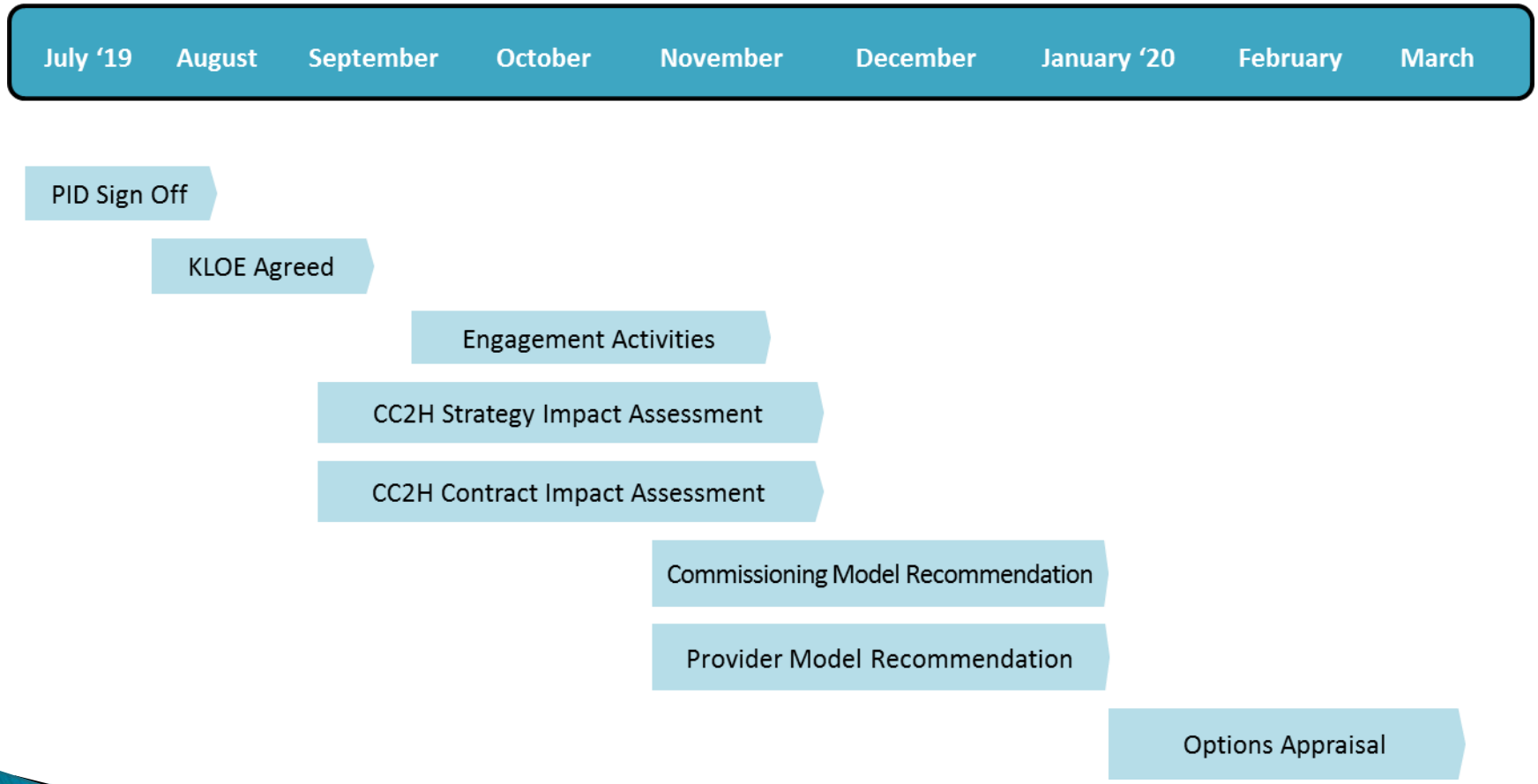
- 2019/20 represents mid point of the CC2H contract
- Reinvigorating community health services is core to the delivery of the *NHS Long Term Plan*, and, with funding to back it up, this represents a radical change in the strategic assumptions that have, to date, underpinned CC2H
- The *NHS Long Term Plan* is not looking for more of the same; whilst several features of CC2H anticipated the developing NHS landscape, the systemic approach to risk-bearing, and the introduction of Primary Care Networks, around which the *NHS Long Term Plan* expects community services to be increasingly organised, are potentially game-changing when considering the continuing fitness for purpose of CC2H
- The formulation, development and mobilisation during 2019/20 of the recently-endorsed *NEE Community Model* could have significant implications for the way community (physical and mental) health and well-being services in North-East Essex are run, none of which is enabled, nor indeed, was originally contemplated in CC2H

Review Objectives

- To identify what has worked well and what not so well, and why, under the existing CC2H contract from the perspectives first, of NEECCG and ECC (*qua* commissioners) and second, of ACE (*qua* lead provider);
- In the light of 1. above, and the goal of reinvigorating community health and well-being services identified in the *NHS Long Term Plan* and, in the context of the emerging NEE Community Model (including PCNs), to consider:
  - What, if any, modifications to the nature and/or scope of CC2H service requirements (including outcomes) should be made to render CC2H fit for future purpose for NEE; and
  - What, if any, modifications to ACE's service, operating, commercial and/or organisational model should be made to render CC2H fit for future purpose for NEE
- In the light of 2. above, to determine whether such modifications are acceptable to all three counterparties to the current CC2H contract and, if they are, to determine whether such modifications can be effectively and lawfully introduced by way of variation to the current CC2H contract between the three counterparties.
- If the co-commissioners, acting in their sole discretion, determine that modifications they believe are necessary can only be achieved via a new sourcing exercise, then they shall pursue such exercise, in accordance with relevant procurement law, enabled by both commissioners exercising Authority Voluntary early termination of the current CC2H contract. All extant rights and obligations of the three parties under the existing CC2H contract will remain intact in the light of such Authority Voluntary termination.
- In the light of the above, to determine what, if any, adverse consequential impact any modifications to the CC2H contract has on ACE's ability to discharge other NHS contract obligations and, if significant, to mitigate such adverse consequences.

Project Governance

Timeline


July '19
August
September
October
November
December
January '20
February
March
PID Sign Off
KLOE Agreed
Engagement Activities
CC2H Strategy Impact Assessment
CC2H Contract Impact Assessment
Commissioning Model Recommendation
Provider Model Recommendation
Options Appraisal

Key Lines of Enquiry: Looking Back

KLOE 1:01 Strategic Scope, Commissioning & Intent

- To what extent did the CC2H procurement reflect the aims of the CC2H strategy

KLOE 1:02 Bid Proposal

- To what extent did the bid meet the aims of the CC2H strategy

KLOE 1:03 Contractual Performance & Impact

- How have the CC2H services performed, both in terms of contractual performance and impact on individuals and the system
- What has influenced that performance, both internally and externally; and how does the contract benchmark against other community services

KLOE 1:04 CC2H Overarching Model Features

- To what extent have the intended 'features' of CC2H been delivered through procurement and contract delivery

Key Lines of Enquiry: Looking Forward

KLOE 2:01 National Context

- How do the priorities of the NHSLTP; learning from elsewhere; a greater focus on prevention and a population health approach need to be reflected in CC2H services in the future

KLOE 2.02: Local Context

- How will CC2H services need to work as part of the Community Model of Care and alongside Primary Care Networks and the new Urgent Treatment Services
- What do members of the public and strategic partners (including NEE HWB Alliance and Suffolk & NEE ICS) want for community health and wellbeing services in the future

Communication & Engagement

Engagement Activities will run for a period of 8 weeks from mid September:

Public Engagement

Public engagement activities will focus on the *Look Forward* element of the view. A range of engagement activities will create feedback opportunities in public places (e.g. inflatapods) and via established networking opportunities, including via Local councillors and MPs

Service User Engagement

Targeted service-user experience will be sought from known users of the CC2H services. Service-users will be asked to feedback both their experience of accessing a service and how they would like to see those services improved in the future. A letter will be sent (by ACE) to an agreed sample of CC2H service recipients who will be provided with postal, telephone and on-line ways in which to feedback. All of which will be directed to Healthwatch Essex.

Partners and Front-Line Staff

Health and Care partners and front-line staff (delivering CC2H services) will be asked to share their views via semi-structured interviews. These interviews will be undertaken on behalf of the CC2H Review by Healthwatch Essex

AGENDA ITEM 7

HOPSC/36/19

Committee Health Overview Policy and Scrutiny

Date 9 October 2019

SOUTHEND HOSPITAL – SITE VISIT

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

Recommendation:

To discuss and note the report on the site visit of Southend Hospital on 26 September 2019.

Four members of the Committee visited Southend Hospital on Thursday 26 September 2019. In addition, Councillors Anne Chalk, Beth Hooper and Lesley Salter from the Southend-on-Sea Borough Council People Scrutiny Committee also joined the visit.

Members spent the afternoon at the hospital hosted by Claire Panniker, Chief Executive and Yvonne Blucher, Managing Director, and other senior members of staff. There was an initial discussion with members of the hospitals' senior management team. Some of the key messages from the discussion:

- Preparations continued to complete the merger of Basildon, Mid Essex Hospitals and Southend Hospitals by April 2020;

- Pressures on A&E and the Emergency Care had exacerbated waiting times for elective care and outpatients' appointments and this was considered one of the most significant trends at the moment. As a result, the hospital was seeking a better balance between emergency and elective work.

- The hospital would be offering orthopaedic surgery at Braintree hospital to reduce pressures on the service being provided at Southend. Some other changes were also planned to relieve pressure on elective care.

- There were good levels of partnership working but in years to come the provision of health care would need to change with greater focus on prevention and care in the community and move away from A&E being thought of as first line of care.

- The Southend estate was not big enough and needed further investment. There had also been investment made in some refurbishment.

- When there were capacity pressures there now would be ‘system calls’ with partners to look to equitably carry the risk across the system with community and social care also involved in finding solutions. No longer would the pressure be just on the hospital.

- There was sharing of good practices across community and social care and looking to standardise practices where possible although there were some differences in discharge processes between local authority areas and between community providers.

- There was also work being done 'bridging the gap' to ensure safe discharge and that there was interim support available until a full support package was put in place.

STP plans – treat and transfer model

- All diagnostic, pre-and post-operative care would still be at local hospitals - only part of care pathway that was moving under the proposals was specialist inpatient care which was estimated to impact on about 15 patients a day.

- Patients would be stabilised at local hospital first and some initial treatment – then, if identified that needed /benefit from specialist care they will be moved to specialist clinical centre.

- Inter-hospital patient transfers: will be commissioning a transport transfer service that will be distinct from the East of England Ambulance Service ‘blue light’ service.

- Non-emergency family and friend transport was still being worked-up and its format largely would be dependent on demand. There were ongoing discussions with community transport providers and local bus companies.

Brexit

There had been a significant reduction in recruitment from Europe. A significant risk could be in care homes and the domiciliary care market where perhaps there is a larger proportionate of overseas workers. Hospitals are reliant on the out-of-hospital care market to help facilitate timely discharges.

Tour

Thereafter, members were given a tour of the hospital visiting a stroke ward, foetal medicine and maternity, High Dependency Unit, X-Ray and Radiology, Musco-skeletal and the Integrated Discharge Team.

AGENDA ITEM 8

HOPSC/37/19

Committee Health Overview Policy and Scrutiny

Date 9 October 2019

CHAIRMAN'S REPORT

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

Recommendation: To note the update (below).

The Chairman, Vice Chairmen and Lead Joint HOSC Members, usually meet monthly in between scheduled meetings of the full Committee to discuss work planning and this often entails talking to ECC and external health officers. This is the latest regular short report of these meetings. In addition, there are also meetings with the Cabinet Member for Health and Adult Social Care on a bi-monthly basis and quarterly meetings with senior officers.

Chairman and Lead Members' catch-up – Monday 23 September 2019.

Dementia pathways – conference call with CP&R/Southend CCG officers: discussed update on temporary reconfiguration of dementia beds from last year and improved community offer now proposed. Agreed: to be included on agenda for 9 October HOSC and include update on patient consultation and benefits for patients.

Conference call with Mid Essex CCG providing general update on some current work**:**

NEE CCG contract oversight item: Agreed to include on agenda for 9 October HOSC. Discussed format and advance questions to frame the briefing paper. Agreed to ask that they use ACE contract and One to One midwives as case studies (and update on review of Care Closer to Home).

Work programme
Agreed:

- Schedule STP/LTP update from all three STP footprints for November HOSC.
- Public Health on updated Deprivation Index to be scheduled for December.
- Primary Care and sensory services items to be pushed back.
- Contingency planning item – work to be done before scheduling a date.

AGENDA ITEM 9

HOPSC/38/19

Committee Health Overview Policy and Scrutiny

Date 9 October 2019

MEMBER UPDATES

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

Recommendation:
To discuss and note updates given by members.

The HOSC Chairman and Vice Chairmen have requested that there be a standard agenda item to receive member updates (usually orally but advance briefing papers can be included in agenda packs if preferred)

All members are encouraged to attend Board and other public meetings of their local health commissioner and providers and report back to the HOSC any issues of interest and/or relevance to the committee.

In particular, the HOSC members who serve as ECC representatives observing the following bodies may wish to update on their attendance at any recent meetings:

Councillor Anne Brown (North East Essex CCG)
Councillor Beverley Egan (Castle Point & Rochford CCG);
Councillor Andy Wood (Essex Partnership University Trust)

In addition, issues arising from the work of the Joint HOSCs established with (i) Suffolk and (ii) Southend and Thurrock respectively, should also be highlighted.

	AGENDA ITEM 10
	HOPSC/39/19

Committee:	**Health Overview Policy and Scrutiny Committee**
Date:	**9 October 2019**
Enquiries to:	**Name: Graham Hughes** **Designation: Senior Democratic Services Officer** **Contact details:** 033301 34574 Graham.hughes@essex.gov.uk

WORK PROGRAMME

Briefings and training

Further briefings and discussion days will continue to be scheduled on an ongoing basis as identified and required.

Formal committee activity

The current work programme continues to be a live document, developed as a result of work planning sessions and subsequent ongoing discussions between the Chairman and Lead Members, is attached (Appendix A). The most recent work planning discussion was undertaken in private session in December 2018 as part of an annual review exercise.

Joint Committees/Task and Finish Group activity

The Committee participates in two Joint Committees with neighbouring authorities as detailed on the second page of the Appendix to this report.

There is no Task and Finish Group activity at present.

Action required by Members at this meeting:

(i) To consider this report and work programme in the Appendix and any further development or amendments;

(ii) To discuss further suggestions for briefings/scrutiny work

Essex Health Overview, Policy and Scrutiny Committee
Work Programme as at 1 October 2019

Date	Theme	Topic	Theme/Focus	Approach and Next steps
9 October 2019	Quality and Transformation of Services	North East Essex CCG - contract management	Discussion on governance and oversight of performance of contracts.	TBC
9 October 2019	Capacity and financial sustainability	Move of mental health and other wards in South Essex and development of community care – *follow up*	HOSC formally consulted in October 2018. Endorsed the urgent temporary action taken. Future permanent service model expected later in 2019.	HOSC to be consulted as part of a full formal engagement process on the future permanent model for older people's dementia services.
6 November 2019	Quality and Transformation of Services	Sustainability and Transformation Partnerships/Integrated Care Systems	Development (and where appropriate implementation) of proposals, partnership working and responses to the NHS England Long-Term Plan.	TBC
4 December 2019	Community healthcare (prevention and early intervention)	Public Health	Updated Deprivation Index (as agreed at September 2019 HOSC meeting)	TBC
4 December 2019	Quality and Transformation of Services/Community healthcare (prevention and early intervention)	Primary Care	Dentistry/Opticians/Pharmacist update from NHS England	Introductory formal session – as agreed during December 2018 work planning discussions
4 December 2019	Quality and Transformation of Services/Community healthcare (prevention and early intervention)	Primary Care – *further follow up*	Contribution to wider system and the STP plans.	To review locality changes from finalised CCG plans and impact of NHSE Long Term Plan.
4 December 2019	Quality and Transformation of Services/Community healthcare (prevention and early intervention)	Sensory care pathways	Review accessibility to services and system working	TBC
February 2019	Capacity and financial sustainability	A&E pressures/ seasonal pressures/admissions avoidance – *further follow up*	Relationship between ambulance performance and hospital capacity pressures.	Follow up to November 2018 and July 2019 sessions/review of winter performance. Operational representatives to be present
TBC	Capacity and financial sustainability	Relocation of cardiology beds	Consultation on proposed service variation to relocate cardiology beds from Broomfield to Basildon Hospitals	Follow-up and feedback on temporary changes made over the winter period.
TBC	Capacity and financial sustainability	Princess Alexandra Hospital sustainability – *follow up*	Initial session in September 2018 looking at plans for capital funding of potential re-build.	Site visit at end of May. Any formal session TBC.
TBC	Community healthcare (prevention and early intervention)	Community providers – *follow up*	Previously looked at the broader role and contribution to wider system. Agreed to review local performance	on hold as may be covered under the discussions on the Long-Term Plan and link with primary care discussions
TBC	Quality and Transformation of Services/Community healthcare (prevention and early intervention)	Primary care – urgent care	Urgent care services update. NHS111 arrangements/out of hours arrangements.	TBC

Essex Health Overview, Policy and Scrutiny Committee
Work Programme as at 1 October 2019

To be programmed:

Date	Theme	Topic	Theme/Focus	Approach and Next steps
TBC	Specialist commissioning issues	Proposals and engagement on relocation of services in London	Details about public consultation launched re: Moorfields eye Hospital was noted at July 2019 HOSC.	TBC
TBC	Community healthcare (prevention and early intervention)	North East CCG – community bed	Further update on proposals impacting on Clacton and Harwich Hospitals	TBC
TBC	Quality and Transformation of Services	Hospital mergers	(i) Legal merger process. (ii) clinical services integration	Some work may be undertaken in Joint HOSCs.
TBC	Quality and Transformation of Services/Equity	Mental health – *follow up*	Partnership working, service changes, access to services. Full Committee reviews: Sept 2017 and April 2018.	Next steps tbc
TBC	Community healthcare (prevention and early intervention)	Hip fractures/Falls Task and Finish Group – *follow up*	Actions and recommendations arising	TBC
TBC	Quality and Transformation of Services	Patient feedback and concerns	Possibly analyse some complaints data and speak with patient forums and service user groups.	Suggested during work planning discussions as part of Annual review exercise in December 2019 - TBC

Work with the People and Families Policy and Scrutiny Committee (PAF)

Led/hosted by PAF	Community healthcare (prevention and early intervention)	Virgin Care 0-19 contract – *follow-up*	Two sessions held with HOSC representatives also present.	Further session summer 2020.
TBC	Quality and Transformation of Services	Autism services and awareness	Raised separately by both committees.	To be scoped in consultation with ECC officers. Joint introductory briefing to be arranged.

Essex Health Overview, Policy and Scrutiny Committee
Work Programme as at 1 October 2019

Sustainability and Transformation Partnerships (STPs) and development of Integrated Care Systems (ICSs)

Full committee

Date	Theme	Topic	Theme/Focus	Approach and Next steps (full committee unless indicated otherwise)
Ongoing	Quality and Transformation of Services	Sustainability and Transformation Partnerships	Seek evidence of joint working across footprints to transform quality of services. Development of Integrated Care Systems.	Joint HOSCs in two footprints continue to look at the detail of proposed service changes. Essex HOSC has high level governance and strategic oversight role.

Joint Health Overview and Scrutiny Committees (JHOSCs)

1. *JHOSC looking at the Mid and South Essex STP (Joint Committee with Southend-on-Sea Borough Council and Thurrock Council)*

   This Joint Committee was established to be the scrutiny consultee for a formal public consultation launched by the STP for various proposed service changes. At the time of this report being written the JHOSC had held four meetings in public and a number of private briefings. Joint HOSC agenda papers
   The JHOSC work programme paused as a result of the STP plans being referred to the Secretary of State by Southend-on-Sea Borough Council and Thurrock Council. The proposals have recently been endorsed by the Secretary of State. Discussions are underway about reconvening the Joint HOSC.

   Essex HOSC nominated JHOSC members: Cllrs Egan (Lead Member), Lumley, vacancy, vacancy (substitutes: Cllrs Chandler, Reeves and Reid).

2. *JHOSC looking at the Suffolk and North East Essex STP (Joint Committee with Suffolk County Council)*

   This Joint Committee was established in anticipation of a formal consultation being launched by the STP for various service changes. A number of public and private briefings have been held. The Joint Committee will be the formal consultee for a number of proposals being finalised by the STP/ICS. Joint HOSC Agenda papers

   Essex HOSC nominated JHOSC members: Cllrs Brown (Lead Member), Harris, vacancy, Wood (substitute: Cllr Erskine).

Hertfordshire and West Essex STP - There are no current joint health scrutiny arrangements with Hertfordshire County Council.