Essex County Council

Health Overview Policy and Scrutiny Committee

10:30	Wednesday, 22 May 2019	Committee Room 1, County Hall, Chelmsford, CM1 1QH

For information about the meeting please ask for:
Graham Hughes, Senior Democratic Services Officer
Andrew Seaman, Democratic Services Officer
Telephone: 03330 134574 or 03330 32177
Email: democratic.services@essex.gov.uk

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1	**Private Pre-Meeting, HOPSC Members Only** To be held at 9:30am in Committee Room 6, County Hall	
2	**HOPSC Membership**	4 - 5
3	**Membership, Apologies, Substitutions and Declarations of Interest**	6 - 6
4	**Minutes**	7 - 10
5	**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.	
6	**Appointment of Vice-Chairman** To invite nominations for the 2019/20 municipal year.	
7	**Recruitment update**	11 - 42

8	**North East Essex CCG - care navigation systems update**	**43 - 49**
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13 Date of Next Meeting

To note that the next committee activity day is scheduled for 9.30am on Wednesday 12 June 2019, in Committee Room 1, 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.

14 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.

15 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.

All Council and Committee Meetings are held in public unless the business is exempt in accordance with the requirements of the Local Government Act 1972. If there is exempted business, it will be clearly marked as an Exempt Item on the agenda and members of the public and any representatives of the media will be asked to leave the meeting room for that item.

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With sufficient notice, documents can be made available in alternative formats, for further information about this or about the meeting in general please contact the named officer on the agenda pack or email democratic.services@essex.gov.uk

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Should you wish to record the meeting, please contact the officer shown on the agenda front page

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

Full Council on 14 May 2019 agreed changes to various committee memberships including the Health Overview Policy and Scrutiny Committee (HOSC). The following changes have been made to the HOSC membership:

Main Membership:

Cllr Andy Wood and Cllr Dr Richard Moore are no longer on HOPSC.

Cllr John Moran and Cllr June Lumley have joined HOPSC

Substitutes:

Cllr June Lumley is no longer a substitute for HOPSC

HEALTH OVERVIEW POLICY AND SCRUTINY COMMITTEE (12)
(9 Con: 1 Lab: 1 LD: 1 NAG)

Anne Brown
Jenny Chandler
Beverley Egan
Ricki Gadsby
Dave Harris
Bob Massey
Maggie McEwen
June Lumley
Jillian Reeves
Stephen Robinson
Colin Sargeant
John Moran

Conservative Subs:
Alan Goggin
Mike Steptoe
Labour Sub:
Patricia Reid
Liberal Democrat Sub:
John Baker
NAG Sub:
Vacant

The HOSC has up to four co-opted non-voting places to offer to borough, city and district councils in Essex whose administrative areas are not represented from amongst the twelve county councillors serving on the Committee. These places offered are for the duration of the municipal year and are subject to review each year in May to coincide with membership changes arising from the May meeting of Full Council.

An analysis of the borough/district council administrative areas represented by the updated substantive HOSC membership will be undertaken soon after Full Council and appropriate invitations issued to local councils not represented. The HOSC will be further updated at its next meeting in June 2019.

Recommendations:

To note

1. Changes to the substantive Membership as shown on the previous page.

2. The approach detailed above to offer co-opted non-voting membership to up to four borough/district councils for the 201/20 municipal year.

3. Apologies and substitutions.

4. Declarations of interest to be made by Members in accordance with the Members' Code of Conduct

Agenda item 3

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	
Councillor R Gadsby	
Councillor D Harris	
Councillor J Lumley	
Councillor B Massey	
Councillor M McEwen	
Councillor J Moran	
Councillor S Robinson	
Councillor C Sargeant	

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 6th March 2019

Present:

County Councillors

J Reeves (Chairman)	R Moore
A Brown	S Robinson
J Chandler	C Sargeant
B Egan	M McEwen
D Harris	P Channer (Substitute)

Co-opted District/Borough Councillors
T Edwards (Harlow)
V Ranger (Uttlesford)

Graham Hughes, Senior Democratic Services Officer, and Andrew Seaman, Democratic Services Officer, were also present in support throughout the meeting.

1. Membership, Apologies, Substitutions and Declarations of Interest.

Apologies had been received from district councillors R Gadsby, J Lumley, B Massey (For whom Councillor Channer Substituted), P Tattersley.

The following Cllrs declared an interest:

Cllr 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.

2. Minutes

The Minutes of the meeting of the Health Overview Policy and Scrutiny Committee (HOPSC) held on 6th February 2019 were approved as a correct record and signed by the Chairman.

3. Questions from the Public

There were no questions from the public.

4. Recruitment Issues

The Chair introduced the Panel and it is noted that Patrick Higgs is currently Acting Director of Commissioning. The committee considered report HOPSC/08/19, this is for further updates following updates from the 16 January.

Present at the meeting were:

Patrick Higgs, Acting Director of Commissioning, Essex County Council (ECC)
Phil Carver, Local Director East of England, Health Education England (HEE)
Anzhelika Coffey, Head of Workforce Intelligence, Health Education England
Gareth George, Workforce Transformation Manager, Health Education England
Saffron Rolph-Wills, Workforce Transformation Manager, Health Education England

During the discussion the following was acknowledged, highlighted and/or noted:

(i) With a 29.7% vacancy rate the Occupational Therapist (OT) role was questioned. It was mentioned that the role does add value particularly in promoting early intervention and prevention and so the objective is to sell the role and increase recruitment.

(ii) North Essex is struggling to get OT's whereas South Essex does not but struggles to get Social Workers. The University of Essex provides OT courses.

(iii) It was noted that a lack of context in terms of time scale, hitting target and being able to ask, 'are we improving?' raised the concern that there needs to be more chronological data to provide evidence of progress.

(iv) Changes in proportions has had an influence on figures. There had been some workforce restructures which made direct historical comparisons more difficult.

(v) Currently testing models to find out which works best to recruit, and it is important to work in partnership. There was confidence that budgets are not the main challenge to recruitment.

(vi) General practice workforce figures - research has shown that this has not provided the satisfied support required. The reduction in GP numbers is a concern and is due to the age profile of people in this role. They are currently looking at initiatives such as using paramedics to do home visits. There was a growth in other direct patient care staff (e.g. clinical pharmacists) to provide further support to, and relieve pressure on, GPs.

(vii) It is acknowledged the increased housing is an issue and further pressure. The development of a medical school at Anglia Ruskin University was critical in preparing for this.

(viii) It is recognised that there are more females becoming GPs and that the impact on them becoming part time to start families etc is noted. STPs use a tool to help predict the part time ratios to help plan for future workforce changes.

(ix) It is a growing trend for GPs to work part time. Figures will be provided with a breakdown; an increasing trend was for GPs to become locums rather than partnership roles.

(x) Mentioning what support is being provided for GPs opening as a business - They spoke about how retired GPs are continuing to give support through training and being part time.

(xi) Overall there has been an increase in workforce numbers, but this may not be clear due to other factors.

(xii) It was noted how do the working conditions affect retention/recruitment - though they are developing learning environments. At first it is seeing/developing the organisation holistically, that sells the roles. And only further down the line that the working conditions become a factor on a career.

(xiii) A point was raised that there is a gap of circa 250-300 GPs in Essex, however, it was countered by the witnesses that, though this is the gap, technology advances could mean that less GPs are needed in future.

(xiv) It was highlighted, that CCGs as well as NHS England outline the scope of their needs and it is the providers that generate the workforce plan.

(xv) Turnover is higher than usual which is affecting vacancy numbers. The independent work force costs more money which may suggest why they are spending the budget while still having a higher vacancy rate that is above ECC 7% vacancy rate factor.

(XVI) A 2018 organisational redesign at ECC had moved the balance of social care staff towards a 70/30 split between qualified and unqualified staff.

xvii) ECC had also introduced senior and practitioner posts to offer more (non-manager) career progression.

(xviii) Agency costs were being pulled down with health organisations increasingly collaborating and using only certain agencies and exerting influence on their charge rates.

(xix) HEE had been allocated 332 trainee places to fill each year in the region and approximately a third were for Essex.

Conclusion
The Chairman thanked them for their attendance and noted that it gave a good insight. From this:

(i) A breakdown on the number of GPs working part-time. In addition to the figures as at now there will need to be trend analysis. And where possible the breakout numbers that have converted to part time from full-time as opposed to those that were appointed part-time to begin with.

(ii) Breakdown on GP retainers – particularly in relation to impact on overall capacity, staying on and/or work continuing to work part-time and full-time.

Meeting adjourned 12:28 - Resumed 12:38

5. Chairman's Report

The report (HOPSC/09/18) was noted and there will be a meeting on the 7th of March to discuss various matters.

6. Member Updates

- There would be a Joint HOSC meeting in Colchester with Suffolk Councillors, on 13 March 2019.

Members discussed:

- What mechanism does this committee want when it comes to feedback from the Councillors serving on the CCG boards, acute trusts and other providers.

- Consulting the cabinet member on such a mechanism and criteria for appointments.

7. Work Programme

The Committee considered and noted report HOPSC/11/19.

8. Date of the Next Meeting

The committee noted that the next committee activity day was scheduled for 09:30 on Wednesday 10 April 2019.

9. Urgent Business

There being no further business the meeting closed at 12:50.

Chairman

AGENDA ITEM 7

HOPSC/12/19

Committee Health Overview Policy and Scrutiny

Date 22 May 2019

RECRUITMENT ISSUES AND WORKFORCE TRANSFORMATION IN HEALTH AND SOCIAL CARE – FOLLOW UP

Report by Graham Hughes, Senior Democratic Services Officer

Contact details: graham.hughes@essex.gov.uk Tel: 03301 34574

Recommendation:

(i) To consider the further information presented and discussion on recruitment and vacancies;

(ii) To consider any remaining issues warranting further work which could focus on specific sectors, providers, job roles or other aspects.

Background

The original suggested HOPSC rationale for looking at recruitment issues and challenges and the outcomes required was as follows:

Seek assurance that the challenges and issues have been recognised and defined at both local, sector and more strategic levels (STP/ICS footprints).

Seek reassurance that there is adequate planning in place to address current shortages (recognising that it may not be possible to resolve solely by recruitment actions).

To seek reassurance from, and understanding of, the different levels of planning and actions being taken.

To understand if there remains certain issues and challenges that cannot be resolved and understand why.

To decide if, as a HOPSC, there is any influence or actions that the HOPSC can have/take to facilitate actions being taken.

To understand if, as local representatives, there a role for HOPSC members to promote careers in Health and how can this be done.

1. On 16 January 2019 the Committee discussed the scale of the problem and specific challenges, and the structures and partnerships that have oversight of the issues with representatives from each the three Local Workforce Action Boards (that oversee each of the three STP footprints in Essex), Health Education England and Essex County Council. A link to the meeting papers is here HOSC 16 January 2019 meeting papers .
   An extract of the minutes of the discussion is attached as **Appendix A**.

2. On 6 March 2019 the Committee discussed further data which broke down vacancies by sector, type of provider, and type of job designation with some trend analysis with Essex County Council and Health Education England. A link to the meeting papers is here HOSC 6 March 2019 meeting papers
   An extract of the minutes of the discussion is attached as **Appendix B**.

3. The March meeting requested further information from Health Education England specifically breaking down the number of GPs working part-time, with some trend analysis, including those who had converted to part time from full-time as opposed to those that were appointed part-time to begin with, and provide a breakdown on GP retainers – particularly in relation to impact on overall capacity, staying on and/or work continuing to work part-time and full-time. HEE have prepared a response and this is attached as **Appendix C**.

4. The HOSC Chairman and Lead Members subsequently agreed that the next step should be that commissioners be invited to explain their role in determining workforce levels. To reflect that health and wellbeing challenges and health inequalities significantly vary across areas, commissioners have been requested that, as a minimum, a commissioner representative from each STP footprint should be present who can cover these divergent areas and issues.

5. It was agreed to request commissioners to respond to the following within an advance briefing paper:

   (i) To what extent are commissioning decisions (and thereby staffing allocated for those services) determined solely by financial and budgetary considerations?

   (ii) What part do nationally (or locally) defined KPIs have in influencing the staffing resource allocated to a service? Are there any other quality considerations that influence staffing levels?

   (iii) To what extent does the Essex Health and Wellbeing Strategy determine local priorities and resources allocated to specific services or are there other overriding considerations?

   (iv) To what extent do differing local health needs and health inequalities determine the staffing resource? E.g. does an area of deprivation have more staffing resource dedicated to it - more community and district nurses?

(v) When a commissioner draws up commissioning plans as part of each budgetary planning cycle what are the factors that influence staffing allocated by the provider?

(vi) To what extent does the provider have to agree the staffing resource allocated for a service with commissioners or is it entirely left with the provider to determine?

(vii) Can certain posts be left vacant (if unable to recruit) and not impact on patient safety or quality of service?

(viii) With the development of STPs, to what extent are resourcing decisions for Essex based services being taken across the border? [particularly applicable to the STP footprints with Hertfordshire and Suffolk]. To what extent are they staying with CCGs?

6. Responses received from commissioners are attached as follows:

(i) Essex County Council as commissioner for social care (**Appendix D**)
(ii) Mid and South Essex CCGs, North East Essex CCG, West Essex CCG consolidated report (**Appendix E**)

Next steps

In considering and seeking further clarification of the attached further data the HOSC may wish to consider any further investigation that it feels is necessary and which could include:

(i) Specific solutions being pursued locally and regionally including training and workforce initiatives;
(ii) Further type of provider, sector or STP level analysis;
(iii) the level and effectiveness of joint/partnership working possible in pursuing actions.

Some of the above may be undertaken by one or more the Joint HOSCs established with neighbouring authorities to scrutinise plans for specific STP footprints.

Further reading:

Kings Fund - Closing the gap - Key areas for action on the health and care workforce Overview - March 2019
https://www.kingsfund.org.uk/sites/default/files/2019-03/closing-the-gap-health-care-workforce-overview_0.pdf

In February 2019 the Health Foundation published its annual assessment of the profile and trends in NHS staffing in England – "A Critical moment: NHS staffing trends, retention and attrition" – a link to that report is below.
http://reader.health.org.uk/a-critical-moment

APPENDIX A

Extract of the 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 16th January 2019

5. Recruitment issues update

The Committee considered report HOPSC/02/19 providing an update on recruitment issues in Essex.

The following joined the meeting:

Phil Carver, Local Director East of England, for Health Education England, mid and south Essex STP Executive Sponsor Workforce Transformation, Co-Chair of mid and south Essex Local Workforce Action Board (LWAB)

Tricia D'Orsi Chief Nurse, Castle Point & Rochford CCG and Southend CCG, mid and south Essex LWAB

Paul Roche, Programme Director, Workforce, Herts and West Essex LWAB/STP

Lisa Llewellyn, Director of Nursing and Clinical Quality, North East Essex CCG, north east Essex LWAB/STP

Peter Fairley, Director, Strategy, Policy & Integration (People), Essex County Council.

Alexandra Green, Director for Local Delivery – West, Essex County Council and Deputy Director of Health and Care Delivery, Essex Partnership University Trust.

In turn each of the above witnesses was invited to briefly introduce the challenges around recruitment and retention in their respective areas.

During those overviews and subsequent discussion the following was highlighted, acknowledged or noted:

(i) There was increasing demand for services and an ageing demographic – for example there was an anticipated 7% and 10% growth in demand for adult social care and for those with Learning Disabilities respectively over the next three years;

(ii) There were difficulties in recruiting staff – shortages in GPs, nurses, social workers and occupational therapists were particularly highlighted;

(iii) Essex County Council had created an extra 50 occupational therapist posts - They currently had 35 occupational therapist vacancies in Essex;

(iv) Currently there was an oversupply of physiotherapists. There was an ongoing challenge to work differently with Higher and Further Education Colleges to encourage better balance of their course offers;

(v) High agency spends were incurred to cover vacancies and there was a broad system intention to reduce the use of locums and agency staff;

(vi) The need to improve staff retention within the wider health system;

(vii) The intention to upskill the workforce as part of career progression (e.g. investing in Healthcare Assistants to become nurses).

(viii) The new course being run at the Anglia Ruskin medical school would take time to 'bear fruit' due to the time required to complete the qualification. They had, however, achieved their target of recruiting 30% of the course complement from the local area.

(ix) Overall, there were approximately 4,500 medical trainees in the regional health system and their actual placements depended on medical specialism, and other local factors such as addressing health inequalities and the quality of the local learning environment and having suitable levels of supervision.

(x) Mid Essex Commissioners were encouraging GPs set to retire to continue practising. Commissioners were also moving towards 15 minute GP consultations as they felt many issues could be dealt with more effectively by having a longer initial consultation period.

(xi) All three STP areas were looking at investing in and trialling more care navigation initiatives and using different ways to re-signpost to alleviate pressure on GP surgeries.

(xii) The overall 12% vacancy rate in Essex was not significantly out of alignment with the East of England average of 11%. The East of England vacancy rate broadly tended to trend between 11.5%-12.5%. The total number of overall vacancies was growing in Essex as the total establishment (i.e. number of posts) had grown.

(xiii) Essex County Council was aspiring to reducing social care vacancies to 10% and the trend was moving in the right direction to meet that target. At the same time as reducing vacancies the County Council had expanded its workforce as well.

(xiv) The Essex Employment and Skills Board had identified the care sector for attention and identified some work streams to help improve recruitment.

(xv) Recruits from the European economic area were a significant contribution to the nursing workforce in particular.

(xvi) There were a number of ongoing initiatives with schools to promote careers in health and social care. E.g. work experience for 14-15 year olds at Harlow Hospital.

(xvii) The Local Workforce Action Boards were looking at developing more formalised arrangements for 'rotational' posts where staff could transition their careers through a framework of multidisciplinary work moving around different employers but staying within the local health system i.e. developing an 'Essex offer'. Similarly, the County Council and Health were looking at opportunities for more joint roles across health and social care.

Conclusion

The Chairman thanked the witnesses for their attendance to support the discussion. It was agreed:

(i) That more data be provided to breakdown vacancies (through stating number of posts that should be filled and how many are actually filled) by sector, type of provider, and type of job designation. To show context, there should also be some trend analysis.

(ii) That a breakdown be provided of the destination of the 200 GPs who completed training each year. i.e. whether they remained in primary care and whether it was within Essex.

APPENDIX B

Extract of the Minutes of the meeting of the Health Overview Policy and Scrutiny Committee held in Committee Room 1, County Hall, Chelmsford, CM1 1QH on Wednesday 6 March 2019

4. Recruitment Issues

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Present at the meeting were:

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numbers is a concern and is due to the age profile of people in this role. They are currently looking at initiatives such as using paramedics to do home visits. There was a growth in other direct patient care staff (e.g. clinical pharmacists) to provide further support to, and relieve pressure on, GPs.

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(xiii) A point was raised that there is a gap of circa 250-300 GPs in Essex, however, it was countered by the witnesses that, though this is the gap, technology advances could mean that less GPs are needed in future.

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(XVI) A 2018 organisational redesign at ECC had moved the balance of social care staff towards a 70/30 split between qualified and unqualified staff.

xvii) ECC had also introduced senior and practitioner posts to offer more (non-manager) career progression.

(xviii) Agency costs were being pulled down with health organisations increasingly collaborating and using only certain agencies and exerting influence on their charge rates.

(xix) HEE had been allocated 332 trainee places to fill each year in the region and approximately a third were for Essex.

Conclusion

The Chairman thanked them for their attendance and noted that it gave a good insight. From this:

(i) A breakdown on the number of GPs working part-time. In addition to the figures as at now there will need to be trend analysis. And where possible the breakout numbers that have converted to part time from full-time as opposed to those that were appointed part-time to begin with.

(ii) Breakdown on GP retainers – particularly in relation to impact on overall capacity, staying on and/or work continuing to work part-time and full-time.

AGENDA ITEM

HOPSC/xx/19

Committee Health Overview Policy and Scrutiny

Date 22 May 2019

Report from: mid and south Essex; and Suffolk and north east Essex CCGs

Report Sponsors:

Caroline Rassell – Accountable Officer, Mid Essex CCG

Tricia D'Orsi – Chief Nurse, Castle Point & Rochford CCG and Southend CCG

Ed Garrett – Accountable Officer, Suffolk and North East Essex CCGs

Lisa Llewelyn – Director of Nursing and Clinical Quality , North East Essex CCG

Key Lines of Enquiry

To understand where and how staffing levels are determined, including identifying the contribution of key performance indicators, financial and budgetary pressures, and commissioning strategies to those levels:

KLOE	Response
What are the differing roles and influence of commissioners and providers in determining workforce levels?	A commissioned service will be staffed by the provider dependent on the needs of the services that are to be delivered. Service specifications are negotiated and will include appropriate agreed staffing levels. It should be noted that ultimate responsibility of workforce skill-mix will be dependent on the ability of the provider to provide a quality service measured through national and local quality outcomes and measures. The move towards outcome-

KLOE	Response
	based contracts will mean less focus on prescriptive staffing numbers, enabling a focus on measurable outcomes provided by a multi-disciplinary team.
To what extent are commissioning decisions (and thereby staffing allocated for those services) determined solely by financial and budgetary considerations?	Although value for money is an important aspect of commissioning decisions this can never be to the detriment of quality of care provision. All commissioning cases are underpinned by quality frameworks informed by Quality Impact Assessments with a focus on many factors including appropriateness of staff to provide safe services.
What part do nationally (or locally) defined KPIs have in influencing the staffing resource allocated to a service? Are there any other quality considerations that influence staffing levels?	Nationally, there are quality metrics that inform local commissioning. ***Extract from the National NHS Standard Contract:*** National Quality Requirements and Local Quality Requirements 36.27 Subject to SC36.28, if the Provider breaches any of the thresholds in respect of the Operational Standards, the National Quality Requirements or the Local Quality Requirements the Provider must repay to the relevant Commissioner or the relevant Commissioner must deduct from payments due to the Provider (as appropriate), the relevant sums as determined in accordance with Schedule 4A (Operational Standards and National Quality Requirements) and/or Schedule 4C (Local Quality Requirements). The sums repaid or deducted under this SC36.27 in respect of any Quarter will not in any event exceed 2.5% of the Actual Quarterly Value. All NHS STANDARD CONTRACT 2019/20 SERVICE CONDITIONS (Shorter Form) SERVICE CONDITIONS 2019/20 NHS STANDARD CONTRACT (Shorter Form) 16 36.28 If the Provider has been granted access to the general element of the Provider Sustainability Fund, and has, as a condition of access: 36.28.1 agreed with the national teams of NHS Improvement and NHS England an overall financial control total and other associated conditions for the Contract Year 1 April 2019 to 31 March 2020; and 36.28.2 (where required by those bodies): 36.28.2.1 agreed with those bodies and with the Commissioners specific performance trajectories to be achieved during the Contract Year 1 April 2019 to 31 March 2020 (as set out in an SDIP contained or referred to in Schedule 2G (Other Local Agreements, Policies and Procedures));and/or

KLOE	Response
	36.28.2.2 submitted to those bodies assurance statements setting out commitments on performance against specific Operational Standards and National Quality Requirements to be achieved during the Contract Year 1 April 2019 to 31 March 2020 which have been accepted by those bodies (as set out in an SDIP contained or referred to in Schedule 2G (Other Local Agreements, Policies and Procedures)), no repayment will be required to be made, nor any deduction made, in relation to any breach of any threshold which occurs during that Contract Year for which such financial control totals and specific performance trajectories have been agreed and/or such assurance statements have been submitted and accepted in respect of any Operational Standard shown in bold italics in Schedule 4A (Operational Standards and National Quality Requirements). Methodologies such as Care Hours and Safer Staffing levels inform providers as to the required workforce mixes that should be operating within their services. This work is led by the Chief Nurse in NHSI.
To what extent does the Essex Health and Wellbeing Strategy determine local priorities and resources allocated to specific services or are there other overriding considerations?	CCGs are responsible for commissioning healthcare including mental health services, urgent and emergency care, elective hospital services, and community care. There is a balance between nationally set priorities (eg as set out in the NHS Constitution and the NHS Mandate), and local priorities. All members of the health and wellbeing board own the health and wellbeing strategy and as members of the Board, CCGs are extremely supportive of the strategy. Its central aims of improving mental health and wellbeing, addressing obesity, reducing health inequalities and supporting those with long-term conditions are core to the services we commission.
To what extent do differing local health needs and health inequalities determine the staffing resource? E.g. does an area of deprivation have more staffing resource dedicated to it - more community and district nurses?	The needs of a population will drive the commissioning position and providers will staff services accordingly. However, it is worth noting that many deprived areas find it difficult to recruit and retain staff as there is a perception that the demands of caseloads and client groups may make roles much more difficult to recruit to. All providers have a rolling programme of recruitment to fill workforce gaps to negate this risk

KLOE	Response
When a commissioner draws up commissioning plans as part of each budgetary planning cycle what are the factors that influence staffing allocated by the provider?	A commissioned service will be staffed by the provider dependent on the needs of the services that are to be delivered. Service specifications are negotiated and will include appropriate agreed staffing levels. It should be noted that ultimate responsibility of workforce skill-mix will be dependent on the ability of the provider to provide a quality service measured through national and local quality outcomes and measures. The move towards outcome-based contracts will mean less focus on prescriptive staffing numbers, enabling a focus on measurable outcomes provided by a multi-disciplinary team.
To what extent does the provider have to agree the staffing resource allocated for a service with commissioners or is it entirely left with the provider to determine?	It is part of a negotiated position before the commissioning case can progress, however, the provider will manage the staffing resource on a day-to-day basis.
Can certain posts be left vacant (if unable to recruit) and not impact on patient safety or quality of service?	A risk assessment would be undertaken and reasonable adjustments would be made with locum and agency staff to provide necessary cover. Regular assessment of caseloads and acuity are taken during the working day and staffing adjusted accordingly by the provider. If posts are to be removed this would be part of a consultation process led by the provider with its staff.
With the development of STPs, to what extent are resourcing decisions for Essex based services being taken across the border? [Particularly applicable to the STP footprints with Hertfordshire and Suffolk]. To what extent are they staying with CCGs?	Suffolk and North East Essex STP is made up of 3 CCGs, each commissioning services on behalf of their respective populations. CCGs have an obligation under the NHS Act 2006 to exercise their functions effectively, efficiently and economically. We ensure that the three CCGs are meeting this obligation by reviewing current working arrangements and identifying opportunities to collaborate. We are also working with local authorities to consider what opportunities there may be for joint commissioning in the future. While the NEE Health and Wellbeing Alliance work collaboratively with partners to meet the needs of our population, where it is appropriate we also commission collaboratively and share best practice with STP colleagues to better meet the needs of our population. e.g. pathology services; ambulance services.

Health Education England

Essex NHS and General Practice Workforce

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NHS Workforce in Essex

Health Education England

Staff in Post (SIP), Full Time Equivalent							Annual Change (SIP), %		
Broad Group	**Professional Group**	**Mar-16**	**Mar-17**	**Mar-18**	**Sep-18**		**Mar-17**	**Mar-18**	**Sep-18**
Professionally Qualified Clinical Staff	Doctors	2,575	2,595	2,695	2,695		1%	4%	0%
	Qualified nursing, midwifery & health visiting staff	7,570	7,565	7,430	7,040		0%	-2%	-5%
	Qualified scientific, therapeutic & technical staff	2,645	2,700	2,905	2,820		2%	8%	-3%
Support to clinical staff	Support to doctors & nursing staff	6,315	6,480	6,380	6,295		3%	-2%	-1%
	Support to ST&T staff	1,365	1,390	1,550	1,500		2%	12%	-3%
NHS infrastructure	NHS infrastructure support	4,040	4,195	4,210	4,105		4%	0%	-2%
	Total (including other staff)	**24,510**	**24,925**	**25,170**	**24,455**		**2%**	**1%**	**-3%**

Note:

Organisations included are Anglian Community Enterprise CIC, Basildon and Thurrock University Hospitals NHS Foundation Trust, Colchester Hospital University NHS Foundation Trust, Essex Partnership University NHS Foundation Trust, Mid Essex Hospital Services NHS Trust, Princess Alexandra Hospital NHS Trust, Provide, Southend University Hospital NHS Foundation Trust. Source: ESR DW

NHS Workforce Vacancies in Essex

Health Education England

Vacancies Filled with Temporaty Staff, forecast outturn as at March 2019, NHSI/HEE Workforce Plans Collection

Staff group	Bank and Agency Use, Full Time Equivalent	% of All Staff
Doctors	348	13%
Qualified nursing, midwifery & health visiting staff	1,154	17%
Qualified scientific, therapeutic & technical staff	128	6%
Support to clinical staff	1,043	15%
NHS infrastructure support	343	9%
Total (including other staff)	**3,016**	13%

Note: Vacancies data includes 5 organisations: Basildon and Thurrock University Hospitals NHS Foundation Trust, Mid Essex Hospital Services NHS Trust, Essex Partnership University NHS Foundation Trust, Princess Alexandra Hospital NHS Trust, Southend University Hospital NHS Foundation Trust.

General Practice Workforce in Essex (data includes 7 CCGs in Essex)

Health Education England

Staff group	Sep-15	Sep-16	Sep-17	Sep-18	Change % during period Sep-15 to Sep-18
All Admin Non Clinical	1,914	1,940	1,881	1,959	2.3%
All Direct Patient Care	267	289	363	405	51.5%
All Nurses	470	489	482	493	4.9%
GP practitioners	906	866	841	833	-8.1%
Total General Practice Workforce	**3,558**	**3,584**	**3,567**	**3,690**	**3.7%**

Note:
Source: NHS Digital collection of GP workforce;
numbers include 7 CCGs in Essex
GP Practitioners group includes GP providers, Salaried GPs, GP Retainers and GP Locums, excludes GP Registrars

Trainee General Practitioners

Health Education England

GP Trainees ST1-ST3, HC			
Date of Census	**Dec-16**	**Dec-17**	**Dec-18**
General Practice - Basildon	40	32	36
General Practice - Chelmsford	61	68	73
General Practice - Colchester	55	38	26
General Practice - Colchester and Ipswich	n/a	20	56
General Practice - Harlow	62	70	73
General Practice - Southend	63	60	61
Total	**281**	**288**	**325**
Source: HEE TIS database			

Forecast output of GP CCTs			
Calendar Year	**Year 2019**	**Year 2020**	**Year 2021**
GP CCTs	**107**	**106**	**104**
Note: year of output is based on Program Completion Date, does not take into account attrition during training			

GPs Participation Rate

Health Education England

Individual level staff in post statistics for GPs was published by NHS Digital (NHSD) for the first time in February this year detailing position for December 2018. This dataset allows to examine working patterns (part-time and full time) by age.

Key findings are as follows (Data tables are sown on the following page)

- As at December 2018 the seven CCGs in Essex submitted data for 1110 GPs in post, equivalent to 812 full time (Note this number excludes estimates for non-submissions, the total estimated FTE number as at December 2018 is 826 FTE)
- Of 1110 GPs, 387 GPs work full time (35%) and 723 GPs work part time
- The proportion of GPs working full time varies across age groups: GPs aged 31-40 have the lowest average proportion (32%) of GPs working full time (except for GPs aged 71+ with 27%) ; the proportion of full time GPs tends to increase with age. Young GPs under the age of 30 also have a higher propensity (35%) to work full time than those aged 31-40.
- The average participation rate for all GPs (full and part time) is 73%;
- The average participation rate for part-time GPs is 53%. Part time GPs under the age of 30 and those aged 51-60 contribute proportionately more hours (at the rate of 57%)

The trend data is scheduled for publication by NHSD at the end of April. This data will allow to examine changes over the period 2015 to 2018.

At present it is not possible to track those who converting from full time to part time work. Publication of further datasets with past years data is scheduled for the end of April 2019, analysis of this data will allow to identify GPs converting from full time to part-time work.

GPs Participation Rate

Health Education England

General Practitioners (GPs), Staff in Post: GP partners/providers, GPs salaried, GP retainers and GP locums

	Working Full Time	Working Part Time	Total GPs
Headcount	387	723	1110
Full time equivalent number	426	386	812

Headcount of Part Time GPs and Full Time GPs by Age Group

Age group	Full Time GPs, HC	Part Time GPs, HC	Total HC	% of GPs working Full Time
up to 30	7	13	20	35%
31-40	83	180	263	32%
41-50	120	231	351	34%
51-60	111	182	293	38%
61-70	56	76	132	42%
71+	10	27	37	27%
unknown		14	14	0%
	387	**723**	**1110**	**35%**

Average Participation Rate of GPs

Age group	Part Time GPs	All GPs
up to 30	57%	73%
31-40	54%	71%
41-50	55%	74%
51-60	57%	77%
61-70	48%	74%
71+	35%	58%
unknown	29%	29%
	53%	**73%**

Source: NHSD December 2018 position, provided data only, excludes estimates

GP Retainers

Health Education England

The numbers of GP retainers are small and volatile. As at December 2018 there were 3 Retainers within the seven CCGs in Essex , providing 1 full time equivalent of service. As GP data at the level of unique identifier is only available for December 2018 it is not possible to identify movements of GPs from other roles to retainer role and the resultant change to full time equivalent. As mentioned above, further data will be available in the future that will allow to examine trends more closely.

GP retainers, Staff in Post

	Sep-15	Sep-16	Sep-17	Sep-18	Dec-18
FTE	0.6	1.6	0.5	1.2	1.0
Headcount	1	3	1	4	3

NHSD Interactive Tool, data sourced: 27 March 2019

GP Retention Initiatives

Health Education England

- The Training Hubs across Essex (Mid and South Essex/North East Essex as part of Suffolk/NEE STP and West Essex as part of Hertfordshire and West Essex) were established to bring together all involved with education and training in Primary Care within a specified geography to: deliver and coordinate education and training, promote multi-professional learning, respond to and plan for local priorities and workforce needs, work across health and social care, support improvements in the quality of education, develop local education capacity and provide continued professional development.

- The benefits of the training hub enables Essex to attract, recruit and retain staff across the STPs to develop a sustainable workforce. The Training Hub provides a system-wide co-ordinated approach to delivering an integrated multi-professional workforce able to best meet the needs of its local population.

GP Retention Initiatives

Health Education England

- The Training Hubs across Essex are involved with some or all of the following programmes around attraction and recruitment of GPs and the wider workforce: Coaching 1:1 for GPs, Next Generation GP, an innovative development programme for GP Trainees and newly qualified GPs aimed at energising, engaging and empowering emerging GP leaders. Piloting 15 minute appointments, which provides more time for patients and greater satisfaction for GPs. The Single Point of Access initiative aims to provide GPs with clinical leadership and a 'go to' clinical lead. The Clinical lead acts as a champion to support identification and engagement with initiatives that will further support and develop retention of clinical staff. A dedicated telephone number and email account has been created for individuals to have an impartial discussion about their future aspirations.

- Network opportunities for GPs to work in a dual role (salaried GP and in a local provider e.g. acute trust or in the community). This is a unique opportunity to work at a strategic leadership level in a supported environment, providing mentorship and support from senior staff for one session per week.

GP Retention Initiatives

Health Education England

- To encourage return to work during maternity leave, there is a programme where GPs can work up to three sessions for a 12 month period as part of their maternity keeping in touch days. GP Fellowship programmes, a programme that provides additional support and development for newly qualified GPs or those in their first few years of practice. The Fellowship programme directly contribute to the transformation of the primary care workforce by supporting both the acquisition of clinical maturity in general practice and extended development in specific clinical or professional areas, furthering both local workforce capability and the career aspirations of the GP fellows themselves.
- In partnership with Essex Primary Care Careers, the Training Hubs have a dedicated website to promote Essex as a place to work for clinical careers, allied health careers, business management careers and medical careers. The Training Hubs arrange and participate in GP Trainee recruitment fairs. At the GP Trainee recruitment fairs, there are facilitated workshops e.g. improving CV and interview techniques, pensions and planning for the future, benefits of coaching and mentoring, introduction to portfolio careers. A scheme to directly re-introducing GPs back in to a primary care/ general practice setting following a period of absence and the GP Portfolio Career supports GPs early in their careers and returning back to work.

GP Retention Initiatives

Health Education England

- There are also international GP recruitment initiatives currently taking place across Essex with Mid and South Essex being part of the national programme

- 3-4 West Essex GP practices are collaborating to utilise the skills of a paramedic through a shared post. This post is providing increased resource to carry out homes visits freeing up GP time and providing effective care to patients.

- West Essex are part of the Hertfordshire and West Essex clinical pharmacy pilot to develop clinical pharmacists in primary care, a role that will enhance the service to patients and increase GP capacity.

How to request information from NHSD

Health Education England

- NHS Digital supplies information and data to the health service, provides vital technological infrastructure, and helps different parts of health and care work together.

- NHS Digital runs services which support the NHS. You can find information on the services which we run on this website, including information which solves most queries.

- If you cannot find the information you need about a specific service, our customer service centre may be able to help. We cannot help with enquiries about the wider NHS.

- Email enquiries@nhsdigital.nhs.uk or telephone us on **0300 303 5678**.

- The customer service centre is open 9am - 5pm, Monday to Friday, except on public holidays.

AGENDA ITEM

HOPSC/xx/19

Committee Health Overview Policy and Scrutiny

Date 22 May 2019

Report from: **Essex County Council Adult Social Care**

Report Sponsors:

Peter Fairley, Director for Strategy and Integration

Key Lines of Enquiry

To understand where and how staffing levels are determined, including identifying the contribution of key performance indicators, financial and budgetary pressures, and commissioning strategies to those levels:

KLOE	Response
What are the differing roles and influence of commissioners and providers in determining workforce levels?	ECC plays a role as both a provider and a commissioner. For example, we employ social workers to undertake Care Act assessments, and we also commission care placements for vulnerable adults. For the provider market, a commissioned service will be staffed by the provider dependent on the needs of the services that are to be delivered. Our contracts and service specifications include requirements around appropriate staffing levels in terms of skills and capacity. We do not specify the exact number of people that a provider needs to employ. For ECC, we establish our staffing requirement by reflecting a range of assumptions and data. For example, we factor in current and projected service user demand; assumptions around

KLOE	Response
	numbers of cases per worker, and reviews per week; and factor in a vacancy rate. We also make assumptions about the split between qualified workers and unqualified workers.
To what extent are commissioning decisions (and thereby staffing allocated for those services) determined solely by financial and budgetary considerations?	Finance plays a part, but the ability of a provider to meet assessed needs is key and service user choice is also an important factor. The prices we pay providers reflect an assessment of the cost of care, based around assumptions of skills and capacity of the workforce to meet care and support needs, as well as affordability for the council. Through our framework agreements for Live at Home services, the council sets out the prices that providers will access if we make placements off the framework agreement. These prices vary by area. Providers select a price for the area(s) they work in which will reflect their own cost base and profit margins.
What part do nationally (or locally) defined KPIs have in influencing the staffing resource allocated to a service? Are there any other quality considerations that influence staffing levels?	For ECC, we monitor several KPIs including assessments completed within 28 days, timeliness of reviews, DTOCs, and safeguards. We also factor in quality of staff morale, engagement survey, and manageable workloads. Any legislative requirements for the provider, will also influence staffing models, as do their obligation to meet Care Quality Commission (CQC) regulations.
To what extent does the Essex Health and Wellbeing Strategy determine local priorities and resources allocated to specific services or are there other overriding considerations?	ECC is extremely supportive of the Joint Health and Wellbeing Strategy. Its central aims of improving mental health and wellbeing, addressing obesity, reducing health inequalities and supporting those with long-term conditions are core to the agenda for adult social care that we enable people to live independently and to live well. Our strategy is about early intervention and prevention and we have set up teams in each locality with this focus. We also consider where we need to do things differently to make progress. One recent decision we have taken is to bring back in-house Approved Mental Health Practitioners to

KLOE	Response
	carry out assessments under the Mental Health Act 1983. This is dedicated team of 10 social workers.
To what extent do differing local health needs and health inequalities determine the staffing resource? E.g. does an area of deprivation have more staffing resource dedicated to it - more community and district nurses?	The needs of a population are factored in. For example, both population size and demand forecasts influence our staffing model. This means for example that West Essex has fewer staff than North because demand is higher in North. It is also worth noting that many deprived areas find it difficult to recruit and retain staff as there is a perception that the demands of caseloads and client groups may make roles much more difficult to recruit to.
When a commissioner draws up commissioning plans as part of each budgetary planning cycle what are the factors that influence staffing allocated by the provider?	Our specifications prepared to meet commissioning plans clearly identify the types of requirements from a staffing resource to meet the contract. In understanding our financial commitments to this, we work closely with colleagues from procurement and finance to model the costs associated with the specification. This reflects quality standards, safe practices and meeting any legislative requirements. This work produces an overall cost to inform the budget requirements for the contract, and in the specification, this informs the allocation of staffing from the provider. As an example under the Care Act 2014 we have several duties: 1) to ensure eligible need is met; 2) to prevent or reduce need where possible; 3) to ensure vulnerable people are safe; and 4) to ensure a diverse and sustainable care market. We also have duties in the event of provider failure. There is also other national policy that we expect to be adhered to e.g national living wage, health and safety policies etc. Our work with providers directly, in particular with the Essex Care Association, is a mechanism to understand specific challenges providers are facing workforce issues, including recruitment and retention. These factors are also used to inform each budgetary planning cycle.

KLOE	Response
To what extent does the provider have to agree the staffing resource allocated for a service with commissioners or is it entirely left with the provider to determine?	This is a matter for the provider.
Can certain posts be left vacant (if unable to recruit) and not impact on patient safety or quality of service?	For ECC, all posts are required in the structure but there is flexibility of turnover and vacancy rates. We use agency to fill gaps. Obviously front line roles are deemed higher priority than non-front line For providers, they will assess safe levels. There are occasions where packages of care are returned to ECC to re-commission when a provider does not have enough staff to support them. Providers will also, as will ECC, make use of the temporary/interim market to manage vacancies and staff requirements to ensure safety of people who use their services; together with deliver a quality service to meet CQC and ECC requirements.
With the development of STPs, to what extent are resourcing decisions for Essex based services being taken across the border? [Particularly applicable to the STP footprints with Hertfordshire and Suffolk]. To what extent are they staying with CCGs?	N/A.

HOSC/13/19

Committee Health Overview Policy and Scrutiny

Date 22 May 2019

North East Essex Clinical Commissioning Group – Care Navigation Systems

At the February 2019 meeting the Committee discussed the development of care navigation systems in primary care with representatives from North East Essex CCG and Anglian Community Enterprise. The latter had introduced a care navigation system in some GP surgeries in the Clacton area and this was used as a case study on which there was specific discussion on some issues arising from the introduction of that system. A link to the meeting papers is here February 2019 HOSC meeting papers .

An extract of the minutes recording the discussion at the February meeting is reproduced in **Appendix A** overleaf. CCG representatives agreed to provide a written response providing some further information as recorded in the minutes and reproduced below.

- Why was ACE the only bidder for the service?
- Had the CCG considered briefing the HOPSC any earlier regarding some if the issues with the introduction of the care navigation system?
- What would the CCG do differently if introducing similar care navigation systems elsewhere in future?
- What targets are being set for ACE?

The CCG response has been received in the form of a letter to the HOSC Chairman and is attached (**Appendix B**).

Councillor Brown will also be able to update the Committee on discussions at recent North East Essex CCG Board meetings on issues around the introduction of the care navigation system in the Clacton area.

Recommendation:

(i) To consider the further information provided by North East Essex CCG; and

(ii) Whether operating issues and challenges have been adequately recognised and mitigated and that lessons have been learnt for the development of other care navigation systems in the CCG area.

Extract of the minutes of the meeting of the Health Overview Policy and Scrutiny Committee held in Committee Room 1, County Hall, Chelmsford, CM1 1QH at 10.30am on Wednesday 6th February 2019

Agenda item 4

North East Essex CCG - Update

The Committee considered report HOPSC/05/19 providing an update on the following:

- Development of urgent treatment service – progress update (HOSC/05/19(i)
- Community Beds – status report (HOSC/05/19(ii)
- Use of Care Navigation Systems (HOSC/05/19(iii)

Present at the meeting were:

- Ed Garrett, Interim Accountable Officer, North East Essex CCG
- Morag Kirkpatrick, Interim Head of Urgent Care, North East Essex CCG.
- Chris Howlett, Programme Director, North East Essex CCG
- Jayne Hiley - Director of Operations and Quality, Anglian Community Enterprise.
- Dr Vaiyapuri Raja, Anglian Community Enterprise and practicing GP.

At the invitation of the Chairman, Councillor Harris led the member discussion on items 4(i) and 4(ii) below and Councillor Sargeant for item 4(c) below.

[Minute for item 4(i) and 4(ii) omitted]

(iii) Use of Care Navigation Systems

During the discussion the following was acknowledged, highlighted and/or noted:

(i) There were significant challenges facing Primary Care in the north east of the county with significant increases in demand exacerbated by recruitment issues.

(ii) The CCG was keen to focus on improving the signposting of services to further manage the demand pressures on GPs in particular.

(iii) The CCG was in discussions with the Local Medical Committee to look at extending GP appointment times

(iv) A care navigation system had been introduced for four GP practices in

Clacton to try and improve signposting people to the most appropriate service to address their need. Care algorithms were used by call handlers to assist signposting supplemented by on-site access to a GP, advanced clinical practitioner or off-site duty doctor.

(v) The care navigation system in Clacton was taking approximately 750 calls a day through 30 telephone lines as opposed to the typical 2-3 at individual GP practices elsewhere. A significant number of calls were prescription-related.

(vi) The CCG and provider were in the early stages of fully evaluating the care navigation system in Clacton although early evidence suggested it had assisted better signposting to services. Overall 90% of calls had been answered within 20 minutes and that situation had further improved in recent weeks. Early indications also suggested some GP time had been freed-up to allow for longer individual consultation times.

(vii) The CCG would continue to encourage further collaboration between different GP practices.

(viii) Local members suggested that there could be further improvements made to dispensing prescriptions and repeat prescriptions and further raise awareness about the importance of cancelling no longer needed appointments and how to do it. The provider was considering the introduction of text reminders for appointments.

(ix) It was mentioned that ACE was given a 10-year contract as this promotes stability for the provider to deliver effective change.

Conclusion:

The Chairman thanked those in attendance. The CCG was requested to provide written answers to the following questions raised by local members in connection with the care navigation system:

- Why was ACE the only bidder for the service?
- Had the CCG considered briefing the HOPSC any earlier regarding some if the issues with the introduction of the care navigation system?
- What would the CCG do differently if introducing similar care navigation systems elsewhere in future?
- What targets are being set for ACE?

APPENDIX B

Response to questions from HOSC regarding ACE:

1. ***Why was ACE the only bidder for services?***

13 suppliers registered an interest in bidding for the Clacton Alternative Provider of Medical Services (APMS) services when they were advertised at EU and national level. A market engagement event was held in July 2017 to seek the views of interested providers and to ensure that from the CCG's perspective there was an appetite for the CCG's vision in Clacton. Nine organisations attended the market engagement event.

One bid was submitted by ACE; and the evaluation of the Invitation to Tender (ITT) was undertaken in accordance with the following principles:

- A fair, open and transparent process
- Clearly stipulated evaluation criteria within the procurement documentation
- The weighted ratio of qualitative and quantitative criteria clearly set out within the procurement documentation
- Confidentiality was maintained throughout the Evaluation Process
- No conflicts of Interest were identified

2. ***Why was ACE given a 10 year contract (it was stated in the meeting that it brought some stability for the provider – were there any other considerations)?***

In north east Essex, the recruitment and retention of staff to work in primary care remains a challenge despite having numerous initiatives in place to attract GPs, nurses and other skilled primary care workers to come and work in our locality. The Clacton APMS tender process happened in 2017/18 in response to the previous GPs leaving the practices. Prior to being awarded the contract, the 4 practices, currently managed by ACE, were particularly challenged in recruiting GPs to permanent positions. Under the Standing Financial Instructions (SFIs) for the primary care delegation at the time, a maximum contract term of 5 years was permissible. However to effect true transformation of the service provision for the three registered patient lists; promote stability; and enhance the ability to recruit highly skilled and motivated practitioners to an area where there was and is a high level of health need and deprivation, a longer term contract was desirable.

Therefore a business case was submitted to NHS England to request an extended contract term of 10 years for the following reasons:

1. Economic and social deprivation
    a. High levels of deprivation with enduring health outcomes – longer contract to embed stability and investment
2. Delivery of an established workforce model
    a. Attracting, recruiting and retaining GPs; longer term job security and incentive to be involved in a longer term change programme; development of different workforce models focused to matching patient needs i.e. recruitment and training of advance nurse practitioners; clinical pharmacists; and emergency practitioners across the group of practices.

b. Strategic alignment with capital investment in the estate and GP Forward View (GPFV)
c. Sufficient time to embed new ways of working and aligning with GPFV and CCG's transformation strategy. Proposed contract term aligned with expiry date of the Caradoc APMS contract which would provide some flexibility in future to meet a GPFV aim to commission primary care at scale. As the biggest patient list in Clacton, the provider would have a leadership role in at-scale work and be able to build a model of care to attract GPs and other health care professionals.

3. Return on investment required by the preferred bidder
    a. Market engagement indicated that a contract less than ten years would not be of interest and a 5 year contract would not be economically attractive. Maximum value for money could be achieved over a longer duration with exit costs occurring once in ten years, with the capitated weighted payment tapering over that term to a local average. Savings made over a ten year term £2.8m

3. What consideration was there about bringing the care navigation pilot issues to HOSC earlier?

As stated previously, prior to being awarded the contract, the 4 practices, currently managed by ACE, were particularly challenged in recruiting GPs to permanent positions. To deliver the new service ACE has had to fill vacancies with locum GPs to work alongside other clinical staff, despite having an ongoing recruitment and retention plan in place. It was important that patients had access to a range of clinicians who can best meet their needs and clinical appointments available at these practices were used effectively and efficiently.

The Care navigation system, namely the telephone system, acts as a single gateway for calls into any of the 4 ACE primary medical service practices. The use of Care navigation at the front of house provides patients with a first point of contact which directs them to the most appropriate source of help. Through a process of care triaging, patients are initially assessed and directed to a clinician who can best meet their needs. This could be to a practice nurse, nurse practitioner, clinical pharmacist or a GP and the patients with the greatest clinical need are prioritised to see a GP.

Prior to the introduction of the telephone system by ACE, patients at several of the surgeries were queuing outside in the streets to book an appointment with a GP. Patients queued in all types of weather and did not always get to see the GP. The introduction of the Care navigation system was to provide patients with better access; reduce inequity; and avoid having to queue for long periods of time and in all types of weather.

Telephone triage systems have been piloted and introduced in a number of various health and care settings for some time and would not normally be something that is brought to the attention of HOSC

4. What would the CCG do differently if another GP provider group would look to introduce similar system elsewhere?

The learning from this transformation project has been extremely useful and ACE were pioneers in developing a single point of access for their GP services, which has mitigated the queues of patients waiting outside of the ACE practices before 8am.

If another GP provider group were to consider introducing a similar system, the CCG would ensure learning would be shared and ongoing monitoring and support from the CCG would be in place to ensure that a high quality service is provided.

While ACE did undertake a review of the practice activity prior to implementing the care navigation system, the CCG advocates a more thorough review is required. Prior to introducing a new system, practices would need to

- Assess the pattern of public access to primary care services in the practices
- Map the call and query volume, including prescription queries and test results to gain better understanding of peak time activity in order that call handling and supervision capacity can be adjusted accordingly.
- Review the types of query being received and at what time of day.
- Consider how clinical triage could be undertaken by the other appropriately qualified and skilled members of staff namely advance nurse practitioners, practice nurses, clinical pharmacist etc.
- Implement a recruitment, retention and development plan for all staff
- Ensure care navigation staff are well trained and supported by clinicians to address complex queries.

Following a thorough assessment of the practice activity, prior to implementing a new system, the key lesson to be learned is the importance of fully engaging, explaining and collaborating with the patient population about

- The need to work collaboratively with patients and the public to help understanding of the new system and the need to adapt their behaviour to access primary care services in a different way and at different times.
- The challenge of recruiting GPs and other practice staff;
- The need to deliver primary care differently with other appropriately skilled clinicians;
- How to effectively access primary care services online where appropriate.
- The care navigation/telephone system to be implemented and how patients can access services more effectively and efficiently
- Being clear what the service can/ cannot deliver from the outset
- The availability and access to other health and wellbeing services within their community

5. ***What performance targets are being set for ACE (an indication was given in the meeting that some would be set – I suggest further indication is given on the anticipated format and timing for this).***

NHSE and the CCG recognise the Care navigation system has experienced difficulties, leading to poor patient experience. ACE has introduced a number of improvements and continues to engage with the public to further improve how patients can access the services they require. ACE continue to aspire to improve the call answering rate and has been working to ensure sufficient staff; efficient triaging processes; reviewed appointment availability improves patient access and eases the pressure on the Care navigation staff. As an example of this improvement, at the beginning of December 2018,

- the average waiting time when the patient had got through was 08:12 minutes
- the longest waiting time when the patient had got through was 45:00 minutes
- 52.26% of calls were answered in 10 minutes or less

As at the beginning of April 2019,

- the average waiting time when the patient had got through was 05:44 minutes
- the longest waiting time when the patient had got through was 36:12 minutes
- 71.94% of calls were answered in 10 minutes or less

North East Essex CCG recognises that the above does not capture how long a patient waits to get through in the first place and continues to monitor the situation on a very regular basis. To improve patient experience and reduce call waiting time, the CCG, working collaboratively with ACE, has introduced an enhanced patient orientated website across the four ACE practices. This enables patients to access primary care services online and includes ordering repeat prescriptions; medication reviews; healthy lifestyle advice; asking a question on line etc , thus reducing the need to phone the Care navigation service. Patients are encouraged to access and use this facility at https://www.caradocsurgery.co.uk/. The CCG does however realise that a number of patients may not have access to online facilities and hope the use of this online facility by those who are able to, should improve access to the Care navigation system and help reduce call waiting times for those without computer facilities. The CCG together with ACE and the Local Authority are engaging with the public, through a variety of ways to introduce them to the use of this facility.

A high volume of the calls to the ACE care navigation system relate to prescriptions and the CCG is working with ACE to develop an additional performance KPI to improve the outcomes for patients in relation to the management of prescriptions. A specific performance measure on the turnaround of repeat prescription is likely to have a positive effect on the number of contacts made to the care navigation system and a higher level of patient satisfaction. This is being developed in line with contract discussions for 2019/20 with ACE.

NEECCG continue to monitor the performance of ACE through contractual meetings and quality assurance visits to ensure improvements are implemented for the benefit of patients. Additional assurance has been requested through the form of an improved, robust and updated Improvement Plan which includes timescales and trajectories/deadlines of when improvements are expected; patient engagement plan; online facilities ; weekly reports, risk assessments, complaints management etc

In addition the CCG have secured the facilitation services of NHSI to work with ACE to improve patient engagement and experience through the ‘Time to care’ national programme.

AGENDA ITEM 9

HOPSC/14/19

Committee Health Overview Policy and Scrutiny

Date 22 May 2019

Report by: Graham Hughes, Senior Democratic Services Officer

Subject – North East Essex CCG - Community Beds project and with development of the community health and well-being hub and spoke model

Background

In February 2019 North East Essex Clinical Commissioning Group (NEECCG) updated the Committee on progress with a community beds project and the development of the community health and well-being hub and spoke model. Link to update paper for that meeting is here February 2019 Community beds update paper

It is expected that an independent report commissioned by the CCG to analyse the feedback received from the public consultation exercise will have been published by the time of the 22 May HOSC meeting. A copy of the report will be circulated to members upon publication (and published on the Essex County Council website alongside this agenda pack) and HOSC members may wish to take this opportunity to make observations and comments on the report. The CCG will not be present at the meeting but any comments from the Committee can be relayed back to them and/or a future discussion item with the CCG can be scheduled if deemed necessary.

HOPSC/15/19

Committee Health Overview Policy and Scrutiny

Date 22 May 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.

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29 April 2019

Agreed the main business for May HOSC

Agreed the main business for June HOSC - Primary Care update on locality plans and the impact of the NHS Long Term Plan on primary care planning. Discussion on other aspects of the Long Term Plan to be deferred until Autumn.

Agreed the main business for July HOSC - Ambulance Service/seasonal planning.

Agreed proposed approach to responding to draft Quality Accounts (see elsewhere in agenda pack)

Developing an Integrated Sensory Pathway - item at future HOSC – Agreed to invite PAF Chairman to planning meeting.

Autism care pathway - Joint introductory briefing for both PAF and HOSC to be planned - probably late June to identify any follow-up workstreams.

Public Health - Agreed to start planning an item on public health challenges - especially around funding, role of and impact of STPs on Public Health. Aim for September HOSC

Cont….

19 March 2018

Review of recent meetings with Cllr Spence and Nick Presmeg's Team
Actions agreed:
Investigate if HOSC can be involved in re-procurement preparation for the children's mental health service contract (EWMHS).
Virgin Care Pre-birth - 19 contract - site visits to each quadrant being led by the People and Families Scrutiny Committee.
Discuss the work ECC is doing on admission avoidance at next meeting with Nick Presmeg prior to help inform the July HOSC item with ambulance trust and hospitals on seasonal pressures planning.

Harlow Hospital site visit – agreed to look for alternative dates

Autism review - Reconfirmed that an initial joint briefing session for HOSC and PAF to be set up. Likely that follow up work will need to focus on either children's or adults services (or do them both separately) as may be too complex to combine due to multiple commissioners and providers.

Recruitment update - Agreed in principle to cancel the April HOSC to allow CCGs more time to plan their update and re-schedule for May HOSC.

Work programme – discussed timings and scheduling of various future items
Discussed considering building in more updates from Cabinet Member (preferably on specific issues rather than 'general update').
Consider setting up mechanism to get feedback from ECC reps serving on CCG and hospital boards - start discussions with Cabinet Office

HOPSC/16/19

Committee Health Overview Policy and Scrutiny

Date 22 May 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)

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, there are two HOSC members who serve as ECC representatives observing the following bodies who 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);

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 12
	HOPSC/17/19

Committee:	**Health Overview Policy and Scrutiny Committee**
Date:	**22 May 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, developed as a result of work planning sessions and subsequent discussions between the Chairman and Vice Chairmen, 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 29 April 2019

Date	Theme	Topic	Focus	Approach and Next steps (full committee unless indicated otherwise)
Ongoing	Quality and Transformation of Services	Sustainability and Transformation Partnerships	Follow up previous HOSC strategic sessions with all three footprints. Seek evidence of joint working across footprints. 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. NHS England to be invited to detail how they maintain oversight and direction of STPs
22 May 2019	Capacity and financial sustainability	Recruitment and retention in the local health economy – *further follow up*	Initial session in January 2019 on the scale of the vacancies and challenges, second session further broke down vacancies by sector, type of provider, and type of job designation.	CCGs to detail commissioning issues that influence staffing levels. Matter Arising – further info on primary care recruitment from Health Education England.
22 May 2019	Community healthcare (prevention and early intervention)	North East Essex CCG – care navigation in primary care -	ACE run GP surgeries - follow-up	Further written update - to be discussed
22 May 2019	Community healthcare (prevention and early intervention)	North East Essex CCG – community beds re-organisation	To review the commissioned independent report on the public consultation feedback on proposed changes to community beds.	Written update to be discussed
12 June 2019	Quality and Transformation of Services/Community healthcare (prevention and early intervention)	Primary Care – *follow up*	Contribution to wider system and the STP plans.	Introductory session in October 2018. Now review more detailed locality changes arising from finalised CCG plans and impact of NHSE Long Term Plan. Commissioner/CCG representation.
24 July 2019	Capacity and financial sustainability	Ambulance Service	Corporate/strategic update.	Opportunity to meet new Chief Executive and challenge strategic priorities
24 July 2019	Capacity and financial sustainability	A&E pressures and seasonal pressures/bed management – *follow up*	Relationship between ambulance performance and hospital capacity pressures.	Follow up to November 2018 session/review of winter performance. Operational representatives to be present
4 September 2019	Community healthcare (prevention and early intervention)	Public Health	Funding and role of and impact of STPs on Public Health.	TBC
4 September 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 2019 work planning discussions

Essex Health Overview, Policy and Scrutiny Committee
Work Programme as at 29 April 2019

September/October	Quality and Transformation of Services	NHS England Long Term Plan	Actions being taken in response to the national plan (excluding Primary Care which will have been discussed in June)	Timing to align with CCG submission deadlines to respond to NHS England. Commissioners to be present.
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*	In September 2018 looked at the broader role and contribution to wider system.	Follow-up session looking at local performance and local variations – on hold as some aspects may be covered under the discussions on the Long-Term Plan
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

To be programmed:

TBC	Capacity and financial sustainability	Temporary move of mental health and other wards in South Essex– *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.
TBC	Capacity and financial sustainability	Temp relocation and ward moves to facilitate St Lukes Primary care development – *follow up*	HOSC formally consulted in October 2018. Endorsed the temporary measures proposed. Future permanent service model expected later in 2019.	HOSC to be consulted as part of a full formal engagement process regarding the future permanent model
TBC	Quality and Transformation of Services	Hospital mergers	(i) Legal merger process. (ii) clinical services integration	Work may be undertaken in Joint HOSCs. (i) Joint HOSC reviews (ii) TBC
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

Essex Health Overview, Policy and Scrutiny Committee
Work Programme as at 29 April 2019

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

Led and hosted by PAF – provisional timing June 2019	Community healthcare (prevention and early intervention)	Virgin Care 0-19 contract	Raised in December 2019 during discussions on work planning as part of an Annual Review exercise,	HOPSC members to join site visits of Family Hubs and follow-up session with commissioners and Virgin Care. Family Hub visits being planned for April 2019. Formal PAF session being planned for June 2019.
TBC	Quality and Transformation of Services	Autism services and awareness (health, social care, educational support)	Raised separately by both committees.	To be scoped in consultation with ECC officers. Joint introductory briefing to be arranged.
TBC	Quality and Transformation of Services	Sensory services		To be scoped in consultation with ECC officers

Joint Health Overview and Scrutiny Committees (JHOSCs) looking at plans from Sustainability and Transformation Partnerships (STPs)

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 had been intending to continue to look at issues and planning beyond the formal consultation. However, the STP plans have now been referred to the Secretary of State by Southend-on-Sea Borough Council and Thurrock Council, and as a consequence, the JHOSC's work has been paused.

   Essex HOSC nominated JHOSC members: Cllrs Egan (Lead Member), Lumley, Moore, Robinson (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. It has held three meetings in public and number of private briefings whilst formal proposals are being developed by the STP and the new combined acute trust (previously Colchester and Ipswich Hospitals). Joint HOSC Agenda papers

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

Task and Finish Group reviews - None at present