



Essex County Council

Health Overview Policy and Scrutiny Committee

10:30	Wednesday, 12 June 2019	Committee Room 1, County Hall, Chelmsford, CM1 1QH
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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 - 8
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	Appointment of Vice-Chairman To appoint a second Vice-Chairman of the Committee, for the 2019/20 municipal year.	
6	Primary Care Update	9 - 28

7	Harlow Hospital - site visit	29 - 34
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11	Date of Next Meeting To note that the next committee activity day is scheduled for 09:30am on Wednesday 24 July 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 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 J Reeves	Chairman
Councillor S Robinson	
Councillor C Sargeant	

Co-opted Non-voting members (max 4):

Invitations have been issued to nominate co-opted non-voting members for HOPSC. These have been sent to the following districts: Braintree, Harlow, Maldon and Uttlesford.

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 22nd May 2019

Present:

County Councillors

Councillor Reeves (Chairman)	Councillor Robinson
Councillor Chandler	Councillor Massey
Councillor McEwen	Councillor Lumley
Councillor Brown	Councillor Egan (Vice-Chairman)
Councillor Gadsby	Councillor Sargeant

Graham Hughes - Senior Democratic Services Officer, Andrew Seaman - Democratic Services Officer and Hannah Fletcher – Health Watch were also present throughout the meeting.

1. HOPSC Membership

Changes to the membership of HOPSC arising from Full Council were agreed. 4 non-voting co-opted places would be offered to district councils as outlined in the agenda paper.

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

Apologies had been received from Councillor Harris and Councillor Moran.

The following Councillors declared an interest:

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.

3. Minutes

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

4. Questions from the Public

There were no questions from the public

5. Appointment of Vice-Chairman

Councillor Egan was nominated by Councillor Chandler and seconded by Councillor Sargeant and by general consent her appointment was agreed. Due to not all the committee being present it was agreed to fill the second Vice-Chair position in the next meeting.

6. Recruitment Update

The Chair introduced the Panel, and the committee considered report HOPSC/12/19.

Present at the meeting were:

Peter Fairley
Director for Integration and Partnerships, Essex County Council

Kirsty Denwood
Director of Resources, North East CCG

Ian Thompkin
Associate Director Corporate Services
NHS West Essex Clinical Commissioning Group

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

- (i) Commissioners assess the needs of a local population, but it was up to providers to determine manpower levels to meet commissioning outcomes.
- (ii) Some key performance indicators might also indicate to a commissioner that staffing levels were inadequate – e.g. missed visits, missed referral targets.
- (iii) It was noted that costs remain an issue due to the minimum wage increasing.
- (iv) Technology was being investigated, how it can help deliver better care.
- (v) It was noted, that recruitment remains a challenge and that ECC have been working closely with the provider market.
- (vi) New roles have been generated as a trial, to appeal to young people, with the intention of filling the vacancy gaps.
- (vii) It was suggested that key worker accommodation should be investigated.
- (viii) It was noted that many students train abroad because it is cheaper; recruiters have recently visited students training overseas to recruit them back to the UK.
- (ix) Asked if there was a likelihood of the vacancy rate going down to 5-10%, the panel responded that they were looking abroad to recruit, creating new roles to relieve work loads and creating different career paths people could follow to help retention.
- (x) Asked where the responsibility sits to improve the vacancy rate, the panel responded that it was important to break down barriers between organisations, to create more realistic levels and to create a much more unified 'system' recruiting body with career paths being much more fluid between different organisations. There was emphasis on getting people under the NHS 'banner'.

- (xi) Occupational therapist vacancy rate is decreasing.
- (xii) It was noted all sectors needed to work towards a common goal and champion careers in health and social care, to look at what an overall package would look like and making sure there is a single universal strategy as opposed to multiple strategies. The sector needed to be prioritised through the work of the Skills Board.
- (xiii) ECC was content with the current training provision.
- (xiv) It was noted that staff issues are monitored directly and indirectly.
- (xv) Defining associates – still qualified, creating a hybrid role, just doesn't require as much training and naturally there is a professional hierarchy from that.
- (xvi) All STPs will have ICS status by 2021, there will be an integrated care trust by 2021 and over the last year Mid & South Essex have employed over 100 people into alternative roles.
- (xvii) When the issue of retiring GPs was mentioned, the panel mentioned that there was not automatically a need to replace every GP due to technological options, and rather to look how can we look at staffing alternatives, especially producing further roles to support a GP.
- (xviii) Further consideration be given as to whether any further evidence was required from Mid & South Essex STP.

Conclusion –

Councillor Robinson, in consultation with the witnesses, summed up the discussion, making the following observations:

- (i) Staff retention was as important as recruitment;
- (ii) There could be greater focus on 'soft' incentives such as better learning and working environments, such as enhanced training opportunities and for staff to be able to progress their careers;
- (iii) To improve reputations as a good employer.
- (iv)** To promote cohesion between organisations;

It was **recommended** that (i) the Health and Wellbeing Board should take on responsibility for promoting and overseeing the ongoing initiatives to improve recruitment and retention in the local health and social care system; (ii) promote and ensure closer working between all partners on the issue including all levels of local government and (iii) that the HOSC should establish a process to monitor progress being made by the HWB and system partners. (iiii) Commissioners agreed to provide further information on What percentage of people come back to the UK after training in places such as Bulgaria.

7. North East Essex CCG – care navigation systems update

Members discussed the latest update received from the CCG (HOPSC/13/19). The following was agreed:

- (i) Members were not assured that key levels of performance (particularly around accessibility) were being maintained.
- (ii) That the CCG be requested to provide further reassurance that they were closely monitoring the situation and that they were pressing the provider to further improve performance. Health Watch views would also be sought.

8. North East Essex CCG – Community Beds

It was agreed that this item be withdrawn.

9. Chairman's Report

The report (HOPSC/15/19) was noted, there were no questions.

10. Member Update

There were no updates.

11. Work Programme

The committee noted and considered report (HOPSC/17/19) It was noted that there was a clear plan for the next three meetings, with primary care being the subject for the next meeting.

12. Date of next meeting

The committee noted that the next committee activity day was scheduled for 09:30 on Wednesday 12 June 2019.

13. Urgent Business

There being no further business the meeting closed at 11:57.

Chairman

HOPSC/18/19

Committee Health Overview Policy and Scrutiny

Date 12 June 2019

PRIMARY CARE UPDATE

Report by Graham Hughes, Senior Democratic Services Officer

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

Recommendation:

To consider:

- (i) the attached consolidated update report on primary care from commissioners;
- (ii) the role and impact of primary care as part of wider 'system working' and STP/ICS plans;
- (iii) next steps for the HOSC and health partners.

Background:

The link to and importance of primary care has been acknowledged in relieving pressures on acute care in a number of recent HOSC discussions. Furthermore, this is also being emphasised in the ongoing development of local Sustainability and Transformation Partnership plans and Integrated Care Partnerships Systems.

The HOSC discussed primary care provision with local health commissioners and a GP representative back in October 2018 focussing on:

Structures and differences (including commissioning responsibilities)
 Strategies, Focus and Influences
 Relationships and partnerships
 Staff recruitment and retention, training and resource
 Maintaining consistency of access and service
 Measuring performance and feedback (including patient surveys)

A link to the agenda papers and minutes for that meeting is here:

[10 Oct 2018 HOSC - agenda papers](#)

A specific action arising from the October meeting was for commissioners to return to update the HOSC on their locality plans in April 2019. The timing for the update

has been delayed by the launch of the NHS England Long Term Plan and commissioners needing time to respond to that.

Commissioners have been requested to provide an update as follows:

- (i) to provide HOSC with update on Primary Care locality planning and to appreciate the differences between areas, whether due to differences in local need (health inequalities) and/or differing commissioning priorities.
- (ii) Set out national offer and direction.
- (iii) Outline the themes from the Long Term Plan (LTP) that impact on Primary Care including GP contract reform.
- (iv) Explain any differences in timelines now as a result of the LTP and also indicate where CCGs are operating on different timelines to each other.
- (v) Set out geographical coverage explaining the role of Primary Care Networks underpinning much of the LTP.
- (vi) Outline the direction coming from the local Sustainability and Transformation Partnership.
- (vii) Explain move towards standardised urgent care pathways and what is being done locally.

Information on recruitment has been minimised as HOSC has been looking separately at recruitment issues. However, commissioners have been asked to cover the change in skill mixes and increasing use of other professionals (physios, pharmacists etc)

Further reading:

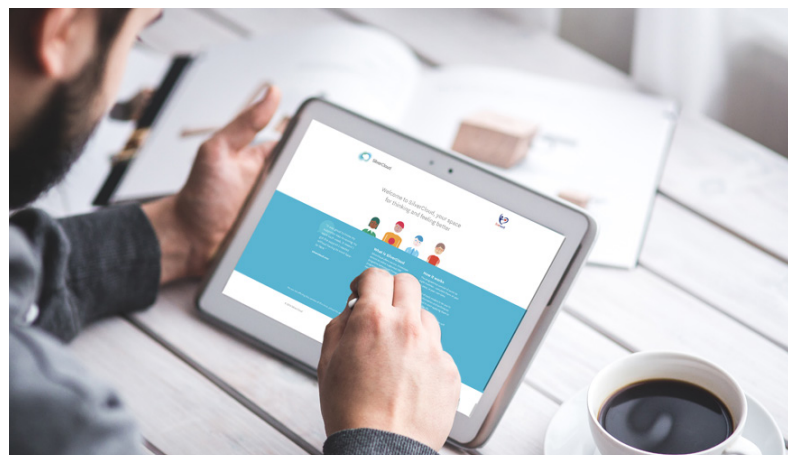
[Royal College of GPs' vision for the future of general practice.](#) – 21 May 2019

[Kings Fund - Primary Care Networks Explained](#) – 13 March 2019

[Primary Care Networks and the NHS Long Term Plan - the New Player on the Pitch](#)
– Kings Fund 3 April 2019

Primary Care

For Essex Health Overview and
Scrutiny Committee (HOSC) June 2019



Introduction & Purpose

October Recap

In October 2018 the HOSC received a report on Primary Care that focused on the contractual framework for General Practice, the challenges faced within this sector in terms of workload, workforce and rising demand and articulated the approach that the five CCG's within the council boundaries were working on to transform General Practice to be fit for the future. This was presented within the context of the evolving STP landscape, and the movement towards Integrated Care Systems, but described how local implementation would vary dependent upon local needs

The key messages built upon in this paper are

- The long-term sustainability of General Practice is a priority for all systems, and there is national contract reform looking to address this
- General Practice in Essex is historically challenged in terms of workforce numbers, relating to traditional roles of Doctor and Nurse, and to manage this there is movement to GP Led as opposed to GP Delivered models of care and the wider diversification of the workforce
- Whilst General Practice is made up of independent contractors there is a view that both 'organisationally' and for the 'system' there is benefit from closer collaboration amongst practices. In October we called these localities and/or neighbourhoods and further progress has been made in this area

The HOSC have requested an update on progress made in delivering these new models of care and addressing practice sustainability/resilience as well as identify new local or national policy which may impact on this journey

What's in scope

The NHS landscape is a vast and complex one, and the transformation of General Practice cuts across several areas such as workforce and digital. This paper focuses on progress made in supporting the resilience and sustainability of General Practice as outlined above and discussed in October.

It provides this update in the context of an evolving landscape following release of two national strategic documents in January of this year. Namely the NHS Long-Term Plan, and 'Investment and evolution: A five-year framework for GP contract reform to implement The NHS Long Term Plan'.

What's out of scope

As the intended focus is transformation to date the paper does not cover General Practice Business as Usual issues (i.e. quality/CQC issues), individual practice performance or other Primary Care (Dentistry, Optometry or Pharmacy). In October we utilised the national General Practice patient survey as a means of assessing patient experience and access to services. The survey has not been re-implemented since October, and as such no further update is provided in this report.

Whilst the paper will touch on workforce developments within General Practice – in terms of additional staff and services commissioned to support General Practice - it does not go beyond this sphere of interest. It is understood HOSC have received separate updates covering workforce and workforce planning.

The paper does include extracts from NHS England's own high-level summary of the NHS Long-Term Plan for the purpose of understanding alignment of the transformation of General Practice as described in this and the previous paper with national policy. Each STP is tasked with developing its own local plan by the Autumn. These are currently in development through the partnerships in place between Local Government, the NHS and other key stakeholders including the public and is therefore out of scope.

Subsequent Policy Direction

Since October there have been two significant publications by NHS England that impact upon General Practice.

The first is the NHS Long-Term Plan, building on the Five Year Forward View and supporting documents including the GP Forward View (GPFV). Summarised below this was developed by Health and Care leaders and describes how the NHS will be fit for the future and get the most value for patients out of every pound of tax-payers' investment.

The second followed shortly after and was the announcement of a five-year reform programme for the GP Contract, agreed between NHS England and the BMA. The document sets out how the General Practice contract will evolve to be fit for the new systems that are emerging and be able to provide the foundations needed for the continued evolution of Integrated Care Systems.

National Policy Changes

Long Term Plan

NHS England state that the plan was drawn up by those who know the NHS best, including frontline health and care staff, patient groups and other experts. This group benefited from hearing a wide range of views, whether through the 200 events that have taken place, and or the 2,500 submissions we received from individuals and groups representing the opinions and interests of 3.5 million people.

The summary below, extracted from NHS England's own summary, sets out the key things they expect people to see and hear about over coming months and years, as local NHS organisations work with their partners to turn ambition into improvements.

The NHS Long Term Plan states that it will

- Making sure everyone gets the best start in life
- Deliver world class care for major health problems
- Support people to age well

Delivering the ambitions of the NHS Long Term Plan

To ensure that the NHS can achieve the ambitious improvements it intends to deliver for patients over the next ten years, the NHS Long Term Plan also sets out how to overcome the challenges that the NHS faces, such as staff shortages and growing demand for services, by:

1. Doing things differently: giving people more control over their own health and the care they receive, encourage more collaboration between GPs, their teams and community services, as

‘primary care networks’, to increase the services they can provide jointly, and increase the focus on NHS organisations working with their local partners, as ‘Integrated Care Systems’, to plan and deliver services which meet the needs of their communities.

2. Preventing illness and tackling health inequalities: the NHS will increase its contribution to tackling some of the most significant causes of ill health, including new action to help people stop smoking, overcome drinking problems and avoid Type 2 diabetes, with a particular focus on the communities and groups of people most affected by these problems.

3. Backing the workforce: continuing to increase the NHS workforce, training and recruiting more professionals – including thousands more clinical placements for undergraduate nurses, hundreds more medical school places, and more routes into the NHS such as apprenticeships. The NHS will become a better place to work, so more staff stay in the NHS and feel able to make better use of their skills and experience for patients.

4. Making better use of data and digital technology: providing more convenient access to services and health information for patients, with the new NHS App as a digital ‘front door’, better access to digital tools and patient records for staff, and improvements to the planning and delivery of services based on the analysis of patient and population data.

5. Getting the most out of taxpayers’ investment in the NHS: working with doctors and other health professionals to identify ways to reduce duplication in how clinical services are delivered, make better use of the NHS’ combined buying power to get commonly used products for cheaper, and reduce spend on administration.

What happens next

Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICSs) are working together with each other, local councils and other partners, to develop and implement their own strategies for the next five years.

These strategies will set out how they intend to take the ambitions that the NHS Long Term Plan details, and work together to turn them into local action to improve services and the health and wellbeing of the communities they serve – building on the work they have already been doing.

STPs are responsible for delivering elements of the HWBBs priorities, as such, local authority officers are fully involved in the development of the STP strategy, and HWBBs will be engaged in this process. As noted above the Long-Term Plan announced the development of Primary Care Networks, further defined as a group of GP practices (and other providers) serving an identified network (geographical area). The success of Primary Care Networks is reliant on individual practices being resilient and sustainable enabling them to engage in what will be some of the most significant changes to the GP Contract in recent years.

GP Contract Reforms

GP Contracts in the main are nationally negotiated, outlining expectations on General Practice and the framework in which they operate. These core contracts are then ‘built’ upon through the utilisation of ‘enhanced service agreements’ or ‘local improvement schemes’ either nationally or locally set.

It was acknowledged in October that the nationally negotiated GP contractual arrangements made it difficult to progress some elements of required change, such as collaboration amongst practices, within the existing framework. The October paper described the differences in delegation arrangements, and therefore responsibility, across the five CCG's.

In January 2019, following publication of the Long-Term Plan, NHS England and the BMA's General Practitioners Committee England announced that they had agreed a five-year framework for the GP contract which confirms the direction for the next ten years¹. In their words the new contract arrangements will deliver the most fundamental change to General Practice in decades. These changes start to align with the requirements previously identified as being challenging to the local system.

The contract reform focuses on two key elements.

1. the existing core contract, with changes being made to a number of areas including indemnity cover, investment in IT and digital technologies, changes to the Quality and Outcomes Framework and importantly a five-year contract settlement seeing practice funding increase each year until 2023/24
2. the announcement of the Network Agreement. A Directed Enhanced Service that all practices were to be offered, and all patients are to benefit from. It is this agreement that is being nationally identified as the vehicle to deliver collaboration amongst practices, as well as with the wider system

The Network Agreement, also being called a Primary Care Network Contract,

- will be introduced from 1 July 2019 as a Directed Enhanced Service (DES). It will ensure general practice plays a leading role in every PCN and mean much closer working between networks and their Integrated Care System. This will be supported by a PCN Development Programme which will be centrally funded and locally delivered. Details of this are still to be released.
- By 2023/24, the PCN contract is expected to invest £1.47 million per typical network covering 50,000 people. This will include funding for more health professionals including additional clinical pharmacists, physician associates, first contact physiotherapists, community paramedics and social prescribing link workers. Bigger teams of health professionals will work across PCNs, as part of community teams, providing tailored care for patients and will allow GPs to focus more on patients with complex needs.

The contract framework will see significant extra investment for improved access to family doctors, expanded services at local practices and longer appointments for patients who need them.

The development of PCN's, under the Network Agreement Directed Enhanced Service, sees the opportunity for significant investment into local services and is intended to be the bedrock of the health system moving forward. It is envisaged this becomes the vehicle to support the aims in the Long-Plan focusing on prevention, population health and health inequalities. The expectation is that PCNs deliver full population coverage.

¹ Investment and evolution: A five-year framework for GP contract reform to implement The NHS Long Term Plan

<https://www.england.nhs.uk/wp-content/uploads/2019/01/gp-contract-2019.pdf>

In October HOSC were advised that collaboration amongst practices was for the willing, and that the contract as it was then did not encourage joint working. The new contract reforms change that landscape. Through the Network DES practices are encouraged and incentivised to collaborate. The contract reforms make clear that new money into General Practice will in the main be through this vehicle.

The Network DES provides the foundation for collaborative working with key outcomes expected to include:

- Improved sustainability for GP practices, including improving the ability of practices to recruit and retain staff
- to provide a wider range of services to patients
- facilitate stronger collaboration with the wider health and care system to deliver the triple integration of
 - Primary and specialist care
 - Physical and mental health services
 - Health with social care

A maturity matrix for PCN's has been issued by NHS England and is attached in Appendix 1. This makes it clear that the expectation is that PCNs are more than just GP practices collaborating to deliver services in the way they have previously done, but are a vehicle that will require cross system working, and the delivery of services that go beyond ill-health and into population health management, supporting people to stay well and have an impact on health inequalities.

Local Strategy Changes

The previous paper summarised the local strategic direction across all five CCG's and the alignment to the three STP's.

In summary these described local strategies that focused on the sustainability of General Practice, and the movement towards models of care that looked at Practices collaborating with each other, and with other partners including Community Services, Social Care and the Third Sector across geographical areas known as localities or neighbourhoods.

These emerging collaborations would form the basis of Integrated Care Systems in North East and West Essex, and the integration of services outside of hospital within Mid and South Essex.

Given the context described above the strategic direction of Commissioners has not changed since October.

Update on Local Progress

Previously HOSC were informed of a movement to undertake two key actions to build practice resilience and support sustainability. The drive behind this is to both ensure general practice can cope with the demands placed upon it, improve patient experience, as well as where appropriate releasing time to care. These two actions were

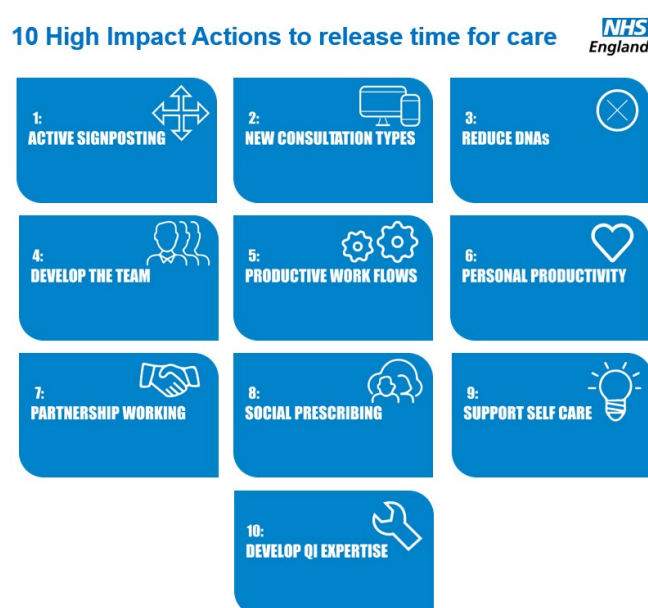
- a. To ensure practices became more resilient individually, and
- b. To support practices to work closer together to achieve economies of scale

Practice Resilience

High Impact Changes

The GP Forward View contained a series of 10 high impact actions that aimed to release time for general practice staff.

These High Impact Actions (HIA) individually and collectively are aimed at improving practice sustainability through improving internal business process, and improving the offer to patients through alternative, and more appropriate, intervention – such as redirection to a diversified clinical workforce, or through social prescribing to more appropriate non-medical interventions.



1. Active signposting
Provide patients with a first point of contact which directs them to the most appropriate source of help. Receptionists acting as care navigators can ensure the patient is booked with the right person first time.
2. New consultation types
Introduce new communication methods for some consultations, such as phone and email. Where clinically appropriate, these can improve continuity and convenience for the patient, and reduce clinical time per contact.
3. Reduce DNAs
Maximise the use of appointment slots and improve continuity by reducing DNAs.
4. Develop the team
Broadening the workforce, to reduce demand for GP time and connect the patient more directly with the most appropriate professional.
5. Productive workflows
New ways of working which enable staff to work smarter, not just harder. These can reduce wasted time, reduce queues, ensure more problems are dealt with first time and that uncomplicated follow-ups are less reliant on GPs consultations.
6. Personal productivity

Staff are the most valuable resource in the NHS. We have a duty to nurture them as well as providing resources and training to ensure they are able to work in the most efficient way possible. This may include improving the environment, reducing waste in routine processes, streamlining information systems and enhancing skills such as reading and typing speed.

7. Partnership working

For a number of years, practices have been exploring the benefits of working and collaborating at greater scale. This offers benefits in terms of improved organisational resilience and efficiency and is essential for implementing many recent innovations in access and enhanced long-term conditions care.

8. Use social prescribing

Refer or signpost patients to services which increase wellbeing and independence. These are non-medical activities, advice, advocacy and support, and are often provided by voluntary and community sector organisations or local authorities.

9. Support self-care and management

Take every opportunity to support people to play a greater role in their own health and care.

10. Build QI expertise

Develop a specialist team of facilitators to support service redesign and continuous quality improvement. Such a team will enable faster and more sustainable progress to be made on the other nine high impact changes.

All CCG's have been working with practices to ensure maximum uptake where appropriate of these high impact actions. Progress across Essex is identified in the table below. As should be expected progress is varied depending upon priority focus within each CCG, and more importantly, within individual practices. Appendix 2 provides detail of each of the HIA and the benefits that should be delivered for practices and their patients.

Number of Practices Engaged and Delivering the High Impact Action

HIA	Basildon & Brentwood	Castle Point & Rochford	Mid Essex	North East Essex	West Essex (i)
1 Active signposting	29	18	39	16	13
2 New consultation types	16	4	43	23	29
3 Reduce DNAs	32	20	43	20	28
4 Develop the team	29	22	41	20	20
5 Productive workflows	3	9	36	16	23
6 Personal productivity	0	0	0	4	25
7 Partnership working	35	23	10	23	31
8 Use social prescribing	35	23	29	9	23
9 Support self care and management	16	0	29	6	26
10 Build QI expertise	14	9	2	3	2
Total Number of Practices in CCG	35	23	43	32	32

(i) These are the practices who are actively delivering the HIA. A number of other practices are engaged and planning to deliver the HIA within this financial year, particularly in relation to Active signposting where another 17 practices have been trained and are planning for implementation, but these have not been included in the above.

Clerical and Administrator Training

As part of the GPFV there is a drive to upskill clerical and administration staff within practices, improving both personal and business processes. Whilst the numbers in the table above identify practice 'implementation' training of staff needs to be wide reaching within practices. The training is intended to cover topics such as Care Navigation and Clinical Correspondence and fall into HIA's 1 and 5.

Across Mid and South Essex Basildon & Brentwood have seen over 90 members of staff trained in Care Navigation, Castle Point & Rochford over 80 practice staff trained and over 100 in Mid Essex.

West Essex had over 150 individual staff members complete a full two-day training package.

In addition to the implementation of the High Impact Actions each area has a more bespoke programme of work to support practices and their local transformation requirements.

Mid and South Essex

The Mid and South Essex Primary Care Strategy outlined a model of care that focused on improving the resilience of General Practice. It described a model that moved to GP delivered to GP led services, and outcomes that put improved GP morale alongside improved patient experience.

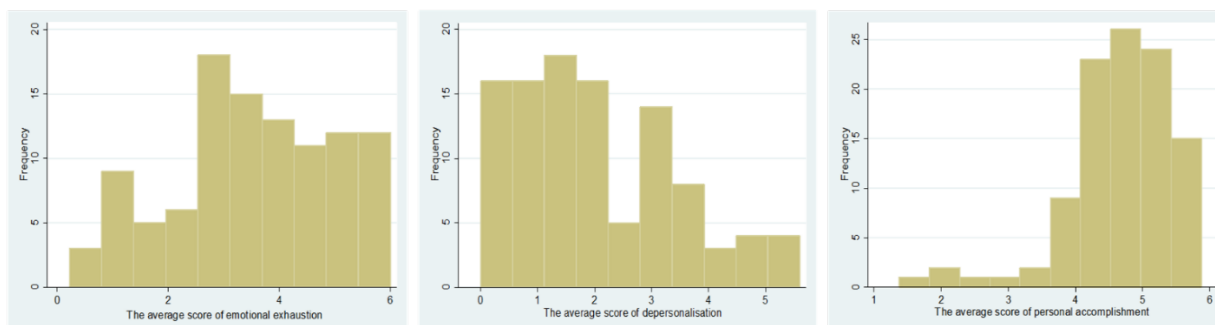
GP Burnout

The strategy committed to assessing GP Burnout – as a way of improving recruitment, retention and morale - through the Maslach Burnout Inventory. The MBI is recognised as a leading measure of burnout, and extensive research has been conducted using this measure. The MBI-Human Services Survey for Medical Personnel has been specially adapted for medical personnel and addresses three scales:

- Emotional Exhaustion,
- Depersonalisation, and
- Personal Accomplishment.

During February and March, we implemented the baseline assessment across the STP, inviting all GP's in the area to participate. 104 opted to engage in this baseline exercise, with over 75% of these coming from the three CCG's that fall within Essex CC boundaries. It will be rerun in six and twelve months. The detailed results have been collated and published by Anglia Ruskin University which in summary show

- The average GP experiences emotional exhaustion between 'A few times a month' and 'Once a week'
- Whilst at the same time they
- have a good attitude towards their patients, which should not have a detrimental effect of their care, and
- feel a positive attitude towards their accomplishments and achievements.



Delivery of the strategic vision is expected to improve these scores over the coming months, with an improvement expected to be seen through future surveys.

Workforce Diversification

Aligning with HIA 4 the strategy focuses on the utilisation of a diversified workforce. Across the STP the key focus has been to enable this diversification at the most appropriate level, and through the most appropriate vehicle. For example, with Mid Essex investment has been through individual practices, whilst in Basildon & Brentwood and Castle Point & Rochford this has been through the commissioning of increased capacity through GP Federations or Alliances covering groups of practices.

Castle Point and Rochford have commissioned an Enhanced Access service through their localities, creating additional capacity during core hours, and into the evenings. The total value of this service enhancement is circa £1.2m and equates to an increase in funding in General Practice of circa 5%. This is an investment in service provision that is expected to increase capacity of General Practice and has seen the appointment of staff including Clinical Pharmacists, Emergency Care Practitioners and Advanced Nurse Practitioners.

Basildon & Brentwood have also looked to diversify the workforce through the commissioning of services across practices, this has included an Acute Home Visiting service, improving the capacity through additional GP and Advanced Nurse Practitioners across practices to see housebound patients.

Mid Essex have seen over 100 new staff, equating to nearly 60 wte, funded within General Practice as part of their foundations programme as described in the October paper.

Reducing 'Did Not Attend's'

Given pressures within General Practice it is important that available appointments are utilised effectively. Missed appointments had previously been raised as an issue amongst General Practice, with the process for patients to follow to cancel being identified as a reason for people not formally notifying practices of their intention to not attend. These DNA's result in patients missing out on accessing help when they need it.

In Mid and South Essex this has started to be addressed through the implementation of a text-based solution that links into GP booking systems, enabling patients to easily cancel their appointment. This has started to see a reduction in DNA's.

In addition to these improvements there are also several pilots underway to look at new ways of working, and upskilling the workforce, that are being tested in pockets of the STP prior to wider adoption. These include

- Fifteen-minute appointments,
- New roles such as First Contact Physio therapists
- Utilising digital access solutions as opposed to traditional face to face contacts, and
- Quality Improvement methodology for practice staff

West Essex

Workforce Diversification

Many of the neighbourhood projects focused on trialling new ways of working in primary care, building on the national initiative within the GP Forward View and 10 high impact changes. 2 neighbourhoods in West Essex, trialled physiotherapists working as part of the general practice team, being the first point of contact for patients with musculoskeletal conditions. 3 neighbourhoods also trialled Emergency Care Practitioners working alongside GPs to support patients who require an urgent on the day home visit. These pilots have been very successful in reducing GP workload and supporting practices to consider recruiting different professionals to address GP recruitment challenges. The CCG is funding these posts in all Primary Care Networks across West Essex in 2019/20.

Transformation Projects

The primary care transformation projects enabled neighbourhoods to piloting new ways of working to meet workforce and workload challenges. Projects were designed and led by neighbourhood leaders generating ownership and energy for effective delivery. The CCG also commissioned proactive support to patients identified as moderate frailty and schemes to tackle variation in primary care. £6 per head was invested as a result of recycled primary care funds. All services have been evaluated at 9 months and informed commissioning arrangements for 2019/20.

	Neighbourhood Primary care transformation projects in West Essex		North Harlow	Central Harlow	South Harlow	North Uttlesford	South Uttlesford	Epping & Ongar	Waltham Abbey	Loughton	Buck's at Hill & Chigwell	Summary Commissioning Plan	Service continuing
		Summary Description											
Positive evaluation & continuing / spread across CCG	Moderate frailty	Virtual review and f2f proactive care										Commission as a LES across CCG	9
	Emergency Care Practitioner	Home visiting service for housebound patients		RIS								Commission across CCG at £1.70 per head	3
	First Contact Physiotherapist	Alternative to GP and early mngt of MSK										Commission across CCG as part of MSK	3
	Enhanced community team	Admin support for community matrons										Commission across CCG - EPUT contract	1
	Breathlessness pathway	Enhanced service for breathless patients										Build into Complex patients LES	1
Pilot yet to complete	Proactive care: temporary housing	Target residents of special accommodation										March Eval'n - part year funding 19/20	1
	Proactive care for severely frail	Enhanced review for severely frail										March Eval'n - part year funding 19/20	1
	Extended appt - one stop shop	Proactive care for LTC/mental health patients										Feb Eval'n - part year funding 19/20 possible	1
	Hub model on the day appointments	Hub model for nursing appts across practices											1
Other funding	Advanced Care Practitioner Coordinator	streamline EOL coordination across practices										May eval'n - part year funding 19/20	1
	Community builder/social prescriber	Improve patient access to vol. sector										Continue through other funding sources	1
At practice discretion Not commissioned	Pooled on the day appointments	hub model for nursing appts across practices										Core funding - for practices to consider	1
	Shared Prevention Administrator	primary care prevention coordination										Core funding - for practices to consider	1
Stopped - not effective	Health check monitors	in practice kit enables patient to self report										Core funding - for practices to consider	1
	Neighbourhood practice nurse	shared nurse resource (project stopped)											1
	Extended appt for mild frail	mild frail extra support											1
Complete	Community GP for vulnerable patients	enhanced visiting for frail patients											1
	IT/recall	IT systems to increase LTC recall											1
	QOF variation reduction	N'hood targets for QOF/screening variation										Develop a new approach	9
												Summary	
												Number definitely continuing	17
												Number possibly continuing	9
												Number not continuing	13
												Total projects	39

Services continuing to be commissioned in 2019/20 are as follows:

- proactive support to complex patients and moderately frail.
- Emergency care practitioners in general practice to support GP home visits
- Physiotherapists in general practice, being the first point of contact for patients with musculoskeletal conditions

North East Essex

Workforce Diversification

Within North East Essex we are actively looking to improve the holistic environment of the GP practice. We have wrapped round a test pilot looking to all kinds of workforce and social interventions, which has decreased the workload and increased the quality and employee experience. NEE has a historic relationship of using a wide range of clinicians as part of its offer to patients. As an STP, we have already exceeded our target through the introduction of roles such as Medical Assistants, Physician Associates, Social Prescribers, Care Navigators and First Contact Practitioners. As these roles have been key in reducing workload it will in turn help recruitment and retention.

Practice Collaboration

All recent guidance has emphasised the benefits of collaborative working between practices and with other providers in the local health and care system.

Over recent years practices had started to become more open to collaboration, potentially as a response to identifying ways to improve General practice workload and become more efficient and in October a few formal and informal arrangements had started to form, as summarised in the table below. These formal collaboration arrangements were generally through vehicles known as Federations or Alliances – GP owned entities developed to support their member practices or provide an alternative vehicle for providing non-core services. They were collaborations of the willing, and by those with a similar vision.

The lack of Federations or Alliances in some areas should not be seen as putting local development at risk or areas at a disadvantage. The creation of the Network Agreement, and movement towards Primary Care Networks, introduced in this paper will result in the delivery of General Practice at Scale, with practices currently working through their arrangements for collaborative working. Whilst there could be a role in service delivery for federations and alliances this is not essential and will be at the discretion of the emerging Primary Care Networks.

The Network Agreement, as part of the nationally negotiated GP Contract, is changing the approach to collaboration and provides a contractual vehicle to commission population wide services.

For practices at its heart the offer is simple - sign up to a network agreement with practices in a geographical footprint to enable delivery of population wide services. If as a practice you do not choose to sign up your patients will be aligned to an appropriate Network and have access to the enhanced service offer through that Network.

This has resulted in a current dual approach to collaboration between practices.

1. Collaborate with those with similar minds
2. Collaborate with those serving the same population

The table below summarises the landscape as it was in October in relation to the development of Federations and Alliances.

GP Practice Collaboration (Federations/Alliances)

Basildon & Brentwood	Castle Point & Rochford	Mid Essex	North East Essex	West Essex
Two established federations.	Two local GP Alliances.	Mid Essex does not have any established alliances/federations.	Three local GP Alliances.	Two local GP Provider Companies.

Primary Care Networks (PCN)

National direction is that the PCNs become a key provider within local landscapes. At present PCN arrangements in the main are newly evolving relationships between practices, that will develop and mature over coming months and years. To date the only formal ask of them is to identify the Networks they wish to form (practices that wish to work together), identify a Clinical Director and the recipient of the funds.

On the 15th May practices were due to submit to commissioners their proposed configuration for Primary Care Networks, or more explicitly the proposals for sign-up to the Network Agreement DES. Following submission, it was anticipated that where key criteria had been met – full population coverage, practice coverage and minimum size (30,000 population coverage for a PCN) – that these would be signed off by CCG's/NHS England by the 31st May. Where criteria have not been met it is expected that this is resolved during June. All CCG's across Essex are working with practices and the Local Medical Committee to achieve full coverage.

All practices within a Network need to sign-up to a Network Agreement that describes how they will work together. This is not due for completion until the end of June after which the first stage of the Network Contract goes live which includes full population coverage for the extended hours service offer.

Whilst there is some discrepancy between the arrangements that were forming as Localities & Neighbourhoods introduced in October, and proposals received from Practices regarding PCN arrangements, irrespective of how practices collaborate the principle around patient care is the same. Access necessary services through your own practice, with the additional offerings and wider collaborations seen as an extension to the core service and experienced as though part of the practices service offer. There is however likely to be a period of transition once PCN arrangements are finalised due to this discrepancy.

Financial Sustainability

- There have been concerns around the financial sustainability of general practice, and the removal of funding from core contracts. In this context it is important to note the following. Previous exercises that resulted in some practices losing core funding was a result of national policy to ensure practices providing the same service offer were being reimbursed at a similar level. The new Contract Reforms guarantee that core contracts will increase in value over the next five years.
- Investments made by CCG's into services above and beyond core requirements are still at the discretion of CCG's, although the development of the Network Agreement does provide a vehicle to

- a. Standardise the offer to patients where traditionally practice sign-up or delivery has been variable, and
- b. For local commissioners – health and social care – to purchase further services through general practice at scale that meet the specific needs of the population served by a PCN
- c. The Network DES, and the financial entitlements that accompany it, is a nationally negotiated offer. It is not for local CCGs to amend and is an expected minimum offer to emerging PCN's
- d. Current financial entitlements under the DES makes available up to 70% of staff costs in line with the stated development programme – 100% for social prescribing link workers. Networks will need to identify where the other 30% of costs, and non-pay costs, will come from. Where Networks do not take up the offer this will be a Network decision, not a commissioner decision.

Early Feedback

As noted in October performance is difficult to measure contractually due to the framework that is in place. Previously the HOSC were presented with the latest results of the GP Patient Survey as indicators of performance, satisfaction and feedback. The results as included in October are the most recent published, as such no update is included in this paper.

Whilst the programme of change is in its early stages, we are starting to identify examples of improved patient experience through this way of working, particularly around the diversified workforce. It is expected over time this sees positive improvements in indicators included in the GP Patient Survey.

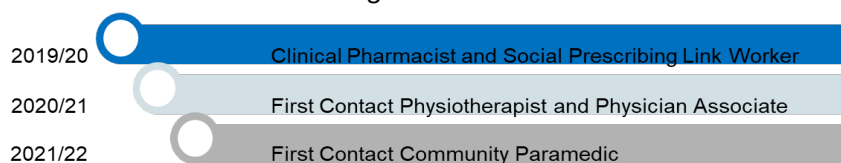
Next Steps

Nationally directed

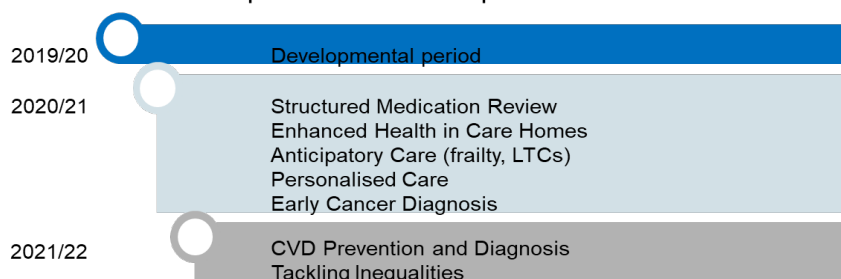
The development of PCN's is being driven through the national process. Over the next three years PCN's will be able to access funding to contribute to the staffing costs associated with a diversified workforce to be accessible through General Practice under an additional roles' reimbursement scheme.

PCN's will also be expected to deliver seven new services detailed in yet unpublished nationally negotiated specifications, and from 2021/22 provide a new, and simpler, access offer to patients bringing together the currently disparate range of service offers for both physical and digital access for patients. This development timeline is illustrated below.

Workforce Growth - New Staff 'Funded' through Network DES



Service Offer Evolution— National Specification Development



These enhancements are expected to remove some of the variability of provision that occur under current arrangements and start to impact on health inequalities and improve population health outcomes. By 2020 NHSE will publish a Network Dashboard that will set out progress on network metrics, covering amongst other things population health.

Local next steps

The transformation of General Practice is a long-term piece of work. The new contract reforms outline an evolution over five years, and as noted above builds the foundations for the next ten.

As such it is important to recognise that this will continue to evolve over time, with requirements changing in response to local need. The next steps locally are not new actions, they are the continuation of work that has already been started, such as further roll out of the High Impact Actions, the continued evolution and support of Primary Care Networks and the journey to closer collaboration between General Practice and the rest of the system. It also includes continued engagement with the public to understand the changes that are being seen within General Practice, particularly the understanding that they will have their needs met by the most appropriate person, and not necessarily a GP.

Collaboration

Areas continue to progress collaborative working between General Practice and the wider system, including Community Health Care services, Social Care, the Third Sector and the populations they serve.

Most of these developments are being driven through local partnerships and forums that include representation from key stakeholders, including within

- a. Mid and South Essex
 - a. South East Essex Partnership covering Castle Point and Rochford
 - b. Basildon and Brentwood Integration and Partnership Forum
 - c. Mid Essex Integrated Community Health & Social Care Programme Board
- b. West Essex's Integrated Care Partnership

With PCNs being seen as important partners in, and a foundation for, future service delivery each area is currently working through how they are represented at the most appropriate forum.

Through this collaboration between General Practice and the wider system we are already seeing Community Nursing Teams, and Social Care Teams, aligned to General Practice, making a real movement towards collaborative working across the system, and access to a wider range of professionals through General Practice. This continued movement is seen as essential for the long-term success of PCN's and is supported by contractual requirements included within the NHS Standard Contract for Community Services. A key focus within all systems over coming months will be how this is operationally delivered.

The focus on collaboration is also supported by the continued focus on individual practice resilience as noted above.

GP Forward View Funding

Following a successful national pilot within Mid and South Essex funding available through NHSE to support four programmes of work – Practice Resilience, Online Consultations, GP Recruitment and Clerical and Admin Training – is being made available through STP's to support delivery of the GPFV and practice resilience. The specific requirements for these four areas – for STPs and CCGs - include

- *ensure that the delegated budgets received are used to support the development of all practices in the context of PCN development;*
- *ensure that the local practice development plans continue to identify those practices who need more intensive and immediate support to stabilise, build their resilience and become sustainable;*
- *maximise retention of experienced, effective staff (doctors, nurses and other health professionals);*
- *CCGs are expected to work with their practices to ensure that by March 2020, 75% of practices are offering online consultations to their patients*

As part of the arrangements all STPs, and CCG's, will have a local plan for the delivery of these requirements. In addition to this all CCGs continue to work with Practices to increase uptake and implementation of the High Impact Actions identified earlier in the paper.

This funding previously flowed through CCGs and as such work in these areas will build upon progress to date.

Recruitment & Retention of GP Workforce

Whilst there is a focus on workforce diversification, and utilisation of other roles, it remains a priority to attract GPs to the area and retain the GP workforce already in the area. Projects have been initiated in previous years and they continue to be an area of focus, including

- International GP recruitment - All CCGs are participating in IGPR. Recruitment is undertaken by third party recruitment companies. Recruitment of potential IGP recruits for Hertfordshire and West Essex commenced in January 2019, with interviews x 10 and practice visits scheduled for June 2019.

In MSE 16 GPs have been recruited thus far through the programme. Four candidates withdrew from the scheme, six are currently on the induction programme and a further six have

completed the scheme and are working as a salaried GP. The MSE recruitment provider is currently working with a number of candidates to commence the recruitment process.

In North East Essex two candidates have been recruited to a practice in Clacton. One is on the performers list with no conditions and the second is going through the Induction and Refresher scheme phase.

- Post CCT GP Fellowship scheme - All STPs are working on implementing these schemes. In the Mid and South Essex STP there is funding for 11 fellows. West Essex CCG have 3 Fellows, part of 11 across their STP. This is a full or part-time development programme for qualified GPs which will facilitate both an individual's career development and local health service needs through the provision of extended skills and experience. The additional professional roles will support STP plans and the programme will support GP recruitment in areas of need. In addition, the programme offers service commissioners the opportunity to develop shared posts between employers (for example across primary and secondary care or between practices and a CCG).
- GP Retention Scheme - Another area of focus for all CCGs. As an example in West Essex a Task and Finish Group set up to survey their needs, their scheme seeks to support GPs to work a minimum of five sessions in general practice per week (equating to a participation rate of 56%) however regions may tailor this approach to the needs of their local workforce.
- GP Retainer Scheme - West Essex have 2 retained GPs. This scheme is intended as short-term support for GPs who have family commitments or health problems which restrict them from working in General Practice in the usual way as partners or salaried GPs. The MSE STP is an intensive support site for GP Recruitment and Retention and through the workforce initiatives have 4 retained GPs. The scheme offers flexibility and educational support.
- GP Portfolio Roles - Systems are looking at creating clinical lead roles to enable GPs to adopt a portfolio career, with interests outside of General Practice. Examples include Diabetes and AF Clinical lead roles in Mid and South Essex and First5 network lead roles in both MSE and West Essex who will develop the establishment of a First5 network in their geographical footprint to contribute to the ongoing GP recruitment and retention agenda across the STP.

Digital Transformation

It is important to recognise that transformation to date has generally focused on the sustainability of the workforce, mainly through diversification and the increase in numbers of staff, and this paper has focused heavily on workforce solutions, and collaboration, as a way of increasing capacity. Moving forward the transformation of General Practice will start to look more at opportunities available through the use of new technologies, and the movement to digital solutions, to manage demand and increase capacity. Whilst there are examples of innovation and progress in this area moving forward the widespread adoption of digital solutions will be a significant contributor to the long-term sustainability of General Practice. Examples of work to date include

- WIFI - providing Wi-Fi for both patients and staff across all practices
- E-Consult - All areas must work towards the delivery of online consultations as noted under the GP Forward View funding section. West Essex have just published their ITT to look at solutions available for video Consultation for their practices, and in Mid and South Essex a process is being followed which should see solutions available for practices from December 2019.
- Integrated Care Records - A single clinical record should improve patient care. My Care Record is being used as the brand to support further interoperability initiatives across the Herts and West Essex STP which now hosts over 150 organisations with all 3 Acute's accessing a digital GP record and in Mid and South Essex a programme of work to implement a single Local Health and Care Record is already well developed.

Appendix

1 – Primary Care Network Maturity Matrix

Element	Foundations for transformation	Level 1 (least mature)	Level 2	Level 3 (most mature)
Right Scale	Plan : There is a plan in place articulating a clear end state vision and steps to getting there, including actions required at team, network and system level.	Practices identify partners for network-level working and develop shared plan for realisation	Practices have defined future business model and have early components in place.	Network business model fully operational.
Integrated Working	Engagement : GPs, local primary care leaders and other stakeholders believe the vision and the plan to get there	Integrated teams , which may not yet include social care, are working in parts of the system.	Integrated teams formalised to include social care, the voluntary sector and easy access to secondary care expertise in at least some sites. Functioning interoperability between practices, including read/write access to records. Data sharing agreements in place.	Fully functioning integrated team. Workforce shared across network Rationalisation of primary care with optimum estate usage . Interoperable systems Integrated clinical records
Targeted care	Time : Primary care, in particular general practice, has the headroom to make change	Analysis on variation between practices is readily available and acted upon. Basic population segmentation is in place, with understanding of needs of key groups and their resource use. Standardised end state models of care defined for all population groups, with clear gap analysis to achieve them. Prototypes in place for highest risk groups.	The system can track data in real time , including visibility of patient movement across the system and between segments, and information on variability New models of care in place for most population segments, including both proactive and reactive models, with standardised protocols in use across the system. Evidence of active sign posting to community assets.	Systematic population segmentation including risk stratification with in depth understanding of needs of each population segment. Routine peer review of metrics in and between networks. New models of care in place to meet needs of all population segments. Internal referral processes in place. Routine peer review of metrics per hub.
Managing resources	Transformation resource : There are people available with the right skills to make change happen	Steps taken to ensure operational efficiency of primary care delivery.	Networks have sight of resource use for their patients, and can pilot new incentive schemes.	Primary care networks take collective responsibility for available funding . Data being used at individual clinical level to make best use of resources.
Empowered primary care		Primary care has a seat at the table for all system-level decision making.		Primary care network full decision making member of ICS leadership.

2 – HIA Benefits Practice and Patients

HIA	Benefits for practice	Benefits for patients
1 Active signposting	Frees GP time. Makes more appropriate use of each team member's skills. Reduces internal referrals.	Improves appointment availability. Reduces low-value consultations and onward referrals. Shorter wait to get to see the most appropriate person.
2 New consultation types	Shorter appointments (eg phone consultation average 50% shorter, 66% dealt with entirely on phone). More opportunities to support self care with e-consultations, text message follow-ups and group consultations.	Greater convenience, often no longer requiring time off work/caring duties. Improves availability of appointments. More opportunities to build knowledge, skills and confidence for self care.
3 Reduce DNAs	Free GP time. Easier to avoid queues developing, through more accurate matching of capacity with demand.	Improves appointment availability.
4 Develop the team	Frees GP time. Makes more appropriate use of each team member's skills. Reduces internal referrals. Improved job satisfaction for administrative staff undertaking enhanced roles.	Improves appointment availability. Reduces low-value consultations and onward referrals. Shorter wait to get to see the most appropriate person.
5 Productive work flows	Frees time for staff throughout the practice. Reduces errors and rework. Improves appointment availability and patient experience.	Improves appointment availability and customer service.
6 Personal productivity	Frees clinicians to do more in each consultation, with fewer distractions and frustrations. Improves staff wellbeing and job satisfaction.	Improved quality of consultations, with more achieved. Reduced absence of staff.
7 Partnership working	Frees GP time, makes best use of the specific expertise of staff in the practice. Creates economies of scale and opportunities for new services and organisational models.	Access to expanded range of services wrapped around the patient in the community. Reduces delays introduced by referrals to different providers.
8 Use social prescribing	Frees GP time, makes best use of their specific medical expertise.	Improved quality of life. Improved ability to live an independent life.
9 Support self care and management	Frees GP time, makes best use of their specific medical expertise.	Improved ability to live an independent life.
10 Build QI expertise	Improved ability to achieve rapid, safe and sustainable improvements to any aspect of care. Increased staff morale and sense of control.	Assurance of continuous improvement in patient safety, efficiency and quality of care.

HOPSC/19/19

Committee Health Overview Policy and Scrutiny

Date 12 June 2019

HARLOW 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 Harlow Hospital on 3 June 2019.

Six members of the Committee visited Harlow Hospital on Friday 3 June.

Members spent the morning with Lance McCarthy, Chief Executive and Michael Meredith, Director of Strategy, discussing hospital performance including key performance metrics, challenges from continuing increases in demand for services, and the development of the strategy for funding a hospital re-build and current status.

Selected slides from a presentation made on the day are attached (Appendix).

Some key points from the discussion:

- 7.5% increase in demand in A&E compared to previous year (second half of financial year).
- Increase in acuity (people being admitted being 'more sick').
- Standardised Mortality ratios - moving down very slightly but there remained an issue about better capturing the complexity of co-morbidity.
- Infection rates had improved
- Increase in cases from nursing homes.
- Increase in cases from population of central Harlow.

- Changes to triage at A&E with a 'streaming officer' now on site to signpost and redirect as appropriate.
- PAH had spent time and money re-shaping the Emergency Department to improve treatment flows and were planning to increase the amount of assessment space.
- Vacancy rates were averaging 11% - registered nurse vacancy rate was running at 25%. Regular churn. Fill rates at 50% (bank first, and then to agencies). Exit interviews reveal that people often move for better career and training opportunities rather than just for money.
- Significant improvement work had been undertaken as a result of previous CQC inspections. PAH were awaiting the formal assessment of an inspection in March/April 2019 - informal feedback had been positive so far.
- Looking to further improve links to community services especially around End of Life Care.
- Further developing stakeholder and partner relationships and trust will drive the further integration of services.
- PAH does not have modern healthcare estate. Poorest quality estate is the tower block where most of the wards were housed.
- It was expected that the same range of services provided at the current site would also be provided from any re-build site although some may be delivered differently in partnership with community and other providers.
- If proceeding with a new rebuild site, then it is possible that PAH may need to do a full public consultation and prepare an advance pre-consultation business case.
- In due course, PAH will need to talk through the engagement process with HOSC for a view on the engagement plan and formal public consultation and timelines.

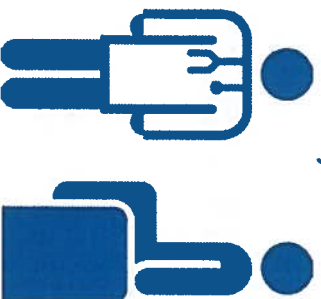
2019/20 in numbers

414



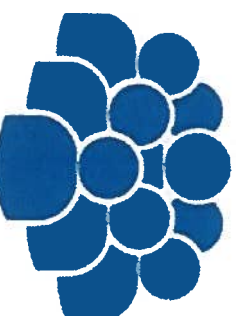
General & Acute
Beds

253,000



Outpatient
Appointments

111,000



ED

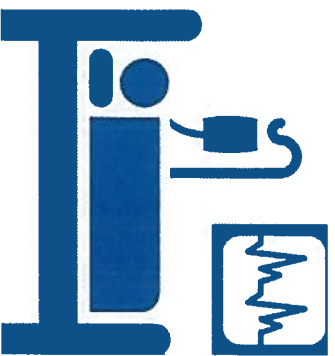
Attendances

c.5,000



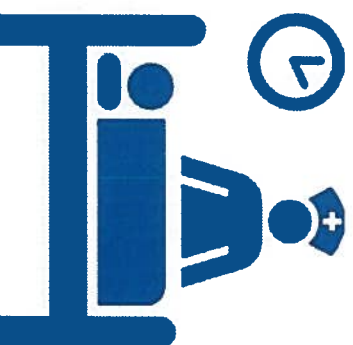
Babies delivered

39,000



Non-Elective
Admissions

28,000



Elective
Admissions

887



Nurses & Midwives
Employed

£232m



Income

£6.2m



Deficit

Our Performance (Quality)

Performance Metric	Target (2017/18)	Performance (April 2019)
Friends and Family score (ED)	90%	92.52%
Friends and Family score (Inpatients)	90%	99.34%
Friends and Family score (Maternity)	90%	99.69%
Mixed Sex Accommodation breaches	0	5
MRSA bacteraemia infections	0	0
Clostridium Difficile infections	10	1
Hospital Standardised Mortality Ratio (HSMR)*	102.3	122.5
Never Events	0	0
1:1 care in labour	100%	100%
VTE risk assessments	95%	98.48%
Hospital acquired pressure ulcers (grades 3 and 4)	0	0



Our Performance (Operational)

Performance Metric	Target (2017/18)	Performance (Mar 2019)
ED 4-hour standard	95%	69.63%
18 week RTT – incomplete pathways	92%	92.3%
6 week diagnostics	99%	99.55%
Cancer 2 week wait target*	93%	98.90%
Cancer 2 week wait for breast symptoms *	93%	86.90%
Cancer 31 day wait for first treatment from diagnosis *	95%	96.90%
Cancer 62 day wait for first treatment from referral*	85%	85.20%
Staff vacancies	7.50%	11.63%
Staff turnover	11%	13.30%



Preferred Way Forward

Scope	What Where	Local Acute Hospital
		✓
		M11 Junction 7a
		✓
Service solutions - How		New build off-site construction
		✓
Service delivery - Who		Estates Contractual partnership arrangement
		✓
Service implementation - When		3.5 years
		✓
Funding		Blended financing model
		✓



Your future | Our hospital

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“The Green Book guidance is the appraisal methodology for assessing costs, benefits and risks to meet investment objectives”

The Green Book guidance was refreshed in November 2018

HOPSC/20/19

Committee Health Overview Policy and Scrutiny

Date 12 June 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 the senior officers.

Monday 3rd June

Agreed actions from discussion:

Vice Chairmanship: discussed seeking a second nomination. Cllr Sargeant to be approached.

12 June HOSC: Essex County Council to be invited to also attend for the primary care item (in addition to health commissioners) - to be asked to report orally on how the County Council links with primary care, how it would like primary care to work in future and linking it with prevention.

Specialist services - correspondence on Moorfields Eye Hospital and Mount Vernon had been received. Investigate further the role of the Outer North East London JHOSC in serving on any specific JHOSCs to be set up, the extent of the role of the Essex HOSC on these issues, and whether any written submission should be made. To be added to July HOSC agenda.

Church Lane GP practice, Braintree - correspondence had been received on continuing concerns. The HOSC Leadership Team to be kept updated.

HOPSC/21/19

Committee Health Overview Policy and Scrutiny

Date 12 June 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 10
		HOPSC/22/19
Committee:	Health Overview Policy and Scrutiny Committee	
Date:	12 June 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 4 June 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.
12 June 2019	Quality and Transformation of Services/Community healthcare (prevention and early intervention)	Primary Care – <i>follow up</i>	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.
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 – <i>follow up</i>	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
September/October 2019	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 – <i>follow up</i>	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 – <i>follow up</i>	In September 2018 looked at the broader role and contribution to wider system.	Follow-up session on local performance – on hold as 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

Essex Health Overview, Policy and Scrutiny Committee

Work Programme as at 4 June 2019

To be programmed:

TBC	Specialist commissioning issues	Proposals and engagement on relocation of services	TBC	TBC
TBC	Capacity and financial sustainability	Temporary move of mental health and other wards in South Essex – <i>follow up</i>	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/ward moves to facilitate Primary care development – <i>follow up</i>	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	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 – <i>follow up</i>	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 – <i>follow up</i>	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 – 27 June	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,	Follow-up session with commissioners and Virgin Care. Family Hub visits being planned for April 2019.
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.
TBC	Quality and Transformation of Services	Sensory services		To be scoped in consultation with ECC officers

Essex Health Overview, Policy and Scrutiny Committee Work Programme as at 4 June 2019

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