Essex County Council

Health Overview Policy and Scrutiny Committee

10:30	Thursday, 07 July 2022	Council Chamber County Hall, Chelmsford, CM1 1QH

For information about the meeting please ask for:
Richard Buttress, Democratic Services Manager
Telephone: 07809 314835
Email: democratic.services@essex.gov.uk

Essex County Council and Committees Information

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.

Members of the public will be able to view and listen to any items on the agenda unless the Committee has resolved to exclude the press and public from the meeting as a result of the likely disclosure of exempt information as defined by Schedule 12A to the Local Government Act 1972.

ECC Guest Wifi
For members of the public, you can now access free wifi in County Hall.

- Please log in to 'ECC Guest'
- Follow the instructions on your web browser

Attendance at meetings
Most meetings are held at County Hall, Chelmsford, CM1 1LX. A map and directions to County Hall can be found on our website.

Access to the meeting and reasonable adjustments
County Hall is accessible via ramped access to the building for people with physical disabilities. The Council Chamber is accessible by lift located on the first and second floors of County Hall.

Induction loop facilities are available in most Meeting Rooms. Specialist headsets are available from Reception.

Online:
You will need to visit the ECC Democracy YouTube Channel https://tinyurl.com/yynr2tpd where you will be able watch live or view the meeting at a later date. If you want to ask a question at the meeting, please email democratic.services@essex.gov.uk by noon on the day before the meeting. Please note that your question must relate to an item on the agenda for the meeting.

Accessing Documents

If you have a need for documents in, large print, Braille, electronically or in alternative languages and easy read please contact the Democratic Services Officer before the meeting takes place. For further information about how you can access this meeting, contact the Democratic Services Officer.

The agenda is also available on the Essex County Council website, www.essex.gov.uk From the Home Page, click on 'Running the council', then on 'How decisions are made', then 'council meetings calendar'. Finally, select the relevant committee from the calendar of meetings.

		Pages
**	**Private pre-meeting for Committee members only** To begin at 9:30am in the Council Chamber, County Hall	
1	**Membership, Apologies, Substitutions and Declarations of Interest** To be reported by the Democratic Services Manager.	5 - 5
2	**Minutes of previous meeting** To note and approve the minutes of the meeting held on Thursday 9 June 2022.	6 - 10
3	**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. No statement or question shall be longer than three minutes and speakers will be timed. On arrival, and before the start of the meeting, please register with the Democratic Services Officer.	
4	**Community inpatient beds** Committee to receive an update on the Community Beds programme in Mid and South Essex.	11 - 51

5	**East of England Ambulance Service Trust** Committee to receive an update from the East of England Ambulance Service Trust.	**52 - 66**
6	**Chairman's Report - July 2022** To note the latest update on discussions at HOSC Chairman's Forum meetings (Chairman, Vice-Chairman and Healthwatch Essex).	**67 - 68**
7	**Member Updates - July 2022** To note any updates of the Committee.	**69 - 69**
8	**Work Programme - July 2022** To note the Committee's current work programme.	**70 - 73**
9	**Date of Next Meeting** To note that the next meeting will be held on Thursday 1 September 2022 at 10:30am.	
10	**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.

11	**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.	

Agenda Item 1

Report title: Membership, Apologies, Substitutions and Declarations of Interest	
Report to: Health Overview Policy and Scrutiny Committee	
Report author: Richard Buttress, Democratic Services Manager	
Date: 7 July 2022	**For:** Information
Enquiries to: Richard Buttress, Democratic Services Manager – richard.buttress3@essex.gov.uk or Freddey Ayres, Democratic Services Officer – freddey.ayres2@essex.gov.uk	
County Divisions affected: Not applicable	

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 Jeff Henry	Chairman
Councillor Martin Foley	
Councillor Paul Gadd	
Councillor Dave Harris	Vice-Chairman
Councillor June Lumley	
Councillor Bob Massey	
Councillor Jaymey McIvor	
Councillor Anthony McQuiggan	
Councillor Richard Moore	
Councillor Stephen Robinson	
Councillor Clive Souter	Vice-Chairman
Councillor Mike Steptoe	

Co-opted Non-Voting Membership

Councillor David Carter	Harlow District Council
Councillor Carlie Mayes	Maldon District Council
Councillor Lynda McWilliams	Tendring District Council

Minutes of the meeting of the Health Overview Policy and Scrutiny Committee, held in County Hall, Chelmsford on Thursday 9 June 2022 at 10:30am

Present

Cllr Jeff Henry (Chairman)	Cllr Carlie Mayes (Co-opted)
Cllr David Carter (Co-opted)	Cllr Jaymey McIvor
Cllr Paul Gadd	Cllr Richard Moore
Cllr Dave Harris (Vice-Chairman)	Cllr Clive Souter (Vice-Chairman)

Apologies

Cllr Martin Foley	Cllr Bob Massey

Remote Attendees

Cllr June Lumley	Cllr Mike Steptoe

The following officers were supporting the meeting:

- Richard Buttress, Democratic Services Manager
- Joanna Boaler, Head of Democracy and Transparency
- Freddey Ayres, Democratic Services Officer
- Jasmine Carswell, Democratic Services Officer.

1. **Election of Vice-Chairman**
   The Committee nominated Cllr Dave Harris and Cllr Clive Harris as Vice-Chairman.

2. **Membership, apologies and declarations**
   Apologies were received from Cllr Bob Massey and Cllr Martin Foley.

   The Chairman welcomed Cllr Stephen Robinson and Cllr Richard Moore to the committee, replacing Cllr Mark and Cory and Cllr Luke Mackenzie respectively.

3. **Minutes of previous meeting**
   The minutes of the meeting held on Thursday 7 June 2022 were approved by the Committee as an accurate record.

4. **Questions from the public**
   No questions from members of the public were received.

5. **GP Provision in Essex**
   The Chairman welcomed the following to the meeting:

   - Pam Green, Alliance Director, North East Essex
   - Avni Shah, Director of Primary Care, Herts and West Essex
   - William Guy, Director of Primary Care, Mid and South Essex

The Committee received the following update covering the following key issues:

- It is a challenging time for the population currently trying to access primary care and there are different perceptions as to why. The health service is under significant strain
- Issues are mainly due to increased demand rather than GP surgeries closing
- Covid-19 has had a significant impact on the delivery of primary care
- A review of primary care has been ongoing for some years but has been impacted because of the pandemic
- Primary care is the front centre of the health service – 80% of health services are delivered through general practice
- Over the past 12 months there has been an increase in activity across the whole of Essex – over half a million appointments
- Primary care is doing a lot to address patient need
- Changes in how appointments are delivered since the pandemic and moved to a telephone triage method
- Gradually this is phasing back but levels have not returned to face-to-face levels from 2019/20
- The triage and telephone approach here to stay and will become a blended method going forward
- Primary care going forward will not be dominated by GP's and will be delivered from different places
- Trying to support practices to better communicate this change of model with patients as it has not always been the case across all practices
- Feedback is being driven by what patients are saying
- Morale in GP practices have hit an all time low, partly due to media reports and demand is outstripping supply
- Primary care cannot work in isolation, it needs collaboration
- Looking towards more digital solutions – video consultations, apps to support patients
- Starting to utilise other providers that can deliver primary care services
- Currently recruiting to new roles in primary care – Care Navigators, Nurse Practitioners, Clinical Pharmacists
- All areas of Essex have an ageing workforce and it is recognised that it will be significant loss of knowledge and experience when they do leave
- Introducing initiatives to improve workforce development, recruitment and retention
- Extended access offer goes live from October 2022 and will be at a primary care network level. The model needs to be tailored to a local population level

Members made the following comments and received responses as below:

- It was noted that health professionals cannot be faulted during appointments, but there are issues around trying to access face-to-face appointments
- Element of customer service is at times unacceptable and is not always possible to maintain dignity when a patient is trying to book an appointment
- People have taken it upon themselves to source alternative methods of care
- Improvements in customer service are much needed

- Receptionists are Care Navigators and should be asking questions in a sensitive way
- During exit interviews with staff, reports of abuse of sometimes given as reasons
- Suggestion that 'mystery shopping' exercise should be undertaken to ensure GP practices are providing a high level of customer service
- Service offers need to be tailored depending on the area/individual to address health inequalities
- Undertaking work to break the perception that access is only available at 8:00am in the mornings
- It is difficult to know what the true demand for primary care is at the moment
- Access to enough GP trainers in surgeries is an issue.

After discussion, it was **Resolved** that:

i) How many people attend A&E who could've been seen by a GP across Essex
ii) Officers were invited to provide a further update on 6 – 8 months

6. Chairman's Report
The Committee noted the information update within the Chairman's report.

7. Member Updates
Members noted the report.

8. Work Programme
The Committee noted the current work programme, and the following comments were made:

- Cllr Gadd made a further request for a list of services and providers that fall under the HOSC's remit

  Update: This information has since been shared with Cllr Gadd and will be made available to other members of the committee.

9. Date of next meeting
To note that the next committee meeting is scheduled to take place on Thursday 7 July 2022 at 10:30am.

10. Urgent business
No urgent business received.

11. Urgent exempt business
No urgent exempt business received.

The meeting closed at 12:40pm.

Chairman

Health Overview Policy and Scrutiny Committee – Matters Arising as of 29 June 2022

Date	Agenda Item	Action	Status
6 January 2022	East of England Ambulance Service Trust	Provide a further update on the progress being made against CQC recommendations in six months' time	Item added to Committee's Work Programme
		Update on performance to be provided in six months' time	Item added to Committee's Work Programme
9 February 2022	Community Children's Services – South East Essex	Provide an update following the transfer of the Lighthouse Child Development Centre to EPUT	Item added to Committee's Work Programme
9 February 2022	A&E Seasonal Pressures	Standing item on the Work Programme. Update to be provided in November 2022 from the acute hospital trusts	Item added to Committee's Work Programme
3 March 2022	Maternity Services at East Suffolk and North Essex Foundation Trust (ESNEFT)	Provide a further update in six months' time on how the Trust is progressing against CQC recommendations	Item added to Committee's Work Programme
7 April 2022	Hospital redevelopment at Princess Alexandra Hospital	Committee to be provided with date for submission of formal planning application	Item added to Committee's Work Programme
		To receive a further update once the business case process is complete,	Item added to Committee's Work Programme

		including whether 2028 delivery date is achievable	
		Sharing detailed plans of new hospital site	Item added to Committee's Work Programme
June 2022	GP Provision in Essex	Updated position to be presented to the Committee in 6 – 8 months' time	Item added to Committee's Work Programme
		Committee asked for data on the number of people who attended A&E that could have been seen by a GP across Essex	Request sent to officers

Reference Number: HOSC/39/22

Report title: Community inpatient beds	
Report to: Health Overview Policy and Scrutiny Committee	
Report author: James Wilson, Transformation Director Mid and South Essex Community Collaborative and Tina Starling, Head of Insight and Engagement at Mid and South Essex Integrated Care System	
Date: 7 July 2022	**For:** Discussion
Enquiries to: Richard Buttress, Democratic Services Manager (richard.buttress3@essex.gov.uk) or Jasmine Carswell, Democratic Services Officer (jasmine.carswell@essex.gov.uk)	
County Divisions affected: Not applicable	

1. Introduction

To update the Essex Health Overview Scrutiny Committee on the work that the Mid and South Essex Integrated Care System (ICS) is undertaking to reconfigure the provision of community beds within mid and south Essex. This will include the work done so far and the pre-consultation engagement undertaken with a range of staff and service users across the three key service areas, intermediate care beds, stroke and frail older people.

2. Action required

The committee is asked to:

- Note this update
- Agree to receive proposals on the consultation approach at a future meeting

3. Background

3.1 At the Committee's meeting in November 2021, a detailed paper was presented which set out the plans of Mid and South Essex ICS to mobilise a significant programme to review the location, configuration and focus of NHS provided community in-patient beds.

3.2 This paper is attached at Appendix 1. The paper outlined the current and pre-COVID-19 configuration of community in-patient beds, together with the case for change. Key factors driving the case for change include the need to:

- implement a **more consistent model for intermediate care beds** that is better aligned with our community-based care services and the wider out of hospital system
- address significant shortages in the way we provide bed-based community **stroke rehabilitation**
- decide whether **urgent, temporary changes made in 2020 to support the response to COVID-19 should be made permanent** or whether a different configuration is now more appropriate

3.3 The November paper signalled that, subject to more detailed work being completed on the options and the completion of pre-consultation engagement (the approach to which was set out), a period of public consultation is likely to be required later in 2022. The Committee was asked to:

- note the plans to commence engagement on the future focus and location of community in-patient beds
- agree to received regular updates on this matter
- note that in future a request may be made to request this committee to form a joint Scrutiny Committee

3.4 Despite a delay to the programme due to Omicron, we have continued to make progress. This includes further refinement of the options, completing an external clinical review (the East of England Clinical Senate) and completion of pre-consultation engagement.

4. Background

4.1 Development of the options

The Committee will recall that historically community in-patient services have been provided from six main sites across mid and south Essex. These sites are located in Billericay, Brentwood, Halstead, Maldon, Rochford and Thurrock, and included intermediate care, stroke rehabilitation and sub-acute frailty services.

4.2 Since the last update to the Committee, we have now completed detailed bed modelling for each service area, building in estimates of likely future demand to determine roughly how many beds are likely to be needed to meet the current and future needs of local people. At a headline level, the modelling suggests that the mid and south system is likely to need to make use of all existing sites in the future.

4.3 Given this, the programme's recent focus has been on identifying options for which services might be provided from each site. To support this, we have completed analysis of:

- Projected travel times for patients, carers and families
- The proposed staffing models for intermediate care and stroke rehabilitation
- The condition of the existing estate
- The likely capital and revenue requirements
- The connections between the beds and other services (for example, the hospital-based stroke pathway)
- An initial integrated impact assessment

4.4 The analysis has been regularly shared with a wide range of stakeholders, including the Directors of Adult Social Care and teams in the council who focus on capacity planning for intermediate and residential care.

4.5 The configuration options and supporting analysis are currently being refined and consolidated into a pre-consultation business case. It is anticipated that the key elements of this will be available for consideration by the Committee later in the Summer.

5. Clinical Senate

5.1 A key element of the programme has been to obtain an independent, external assessment of the service model and configuration options being developed. This has now been provided by the East of England Clinical Senate, who convened a panel of 12 experts to review the programme's proposals.

5.2 The Panel conducted its review in March and April 2022. The Panel included patient representatives as well as clinical leaders for stroke, intermediate care and frailty services.

5.3 The questions the Senate was asked to consider were:

- Overall – are the emerging options for the future configuration of community inpatient beds likely to result in good patient outcomes and support the flow of patients through the system's beds?

- Intermediate care beds: is the clinical model for ageing well, our older peoples programme and the proposed focus and potential locations of community beds likely to contribute to improving outcomes for patients?

- Stroke: is the proposed introduction of dedicated, ring fenced stroke rehabilitation beds in the community aligned with the current evidence base and likely to improve patient outcomes?

- Sub-acute frailty: is the model that has been developed clinically sound and likely to result in at least comparable outcomes to acute in-patient wards for frail older people, and how might it be further developed over time?

5.4 The Senate report – which is owned by the Senate, not the ICS programme - will be published later in 2022. An early version has however been shared and is broadly positive in its assessment of the models of care, the work to date and the clinical pathways and the emerging options. The final report will include recommendations on how the proposals might be further developed or strengthened, which will be addressed prior to any public consultation.

6. Pre-consultation engagement

6.1 As part of the pre-consultation engagement, we commissioned a specialist consultancy to support our work. Kaleidoscope undertook this work in-between Jan-April 2022.

6.2 They undertook both qualitative individual and group interviews which were conducted virtually. There were semi-structured interviews and small public groups with 15 participants.

6.3 Engagement with staff was undertaken through three workshops, supported by an online survey that was available to all staff.

6.4 43 local and national insight and evidence documents were also evaluated as part of the literature review and Kaleidoscope undertook a thematic analysis of the emerging themes.

6.5 The final engagement report is attached to this paper as Appendix 2.

7. Highlights from the engagement report

7.1 Some of the key themes from the engagement were;

- Local access and getting care at the right time was identified as one of the most significant challenges associated with community bed-based care and very important for a patient's rehabilitation or enablement journey.

- Challenges around transport cost and availability was a recurrent theme and 10-20 miles away, was considered a long way. There was an overwhelming consensus that the location of community beds provision should be as geographically close to patients' homes as possible.
- Community in-patient settings provided an opportunity for more holistic, personalised care, compared to the pressures of acute hospitals, which was seen as a positive benefit.
- Negative impact of failed discharges was a significant theme.
- There were concerns about whether the in-patient community care workforce has the skills and training to support patients with increasingly complex needs, along with the right facilities to support those patients. It was also important to ensure that the settings are appropriate for stroke rehabilitation and that the patients have speed of access to those services.

7.2 And finally; the ‘home first’ approach was widely seen to be the best approach where the relevant skills and capacity were available.

8. Key themes around staffing

8.1 Key messages from the staff workshops included;

- Locations require appropriate staff numbers with right skills mix and to fill vacancies quickly
- There should be less reliance on agency staff
- Multi-Disciplinary Team working is essential
- Therapy staff provision should be provided seven days a week

9. Conclusion

9.1 The importance of good community bed-based care was felt across all stakeholder groups with quality rehabilitation and reablement emphasised as a vital part of a patient’s journey and recovery.

9.2 This should include improved discharge planning and support to get patients home, a strong, resilient, and well-trained workforce plus good communication (both between staff and patients and carers and between community bed-based care and other parts of the system).

10. List of Appendices

Appendix A: Community Beds in Mid and South Essex
Appendix B: Report from pre-consultation engagement with community, staff and patient stakeholders – April 2022

Reference Number: HOSC/__/21

Report title: Community Beds in Mid & South Essex	
Report to: Health Overview and Scrutiny Committee	
Report author: Andy Vowles / Claire Hankey, Mid & South Essex Health & Care Partnership	
Date: 03 November 2021	**For:** Discussion
Enquiries to: Richard Buttress, Democratic Services Manager (richard.buttress3@essex.gov.uk) or Jasmine Carswell, Democratic Services Officer (jasmine.carswell@essex.gov.uk)	
County Divisions affected: Not applicable	

1. Introduction

The purpose of this paper is to (a) update the Committee on the current status of community inpatient beds across mid & south Essex, following recent changes that were implemented as a result of COVID; and (b) to advise the Committee of our plans to now commence a period of engagement on the future function and location of these beds.

In discussion with the Committee, we plan to commence engagement with the public, our staff and stakeholders in November 2021 in order to help shape and refine the possible future service model, with a view to commencing public consultation in early 2022.

2. Action required

The Committee is asked to:

- Note the plans set out in this paper to commence engagement on the future focus and location of community inpatient beds in mid & south Essex; and
- Agree to receive regular updates from the mid & south Essex Health and Care Partnership on this matter; and
- Note that in future the mid & south Essex Health and Care Partnership may request that this Committee form a joint Scrutiny Committee with colleagues from Thurrock and Southend committees

3. Background and key issues

Overview

Community hospital inpatient beds provide short-term rehabilitation services to care for people who are either too unwell to stay at home or who are being discharged from hospital but require additional support. Very often, these are frail older members of the community who have been admitted to one of our main acute hospitals, or are people who have suffered a stroke and who, following a short stay in a main acute hospital,

require specialist bed-based rehabilitation.

Across mid and south Essex, we have historically had around 115 community beds spread across several locations. The main sites are:

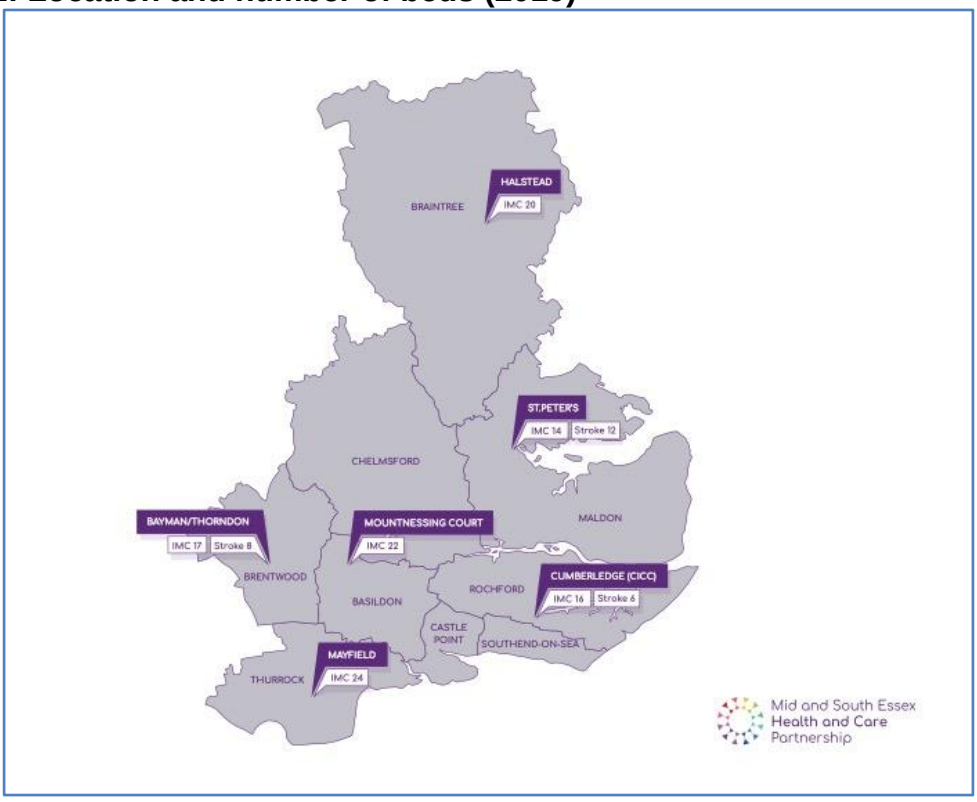
- Billericay
- Brentwood
- Halstead
- Maldon
- Rochford
- Thurrock

Over the last 18 months, an average of 200 people were admitted to these beds each month, and the average length of stay is 18 days. The most common reason for admission is rehabilitation.

Configuration of community beds – 2019

The exhibit below shows the location and number of community beds in 2019*, prior to any of the changes introduced in response to COVID*. At that point, there were two main types of beds – intermediate care (IMC), which generally provided care for people who were well enough to be discharged from a main hospital but were not yet able to return home, and stroke care beds, which provided rehabilitation for people who had suffered a stroke.

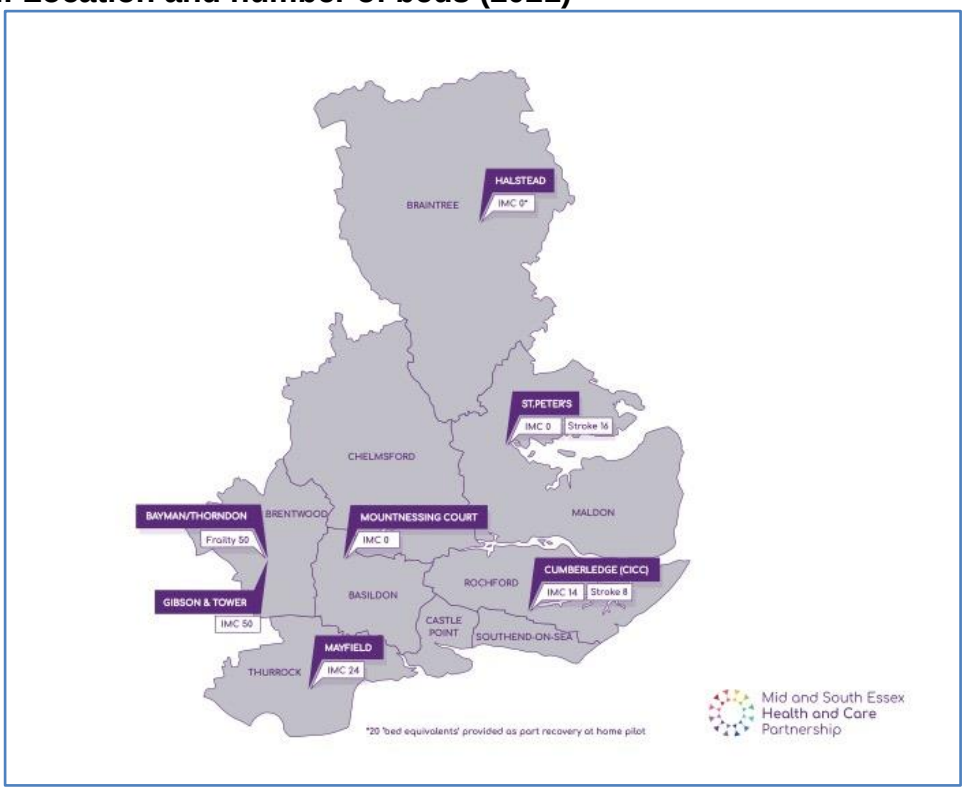
Exhibit 1: Location and number of beds (2019)



Configuration of beds - 2021

One of the many urgent changes made in response to COVID was to significantly alter the location and mix of community inpatient beds. These changes resulted in the following configuration, which remain in place currently:

Exhibit 2: Location and number of beds (2021)



A key change that was introduced involved moving two acute wards that focus on caring for frail older people from the main Basildon Hospital site to Brentwood Community Hospital. This was driven by the need to rapidly increase capacity at the main hospital to meet the additional demands of the first and second waves of the pandemic (especially the need for more critical care beds); the importance of physically separating people with and without COVID in order to minimise the spread of infection; and the need to make best use of the available staff.

In addition, as part of the urgent changes intermediate care beds were relocated from both St Peter's Hospital in Maldon, and Mountnessing Court, Billericay.

In the north of the County (Halstead), we replaced the community beds with an intensive home recovery service, with the teams who were previously based on the ward providing intensive support to people in their own homes.

The case for change

Following the urgent changes made to the configuration of community beds as part of the response to COVID, in recent months a number of our clinical leaders been considering what the future configuration of community inpatient and acute frailty beds

could look like. Our work has been driven by the twin objectives of improving outcomes for patients and ensuring we make best use of the available resources and capacity.

In considering these issues, we have been looking at four main elements: overall hospital bed capacity and flow; stroke rehabilitation; intermediate care; and frailty. These four elements form the core of the emerging case for change.

Overall bed capacity and flow

One of our key considerations is how in future we use the available bed capacity – acute as well as community hospital - to support the overall 'flow' through the system. Getting this right is key to ensuring that we have enough capacity to both respond to emergency pressures (including any future waves of COVID) and to reduce waiting times for elective or planned care.

Alongside a wide range of services and partners, community inpatient beds play a key role in enabling people to be discharged from our main hospitals as soon as they are medically fit; without this capacity, people's length of stay in our main hospitals would increase, making it more difficult to ensure there are beds available for emergencies.

Alongside this, as a result of COVID we now have long waiting lists for elective or planned care. We are determined to reduce these waiting times as quickly as possible, and to do so we need to ensure there is sufficient bed capacity (including in critical care).

Stroke

There are very clear national standards for optimising stroke care, including for rehabilitation following emergency treatment at a main acute hospital. Meeting these standards will be key if we are to consistently achieve the best possible outcomes for all people across mid and south Essex who suffer a stroke.

Initial work by our clinical leaders and their teams suggests that, to meet these standards and to take account of our growing, aging population, we will need to increase the total number of stroke rehabilitation beds we have, and may need to consider consolidating the number of sites services are provided from. This is to ensure that the vital specialist skills that are required for successful rehabilitation are not diluted.

Our objective is to make sure that in future we improve outcomes for patients by developing a consistent approach to stroke rehabilitation across mid and south Essex.

This work builds on the 2017/18 consultation *your care in the best place*[1], which considered a wide range of issues, including how the three hospitals in mid and south Essex might in the future work together to improve outcomes by separating planned and emergency care as far as is possible, and by concentrating a small number of highly specialist services (such as stroke, complex gynaecology, respiratory and urology, as well as vascular services) on to a single site. The consultation also proposed the closure of Orsett hospital, after existing services had been appropriately located, a process which was underpinned by a Memorandum of Understanding.

[1] For more detail on the 2017/18 consultation, refer to the Decision Making Business Case (DMBC), http://v1.nhsmidandsouthessex.co.uk/decision-making-business-case/

Intermediate Care

Intermediate care beds form one element of a much broader set of services that aim to help people remain in their own homes for as long as possible or, if they require admission to an acute hospital, support their discharge and return home.

Our clinicians have been considering the future role of community intermediate care beds as part of our wider work as part of our local response to the national Ageing Well programme, including getting the balance between beds and wider community resources right. Our initial assessment suggests that although we have roughly the right number of beds in total, there is some inequality of access across mid and south Essex, and there is unwarranted variation in the care model across the patch. We think that we could do more to embed a more consistent care pathway across mid and south Essex, building on the evidence base and our own experience.

Our objective is to ensure that in future the role of intermediate care beds is clearly and consistently defined across mid and south Essex. Within this, the engagement will enable us to ensure that any proposals for future community inpatient provision are fully aligned with emerging place-based/Alliance plans, as well as the wider pattern of services provided by other partners, including social care.

Frailty

As noted above, during COVID we moved two acute wards (approximately 50 beds) that focus on caring for frail older people off the main Basildon hospital site to Brentwood Community Hospital.

We are currently evaluating outcomes for patients in these two relocated wards. Based on this information and other information, we will need to decide whether to make this temporary change permanent; whether to move the two wards back to the main hospital site; or whether to explore alternative locations for these wards.

<u>Timetable</u>

We are keen to now discuss some of the thinking so far and possible models for the future configuration of community beds with the public, staff and wider stakeholders. This will help us to identify the full range of options, as well as the pros and cons of each. We plan to do this during November and December 2021.

Following this initial engagement phase, we hope to be in a position to clearly articulate the most promising options for the future number and locations of intermediate care beds, and to then use this as the basis for formal public consultation. We will work closely with this Committee on the details and timing of this, but at this point we envisage starting consultation in early 2022.

Depending on the results of any future consultation, we anticipate that we will be asking the relevant Boards to make decisions on the future configuration in the summer of 2022, with implementation commencing in the Autumn.

Proposed engagement process

The focus of our pre-consultation engagement will be on seeking the opinions of patients, carers, stakeholders and partners on the local health services to be provided in a number of community inpatient settings and to gather views on current and potential service offers.

Alongside this, we will also ask for views on the criteria that we are likely to use in future as we seek define and narrow down future options.

We will examine themes and insight from our existing engagement work, with particular reference to the conversations had around the develop of our local response to the NHS Long Term Plan.
The main focus of our approach will be on the patients and people who represent patients that could be directly affected by the potential changes in the provision of community beds. We plan to do this through targeted engagement, with a strong emphasis on the views of carers.

Will we seek to work with advocacy and support groups including Age UK Essex, The Stroke Association and Essex Carers Support to promote this dialogue.

Over the next few months our clinicians will continue to undertake detailed work to further develop possible service models. As part of this, we will be considering the potential to improve clinical outcomes and patient experience; the impact on staffing; the numbers and types of patients needing our services; and the financial requirements.

We will also be engaging with staff who currently provide services in order to gather their views and insights as we develop our thinking.

This period of pre-consultation engagement with the public and other stakeholders will help to inform and refine the possible service models and options. As part of this we will be engaging with Local Authorities in particular Adult Social Care colleagues on the whole system impacts.

This will then be incorporated into a pre-consultation business case for consideration by a range of groups across mid and south Essex, as well as by NHS England as part of the assurance process.

During this period we will also be engaging with the East of England Clinical Senate, who will provide and external clinical view of emerging thinking and service models.

The proposals contained in the final pre consultation business case will then be subject to formal public consultation. We will work closely with colleagues from the three mid and south Essex HOSCs to agree the details of this process.

Both the pre-consultation and any subsequent formal consultation will be progressed based upon the following principles:-

- We will fulfil our statutory duties to inform staff, the public, patients and stakeholders about proposed changes in service delivery
- We will be transparent and accountable in the rationale for the current situation and

future proposals

- We will consider all suggestions put forwards in the development of options
- We will seek to maintain the reputation of the NHS as a whole; and
- We will respond to questions raised by those with concerns in a timely and informative manner.

Joint HOSC

As any future consultation would span the whole of mid & south Essex, at the appropriate juncture we would be keen to discuss with the Committee the potential to form a Joint Health and Overview Scrutiny Committee (JHOSC), comprising members from Thurrock Council, Southend-on-Sea Borough Council and Essex County Council.

4. Update and Next Steps

Subject to discussions with this Committee, and with the Overview and Scrutiny Committees in Thurrock and in Southend, we plan to start our engagement activities later in November, and to continue discussions for approximately 2 months.

We propose bringing back a summary of the main points from the engagement to this Committee in early 2022, together with a plan – for discussion – on how and when to move to public consultation on the main options. In general, 'formal' public consultations take place over a 12 week period, although naturally this varies depending on the topic and when the consultation is held.

KALEIDOSCOPE Health and Care

Mid and South Essex Health and Care Partnership

Improving community bed-based care in Mid and South Essex

Report from pre-consultation engagement with community, staff and patient stakeholders

April 2022

Contents

About this report

The engagement

This report presents findings from a qualitative engagement programme with community bed-based care patients, staff and community stakeholders including (representatives from carers, health and care professionals working along the pathway, VCSE organisations and members of the public within Mid and South Essex). The engagement, conducted by Kaleidoscope Health and Care, was carried out between February - and April 2022 and sought to understand what is important to stakeholders regarding the configuration of community inpatient beds. Learnings from this programme will be provided to Mid and South Essex Health and Care Partnership, to inform decision making when in the next stage of this consultation process.

Acknowledgements

Kaleidoscope Health and Care would like to thank all project team stakeholders and participants, who gave up their time to share their experiences and insights. Errors and omissions are the responsibility of the authors alone and maybe queried by contacting chloe@kscopehealth.org.uk

Background & Introduction

Background

Community hospital inpatient beds provide short-term rehabilitation services to care for people who are either too unwell to stay at home or who are being discharged from hospital but require additional support. In Mid and South Essex, these patients are often frail, older members of the community who have been admitted to one of four acute hospital sites, or are people who have suffered a stroke and who, following a short stay in a main acute hospital, require specialist bed-based rehabilitation.

The impact that the coronavirus (COVID-19) pandemic has had on NHS and social care systems cannot be overstated, catalysing changes in service delivery and lasting impacts on relationships across the sector. The pandemic has had a significant effect on the way hospitals manage and deliver services, which has had an impact on the availability and use of hospital beds. In Mid and South Essex Health and Care Partnership, these changes were driven by the need to rapidly increase capacity at the main hospital to meet the additional demands of the first and second waves of the pandemic (especially the need for more critical care beds); the importance of physically separating people with and without COVID in order to minimise the spread of infection; and the need to make best use of the available staff.

The pressures mentioned above as a result of the Covid-19 pandemic led to urgent changes being made to the location and mix of community inpatient beds. This notably included:

- Moving two acute wards that focus on caring for frail older people from the main Basildon Hospital site to Brentwood Community Hospital.
- Relocating intermediate care beds from both St Peter's Hospital in Maldon, and Mountnessing Court, Billericay.
- In the north of the County (Halstead), community beds were replaced with an intensive home recovery service, with the teams who were previously based on the ward providing intensive support to people in their own homes.

A map of these changes can be found in appendix 1

Following these urgent changes, clinical leaders across MSE Health and Care Partnership have been considering what the future configuration of community inpatient and acute frailty beds could look like; driven by the twin objectives of improving outcomes for patients and ensuring the partnership makes best use of the available resources and capacity. In considering these issues, this pre-consultation exercise is looking at four main elements: overall hospital bed capacity and flow; stroke rehabilitation; intermediate care; and frailty (or care for the elderly).

Aims of this engagement

In considering these issues, this pre-consultation exercise explored the following four areas:

- What do ideal bed based community services look like to stakeholders?
- What are people's current experiences of bed based community services?
- What changes would improve their experience of bed based community services?
- What are the most important factors for us to consider in making decisions around how we provide community bed-based care, intermediate care, stroke rehabilitation and frailty?

This qualitative led engagement was combined with a document review to understand the issues that are important to people who are most affected, or likely to be affected, by the services and changes to them. This notably included: patients and their representatives, local advocacy, support and VCSE groups such as the Stroke Association. Furthermore, details on the method and stakeholder reach during this engagement are included in the next section of this report.

Methodology

Community engagement

Kaleidoscope designed a mixed-methods evaluation using primarily qualitative data collection methods. Between January 2022 and April 2022, the team from Kaleidoscope undertook a desktop literature review, the evidence uncovered during this review was presented as a separate report. The qualitative strand of this engagement consisted of semi-structured individual interviews and semi-structured group interviews. All interviews were conducted virtually; in part to accommodate the schedules of participants and the project team, and in part due to the ongoing pressures posed by Covid-19.

Table 1: Summary of activities and outputs

Literature Review	Reviewed (and included) 43 documents
Semi-structured interviews and small groups (public)	15 participants
Analysis	Thematic analysis of emergent themes
Reporting	Final engagement report Literature review report

Commented [1]: Is there a way of capturing the number of people or stakeholders we approached? 15 is going to seem like a pretty small sample size!

Commented [2R1]: @chloe@kscopehealth.org.uk do we have this anywhere?

Commented [3R1]: @claire.hankey1@nhs.net I believe you lead on the invite distribution. Do you have the number for this by chance?

Table 2: Stakeholder breakdown (community engagement)

Stakeholder category	Number of stakeholders engaged
Healthwatch representatives	2
Community advocacy groups/residents	6
Acute clinicians	1
Stroke advocacy & VCSE organisations	5
Other VCSE organisations	1

Staff engagement

Alongside a programme of community engagement (facilitated by Kaleidoscope Health and care) Mid and South Essex Health and Care Partnership internally led a programme of engagement for staff. Staff were invited to three one-hour sessions to share their thoughts and views around the future provision of community beds in mid and south Essex. Staff members were provided with a programme narrative beforehand to explain the purpose of each session. There was a good representation of staff professions and groups at each session, including clinical and non-clinical.

Each session focused on four key questions:

- What is important to your patients and their carers and why?
- What enables you to deliver great care?
- What are the barriers to delivering great care?
- If you could change one thing about the provision of community beds in Mid and South Essex what would it be?

A survey of the same questions was available to all staff who were unable to attend or preferred a survey method.

A breakdown of activities and an estimated number of engaged staff members is summarised in table 3.

Table 3: Summary of staff engagement

Activity	Estimated number of staff engaged
Intermediate Care Workshop (24th February 2022)	20

Stroke Rehabilitation Workshop (24th February 2022)	20
Acute Care of the Elderly Medical Wards (23rd February 2022)	10
Mentimeter Survey	20 respondents

Patient engagement

A small number of patients were engaged as part of this process. Overall, patient engagement was limited (in part) due to infection control measures within wards. The project team was assisted by colleagues within the Essex Partnership University FT and North East London FT Patient Experience Services. Volunteers assisting these services were provided with a discussion guide, and instructed to interview patients within wards.

A total of 10 patients were interviewed, participating patients were aged between 68-86. 5 patients were recovering from a stroke, 5 had long term conditions (COPD, Diabetes) and had falls.

Community Engagement

General themes

This section provides an overview of the evidence emerging from community stakeholders in regards to what is important in the general provision of community bed-based services, this includes:

- The importance of the community care inpatient setting
- Access: including locality and getting care at the right time
- Ensuring great quality care
- Developing and supporting the workforce
- Personalised care and patient and carer activation
- Discharge from community bed-based care

Across this section we have avoided referring to ‘intermediate care’ as it was not terminology used by the stakeholders we engaged . We have identified particular themes relating to stakeholders' experiences of stroke rehabilitation and care for the elderly which will be discussed in later chapters.

The importance of the community care inpatient setting

Across the interview process, respondents emphasised the importance of community inpatient settings as a valuable point along the pathway. Some respondents discussed how community beds create an environment where patients feel safe and able to get care in a place that works for them. Stakeholders highlighted that not everyone has suitable accommodation to care

for people in their own homes and that it can create a stressful or potentially unsafe environment, preventing patients from getting the right care.

The value for community inpatient settings was particularly apparent to patients coming out of acute settings but still in need of additional support or rehabilitation in a community bed before returning home. Stakeholders across our interviews highlighted how in comparison with acute hospitals, community beds offered an opportunity for more holistic care, with more time to focus on the patient, their goals and preferred outcomes rather than just treating a condition. One stakeholder working in an acute hospital described how they felt the constant need to make pragmatic decisions to free up beds due to operational pressures. However, in community bed-based care, there is more time to support people through rehabilitation and enablement to meet their personal outcomes.

> *"In community care the focus on enablement and rehabilitation [means] there is the flexibility to take a bit more time to get a better outcome".*

Interestingly, this perspective is mirrored in the patient experience, as many felt acute settings were more dehumanising and had concerns around being in hospital longer than necessary and being perceived as a "bed blocker". Whereas, stakeholders highlighted that patients in community beds did not feel rushed and were supported to maintain their sense of self.

> *"There is more time, effort and opportunity to treat a person more carefully and personally".*

Local access and getting care at the right time

Across the engagement, local accessibility concerns and geographical factors were identified as one of the most significant challenges associated with community bed-based care. Stakeholders emphasised that the location and distribution of beds meant that patients were often admitted to locations that are further from home, with many reporting that patients felt isolated from their homes and families, and carers and loved ones felt stressed by being unable to visit.

We identified two main contributors feeding into people's concerns around bed locations and distances from home. Firstly, many emphasised the major challenges around transport, including the rising cost and limited public transport options across the area. Many highlighted how this sense of disconnect has been particularly heightened in the pandemic due to the lack of visiting, and inability to access public transport.

> *"We don't have good bus services and not everybody can drive when you get to a certain age"*

Secondly, across the interviews with carers, families and residents, there was a strong sense of connection to individual places, towns and localities. While, geographical distances between areas of Mid and South Essex and not objectively large, many residents feel so connected to their local area or community inpatient setting, that being admitted to a bed on the other side of the patch, perhaps 10-20 miles away, was considered very distant and separate to them.

> *"You don't realise how much it means to people, returning back to Halstead...from the windows, you could see across Halstead and it meant other elderly relatives could visit them… When my mum died it made me feel better being where we were (local) and not in a big acute surrounded by other people on a ward"*

While commissioners have limited control over public transport, and people's sense of place, what is clear is having regular contact and connection to carers, families and loved ones is extremely important for patients in community beds. While the overall preference is the 'closer to the family the better', some respondents recognised that beds can't be available in every local area. In light of this community bed-based services should consider how to support connection and contact between patients and families if geographical constraints are a concern, particularly ensuring good communication and keeping families and carers up to date with patients' care and their progress.

Alongside local accessibility, temporal access and getting the right care at the right time were continually highlighted as important factors in people's experiences of community bed-based care. Stakeholders highlighted how timely access to community bed based care is particularly important for a patient's rehabilitation or enablement journey. Many highlighted this is particularly significant when patients are being discharged from an acute setting, as while they wait for a community bed they may lose strength and are unable to access the care they need. Stakeholders identified the particular resources that are more available in community bed-based care including, physiotherapy and getting people moving again to improve mobility, getting the correct medication and accessing additional professional support including psychologists. One stakeholder described the tension between wanting community beds to free up more quickly to take in stranded A&E patients but recognising the longer community patients have within their bed the better their outcomes in terms of mobility and independence.

> *"From the time of referral for a community bed, a patient might wait a week or longer, the difficulty is that they are not getting the therapy they need to enable them to go home. They are lying in bed, losing muscle strength, as they can't access the rehab they need."*

One question and possible solution to bridging the gap between the transfer from acute to community hospital was raised around how much care could start before admission. One stakeholder challenged whether it would be possible to start some rehabilitation and enablement care within the acute and begin conversations pre-admission around what the patient's personals goals are from community bed-based care, so they arrive at the community hospital with a clear set of outcomes.

Ensuring great quality care

Across our engagement, accessing high quality, compassionate and responsive care was continually highlighted as one of the most important factors in people's experiences. Interviewees identified community inpatient facilities providing good care, including St Peters and Cumberlege. As previously discussed, it was largely considered that community inpatient settings provided an opportunity for more holistic, personalised care, compared to the pressures of acute hospitals. A community action stakeholder group representing a recently closed community

hospital emphasised the value of 'low-tech, high nursing care', which focuses on time, enabling independence, and providing the best quality of life for terminally ill patients.

> *"Low tech and high nursing care: lots of time to help people get better, we don't need high tech, we need time and care"*

Across the engagement, a key challenge for maintaining good quality care is the increasing complexity of community bed patients. Stakeholders highlighted that the pressures of the pandemic created an emphasis on freeing up capacity in acute hospitals, in turn creating challenges for community bed based rehabilitation to take on more complex patients. In these instances, the patient's primary health problem will have been dealt with in the acute hospital, but they may be discharged to a community bed with other unmet needs. One stakeholder estimated that currently, up to 50% of community bed patients require more complex diagnostics and specialist help.

We identified three main challenges associated with the increased complexity of patients which we will further discuss below, these include:

- Patients with complex needs not able to take part in therapy and rehabilitation activities
- Slow and limited access and diagnostics between community and acute settings
- Community bed workforce don't have the skills and training needed to care for more complex patients.

Firstly, while traditionally patients were generally discharged to community beds for rehabilitation and enablement, the increased complexity of patients meant they may now they may have other health conditions that would limit their ability to take part in therapy. This sets unrealistic expectations on how quickly a patient will be able to go through rehabilitation and recover and risks patients being held in community beds longer than planned.

> *"Patients who would have been solely for rehab, now have other health issues, need ongoing diagnostics... This sometimes hinders their ability to take part in therapy."*

Secondly, once patients have been discharged from the acute hospital to a community inpatient setting, there can be limited resources to access specialist acute care. An acute stakeholder described how urgent transfers of patients from community to acute hospitals are possible if the patient's safety is at risk, however, there is limited access to urgent diagnostics and specialists within community hospitals. They described how community hospital referrals are triaged by the acute hospital in a similar way to primary care referrals and may result in delays

Developing and supporting the workforce

Thirdly, there were concerns about whether the inpatient community care workforce always has the skills and training to support patients with increasingly complex needs. Stakeholders noted while the staff are highly capable of delivering great rehabilitation and enablement care they have varied experience in working in acute settings and managing patients with more complex needs.

This poses a risk to their ability to provide the right care needed for this new cohort of complex patients.

> *"In St Peters - we are taking on more complex patient needs, I have experience of working in the acute, our matron has the skills too. But the majority of the nursing team does not, they have rehabilitation and therapeutic skills. So to ask them to take on a higher number of acute cases is a risk."*

Across the engagement there was strong praise for staff resilience and supportive workforce culture. Many stressed the importance of having the right workforce and culture needed if a service is going to achieve its goals of supporting patients. Stakeholders praised the culture among frontline staff in community bed units across Mid and South Essex, including St Peters and Halstead. This is particularly significant in the context of the pandemic and a very demanding period. Stakeholders praised both the personal resilience of staff and the system and provider interventions to boost morale.

> *"We have been through a rough period, it's easy for staff members to develop empathy fatigue. This is not happening in MSE, people are still going above and beyond."*

Personalised care and patient and carer activation

A major theme across the engagement is the importance of taking a personalised approach throughout community bed-based care. Stakeholders spontaneously mentioned and supported the key components of personalised care models[1], including: patient choice, shared decision making, patient activation, community-based support and personalised care and support planning. As previously discussed, community inpatient settings offer an opportunity for a more holistic approach to care with more time to focus on the patient, their goals and preferred outcomes. One stakeholder highlighted the importance of how professionals work with patients and their carers so they can visibly recognise the progress they are making. They discussed how this involves holistically reframing a patient's outcomes, and moving away from traditional medicalised bio-markers of success and towards outcomes that are personal to a patient's life.

> *"[An example of personalised outcomes for one patient] was making Christmas cake with their grandchild' after being treated for bad arthritis. This is fundamental to community care particularly."*

Stakeholders highlighted that patients should be enabled to be active partners in community bed-based care delivery. This includes helping them to understand their options, and ensuring they don't feel passive but actively able to participate in choices around their care.

> "*Patients and carers should understand their options and have a degree of personal choice"*

Good communication between healthcare professionals and patients and carers and supporting independence was seen as key contributors to enabling and activating patients in their care. Many stakeholders discussed the importance of

[1] https://www.england.nhs.uk/personalisedcare/

regular and consistent communication from healthcare professionals, both with the patient and carers/families. This supports all parties to feel involved with decisions around care. Additionally, many discussed the importance of promoting patients' independence while they are in a community bed, and how supporting them to look after themselves can have a positive effect on their health and recovery.

> *"Patients were encouraged to get up and get dressed, which was good for morale and meant people were home quicker."*

One particular stakeholder highlighted the importance of co-designing community bed-based services with the patient to support meaningful improvement. They emphasised how consulting with patients can have a huge impact on the effectiveness of services, and can uncover new solutions to challenges. They highlighted a particular example of successful co-design to address high rates of falls in hospital toilets among stroke patients. After consulting with patients it was revealed that those who had left-handed strokes often fell when they had to lean to the toilet roll on the left-hand side, this led to a very simple change but drastically reduced risk and improved outcomes for stroke patients. Examples such as this highlight how small interventions engaging with patients can have a huge impact on improvement across the pathway.

> *"Co-design can make services really effective and responsive. How can we start those conversations around improvement? What are the outcomes in a less medicalised context? How are they co-designed with people with lived experience?"*

Additionally, ensuring community bed-based services are culturally appropriate, adaptive and supportive to patients from different backgrounds was a key theme in the engagement. One stakeholder highlighted how community bed service providers need to be culturally competent through an EQIA lens and must recognise how health inequalities might impact a patient's experience. Providers should seek to support any requirements and be mindful of the particular stress or confusion that might affect patients from inequality backgrounds.

> *"Community bed-based services need to be sensitive to the needs of patients whose first language isn't English, have different diets or are religiously observant."*

Discharge from community bed-based care

The importance of proactive discharge planning from community hospitals to a patient's home and the negative impact of failed discharges was a significant theme across the engagement. Stakeholders emphasised the need for robust discharge planning, ensuring patients have a suitable environment to be discharged to, equipment is in place and support is available when they get home. Furthermore, they highlighted the importance of ensuring that all relevant parties are linked together during discharge including community, social and primary care and families and carers. The impact of not getting this right was felt across stakeholder groups emphasising the disappointment and frustration at failed discharges. Failed discharges were felt to be major setbacks in a patient's journey and a blow to carers' and patients' morale. Suggested ways of reducing failed discharges were ensuring joined-up care is set up before a patient returns home and strengthening community teams to support emergencies.

"The process from hospital to home was traumatic for me, failed discharge after failed discharge. We were at a loss…[they said] come to collect your loved one and then get on with it. The emotional distress to the patient and the carers is immense. The transition could be a lot smoother, a link from inpatient to the outside would make a huge difference."

Furthermore, stakeholders recognised the significance of considering patients' wider determinants of health and potential health inequalities when planning for discharge. Many emphasised the importance of a more holistic view at discharge, considering beyond a patient's specific condition, but psychological needs and support, the suitability of the environment they are being discharged to, and the capacity, capability and support for the carers.

Further integration with other parts of the system was considered to be a key enabler in supporting successful discharge and providing the best transition to care at home. Several mentioned the frustration of having to continually retell your story once coming out of inpatient care, and questioned whether more could be done to link up health and care professionals during discharge. Particular examples of good practice included strong support from primary care and the VCSE sector. Stakeholders highlighted how GPs play an important role as the first port-of-call when a patient arrives home and can help to connect with other offers in the community. Similarly, many praised the wealth of support offered by the VCSE sector across Mid and South Essex, enabling patients and carers to access a variety of services to support their needs and build resilience and connection.

"The voluntary sector has been integral. This is through formal support, or befriending services, also social prescribing and community care that enables the patient to move back into where they'd like to be (closer to home)"

"GP connected them with link workers and social prescribing came in. This created a connected package of support"

Stroke

This section proves an overview of the evidence emerging from participants in regards to what is important when providing care for stroke patients. A number of these key themes align with the evidence detailed in the previous section, this includes:

- the importance of co-designing care with stroke survivors, personalised care which involves the survivor (patient) not just the carer and clinicians,
- involving and supporting the family, helping to reduce readmission
- the role of and impact of the VCSE sector,
- access for families and carers, and speed of access for a patients rehabilitation,
- changes to bed configuration needs to be supported by good transport,
- accounting for higher acuity/complexity and the impact on the pathway/impact on patient participation,
- maintaining a sense of self and the role of community hospitals play in this,

- ensuring that settings are appropriate for stroke rehabilitation

Personalised care

Care which places the patient at the centre of decisions was a key theme emerging from interviews with stroke stakeholders and underpinned several of the themes covered in this section. The merits of a personalised approach to care were mentioned both in the context of direct benefits to patients, but also to the wider system (E.g. impacts on stroke pathway, effectiveness and efficiency).

> *We should be moving into the co-design space for rehabilitation pathways, really thinking about what the steps in the pathways could be simplified. Having conversations between professionals and patients, getting professionals to think about outcomes beyond the medical context. We need to be co-designing with patients and people who have lived experience, building that into what we're doing. The impact on the pathway could be impressive.*

Stakeholders representing stroke advocacy groups and charities agreed that there was no universally accepted approach to providing support for stroke patients, emphasising that no two strokes are the same and each patient's situation is unique. These stakeholders raised the importance of involving stroke survivors in decisions and advice regarding their care, ensuring clinicians do not alienate the survivor through only communicating with carers and families (pertinent in stroke cases where the survivor has communication difficulties).

The role of the family and carers in supporting a stroke survivor through their rehabilitation was emphasised by stakeholders, as was the support that care providers in helping to facilitate this. Stakeholders reported that actively involving the family throughout a survivor's rehabilitation helped to improve the likelihood that a survivor's rehabilitation will continue at home. Stakeholders representing stroke advocacy organisations noted the need for effective communication and training for carers and families, highlighting the associated risks of dropping families into caring responsibilities overnight without the necessary preparation. These stakeholders reported that having nominated social workers was an effective intervention, acting as a consistent, familiar conduit to the family.

Stakeholders also raised the importance of ensuring effective communication and touchpoints for information between stroke survivors, carers and services providing support, particularly following the survivor's discharge from community bed-based settings back to the home. This was raised both in relation to formal providers (I.e primary care) and the important role the VCSE sector plays in providing informal support.

The role of the VCSE sector

Stakeholders representing VCSE organisations emphasised the importance of stopping stroke survivors from feeling like 'they had been dropped off a cliff' following discharge from community rehabilitation. This included utilising resources through commissioned services, providing an informal community response such as befriending services, linking to other individuals with lived experience (both for carers and stroke survivors) and promoting self-management to enable patients to take action on their own health. These stakeholders, local to Mid and South Essex, highlighted the negative impact

Covid-19 has had on these services, warning that provision was ‘patchy’ across the area as a result of the pandemic.

Holistic approach to care & maintaining a sense of self

Consistent with the theme of person-centred approaches to care, stakeholders noted the importance of viewing the needs of stroke survivors (especially following discharge from community rehabilitation) holistically, in addition to their clinical requirements. This included a wider consideration of the determinants of a survivor's health and wellbeing, including psychological needs, support for their family and lifestyle achievements beyond medical progress.

In addition, stakeholders reported the importance of survivors ‘maintaining a sense of self’ throughout their care journey. Given the devastating impact a stroke can have on the body, survivors' sense of self can be negatively impacted including their ability to accept and reflect on their condition, make positive adjustments, and take control of their wellbeing. Stakeholders in this engagement process highlighted those care settings, and the associated level of personalisation associated, have a large role to play in helping to maintain this. Stakeholders indicated that in stark contrast to acute hospital settings, community bed-based care was more likely to provide a holistic package of care for a stroke survivor, allowing for more time to treat the person, not just the condition.

> *“One thing that comes out strongly when people speak about community bed-based rehab is the difference it provides compared to being in an acute hospital setting. People start to get their sense of self back. I’ve spoken to a client recently who was telling me about the loss of dignity in an acute setting, one example was her care team allowing her to wet herself in bed (as the care team thought it was the best option due to safety and how busy they were). They thought they were doing the right thing, but it had a devastating impact on the rest of her stay. She mentioned that no one brushed her hair, she didn’t feel like herself. I think that's the difference between acute and community rehab beds, you start to get that sense of self back through a more personalised level of care”.*

Bed locations & Accessibility

Stakeholders highlighted the impact that the location of stroke rehabilitation beds has on experience and outcomes for stroke survivors, particularly regarding the ineffectiveness of interim care placements (such as within specific care homes). These stakeholders reported they had seen patients discharged to intermediate care settings where the services were not equipped or organised to meet their needs, leading to a patient's progress going backwards. Stakeholders also referenced specific care homes within the area where staff did not understand the formal process around discharge, leading to survivors being discharged back home without a proper impact assessment.

Accessibility was another key theme highlighted by stroke care stakeholders. This was firstly in regards to speed of access to stroke rehabilitation, helping to make progress as quickly as possible following a stay in an acute setting (and the associated impacts of immobility). Accessibility was also raised in relation to the

location of stroke services; stakeholders reported the negative impact of relocating stroke rehabilitation beds where this has an impact on the ability of friends and family to visit. This was reported both in relation to the negative impact this has on the family and carers (the pressures of being further away from loved ones), the difficulty of VCSE organisations to keep track of clients when they have been moved out of the area, and also the impact on the stroke survivor; as connection with family was seen as an integral determinant of health and part of the rehabilitation journey.

> *"People are angry if they can't reach their loved ones, and for the stroke survivor themselves…to not have that connection with family (or to have it limited by public transport costs or barriers), it's a determinant of health to have that connection with your family, it's part of your rehab journey and if you feel disconnected this won't aid your rehab".*

Supporting this, stakeholders reported that the pandemic had heightened the impact that continued connection with family and friends has on in-patients. Stakeholders highlighted that rising travel costs and an inadequate public transport system had made it more difficult for families and carers to visit their loved ones. This highlighted the need for bed reconfiguration to be supported by adequate local transport systems.

> *"The pandemic heightened access issues…people didn't want to, or couldn't use public transport and private taxis are too expensive. When services are reconfigured, if it's explained properly to communities (that it's so patients can get the right care, in the best place with the best team) they understand that…but if the transport systems don't underpin that it becomes a massive emotive issue for everyone".*

Increased acuity in community settings and the impact on rehabilitation

Stakeholders reported the impact of discharging stroke survivors from an acute setting to a community rehabilitation setting with higher acuity. As mentioned in the previous chapter, this increase in the number of patients with complex health needs has, in part, been driven by a national emphasis to create capacity in acute hospitals (particularly post-pandemic). This means that patients are presenting care needs beyond their rehabilitation activities, care needs that previously would have been picked up by acute providers. Stakeholders highlighted that this presents the following challenges:

- Following discharge from an acute setting to a community rehabilitation setting, patients may face delays in accessing specialist care,
- delays in addressing these care needs lead to a reduction in the patient's ability and capacity to engage in their rehabilitation,
- current time limitations on community bed based rehabilitation mean that survivors who do not engage in their rehabilitation early enough may be discharged home without the proper tools necessary to continue their rehabilitation at home (leading to poorer outcomes and higher rates of readmittance)

> *The biggest challenge we face is that we are taking on more complex patients in community rehabilitation settings. The patients have their primary issue dealt with, which may be their stroke…but they now have unmet needs that the acute hospital could have picked up before they*

send the patient to a community hospital. Their problem isn't making them critically ill but it's impacting their ability to participate in the therapy.

"The patient should be in a place where they can get the most out of their rehabilitation, not medically unwell so they can't derive benefit from it. After a stroke, patients can be depressed…every time a therapist asks if they would like to participate in their therapy, they are asked to leave them alone. They need to be supported to get the most out of their therapy/rehabilitation".

Stakeholders reported that differing scales of rehabilitation are needed to account for this increase in complexity amongst stroke survivors. Stakeholders reported cases where stroke survivors had felt rushed through the system, discharged without having the necessary tools needed to cope at home and not fully understanding their situation (I.e. the stroke they have had and the support they will need). These stakeholders suggested an increase in the number of touchpoints throughout the patient pathway, accounting for 'slow burners', or patients who face delays in engaging with their rehabilitation due to higher acuity. Stakeholders noted that this would lead to benefits for the patient and system alike, reporting that currently there was an issue with a delay in accessing ongoing community therapy for patients who had already been discharged home (going to the 'bottom of the pile') resulting in poorer progress and outcomes for these stroke survivors. These stakeholders also reported that the wider system would benefit financially from interventions that focussed on readmission avoidance.

Care for elderly patients

This section provides an overview of the evidence emerging from participants in regards to what is important when providing care for elderly patients, including those living with frailty. This includes:

- Access to services for patients, families and carers,
- care supported by good communication between patients, carers, families and clinicians,
- the value of a holistic approach (especially around the discharge process),
- and the impact of care settings

Accessibility

Access to services in a local setting was reported by stakeholders to be a key factor in shaping elderly patients' care experience. This was firstly noted in regards to the benefit to the patient themselves, this included: elderly patients nearing the end of their life having the opportunity to die in their own community, and the benefits of remaining closer to home and their families.

Accessibility was also raised in relation to the impact on the patients' families; stakeholders reported that elderly family members struggle more with transport options (I.e. elderly family members are less likely to drive) and this is heightened if they are forced to travel further away to see their loved ones, these stakeholders also highlighted that limited visiting times and inadequate local transport options compounded this issue. Stakeholders recognised that holding beds for residents was neither a reasonable nor realistic proposal, however,

these stakeholders called for a smarter approach to bed usage to mitigate the impacts of patients and families having to travel further away.

The impact of care settings

Similarly in other sections in this report, the impact of care settings was reported by stakeholders to be an important factor when considering ideal care for elderly patients. Care settings were often mentioned concerning the differences between inpatient care within acute and community hospital settings, this included:

- Getting elderly patients into settings where mobility is encouraged; beneficial to elderly patients by reducing the negative impacts of losing muscle strength,
- being in a familiar community environment as opposed to an acute setting which could be frightening, unfamiliar and pose more of a risk to elderly patients due to the acuity of the patients around them,
- community hospitals represented a controlled setting where patients could test new medication and have timely access to specialist support to aid in rehabilitation (such as psychologists and physiotherapists),
- community hospital settings were linked to a patient-centred approach, underpinned by the stakeholder perception that clinicians within these settings could spend more time with patients.

Effective communication

Stakeholders reported that effective communication was a core component of providing great care to elderly patients. This point was raised particularly in relation to patients who were living with conditions such as dementia, providing clear and accessible communication routes for families and carers to ask questions; keeping them informed about their loved ones' care needs. Stakeholders reported that ideal care would be the facilitation of a partnership between patients, carers, families and providers/clinicians. Good communication and the care that falls out of this were reportedly undermined by a lack of resources or available time amongst healthcare professionals. This was seen as an issue for patients who may require more time to engage in their care, meaning that families were left to fill in care gaps.

> *"In an ideal world, it would be a partnership between the patient, carers, the patient's family and the providers of care. Communication is absolutely key, particularly for bed-based care…for a person with dementia being in hospital can be very confusing…the main thing is that the family and carers feel as if they have someone to talk to within the hospital environment."*

Holistic approach to care (understanding the whole picture)

Stakeholders reported that taking a holistic view of the patient and their situation at home was key to avoiding 'failed discharge'; where patients are discharged home without ensuring there is adequate support for them in that setting. Failed discharge means that patients are at (avoidable) risk, there is a higher likelihood of them returning to hospital which has negative consequences for the patient (morale, poorer outcomes) and for the system as a whole due to the financial implications. Stakeholders reported that the realities of a patient's home situation may be different to what is recorded, effective communication between clinicians, patients and families/carers (that enables choice and input) was seen as

paramount to ensure that patients are not discharged into unsafe environments or stuck in hospital settings for longer than is necessary.

> *Until someone has spoken to someone at home and discovered simple things like not having a downstairs shower, not having the right stuff to keep on top of their care…or if you're looking to discharge an elderly patient who's 6ft 5 and you're asking a 5ft 1 elderly partner to look after them. There is what works on paper and the realities of what is going on at home…excellence would be looking at that whole picture.*

Another example raised by stakeholders, focussing on undiagnosed learning disabilities also demonstrates this point:

> *We've done a lot of work recently on understanding inequalities, one thing we've found is that there are a lot of people with undiagnosed learning disabilities who are living with elderly parents…it's not taking a lot for those parents to not be able to manage their care, however, if they're not known to services they don't have that package of care in place. There's a blindspot there…if mum or dad is moved into bed-based care, what is the situation they leave behind? It's the same vice versa, what happens if the parent can't manage those caring responsibilities and end up stuck in the acute or step down care as there isn't a safe space to discharge to.*

Stakeholders also noted that community care teams and local community support groups should be deployed on a wider scale following discharge, to ensure adequate care for these patients. Stakeholders also reported the need to ensure that support was offered to carers after discharge, particularly for older carers. These stakeholders highlighted the potential negative impact of carers putting off their own health needs to prioritise their caring responsibilities, both on the carer themselves and the person they are caring for.

Staff Engagement

This section provides an overview of the evidence emerging from a series of engagement activities with staff members across Mid and South Essex Healthcare Partnership, this includes:

- Workforce
- Patient Care
- Environment/location, facilities and equipment
- Communication

Workforce

Workforce was seen as a vital area for further improvement in order to deliver better care. Overall, three areas were identified as needing consideration: the number of staff (which is currently perceived to be low with too many unfilled vacancies and recruitment often taking too long), the types of staff such as having the right skill mix and experience, and the passion, motivation and collaboration of staff.

For current staff, it is felt that their available time is sometimes insufficient to give the patient the best possible care. Staffing numbers were seen as a barrier to delivering great care and it was seen as key for the staffing numbers to increase, there were also specific comments regarding the need for more resources for inpatient staff numbers with a good team being described as including higher level medical colleagues, nurses, health care assistants, physiotherapists and occupational therapists, as well as more provision of the smaller professional teams such as Speech and Language Therapists and Dietetics. Staff commented that they wish to be consulted in the setting up of new services to agree adequate resourcing levels.

Staff also identified the need for more permanent (as opposed to agency) staffing to provide a solid core of full and part time staff who understand the important routines, protocols and attitude to work in a challenging environment such as a hospital ward. It was also suggested that teams need the ability to flex staffing across the acute and community to cover where needed based on changing pressures.

A need to improve working conditions, pay and morale was also raised by some people. Staff stated that they sometimes feel pressured by Key Performance Indicators which they suggest can be a barrier to the care they should be providing and that Standard Operating Procedures do not always fully reflect what they are trying to achieve. They would also like to remove some of the bureaucracy and processes which are antiquated and remove autonomy of staff.

Up to date training and development (both personal and professional development) opportunities were also important to staff as an enabler for delivering great care. One member of staff suggested increasing shadowing opportunities for both development and cooperation to increase understanding between teams and their differences or challenges.

For intermediate care and stroke teams, staff felt that there needs to be a shared reablement ethos, where every opportunity for rehabilitation activity is used to encourage patients, such as supporting them to make their own breakfast or undertake self-management such as toileting and washing where they are able to do so. All staff should be offering a rehabilitation approach to maximise patient potential.

Staff stated they should also be working together as a team as it was commented ‘teamwork enables delivery of great care’ and we should be setting goals with the patient that all teams are working towards in collaboration. Patients should also have access to all members of a Multidisciplinary Team (MDT) who are needed to assist the patients recover. MDT working is considered essential and MDT should also involve the wider health and care system, not just those within the community bed provision. It was felt that specialist teams are currently too inaccessible and is a barrier to delivering great care, and so across mid and south Essex there should be equal access to the right therapists in a timely manner. Joint working between therapists and families or carers should also be increased. Furthermore staff felt there needed to be provision for therapy staff seven days a week to ensure therapy is continuous and minimise delays to discharge. There also needs to be a reduction in waiting time access to psychological support, social care and community support.

Patient Care

Working through the patient journey, it was first commented that all health and care colleagues would benefit from shared patient records. For the patient, this would mean they do not have to repeat their story so frequently. For colleagues this would allow them to understand the needs of patients they are due to receive and may alleviate the current 'lack of integration of health and social care elements of intermediary care and community care.'

It was also noted that there are times where patients arrive who are too unwell to benefit from rehabilitation and the types of referrals need to be reviewed. Staff also wish to remove differences in commissioning to reduce variation and specifically suggested we 'stop trying to make patients fit a box,' and instead provide care specific to the patients needs.

Staff believe patients want and need person centred care which takes a holistic approach. For rehabilitation patients in particular, families need to be able to visit and engage with their therapy needs and be part of the rehabilitation process. Good rehabilitation should have the appropriate level of rehabilitation to optimise the patients' chances of continuing to live their lives as they choose, such as intensive therapy within community bed provision to get them home as quickly as possible. Functional independence was a point of note from staff believing the patient needs to gain as much independence and mobility or function before returning home and that we should be driven by good outcomes and recovery. Presently the opposite is felt by some staff who commented on length of stay targets leading the patient journey and putting pressure on staff to discharge to enable greater flow into the service, rather than being led by goals specific to each patient. Once a patient is discharged there is a need for a more responsive Early Supported Discharge provision to help enable discharge as soon as the patient can be safely managed at home. It was also noted there is a current lack of social care provision following rehabilitation.

Staff highlighted that patients need to trust in the care being delivered and the staff providing it with more continuity of care and more 'joined up' services supporting the patient. Patients and their families need to feel involved in decisions and care and patients need to feel a sense of progress or validation. There also needs to be greater support for the patient's families or partner to stop the patient feeling like a burden. Family members need to receive input to help support or care for the patient at home; 'support for the families if the patient requires a carer can improve their functional status and reduce the burden to acute hospital admissions.'

Other specific points for improvement identified include; making better food choices available and better quality of food, improvement in patient transport waiting times, availability of immediate medication such as pain relief in the community, and easier to navigate escalation processes if the patient becomes more unwell with comments that there are 'currently poor escalation procedures.'

In summary staff would like to increasingly develop needs-based services driven by patients rather than time limits or pathways, equity of access across mid and south Essex, flexible pathways, and community beds provision available if needed.

Environment/location, facilities and equipment

The location of care and the facilities or equipment to deliver care were of huge importance to staff, with many comments regarding a challenges over resources both in the variety and quantity.

The first point of note was that staff feel the 'home first' approach should always be the guiding principle to decide on the most appropriate care for patients. However, staff acknowledged that the patient's place of residence may not always be the optimum or safest environment, and therefore there needs to be community bed provision with the right facilities to support the patient including those with complex rehabilitation needs. The provision of hospital-based therapy provided by multidisciplinary teams can give patients the confidence to go home, as opposed to patients perhaps only receiving one visit per day to a home setting where progress may therefore be limited.

There was overwhelming consensus that the location of community beds must be as geographically close to patients' homes as possible. Staff commented that they have known patients to decline care if it's too far away from their home. It was also commented that provision needs to be as equal as possible across mid and south Essex to reduce current variations.

Location is also important in enabling families or friends to visit the patient. This was seen as key to both the patient's experience, and also care, as visits keep patients connected to home and motivated to recover while enabling the family to be involved in the rehabilitation and prepares them to support the patient at home. (See Patient Care section for further information.)

It was also strongly felt that the location of community beds should ideally be easily accessible by public transport to enable visitors as transport to community hospitals is seen as a long term problem. Patient transport services can also a barrier to preventing care with staff reporting long waits for the patient to be transferred and the time of transfers often happening too late in the day to give the patient adequate time to acclimatise to the new setting before it is time to go to bed.

Where community bed provision is required, staff described in detail the need for modern facilities and the necessary equipment to deliver personalised care relevant to the patients, especially rehabilitation. Part of this is driven by the comments described in the Workforce section that all activities should be part of rehabilitation, for example there should be kitchens which can be used with the patient at meal times, rather than just an Activities of Daily Living Assessment kitchen. The overall inpatient environment should also be made to feel or function more like a home than a hospital. Other suggestions outlined included a gym, parallel bars, riser recliner chairs, tilt in space chairs, and walking hoists. It was noted that while some of this equipment may already be available there is not enough of it to support patients. Other suggested patient facilities included; a day room for elderly care, better facilities for dementia patients, and better equipment for patients own use including televisions and telephones.

The types of bed provision were also discussed, with staff commenting that there needs to be slow stream bed provision, for further information see the previous 'Patient Care' section.

The optimal scenario for community bed provision was described as a dedicated community hospital or purpose-built rehabilitation unit, with the wrap-around

community services working in partnership with this. It should cover a wide range of patient needs including non-weight bearing patients and be able to cater for recuperation prior to rehabilitation. The community beds at place level should have seven days a week therapy provision with the Frailty Virtual wards co located.

Communication

Communication was a strong theme across all three staff groups and ranged from communication with patients to relationships with other providers.

Staff feel it is important for patients to only have to tell their story once and not repeat themselves at each stage of the patient journey or with different healthcare professionals. Good communication from health care providers to the patient was also seen as essential to give them an understanding of what has happened to them and what their options are, this will enable the patient to have a voice in their own care and share decision making. It was also expressed that better communication would help manage patient expectations, and in particular that expectations need to be set in the acute hospital settings, for patients to understand the pathway and to have a realistic view of what the rehabilitation in community bed provision will involve. Post discharge communication could also be improved through support networks and better patient follow up.

Communication between health and care providers was also highlighted as requiring improvement. Communication at the point of referral needs to provide the right information to the service receiving the patient, before the patient arrives and there is a need for robust medical information from the referring acute hospital. Examples given include miscommunication as to the reason for the transfer of patients, medical notes not always following the patient, and inappropriate referrals.

Digital systems could improve communication and staff proposed access to patient information and shared records to enable them (along with other providers) to deliver great care. Staff would like to see IT systems support better communications across the whole pathway, with particular mention of health and social care record systems.

Communication could also enable better collaboration between health and care providers, it was noted that services currently work in isolation and are lacking good relationships between organisations, which is seen as a barrier to delivering great care. A suggestion was made that providers need a shared vision and commitment to define what great care is and then to deliver it together. Staff would like transparency in communication and responsiveness across services, with onward referral services noted as currently being too unresponsive.

Patient engagement

When asked what great community care should look and feel like, patients described a number of factors that contributed to their experience. The importance of delivering care with kindness was noted by patients, ensuring that they are provided with emotional support as well as physical support. The provision of empathetic care was noted by some patients as being reliant on staff having more time, or not 'being rushed off their feet' to deal with emergencies.
24 Improving community bed-based care in Mid and South Essex: Engagement Report

These patients also made direct comparisons with the care they received in an acute hospital setting, explaining that staff in those settings had less time for person centred care.

Patients who had recently had a stroke emphasised the importance of kindness within care; made in reference to the emotional condition of an individual following a stroke and highlighting the impact that an empathetic approach has on a patients journey and recovery. Patients noted that the kindness and encouragement they had received through their care had directly impacted their will to live following their stroke.

> *Offer of emotional support as well as physical support is just as important. After a stroke your emotions are all over the place and every single person here genuinely cares and you can feel that as a patient.* **Patient**

Patients also reported the impact of a positive atmosphere during rehabilitation, providing encouragement, when asked how this could be improved some patients requested more group activities (providing a fun element) and more activities to break up the care routine.

> *All the people are merry and make me feel grateful to be making progress.* **Patient**

Patients also mentioned elements to their care that made them feel good about themselves, or more than just a patient. This included:

- providing patients with haircuts,
- providing quiet spaces for patients,
- providing opportunities to be sociable,
- providing amenities such as television, and computer access,
- access to natural light,
- good food,
- access to a chaplain

Patients commented on the importance of feeling prepared to go home, supported by effective communication from staff (particularly communicating when the patient should be going home), and daily therapy sessions that built up their strength and confidence (leading up to the completion of their care journey). Patients reported the importance of feeling confident in their ability to manage their health condition, or safe in the knowledge that they have support from health services should they require it.

> *They teach us to care for ourselves in preparation to go home. I am not nervous to go home now.* **Patient**

The role of the family throughout the recovery process was also mentioned by patients, this included visitation times for family members and helping patients communicate with family virtually. When asked how this could be improved; some patients requested free parking for family members and a change to visitation rules, notably allowing a second person to be able to visit.

> *Great care helps me to keep communicating with my family back home…the nurses have taught me how to make video calls.* **Patient**

Several patients mentioned that they would like to receive community bed-based care close to home, or in their own home where possible. Although this point was not explored in detail, care close to home was raised by some patients in reference to visitors. One elderly patient highlighted that they had less visits from friends and family due to them being further away from their community.

> *"Be nearer home as my visitors cannot travel this far regularly…Its far from home so my visitors cannot see me frequently (they are all in their 80s)"* ***Patient***

When asked about other factors they would improve, or what had not gone so well, several patients reported feelings of boredom, made worse by the fact they had been in hospital for what felt like a long time. Patients understood that this was due to issues within the discharge process.

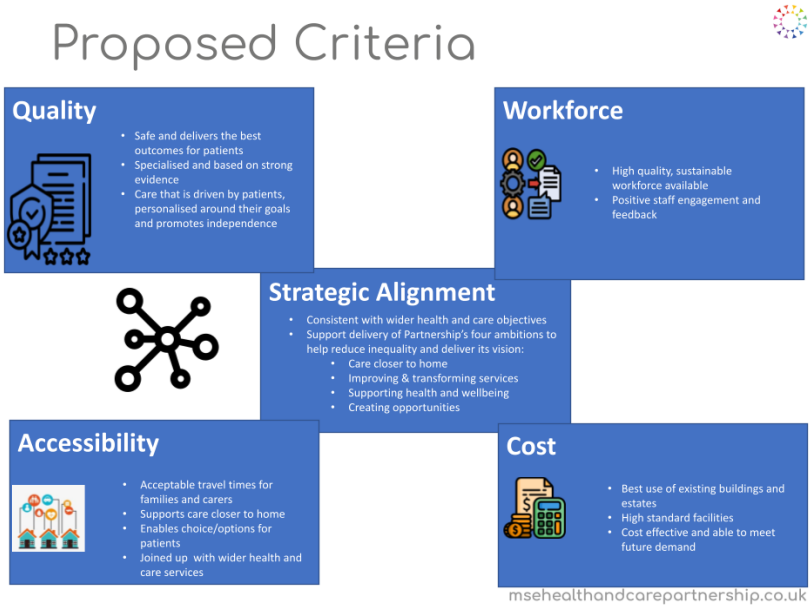
> *I have been waiting to go home for weeks. I was told it's because there is a delay in my care package…It would be good if there was better communication with social services and me and my son were told what was happening.* ***Patient***

Testing decision making criteria

As part of the community and patient semi-structured interviews, Kaleidoscope tested a slide containing a potential set of criteria that could be used in decision-making about future service configurations in community bed-based care in Mid and South Essex.

The slide is shown in figure 1:

Figure 1: Proposed criteria slide



The team explained the proposed use of the slide but otherwise shared it without commentary, allowing time for participants to initially react to whatever seemed important to them. Participants were then invited to comment on each of the criteria individually, remarking on what they felt excellence looked like in each. Finally, stakeholders were asked to prioritise the decision-making criteria, implying a weighting that could be used in reaching decisions.

It should be stated that participants varied in their level of interest in this question, and not all engaged with it. However, some participants provided thoughtful and detailed responses which are summarised in this section.

Overall

Stakeholders were receptive to the necessary simplification of the slide, which presents a complex and interlocking decision framework as a single, static set of criteria. One stakeholder noted that it was difficult to assess the criteria in isolation from the governance process within which they would be used. A well-designed governance process, with appropriate participation from stakeholders, would locate the criteria within a conversation. Such a conversation would bring the criteria to life. It would develop and interpret them using a range of perspectives - place and system, patient and professional, intermediate care and rehabilitation. Without this context, aspects of the slide raised several questions and concerns, even while participants recognised the individual criteria as well-intentioned and appropriate.

They also observed that the criteria are not mutually exclusive. In other words, they do not represent a menu of choices from which some elements can be selected or prioritised, and others rejected or deprioritised. Rather, all elements are needed to produce a viable configuration of services. Across both community and patient stakeholder groups “quality” was identified as the pre-eminent

criterion, recognising the offered description of quality as valid. One stakeholder felt that investment should prioritise quality and the workforce, while recognising that the one leads to the other, as means to ends. Among patient groups, accessibility was also recognised as a leading decision-making criterion.

Stakeholders identified the following elements as potentially missing or under-emphasised in the existing framework:

- the patient perspective
- the composition of the workforce
- local flexibility and patient choice
- value as opposed to cost

Patient perspective

Patients and their representatives seemed to struggle slightly to see the patient voice in the criteria. "How," one asked, "can these criteria be explained through the experience of the patient?" The slide we showed was identified as a tool for managers to make decisions on behalf of patients, rather than as a tool for co-creation. Was there a risk that services designed in this way would be "done to" patients rather than done with them? Nevertheless, stakeholders did recognise the importance of the patient-centred criteria already in place:

> *"If you get personalisation right it's the gold standard."*

> *"Enabling choice for patients is great for people with dementia."*

Composition of the workforce

Some stakeholders wanted to see more focus on the composition of the workforce within community inpatient settings. They were concerned about continuity of care and wanted an explicit intention to minimise the use of bank staff.

> *"If you have someone staying on a ward for two weeks, if they see the same 5 people the care is consistent and more likely to be high quality… they can get to know the patients. If it's bank nurses, then there is a lack of consistent care and that becomes haphazard"*

Others noted the challenge presented by the fact that community settings can be staffed by people from different organisations, reporting that it was important that these staff are supported and led to evolve a shared common purpose.

> *"The workforce in community hospitals come from multiple providers. The community provider would normally employ the nursing and therapy staff…but there may be a clinical psychologist from another provider, doctors from acutes or GP surgeries. We need to make sure that staff from different organisations share a common goal…there is a tendency or risk of prioritising what works best for your employer."*

The varied, evolving and complex needs of patients in community settings require an equally varied range of skills. Stakeholders recognised, and valued, the contribution of and care provided by nursing staff, but noted that, as intermediate care beds are occupied by patients who are still in the early stages

of their recovery, access to specialist skills becomes necessary. These skills include but are not limited to, appropriately trained medical staff.

The need for appropriately trained staff for these complex settings raised the question of training overall, which participants felt should be brought out in the criteria.

Local flexibility and patient choice

Stakeholders recognised that the introduction of choice, both for patients and for service managers and local commissioners, adds complexity to decision-making.

> *"People don't like to travel very much, but I have never heard people talk the same way about hospitals or hospital treatment. I'm sure people would like things closer but there's only so much you can do."*

This comment implicitly recognises that there are limits to the amount of choice and flexibility that can be offered if at the same time you want to offer settings that are appropriately equipped and staffed.

Stakeholders noted the importance of local decision making. Exacerbation plans detail what happens if a person living with a long term condition becomes iller, particularly in a way that is an unfortunate consequence of their condition. They are an integral part of personalised healthcare. Local decision-making is essential to exacerbation plans, because these plans often specify that patients are not admitted to the emergency department, and identify an alternative setting. This alternative pathway may not reflect the "standard" pathways used for patients who do not have an exacerbation plan. However, in the context, it is clinically appropriate. This flexibility can only be achieved where decision-making is devolved and patients are able to make decisions with their own local services.

One stakeholder noted that choices are needed by professionals as well as patients. The system needs to be flexible enough to accommodate everyone who has a rehabilitation need, for whatever reason. At the moment, patients who do not fit the eligibility criteria can risk getting stuck in acute beds.

> *"Staff working for that patient will advocate for the patient…they would want the best outcome for the patient [and not necessarily the normal pathway step]."*

Finally, some stakeholders stressed the need to respect local variation in the configuration of services. This reflected both variation in the services currently available, and also the need to integrate with health and social care services in the patient's own locality, which will inevitably vary.

Against this, one stakeholder noticed the absence of the inequalities agenda from the decision-making criteria.

Value as opposed to cost

Reacting specifically to the cost criteria, some stakeholders agreed strongly with the intention to make the best use of existing resources. But others felt that an emphasis on cost as a proxy for value was misplaced. One argued for the

capability to assess the “longitudinal” or lifetime cost of patient care as part of decision-making.

> *“If you get the right care the first time, it will have a longer impact…there is a fiscal return on getting care right, so you avoid emergency admittance and acute care”*

This longer-term perspective is perhaps reflected in the intention to create opportunities for further strategic alignment. However, this criterion was not well understood and perhaps needs reframing.

Conclusion

In conclusion, this engagement has identified the major themes of what is important to stakeholders regarding community bed-based care in Mid and South Essex. This is emphasised by the clear alignment and agreement between the community, workforce and patient stakeholder groups. The importance of good community bed-based care was felt across all stakeholder groups with quality rehabilitation and reablement emphasised as a vital part of a patient’s journey and recovery. There is strong alignment in the key themes and characteristics identified for quality community bed-based care across the community, workforce and patient stakeholders including:

- access to the right care at the right time,
- a holistic and personalised approach to care,
- good communication (both between staff and patients and carers and between community bed-based care and other parts of the system),
- discharge planning and support to get patients home,
- and a strong, resilient and well-trained workforce.

Similarly, there is clear agreement across stakeholders on the major challenges facing community bed-based care in Mid and South Essex. Particularly, the issues relating to access, the geographical location of beds and access closer to patients’ homes. While this is a challenging issue to address, especially in the context of external, transport and cultural factors in Mid and South Essex, our findings demonstrate good communication and carer and family activation can help alleviate some concerns. Additionally, the pressure of the pandemic and its strain on community bed-based care and the broader system is a major challenge identified in this engagement. As a consequence, the increased complexity of patients has had strong implications on care delivery and patient outcomes. This engagement identified potential areas to address this challenge including good MDT working, ensuring the workforce has the relevant training, development, systems and infrastructure to support them deliver care and strong connections to other parts of the system for effective admission and discharge in and out of community inpatient settings.

Report title: East of England Ambulance Service Trust	
Report to: Health Overview Policy and Scrutiny Committee	
Report author: Tom Abell, Chief Executive, East of England Ambulance Service Trust and Chris Lewis, Public Affairs Officer, East of England Ambulance Service Trust	
Date: 7 July 2022	**For:** Discussion
Enquiries to: Richard Buttress, Democratic Services Manager (richard.buttress3@essex.gov.uk) or Freddey Ayres, Democratic Services Officer (freddey.ayres2@essex.gov.uk)	
County Divisions affected: Not applicable	

1. Executive Summary

1.1 We continue to make good progress with the actions identified by the CQC in 2020 and our follow-up core inspection has already taken place. Five new permanent directors appointed since Chief Executive Tom Abell joined the Trust last Summer.

1.2 Exceptional pressures in both the volume of patients and the seriousness of patient conditions have continued through winter and into summer – this has been experienced across the NHS.

1.3 We have put a range of measures in place to help mitigate these pressures and help us reach urgent patients faster – and help less urgent patients get the help they need quickly.

1.4 These include:

- Recruiting and training over 100 call handlers - and are recruiting more - to help reduce call answering time.
- Increasing the number of private ambulances, we have on shift.
- Recruiting additional clinical staff.

1.5 We can confirm there are no plans to close Shoeburyness Ambulance Station in the current financial year (22/23). EEAST will continue to operate from the current site and any future plans will be developed through proactive stakeholder engagement including with this committee.

1.6 Our apprentices continue to qualify with our new training provider, MediPro.

2. Improvement programme

2.1 The Trust continues to make good progress with the actions identified by the CQC report of September 2020. Our progress is checked and challenged by regional NHS England with the CQC and other stakeholders including NHS partners, Healthwatch, union, education and professional bodies.

2.2 Of the 174 actions identified by the CQC, 95% are complete with 15

outstanding actions. Currently 8 actions remain open and are green or amber.

2.3 As part of the change in oversight measures, the Trust had shifted from special measures to the new System Oversight Framework (SOF) regime.

2.4 In May, we had a follow-up inspection. We have yet to receive the formal report, as anticipated, they also identified several areas for improvement – this included:

- Issues around morale and access to training
- The impact of the Trust being on heightened surge levels for extended periods of time
- Staffing issues within AOCs, including the impact of the significant increase in the number of call handlers has had within the centres
- Lack of progress in the culture of the AOCs
- The challenges of meeting planned staffing levels whilst recruitment activities are ongoing and high sickness rates are being experienced
- Issues around estates and equipment, particularly the current condition of Chelmsford AOC in advance of its planned refurbishment this year
- Some incidences where medicines management best practice arrangements were not being consistently followed
- Some incidences where COVID related infection control procedures were not being followed

2.5 We have taken this feedback very seriously and for those areas where we did not already have activities in place to improve, we have taken steps to rectify the issues raised.

2.6 As this report is prepared the CQC have carried out an inspection on the ‘well-led’ category and the outcome of this inspection is likely to be received and enter a period of checking and confirmation as this report is being compiled. We will be able to discuss this inspection further at our next report to the committee.

3. Changing EEAST's culture

3.1 Changing the culture of the organisation so that everyone feels safe in their place of work and can speak up if they see poor behaviour, is one of the organisation's most urgent priorities.

3.2 It was one of the key pledges that new CEO Tom Abell made to staff when he commenced his role, and it is a major part of the Fit for the Future Programme.

3.3 Tom is holding regular meetings with staff and leaders across our Trust to talk frankly about these issues and how to deliver change.

3.4 Staff are engaged through weekly leadership messages and online *We Are EEAST* briefings from the chief executive and senior managers have continued weekly throughout the last few months, alongside regular on-site presence across the Trust.

3.5 Our leadership messages are now shared weekly by email to all staff as this was highlighted as the preferred method in our communications survey.

3.6 The Chief Executive is also visiting acutes and Integrated Care System (ICS) areas on a six-week rotation and is joining Hospital Ambulance Liaison Officers (HALOs) around the region, to see first-hand the delays and experience our staff and patients see daily.

3.7 These actions have been supported by more than 700 sessions with staff on the range of cultural challenges faced by the Trust, alongside ongoing advice and support provided to managers on how to improve support to staff.

3.8 Reviews of the Trust's governance and culture have been completed and actions agreed. Governance now sits under the Director of Corporate Affairs and Performance to strengthen our approach to robust governance and transparency.

3.9 As highlighted in our submission to the EHRC in October, EEAST has now carried out over 2,000 actions towards embedding cultural change. These have included:

- The appointment of Hein Scheffer as Director of Strategy, Culture and Education
- More than 140 staff providing wellbeing support to colleagues by acting as ambassadors, champions or mental health first aiders
- Investing an additional £170,000 into staff health and wellbeing over winter which included increasing support for mental health and musculo-skeletal issues – the main causes of staff sickness
- Removing the cap from mental health support sessions for staff
- Hiring a special team to assist with completing and closing the outstanding backlog of Employee Relations (ER) cases. The vast majority of these have now been closed.
- Strengthening the Freedom to Speak Up service with additional resource and has seen a 900% increase in the number of contacts to the Freedom to

Speak Up service in comparison to last year). EEAST is also seeing high numbers of contacts for formal complaints. This is an important signal that some of the systems and processes are beginning to work better, and people have greater confidence that their concerns will be both heard and acted upon. Further additional resources have been agreed to deal with ER casework as staff come forward and the numbers continue to increase.

- Over 45 different areas of support, coaching and guidance have been provided to managers and staff within the Trust including skills development, team building, signposting, supporting change initiatives, difficult conversation training, identifying inappropriate behaviours, relationship building, developing behaviours and early interventions.
- A suite of manager training and staff values and behaviours training has been established and is in place for staff to access, supplementing the reviewed, revised stronger Trust policies that are now in place.
- In May 2022, the Trust took swift action when it was found that a number of staff had broken the staff guidelines by making inappropriate posts on a private social media account.

4. Equality and Human Rights Commission (EHRC)

4.1 Good progress continues on Equality and Human Rights Commission compliance - all actions in our original plan are now complete.

4.2 Our first monitoring point submission was made in October 2021, and we are preparing for our next monitoring point.

4.3 Our recent harassment survey has indicated a significant reduction in the number of sexual harassment incidents experienced by staff.

4.4 In the last year, we have taken a range of significant actions to address the deep-rooted cultural issues within our Trust, including:

- Strengthening our disciplinary processes
- Significant progress in resolving historic formal complaints from staff
- Encouraging people to speak up with a 900% increase in people coming forward due to our ‘Speak Up, Speak Out’ (Freedom to Speak Up) campaign
- Significant work with local teams to help address culture change issues
- More than half of staff have currently undertaken comprehensive new values and behaviours training

This work has resulted in:

- 5% reduction in bullying and harassment from managers
- 76% reduction of staff currently experiencing sexual harassment.
- 41% reduction in staff who have experienced sexual harassment in the past

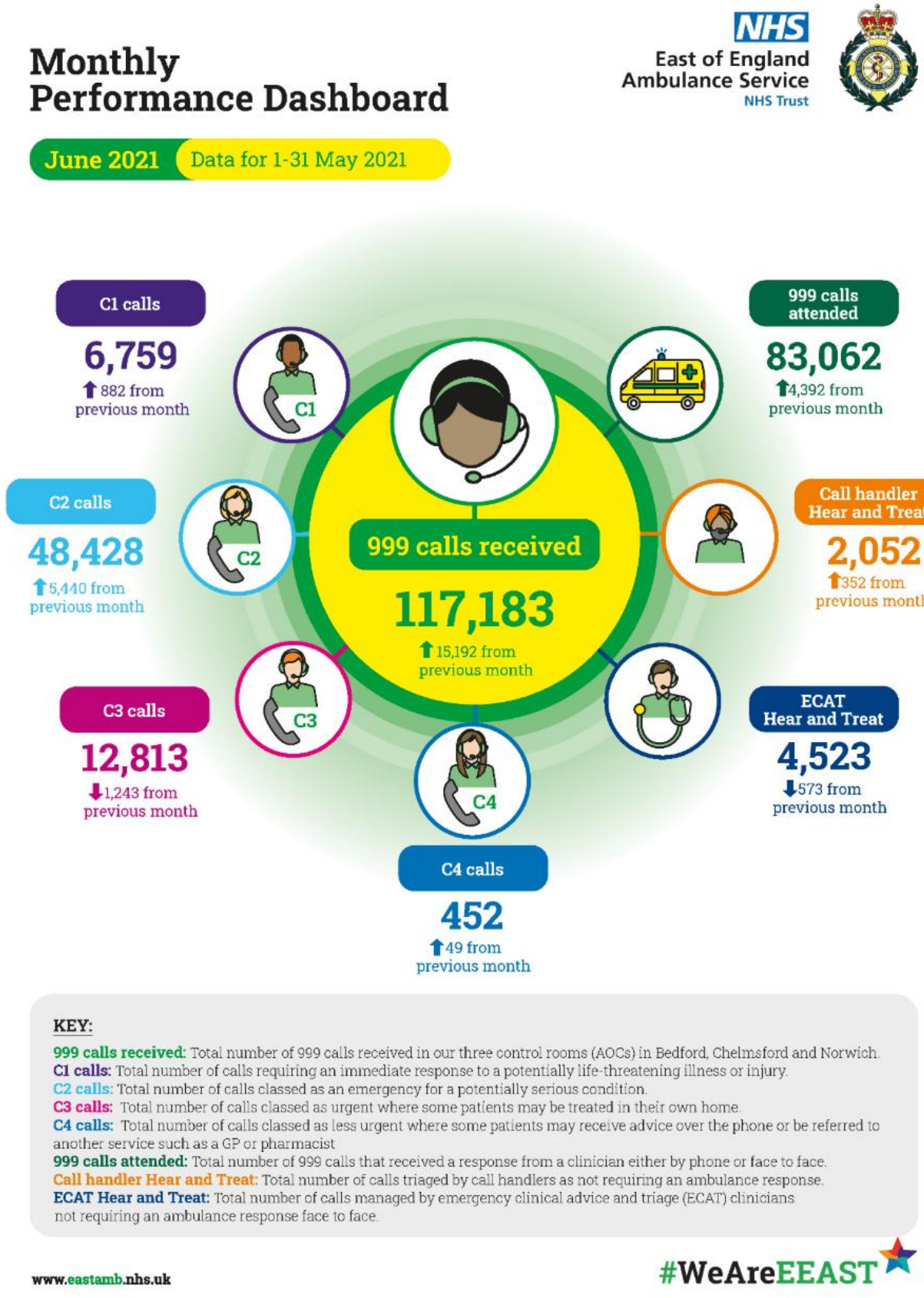
5. Ofsted

5.1 Following the termination of our in-house education provider contract following an Education and Skills Funding Agency (ESFA) inspection, we worked closely

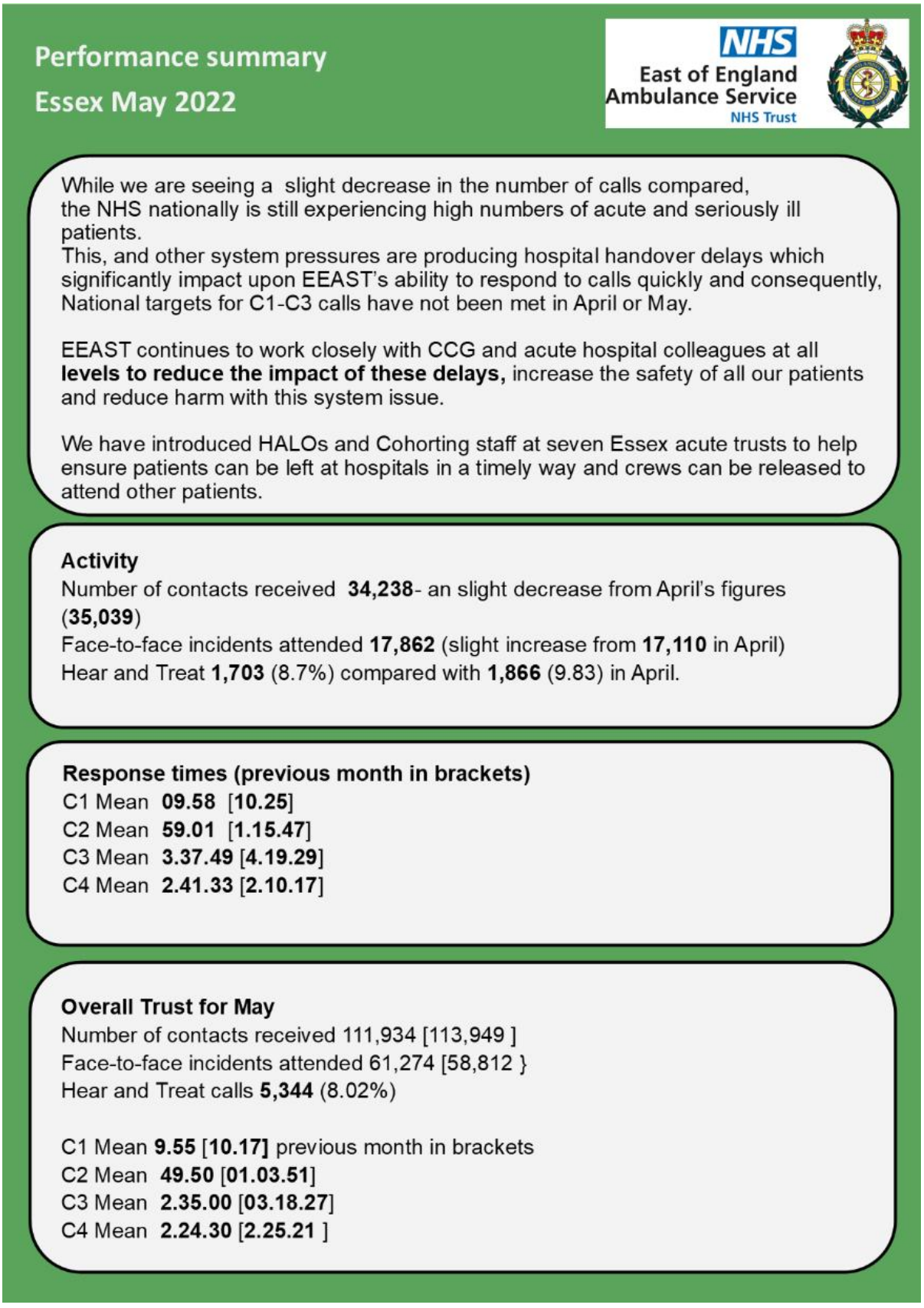
with Health Education England to source an alternative provider - the education provider MediPro.

5.2 We have worked closely with MediPro to transfer apprentices with minimum disruption to learners and in January the first cohorts of apprentices passed the theory section of their training and moved into the work placement stage.

6. Regionwide performance overview



7. Local Performance



7.1 The exceptional operational pressure on ambulance services continues nationally, with a resultant impact on patient safety, staff welfare and culture.

7.2 This is predominantly attributable to increased demand, handover delays and continuing high levels of staff sickness, and is resulting in avoidable patient harm at a system level.

7.3 The Trust has been operating REAP 4 (Resource Escalation Action Plan 4) since late summer 2021. The national REAP framework is designed to maintain effective and safe operational and clinical response for patients. REAP 4 is the highest escalation alert for ambulance trusts and is currently the status of nearly all ambulance Trusts in England.

7.4 Despite unprecedented patient demand, we have worked hard to ensure that we are able to respond to calls in order of need, prioritising Category One (C1) calls (immediately life threatening) first.

7.5 The increase in patient numbers has also seen an increase in *seriously* ill patients.
EEAST is contracted on the basis that 8% of our calls will be the most serious C1 category.
In recent months this figure has been between 10
To tackle the pressure on C1 calls during winter, we developed the C1 Performance Plan.
This created 24 key points around the region.

7.6 Our local key points include Chelmsford, Basildon and Southend where peak C1 calls were predicted. These points are covered with C1 responders, including Rapid Response Vehicles, ambulances and Community First Responders. These points are reviewed daily by local teams to ensure the best way to maintain cover. This is to ensure that we maintain a safe service to our sickest patients.

7.7 We are taking a number of additional steps to improve patient response times across the region including:

- Recruiting and training over 100 call handlers - and are recruiting more - to help reduce call answering times.
- Increasing the number of private ambulances, we have on shift.
- Recruiting additional clinical staff.

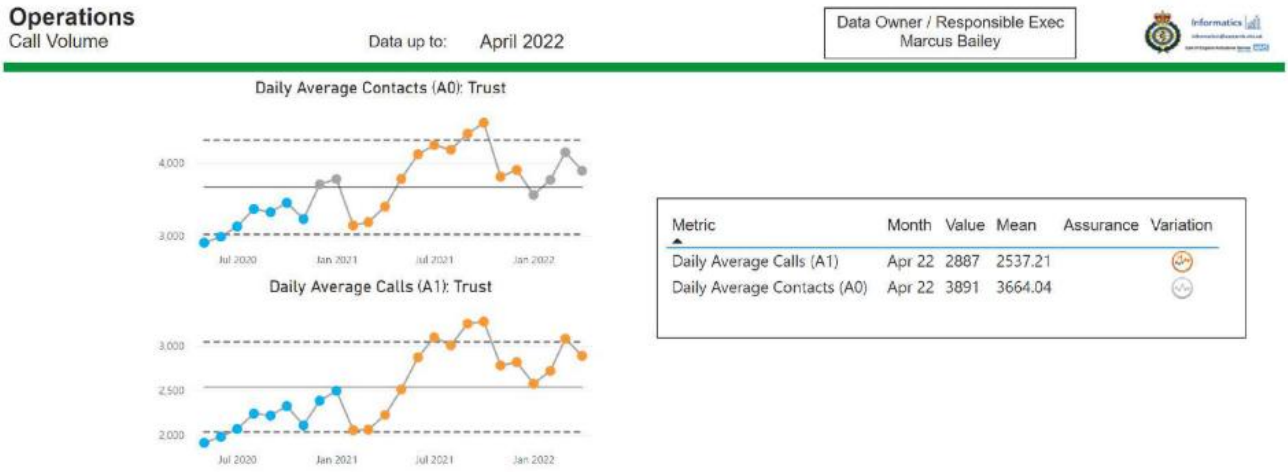
8. Region-wide performance overview

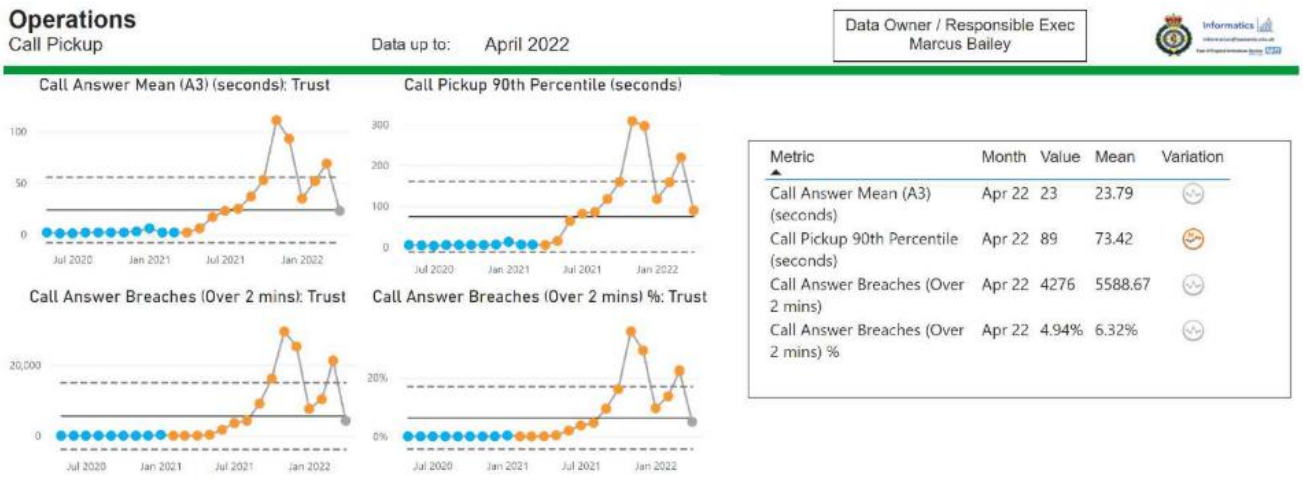
8.1 The figures below are for April performance:

- The Trust averaged 2,887 contacts a day during April (3,600 during March). A0 (below) indicates the overall number of ambulance control room contacts (including those dispatched from NHS 111, from other healthcare professionals and other blue light services. This does not include abandoned calls.

- A1 includes calls answered on 999 emergency lines. It does not include Police, Fire, or HCP calling direct dial numbers or from NHS 111.

    - C1 calls: total number of calls requiring an immediate response to potentially life-threatening illness or injury
    - C2 calls: total number of calls classed as an emergency for a potentially serious condition (e.g. stroke)
    - C3 calls: total number of calls classed as urgent where some patients may be treated in their own home (e.g. falls)
    - C4 calls: total number of calls classed as less urgent where some patients may receive advice over the phone or be referred to another service such as a GP or pharmacist





9. Local Performance

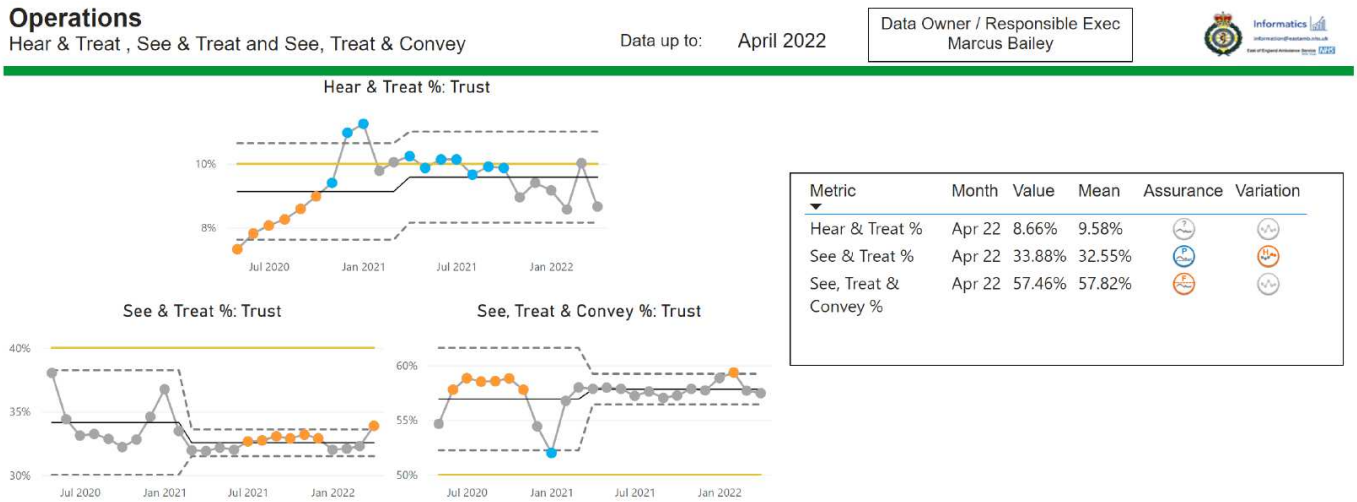
9.1 Hear & Treat involves a call handler or emergency clinical advice and triage clinician triaging the call and providing clinical advice by phone or video as a way of avoiding taking the patient to hospital. Increased use of Hear & Treat has led to a reduction in the number of patients taken to hospital emergency departments over the winter months.

9.2 While maximising our community response capabilities by avoiding crews being delayed at calls that did not require an ambulance, it also allows those non-urgent patients to get the help they need quickly.

9.3 We have resourced this with the deployment of 35 advanced paramedics within our Ambulance Operations Centres to undertake triage, closing at least 15 calls in a 12-hour shift and:

- Ensure the sickest patients are prioritised and responded to first - improving patient safety.
- Triaging calls, to ensure accurate risk stratification and avoid sending physical responses when utilising alternative care pathways is clinically appropriate,
- Directing advanced/specialist paramedics in RRVs to those patients where conveyance avoidance can be achieved.

9.4 The Trust is also exploring use of Consultant Connect alongside the above activities to provide medical input to clinical decision-making and appropriate signposting and care for patients.
Consultant connect enables



10. Hospital Handovers

10.1 Hospital handover delays continue to impact on performance.

10.2 The average Arrival to Handover time has slightly improved since the previous month and is currently at 00:44:16. The percentage of handovers over the 15-minute target remains static at 79.05%.

10.3 Another action we have taken to improve C1 response times has been to maximise the number of double-staffed (traditional) ambulances to ensure that our fleet flexibility for any type of call is maximised, alongside establish priority points for some Rapid Response Vehicles (RRV).

10.4 The impact of increased demand is also being felt at acute trusts where they have reported an increase in both footfall to emergency departments and in the severity of the patients. Although we are not conveying a higher percentage of our patients, the impact on the Ambulance service is increased handover times.

10.5 We continue to work closely with partners across the system to try to minimise handover times at hospitals. This includes Hospital Admissions Liaison Officers (HALO) at each of the acute trusts; staffing areas of the hospital and providing other support to help release ambulances back into the community to meet patient needs.

10.6 The Trust has updated its Standard Operating Procedure for Intelligence Conveyance (IC).
IC is the conveyance of patients to a hospital that may not be their local or normal hospital.
It distributes patients arriving at A&E Departments taking into account data about ambulance arrivals and other measures of Emergency Department pressure. This should support patient safety and enable the crews to make decisions as to which hospital is under the least pressure. There are exclusions to this which involve patient diagnosis and other criteria.

11. Local issues and programmes

11.1 Handover performance at Essex Hospitals:

Hospital delays significantly impact upon our ability to provide a sufficient response.

When ambulances are held at Emergency Departments, it means on-the-road resource is lost. When this occurs, after bringing in available temporary support from the next nearby resources, we will often be forced to hold 999 patients in queue, for allocation until resource becomes released at handover. Patients that have to wait are constantly assessed and prioritised in order of clinical need.

They are also “welfare-checked" by clinicians in our 999 Control centres, who make clinical judgements as to which patients’ conditions may be worsening or stabilising and their priority is then escalated or de-escalated as required.

11.2 Essex Hospital Handover Delays

For the week ending 26/06/2022 the average arrival to handover delay at Essex Hospitals was 38 minutes, but this has come down from an average of 49 and 53 minutes for the previous two weeks (National target is 15 minutes).

11.3 EEAST continues to work closely with CCG and hospital colleagues at all levels to identify and reduce the impact of these delays as much as possible. We have dedicated Hospital Arrival Liaison Officers (HALOs) deployed at all Essex acute hospital sites. They work with NHS colleagues in the trusts to identify barriers to timely patient handovers, provide smoother patient transitions and offer support at times of increased demand.

11.4 “111 First”, where the public are encouraged to contact 111 if they have an urgent care need, continues to be one of the tools the NHS can use to improve response times and delays at hospitals. The 111 service allows patients to be directed to the right service that can meet their needs quickly, first time. They have access to pre-bookable slots in Emergency Departments, a range of same-day emergency care clinics and to a 2-hour urgent response from the community.

11.5 By pre-booking urgent care services within hospitals and the community we expect to see reduced congestion in Emergency Departments that will free up resource to improve ambulance handover.

11.6 We have a number of Early Intervention Vehicles (EIVs) operating across Essex. These help to maximise the number of patients that can remain safely in their own home without being taken to A&E. These include a Falls and Urgent Care EIV in North East Essex and a Rapid Intervention Service EIV in West Essex.

11.7 EEAST’ senior management meet weekly to review performance and take action to support areas where performance recovery is needed. Actions are also reviewed where specific planning is needed e.g. seasonal or event planning.

12. Alternate care pathways and admission avoidance

12.1 In West Essex, we are holding a two-week trial using daily calls with the Community Provider (EPUT) to look at patients currently on the 999 stack that may be more suitable to be seen in the community. The trial has been successful to date and helped strengthen relationships between both NHS Providers.

12.2 Also as part of the local admission avoidance strategy, the Rapid Intervention Service - teams of Advanced Paramedics - support local GPs practices by providing urgent face-to-face interventions for acutely unwell patients who would normally require an ambulance. The team are linked into the integrated community teams and can receive referrals from GPs, EEAST crews, Community Teams and Care Homes via the Single Point of Access.

12.3 Rapid Intervention Service crews can set up six-week reablement care packages, physio, OT and palliative care when required. Clinicians are able to perform near-side blood and MSU testing and review patients enabling them to deliver outstanding care in the community. There has been evidence to show that this innovative scheme has led to a reduction of 17% acute admissions into the local ED with 80% of patients discharged on scene.

12.4 Rapid Intervention Services cover Epping and Waltham Abbey PCN, Harlow PCN and Loughton PCN.

12.5 An Ambulance Improvement Week is being held across Mid and South Essex from the 4th-10th July 2022. This event is aimed at identifying, raising awareness and understanding issues faced by our system and identifying solutions to these issues. In particular, the event will examine issues around attending patients in the community (trying to access alternative care pathways to avoid conveying) and those that Hospital staff face in offloading patients and taking clinical handovers.

12.6 Numerous Health and Social Care partner organisations have volunteered staff (including A&E Consultants, Chief Nurses, Directors of Operation and Local Authority Directors) to come and undertake an observation shift with EEAST staff and we have designed a bespoke data collection for the event. The EEAST Executive Leadership Team, Clinical Leads and other teams will also be participating.

13. Late finish programme

13.1 Numerous Late finishes have a big impact on staff's homelife and wellbeing and last year we trialled a new programme to reduce late finishes (https://ntk.eastamb.nhs.uk/news/trial-aims-to-reduce-late-finishes-for-dsa-and-rrvs.htm).

13.2 The main expected benefit is a reduction in the frequency and length of late finishes.

Other anticipated benefits include:

- Improvement in road staff well-being due to reduced impact on personal lives.
- Reduced fatigue and, consequently, improved staff safety.
- Reduction in late starts and thus better resource availability at shift start due to:
  oncoming crews less likely to have to wait for a returning vehicle.
- fewer crews coming in late for their following shift.
- Time available for off-going crews to ensure vehicle is ready for the next shift.
- Reduced frequency of oncoming crews needing to go Out of Service to restock/refuel or deal with vehicle maintenance issues.
- Associated cost savings in reduced incidental overtime.
- Improved 'Handover to Clear' times.

13.2 The late finish programme has now been embedded into ongoing operations practise.

15. Covid 19

15.1 The Trust is also exploring use of Consultant Connect alongside the above activities to provide medical input to clinical decision-making and appropriate signposting and care for patients.
Consultant connect enablesWe have continued to adapt to the latest phase of the COVID pandemic.

15.2 The course of two doses of vaccine has been completed by more than 90% of our staff, putting us in the top 20 of trusts for staff vaccination rates, and all staff were offered a booster dose.

15.3 We continue to monitor and mitigate the COVID risks to our staff and patients - and we are actively reminding all staff of the importance of following the latest COVID protocols at all times.

16. Conclusion

16.1 The additional guidance and support we are receiving as a consequence of the CQC Report and being in the Recovery Support Programme, are enabling EEAST to address the serious cultural issues across the organisation, and work is now moving at pace.

16.2 We are making good progress towards our improvement targets and being taken out of 'Special Measures'.

16.3 On performance, the picture remains complex as many of the challenges we face are at the system-level nationally and not being faced by EEAST alone. Hospital handover delays are one such system-issue and we have resourced this with HALO and Cohorting officers to work closely with the CCGs and colleagues in Acute Hospitals to identify and resolve these issues collaboratively.

16.4 To get the latest information about EEAST, including an update from the Chief Executive, please subscribe to our newsletter for stakeholders: InTouch EEAST www.eastamb.nhs.uk/intoucheeast.htm

Reference Number: HOSC/41/22

Report title: Chairman's Report	
Report to: Health Overview Policy and Scrutiny Committee	
Report author: Richard Buttress, Democratic Services Manager	
Date: 7 July 2022	**For:** Information
Enquiries to: Richard Buttress, Democratic Services Manager – richard.buttress3@essex.gov.uk or Freddey Ayres, Democratic Services Officer – freddey.ayres2@essex.gov.uk	
County Divisions affected: Not applicable	

1. Introduction

1.1 This is the latest update reporting on discussions at HOSC Chairman's Forum meetings (Chairman, Vice Chairmen and Lead JHOSC Member).

2. Action required

2.1 The Committee is asked to consider this report and identify any issues arising.

3. Background

3.1 The Forum usually meets monthly in between scheduled Committee meetings to discuss work planning. In addition, there are also meetings with the Cabinet Member for Health and Adult Social Care on a bi-monthly basis and quarterly meetings with senior officers.

4. Update and Next Steps

4.1. The Forum met on 22 June 2022 with Chris Martin, Director of Strategic Commissioning and Policy (C&F) and Emily Oliver, Head of Strategic Commissioning and Policy to discuss the proposed joint Task and Finish Group looking at Children's Mental Health Services in Essex, following a motion received at May's Full Council meeting.

4.2 A number of areas that the Task and Finish Group could look into in more detail were suggested and will be included in the scoping document which is currently being drafted.

4.3 It was acknowledged that whilst there are certain services in the system that are not performing as strongly as they could, there are services that are performing well.

4.4 The scoping document once finalised, will be shared with all HOSC Members.

5. List of Appendices – none

Reference Number: HOSC/42/22

Report title: Member Updates	
Report to: Health Overview Policy and Scrutiny Committee	
Report author: Richard Buttress, Democratic Services Manager	
Date: 7 July 2022	**For:** Discussion
Enquiries to: Richard Buttress, Democratic Services Manager – richard.buttress3@essex.gov.uk or Freddey Ayres, Democratic Services Officer – freddey.ayres2@essex.gov.uk	
County Divisions affected: Not applicable	

1. Introduction

This is an opportunity for members to update the Committee (See Background below)

2. Action required

2.1 The Committee is asked to consider oral reports received and any issues arising.

3. Background

3.1 The Chairman and Vice Chairman have requested a standard agenda item to receive updates from members (usually oral but written reports can be provided ahead of time for inclusion in the published agenda if preferred).

3.2 All members are encouraged to attend meetings of their local health commissioners and providers and report back any information and issues of interest and/or relevant to the Committee. In particular, HOSC members who serve as County Council representatives observing the following bodies may wish to provide an update.

4. Update and Next Steps

Oral updates to be given.

5. List of Appendices – none

Reference Number: HOSC/43/22

Report title: Work Programme	
Report to: Health Overview Policy and Scrutiny Committee	
Report author: Richard Buttress, Democratic Services Manager	
Date: 7 July 2022	**For:** Information
Enquiries to: Richard Buttress, Democratic Services Manager – richard.buttress3@essex.gov.uk or Freddey Ayres, Democratic Services Officer – freddey.ayres2@essex.gov.uk	
County Divisions affected: Not applicable	

1. Introduction

1.1 The current work programme for the Committee is attached.

2. Action required

2.1 The Committee is asked:

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

(ii) to discuss further suggestions for briefings/scrutiny work.

3. Background

3.1 Briefings and training

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

3.2 Formal committee activity

The current work programme continues to be a live document, developed as a result of work planning sessions and subsequent ongoing discussions between the Chairman and Lead Members, and within full committee.

4. Update and Next Steps

See Appendix.

5. List of Appendices - Work Programme overleaf

Prove Health Overview Policy and Scrutiny Committee
Work Programme – July 2022

Date	Topic	Theme/Focus	Approach and next steps
July 2022			
July 2022	East of England Ambulance Service Trust	Committee to receive an update on the progress being made against CQC recommendations	
July 2022	Mid and South Essex Community Beds programme	Committee to receive briefing following completion of engagement process	
September 2022			
September 2022	South-East Essex Community Children's Services – Lighthouse Child Development Centre	Committee to receive an update following the transfer of the Lighthouse Child Development Centre to EPUT	
September 2022	Winter Flu	Committee to receive a report on preparations for the Winter period	
September 2022	Mental Health Services	Committee to receive a further update on the mental health response to the pandemic and future service planning for changes in demand.	
October 2022			
October 2022	Maternity Services at East Suffolk and North Essex Foundation Trust (ESNEFT)	Committee to receive a further update on how ESNEFT is progressing against CQC recommendations	

October 2022	Princess Alexandra Hospital – new hospital update	Committee to receive further update on the new hospital development, including: - Sharing detailed plans of new hospital site - Confirmation of date for planning application submission	
November 2022			
November 2022	A&E Seasonal Pressures	Committee to receive updates from the hospital trusts on their preparations for Winter	
December 2022			
December 2022	GP Provision in Essex	Committee to receive further update on current position following previous briefing in June 2022	
January 2023			
Autism Strategy	Autism Strategy	Committee to receive an update on Autism Services following initial report in January 2021. Scope set out as below: ▪ Referral and diagnosis times ▪ Transitions between children and adult services ▪ The number of people across Essex affected by Autism	

		The impact of Covid-19 on Children's Autism services.	

Items to be programmed	Topic	Theme/Focus	Approach and next steps
TBC	New NHS Hubs	Further scoping required	
TBC	Essex Partnership University Foundation Trust (EPUT Linden Centre review	Further scoping required	
TBC	Hospital waiting times – overview of all Essex hospitals	Further scoping required	
TBC	NHS 111 – impact of GP's directing people to that service	Further scoping required	
TBC	Section 106 monies within the NHS	Further scoping required	
TBC	Digitalisation of access to health	Further scoping required	