Appendix 1

List of Organisations / Acronyms / Abbreviations

List of Acronyms / Abbreviations

Organisational acronyms

WJC	William Julien Courtauld
NHSE	NHS England
MSE	Mid and South Essex
ICS	Integrated Care System
ICB	Integrated Care Board
CCTF	Community Capacity Task Force
CICC	Cumberlege Intermediate Care Centre
MNC	Mountnessing Court
MSEFT	Mid and South Essex NHS Foundation Trust
NELFT	North East London NHS Foundation Trust
BCH	Brentwood Community Hospital
MSECC	Mid and South Essex Community Collaborative – comprises Provide, EPUT and NELFT
EPUT	Essex Partnership University NHS Foundation Trust
Mid and South Essex Alliances	The Alliances are a partnership of many organisations across health, social care and the voluntary sector working together to ensure the population of mid Essex live well. Across Mid and South Essex they are divided into the following alliances Mid Essex Basildon and Brentwood South East Essex Each Alliance has an appointed director

Further used Acronyms/Abbreviations

PCBC	Pre-Consultation Business Case
IMC	Intermediate Care
SRU	Stroke Rehabilitation Unit
ESD	Early Supported Discharge
MLBU	Midwifery-Led Birthing Unit
ToCHs	Transfer of Care Hubs
P2	Pathway 2
IDTs	Integrated Discharge Teams
HASU	Hyper-acute stroke unit
SSNAP	Sentinel Stroke National Audit Programme
PCNs	Primary Care Networks
OP	Outpatients
D2A	Discharge to Assess
CCORG	Clinical and Care Outcomes Review Group
NAIC	National Audit of Intermediate Care
BGS	British Geriatric Society
UCL	University College London
UCLP	University College London Partners

AHP	Allied Health Professions
BMJ	British Medical Journal
NICE	National Institute for Health and Care Excellence
NPEU	National Perinatal Epidemiology Unit
PFI	Private Finance Initiative
IPC	Infection Prevention and Control
BCH	Brentwood Community Hospital
ShCR	Shared Care Record
POCT	Point-of-Care Testing
I&E	Income and Expenditure
ICU	Intensive Care Unit
HDU	High Dependency Units
PROMs	Patient Reported Outcome Measures
HOSC	Health Oversight Scrutiny Committee
HWBB	Health and Wellbeing Board
FOI	Freedom of Information
SOAC	System Overview and Assurance Committee
DMBC	Decision-making Business Case

Appendix 2

MSE Context and Reconfigurations of Community Beds since 2020

Mid and South Essex Health and Care Partnership

Appendix Two – MSE Context and Reconfigurations of Community Inpatient Beds since 2020

Prior to 2020, NHS community inpatient beds were provided at six main sites across MSE:

- Halstead Community Hospital
- St Peter's Community Hospital in Maldon
- Brentwood Community Hospital (Thorndon Ward)
- Mountnessing Court in Billericay
- Cumberlege Intermediate Care Centre (CICC) in Rochford
- Mayfield Ward at Thurrock Community Hospital

Overview of pre-2020 community bed configuration

The vast majority of patients admitted to our intermediate care wards come from one of the three main acute hospital in MSE, and are people who require an intensive period of rehabilitation or additional support before they were well enough to return to their own home or usual place of residence.

There have historically been no ringfenced community stroke rehabilitation beds in MSE. Instead, provision has been either at one of three community hospital sites (Rochford, Maldon and Brentwood) where patients who have suffered a stroke were cared for on mixed stroke/intermediate care wards, or Basildon and Southend Hospitals where – contingent on bed availability, rehabilitation was provided on acute wards.

In total, across MSE there were approximately 113 intermediate care beds, 26 stroke rehabilitation beds in community hospitals, and up to 24 stroke rehabilitation beds at two acute sites (depending on bed availability):

Number of intermediate care and stroke rehabilitation beds prior to 2020

Location	Ward	IMC	Stroke rehab	Provider
Rochford (South East)	Cumberlege (CICC)	16	6	EPUT
Halstead (Mid)	Halstead	20		Provide
Thurrock	Mayfield	24		NELFT
Billericay (South West)	Mountnessing Court	22		EPUT
Maldon (Mid)	St Peter's	14	12	Provide
Brentwood South West)	Thorndon	17	8	NELFT
Southend Hospital (South East)			(~12)*	MSEFT
Basildon Hospital (South West)			(~12)*	MSEFT
Total		113	26	

*not dedicated stroke rehabilitation beds

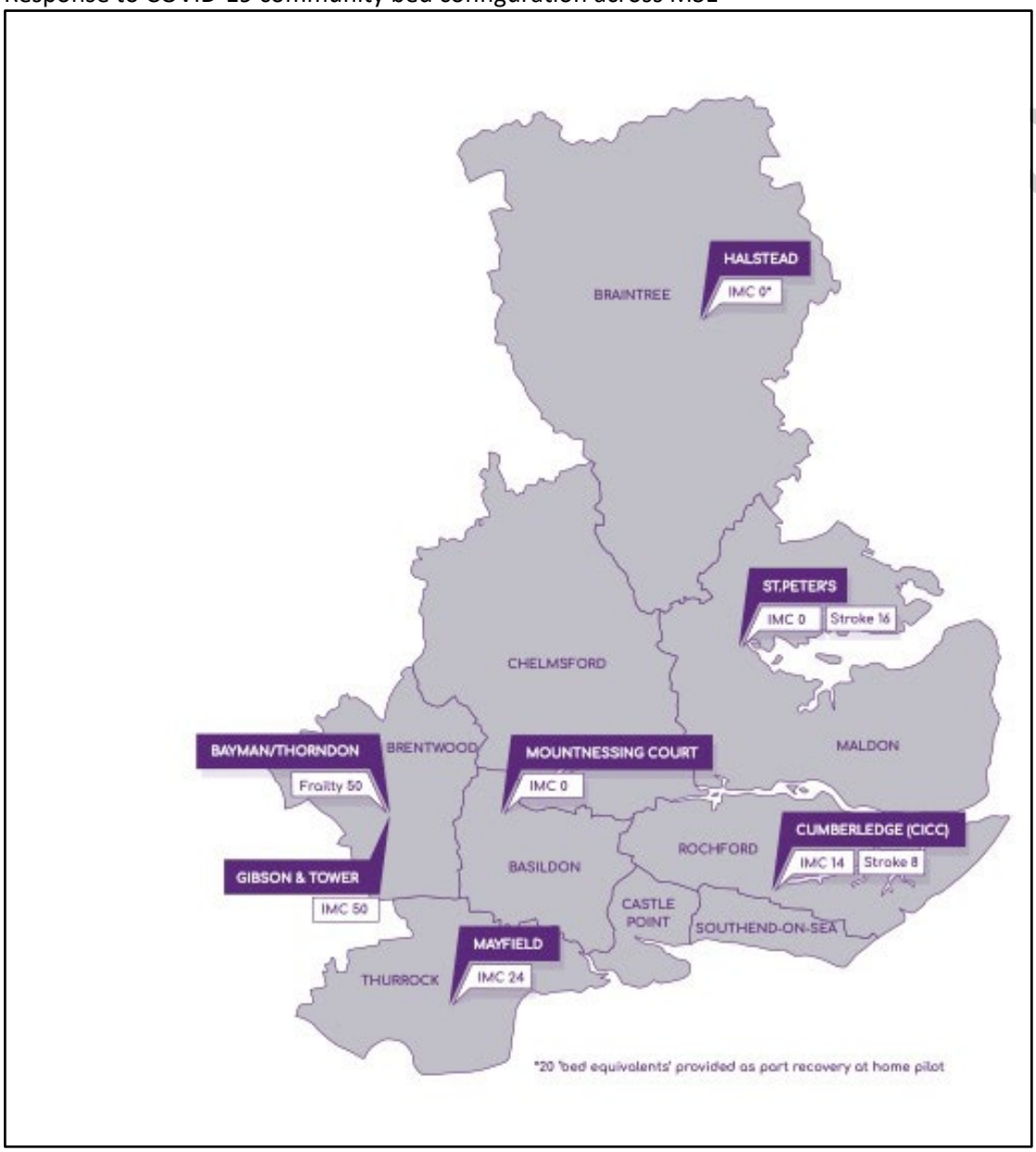
As part of the system response to Covid, in 2020 four significant changes were rapidly introduced:

- Intermediate care bed provision was consolidated from six sites to three
- Two acute frailty wards were relocated from Basildon Hospital (a main acute site) to Brentwood Community Hospital, to enable the urgent expansion of critical care capacity at the former
- To enable this, an additional three wards were opened at Brentwood Community Hospital (a previously unused ward and two temporary wards)

- A 'recovery at home' pilot was established in Halstead in the North of the patch, to replace the capacity that had been provided by the community inpatient beds

This resulted in the following configuration, which remains the position currently:

Response to COVID-19 community bed configuration across MSE



As a result of these changes, the revised number and type of beds at each site was then:

Mid and South Essex Health and Care Partnership

Number of intermediate care, stroke rehabilitation and community based frailty beds in response to Covid-19

Location	Ward	IMC	Acute Frailty	Stroke rehab.
Rochford	Cumberlege (CICC)	14		8
Halstead	Halstead	0 (20)*		
Thurrock	Mayfield	24		
Billericay	Mountnessing Court	0		
Maldon	St Peter's	0		16
Brentwood	Bayman & Thorndon (acute frailty) Gibson & Tower (IMC)	50	50	
Total		88 (108*)	50	24**

*20 bed equivalents provided in Halstead as part of recovery at home pilot
** Some additional stroke rehabilitation beds remain at Basildon and Southend Hospitals, depending on wider bed pressures

The main changes, therefore, were:

- A reduction in the number of intermediate care beds and in the sites providing them
- The establishment of two acute frailty wards in the community
- A further limitation on the number of stroke rehabilitation beds available.

Because these changes were introduced at pace and in response to an unprecedented crisis Covid 19), there was not – and has not been – engagement or public consultation.

In early 2023 the changes made as a response to Covid 19 were reversed. The acute frailty beds at Brentwood Community Hospital returned to acute hospital sites, Gibson and Tower ceased to be used as inpatient wards as they did not comply with required standards. Bayman Ward was vacant until the community bed reconfiguration in preparation for the winter of 2023/24 undertaken in October 2023. Thorndon Ward, 25 beds, became an intermediate care facility once more.

Halstead Hospital, 20 beds and Mountnessing Court, Billericay, 22 beds were reopened for intermediate care. This took the bed complement to 105 for intermediate care and 24 for stroke rehabilitation.

This then changed to 99 intermediate care with a potential for 39 stroke rehabilitation beds as the reconfiguration of community beds for winter 2023/4 came into effect.

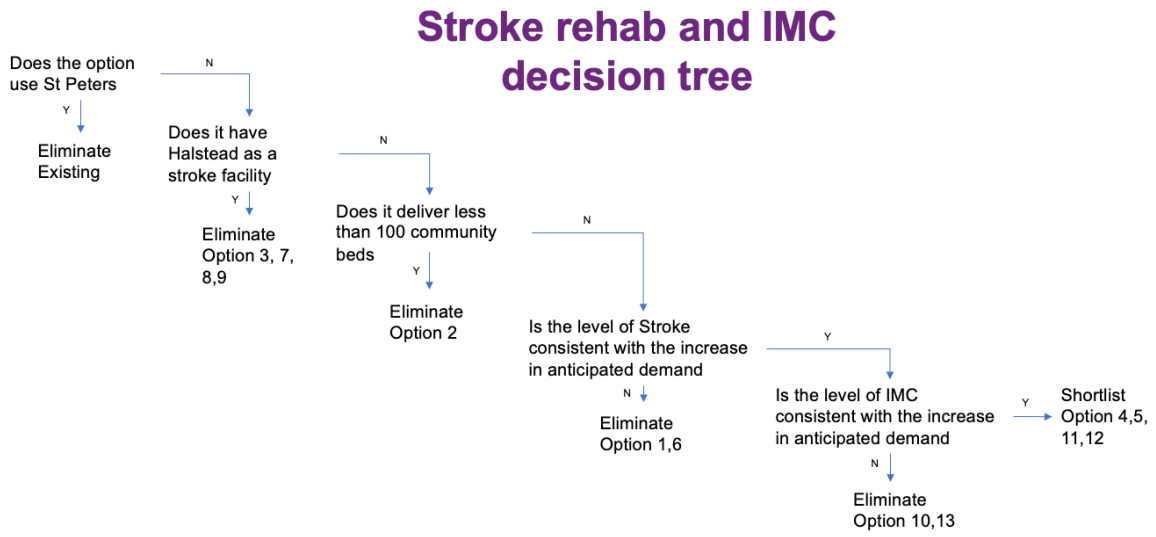
Appendix 3

Options Appraisal

Options appraisal

Stroke rehab & IMC

	Existing	Option 1	Option 2	Option 3	Option 4	Option 5	Option 6	Option 7	Option 8	Option 9	Option 10	Option 11	Option 12	Option 13
	IMC/Stroke	IMC/Stroke	IMC/Stroke	IMC/Stroke	IMC/Stroke	IMC/Stroke	IMC/Stroke	IMC/Stroke	IMC/Stroke	IMC/Stroke	IMC/Stroke	IMC/Stroke	IMC/Stroke	IMC/Stroke
St Peters	0/16	0	0	0	0	0	0	0	0	0	0	0	0	0
MNC	22/0	22/0	0	22/0	22/0	0	0	22/0	0	0	0	22/0	22/0	0
CICC	14/8	8/14	8/14	8/14	8/14	8/14	14/8	8/14	8/14	8/14	22/0	22/0	0/22	0/22
Halstead	20/0	20/0	20/0	0/20	20/0	20/0	20/0	10/10	10/10	10/10	20/0	20/0	20/0	20/0
Mayfield	24/0	24/0	24/0	24/0	24/0	24/0	24/0	24/0	24/0	24/0	24/0	24/0	24/0	24/0
Brentwood	25/0	25/0	25/0	25/0	25/25	25/25	25/25	25/0	25/0	50/0	0/50	0/50	25/25	25/25
Total IMC/Stroke	105/24	99/14	77/14	79/34	99/39	77/39	83/33	89/24	67/24	92/24	66/50	88/50	91/47	69/47
Total Beds	129	113	91	113	138	116	116	113	91	116	116	138	138	116



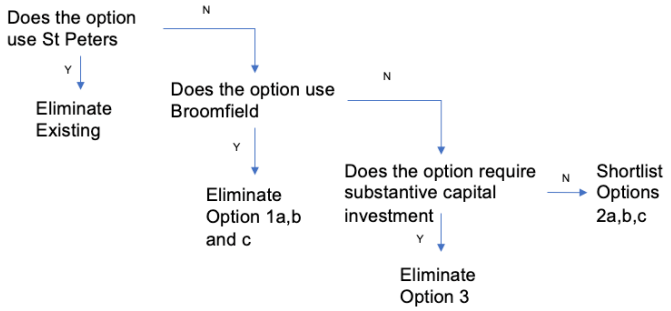
Criteria	Weighting	Rationale	Existing	Option 4 99/39	Option 5 77/39	Option 11 88/50	Option 12 91/47
Finance (total 25%)							
Financial Affordability	25%	Options with fewer beds should minimise costs and reduce any requirement for temporary staff. Concentrating expertise on fewer sites is likely to stimulate recruitment and retention and minimise overhead costs. Scores have also been reduced for options with a combined IMC/SRU incurring a higher cost to staff IMC units due to national guidance requiring staffing to SRU levels for all beds	5	10	13	14	14
Strategy (total 25%)							
Moving towards the assessed bed requirement for stroke rehabilitation	5%	Options with fewer than the requirement of 48 beds for the MSE population and/or are provided in more than a single unit have reduced scores. Existing arrangements have fewer community stroke rehabilitation beds than any of the options.	1	3	3	5	4
Clinically supported solution/fit with system clinical strategy	15%	The existing option does not provide the level of stroke – rehab in line with anticipated demand and overstates the required amount of IMC. Options with a combined IMC/SRU facility have reduced scores due to reduced opportunity for development of staff specialised in stroke rehabilitation	5	7	6	15	15
Fit with system estate strategy	5%	Options with Mountnessing Court are assumed not to reflect system estates strategy.	1	3	5	3	3

Criteria	Weighting	Rationale	Existing	Option 4 99/39	Option 5 77/39	Option 11 88/50	Option 12 91/47
Quality (total 50%)							
Provision of a safe, secure, quality care environment	10%	The existing distribution of bed includes use of accommodation at St Peter's Hospital which is not of an acceptable standard. The options that include use of Mountnessing Court have been reduced based on the estates assessment.	2	7	10	7	7
Accessible from main centres of population in MSE	10%	Options with Mountnessing Court offer greater access to people in the West of the MSE catchment. St Peter's is accessible to Malden and surrounding area, but its continued use for in-patients is unacceptable. Under existing arrangements there are no stroke rehabilitation beds in the west of the catchment.	7	8	7	8	8
Impact on capacity-supporting the health and care system to manage future demand.	20%	Options with more beds should have greater ability to account for the anticipated increase in demand and population growth pressures. Considerations for the impact in future demand for community beds within stroke rehab and IMC are impacted by population growth, the use of the acute facility, the integration with local authority provision and national guidance. Existing arrangements have fewer stroke rehabilitation beds than the five options and continue the underuse of modern facilities at Brentwood Hospital. Additional stroke beds would enable the proposed 3 neuro-rehab beds to be incorporated there	5	12	10	17	15
Impact on workforce-ability to recruit and retain skilled staff	10%	Existing arrangements require the use of temporary staff. Options concentrating community stroke rehabilitation beds in a single unit are likely to be more attractive to skilled staff. A combined IMC/SRU unit is deemed to be less desirable due to the increase in staffing requirements needed to staff all beds to SRU level	5	7	7	10	10

Maternity

Existing	Option 1a	Option 1b	Option 1c	Option 2a	Option 2b	Option 2c	Option 3
	Broomfield			William James Courtauld (WJC)			Maldon Health Hub
Status Quo	Absorb into Bromfield	Broomfield + Maldon Hub	Broomfield + WJC	WJC stand alone	WJC + Maldon facilities	WJC + co-location with primary care	Maldon Health Hub
St Peters maternity services continues as a MLBU	Move St Peter's inpatient and outpatient Maternity services to Broomfield	Move St Peter's inpatient Maternity services to Broomfield and outpatient services to a Maldon Hub	Move outpatient Maternity services to Broomfield and leave inpatient services at WJC	Move St Peter's inpatient and outpatient Maternity services to WJC	Move St Peters inpatient Maternity services to WJC and re-provide outpatient services for Malden residents locally	Move St Peters inpatient Maternity services to WJC and re-provide outpatient services in co-location with a Maldon primary care development	Inpatient and outpatient in a Maldon Health Hub (note: this option was eliminated as there was no immediate prospect of undertaking a development of the magnitude required)

Maternity decision tree



Criteria	Weighting	Rationale	Existing	Option 2a WJC providing birthing and OP services	Option 2b WJC + local OP service for Maldon residents	Option 2c WJC + co-location with primary care
Quality (total 60%)						
Provision of a safe, secure, quality environment	20%	Should the stroke rehabilitation beds at St Peter's transfer the midwifery-led unit will be isolated adjacent to a large unoccupied building. The WJC Birthing Unit, St Michaels Hospital, Braintree offers high quality accommodation. Considerations have been made considering the short- and medium-term provision of services. Residents of Maldon and surrounding districts would have to travel to Braintree for outpatient services	5	10	20	15
Accessible for women in the north and north east of the MSE catchment	10%	St Peter's offers good access to Malden and surrounding districts. Local residents would be required to travel to Braintree for outpatient services. Braintree offer better access from the larger centres of population around Braintree and Chelmsford for inpatient activity.	5	7	10	5
Sufficient capacity to meet likely case numbers	10%	Case numbers at the St Peter's unit are relatively small even when pre-and post-natal admissions are included. Services provided at Braintree would potentially stimulate demand for a freestanding midwife-led unit. Locally provided services will relieve the pressure on capacity at Broomfield. Ability to increase the footprint to accommodate demand has been considered in scoring.	10	5	10	8
Impact on workforce-ability to recruit and retain skilled staff	20%	The St Peter's Unit has been closed periodically because of staff shortages. Proximity to the obstetric unit would enable midwives to be deployed more flexibly and may be professionally attractive. A Braintree Unit would be closer than St Peter's to larger centres of population and would be located in a modern facility, both supporting recruitment and retention. Some midwives prefer to work in midwifery-led birthing units.	10	15	20	15

Criteria	Weighting	Rationale	Existing	Option 2a WJC stand alone	Option 2b WJC + local OP service for Maldon residents	Option 2c WJC + co-location with primary care
Finance (total 15%)						
Financial Affordability	15%	Stranding the unit at St Peter's will require certain overhead costs. Converting sites within the town centre to create a local facility will require certain overhead costs. Co-location within the primary care facility would be subject to business case approval. A stand-alone unit at WJC would require modifications to contain the inpatient and outpatient activity, subject to the limitations of the CDC development. An increase in bed base and clinic space would have a positive impact on communications and political acceptability as well as increasing flexibility around workforce.	5	5	8	5
Strategy (total 25%)						
Clinically supported solution/fit with System clinical strategy	20%	An MLBU unit at Braintree would meet system strategy requirements. However, access for residents of Maldon and surrounding districts is a critical consideration. 2c would be a good strategic fit, but there is no evident practical way of achieving co-location in the short term.	0	10	15	10
Fit with System estate strategy	5%	Outpatient as well as inpatient services were available at St Peter's. The current estate is unsuitable for the provision of health care in the 21st century. Plans are needed to house outpatient, diagnostic, nursing and therapy services elsewhere in Maldon and district.	0	2	5	4
Total			35	54	88	62

Appendix 4

Integrated Impact Assessment

MID & SOUTH ESSEX COMMUNITY CAPACITY

INTEGRATED IMPACT ASSESSMENT

Strategy Unit

MID AND SOUTH ESSEX NHS FOUNDATION TRUST

TABLE OF CONTENTS

INCLUSIONS FOR NEXT DRAFT

- FEEDBACK FROM CONSULTATION
- STAFF FEEDBACK

1. Introduction

A key commitment for Mid & South Essex ICS is to deliver a comprehensive plan for community care across the system. An important component of this is delivery of an Integrated Impact Assessment of proposed solutions. A robust analysis over 93 pages can be found in the accompanying Annex document, including a literature review of over 100 sources of information.

Why an Integrated Impact Assessment?

An integrated impact assessment supports decision making by evaluating the impact of a proposal, informing public debate and supporting decision makers to meet their Public Equality Sector Duty.

The assessment was achieved by undertaking and combining three different methods reflecting best practice guidance summarised in the methodology section.

In relation to equality, these responsibilities include assessing and considering the potential impact which the proposed service relocation could have on people with characteristics that have been given protection under the Equality Act, especially in relation to their health outcomes and the experiences of patients, communities and the workforce. With reference to health and health inequalities, the responsibilities include assessing and considering the impact on the whole of the population served by the relevant statutory bodies and identifying and addressing factors which would reduce health inequalities, specifically with regard to access and outcomes.

What is included in an Integrated Impact Assessment?

- Undertake and complete a full Integrated Health Inequalities and Equality Impact Assessment (IIA) prior to the consultation process of the community capacity programme's proposed changes.
- Provide recommendations based on the evidence review conducted as part of the IIA to inform an action plan developed and owned by Mid and South Essex Integrated Care System
- Ensure the report contains evidence that decision-making arrangements will pay due regard to equalities and inequalities issues and the Brown principles[1].

The assessment uses techniques such as evidenced based research, engagement and impact analysis to understand the impact of change on the population, the impact on groups with protective characteristics and the impact on accessibility and quality of services. The aim of the report is to understand and assess the consequences of change whilst maximising positive impacts and minimising negative impacts of the proposed change.

This IIA is made up of 3 chapters:

- *Equality Impact Assessment*
- *Health inequalities impact assessment*
- *Health impact assessment*

Applicable Standards and Principles

Key legal principles and guidance recognised and referenced as part of this document are:

Equality

[1] [1] R. (Brown) v. Secretary of State for Work and Pensions [2008] EWHC 3158 at paras 90-96.

- s.149 - Public Sector Equality Duty (PSED) of the Equality Act 2010.
- Equality and Human Rights Commission's paper (2012).
- Brown Principles.
- The Public Services (Social Value) Act 2012.
- The Autism Act 2009.
- The Children's Act 2004.
- Section 13G/section.14T of the NHS Act 2006*.

Health and health Inequalities

- Amendments to the National Health Service Act.
- The Health and Social Care Act 2012.
- NHS Five Year Forward View and NHS Long Term Plan.
- The NHS Constitution
- The Climate Change Act 2008

What is the scope of this IIA?

- The current and future patients in Mid and South Essex ICS
- The population served by Mid and South Essex ICS
- The current workforce in Mid and South Essex ICS

2. Methodology

An **evidence review** of health issues and the risk factors for the specific patient/client groups impacted by the move as well as general population. This will ensure all population groups with the potential to be impacted are considered.

Descriptive analysis of the current patient population and health landscape within England. This includes specific emphasis on areas covered by Mid and South Essex. This analysis has been used to establish an understanding of the scale of impact. This ensures the response to the impact is proportional to its scale.

Comparative analysis to assess whether different groups of the patient population/staff population, namely those that fall under protected characteristics, are disproportionately impacted by the proposed changes. This is done within the context of equality and diversity, health inequalities and population health impact. For each category of assessment, themes are used to assess impact following a description of the effect using evidence/data, whether it was positive or negative and would be difficult to remedy or be irreversible.

Assessing future demand for the service and potential impact upon different groups of the patient and workforce population in the context of equality and diversity, health inequalities and population health impact.

Each impact was prioritised based on:

1. **Probability** of the impact occurring (using a decision matrix combining scale and duration)
2. **Scale** of those impacted
3. **Duration** of the impact e.g., short, medium or long term

3. Proposed Models

Mid and South Essex shortlisted 4 proposed options for Stroke and Intermediate Care following an options appraisal. For the purposes of the report, these have been renamed Models A-D, however, the corresponding option number has been provided in the table below for consistency and clarity. The below refers to the number of beds available in each model.

	Existing	**Model A (Option 4)**	**Model B (Option 5)**	**Model C (Option 11)**	**Model D (Option 12)**
	IMC/Stroke Beds	IMC/Stroke	IMC/Stroke	IMC/Stroke	IMC/Stroke
St Peters (Maldon)	**0/16**	0/0	0/0	0/0	0/0
Mountnessing Court (Basildon)	**22/0**	22/0	0/0	22/0	22/0
CICC (Rochford)	**14/8**	8/14	8/14	22/0	0/22
Halstead (Colchester)	**20/0**	*20/0*	*20/0*	*20/0*	*20/0*
Mayfield (Thurrock)	**24/0**	*24/0*	*24/0*	*24/0*	*24/0*
Brentwood	**25/0**	25/25	25/25	0/50	25/25
Total IMC/Stroke	**105/24**	**99/39**	**77/39**	**88/50**	**91/47**
Total Beds	**129**	**138**	**116**	**138**	**138**

As a result of the St. Peters closure proposed in all 4 models, there are impacts to maternity and outpatients and diagnostics, which also takes place there. Therefore, the below outlines 3 future options for maternity. The models refer to the movement of maternity to William Julien Courtauld (WJC) in Braintree Community Hospital.

	Model 1	**Model 2**	**Model 3**
	Inpatient & Outpatient to WJC	Inpatient WJC Outpatient in Maldon	Inpatient WJC Outpatient co-location with Primary Care development
Inpatient Activity	6 beds	6 beds	6 beds
Outpatient Activity	8, 500 outpatient appointments	8, 500 outpatient appointments	8, 500 outpatient appointments

Below are the proposed options for outpatients and diagnostics. Each row indicates where outpatients and diagnostic clinics could be located in the future, however, this is still in progress.

Proposed Outpatient Models	Midwife episodes & Obstetrics, gynaecology, Glucose testing, paediatrics and SLT within Maldon, with midwife and neonatal in WJC
	Phlebotomy, District Nurses, ESD and Cherry tree at Maldon
	MSK, Physiotherapy & AHP at Maldon
	All other outpatient services potentially located in Maldon or where clinically appropriate

4. Positive Impacts

- The proposed closure of St. Peters will allow for stroke patients to receive care in better equipped facilities and provide appropriate room for expansion to meet the population's needs.
- Increased opportunity for patients to be treated at home improves patient outcomes.
- For stroke patients who meet the criteria to be treated outside of the acute hospital, receiving care in community bedded setting both reduces risks associated with acute care (e.g., hospital-acquired infection etc), and provides access to dedicated rehab care, optimising patient outcomes.
- By improving the IMC offer and increasing stroke capacity in community, The population of MSE will have access to optimised community care which will keep care closer to home for patients and improve facilities, training for staff and rehab opportunity following a stroke.
- Models are not necessarily reducing IMC capacity, but rather right sizing the capacity to ensure that patients who can be cared for at home have the opportunity to go home which results in improved patient outcomes.

IMC and Stroke Models

- Models A and D (Options 4 and 12) ensure IMC bed numbers remain consistent with existing demand and keep an IMC presence across the MSE footprint, whilst accommodating the stroke expansion which is important to meet the future demands of the population.
- Model B (Option 5) may result in a reduced IMC bed base too quickly and reduce the geographical footprint for IMC offered to patients as there would be no IMC community beds in both Maldon and Basildon.
- Model C (Option 11) proposes dedicated IMC facilities across 4 areas in MSE. Dedicated IMC will enable development of specialist staff skill sets, care processes, easier audit and monitoring, and greater potential for research and innovation.
- Models C and D (Options 11 and 12) offer dedicated Stroke care options at Brentwood or Rochford. This will enable development of specialist staff skill sets, care processes, easier audit and monitoring, and greater potential for research and innovation.
- Analysis conducted, 95% of all patients attending any of the community hospital locations identified in the options, can get to these locations via car in 27-33 minutes. Public Transport does take longer for patients overall, with 67% of people in Mid and South Essex living within 45 minutes of any of the community hospitals and 91% living within 60 minutes.

Maternity Models

- All maternity models propose inpatient activity at WJC in Braintree. This will mean increase in access to maternity services for patients as St. Peters would often need to close due to

the challenges with the St. Peters facility. Patients will have access to better, more modern facilities which are consistently open and available.

- Maternity Model 2 proposes a Maldon Hub which would keep services in Maldon so patient did not need to travel to Braintree and would allow for all care to take place in one place.
- Maternity Models 2 and 3 propose inpatient activity to move to Braintree, however, outpatient activity to remain closer to home.
- Within Maternity, 95% of patients get to St. Peters in 29 minutes by car. The majority of patients who attend St. Peters Maternity currently are from CM1, C09 and CM7. The average driving time from these areas to WJC is 37 minutes. And on average across the whole of MSE the average drive time to WJC is 29 minutes. This was also looked at because 50% of all patients who attend maternity at St. Peters are from Maldon. 95% of patients get to St. Peters in 102 minutes by public transport. This would reduce to 92 minutes to go to WJC.

Outpatients and Diagnostic Model

- The proposed model plans to keep outpatients and diagnostics in Maldon locally and more centrally located for those who use public transport. The proposed locations are also familiar locations many patients may prefer and feel more comfortable in.
- By outpatient and diagnostics being located locally in the town centre, transport links are improved which could make travel cheaper and easier for patients.
- Some carers may find this easier as patients may be able to get to appointments alone and patients may have a greater independence due to this.
- Those with Mental Health conditions may have mixed responses to the proposed changes. Some patients may prefer a more familiar and less clinical environment than would be provided by town centre locations.
- District nurses and early support discharge working in an integrated way in Maldon could impact all patient's pathways positively, allowing for an integrated approach to discharge and support at home.
- Having improved facilities for MSK conditions could support optimised rehabilitation.
- 95% of all patients who are outpatients at Maldon live within a 23-minute drive of St. Peters. Central Maldon is up to 6 minutes by car from the original St. Peters site. There is a bus and coach station and bus stops across Maldon.

Environmental Impacts

- **Boosting Local Economy and Assets:** By providing outpatient services in Maldon, local shops and may see the benefit of an increased population of customers which could help to sustain local businesses.
- **Healthy travel:** High streets are more accessible to people without cars than out-of-town centres and offer a chance to promote other sustainable forms of travel. In the longer term, car use is likely to decline and public transport, walking and cycling will be the normal way to access town centres, meaning high street design needs to evolve. Low traffic

neighbourhoods have also been shown to increase life expectancy. By increasing outpatient and diagnostics locally in Maldon town, these benefits may be realised.

- **Reducing Carbon Emissions:** The closure of St. Peters could also reduce Mid and South Essex's carbon footprint as the building was originally built in 1872 and, despite improvement works being carried out since, does not efficiently use energy due to its vast size and likely it is difficult to isolate effectively.
- **Local Community & Culture:** The proposed model for outpatients and diagnostics could use local amenities to boost pride in the local community. The difficulty will be to sustain this if patients are not from the area, however, the majority do live near Maldon so this impact still could be seen.

5. Adverse Impacts

- Reducing IMC capacity in community could have positive impacts long term as more patients will move to appropriate pathways, including home based care. Only those who need to be in inpatient intermediate care beds will be. This, however, could have short term implications whilst the infrastructure is being put in place to ensure patients are on the right pathway.
- If outpatient services are moved across multiple primary care locations, then patients could find travel to these different locations difficult. Cohorts who may find this challenging are those who have difficulty with mobility or disability, those who rely on public transport, those with mental health conditions and carers or unpaid carers. The proposed models would, however, where possible try to promote more home-based care rather than inpatient care, optimising patients' outcomes and reducing travel when not necessary.
- For patients who could receive care at home rather than in IMC beds, this could put more responsibility on carers which could result in anxiety or fatigue. Virtual wards etc offer support to carers and relatives including training when needed and regular visits or support in line with patient need.
- Increased opportunity for patients to be treated at home improves patient outcomes but relies on appropriate infrastructure in place to allow MSE to move from 105 beds to a reduced number.

IMC and Stroke Models

- Models A and B allow for stroke beds in multiple places around MSE which could be beneficial for patients in terms of travel but offers 39 beds, which in a growing stroke population may be low in capacity in 5 years' time.
- Model B (Option 5) proposes the closure of Mountnessing Court in addition to St. Peters. Mountnessing Court Is located in Billericay, Basildon. Basildon has the high rates of complex needs such as deprivation, homelessness, substance abuse, unpaid carers, mental health conditions etc. Therefore, removing a care facility in an area of complex need could be challenging for people who live there.

Maternity Models

- In Models 1-3 patients will need to travel to Braintree for at least their inpatient care, if not all care. Some patients may live closer to St. Peters than Braintree and travelling further for maternity services could result in additional cost to them. This could impact patients with disabilities, living in deprived areas, those who are reliant on carers for transport etc. On average, however, the average journey time for patient overall is similar.
- Maternity models 2 and 3 propose inpatient activity at Braintree but outpatient activity co-located with primary care development. This could reduce feelings of consistency in care for patients who would feel more comfortable at one location and may result in more travel for patients between locations.

Outpatient & Diagnostic Model

- Ophthalmology and audiology patients may experience some sensory impairment which could mean they may find attending an appointment in a busier high street setting more challenging or less comfortable.
- Those with a disability or any other conditions which could impact mobility, e.g., MSK, obesity etc, may find travel in local built-up areas more difficult as this may require more walking from local car parks.
- Some patients, particularly those with multi-morbidities, may find it difficult to keep track of where their appointment is if they attend multiple locations.
- Some carers may find travel easier, and others may find travel more difficult based on these proposed changes. It is important to note that as not all patients live in Maldon, therefore travelling to the local centre may be more difficult, e.g., to park or because more walking is required.
- Those with Mental Health conditions may have mixed responses to the proposed changes. Some patients may feel anxious about new locations in a busier setting.
- When looking at those who attend outpatient and diagnostic clinics at St. Peters, approximately 0.5% live in the 20% most deprived, followed by 14% in the second quintile. This equates to 2,823 patients living in deprivation in some way either in the 1st or second quintile.

Environmental Impacts

Carbon Emissions: It is important to consider that only 40% of patients who would attend St. Peters actually live in Maldon. Therefore, by creating spaces in Maldon for outpatient services, this may generate more pollution and traffic in the centre of Maldon as many may continue to drive.

Parking Challenges: By providing outpatient services in local areas, this could create a pressure on local car parks that are not equipped to deal with an increase in demand that may be generated.

6. Evidence Based Recommendations

Patients

1. It is recommended to engage with residents in MSE from ethnic minorities as 29% of patients at St. Peters are from an ethnic minority.
2. It is recommended to engage with those over 65 as the large majority of patients in IMC and stroke beds were over 65. When engaging on matters related to Stroke reconfiguration, 38% of stroke patients are aged 40-69, therefore, it is important to also consider this age group when engaging.
3. It is recommended to engage with Males and Females proportionately. Some proposed changes impact Males more than females and vice versa, therefore engagement of both Males and Females equally is advised.
4. It is recommended to engage with people living in deprived areas across MSE, particularly related to changes to outpatient services from St. Peters. If outpatients are spread across multiple locations, patients may be required to travel further which could be costly.
5. It is recommended to engage with women of child-bearing age to understand how the proposed changes to maternity impact them.
6. There will be plans to move outpatient appointments to virtual appointments where possible to save on unnecessary travel for patients. It is important to consider areas of digital exclusion when rolling this out.
7. It is recommended to engage with patients with mobility and sensory conditions, such as, MSK, ophthalmology and audiology patients to understand their needs with regards to travel and the impact of navigating a high street setting.
8. It is recommended to consider where services will be best co-located to reduce patient travel and ensure that facilities (e.g., X-Ray) are accessible and comfortable for patients.
9. It is recommended to engage with patients who do not live in Maldon but attend Maldon outpatient services to understand how the proposed model of outpatient and diagnostic services in Maldon town would impact them.

Staff

10. It is recommended to engage with staff working in the community hospitals and acute to understand the impact to workforce of the proposed changes.
11. It is important to engage with staff who would be working in the proposed new outpatient and diagnostic locations to understand the impact of this change to them and how the environment will impact their work, If at all.

Services

12. It is recommended to engage with those with Dementia and Dementia Services to understand how patients and service users are impacted.

13. It is recommended to engage with Falls Services to understand how patients and service users are impacted.
14. It is recommended to engage with substance misuse services and service users to understand how they may be impacted. Basildon has the highest volume of people living with drug misuse and risk of alcohol related illness. Therefore, Model B would be reducing IMC services in that area.
15. It is recommended to engage with mental health services and carers/ unpaid carers and/or services who support carers to understand the impact of travelling to a different location for IMC or Stroke care which may be further from their home. It is also important to understand the impact of increased home-based care on mental health. For patients who could receive care at home rather than in IMC beds, this could put more responsibility on carers which could result in anxiety or fatigue.
16. It is recommended to engage with local authorities to understand transport links offered to primary care locations which may be used for outpatient appointments previously at St. Peters. This can be provided to patients who may be reliant on public transport to reach appointments.
17. It is recommended to engage with those who live alone or those who provide home based services such as virtual wards to understand the impact of the proposed models on patients who do not have additional support at home.
18. It is recommended to engage with pregnancy diabetes services and other complex conditions during pregnancy to understand how patients will be impacted by the proposed changes.
19. It is recommended to explore if parking is more limited and the cost, if any, to park needs to be considered.

7. Assessment of Impact

Proposed Community Hospital Capacity for Stroke and IMC beds.

●	Positive Impact
●	Adverse Impact
●	Neutral Impact

		Model A (Option 4)	Model B (Option 5)	Model C (Option 11)	Model D (Option 12)
Equality Impact Analysis	Age	●	●	●	●
	Disability	●	●	●	●
	Sex	●	●	●	●
	Pregnancy & Maternity	Separate Deep Dive			
	Marital Status	●	●	●	●
	Race	●	●	●	●
	Sexual orientation	●	●	●	●
	Religion or Belief	●	●	●	●
	Gender reassignment	●	●	●	●
Health Inequalities Analysis	Deprivation	●	●	●	●
	Carers and Unpaid Carers	●	●	●	●
	Homelessness	●	●	●	●
	Mental Health	●	●	●	●
	Substance Misuse	●	●	●	●
	Gypsy, Roma and Traveller communities	●	●	●	●
Health Impact Assessment	Dementia	●	●	●	●
	Falls	●	●	●	●
	Stroke	●	●	●	●
	Frailty	●	●	●	●

Proposed Models for Maternity Inpatients and Outpatients.

		Model 1 Inpatient & Outpatient to WJC	Model 2 Inpatient WJC Outpatient in Maldon	Model 3 Inpatient WJC Outpatient co-location with Primary Care development
Equality Impact Analysis	Age			
	Disability			
	Sex			
	Pregnancy & Maternity			
	Marital Status			
	Race			
	Sexual orientation			
	Religion or Belief			
	Gender reassignment			
Health Inequalities Analysis	Deprivation			
	Carers and Unpaid Carers			
	Homelessness			
	Mental Health			
	Substance Misuse			
	Obesity			
	Gypsy, Roma and Traveller communities			
Health Impact Assessment	Diabetes			

Proposed Model for Outpatient and Diagnostic services from St. Peters.

		Outpatients & Diagnostics Proposed Locations			
		1. Midwife episodes & Obstetrics, gynaecology, Glucose testing, paediatrics and SLT within Maldon, with midwife and neonatal in WJC	2. Phlebotomy, District Nurses, ESD and Cherry tree at Maldon	3. MSK, Physiotherapy & AHP at Maldon	4. All other outpatient services potentially located in Maldon or where clinically appropiate
Equality Impact Analysis	Age				
	Disability				
	Sex				
	Pregnancy & Maternity				
	Marital Status				
	Race				
	Sexual orientation				
	Religion or Belief				
	Gender reassignment				
Health Inequalities Analysis	Deprivation				
	Carers and Unpaid Carers				
	Homelessness				
	Mental Health				
	Substance Misuse				
	Obesity				
	Gypsy, Roma and Traveller communities				
Health Impact Assessment (only for options which impact conditions directly)	Ophthalmology				
	Musculoskeletal conditions				
	Neurology				
	Dermatology				

8. Next Steps

This report is an iterative process. All recommendations are shared with communication colleagues to help support engagement with the public and gaining appropriate representation through the consultation. All feedback from the consultation, including from staff and residents will be incorporated into the next draft of the report, where the impact assessment will be revisited and reassessed with the additional information provided through engagement. A new draft of this

document will then be developed and help inform plans to mitigate against any adverse impacts that may be identified.

Appendix 5

Financial Overview

Financial Overview

STATEMENT OF COMPREHENSIVE NET INCOME - OPTION 4 Whole System Position including the Investment over the Appraisal Period *	2024/25 £'000	2025/26 £'000	2026/27 £'000	2027/28 £'000	2028/29 £'000	2029/30 £'000	2030/31 £'000	2031/32 £'000	2032/33 £'000	2033/34 £'000	2034/35 £'000	Total £'000
Operating income from patient care activities												0
Other operating income	(287)	(293)	(299)	(305)	(311)	(317)	(323)	(330)	(336)	(343)	(350)	(3,492)
(Employee expenses)	384	392	400	409	417	426	435	444	453	463	473	4,695
(Operating expenses excluding employee expenses)	(277)	(277)	(277)	(277)	(276)	(276)	(276)	(275)	(275)	(275)	11	(2,749)
Less Cash Releasing Benefits												0
Operating surplus / (deficit)	(180)	(178)	(175)	(172)	(170)	(167)	(164)	(161)	(158)	(155)	134	(1,545)
Finance Income												0
(Finance Expense)												0
(PDC Dividends Payable)	(47)	(37)	(27)	(17)	(7)	3	13	23	33	43	48	24
Investment Revenue												0
Other Gains / (Losses) (including disposal of assets)		500										500
Gains / (Losses) on transfers by absorption												0
Retained surplus / (deficit)	(227)	285	(202)	(190)	(177)	(164)	(151)	(138)	(125)	(112)	181	(1,021)
Adjustments (including PPA, IFRIC 12 adjustment)												0
Adjusted financial performance retained surplus / (deficit)	(227)	285	(202)	(190)	(177)	(164)	(151)	(138)	(125)	(112)	181	(1,021)

This table consolidates all movements in cost, for all System Partners.

Key Points of Note

1. The model covers an 11-year period, given that the forecast capital investment associated with the relocation of services from St Peter's Hospital will be fully depreciated by year 10.
2. Inflationary movements year-on-year are consistently calculated with reference to the assumptions made within the System-wide Medium Term Financial Plan.
3. The favourable position in the 2025/26 financial year represents the forecast non-recurrent I&E/revenue gain upon disposal of St Peter's Hospital.
4. The favourable position in the 2034/35 financial year reflects the forecast capital investment (see (1) above) will be fully depreciated by the end of 2033/34.
5. All changes in Provider revenue expenditure patterns will need to be reflected as corresponding changes in income flow, transacted via the ICB.

STATEMENT OF COMPREHENSIVE NET INCOME - OPTION 5 Whole System Position including the Investment over the Appraisal Period *	2024/25 £'000	2025/26 £'000	2026/27 £'000	2027/28 £'000	2028/29 £'000	2029/30 £'000	2030/31 £'000	2031/32 £'000	2032/33 £'000	2033/34 £'000	2034/35 £'000	Total £'000
Operating income from patient care activities												0
Other operating income	(287)	(293)	(299)	(305)	(311)	(317)	(323)	(330)	(336)	(343)	(350)	(3,492)
(Employee expenses)	3,727	3,805	3,885	3,967	4,050	4,135	4,222	4,310	4,401	4,493	4,588	45,582
(Operating expenses excluding employee expenses)	324	1,466	1,500	1,534	1,578	1,612	1,646	1,680	1,715	1,749	2,068	16,873
Less Cash Releasing Benefits												0
Operating surplus / (deficit)	3,764	4,978	5,086	5,196	5,317	5,430	5,545	5,661	5,779	5,899	6,306	58,963
Finance Income												0
(Finance Expense)												0
(PDC Dividends Payable)	(47)	(37)	(27)	(17)	(7)	3	13	23	33	43	48	24
Investment Revenue												0
Other Gains / (Losses) (including disposal of assets)		500										500
Gains / (Losses) on transfers by absorption												0
Retained surplus / (deficit)	3,717	5,441	5,059	5,179	5,310	5,433	5,557	5,684	5,812	5,942	6,354	59,488
Adjustments (including PPA, IFRIC 12 adjustment)												0
Adjusted financial performance retained surplus / (deficit)	3,717	5,441	5,059	5,179	5,310	5,433	5,557	5,684	5,812	5,942	6,354	59,488

**** This table consolidates all movements in cost, for all System Partners.***

Key Points of Note

1. The model covers an 11-year period, given that the forecast capital investment associated with the relocation of services from St Peter's Hospital will be fully depreciated by year 10.
2. Inflationary movements year-on-year are consistently calculated with reference to the assumptions made within the System-wide Medium Term Financial Plan.
3. The less favourable position in the 2024/25 financial year is based on an assumption that the saving from vacating Mountnessing Court would not materialise until 2025/26.
3. The favourable position in the 2025/26 financial year represents the forecast non-recurrent I&E/revenue gain upon disposal of St Peter's Hospital.
4. The favourable position in the 2034/35 financial year reflects the forecast capital investment (see (1) above) will be fully depreciated by the end of 2033/34.
5. All changes in Provider revenue expenditure patterns will need to be reflected as corresponding changes in income flow, transacted via the ICB.

STATEMENT OF COMPREHENSIVE NET INCOME - OPTION 11 Whole System Position including the Investment over the Appraisal Period *	2024/25 £'000	2025/26 £'000	2026/27 £'000	2027/28 £'000	2028/29 £'000	2029/30 £'000	2030/31 £'000	2031/32 £'000	2032/33 £'000	2033/34 £'000	2034/35 £'000	Total £'000
Operating income from patient care activities												0
Other operating income	(287)	(293)	(299)	(305)	(311)	(317)	(323)	(330)	(336)	(343)	(350)	(3,492)
(Employee expenses)	1,124	1,148	1,172	1,196	1,222	1,247	1,273	1,300	1,327	1,355	1,384	13,748
(Operating expenses excluding employee expenses)	(961)	(974)	(987)	(1,000)	(1,004)	(1,017)	(1,030)	(1,044)	(1,057)	(1,070)	(798)	(10,942)
Less Cash Releasing Benefits												0
Operating surplus / (deficit)	(124)	(119)	(114)	(109)	(93)	(87)	(80)	(73)	(65)	(57)	236	(685)
Finance Income												0
(Finance Expense)												0
(PDC Dividends Payable)	(47)	(37)	(27)	(17)	(7)	3	13	23	33	43	48	24
Investment Revenue												0
Other Gains / (Losses) (including disposal of assets)		500										500
Gains / (Losses) on transfers by absorption												0
Retained surplus / (deficit)	(171)	344	(141)	(126)	(101)	(84)	(68)	(50)	(33)	(15)	284	(161)
Adjustments (including PPA, IFRIC 12 adjustment)												0
Adjusted financial performance retained surplus / (deficit)	(171)	344	(141)	(126)	(101)	(84)	(68)	(50)	(33)	(15)	284	(161)

This table consolidates all movements in cost, for all System Partners.

Key Points of Note

1. The model covers an 11-year period, given that the forecast capital investment associated with the relocation of services from St Peter's Hospital will be fully depreciated by year 10.
2. Inflationary movements year-on-year are consistently calculated with reference to the assumptions made within the System-wide Medium Term Financial Plan.
3. The favourable position in the 2025/26 financial year represents the forecast non-recurrent I&E/revenue gain upon disposal of St Peter's Hospital.
4. The favourable position in the 2034/35 financial year reflects the forecast capital investment (see (1) above) will be fully depreciated by the end of 2033/34.
5. All changes in Provider revenue expenditure patterns will need to be reflected as corresponding changes in income flow, transacted via the ICB.

STATEMENT OF COMPREHENSIVE NET INCOME - OPTION 12 Whole System Position including the Investment over the Appraisal Period *	2024/25 £'000	2025/26 £'000	2026/27 £'000	2027/28 £'000	2028/29 £'000	2029/30 £'000	2030/31 £'000	2031/32 £'000	2032/33 £'000	2033/34 £'000	2034/35 £'000	Total £'000
Operating income from patient care activities												0
Other operating income	(287)	(293)	(299)	(305)	(311)	(317)	(323)	(330)	(336)	(343)	(350)	(3,492)
(Employee expenses)	1,514	1,546	1,578	1,611	1,645	1,680	1,715	1,751	1,788	1,826	1,864	18,519
(Operating expenses excluding employee expenses)	(164)	(164)	(164)	(164)	(154)	(154)	(154)	(154)	(154)	(154)	131	(1,450)
Less Cash Releasing Benefits												0
Operating surplus / (deficit)	1,064	1,090	1,116	1,143	1,180	1,209	1,238	1,267	1,297	1,328	1,645	13,577
Finance Income												0
(Finance Expense)												0
(PDC Dividends Payable)	(47)	(37)	(27)	(17)	(7)	3	13	23	33	43	48	24
Investment Revenue												0
Other Gains / (Losses) (including disposal of assets)		500										500
Gains / (Losses) on transfers by absorption												0
Retained surplus / (deficit)	1,016	1,552	1,089	1,126	1,173	1,211	1,250	1,290	1,330	1,371	1,692	14,101
Adjustments (including PPA, IFRIC 12 adjustment)												0
Adjusted financial performance retained surplus / (deficit)	1,016	1,552	1,089	1,126	1,173	1,211	1,250	1,290	1,330	1,371	1,692	14,101

** This table consolidates all movements in cost, for all System Partners.*

Key Points of Note

1. The model covers an 11-year period, given that the forecast capital investment associated with the relocation of services from St Peter's Hospital will be fully depreciated by year 10.
2. Inflationary movements year-on-year are consistently calculated with reference to the assumptions made within the System-wide Medium Term Financial Plan.
3. The favourable position in the 2025/26 financial year represents the forecast non-recurrent I&E/revenue gain upon disposal of St Peter's Hospital.
4. The favourable position in the 2034/35 financial year reflects the forecast capital investment (see (1) above) will be fully depreciated by the end of 2033/34.
5. All changes in Provider revenue expenditure patterns will need to be reflected as corresponding changes in income flow, transacted via the ICB.

Appendix 6

Clinical Senate Report and Recommendations

Mid and South Essex Health and Care Partnership

Appendix Six - Report of the Clinical Senate Independent Review of Community Inpatient Beds held on 04 and 06 April 2022

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Glossary of abbreviations used in the report

AHP	Allied Health Professional
CCG	Clinical Commissioning Group
EPUT	Essex Partnership University NHS Foundation Trust
ESD	Early Supported Discharge
FREDA	Frailty, End of Live & Dementia Assessment
HASU	Hyper-Acute Stroke Unit
ICS	Integrated Care System
ICSS	Integrated Community Stroke Service
IT	Information Technology
MDT	Multi-Disciplinary Team
MSE	Mid and South Essex Health and Care Partnership
NELFT	North East London NHS Foundation Trust
PCN	Primary Care Networks
PREMs	Patient Reported Experience Measures
PROMs	Patient Reported Outcome Measures
SSNAP	Sentinel Stroke National Audit Programme

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Foreword from Clinical Senate Chair

The Clinical Senate was delighted to support Mid and South Essex Health and Care Partnership by providing independent clinical advice on their proposals for the future configuration of community inpatient beds resulting from the urgent service changes made in response to the COVID-19 pandemic.

The Clinical Senate was very pleased to support the MSE team once again by arranging an accelerated review process to mitigate the delay caused by the COVID-19 related suspension of the Clinical Senate's activities by the NHS England and NHS Improvement East of England Regional Executive and meet MSE's timeline for system-wide consultation. A Panel was therefore convened at short notice and met over three evenings, resulting in nine recommendations for MSE to consider.

I would like to thank the MSE team for providing such clear and comprehensive information and attending the final session to respond to questions in such an open and honest way. I would also like to thank Dr Hazel Stuart for Chairing the Pre-Panel meeting and all the panel members for asking searching questions and contributing with their wide and varied expertise and, of course, for giving up their personal time.

We wish the MSE teams well with their ongoing work and very much hope we can assist them again in the future.

Dr Bernard Brett

East of England Clinical Senate Chair and Clinical Review Panel Chair

1. Executive Summary

The East of England Clinical Senate provided an independent clinical panel review of the proposal for the Mid and South Essex Health and Care Partnership's (MSE) future configuration of community inpatient beds.

The panel were asked to review the proposals, focusing on specific questions asked by MSE. The panel has responded to each of these questions and has made a number of recommendations for the MSE team.

The specific questions asked, and the Panel's response are:

1. **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?**

   The Panel felt that the emerging options had the potential to deliver good patient outcomes and support patient flow.

2. **Intermediate care beds: Is the clinical model for ageing well and the proposed focus and potential locations of community beds likely to contribute to improving outcomes for patients?**

   The Panel supported the clinical model.

3. **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?**

   The Panel supported the introduction of dedicated, ring-fenced stroke rehabilitation beds to deliver more consistent and resilient care.

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

The Panel felt that many elements of the sub-acute frailty pathways were very positive. Moving forward the Panel felt that more could be done to build on the Recovery at Home pilot.

The Panel have made several recommendations of focus to the MSE team from this review. These are:

- **Recommendation 1:** Optimisation of the Stroke pathway
- **Recommendation 2:** Digital solutions
    - **Recommendation 2.1:** Digital pathway communications
    - **Recommendation 2.2:** Digital virtual ward
    - **Recommendation 2.3:** Digital development for families and carers
- **Recommendation 3:** The development of a comprehensive Workforce Strategy.
- **Recommendation 4:** Focus on ensuring system leadership is enhanced at all levels.
- **Recommendation 5:** Further focus on pathway transformation using learning from the Recovery at Home pathway.
- **Recommendation 6:** Outcomes – to accelerate the approach to using outcomes-based tools.
- **Recommendation 7:** A continued focus on access with co-production.
- **Recommendation 8:** Further development of the Bed Bureau function with enhanced clinical input, facilitating more of the pull model and oversight of whole pathways of care.
- **Recommendation 9:** The Panel were very impressed with much of the work around frailty and stroke but felt there would be significant_benefit in increasing the level of social care involvement.

The areas of the recommendations above should be read in the context of the broader findings of the clinical review panel as laid out in the Key Findings (Section 4) of this report.

2. Introduction

The challenge presented by COVID-19 led to the urgent reconfiguration of community inpatient beds across mid and south Essex. This included consolidating the provision of intermediate care beds on to a smaller number of sites, establishing a Recovery at Home pilot and relocating two hospital acute frailty wards from a main acute unit to a community hospital. Rather than simply reverting to the 'as was' configuration, which had a range of shortcomings, MSE have in recent months been developing options for the future number, role and location of their community beds, including how to make better use of these assets to support choice, personalisation and patient experience. The plan is to consult the public on these options in 2022.

MSE have approached the Clinical Senate to provide an independent clinical review of the proposals focusing on the future configuration of community inpatient beds. The programme is focused on community beds and has three distinct strands:

- Intermediate care: beds which are primarily used to enable older people to be discharged from a main acute hospital for a short period of personalised, goal-based rehabilitation, when they are not yet well enough to return to their usual place of residence,

- Stroke rehabilitation beds: those patients who have had a stroke and will benefit from a period of focused rehabilitation in a dedicated facility and

- Sub-acute frailty: a sub-set of frail patients that have been admitted to Basildon Hospital who will benefit from being transferred to a sub-acute medical setting.

As well as looking at each of these service areas and pathways separately, MSE are considering the key role that these beds collectively play at a system-level in enabling the smooth and appropriate 'flow' of patients through the MSE acute hospitals; in helping to meet emergency demand, especially during winter (and COVID-19) peaks; and in supporting the MSE elective recovery programme.

3. Methodology and Governance

3.1 Clinical review panel members (Appendix 2) from within and outside of the East of England and patient representatives (experts by experience) were identified by their clinical expertise and background and invited to join the review panel. All panel members signed conflict of interest and confidentiality declarations (Appendix 3).

3.2 Terms of Reference for the review were agreed between Dr Bernard Brett, Chair of East of England Clinical Senate and James Wilson, Transformation Director, Mid and South Essex Health and Care Partnership (Appendix 1).

3.3 The evidence received on 22 March 2022 was discussed at the pre-panel teleconference on 29 March 2022, chaired by Dr Hazel Stuart in the absence of Dr Bernard Brett, to prepare panel members and discuss potential key lines of enquiry.

3.4 Two clinical review panels took place on 04 April and 06 April 2022. The MSE team attended on 06 April 2022 to respond to questions raised by the panel on 04 April 2022 and provide further supporting and contextual detail. The proposals were discussed with the panel in more detail.

3.5 Sections of the draft report were sent to the clinical review panel members for review and confirmation of accuracy and to the MSE team for review for points of accuracy on 05 May 2022.

3.6 The final draft of the report was submitted to the East of England Clinical Senate Council on 27 June 2022. Senate Council agreed that the clinical review panel had fulfilled the Terms of Reference for the review and confirmed the report.

3.7 East of England Clinical Senate will publish this report on its website at an appropriate time and as agreed with the sponsoring organisation.

4. Summary of Key Findings:

4.1 The Panel thanked the MSE team for the information and engagement with the Panel, their open and honest approach, as well as the willingness of the MSE team to answer the questions from the Panel.

4.2 The Panel were very positive towards the MSE team seeking advice and engagement with the Clinical Senate.

4.3 Following the submission of evidence and additionally the presentation session to the Panel, including discussion between the MSE team and the Panel in the form of question and answers, the Panel have developed this report which includes the key findings of the Panel as well as recommendations for consideration by the sponsoring organisation.

4.4 **Stroke pathway**: **Please refer to Recommendation 1**
The Panel recognised much work had already been undertaken but felt there needed to be a continued focus on optimising the stroke pathway with an aim to minimise the number of patient moves where possible, and ensure that the appropriate criteria and assessments are in place to deliver the correct pathway for each patient. The Panel felt further work was also needed to ensure there were clear criteria for all the possible pathways.

Concentrating stroke rehabilitation services on two sites would provide more resilience than the previous model but still could be challenging in terms of

staffing. The Panel felt that the two rehabilitation units should work together as much as possible to share staffing resource and build in resilience.

On 28 February 2022, a national service model for an Integrated Community Stroke Service (ICSS) was published by the NHS[1]. The ICSS is part of the National Stroke Service model and is an integrated seven days per week service, providing early supported discharge, high-intensive and needs-based community stroke rehabilitation and disability management.

The Panel explored the components of the ICSS model with the MSE team. The MSE team advised that the Early Supported Discharge (ESD) team supports discharge from the acute stroke unit as well as receiving patients who have been an in-patient, so already follows the new ICSS model. The referral process is through a well-established joint care pathway document that accompanies the patient in paper form, as well as being held in an electronic shared drive. The MSE team presented that having a shared document that can be inputted by the acute and ESD teams works well and has brought a sense of trust between the teams.

The proposed model with ring-fenced beds will fit well with the ICSS model, will have clarity in terms of pathways and the standards will continue to be monitored by the Sentinel Stroke National Audit Programme (SSNAP) as currently.

The Panel also discussed with MSE the future modelling around the Hyper Acute Stroke Unit (HASU) as this is an important part of the stroke pathway. It was noted that patients could move at least three times after initial hospital contact (to Acute Trust for initial assessment and treatment, to the HASU when established, back to the original Trust for post HASU care and then to community rehabilitation). The suggested changes in community provision will not negatively impact on this. It

[1] NHS England (2022) National service model for an integrated community stroke service https://www.england.nhs.uk/publication/national-service-model-for-an-integrated-community-stroke-service/ accessed 21.02.2022

was also noted that post-acute care could include the ESD service, community rehabilitation, local Trust rehabilitation or rehabilitation at home. MSE explained that this is an area where senior clinical input and decision making is required.

The Panel wished to understand more about the inclusion and exclusion criteria for these community beds. MSE informed the Panel that the short-term plan is for a Level 3 rehabilitation service. However, when considering the level of physician input and upskilling of therapists and nurses to take on senior leadership roles, there could be potential to develop some in-house level 2b rehabilitation provision, at least while patients wait for tertiary units, but this is not the plan for the short term.

4.5 Digital: Please refer to Recommendation 2.1, 2.2 and 2.3.

The Panel recognised that significant work had already been undertaken in considering digital solutions throughout patient pathways and to facilitate transformation of patient pathways. The widespread use of a single system (SystmOne) amongst primary care and community providers with enabled access for other providers such as the Out of Hours service and the Hospice service was a very positive step. However, it seems that this does not currently provide seamless communication so referral forms are used to provide relevant clinical and social care information. It was noted that the ability to access an electronic system does not mean this is necessarily routine practice if this is not the primary system a clinician uses. The Panel felt there was a need to continue to work towards enhanced digital information sharing across clinical pathways**.**

The Panel heard that MSE had gained experience in the use of virtual wards during the COVID-19 pandemic and in specialities such as frailty, respiratory and end of life care, with roll out planned in cardiology soon. The development of virtual wards is on-going and is being considered in service design, bed capacity and configuration. The Panel were also informed that not all the existing estate is set up for digital enablement.

The Panel noted that other technology such as virtual monitoring may also enable more patients to be cared for through the Recovery at Home pathway.

The proper set-up and use of virtual wards, where appropriate, should be increased to enable more rehabilitation at home. The experience already gained in response to the COVID-19 pandemic and for patients with respiratory problems should be built on further.

Digital solutions may also offer part of the solution to family and carer access challenges, but this should not be instead of Recommendation 7 regarding transport access. Co-produced digital solutions are more likely to produce positive end results for the MSE team.

4.6 Workforce: Please refer to Recommendation 3

There are national shortages of staff from many professions involved in delivering rehabilitation services. The Panel concluded that it will be a challenge to maintain appropriate staffing levels with the required competencies in all areas, for example stroke rehabilitation is planned to take place on two community hospital sites and on an outpatient basis. The Panel questioned whether there was more that could be implemented around building shared competencies with staff working in the social care sector. The Panel were impressed with the training already developed to deliver competency training in end-of-life care, personalised care and frailty assessment, but were not sufficiently assured that MSE have the required capacity to truly deliver this ambitious system-wide training.

4.7 System leadership focus at all levels: Please refer to Recommendation 4

The Panel were advised that clinical leadership is at the heart of the MSE ICS with a system of Stewardship being used. Stewardship is about bringing together front-line staff and managers within a care area to improve quality and make better use of resources. It consists of a values-based approach which the clinical leadership team believe assists in embedding skills. Ageing Well and stroke care are included within this programme as are frailty, end of life care, anticipatory care and personalisation across the MSE ICS system.

There is a clinical leadership competencies training package which has strong clinical oversight from various clinical leaders to support teams working directly

with patients. The Panel heard that there is an ambitious learning and education programme across MSE to embed this training programme which is planned to commence in May 2022, with a series of workshops sharing the culture change towards shared decision making. A learning academy platform is being built so that all tiers of staff can engage in the training. This includes the development of assessment tools for all professions to ensure a consistent approach. It is planned that this will be an on-going programme of work to support the change.

The Panel felt there should be a focus on ensuring that system leadership is enhanced at all levels. Although there is evidence of strong system-level leadership and impressive plans in place for consistent training, the Panel considers that there is an ongoing need to continue to work to ensure leadership at the shop floor level is also strong and consistent (although MSE may be ahead of many other systems in their planning). The Panel advised that MSE should ensure that AHP and nursing leadership is enhanced to enable empowered decision making on the ground. Leadership development should also be designed to help deliver cultural change.

4.8 Pathway transformation: Please refer to Recommendation 5

The Panel felt that the Recovery at Home pilot in the Halstead area seemed to have been very successful and the Panel were impressed with this work. The Panel feel that even more focus on learning from this pilot should be taken into account with consideration for pathway changes throughout the MSE system and potentially reconsideration of the number of beds required in the longer term.

4.9 Outcomes: Please refer to Recommendation 6

Whilst the Panel were impressed with the Patient Reported Outcome Measures (PROMs) tool used for the Recovery at Home service, including the element looking at patient and carer goals, and the plans to standardise this type of approach throughout the MSE system, the Panel felt this key patient-focused work could be further accelerated

The Panel heard the MSE clinical team describe an Ageing Well dashboard which is being developed. This dashboard will include both “business as usual”

indicators as well as additional indicators that traditionally were not previously measured across the bed base and the Recovery at Home pathways. These include patients' personalisation in their own goals, goal attainment measures and whether patients' desired goals are reached, as well as health related quality of life indicators. Through the development and embedding of this dashboard, each service will be able to see the difference that they are making beyond the use of traditional activity measures. This is considered critical in the Ageing Well dashboard.

The MSE clinical team described the use of some of the tools they are using to help build this dashboard such as the Frailty, End of Life and Dementia Assessment (FREDA) tool and the Comprehensive Geriatric Assessment toolkit to evidence delivery of high impact and high evidence interventions that are known to improve outcomes in frailty. Use has been made of learning from the Recovery at Home pilot and it is envisaged the dashboard will also be rolled out across the community bed base. This includes use of consistent code capture so that there is evidence of what is actually happening. All providers will use the same tool as it is being rolled out across the ICS as a whole system approach, including Primary Care Network and Integrated Neighbourhood models.

4.10 Access: Please refer to Recommendation 7

The Panel were informed that patient, family and carer access to the community sites, is recognised as a key part of the proposal. Direct patient, family and carer access to the sites has been studied. Additionally, the Panel were presented with documentation demonstrating travel times. However, the MSE team are also planning to conduct an Integrated Impact Assessment, which is complex, but will include public transport access for family and carers.

Access, particularly for those using public transport, is likely to be a challenge for many families and carers. The location of community beds is, understandably, based on the current estate rather than necessarily the ideal locations for facilitating access (the Panel recognised that there are constraints on capital resources). Within the recommendations the Panel consider that co-produced

solutions are important, by engaging with local transport services, councils and the voluntary sector, as well as patients and carers**.**

4.11 Bed Bureau: Please refer to Recommendation 8

The Panel sought to understand the clinical leadership of the existing Bed Bureau and its decision making. The Panel were informed that the Bed Bureau is a capacity tool that is an administrative function that can draw on clinical input as required. The MSE team acknowledged that this is an area where they are reviewing the vision and plans for the long-term Discharge to Assess and Transfer of Care models. The MSE team advised that this is part of a wider aspect to be reviewed within patient flow work and improvement, looking to achieve consistency in transfer of care from the acute hospitals.

The Panel agreed that a single point to coordinate the access to, and use of, community rehabilitation services made sense. They agreed that this could be enhanced further with a multidisciplinary clinical and social care team which is part of the existing Discharge to Assess plans across MSE. This would also give an opportunity for quality improvement activity including increased capability to shape pathways for the future. The Panel heard about the desire to move to more of a pull rather than push model but did not feel that this particularly came across in the descriptions of the pathways so far. The Panel felt that enhanced clinical input could also help move the Bed Bureau into more of a pathway coordination team.

4.12 Social Care: Please refer to Recommendation 9

The Panel were impressed with much of the work around frailty and stroke but felt that although there were regular meetings with the Director of Adult Social Services and with their commissioning teams, there seemed to be less social care participation and input in the development of the MSE plans as they were presented than would ideally be the case. The Panel felt it was very important to ensure that social care is fully incorporated into future planning and development, thinking about the context of the whole person, which includes family and carers.

4.13 Engagement and implementation of findings

The Panel were impressed with the degree of engagement, despite the COVID-19 pandemic which had clearly made this challenging. The Panel were informed that there is an external company working with the MSE team on the development of a report.

There has been pre-consultation engagement directly with patients; with existing staff teams; and focus groups with public and external stakeholders. Emerging themes shared with the Panel include participation of family, not just with visiting but involvement in care plans post discharge, including training and up-skilling family members. From patients there had been feedback regarding the need for good discharge planning; clear communication both within and across professionals, and also with families and patients at every point in their care journey; and personalisation in recognising that everyone's circumstances are different.

The Panel were made aware that during consultation MSE are keen to work with families, carers and friends to determine how to improve and develop direct engagement with patient care where required. The consultation will explore whether there are opportunities (if appropriate) to deliver training, for example on wound care and medication.

The Panel suggest that MSE must carefully consider the key messages being collected through the engagement process and deliver on them.

4.14 Health Inequalities

The Panel heard that work on Health Inequalities is in progress and will be taken further forward. Across the ICS, Health Inequalities are one of the agreed priorities. Recently the MSE team have started using an Integrated Impact Assessment in which inequalities features as a central element.

4.15 Governance

The Panel wanted to understand the governance and responsibility around the multiple pathways involving multiple providers. The MSE team advised that their

system is inherently complex in that there are three separate community providers and one acute provider operating across three sites. The community providers now work under one Community Collaborative, which brings together three sovereign organisations and so in terms of clinical leadership and clinical governance this does rest with each of these organisations. However, in the programme for this proposal, the clinical leadership is as discussed in the Clinical Leadership part of this report (please refer to 4.7 above). The ICS has an accountable Medical Director.

With the sub-acute frailty wards the clinical governance and leadership is the responsibility of the geriatric medicine staff from the Basildon Hospital site.

The MSE team explained to the Panel that across the three parts of the Community Collaborative, there are different arrangements. Essex Partnership University NHS Foundation Trust (EPUT) run Mountnessing Court and Cumberlege; North East London NHS Foundation Trust (NELFT) run the intermediate care beds at Brentwood and Mayfield; Provide CIC run St Peter's and Halstead; and Basildon Hospital run the two sub-acute wards on the Brentwood site.

The Panel heard that transfer of care to primary care, in terms of discharge planning, is made easier because all of primary care use SystmOne.

For stroke rehabilitation, the MSE team informed the Panel that there is a well-established nurse led model which will continue to be built upon for the future.

4.16 Estate

The Panel heard that the plan to develop the beds in the south geography of the MSE system is a legacy of where the estate has been historically located and is not fully aligned with population density or need. There are capital restraints around making significant changes to the estate. The population density is also greater in the south of the system.

4.17 Sub-acute frailty – acute, deteriorating patient

The Panel were reassured to hear about the seven-day consultant presence on ward sites, out of hours medical presence, equipment and diagnostic provision. The MSE team explained that patients who are transferred to the sub-acute frailty wards are carefully selected by the geriatric medicine staff, identifying those patients who are least likely to require other speciality input. If the patients are felt to require further specialist input, then they are not considered for transfer from the acute hospital to the community hospitals

The Panel were informed that very few of the patients transferred to the community hospitals had required transfer back to the acute hospital for treatment of an acute deterioration or for other clinical reasons. The Panel do however feel that MSE need to give consideration to the triggers for transfer and clarity of provision for the transfer to the acute site, of any clinically deteriorating patients and the management of urgent situations.

4.18 Voluntary sector

The Panel heard about how the voluntary sector links in with all of the community beds. There is recognition by the MSE team that now that we are coming out of the COVID-19 pandemic that there is potential to revisit the opportunities for strengthening links with the voluntary sector.

4.19 Additional comment noted at Clinical Council meeting on 27 June 2022

The Clinical Senate Council noted the beds were ringfenced for stroke use only and broader neurological rehabilitation may need more attention. It was suggested for MSE to have a Quality Impact Assessment for general rehabilitation that would add to the further development of rehabilitation services.

5. Conclusions:

The Panel felt there was a clinical basis to support the proposal. The location of the beds, constrained by the current estate, could however impact on the access for patients' families, carers and friends. The relocation of the frailty wards will have benefits to acute hospital capacity and therefore potentially to patient flow. The Panel were reassured that the same consultants who selected suitable patients for transfer to the community hospitals were also the consultants who continued to be responsible for patient care on the frailty unit.

The Recovery at Home pilot in the Halstead area appears to have been very successful and the Panel were particularly impressed with the PROMs tool used with a focus on patient and carer goals. Further learning from the pilot and incorporating this learning in pathway development, is featured within the recommendations.

The key questions the Clinical Senate were asked to address in this review and the response of the Panel are as follows.

1. **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?**
   In answer to question one: The Panel felt that the emerging options had the potential to deliver good patient outcomes and support patient flow, although the MSE team are advised to take account of the recommendations to help ensure that this is delivered.

2. **Intermediate care beds: Is the clinical model for ageing well and the proposed focus and potential locations of community beds likely to contribute to improving outcomes for patients?**
   In response to the second question: The clinical model, aimed at trying to help patients return to their previous level of functioning, was supported, along with the plans to enhance staff training to support understanding of personalised care, frailty assessment and end of life care. The locations of

the community beds are constrained by the location of the current system-wide viable estate. If the potential access issues for family and carers are addressed and the Panel's recommendations are taken into account, then improvement in patient outcomes should be achieved.

3. **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?**

   In response to the third question: The Panel fully supported the introduction of dedicated, ring-fenced stroke rehabilitation beds. This is likely to help deliver more consistent and more resilient care. Two sites will deliver a better solution in terms of access than one, but the Panel felt that this could still prove to be a challenge in terms of maintaining appropriate staffing levels. The Panel felt that cross site working may be required for several staff groups. Please refer to the Recommendations.

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

   In response to the fourth question: The Panel felt that many elements of the sub-acute frailty pathways were very positive. These include the enhanced staff training to help assess frailty more consistently, the dedicated inpatient area for the care of patients suffering from frailty and the single team making many of the initial assessments and then being responsible for delivering rehabilitation.

Moving forward, the Panel felt that more could be done to build on the Recovery at Home pilot. This includes the use of virtual technology, new ways of working and enhanced liaison with the voluntary sector which may enable more patients with frailty to avoid inpatient stays altogether. Please refer to the Recommendations.

6. Recommendations:

Recommendation 1

Optimisation of the Stroke pathway.

The Panel recommends further co-produced work be undertaken to optimise the Stroke pathway.

The Panel recognised much work had already been undertaken but felt there needed to be a continued focus on optimising the stroke pathway with an aim to minimise the number of patient moves in the overall stroke pathway where possible, and ensure that the appropriate criteria and assessments are in place to deliver the correct pathway for each patient. It was noted that patients could move at least three times after initial hospital contact. The Panel felt further work was also needed to ensure there were clear criteria for all the possible pathways.

Concentrating stroke rehabilitation services on two sites would provide more resilience than the previous model but still could be challenging in terms of staffing. The Panel felt that the two rehabilitation units should work together as much as possible to share staffing resource and build in resilience.

Recommendation 2.1

Digital pathway communications.

The Panel recommends that MSE ensure that digital solutions enable seamless communication throughout patient pathways and facilitate transformation of patient pathways.

Recommendation 2.2

Digital virtual ward.

The Panel recommends that MSE further develop the use of virtual wards and virtual monitoring to enable more rehabilitation at home.

Recommendation 2.3

Digital development for families and carers.

The Panel recommends that co-designed digital solutions should be developed to address family and carer in-person visiting and challenges.

Recommendation 3

The development of a comprehensive Workforce Strategy.

The Panel recommends the development of a comprehensive Workforce Strategy with ongoing focus on new ways of working, new roles, and competency sign-off, as well as recruitment and retention.

Recommendation 4

Focus on ensuring system leadership is enhanced at all levels.

The Panel recommends that there should be a focus on ensuring that system leadership is enhanced at all levels.

Recommendation 5

Further focus on Pathway transformation using learning from the Recovery at Home pathway.

The Panel recommends that even more focus on learning from the Recovery at Home pilot is taken into account with consideration for co-produced pathway changes throughout the MSE system and potentially reconsideration of the number of beds required.

Recommendation 6

Outcomes - to accelerate the approach to using outcomes-based tools.

The Panel recommends that the plans to standardise the use of outcomes-based tools, which include patient and carer goals, should be accelerated throughout the MSE system.

Recommendation 7

A continued focus on access with co-production.

The Panel recommends that co-produced solutions should be developed by engaging with local transport services; councils; the voluntary sector; and patients, families and carers.

Recommendation 8

Further development of the Bed Bureau function with enhanced clinical input, facilitating more of the pull model and oversight of whole pathways of care.

The Panel recommends that enhanced clinical input could be provided into the Bed Bureau to move it to more of a pathway coordination team.

Recommendation 9

The Panel were very impressed with much of the work around frailty and stroke but felt there would be significant benefit in increasing the level of social care involvement.

The Panel recommends increasing the level of social care involvement in the developing plans.

APPENDIX 1: Terms of Reference for the Review

NHS
East of England
Clinical Senate

East of England Clinical Senate

Independent Clinical Review of Mid and South Essex Community Inpatient Beds

04 and 06 April 2022

Terms of Reference agreed by:

Commissioning organisation: **Mid & South Essex Health and Care Partnership**

Responsible / lead officer:

James Wilson, Transformation Director, Essex Partnership University NHSFT, Provide, North East London NHSFT

Community Inpatient Beds Programme Senior Responsible Officer

Signature 

Panel chair:

Dr Bernard Brett, East of England Clinical Senate Chair, on behalf of East of England Clinical Senate

Signature

Date: 22 March 2022

Supporting / background information for the clinical review for completion by commissioning organisation.	
When is the advice required by? Please provide any critical dates	The advice is required to feed into the Pre-Consultation Business Case (PCBC), which will be considered by the Joint Committee of the five Clinical Commissioning Groups. This is being developed during March and April 2022, so a draft report, including recommendations, is requested by mid-April. This will enable the key findings, recommendations and system's draft responses to be incorporated.
What is the name of the body / organisation commissioning the work?	Mid & South Essex Health and Care Partnership (to become Mid & South Essex Integrated Care System on 1 July 2022, subject to legislation).
How will the advice be used and by whom?	The advice will be used by the programme in several ways: • To further develop and finalise the proposed configuration of community beds for intermediate care, stroke rehabilitation and sub-acute frailty, prior to public consultation in summer 2022 • To feed into the PCBC • As part of the Stage 2 NHSE assurance process
What type of support is Senate being asked to provide: a) Assessment of clinical services b) Early advice to inform a clinical service model c) Review of proposed clinical model(s) (or follow up review from b above) d) Review of case for change, including the appraisal of the clinical evidence) e) Informal facilitation to enable further work f) Clinical reconfiguration or integration related to merger of trusts g) Advice on complex or (publicly) controversial proposals for service change h) Other?	The Senate is being asked to: • Consider the clarity of the case for change, noting that urgent changes (without consultation) were made to the community bed configuration in MSE as part of the system's response to Covid, and decisions now need to be taken on the future focus and location of these beds • Review the clinical models and evidence presented – focusing on the role of community inpatient beds within them – for the three key elements of the programme: intermediate care; inpatient stroke rehabilitation; and sub-acute frailty at Brentwood Hospital • Offer advice on how the proposals might be further developed or strengthened
Is the advice being requested from the Senate a) Informal early advice or a 'sense check' on developing proposals	The advice is being requested to inform Stage 2 of the NHS England assurance process, prior to planned public consultation in the summer of 2022

b) Early advice for Stage 1 of the NHS England Assurance process c) Formal clinical review to inform Stage 2 of the NHS England Assurance process and/ or your Consultation Business Case d) Other?	
Does the matter involve revisiting a strategic decision that has already been made? If so what, by whom and when?	Some elements of the proposed approach to stroke rehabilitation are relevant to a previous consultation (which focused on acute reconfiguration) held in 2017 ('your care in the best place'). This consultation was wide ranging, encompassing a number of acute specialties, one of which was stroke and the proposed establishment of a hyper-acute stroke unit (HASU) at Basildon Hospital. Further details of this consultation are included in the evidence submitted (overview and context section).
Is the matter subject to other advisory or scrutiny processes?	No

Aims and objectives of the clinical review

In 2020 as part of its response to Covid MSE made a number of urgent changes to the focus and location of its community inpatient beds. The key changes were:

- Consolidation of intermediate care beds from six sites to three
- The relocation of two frailty wards from the main Basildon Hospital site to Brentwood Community Hospital (~10 miles away), to enable critical care capacity at Basildon to be rapidly expanded
- The mobilisation of a recovery at home service for the Halstead area of Mid Essex

As these changes were urgent, it was not possible to engage or consult on them prior to their introduction.

As a result, in 2021 MSE began a programme to determine what the future focus, configuration and location of community beds should be. This will require public consultation, which is planned for the summer of 2022.

There are three main service areas affected by this work:

- Intermediate care beds, which in MSE focus on supporting patients who have been admitted to one of the three main acute hospital and who require a period of bedded recovery and rehabilitation before they can return home
- inpatient stroke rehabilitation beds, which have never previously been ring-fenced

- the sub-acute frailty beds (two wards), which are currently provided at the Brentwood Community Hospital site with care provided by the Basildon Hospital acute team.

Scope of the review

The scope of this review is the future number, focus and location of community inpatient beds across Mid & South Essex.

As outlined above, there are three main service areas that are within scope:

- Intermediate care beds
- Inpatient stroke rehabilitation beds
- Sub-acute frailty beds at Brentwood Community Hospital

Out of scope

Although the wider care models and pathways that the inpatient community beds form part of are clearly relevant to this review, they are not themselves within scope, and they will not be part of any future public consultation.

For example, although MSE's broader strategic approach to ageing well is set out in the evidence submitted - as this will help the Panel to determine the place of community inpatient beds with it - the Senate are not being asked to specifically comment on the overall approach. Rather, the focus is on the proposed number, focus and location of the beds themselves.

The same logic applies to the overall stroke pathway, which encompasses prevention right through to post-rehabilitation. This is described for context but the focus of the review is on the proposed ring-fenced inpatient stroke rehabilitation beds, including the number and location.

Purpose of the review

The Clinical Senate is being asked to review the available evidence, provide a desk top review and make appropriate recommendations to the programme from its findings.

The central questions the Clinical Senate is being asked to address in this review are:

1. **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?**
2. **Intermediate care beds: Is the clinical model for ageing well and the proposed focus and potential locations of community beds likely to contribute to improving outcomes for patients?**

3. **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?**
4. **Sub-acute frailty: Is the model that has been developed clinically sound and likely to result in at least comparable outcomes for frail older people, and how might it be further developed over time?**

For info only – the following information is standard to all clinical review panel terms of reference:

When reviewing the case for change and options appraisal the clinical review panel (the panel) should **consider whether these proposals deliver real benefits to patients. The panel should also identify any significant risks to patient care in these proposals.** The panel should consider benefits and risks in terms of:

- Clinical effectiveness
- Patient safety and management of risks
- Patient experience, including access to services
- Patient reported outcomes.

The clinical review panel is not expected to advise or make comment upon any issues of the NHS England Service Change Assurance process that will be reviewed elsewhere (e.g. financial elements of risk in the proposals, patient engagement, GP support or the approach to consultation). However, if the panel agreed that there was an overriding risk in any of those areas that should be highlighted in the panel report.

Questions that may help the panel in assessing the benefit and risk of the proposals include (but are not limited to):

- Is there a clear vision for the proposals, i.e. what is the intended aim?
- Are the expected outcomes and benefits of delivery for patients of this proposed model clear and are there clear plans for how it / they will be measured?
- Is there evidence of clinical leadership and engagement in the development of the options/ preferred model?
- Is there evidence that the proposals will improve the quality, safety and sustainability of care? (e.g. sustainability of cover, clinical expertise).
- Is there evidence that the proposed model will ensure equity in access to services for the population you serve, and how it could reduce inequalities in health?
- If there is a potential increase in travel times for some patients, is this outweighed by the clinical benefits?
- Do the proposals support better integration of services from the patient perspective?
- Do the proposals explain how the model be staffed? Is there appropriate information on recruitment, retention, availability and capability of staff and the sustainability of the workforce?

- Do the proposals reflect up to date clinical guidelines and national and international best practice e.g. Royal College reports?
- Will these proposals meet the current and future healthcare needs of their patients within the given timeframe of the planning framework (i.e. the next ten years or more)?
- Do the proposals align with the local strategies and delivery plans (e.g. Sustainability and Transformation Plans / Integrated Care System plans and strategy)? Do they demonstrate alignment / integration of services (e.g. the link between primary care / social care / mental health services/ community services and acute provision including information systems)?
- Do the proposals demonstrate good alignment with national policy and planning guidance?
- Does the options appraisal consider a networked or Alliance approach - cooperation and collaboration with other sites and/or organisations?
- Will the proposals reflect further the delivery of the NHS Outcomes Framework?
- Do the proposals uphold and enhance the rights and pledges in the NHS Constitution?
- Is there an analysis of the clinical risks in the proposals, and is there an adequate plan to mitigate identified risks?

The clinical review panel should assess the strength of the evidence base of the clinical case for change and proposed models and make clear its key findings and recommendations in a report to the commissioning organisation.

Timeline:

The clinical review panel will be held on the 04 and 06 April 2022. A schedule of agreed key dates can be found at Appendix A.

Reporting arrangements:

The clinical review panel will provide a report to the Clinical Senate Council which will ensure the panel met the agreed Terms of Reference, agree the report and be accountable for the advice contained in the final report.

Methodology:

The most appropriate methodology for the review will be agreed with the commissioner of the review and Senate Council. There are a number of options, the most usual methodology will be a face to face clinical review panel, providing the commissioner of the proposals the opportunity to have a two-way discussion of the proposals with the review panel. In this case, the review will be undertaken by a combination of

- desk top review of the documentation (evidence) provided,
- a pre-panel teleconference for panel members to identify the key lines of enquiry and
- a review panel meeting to enable presentations and discussions to take place.

Other approaches may include a desktop review, and short review by teleconference. Full methodology will be agreed in all cases.

Report of the clinical review:

A draft report will be made to the commissioning organisation for fact (points of accuracy) checking prior to publication.

Comments / correction must be received from the commissioning organisation within **six working days**.

The report will be submitted to a meeting of Clinical Senate Council on a date to be confirmed, but to fit in with the MSE next stage timelines, to ensure the review has met the agreed Terms of Reference and to agree the report.

The final report will be issued to the commissioning organisation following the Council Senate Council meeting. The commissioning organisation forthwith becomes the owner of the report.

Communication, media handling and Freedom of Information (Act) requests:

Communications in respect of the review will be managed by the commissioning organisation. The Clinical Senate will publish the report once the service change proposal has completed the full NHS England process, or at a time that is appropriate to the proposals. This will be agreed with the commissioning organisation.

The commissioning organisation, as the owner of the report and any evidence and or data provided for the review, will be responsible for handling any formal requests for information under the Freedom of Information Act 2000, irrespective of whether the request is received by either the Clinical Senate or commissioning organisation. (note: NHS Commissioning Board known as NHS England is the statutory body with responsibility for FOI requests received either directly or by the Clinical Senate and will be advised of all such requests received directly by the Clinical Senate and confirmation that the commissioning organisation will be responding to the request).

Confidentiality:

Notes of the discussion will be taken on the day in order to develop a report. Once the final report has been issued to the commissioner of the review, the notes will be securely destroyed along with the evidence set provided.

All clinical review panel members will be required to sign a Confidentiality Agreement and declare any interests, potential or otherwise.

The detail of any potential, or actual, conflict of interest will be discussed with the Panel Chair who will make a final decision on the participation of the Panel member. This may also be discussed with the commissioning organisation and agreement made between them and the Clinical Senate as to whether or not the member will join the review panel.

Resources:

The East of England Clinical Senate will provide administrative support to the clinical review panel, including setting up the meetings and other duties as appropriate.

The clinical review panel may request any additional existing documentary evidence from the commissioning organisation. Any requests will be appropriate to the review, reasonable and manageable. The review panel will not ask the commissioner of the review to provide new evidence or information that it does not currently hold.

Accountability and governance:

The clinical review panel is part of the East of England Clinical Senate accountability and governance structure.

The East of England Clinical Senate is a non-statutory advisory body and will submit the report to the commissioning organisation, who will be the owners of the final report.

The commissioning organisation remains accountable for decision making but the clinical review panel may wish to draw attention to any risks that the commissioning organisation may wish to fully consider and address before progressing their proposals.

Functions, responsibilities and roles of the parties:

The **commissioning organisation** will

i. provide the Clinical Senate review panel with the clinical case for change, options appraisal and relevant background and current information, identifying relevant best practice and guidance. Is it recommended that the evidence supports the questions laid out above. The level of detail though will be appropriate and in proportion to the stage of development of the proposals. For NHS England Service Change Assurance process 'Stage 2' reviews, Clinical Senate provides supporting information on the evidence it would expect to see
ii. respond within the agreed timescale to the draft report on matter of factual inaccuracy
iii. undertake not to attempt to unduly influence any members of the clinical review panel during the review
iv. be responsible for responding to all Freedom of Information requests related to the review and proposals and
v. arrange and bear the cost of suitable accommodation (as advised by Clinical Senate support team) for the panel and panel members.

Clinical Senate Council and the commissioning organisation will

i. agree the Terms of Reference for the clinical review, including scope, timelines, methodology and reporting arrangements.

Clinical Senate Council will

i. appoint a clinical review panel, this may include members of the Clinical Senate Council and Assembly, external experts, and / or others with relevant expertise. It will appoint a Chair of the review panel
ii. consider the review recommendations and report and consider whether the clinical review panel met the Terms of Reference for the review
iii. provide suitable support to the panel
iv. issue the final report to the commissioning organisation and
v. promptly forward any Freedom of Information requests to the commissioning organisation.

Clinical review panel will

i. undertake its review in line with the methodology agreed in the Terms of Reference
ii. follow the report template and provide the commissioning organisation with a draft report to check for factual inaccuracies
iii. submit the draft report to Clinical Senate Council for comments and will consider any such comments and incorporate relevant amendments to the report.

Clinical review panel members will undertake to

i. declare any conflicts of interest and sign a confidentiality agreement prior to having sight of the full evidence and information
ii. commit fully to the review and attend all briefings, meetings, interviews, panels etc. that are part of the review (as defined in methodology)
iii. contribute fully to the process and review report
iv. ensure that the report accurately represents the consensus of opinion of the clinical review panel and
v. comply with a confidentiality agreement and not discuss the scope of the review nor the content of the draft or final report with anyone not immediately involved in it. Additionally, they will declare, to the Chair of the clinical review panel and the Head of Clinical Senate, any conflict of interest that may materialise during the review.

Clinical review panel members:

Members of the clinical review panel sit in their own personal or professional capacity; they do not represent the opinion of their employing or professional body. All clinical review panel members sign an agreement of confidentiality and declare any potential conflicts of interest. Clinical review panel members names and areas of expertise will be shared by the clinical Senate with the commissioning organisation prior to the pre-panel.

Appendix A – Key Dates		
Action	**Date (no later than)**	**Who**
1. Commissioning team request clinical review – date & methodology agreed with Senate	**11.03.2022**	**Andy Vowles/ Mary Parfitt**
2. Terms of Reference for review completed, agreed and signed off	**18.03.2022**	**Andy Vowles/ Bernard Brett**
3. All panel members identified and confirmed	**18.03.2022**	**Mary Parfitt**
4. All panel members confidentiality agreements and declarations of interest signed (NB for each individual Panel member, individual agreement must be signed and received back by Clinical Senate prior to Evidence Pack being sent to individual member)	**18.03.2022**	**Mary Parfitt**
5. All papers and evidence for the review panel to be received by eoeclinicalsennte.nhs.net	**21.03.2022**	**Andy Vowles**
6. Evidence pack and Terms of Reference to be sent to panel members	**22.03.2022**	**Mary Parfitt**
7. Pre-panel teleconference call	**29.03.2022**	**All Panel Members invited (NB Not MSE)**
8. Key Lines of Enquiry / Agenda for Clinical Panel review meetings issued	**01.04.2022**	**Mary Parfitt**
9. Clinical Panel Review	**04 & 06.04.2022**	**All Panel Members. Potential availability of MSE for questions on 06 April 2022 only**
10. Draft report to MSE (Andy Vowles) for points of accuracy	**05.05.2022**	**Mary Parfitt**
11. MSE response on points of accuracy	**20.05.2022**	**Andy Vowles**
12. Clinical Senate Council consider report	**Date tbc, but to fit in with MSE next stage timelines**	**Bernard Brett**

APPENDIX 2:

Membership of the Clinical Review Panels held on 04 and 06 April 2022

Clinical Review Panel Chairs:

Dr Bernard Brett (Chair of Panel Sessions held on 04 and 06 April 2022)
Dr Bernard Brett MB, BS, BSc, FRCP, Advanced Medical Manager (BAMM) is Deputy Medical Director and a consultant Gastroenterologist at the Norfolk and Norwich University Hospitals NHS Foundation Trust, and also works at the James Paget University Hospitals NHS Foundation Trust. He has a strong interest in Management and Leadership. He is the current Chair of the Clinical Services and Standards Committee (CSSC) for the British Society of Gastroenterology (BSG), recently completed his term as the BSG Quality Improvement Lead and is the regional Endoscopy Clinical Transformation Lead for the East of England.

Bernard has held the post of Chair of the East of England Clinical Senate since July 2014 and has chaired more than fifteen independent clinical review panels. In 2016 he won the Health Education East, 2016 NHS Leadership Recognition Award for 'Leading and Developing People'. He has also held several senior management posts over the last twenty years including the following roles whilst at the James Paget University Hospital; Medical Director, Responsible Officer, Deputy Medical Director, Divisional Director, Director of Patient Flow and Appraisal Lead. He previously led the East of England's project to develop a unified drug chart for the region. Bernard has spoken at regional and national meetings on a range of topics including '7-day working' and been an invited speaker on the topic of 'Improving Colonoscopic Adenoma Detection Rates' and 'The Future of Gastroenterology Services.'

His clinical interests include Bowel Cancer Screening (he has been an accredited bowel cancer screening Colonoscopist for the last 15 years); Therapeutic Endoscopy and Endoscopic Retrograde Cholangiopancreatography (ERCP). His educational interests include communication skills and endoscopic training – he is Senior Faculty Member of the Regional Endoscopy Training Centre in Norwich and was on the Faculty for Regional Trainer Development Programme Module, 'Learning and Teaching Communication Skills' for over 10 years.

Dr Hazel Stuart (Chair of Pre-Panel Session held on 29 March 2022)
Dr Hazel Stuart MBBS, DRCOG, FRCA, FICM is Medical Director and a Consultant Anaesthetist with an interest in Intensive Care Medicine at the James Paget University NHS Foundation Trust in Gorleston.

She has had an interest in leadership for many years and has held a variety of posts within the Trust including Transformation Lead, Deputy Medical Director and is also a Caldicott Guardian.

Hazel has been a member of the clinical reference group for Hyperbaric Medicine commissioning and has an interest in diving medicine.

In 2016 she completed the Nye Bevan programme and received a NHS Leadership Academy award in Executive Healthcare Leadership. She has an interest in reflective learning and collaborative working and is an Honorary Senior Lecturer at the University of East Anglia.

Panel Members:

Louise Connolly - Occupational Therapist
A senior allied health professional working in a large Community NHS Trust. Louise is an Occupational Therapist specialising in Neurological Rehabilitation with over nineteen years of operational management experience managing a range of specialist and generalist multidisciplinary teams.

Having completed her MSc in Senior Healthcare leadership at the NHS Leadership academy, she is currently Clinical Quality Lead in Herts Community NHS Trust facilitating the continued embedding of evidence-based practice into front line Community teams and supporting the strategic development of Community and Rehabilitation Services. Louise has also been leading Discharge Home to Assess pathways during the pandemic and working on the implementation of new COVID system wide pathways. With effect from 01 April 2022 Louise will be moving into a new role as Allied Health Professional Faculty Lead across Herts and Essex Integrated Care System
(Apologies sent for the 04 April 2022 Panel Session)

Charlotte (Charlie) Dorer - Associate Director, Allied Health Professionals
Charlie is a physiotherapist by background, and about to move to a new role to work for NHSE/I as the Senior Quality Improvement Manager for the Stroke Rehabilitation (SQuIRE) project in the East of England.

Charlie has over twenty years' experience in stroke and neurological rehabilitation. She has undertaken both clinical and strategic roles during her career. Charlie's previous substantive role was as a Clinical Lead for Stroke and Neuro Rehabilitation providing her with in-depth subject knowledge and experience across community stroke and neuro rehabilitation. Currently she is in a strategic position working in a Community Trust leading the AHP workforce across all directorates (Community Health and Well-being, Learning Disabilities and Autism and Mental Health). In this role, she has focused on key development themes involving workforce planning on integrated pathways, operational delivery including safer staffing and maximising patient outcomes

Louise Dunthorne – Senior AHP
Since qualifying in 1990 Louise has spent a considerable number of years gaining experience at some of the large London teaching hospitals, including Charing Cross and The Royal London, where her passion for Stroke and Neurology was ignited, while working on the Trauma Unit and Neuro Surgery Critical Care.

Since then, she has specialised in Neurology and Stroke, being involved at Executive Committee level for ACPIN (Association of Chartered Physiotherapists in Neurology) for over ten years. She then completed a Diploma in stroke care in 2004, and Masters level modules in Effective Practitioner, Work based Learning and Work Place Coaching, securing a Post Graduate Certificate in Clinical Practice in 2008.

Louise also held the position of Chair for Regional ACPIN between 2021-15 and was honoured to receive a Distinguished Service Award by National ACPIN in 2016.

Louise works as a Clinical Specialist and Professional Lead for Stroke / Neuro at Ipswich Hospital, (ESNEFT) and Extended Scope Practitioner under a PGD for injecting Botulinum Toxin as part of the Spasticity Management Clinic. She also holds the post of AHP Clinical Lead for North ISDN, (Integrated Stroke Delivery Network). These roles necessitate reporting to ICS Stroke Board, ICS Neuro Rehab Board, East of England Neuro-Rehabilitation Steering Group and the East of England Stroke Programme Board on delivering results towards achieving the vision of the NHS Long Term Plan within Stroke and Neurology care.

Ruth Empson - Specialist Nurse Coordinator for Integrated Stroke ESD & Neuro Rehabilitation Service
Ruth is also the East of England North Integrated Stroke Delivery Network (ISDN) Lead Nurse (Secondment). Previously she was Lead Nurse for Acute Stroke Services at West Suffolk Hospital NHS Foundation Trust and Coordinator for Community Stroke & Neuro Rehabilitation Services, South West London Community NHS Trust.
(Apologies sent for the 06 April 2022 Panel Session)

Louise Gilbert - Advanced Specialist Physiotherapist
Louise is currently working as an Advanced Specialist Physiotherapist in Early Supported Discharge for Stroke (ESD) and has a shared team lead role. She has specialised in Neurological rehabilitation since 1993 working in both the acute and community settings and moved to Norfolk from London in 2007.

Louise completed her masters in Physiotherapy and PGCTLHE at the University of East London (UEL) in 1999 and 2000 and worked as a lecturer in Physiotherapy at the UEL from 1998 – 2003.

She has a keen interest in research and has been fortunate in her current post to have gained experience both as co-applicant, clinical researcher and principal investigator for local and national stroke studies.

Christine Hancock – Expert by Experience
Christine is a retired Social Work Manager and Commissioner who has had 24 years' experience of working with three different Local Authorities in Adult Care planning and procurement. During this time she was involved with implementing the Community Care Act 1990 and the Health and Social Care Act 2012, hospital discharges, care at home, direct payments, supported housing and long term residential/nursing home placements.

Christine has also undertaken residential and supported living reviews for Adults with special needs in the Eastern region in receipt of direct payments and support from their respective Local Authorities

Dr Kneale Metcalf – Stroke Consultant
Dr Metcalf is a Stroke Consultant at the Norfolk and Norwich University Hospital, appointed in 2001. Post graduate training was in Oxford. Kneale led service development in Norwich including establishment of a Rehabilitation Unit and Stroke Early Supported Discharge Service. He is an Honorary Senior Lecturer at the University of East Anglia with a leadership role in final year undergraduate Medicine. He is on the East of England Stroke Telemedicine clinical rota. He retains a research interest with active participation in local and multi-centre stroke trials. Kneale was also appointed as Consultant liaison for Clinical Coding in Norwich in 2021. In 2021 he was appointed Clinical Lead for the Integrated Stroke Delivery Network East of England (North).

Dr Stuti Mukherjee – GP
Dr Stuti Mukherjee is a General Practitioner, a Macmillan GP and GP Clinical Lead for Cancer at Cambridgeshire & Peterborough CCG / ICS. She enjoys working as a Generalist, and has a special clinical interest in cancer, dermatology and end of life care.

Dr Deyo Okubadejo MBBS FRCP
Dr. Deyo Okubadejo is a Consultant Physician with an interest in Frailty and Falls and Syncope in Older People. He participates in the Consultant rota for acute and general medical on-call at Peterborough City Hospital. He is currently the Divisional Director for the Emergency and Medicine Division at North West Anglia NHS Foundation Trust and Chair of the East Anglia Region British Geriatrics Society.

Tanya Riddlesdell - Stroke Therapy Lead
Tanya trained at the University of East London and qualified 1994, Junior rotations at St Thomas' and Guys Hospital, Specialising in Neurology & Stroke at King's College London and Addenbrooke's Cambridge. Developed community skills from 2000 working as the Neurophysiotherapist in Intermediate Care across Huntingdonshire + Stroke Ward & Neurology patients in hospital. Tanya developed the Therapy and Rehabilitation Service team bringing a variety of professionals together to find solutions for individuals with neurological impairments in their own homes. Completed a MSc in Advanced Neuro Physiotherapy at UCL, 2007. Managerial

experience as Team Lead for Melton and Rutland Community Hospitals & Community for 18 months, having to leave due to caring duties for in-laws and my son post neurosurgery for epilepsy, alongside part-time work combined NHS, self-employed and case management. Current full-time role as Stroke Therapy Lead at North West Anglia Trust, but leaving to work in Leicestershire in May 2022.

Clinical Senate Support Team:

Mary Parfitt	East of England Interim Head of Clinical Senate, NHS England
Elizabeth Mabbutt	East of England Clinical Senate Senior Project Officer
Christina Wise	East of England Clinical Senate Senior Project Officer

APPENDIX 3: Declarations of Interest

All panel members were required to declare any interests.

All panel members certified that:

a) To the best of their knowledge, they did not have any actual or apparent direct or indirect, monetary or non-monetary conflicts of interest which would impair their ability to contribute in a free, fair and impartial manner to the deliberations of the panel, and

All panel members agreed to notify the Clinical Review Chair promptly if:

b) A change occurred during the course of this work

c) They discovered that an organisation with which they have a relationship meets the criteria for a conflict of interest

APPENDIX 4: Review Panel Agenda

AGENDA

Independent Clinical Review of proposal for Mid and South Essex Health and Care Partnership (MSE) Community Inpatient Beds

Discussion to be spread over two panels to be held via MS TEAMS on Monday, 04 April 2022 from 18.00 – 19.30 and Wednesday, 06 April 2022 from 18.00 – 19.30

Clinical Senate is asked to review the available evidence, discuss with panel members and make appropriate recommendations from its findings on the proposals for community inpatient beds put forward by Mid and South Essex Health and Care partnership (MSE)

The key questions Clinical Senate is being asked to address in this review are:

1. **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?

2. **Intermediate care beds:** Is the clinical model for ageing well and the proposed focus and potential locations of community beds aligned with best practice and likely to contribute to improving outcomes for patients?

3. **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?

4. **Sub-acute Frailty:** Is the model that has been developed clinically sound and likely to result in at least comparable outcomes for frail older people, and how might it be further developed over time?

Monday 4 April 2022 – Panel 1

Time	Item	Lead
17.55	Join Teams Meeting	Panel Members
18.00 - 18.15	Welcome, Introductions & Outline of the Review Panel	Dr Bernard Brett
18.15 - 18.30	Additional information provided by MSE in response to the Draft Key Lines of Enquiry (KLOEs) identified by the Pre-Panel on 29 March 2022	Dr Bernard Brett/ Panel Members
18.30 - 19.25	Confidential Panel Discussion of MSE's Proposals for: • Intermediate Care Beds • Stroke • Sub-Acute Frailty • Overall	Panel Members
19.25	Next Steps for Wednesday 6 April 2022 - Panel 2	Dr. Bernard Brett
19.30	Close	Dr. Bernard Brett

Wednesday, 6 April 2022 – Panel 2

Time	Item	Lead
17.55	Join Teams Meeting	Panel Members
18.00 - 18.15	Welcome, Introductions & update from Panel 1 held on Monday 4 April 2022	Dr Bernard Brett
18.15 - 18.45	Discussion / Questions and Snswers with MSE: • Andy Vowles, Programme Director • Dr Sarah Zadie, Overall Clinical Lead • Dr Steve Waters, Sub-acute Frailty Lead • Dr Kirthi Ramanthan, Stroke Lead • Gerdi Du Toit, Programme Director for Ageing Well	Panel Members/ MSE team
18.45 - 19.00	Confidential Panel Discussion of MSE's Proposals for: • Intermediate Care Beds • Stroke • Sub-Acute Frailty • Overall	Panel Members
19.00 - 19.25	Panel Summary • Key Findings and Recommendations for the 4 key questions	Panel Members/ Dr. Bernard Brett
19.25 - 19.30	Next Steps	Dr. Bernard Brett
19.30	Close	Dr. Bernard Brett

Next steps – information for Clinical Review Panel Members: **1.** A draft report will be sent to the MSE team and Clinical Review Panel Members for a points of accuracy check no later than 19 April 2022, for response by 04 May 2022 **2.** The plan is for the full report to be submitted to Clinical Senate Council on 27 June 2022 to ensure it has met the agreed Terms of Reference and to agree the report. If, in discussion with MSE, the report is required prior to this date, an extraordinary Clinical Senate meeting may be convened. The final report will be issued to the commissioning organisation following the Council Senate Council meeting at which the report is reviewed. The commissioning organisation then becomes the owner of the report.	

KEY LINES OF ENQUIRY

The clinical review panel raised a number of areas for further exploration at its pre-panel call on 29 March 2022. These have been developed into key lines of enquiry (KLOE) for the commissioning organisation to address. The commissioning organisation is invited to address any of these by email prior to the first panel evening to be held on Monday 4 April 2022. Please note, the discussion by the panel will not be restricted to these areas alone.

The KLOE's are:

1. **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?**
   - **a) Access & Travel for family, carers and friends**:
     - What scoping of overall supply of transport public services has taken place (e.g. frequency, availability) to factor in potential future changes?
     - How will this work with family engagement in the patient's care?
   - **b) Engagement/feedback:**
     - What engagement with public and patients has been carried out prior to formal consultation?
     - How are MSE going to make it a better service for patients? What measures are being used to evidence this?
     - The panel would like to see more data on outcomes data, specifically in PROMs, PREMs, and SSNAP (accepting some SSNAP is not relevant to the scope of this review).
   - **c) Digital:**
     - The panel would like to see, if available, a projected plan for related digital transformation and sharing of information with all parts of the pathways.
   - **d) Clinical leadership and workforce:**
     - What is the clinical leadership and projected workforce for each of the three proposals?

- What clinical leadership models have been explored and what are the expected opportunities for multi-disciplinary leadership e.g. senior clinical AHP leadership?

e) Hand-off:

- What is the planned future integration back into community services such as primary care and other community teams e.g. DN's, Geriatric Assessment?

f) Future pathways:

- What is the relationship of the proposals to place based care?
- What are the interfaces – is it by geography?

2. Intermediate care beds: Is the clinical model for ageing well and the proposed focus and potential locations of community beds likely to contribute to improving outcomes for patients?

a) Learning from community pilot in Halsted (Care at Home):

- What is the learning from this pilot and what from this learning has been uplifted into the pathway proposals?
- How widespread is this learning envisaged to be across the whole pathways?

b) Pathway development:

- What differentiates the intermediate care pathway from the straight to home pathway?
- What scoping has taken place around integration and use of the voluntary sector?
- How will MSE mitigate the push model?

3. 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?

a) Criteria:

- What is the proposed inclusion and exclusion criteria for admission? e.g. Feeding tubes (PEG, NGT)

b) Discharge processes:

- What is the Early Supported Discharge and social care involvement in the pathways?
- Please clarify the content of the rehabilitation pathway in the discharge processes.
- Are there specific pathways for younger patients and if so please elaborate.
- The panel would like further detail on the rehabilitation pathways into the community.

c) Workforce:

- The panel would like to be provided with a more comprehensive staffing model, including medical input for complex care, if available now?
- Is there integration of community and acute staff for stroke?

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

a) The panel would like further information on what services and speciality access to investigations, specialist advice and infrastructure (e.g. oxygen availability, X-ray facilities) will be available to patients in the community inpatient beds?

b) What are the MSE plans to enable and improve on this?

Clinical Review Panel Members		
Name	**Area / Organisation**	**Role / Area of Expertise**
Dr Bernard Brett – Chair	Clinical Senate Chair	
Dr Hazel Stuart – (Pre-Panel Chair)	East of England Senate Council Member	Medical Director, James Paget University Hospitals NHS Foundation Trust
Louise Connolly	Hertfordshire Community NHS Trust	Occupational Therapist specialising in Neurological Rehabilitation, Clinical Quality Lead
Charlotte Dorer	Coventry & Warwickshire Partnership Trust	Associate Director of Allied Health Professionals
Louise Dunthorne	East Suffolk & North Essex NHS Foundation Trust	Senior AHP
Ruth Empson	Cambridgeshire & Peterborough NHS Foundation Trust	East of England (North) Integrated Stroke Delivery Networks Lead Nurse, Coordinator Integrated Stroke Early Supported Discharge & Nero Rehabilitation
Louise Gilbert	Norfolk Community Health & Care NHS Trust	Advanced Specialist Physiotherapist – Early Discharge for Stroke
Christine Hancock		Expert by Experience
Dr Kneale Metcalf	Norfolk & Norwich University Hospitals NHS Foundation Trust	Stroke Consultant & & Clinical Lead, East of England (North) Integrated Stroke Delivery Networks
Dr Stuti Mukherjee	Cambridge and Peterborough CCG	GP, Macmillan GP & Joint Clinical Lead, Cancer
Dr Deyo Okubadejo	North West Anglia NHS Foundation Trust	Consultant Physician in Medicine for Older People & Divisional Director for the Emergency and Medicine Division, Peterborough City Hospital
Tanya Riddlesdell	North West Anglia NHS Foundation Trust	Neurophysiotherapist & Stroke Therapy Lead
In Attendance		
Mary Parfitt	NHS England and NHS Improvement	Interim Head of Clinical Senate
Elizabeth Mabbutt	NHS England and NHS Improvement	Clinical Senate Project Officer
Christina Wise	NHS England and NHS Improvement	Clinical Senate Project Officer

APPENDIX 5: Summary of evidence set provided

Ref	Evidence	Explanation
01	Slide Pack of Evidence	Including: • Summary • Overview & Content • Case for Change • Configuration Scenarios • Improving Outcomes • Workforce • Access • Clinical Engagement & Leadership • Public, Stakeholder & Staff Engagement • Timetable • 5 Data Appendices
02	MSE's response to the Key Lines of Enquiry arising from the pre-panel teleconference held on 29 March 2022	
03	MSE's response to the Themed Questions arising from the first panel session held on 04 April 2022	

End of Report

Appendix 7

Travel Analysis

Appendix Seven - Travel Analysis

Stroke Rehabilitation

Key areas to highlight:

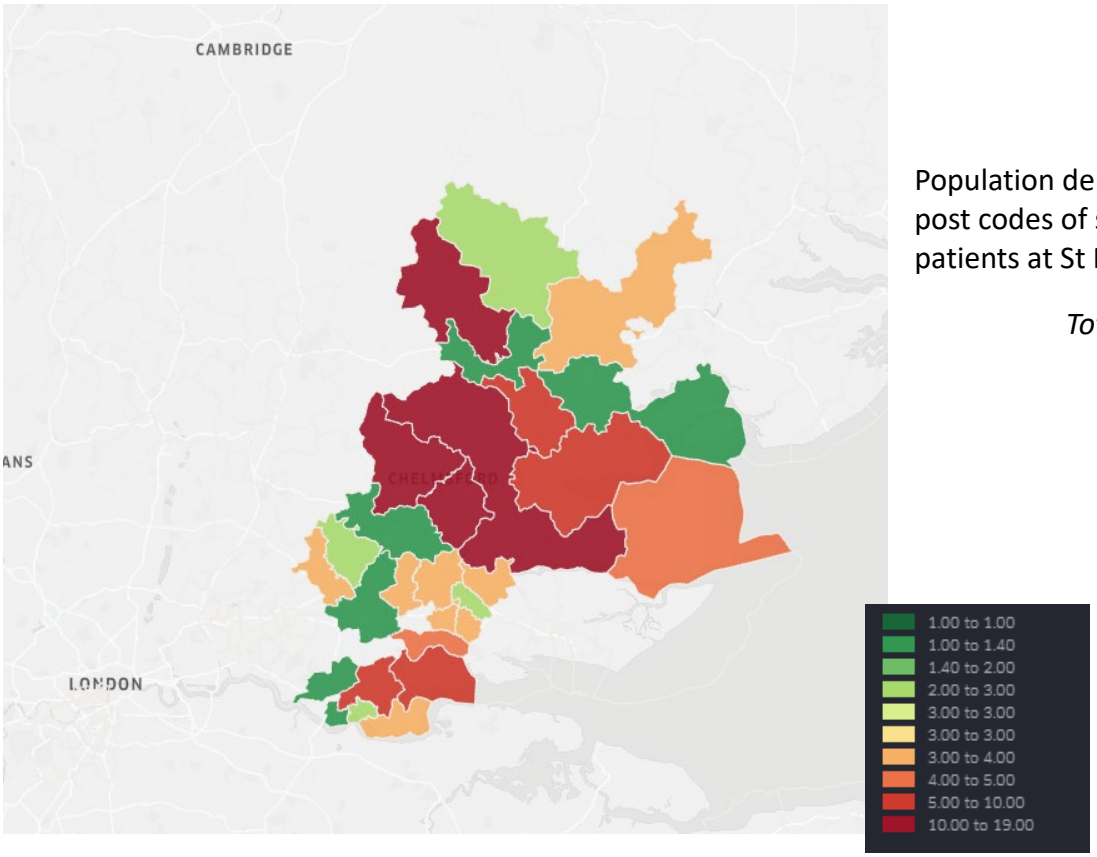
118 patients' post code data were provided.

To travel between the two post codes on **public transport**:

- **92 patients** would see a **decrease** in travel time to reach Brentwood vs St Peter's.
- **26 patients** would see an **increase** in travel time to reach Brentwood over St Peter's.

To travel between the two post codes as **land travel / via car:**

- **53** patients see a **decrease** in in travel time to reach Brentwood vs St Peter's.
- **65** patients see an **increase** in in travel time to reach Brentwood vs St Peter's.
    - Of those with an increase in time, **28** patients see an increase of **10 miles** or less.



Population density map of the post codes of stroke rehab patients at St Peter's 2022-2023.

Total = 118

St Peter's:

The following map visualises the length of duration to travel via **public transport** from **St Peter's** (CM9 6EG).
It assesses the time taken on a weekday morning, with the increase in lightness of colour referencing an increase in journey length.

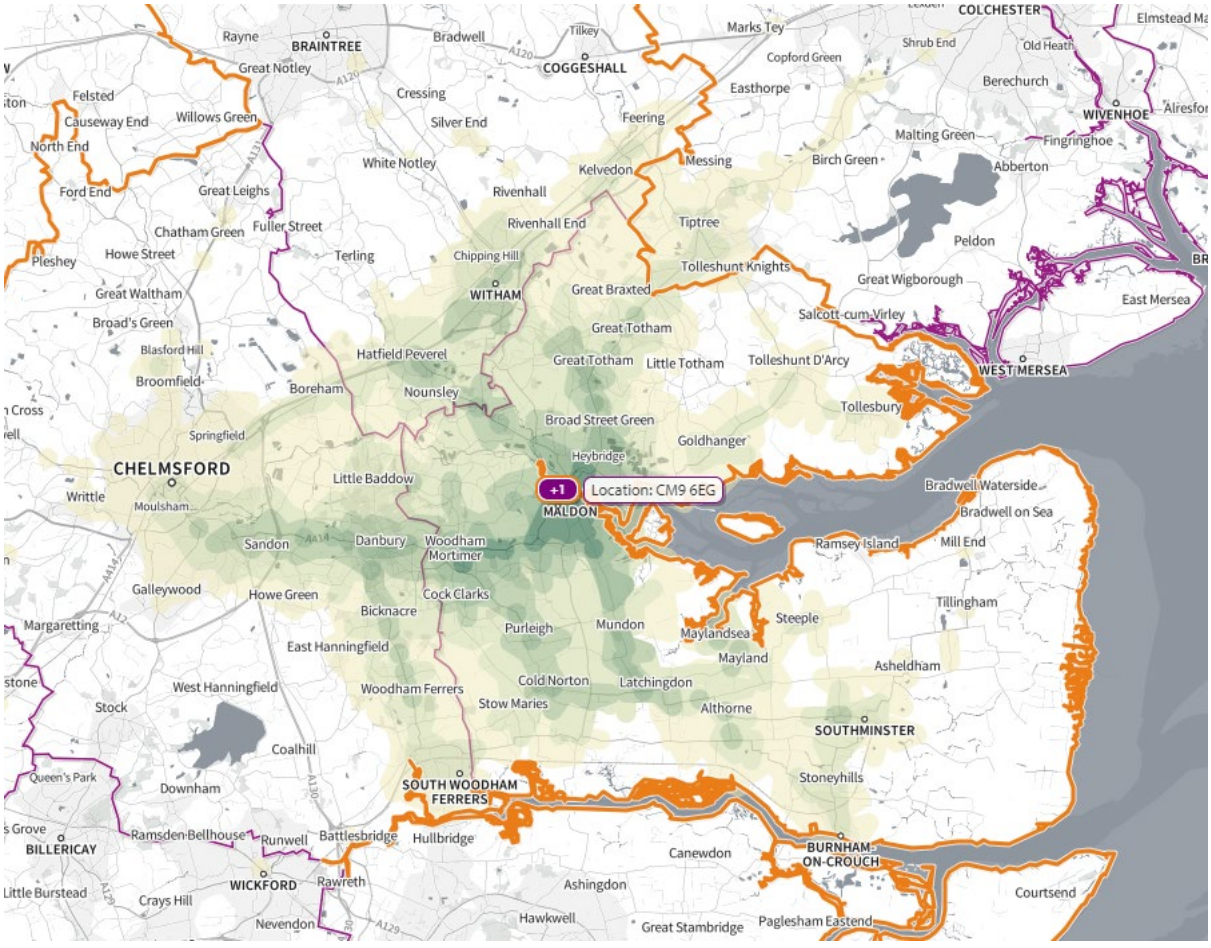
Reachable within 10 minutes =

Reachable within 20 minutes =

Reachable within 30 minutes =

Reachable within 45 minutes =

Reachable within 60 minutes =



St Peter's:

The following map visualises the length of duration to travel via **car / land travel** from **St Peter's** (CM9 6EG).
It assesses the time taken on a weekday morning, with the increase in lightness of colour referencing an increase in journey length.

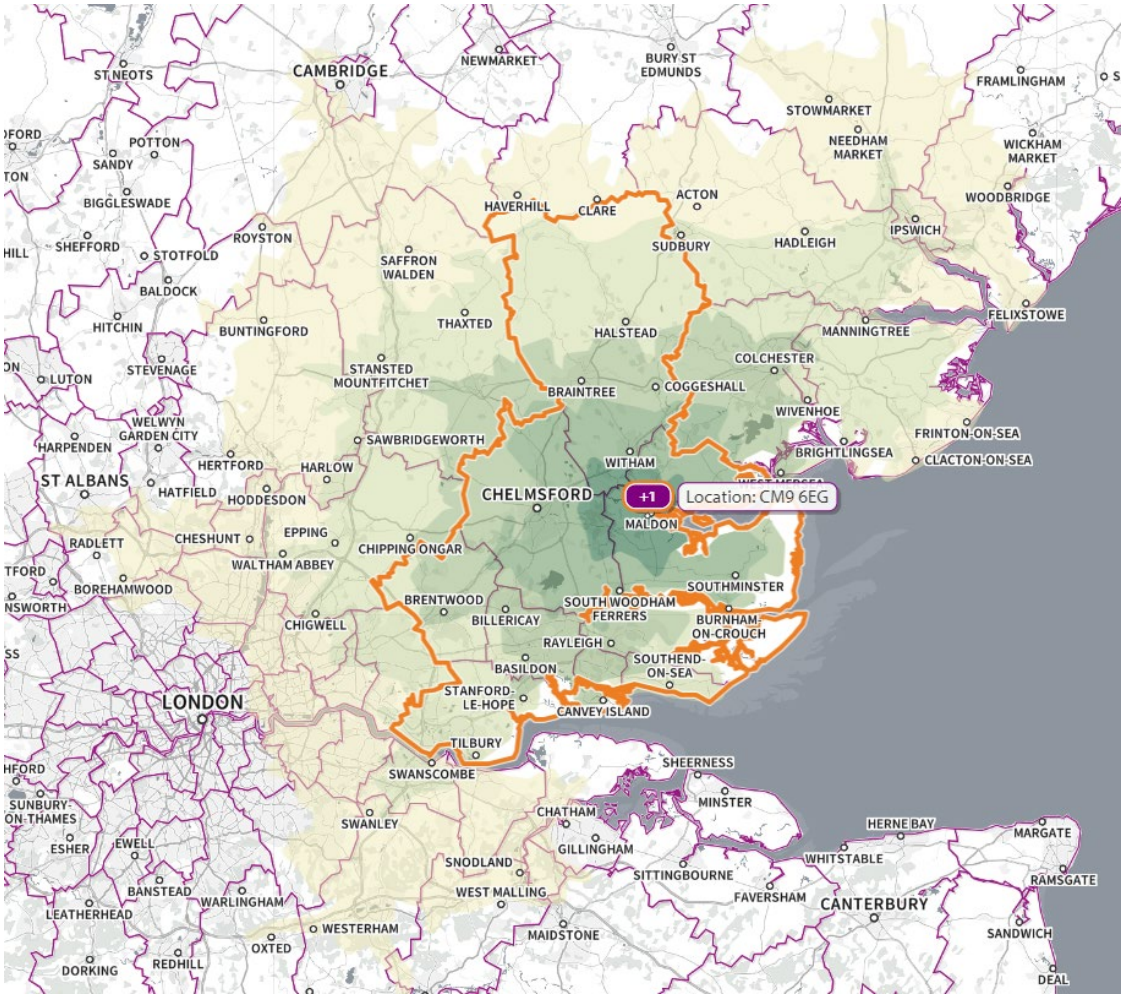
Reachable within 10 minutes =

Reachable within 20 minutes =

Reachable within 30 minutes =

Reachable within 45 minutes =

Reachable within 60 minutes =



Brentwood:

The following map visualises the length of duration to travel via **public transport** from **Brentwood** (CM15 8DR).
It assesses the time taken on a weekday morning, with the increase in lightness of colour referencing an increase in journey length.

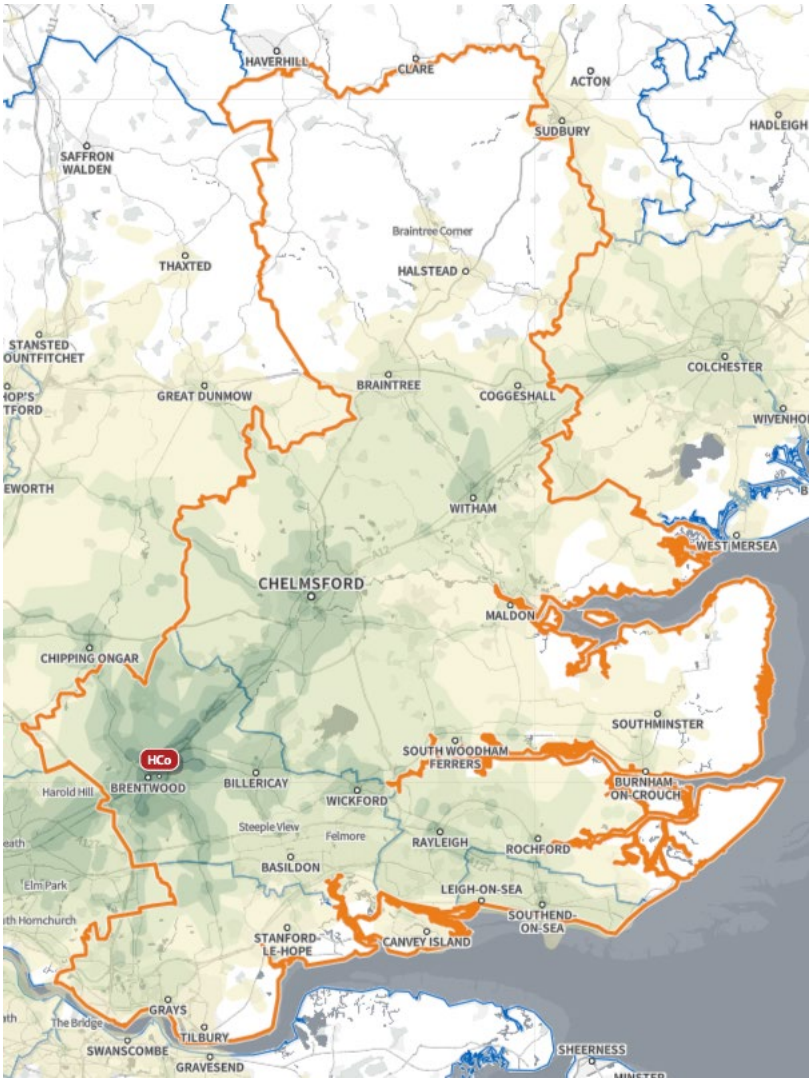
Reachable within 20 minutes =

Reachable within 40 minutes =

Reachable within 60 minutes =

Reachable within 90 minutes =

Reachable within 120 minutes =



Brentwood:

The following map visualises the length of duration to travel via **car / land travel** from **Brentwood** (CM15 8DR).
It assesses the time taken on a weekday morning, with the increase in lightness of colour referencing an increase in journey length.

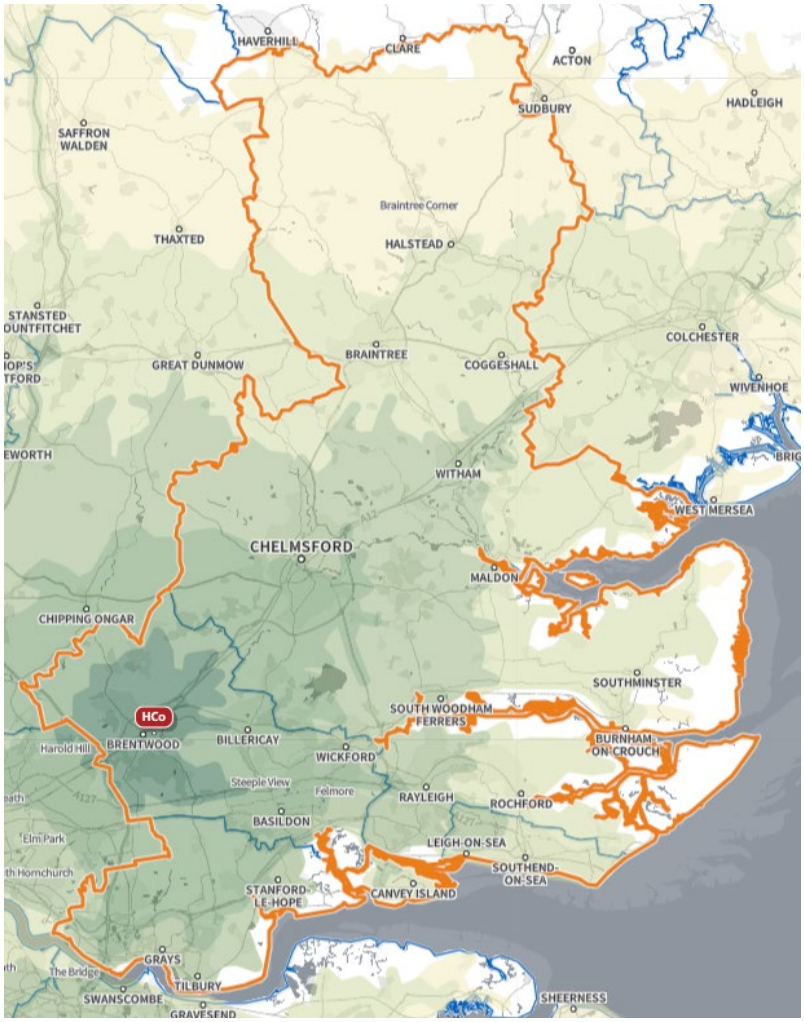
Reachable within 10 minutes =

Reachable within 20 minutes =

Reachable within 30 minutes =

Reachable within 45 minutes =

Reachable within 60 minutes =



Maternity

Key areas to highlight:

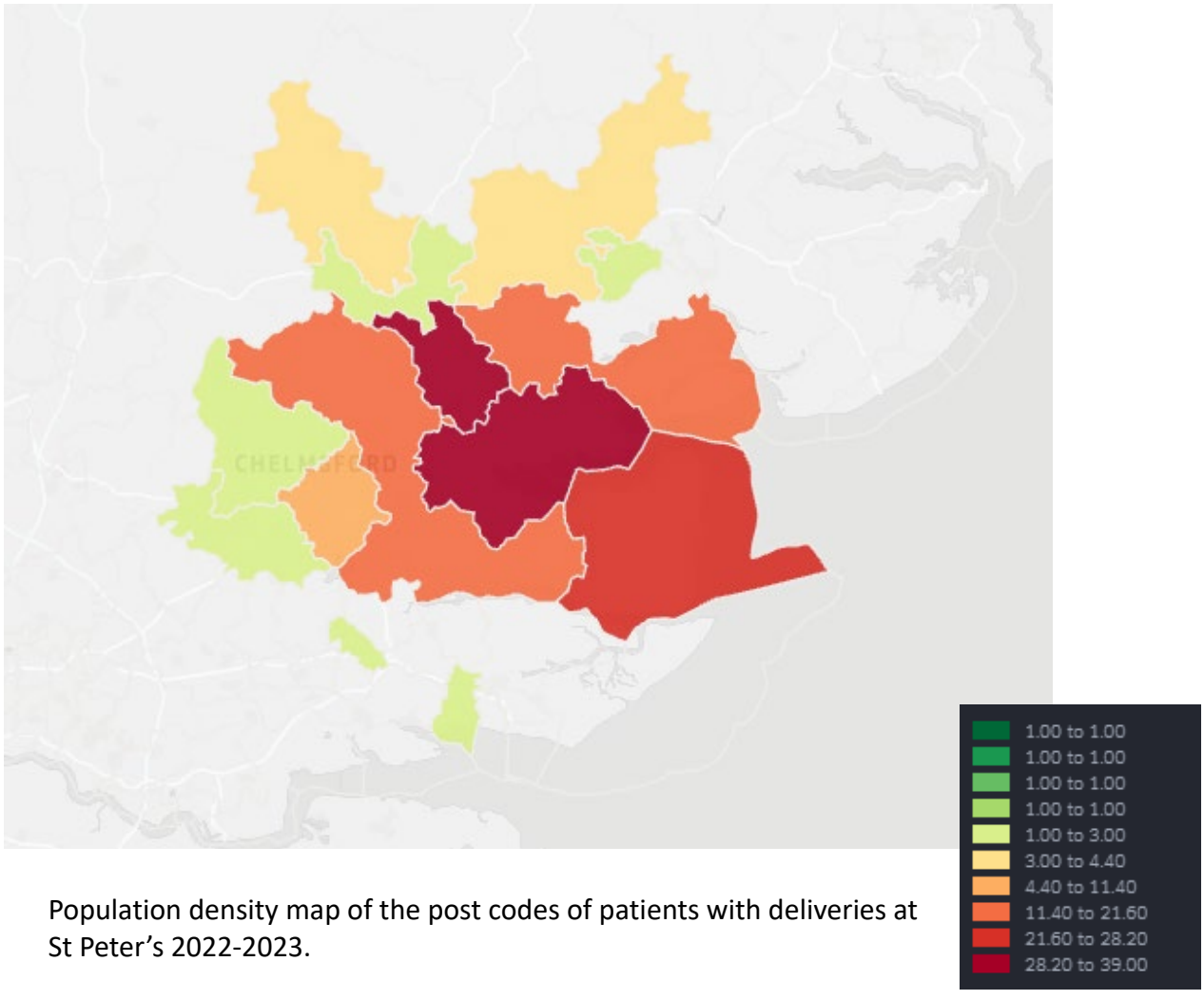
409 patients' post code data were provided.

To travel between the two post codes on **public transport**:

- **165 patients** would see a **decrease** in travel time to reach Braintree vs St Peter's.
- **244 patients** would see an **increase** in travel time to reach Braintree over St Peter's.

To travel between the two post codes as **land travel / via car:**

- **159 patients** would see a **decrease** in travel time to reach Braintree vs St Peter's.
- **250 patients** would see an **increase** in travel time to reach Braintree over St Peter's.
    - The average increase in time is 20 minutes.



Population density map of the post codes of patients with deliveries at St Peter's 2022-2023.

St Peter's:

The following map visualises the length of duration to travel via **public transport** from **St Peter's** (CM9 6EG).
It assesses the time taken on a weekday morning, with the increase in lightness of colour referencing an increase in journey length.

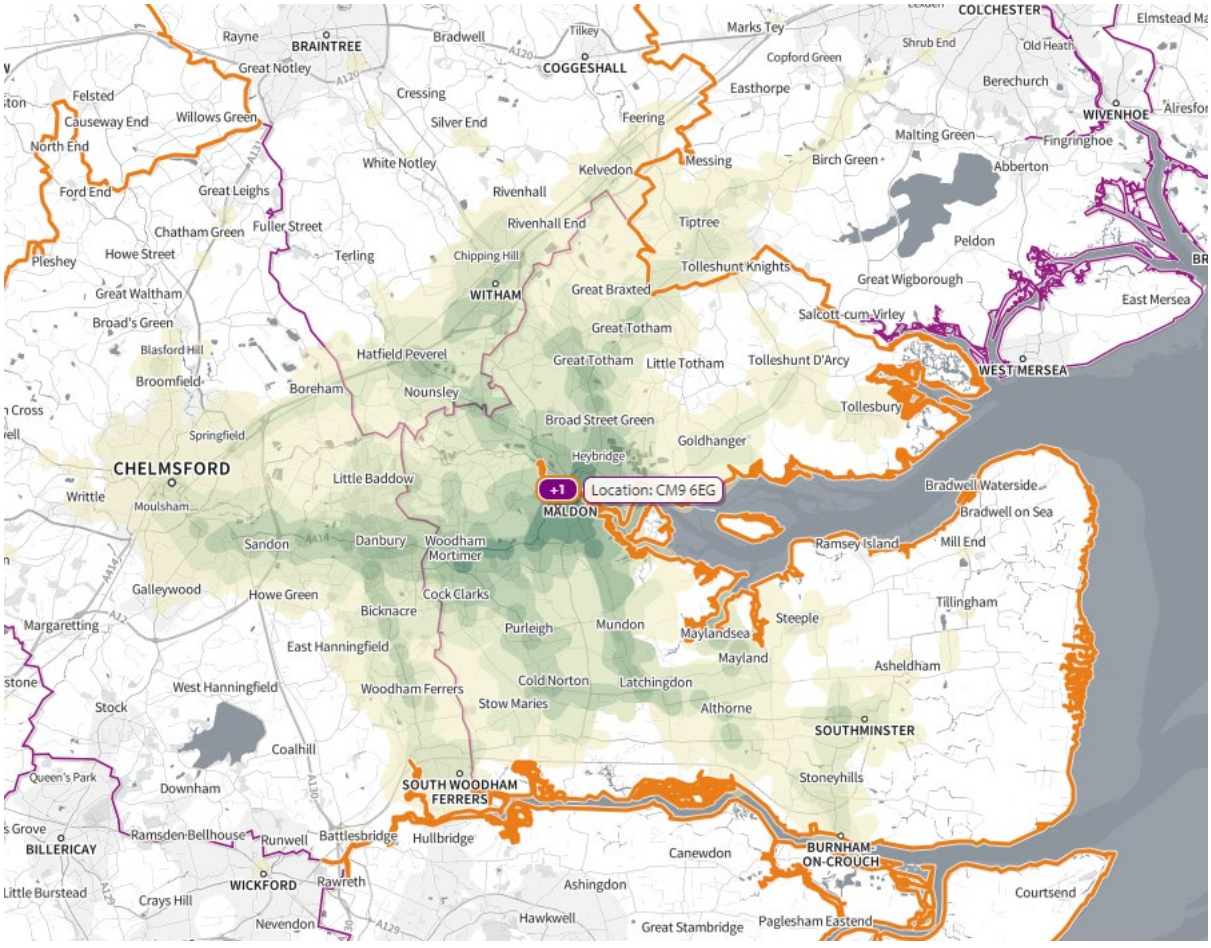
Reachable within 10 minutes =

Reachable within 20 minutes =

Reachable within 30 minutes =

Reachable within 45 minutes =

Reachable within 60 minutes =



St Peter's:

The following map visualises the length of duration to travel via **car / land travel** from **St Peter's** (CM9 6EG).
It assesses the time taken on a weekday morning, with the increase in lightness of colour referencing an increase in journey length.

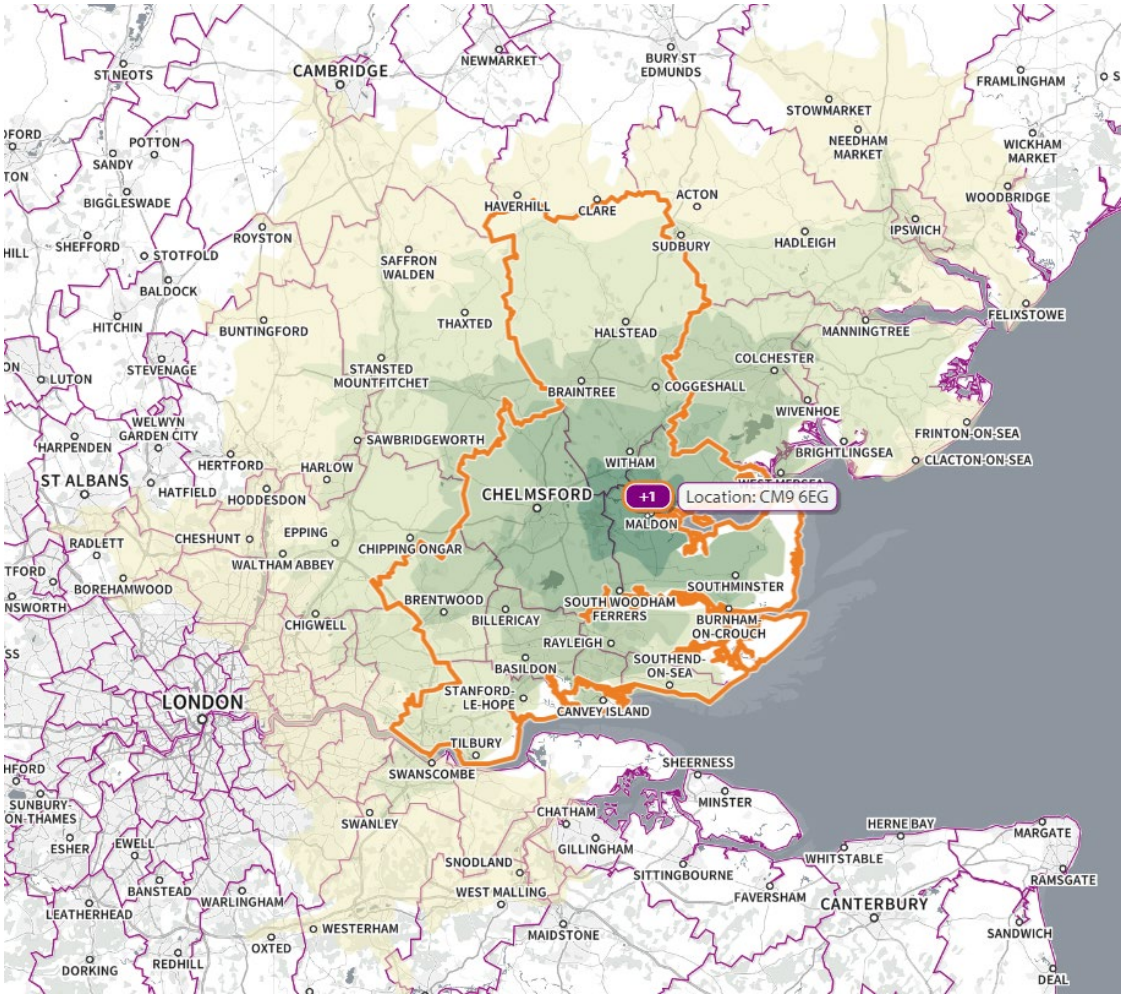
Reachable within 10 minutes =

Reachable within 20 minutes =

Reachable within 30 minutes =

Reachable within 45 minutes =

Reachable within 60 minutes =



Willian Julien Courtauld at St Michaels Braintree:

The following map visualises the length of duration to travel via **public transport** from **William Julien Courtauld at St Michaels Braintree**
It assesses the time taken on a weekday morning, with the increase in lightness of colour referencing an increase in journey length.

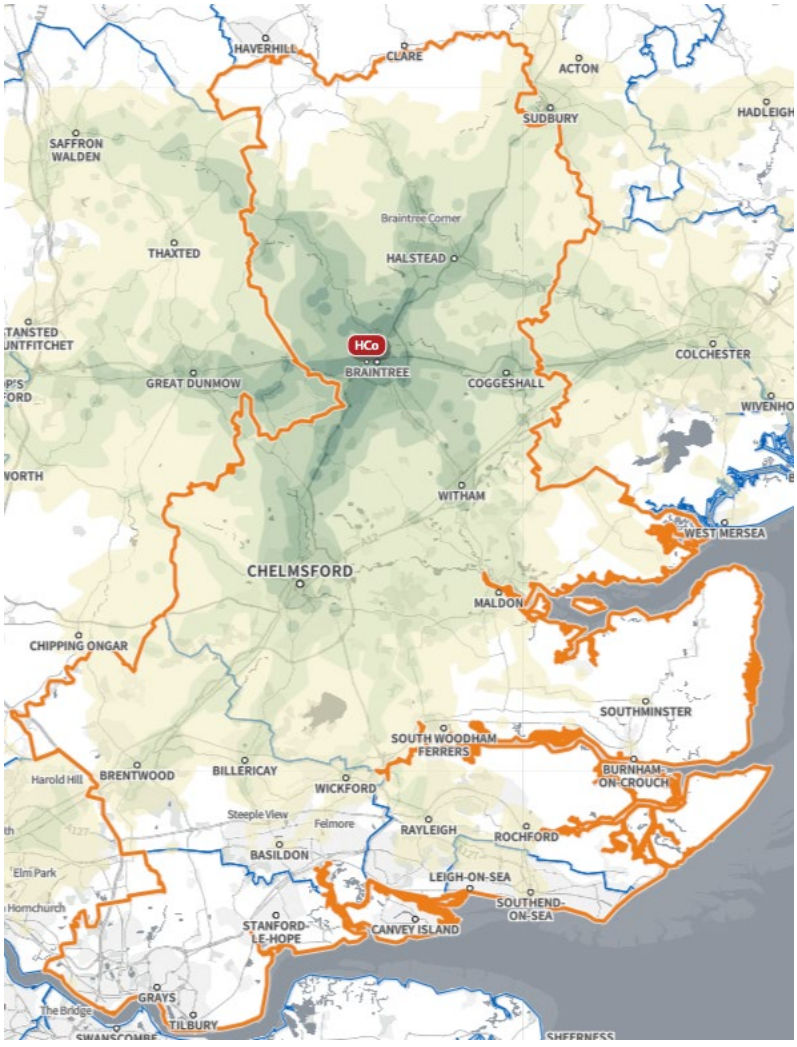
Reachable within 20 minutes =

Reachable within 40 minutes =

Reachable within 60 minutes =

Reachable within 90 minutes =

Reachable within 120 minutes =



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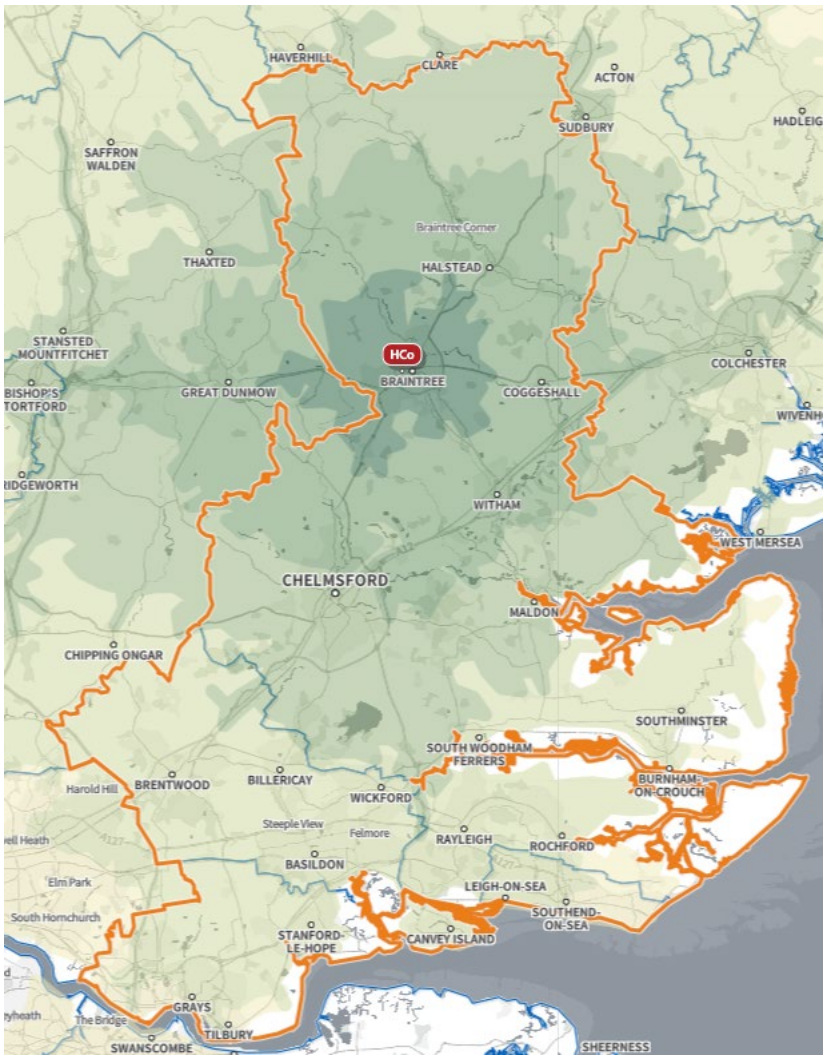
Reachable within 20 minutes =

Reachable within 30 minutes =

Reachable within 45 minutes =

Reachable within 60 minutes =



Blue Light

- Cat 1 calls may not always be a life-threatening condition once support arrives however, if it was and the patient needed to be conveyed the patient under emergency blue light conditions, the following time frames are applicable:
    - St Peter's Hospital Maldon to Broomfield = 25mins approx
    - Braintree Community Hospital to Broomfield = 12mins approx.
- Every journey depends on road conditions, time of day and patient presentation.

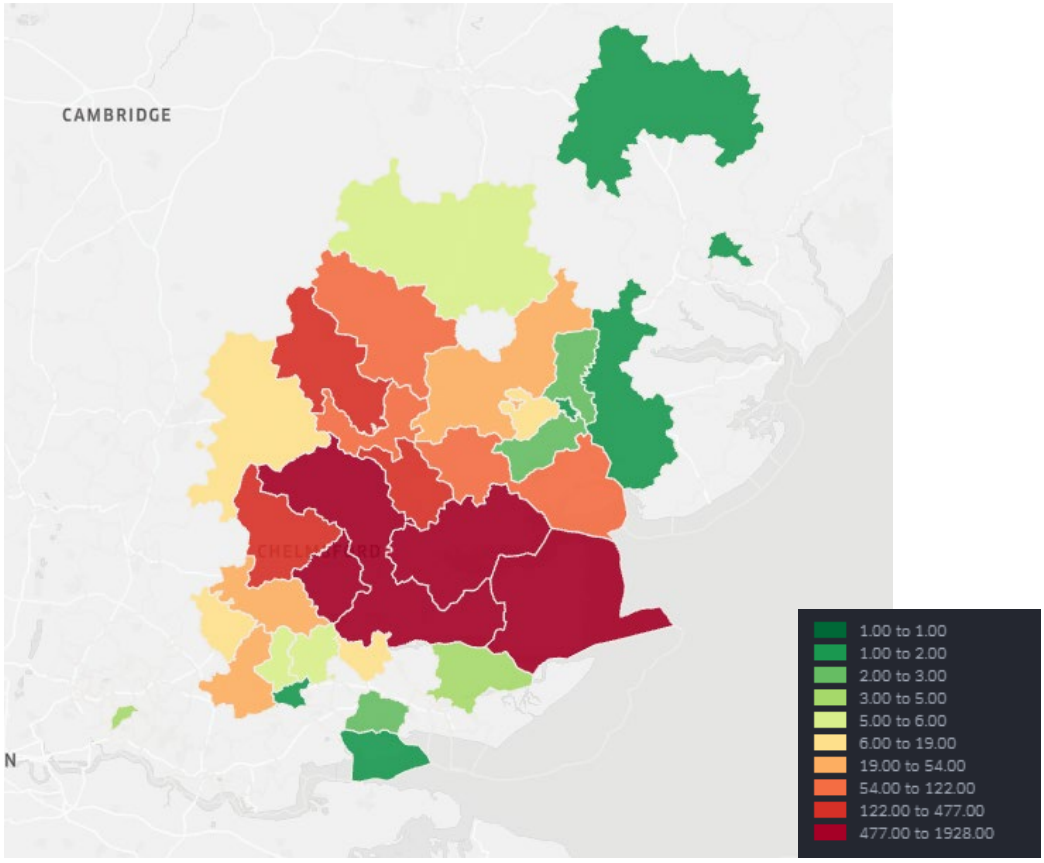
Outpatients

Key areas to highlight:

For 2023, 5574 outpatients' post code data was provided (from Provide), spanning across several different services.

Almost 90% of the patient's data provided live within just 5 post codes:

CM9
CM3
CM0
CM2
CM8



Population density map of the post codes of outpatients at St Peter's 2023.

Total = 5574

St Peter's:

The following map visualises the length of duration to travel via **public transport** from **St Peter's** (CM9 6EG).
It assesses the time taken on a weekday morning, with the increase in lightness of colour referencing an increase in journey length.

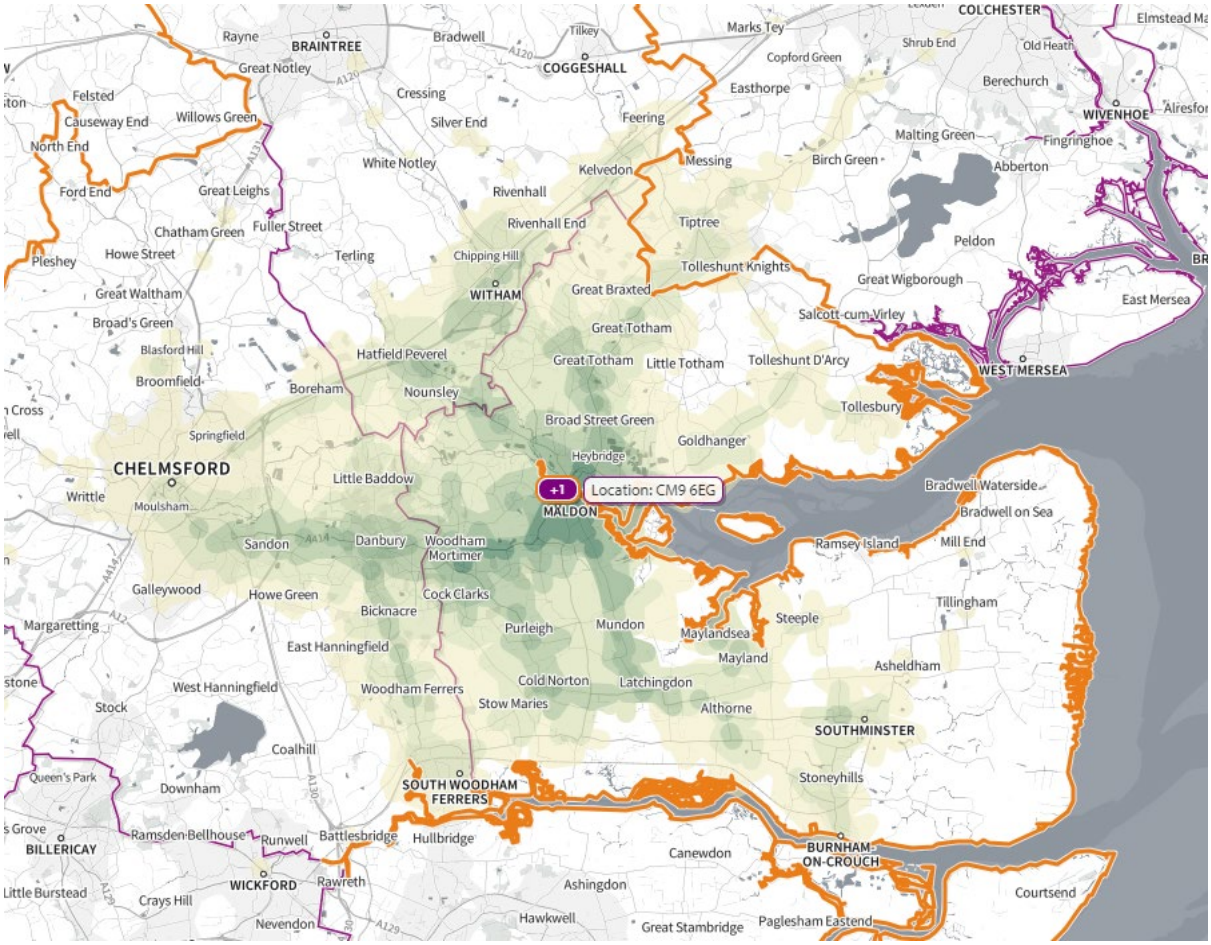
Reachable within 10 minutes =

Reachable within 20 minutes =

Reachable within 30 minutes =

Reachable within 45 minutes =

Reachable within 60 minutes =



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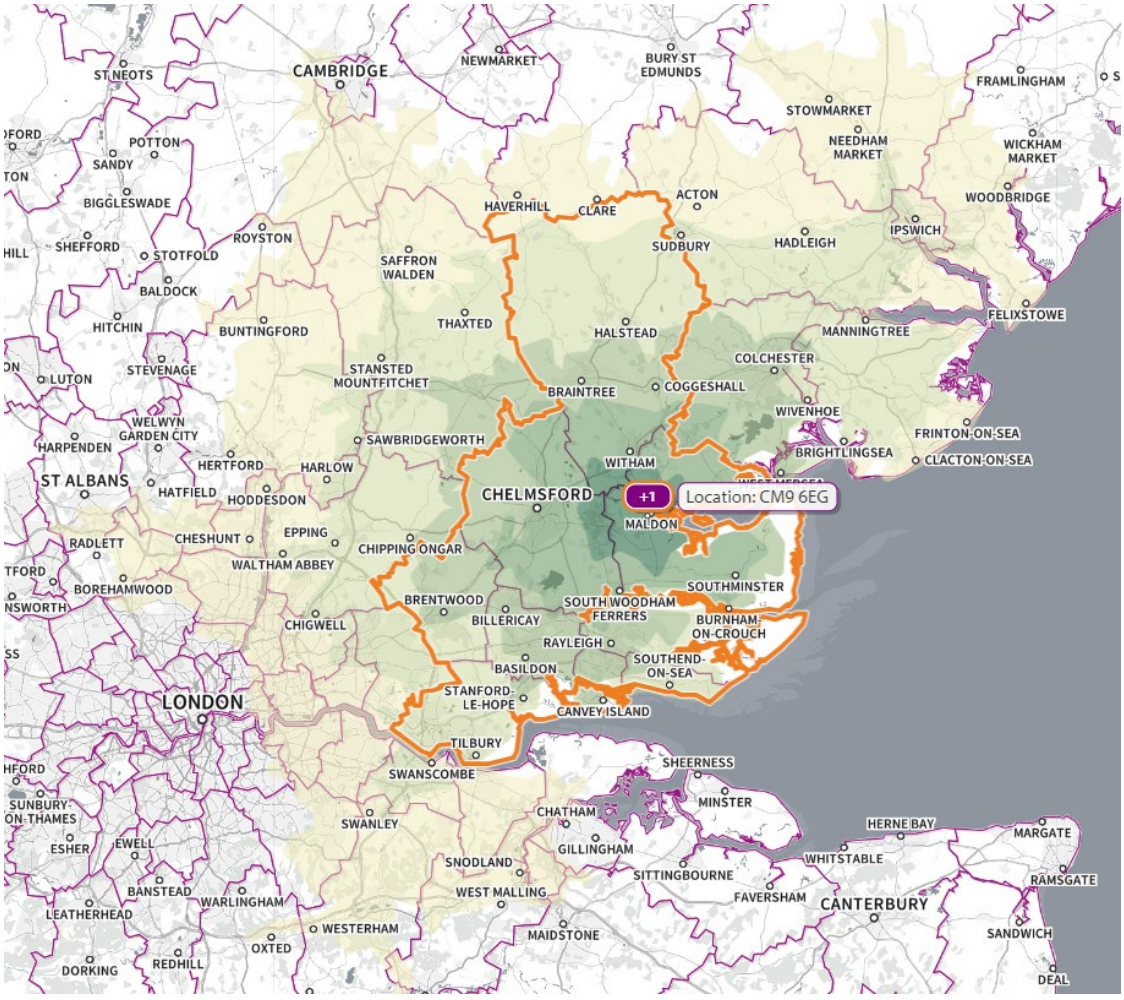


Appendix 8

Communications and Engagement Plan

NHS Mid and South Essex Integrated Care Board (MSE ICB)

Public consultation on proposals for future arrangements for inpatient services at our community hospitals, freestanding midwife-led birthing, and services provided at St Peter's Hospital, Maldon

A document by Stand

As at 11th January 2024

Document Control:

This is a working document. Comments are welcomed.

Current Version	Dated	Changes since last version
V1.0 (SF)	8 December 2023	
V2.0 (GC)	4 January 2024	Updated in person events Appendices placeholders
V3.0 (TS)	11 January 2024	

Contents

1. Purpose of this document

This document outlines our consultation intentions regarding proposed changes to some services provided by NHS Mid and South Essex Integrated Care Board (ICB).

This document sets out the plan for the consultation, and includes the context of the consultation, how the consultation will be run and the involvement activities to be carried out to make sure all the local residents have an opportunity to share their views.

The accountable body for the consultation is NHS Mid and South Essex ICB. The services impacted by the proposals are provided by Mid and South Essex NHS Foundation Trust, Essex Partnership University NHS Foundation Trust and Provide.

The consultation plan will be informed by a consultation reference group. This will include patient representatives, voluntary sector organisations, clinicians and Healthwatch to guide the process.

2. The proposals

Our proposals are:

- To change how and where people receive inpatient intermediate care services and stroke rehabilitation inpatient services that are provided from community hospitals.
- To make the relocation of a midwife-led birthing unit from St Peter's Hospital, Maldon to St Michael's Health Centre at Braintree Community Hospital permanent.
- To develop a plan that will move all the other services provided at St Peter's Hospital to other locations.

If all these proposals are agreed, it will mean that all the services provided at St Peter's Hospital in Maldon move to other sites. After that it is likely that Mid and South Essex NHS Foundation Trust will make a decision about the future of the St Peter's Hospital site.

3. Background / the consultation process

Recent engagement has shown a high level of interest.

We are committed to:

- Being open in communicating about the proposals, and using a range of ways to provide information.

- Actively engaging with people who might be affected by the changes.
- Reaching out to people whose life circumstances could mean the impact of change is greater.
- Providing a range of opportunities for people to share their views and experiences.
- Considering what matters most to people, and taking views into account during the decision making process.

The consultation will run from 25 January 2024 for eight weeks. Planned activities are detailed later in this document.

During the consultation period, engagement will be overseen by the consultation reference group to ensure we are listening to a range of people and organisations. If we are missing key groups of people, or not hearing from sufficiently diverse groups of people, we will adjust our activities accordingly.

A draft report of the analysis of the feedback will be shared for comments before being published on the Mid and South Essex ICB website. This should happen within three months of the end of the consultation period.

4. Legal duties

4.1. Why we need to involve people

There are a range of legal and regulatory requirements to involve people in NHS change.

Section 242 of the NHS Act 2006 (as amended by the Act 2012) requires NHS organisations to involve and consult patients and the public in:

- The planning and provision of services.
- The development and consideration of proposals for changes in the way services are provided.
- Decisions to be made by NHS organisations that affect the operation of services.

Section 244 of the NHS Act 2006 requires NHS organisations to consult relevant Overview and Scrutiny Committees (OSC) on any proposals for a substantial development of the health service in the area of the Local Authority, or a substantial variation in the provision of services.

4.2. The NHS Constitution

NHS Constitution gives the following rights and pledges to patients:

"You have the right to be involved, directly or through representatives, in the planning of healthcare services, the development and consideration of proposals for changes in the way those services are provided, and in decisions to be made affecting the operation of those services."

"The NHS commits to provide convenient, easy access to services within the waiting times set out in the Handbook to the NHS Constitution (pledge)";

"The NHS commits to make decisions in a clear and transparent way, so that patients and the public can understand how services are planned and delivered (pledge)"

"You have the right to receive care and treatment that is appropriate to you, meets your needs and reflects your preferences."

4.3. Equality and diversity

Information will be provided in different formats and languages if requested, including BSL and Easy Read. As part of the engagement activity, respondents will be asked to provide demographic information covering the following nine protected groups under the Equality Act 2010.

These are:

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

4.4. Gunning Principles and best practice

When we consult people about changes to public services, it's important we make sure we adhere to the following principles. By doing so, we meet our legal duties about informing and involving people, and ensure our consultation is easy to take part in.

The Gunning Principles say that we must:

- Talk with people when our proposals are at a formative stage. This means a final decision has not been made. We can still change the proposals based on what people have to say.

- Make sure we provide enough information, in ways that are easy to understand, so that people can understand what is being proposed, and how any changes might affect them.
- Allow people time to get involved. i.e. enough time to peruse information, attend events, answer surveys and otherwise share views.
- Listen to what people say and take their views into consideration before making any final decisions.

5. Involvement approach

The consultation starts 24 January 2024 and will run for eight weeks. During this time there will be a number of ways for people to get involved.

5.1. Surveys

Two surveys were carried out in November and December 2023 to ask people about the proposals in their early stages. 197 people responded. Survey reports are available.

A new survey about the proposals will be available on our involvement website - Engagement HQ. The survey is in four sections, so people can share views about the services that matter most to them.. The survey questions are attached at Appendix 1

5.2. Face-to-face discussion sessions

There will be 5 face-to-face discussions in different locations:

- Burnham
- Thurrock
- Southend
- Chelmsford
- Basildon

These locations have been chosen as the proposals could affect people living in these areas and the services that they use. We also want to ensure we hear from a range of people who are likely to have different experiences of the services proposed to change.

The sessions will take place in accessible community spaces, within easy reach of public transport routes.

Each session will last about one hour 30 minutes details for these events can be found in section 7 of this document.

During the session, the ICB and facilitators will share information about the proposals and how we think the changes might affect people and the

services they use. People will have the chance to ask questions, share their views and talk about how they think the changes could affect their lives.

People will be able to register for sessions in advance, so that numbers can be monitored, so the ICB can check it's hearing from a diverse range of people, and so contingencies can be made if more people register than the venue can accommodate.

5.3. Online discussion sessions

There will be 5 online sessions using Microsoft Teams. One session for each element of the proposal, and one general session:

- Stroke rehabilitation
- Intermediate care beds
- Midwifery -led birthing unit
- Other patient services at St Peter's Hospital, Maldon
- General session about the proposals as a whole

The sessions will be facilitated by a member of Stand, and people from the ICB - including clinical leads - will be available to answer questions.

People will need to register in advance to join the online sessions, but there will not be a maximum number of participants.

Recordings and transcriptions of the online sessions will be available during the consultation period.

5.4. Public hearing

Public hearings give people who have specific views or would like to present a different point of view to provide evidence to the decision makers who can ask questions about the evidence presented.

The public hearing will involve a panel of experts from the ICB. Participants will be asked to register their interest in presenting information to the panel.

The Panel will listen to people's evidence and ask and answer questions. Everything put to the Panel will form part of the consultation exercise.

There will be one public hearing event held in Maldon town.

A full scope for the public hearing is included as Appendix 2 and will be supported by a specific communications plan.

5.5. Voluntary and Community Sector Organisation (VCSO) - led discussions

There will be 10 of these discussions held in total. VCSOs will be targeted to ensure we are hearing from a diverse group of people as those identified in the equality impact analysis.

Groups facilitators will be provided with a toolkit and will run their own sessions, gathering feedback and comments from their group. The output of these sessions will be included in the consultation analysis.

Micro grant payments will be provided to those groups taking part.

5.6. Other ways to get involved

Engagement HQ: (online engagement platform) will include documentation about the proposals and ways for people to give comments (as well as linking to the survey).

Email: during the consultation period, people can email

Social media: during the consultation period, people will be able to ask questions and talk to us on our social media pages

Telephone interviews will be offered to support those who may need it to ensure that they are able to understand the information contained within the documents and to ensure that all participants in the consultation have enough information and are able to give informed feedback in a telephone call. If translation is required then this can be arranged.

5.7. Audiences

Intermediate Care Beds:

- People aged over 60
- People with compromised immunity
- People with long-term conditions
- Disabled people - including people with learning disabilities
- Carers

Stroke rehabilitation:

- People with lived experience
- Carers
- People aged over 60
- People with existing neurological conditions
- People with cardiovascular conditions

Birthing unit:

- Women - especially aged between 20-50
- Trans men
- Partners and carers

Other services:

- Current and recent patients
- Carers
- Disabled people - including people with learning disabilities
- People with long term conditions
- People with enduring mental health conditions

General - about all changes:

- People living in catchment areas for affected services
- People who might not currently use services, but whose circumstances, characteristics, or health conditions mean they could be more significantly impacted
- Related voluntary sector organisations/community groups
- Health and care services providers
- Partner organisations - including Healthwatch
- Related boards and statutory bodies
- Staff
- Councillors and MPs

5.8. Channels

MSE ICB has existing channels of communication – website, newsletters, social media, Engagement HQ – which can be used to promote this activity and to ensure that all those who wish to take part are able to access relevant information and have the opportunity to be involved.

Promotion channels identified are:

- Information provision
  - Media releases to local media
  - Staff newsletters: weekly, deadline Monday before 12.00
  - Videos / podcasts (with captions/signed/other languages/transcripts?)
  - Voluntary sector newsletters/emails/social media
  - System briefings for MPs, other partners and councils a week before we go live
- Involvement
  - Facebook
  - X (Twitter)
  - Website: www.midandsouthessex.ics.nhs.uk
  - Engagement HQ
  - Instagram

5.9. Accessibility

It is important that everyone who wants to contribute has the opportunity to do so. Accessibility of information and access to the events and surveys is key to ensuring that the involvement exercise hears all voices. Steps are being taken to ensure the digitally excluded can be involved, for example through opportunities to take part in a phone interview.

All information produced to support this involvement will be written in language that can be easily understood. Technical phrases and acronyms will be avoided. Information will be produced in other formats as required, to reflect the needs of the population. This might include, but is not limited to:

- Easy read
- Different languages
- Large print
- Accessible electronic formats
- Audio Interpreters at public events

When materials in this toolkit, for example web copy, are utilised, they will be presented in line with accessibility guidelines.

6. Key messages

6.1. Key messages about the proposed changes:

- St Peter's Hospital is not fit for purpose in its current state. Renovation is unlikely to be practical due to the inherent costs. A decision will be made on the future of St. Peter's Hospital.
- All services currently provided out of St Peter's Hospital will need to be provided at alternative locations and/or in alternative ways. This consultation is about gathering views about the proposals for those alternatives.
- The four areas of services affected are: intermediate care, stroke rehabilitation, the birthing unit and outpatient services.
- For intermediate care and stroke rehabilitation, the primary interest is the location of beds for patients using the services.
- Intermediate care is proposed to be provided at ….
- Stroke rehabilitation is being considered alongside intermediate care, and the proposals are for the services to be provided in the same locations.
- The birthing unit is proposed to move Maldon to St Michael's Health Centre at Braintree Community Hospital permanently (currently hosted there as a temporary measure).

- Outpatient services covers a multitude of different clinics. Patients and the public will be consulted for thoughts about alternative ways to provide these clinics later in the consultation.
- A period of pre-consultation has already taken place. This included discussion groups with the public, clinicians and partners such as Healthwatch, and two surveys. The results of the pre-consultation informed the pre-consultation business case, which can be found …
- Other insight from patients, staff and partners has fed into the pre consultation business case. For example patient experiences of the various service pathways, and information about numbers of beds forecast to be needed.
- All documentation will be available on Engagement HQ.
- People will be invited to share their views and ask questions via Engagement HQ, via a dedicated email address, through monitored social media and via the involvement activities taking place during the consultation period.

6.2. Key messages about the case for change:

- Ensure health and care services can respond to increased demand for services.
- Improve patient outcomes in line with best practice and national guidelines.
- Increase access to local neuro-rehabilitation services.
- Support recruitment and retention of staff.
- Address the problem that some of the estate is unsuitable to deliver safe, high quality care.
- Ensure best value and most expedient use of resources.
- Meet the evolving needs of residents living in mid and south Essex.
- The importance of people having their say on the proposals.

6.3. Other messages:

The consultation mandate:

- Describes the purpose of the consultation.
- What the ICB wishes to achieve through consultation.
- The specific areas where we need to understand the potential impact of the proposals.
- How the ICB will respond to inform their decision, and respond to the feedback.
- The proposal(s):
- Description of the proposal.
- Benefits of proposals.
- Within the proposal highlight the need to understand the impact on service users, patients, carers, staff and public.
- Set out clearly what can be influenced, what can't.

- Set out clearly the interdependencies with other transformation projects.
- Include all changes needed to implement the proposals.
- Set out funding/financial implications.
- How the proposals were developed
- Ongoing engagement and involvement
- How the engagement and involvement has influenced proposals.
- Show how the proposal meets financial and clinical objectives.

7. Timescales

The involvement activity will take place from 25 January to 21 March 2024.

Date	Activity
25 January – 21March 2024	Survey
	In person events
30 January 2024 5:00 – 6:30pm	The Forum Southend
5 February 2024 6:00 – 7:30pm	Beehive Centre Thurrock
5 February 2024 time TBC	Basildon TBC
7 February 2024 6:00 – 7:30pm	Civic Centre Chelmsford
6 March 2024 Two sessions 4:00 – 5:30pm 6:30 – 8:00pm	Ormiston Rivers Academy Burnham on Crouch
	Online events
12 February 2024 2:00 – 3:30pm	Maternity online session
13 February 2024 2:00 – 3:30pm	Stroke online session
15 February 2024 10:30 – 12 noon	Intermediate care beds online session
26 February 2024 2:00 – 3:30pm	Outpatient services online session
28 February 2024 6:00 -7:30pm	Online session covering all changes
	Public hearing
19th March 2024 12:30 – 8pm	Town Hall Maldon
Dates to be confirmed	VCSO-led groups

8. List of resources

Materials have been created for each activity based on branded templates to ensure consistency of branding and messaging. Materials include:

- Presentations for sharing with the public and staff
- Website copy
- FAQs
- Surveys
- Media message matrix
- Videos
- Accessible information
- Podcast

9. Briefings

[MPs, HOSC, Trust Board, stakeholders, partners…]

10. Risks

Risks and mitigations will be managed by the Executive Management Team and the ICB Board. Risks around communications and engagement will be fed into overall Risks log for the project.

Communications and engagement risks will be identified and regularly reviewed and assessed throughout the consultation and mitigating actions put in place to respond to issues.

Risk	Impact of risk	Mitigating action
Lack of engagement from target audiences	Targets not met, impacting overall consultation and ability to deliver required outcomes	Regular, appropriate and easily understood communications, driving awareness and understanding and makes links to other workstreams so not viewed as “another thing.” Insight supplied by a consultation reference group to inform our approach.
Lack of consistency in messaging	Confusion among audiences, loss of reputation and credibility	Following central messaging and embedding this in local comms. Sharing this with partners for use in their own comms

Proposals in the consultation perceived as already implemented or a 'done deal'	Loss of trust, engagement	Ensure through all communications that employees and the public understand the journey so far and understand the rationale for change.
Campaign group(s) challenge proposals	Risk of misinformation	Ensure consultation documents outline how the proposals have been developed and the benefits for services users. Ensure all engagement is logged. Ensure we are prepared through the processes in place to receive petitions.
Message fatigue	People start to 'switch off'	Refresh comms content and creative in line with phases of the consultation involvement activity.
Message overload	Confusion, 'too much to take in', start to 'switch off' or the opposite	Timed and considered comms that are relevant to that stage in the consultation.
Poor channel selection	Low levels of engagement and understanding	Ensure channel(s) are relevant to the audience e.g. not everyone is online
Lack of credibility in the content	Low levels of engagement, people become suspicious	Remain consistent with messaging/content, use local/peer spokespeople to build confidence
Comms are not seen as relevant to the audience e.g. general public	Little notice is taken if people fail to see how this affects them	Case studies / examples using 'real people'

11. Contact details

[List of who to contact within Stand and key contacts]

12. Appendices

Appendix 1 - Survey questions

Appendix 2 - Public hearing scope

Appendix 9

Pre-Consultation Engagement Report

Appendix Nine - Pre-consultation engagement report on the future configuration of community inpatient beds, midwife-led birthing care and Ambulatory Services in Maldon and surrounding areas

Document Control:

Date: 15.12.2023
Version: 7

Purpose

This report presents findings from recent quantitative and qualitative engagement activity with patients, staff and community stakeholders including representatives from carers, health, and care professionals, VCSE organisations and members of the public within mid and south Essex.

The engagement, conducted by Mid and South Essex Integrated Care Board and supported by its partners, was carried out between November and December 2023, and sought to understand what is important to stakeholders regarding:

- The future configuration of community inpatient beds
- Midwife-led birthing care
- Ambulatory Services in Maldon and surrounding areas

This engagement work supplements findings from a previous qualitative engagement programme undertaken in February-April 2022 that focussed on community bed-based care.

This report was completed by Kaleidoscope Health and Care and 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?

Learnings from this engagement work and the previous where applicable will be provided to inform decision making during the next stage of this consultation process.

Healthwatch Essex, Healthwatch Thurrock and Healthwatch Southend review statement

Healthwatch Essex endorse this pre-consultation engagement report on the future configuration of community inpatient beds, midwife-led birthing care, and Ambulatory Services in Maldon and its surrounding areas. Our organisation is committed to using the lived experiences of Essex residents to improve health and care services. We therefore commend the variety of perspectives captured in this report, incorporating the views of members of the public, patients, their families, and carers, and staff working within the services under consideration. These perspectives have

been captured using a range of different of methods, therefore ensuring the accessibility of the engagement. This approach is important given the diversity of services being reconfigured. We recommend that Mid and South Essex Integrated Care Board continue to adopt a mixed method approach for the full consultation.

This pre-consultation report explores feedback relating to each service in turn, delineating between public, patient, and staff perspectives. Overarching themes that emerged included: communication; the need for local, accessible services; the importance of patient choice; and the quality of services. Any proposed service changes need to be communicated clearly to both staff and members of the public in a timely manner. Proposed plans must recognise the position that St Peter's Hospital holds in the local community. Communication must be sensitive to residents' attachment to the site. A strong emphasis was placed on "local services for local people". Services need to be accessible to residents across the district, and proposals should consider the potential limitations of public transport infrastructure in more rural areas. Staff emphasised the need for modern, purpose-built facilities to ensure the quality of care that they provide. Members of the public in turn praised health care when they felt thoroughly supported in comfortable surroundings.

This report has successfully captured how the relocation of services will affect people's everyday lives, as articulated in their own words. Their accounts highlight, for example, the impact of travelling 50 minutes as opposed to 20 to access maternity care, elderly people's anxieties about driving to new places, and the period of adjustment staff require when relocating services. Healthwatch Essex strongly recommend that Mid and South Essex Integrated Care Board continue their commitment to capturing the lived experience and perspectives of members of the public, staff, and the VCSFE sector, to further understand these issues in the full public consultation on this service reconfiguration.

Dr Kate Mahoney

Research Manager, Healthwatch Essex

December 2023

1. Background and introduction

1.1. NHS Mid and South Essex (Mid and South Essex Integrated Care Board) and key health and care partners have been exploring how to meet the needs of the population in a sustainable way. The role of the Mid and South Essex Integrated Care Board is to join up health and care services, improve people's health and wellbeing and reduce health inequalities. NHS bodies all have a legal duty to deliver a 'Triple Aim' i.e., value to person, value to the population and value to the health and care economy and the communities they serve. A key objective is helping local people receive the right care in the right place.

1.2. It is vital that long-term solutions for community services deliver high quality and sustainable care enabling the best outcomes for local people living in mid and south Essex.

1.3. Previous engagement work (referenced above) has focussed on longer-term options for community hospital inpatient care following changes being made to the location and number of community inpatient beds during COVID-19. Specifically, the changes to the location and number of community inpatient beds impacted the provision of intermediate care beds (IMC) and stroke rehabilitation beds. Intermediate care beds generally provided care for people who were well enough to be discharged from a main hospital but were not yet able to return home. Stroke rehabilitation beds provided rehabilitation for people who had suffered a stroke. These changes were made without public consultation because of the urgency of the situation.

1.4. Since this time, further urgent adjustments to service provision have been made to ensure the NHS can offer safe, efficient, and effective healthcare services during winter 2023/24. Part of this decision making was driven by rising safety concerns about the St Peter's Hospital estate in Maldon. This saw all bed-based inpatient care together with the Midwife-led birthing Unit (MLBU) at St Peter's Hospital relocate to alternative facilities in mid and south Essex.

1.5. Following these urgent changes, clinical leaders across mid and south Essex have been considering what the future community services could look like. They are driven by the twin objectives of improving outcomes for patients and ensuring the partnership makes the best use of the available resources and capacity.

1.6. Ongoing concerns linked to the long-term sustainability of St Peter's Hospital have resulted in the decision to explore proposals for alternative options that relocate all services.

1.7. This engagement was part of a pre-consultation process, ahead of formal consultation with the public which is planned for 2024.

2. Methodology

2.1. This pre-consultation engagement activity started in November 2023. A snapshot of the engagement was taken in December 2023 to provide scope for analysis and integration into the pre-consultation document. Communications, and engagement colleagues in addition to clinical staff conducted engagement in the following forms: surveys, focus groups (both in person and online), staff engagement sessions (both in person and online) and a targeted email address on the ICB website.

2.2. Survey responses

2.2.1. An online digital engagement platform called "MSE Virtual Views" was established to ensure that staff, patients, and members of the community were able to submit their feedback and provide suggestions on how to improve healthcare services. At St Peter's Hospital the survey was advertised through posters with QR codes. Hard copies of the survey were also provided in the waiting area at St Peter's Hospital to ensure access was varied and inclusive. Clinical staff supported patients to fill in the survey and discuss their views where additional support was needed.

2.2.2. Across the engagement platform MSE Virtual Views, over 170 views were collected via two different surveys. Each response has been analysed to ensure that key themes arising from the pre-consultation engagement were incorporated into the pre-consultation business case (PCBC), for which this document is an appendix. The collation of all responses can be found in the accompanying document.

2.3. Focus groups (face to face and online) engagement.

2.3.1. Mid and south Essex covers nine districts and boroughs: Basildon, Braintree, Brentwood, Castle Point, City of Chelmsford, Maldon, Rochford, Southend-on-Sea (also referred to as Southend) and Thurrock.

2.3.2. The interim winter changes and the developing proposals impact the districts and boroughs in different ways; therefore, an integrated impact assessment was completed.

2.3.3. An integrated impact assessment supports decision making by evaluating the impact of a proposal, informing public debate, and supporting decision makers to meet their Public Equality Sector Duty. In this regard, an Integrated Impact Assessment (IIA) indicated groups of interest who would be affected by the proposals and highlighted the need for engagement.

2.3.4. We engaged with approximately 120 people from the following groups by attending existing meetings or events that were being held both in person and online:

- Maldon Stroke Club
- Thurrock Stroke and Carers Group
- Blackwater GP Surgery PPG (Patient Participation Group)
- Healthwatch Essex AIS (Accessible Information Standard) Working Group
- Slipper Exchange run by Age Concern Southend-on-Sea and hosted by Havens Hospices
- Carers First
- Canvey Community Supermarket Bus
- Brentwood Stroke Club
- Stroke Association
- SEE Alliance Winter wellness event
- Ad hoc engagement with women and birthing people at William Julien Courtauld at St Michaels, Braintree, and St Peter's Hospital

2.4. Staff engagement

An engaged workforce is essential to delivery of key services. We engaged with over 250 members of staff, ranging from: those working in Community inpatient beds at St Peter's Hospital, Maldon, and Brentwood Community Hospital; maternity staff across St Peter's Maldon and William Julien Courtauld (WJC) at St Michael's in Braintree; and consultants and supporting staff providing Ambulatory Services at St Peter's Hospital, Maldon.

2.4.1. Engagement across staffing groups was made up of online and in person meetings and focus groups. Staff were also encouraged to fill in MSE Virtual views if they preferred.

2.4.2. The themes arising from staff engagement that will be explored in subsequent sections are as follows:

- Communication and Engagement
- Patient Choice and Service Delivery
- Workforce
- Accessibility
- Location of Services

2.5. ICB website

2.5.1. A targeted email address was set up on the Contact Us page of the MSE website. This enabled individuals, local community and campaign groups, councils and other stakeholders to contact us should they have follow up questions or queries. This platform will remain open.

3. Community Beds

3.1. Context

We engaged with patients and associated community groups in addition to staff to understand their views regarding community inpatient beds. This section provides an overview of the evidence emerging from pre-consultation engagement. The feedback provided was then grouped into themes. The emerging themes can be split into feedback relating to patients and associated community engagement, and staff engagement.

3.2. Patients and associated community engagement

The key themes arising from patients and associated community group engagement:

- Accessibility
- Condition of the St Peter's Estate
- Location of Services

3.2.1. Accessibility

The cohort of patients that typically use community beds in relation to stroke rehabilitation and intermediate care are typically elderly and/or frail. Therefore, access to services in a local setting was a significant issue amongst patients and community groups.

The specific areas raised during engagement concerning accessibility were:

- Distance of travel for the receiver of the treatment
- Access routes for friends, families and carers and the potential threat of isolation
- Frequency of public transport.

Distance of travel for the receiver of the treatment

Elderly responders noted their apprehension to drive long distances, especially to parts of the area that were unfamiliar to them.

Access routes for friends, families, and carers

A range of views were provided when looking at the impact on friends, families and available community groups that support the rehabilitation journey.

Some responders were extremely vocal about the need for their relative to receive nearby treatment as isolation from family, friends and carers can have a negative impact on rehabilitation.

> *"We require local services for local people; travelling to Halstead or Brentwood should not have to be a consideration for many frail elderly or unwell people, especially as it isolates them from their family & friends." – Local Maldon Resident*

As a result of the interim winter changes, 16 stroke rehabilitation beds were moved from St Peter's Hospital, Maldon to the Bayman ward at Brentwood Community Hospital. In addition, the number of stroke rehabilitation beds delivered at Cumberlege Intermediate Care (CICC) in Rochford increased from 8 to 14. Users of the services after the interim winter changes said the following:

> *"With everyone pulling together to make my stay comfortable with personal communication with nurses, physiotherapists and carers." – Patient at Brentwood Community Hospital*

> *"Therapy was great, very glad I came as I can now walk again, I have been treated with dignity and respect by the health care assistants." – Patient at Brentwood Community Hospital*

Frequency of public transport

The public transport networks within MSE were highlighted as a particular concern, with many responders from the Maldon area expressing a difficulty to travel across the Maldon District. With the public transport

infrastructure as it stands, and the current financial climate, it is perceived that an additional burden and potential cost will be placed disproportionally on the elderly because of these changes.

> *"I visited my father almost every day when he was in stroke rehabilitation, I would not have been able to get to Brentwood by public transport". – Family member of patient accessing stroke rehabilitation*

> *"It is so important to have community facilities. Not everyone has access to a car, and public transport links are shocking. The care received at these local hospitals is vital to the communities." – Local Resident*

Accessibility was, and continues to be, a prominent theme of discussion. When asked "What about your care is most important to you?", participants ranked 'Ease of access' as the third most important behind 'Right treatment at the right time' and 'Best clinical treatment'.

3.2.2. Condition of the St Peter's Estate

Community sentiment showed a strong attachment to St Peter's Hospital building. Participants used phrases such as "much loved" and "special place" to describe its position within the community. St Peter's Hospital was seen as an asset because of its local provision of community-based services, historical precedence in the town and its accessibility for local people. Reference was made to those residing in the Dengie, for which St Peter's Hospital was instrumental in accessing community-based services.

Patients and community groups strongly asserted that repairing the site would be their first preference. Participants recognised that the site was not meeting the expectations of a modern NHS service, but the extent of the financial constraints and the works required was not known.

> *"I agree St Peter's is currently not fit for purpose and must be inefficient money pit not to mention safety. My personal preference would be for the NHS to sell some or all of the current site and have a purpose-built community health centre/hospital with good parking." – Local Maldon Resident*

When delving into the estates concerns in more detail, it was evident that the provision of care and the building were often interlinked. Patients and community groups wanted and need a safe and modern facility that provides the services that they need and enables staff to make the most of modern equipment and purpose-built facilities.

3.2.3. Location of Services

The location of the facilities was of huge significance to the patient and community groups. A key theme emerging from the engagement was the need for all future considerations to think about the demographic growth of Maldon and the expansion of both a growing and ageing population.

The optimal scenario was described to be “local facilities for local people”.

> *“St Peter’s is such an important facility for the people of mid Essex, particularly those who live further out e.g.: Dengie for whom travelling further afield results in a great distance. It is important to have some type of similar community-based service in this area, would be a great shame to lose it entirely.” – Local Maldon Resident*

Although there was a strong attachment to the physical space of the building, equity was a high priority. Areas such as the Dengie were mentioned frequently and the need to integrate these residents into a location that they could also access.

3.3. Staff engagement

This section provides an overview of the evidence emerging from a series of staff engagement sessions with those supporting community beds across mid and south Essex. There was a particular emphasis on those who supported the delivery of the interim winter changes. The key theme emerging from the engagement was Communication and Engagement.

3.3.1. Communication and Engagement

Communication was a strong theme across the staffing groups, covering communication on the St Peter’s Hospital stroke rehabilitation unit, communication with patients, and communication with management. Staff felt quite strongly that the communication regarding the interim winter changes and the development of proposals going forward was not always clear. Good communication and engagement were seen as an essential component to feeling valued, understood and supported through any proposed changes.

Staff acknowledged that communications had been shared but were often difficult to digest. At times, this led to stress, confusion, and difficulties answering patient queries. Staff reiterated that their priority was their patients and continuous care. A lack of information on the potential changes necessary for winter put a strain on the service that they felt they could provide.

As an overall assessment of the winter changes, staff highlighted that earlier engagement with them from management would have been preferred. Staff felt that consistent communications, transparency, and

clarity on how quickly the changes would be implemented would have helped their understanding.

4. Maternity Services

4.1. Context

Midwife-led birthing units enable women and birthing people who have low risk or uncomplicated pregnancies to have deliveries in a comfortable environment which can be more homely than labour wards. As part of the interim winter changes, inpatient activity – namely the midwife-led birthing unit at St Peter's Hospital, Maldon – was moved to William Julien Courtauld at St Michael's in Braintree. This move meant that the midwife-led birthing unit could remain open for women and birthing people as an alternative to delivery on a labour ward.

Since the transition (to the time of writing), 19 births have taken place at William Julien Courtauld at St Michaels in Braintree.

We engaged with patients and associated community groups, in addition to staff, to understand their views regarding maternity services. This section provides an overview of the evidence emerging from pre-consultation engagement. The emerging themes can be split into feedback relating to patients and associated community engagement, and staff engagement.

4.2. Patients and associated community engagement

This section provides an overview of the evidence emerging from the engagement concerning maternity services. The themes emerging from engagement with patients and associated community groups is as follows:

- Accessibility
- Location of Services
- Patient Choice

4.2.1. Accessibility

Women and birthing people travel from across the Maldon District to use the midwife-led birthing unit previously located at St Peter's Hospital, Maldon. Where participants live across the district has a significant impact on the availability of public transport networks and the accessibility of travel by road. Women and birthing people shared quite strongly the challenges faced in accessibility due to the relocation of the midwife-led birthing unit.

"It was very important to me that I could get to St Peter's quickly. I live in Burnham-on-Crouch and so St Peter's is 25 minutes rather than the minimum 50-minute journey to Broomfield." – Burnham-on-Crouch Resident and previous maternity inpatient at St Peter's Hospital

However, women and birthing people who live north of Maldon town centre have shared positively about the use of the service at William Julien Courtauld, citing that the facility is purpose built and affords them the opportunity for a low-risk birth, as they had hoped.

"The whole experience from start to finish was amazing! The staff were supportive, knowledgeable, and very caring. I felt totally at ease with them which helped me labour better. I have already been recommending WJC". – Maternity inpatient at William Julien Courtauld

Ultimately women and birthing people want stress caused by uncertainty minimised during the pregnancy. Therefore, it is essential that local outpatient facilities are provided to enable certainty, ease of access, and the availability of a network of support within the community they live. These services should be accessible by car and public transport and take into consideration geographical difficulties in access.

4.2.2. Location of Services

St Peter's Hospital is held in high regard by the public and residents of Maldon. Many participants shared stories of births within families and across generations. There is a strong and active social media community who are extremely passionate about the maternity services provided within the Maldon area. It was evident that the users of the service felt supported and personally connected to the staff. The quality of the service provision overshadowed discussions on the condition of the estate.

"The atmosphere at St Peter's was stress free and the staff were amazing. You can tell straight away the whole atmosphere is different at this hospital, they were able to give me one on one breast feeding advice when needed. They provided healthy home cooked meals. The staff were happy, friendly, and ready to answer any questions. My whole experience from my first midwife appointment at St Peter's was positive."

Despite the attachment to the St Peter's Hospital building, respondents recognised the need for investment to provide a modern NHS service. Comments such as "It has amazing potential", "requires some love", and "in need of maintenance" were used to describe the facility. Patients and community groups were clear that the provision of services needed to be fit for the changing needs of the Maldon population, with the priority being on delivering high quality care in a local facility.

4.2.3. Patient Choice and Service Delivery

Staff shared that there has been a mixed response from the women and birthing people who access the Midwife-led birthing unit and supporting maternity services. Generally, women who have attended the William Julien Courtauld at St Michael's in Braintree have been happy with the service,

> *"Midwives at WJC got my baby breathing and rescued us from a very traumatic situation. We were treated with so much kindness afterwards, at both WJC and Broomfield. Were eternally grateful for our care." – Patient at William Julian Courtauld Midwife-led birthing unit*

> *"I have been impressed with the care and communication from the midwives that work there, and it is a very calm place to be." – Patient at William Julian Courtauld Midwife-led birthing unit*

Women and birthing people from the south and east of the district have found that the movement of services made them rethink their birthing location.

Staff conveyed that there was a lot of emotion around St Peter's Hospital; the family histories of births impact the attachment to the facility. The midwife-led birthing unit provides a low-risk alternative birth to the acute setting. Therefore, a Maldon based Hub was popular amongst residents and community groups and seen as an imperative for the continuity of the service for the growing population.

4.3. Staff engagement

This section provides an overview of the evidence emerging from a series of staff engagement sessions from those supporting maternity services across mid and south Essex at St Peter's Hospital and William Julien Courtauld at St Michael's in Braintree.

The themes concerning staff engagement are as follows:

- Workforce
- Patient Choice and Service Delivery
- Communication and Engagement

4.3.1. Workforce

Midwifery faces national recruitment challenges that are not unique to mid and south Essex. Securing the skilled workforce with the experience and

motivation is essential to the longevity of the service. The impact across the workforce has been varied depending on the base location of the member of staff.

Some staff members shared that they have found the transition difficult. These staff added it has been challenging to adjust to the new environment noting an absence of support from the senior leadership team. Although staff were supported to make the changes, they felt that there had not been much intervention from the senior team. This led to concerns about the temporary nature of the changes and whether William Julien Courtauld at St Michael's in Braintree would remain open. Some staff felt connected to St Peter's Hospital and found the loss of inpatient births difficult to comprehend.

Other staff responded extremely positively to the changes:

> *"Staffing has never been better, with only 5 vacancies across the team, so staff can be dedicated to where the resource is needed. Including supporting more home births." – Midwife*

Ultimately, staff wanted to ensure that the workforce were equipped to keep delivering the high standard of care that has been at the heart of the community for as long as it has. This included maintaining the wrap around support for families, prioritising, and sustaining personalised care, good relationships with the midwives and the education team.

In addition to this, staff advocated the need to check the physiology of women and birthing people when booking them in, so informed choices can be made about where they can give birth safely. If women and birthing people had to be transferred to Broomfield to support delivery, they received the most appropriate advice and treatment.

4.3.2. Patient Choice and Service Delivery

Staff considerations for Patient Choice focused on the right for residents, to have midwife-led care, if they meet the criteria. Some members of staff expressed fears that choice would be limited for residents in Maldon as the travel distance between Maldon and Braintree would drive traffic to Broomfield.

> *"Maternity is an area of care that cannot be overlooked and swept under the carpet. What happens in maternity affects public health, health conditions and lifelong care for some people. Women have the right to access midwifery led care and they don't care if the building is "old". If you do close this unit, it would be absolutely essential to open a new maternity unit in Maldon to support these families." – Midwife at St Peter's Hospital*

"The maternity services at Broomfield are under too much pressure and many women do not wish to travel to WJC due to distance." – Midwife at St Peter's Hospital

The cohorts presenting at the midwife-led birthing unit felt that locally based facilities should remain in Maldon to serve the needs of the growing population.

4.3.3. Communication and Engagement

Once again Communication and Engagement was a strong theme across the staffing groups and ranged from communication on the unit, communication across St Peter's Hospital services, communication with patients, and communication with management.

Staff felt quite strongly that the communications regarding the relocation of the interim winter changes and the development of the proposals going forward was not always clear. Staff shared that they sometimes heard conflicting information through informal channels. This contributed to their feelings of vulnerability.

Staff reiterated their commitment to delivering the best outcomes for patients and to ensure that women and birthing people felt supported in their journey. Going forward, clear, early, and consistent engagement was requested to ensure that everyone felt as though they were contributing to the same goal. As a practical application of this, the following recommendations were noted for further exploration:

- Assess the Clacton model of midwife-led birthing unit – this is a demountable building that is opened on demand.
- With the existing configuration – can opening hours extend to support breast feeding?
- Additional equipment to support more home births.

Suitability of the alternative suggestions proposed will be included when the full consultation is launched.

5. Ambulatory Services

5.1. Context

5.1.1. Ambulatory Services encompass services such as Phlebotomy, Podiatry, Psychology and many more. 18,000 outpatient appointments are delivered annually with just over 50% of those appointments within maternity outpatients. As a result of the wide-ranging nature of these services, the patient and community groups associated with them are vast

and their cohorts cut across all characteristics. St Peter's Hospital is a hub for Ambulatory Services, with a communal waiting room for patients, families, and carers irrespective of the service they are going to use. As a result, in addition to online engagement, a strong emphasis was placed on utilising the waiting area to gather feedback in person.

5.1.2. Despite the wide variety of services and the varied use of the facilities, there were some common themes that emerged from the pre-consultation engagement.

5.1.3. This section provides an overview of the evidence emerging from pre-consultation engagement concerning Ambulatory Services and has tried to aggregate a diverse cohort of opinions. The feedback provided was grouped into themes. The emerging themes can be split into feedback relating to patients and associated community engagement, and staff engagement.

5.2. Patients and associated community engagement

The key themes emerging from patients and associated community groups are as follows:

- Quality of service
- Accessibility
- Location of Services

5.2.1. Quality of service

Stakeholders were overwhelmingly positive when providing feedback on the Ambulatory Services provided at St Peter's Hospital. Patients were particularly complimentary about staff, the level of support, personalisation of treatment and largely a timely delivery of the services.

> *"Always seen in timely manner, staff are usually very kind and happy". – Patient, Ambulatory Services, St Peter's Hospital*

> *"St Peter's is warm and welcoming; your care feels personalised when here. You feel that you are listened to, 'seen and heard'; rather than at the main hospital where it is always too busy, hectic, and overwhelming and you just feel like 'a number'." - Patient, Ambulatory Services, St Peter's Hospital*

Patients made reference to technological developments that were put in place post-Covid and have continued to improve the quality of the services provided.

> *"The booking system for Phlebotomy introduced after COVID is Great!" – Patient, Phlebotomy services, St Peter's Hospital*

However, this was not a consistent picture across all services. Some responders felt the clinic organisation was “inconsistent” and an “overhaul” to increase clinics was needed.

It was clear from the feedback received that staff appreciation was high and well regarded amongst patients. Further investigation is required into the services that, according to patients, are not operating to an optimal level. This could involve sharing learning from services rated highly throughout this engagement period.

5.2.2. Accessibility

As with other services, patients and community groups highlighted the importance of the accessibility of services. Elderly patients, women and birthing people were particularly vocal in their concerns about accessing Ambulatory Services. This was due to the frequency in which they would need to attend.

> *“St Peter’s is an important location. It is the one venue that can be reached by bus without complicated changes” – Local Maldon Resident*

Entwined with accessibility is the Location of Services.

5.2.3. Location of Services

As with the other services, there was notable concern about the growing population of Maldon Town and District. Participants were concerned about the service’s ability to cope with this growth in demand, whilst also ensuring that people were able to access services locally.

Commuting to St Peter’s Hospital was considered a “stress free” experience. Its location meant the avoidance of traffic, delay, and the uncertainty of navigating unfamiliar geographies. Patients displayed an awareness that the St Peter’s Hospital facility was not modern and does “require some investment”. They also acknowledged that a balance must be found as the location of the services was a significant benefit of the current arrangement.

Alternative suggestions were made for the delivery of services. In these suggestions, patients prioritised the delivery of a local based service rather than the physical estate used to host the service.

> *“Local is important and being Maldon born, but with a total understanding of the NHS it’s finding a balance. Perhaps using GP surgeries for outpatient appointments that don’t need equipment”. – Patient, Ambulatory Services*

Engagement with those who had to frequently use Ambulatory Services emphasised the value of having local services. The proposals within the consultation to relocate services should explore Maldon facilities, enabling local people to triangulate their access, location, and quality of service concerns into an optimal delivery model.

5.3. Staff engagement

This section provides an overview of the evidence emerging from a series of staff engagement sessions with those supporting Ambulatory Services at St Peter's Hospital. During this process, staff working within Ambulatory Services were highly engaged, and supported engagement with patients. Clinical staff fed back to operational teams on the requirements needed to deliver their service. The themes arising from staff engagement for Ambulatory Services focused on staff concerns for the patient cohort.

The themes concerning staff engagement are as follows:

- Accessibility
- Location of services

5.3.1. Accessibility

Staff spoke highly of the Ambulatory Services provided at St Peter's Hospital. Staff were keen to highlight accessibility as a key priority due to the frequency of visits by those who use Ambulatory Services. Staff shared that elderly patients who use multiple services within St Peter's Hospital would find it difficult to access these services via public transport. St Peter's Hospital provides a hub where multiple services can be accessed during one visit.

> *"St Peter's Hospital and particularly outpatients provide a superb service to the District of Maldon. Many elderly patients struggle to use public transport; Try asking the local elderly population how easy it is to travel for hours on public transport for blood tests, local consultant led appts etc..." – Member of staff, Ambulatory Services, St Peter's Hospital*

Staff continued to add that St Peter's Hospital supported the movement of patients from Broomfield Hospital in times of pressure. They maintained that a community-based alternative to support the hospital was essential to providing timely access to treatment.

> *"Given how overwhelmed Broomfield often is it makes perfect sense to continue to use St Peter's for outpatient appointments to both relieve*

pressure from other hospitals whilst also providing an invaluable local service..." – Member of staff, Ambulatory Services, St Peter's Hospital

5.3.2. Location of Services

Staff were quick to highlight the importance of maintaining community-based facilities for Ambulatory Services. This was due to the anticipated rate of growth within the district.

"With all the extra housing going up in the Maldon district, a community hospital is now needed more than ever." – Staff member, Ambulatory Services, St Peter's Hospital

Staff identified the need to provide an NHS service that was fit for purpose, emphasising locally based solutions as the best way to balance population growth and service need.

"Maldon as a town and the district in general is expanding at an astonishing rate. Any plan to draw down services at St Peter's can only be considered once a new Health Hub has been built and opened allowing current services at St Peter's (especially the vital outpatient element) to be retained locally." –Staff member, Ambulatory Services, St Peter's

"Keep our local services local to provide continuous safe care!" –Staff member, Ambulatory Services, St Peter's Hospital

In summary, staff within Ambulatory Services want to ensure that the services support the needs of the population, provide relief for the acute hospitals in times of peak activity and continuously deliver safe care to patients. The proposals within the consultation to relocate services should explore Maldon facilities, enabling staff to balance their access and location concerns into an optimal delivery model.

6. Conclusion

In conclusion, this engagement identified the themes of most significance to stakeholders regarding:

- The future configuration of community inpatient beds
- Midwife-led birthing care
- Ambulatory Services in Maldon and surrounding areas

The importance of community-based provision was emphasised

throughout the engagement period. Patients, community groups and staff are extremely passionate about the provision of community-based services and the need to ensure that they were well maintained, evolving to serve the needs of the changing population.

When asked “what about your care is most important to you?”, the responses of the survey highlighted the following ranking:

1. Right treatment at the right time
2. Access to the best clinical treatment
3. Ease of access
4. Specialist centre for your condition
5. Enough staff on duty
6. Family and friends close by
7. Quality of building where care delivered.

The themes highlighted in the pre-engagement consultation create an opportunity for simple recommendations to be implemented to ensure that patients, community groups and staff continue to work together collaboratively to deliver the best outcomes for the people of mid and south Essex. These recommendations include:

- Good Communication and Engagement – misunderstandings and misinformation within all engagement groups was prevalent. Ensure that simple and clear messaging is always provided to all affected groups.
- Focus on Equity and Inclusion – ensure that the consultation is wide-reaching and inclusive.
- Accessibility – focus on local based solutions where possible.
- Patient Choice – support initiatives that continue to maximise Patient Choice. This may require alternative solutions to be developed but this is encouraged and welcomed by staff and patients.

A full spreadsheet of responses can be found in the attached appendix alongside how this has impacted the development of the pre-consultation business case.

Appendix 10

Stroke and IMC Audit

Stroke and IMC Audit

Stroke

What are we doing?
A stroke audit was conducted across all sites in MSE where stroke services are provided. This includes Acute, ESD and Stroke Rehabilitation (SRU). The audit documented patients against pre-determined categories to understand more accurately the patient cohorts, the demand for certain pathways and if our capacity currently reflects the needs of our patients.

Who's done it?
Patients were audited by clinical members of staff who attended several standardisation meetings to ensure all definitions and criteria were universally understood. Documentation was provided in advance of the audit commencing and daily drop-in sessions were available to discuss any questions / concerns as the audit progressed.

When was it done?

The audit ran from the 4th September until the 2nd October 2023 for ESD and SRU, and from 18th September until 16th October for Acute.

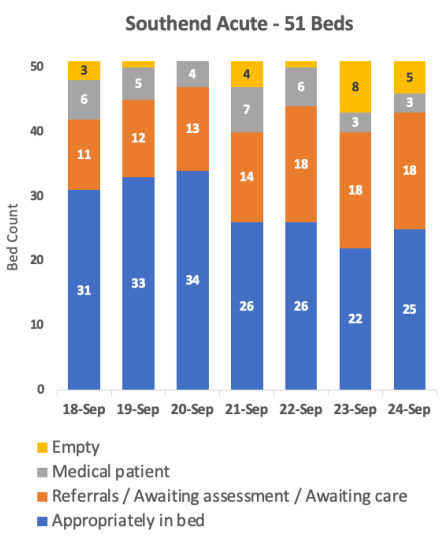
The 'perfect week' of data, 18th September to 24th September, is utilised in the following analysis.

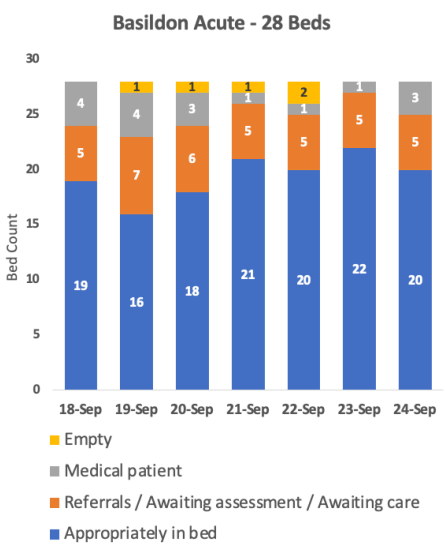
Why have we done it?
In order to deliver the best patient care, we must review our services against national guidance, our peers and the evolving needs of our demographic. To do this, we need to understand who we are serving in more depth, providing visibility of any pain points in the patient pathway. A stroke audit was last conducted in January 2023, and although a useful exercise, concerns have been raised around aggregating the data to make comparable assessments across sites. This audit seeks to incorporate the lessons learned from the previous audit by standardising the template, criteria for assessment and patient definitions. The outcome of this audit will be utilised in the review of the long-term configuration for stroke services within MSE and will feed into the Pre Consultation Business Case appendix.

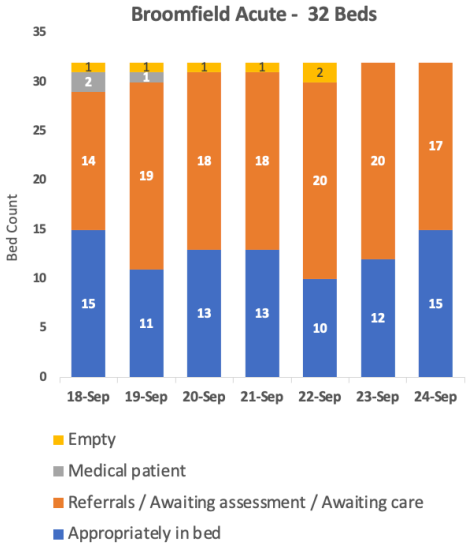
Acute summary

High-level groupings of the acute

The below shows a daily breakdown of the perfect week for the acute sites. All possible categories (33) were further bucketed into the following 4 groups. Note that 2 of Southend's 51 beds below are escalation beds and 7 are medicine funded beds.





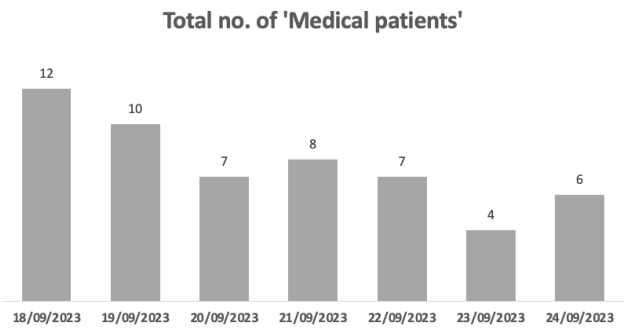


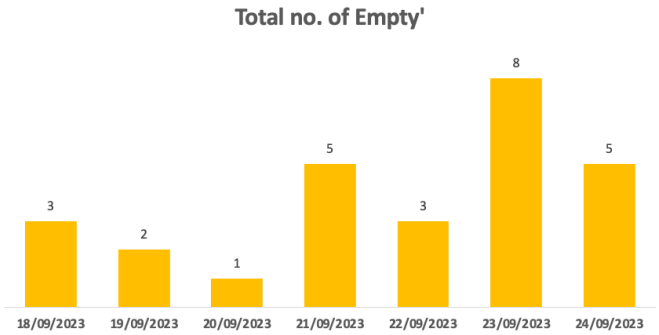
Acute Deep Dive

Further detailing

Of the 4 key groups outline on the previous slide, the total volume across the 3 sites for the 'Medical patient' and 'Empty' groups were calculated. The below shows this total on a daily basis across the perfect week. Note that 2 of Southend's 51 beds below are escalation beds and hence are not routinely opened / included in their usual bed numbers. This is particularly important when considering the Empty volumes. 7 of their total bed volume are medicine funded beds.

In addition, whilst the 'Medical patients' group refers to non-stroke medical patients, this can be reflective of stroke mimic patients as well as those with a condition non-stroke related and hence whilst initially should be in a stroke bed, they then should then be discharged to a medicine ward where there is often no capacity, and thus the patient stays on the stroke ward.

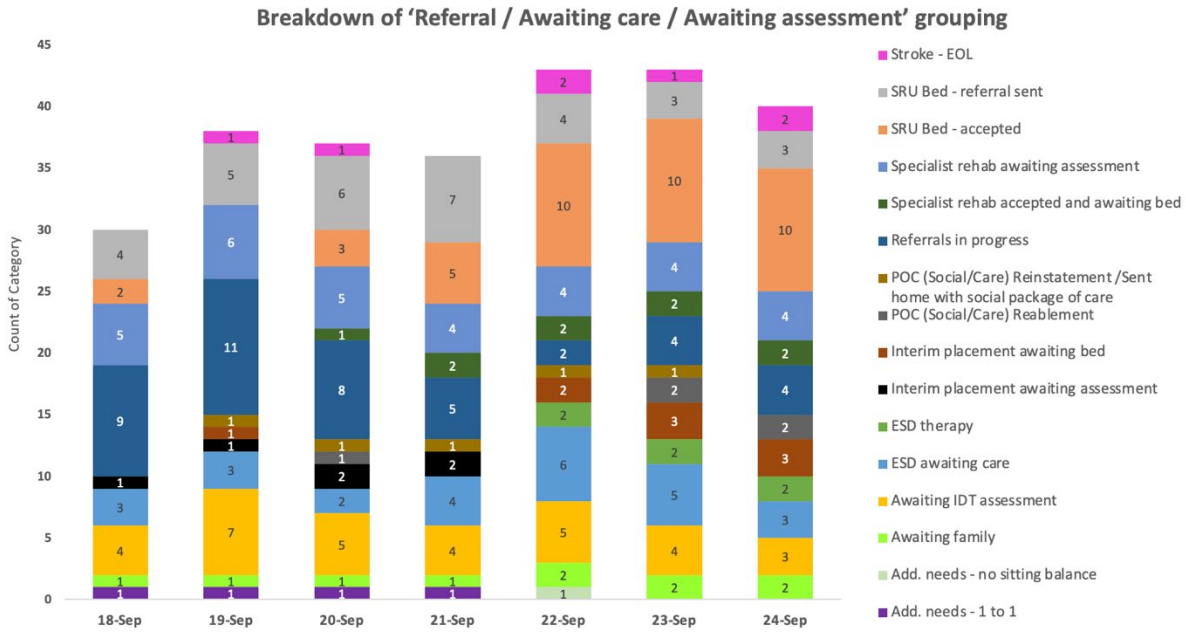




Referral / awaiting breakdown

The following graph shows the breakdown of the categories for the 'Referral / Awaiting care / Awaiting Assessment' group.

It collates all categories within this grouping across the 3 acute sites for each day of the perfect week.



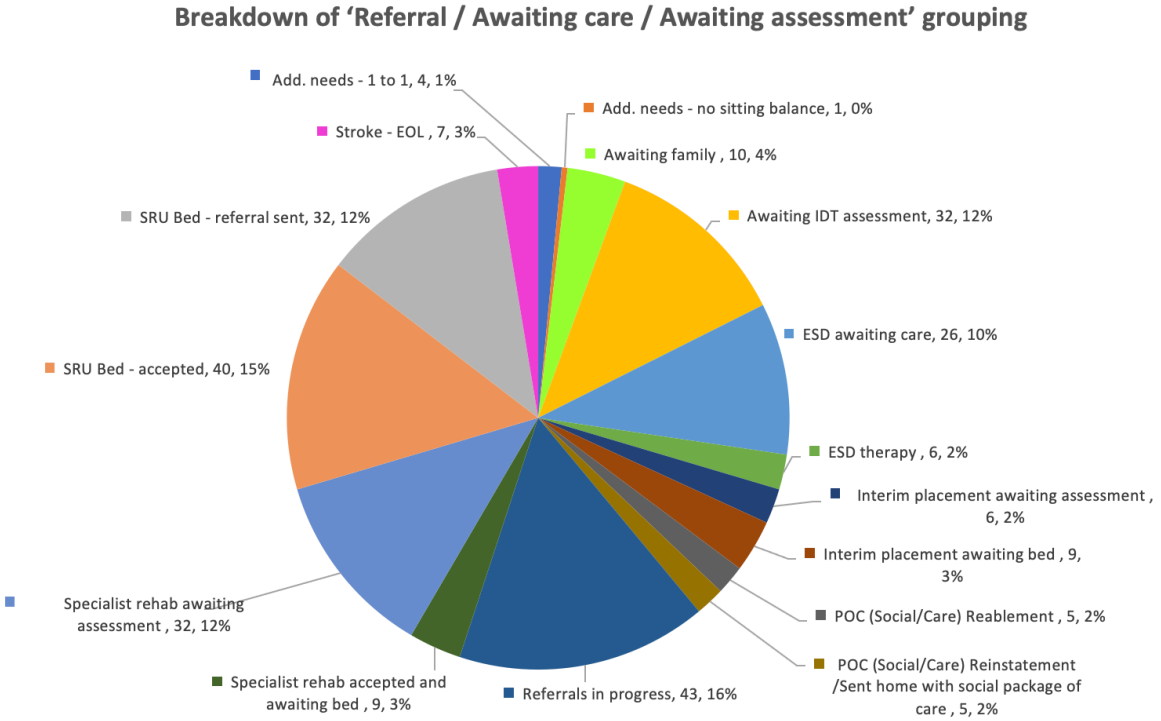
Referral / awaiting breakdown

The following graph shows the breakdown of the categories for the 'Referral / Awaiting care / Awaiting Assessment' group.

It collates all categories within this grouping across the 3 acute sites across the perfect week.

The **three categories** utilised most were:

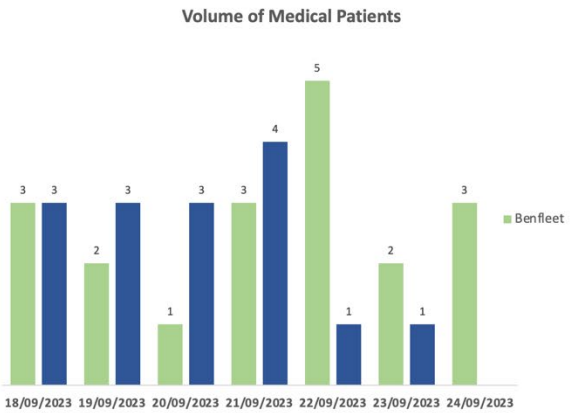
1. Referrals in progress
2. SRU Bed – accepted
3. Awaiting IDT assessment, and Specialist rehab awaiting assessment

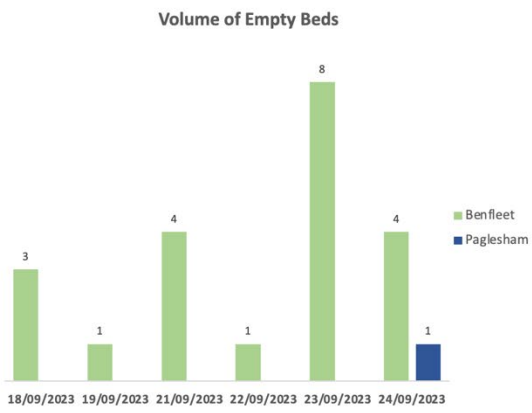


Southend acute – deep dive

Further detailing

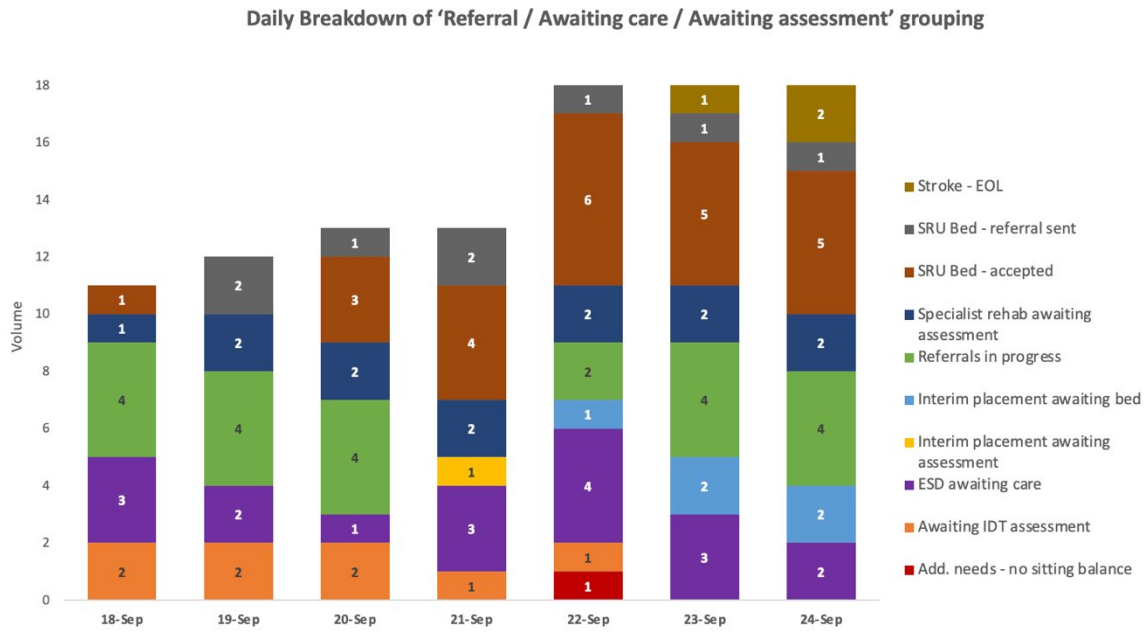
Of the 4 key groups outlined on the previous slide, the total volume for Southend for the 'Medical patient' and 'Empty' groupings is provided below, broken down by Paglesham vs Benfleet.





Referral / awaiting breakdown

The following graph shows the breakdown of the categories for the 'Referral / Awaiting care / Awaiting Assessment' group for Southend, broken down daily.

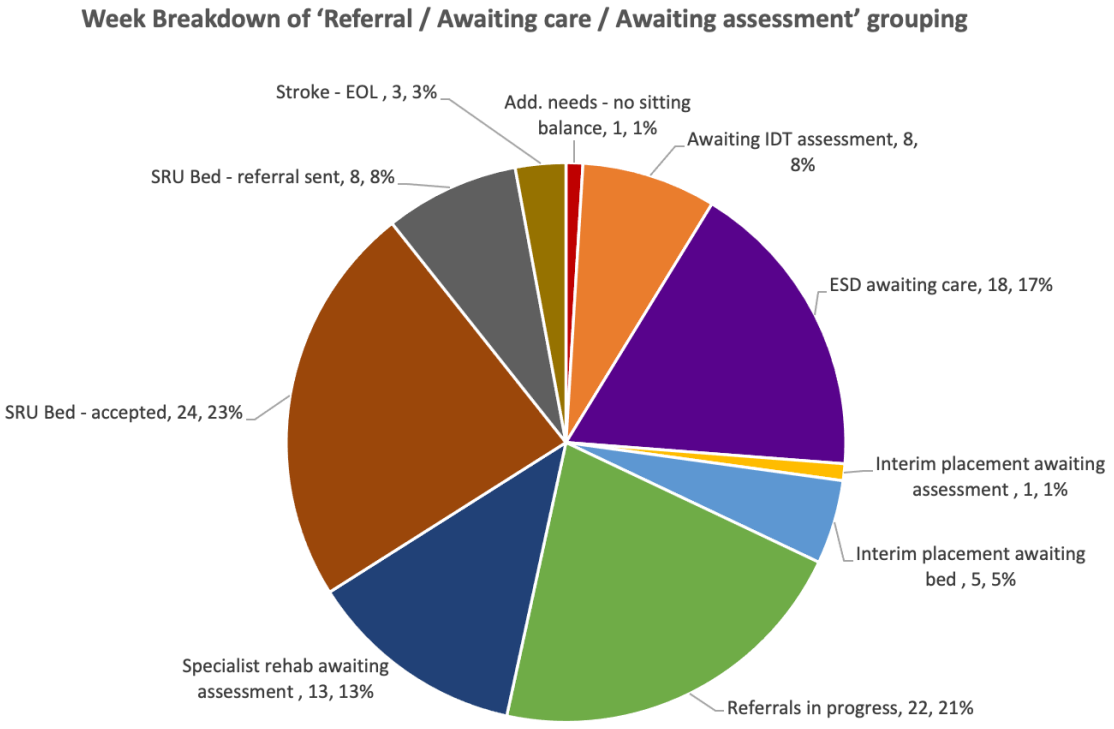


Referral / awaiting breakdown

The following graph shows the breakdown of the categories for the 'Referral / Awaiting care / Awaiting Assessment' group for Southend, across the week.

The **three categories** utilised most were:

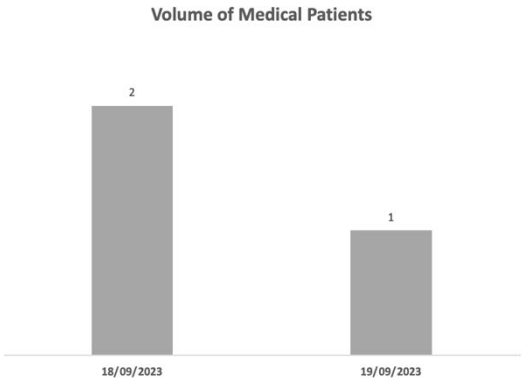
1. SRU Bed – accepted
2. Referrals in progress
3. ESD awaiting care

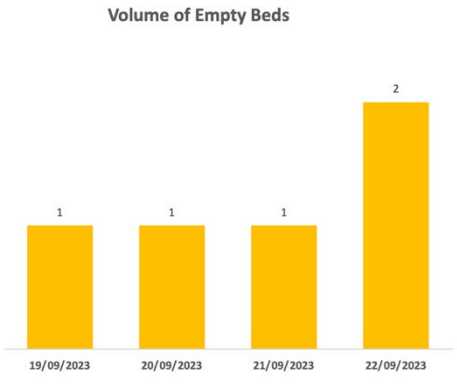


Basildon Acute deep dive

Further detailing

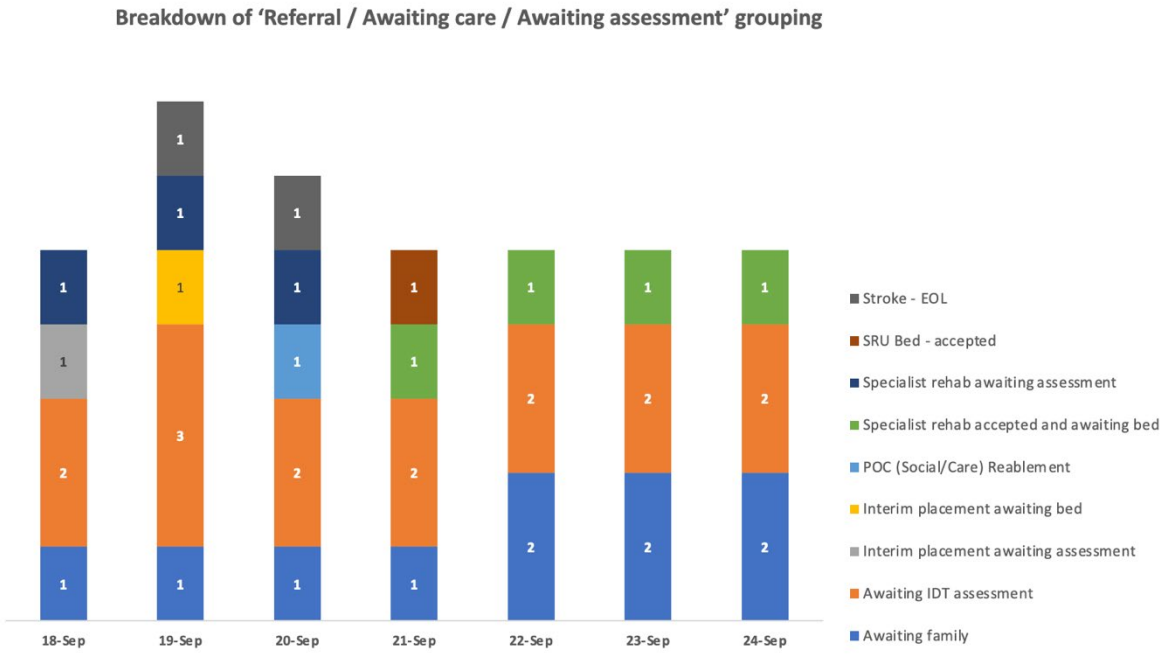
The below shows the total volume for Basildon's acute for the 'Medical patient' and 'Empty' groupings, across the perfect week. Days with no record are due to no medical patients / empty beds recorded on that day.





Referral / awaiting breakdown

The following graph shows the breakdown of the categories for the 'Referral / Awaiting care / Awaiting Assessment' group for Basildon, broken down daily.

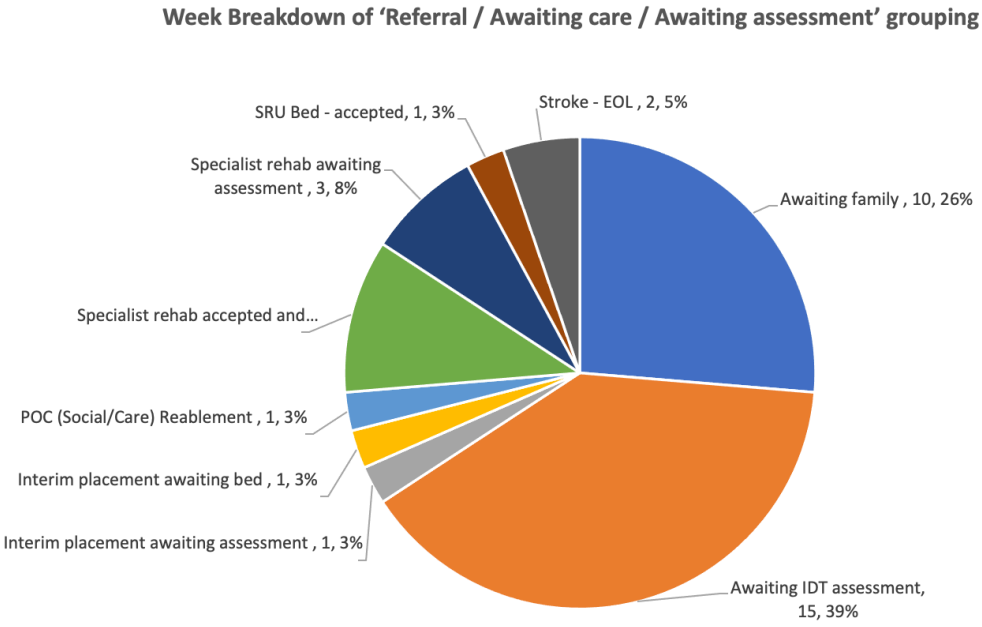


Referral / awaiting breakdown

The following graph shows the breakdown of the categories for the 'Referral / Awaiting care / Awaiting Assessment' group for Basildon, across the week.

The **two main categories** utilised most were:

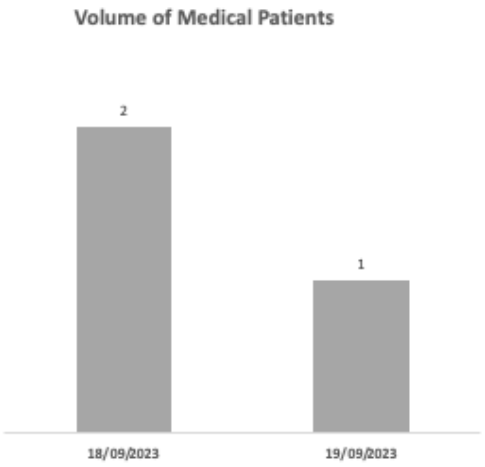
1. Awaiting IDT assessment
2. Awaiting Family

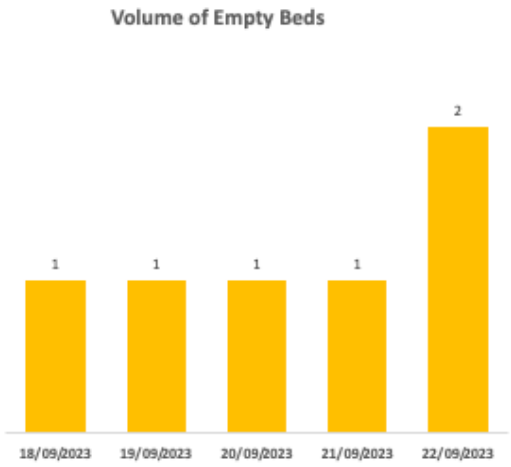


Broomfield acute – deep dive

Further detailing

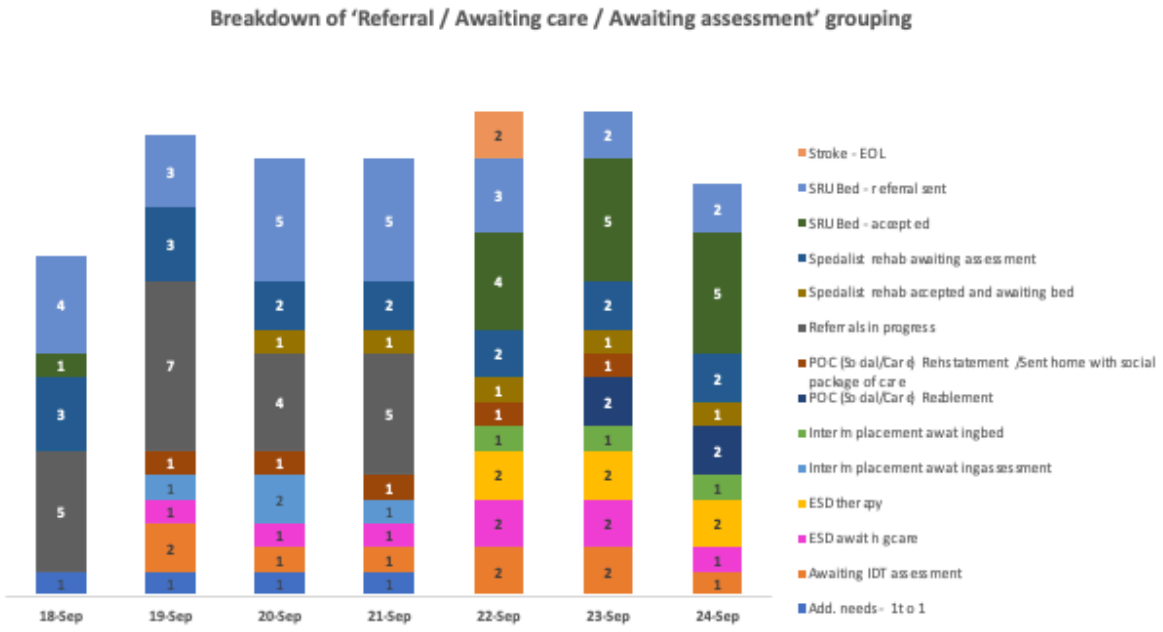
The below shows the total volume for Broomfield's acute for the 'Medical patient' and 'Empty' groupings, across the perfect week. Days with no record are due to no medical patients / empty beds recorded on that day.





Referral / awaiting breakdown

The following graph shows the breakdown of the categories for the 'Referral / Awaiting care / Awaiting Assessment' group for Broomfield, broken down daily.

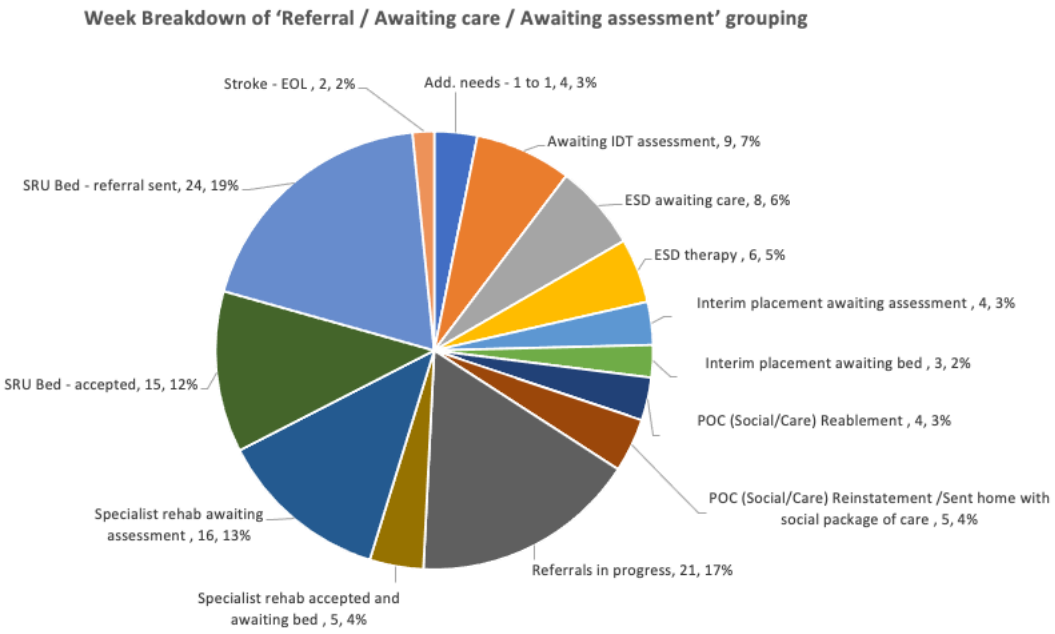


Referral / awaiting breakdown

The following graph shows the breakdown of the categories for the 'Referral / Awaiting care / Awaiting Assessment' group for Broomfield, across the week.

The **three categories** utilised most were:

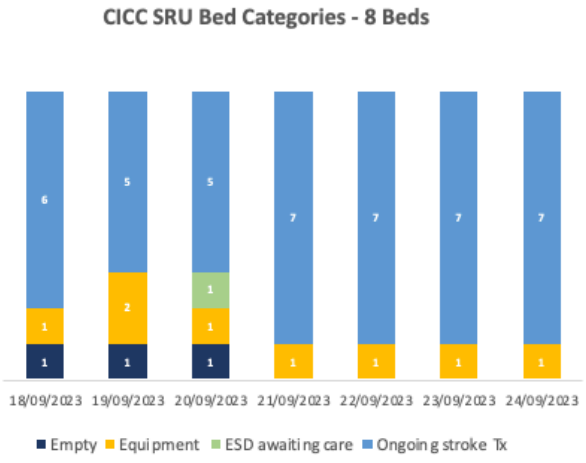
1. SRU Bed – referral sent
2. Referrals in progress
3. Specialist rehab awaiting assessment

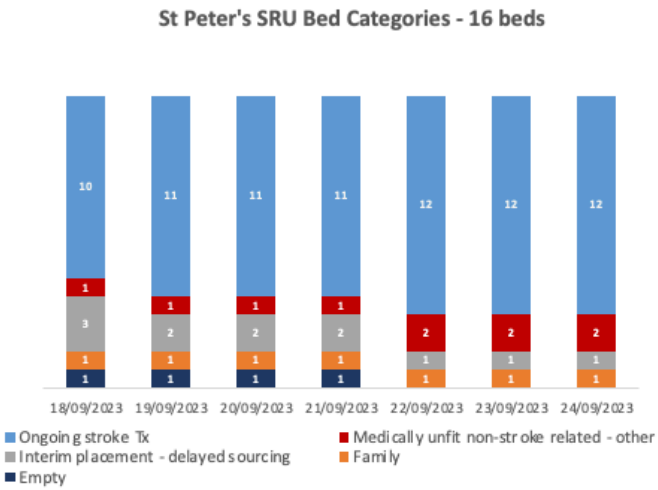


SRU Outcomes

Categories of the SRUs

The below shows a daily breakdown of the perfect week for the two SRU sites, St Peter's and CICC. All categories selected are displayed below – there was not as much variety in the categories selected as there was in the acute and hence further grouping was not required.



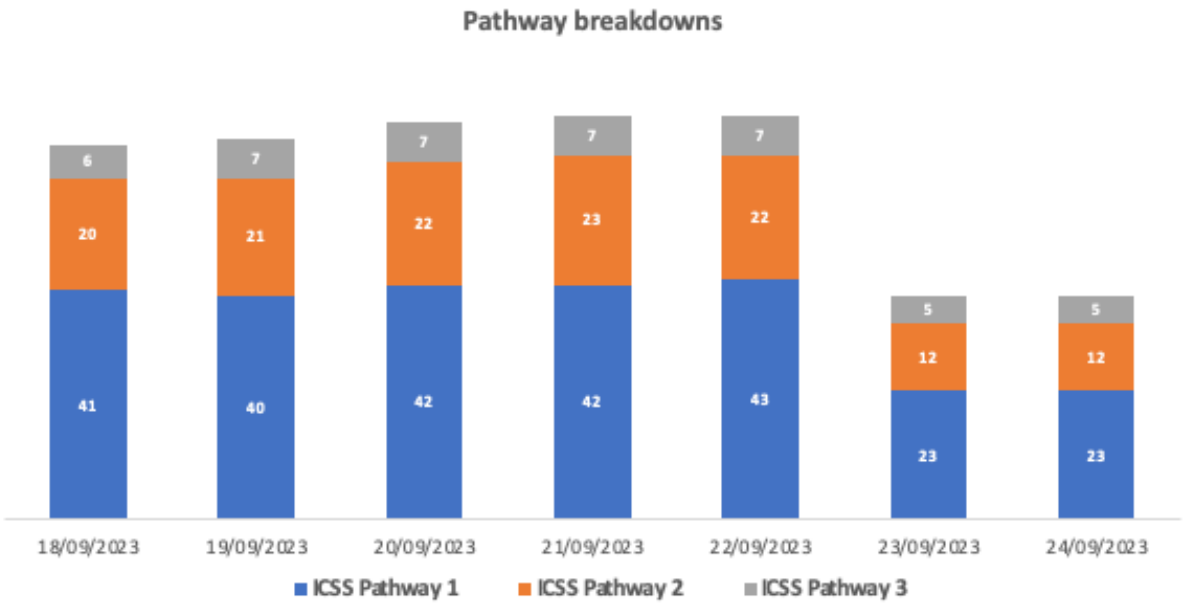


ESD Outcomes

Categories of the SRUs

The graph below shows a daily breakdown of the ICSS pathway of all caseloads, across the ESD services (Southwest, Southeast, Mid – St Peter's).

Note that Southwest's ESD service does not operate on weekends and hence reduced volumes for the 23rd and 24th.



ICSS Definitions (Integrated Community Stroke Service)

Pathway 1: Home with ICSS input (most patients) The patient is discharged home with ICSS input seven days a week.

Pathway 2: Home with ICSS input combined with daily social care support.

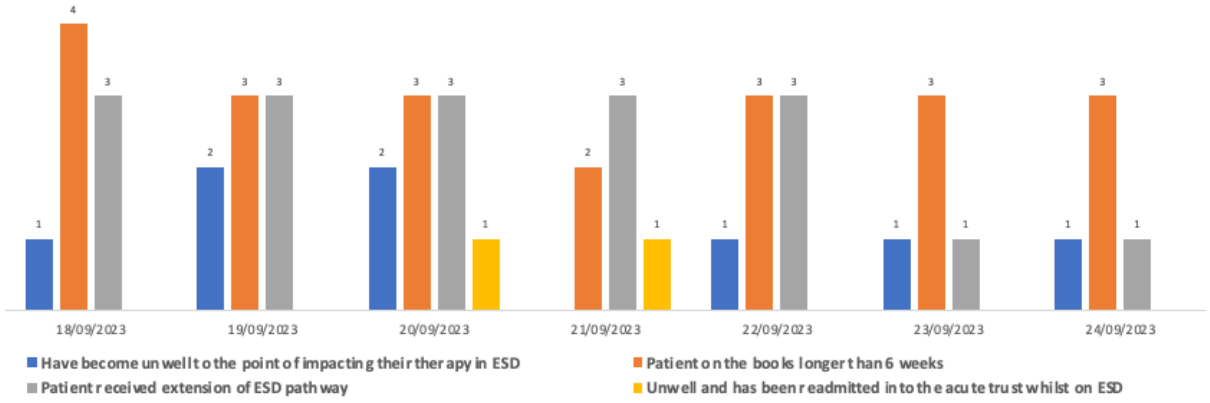
Pathway 3: Discharged to a residential/nursing home (Stroke rehabilitation services should assess and treat people with stroke living in a care home in exactly the same way they do patients living in their own home.)

Categories of the SRUs

The below graph shows a daily breakdown of volume across the patch for 4 key categories identified for ESD. This can be further provided by location if requested. Note that Southwest's ESD service does not operate on weekends and hence will impact numbers for the 23rd and 24th.

Patient received extension of ESD pathway: *Where an application has gone in and further, additional weeks of treatment is agreed.*

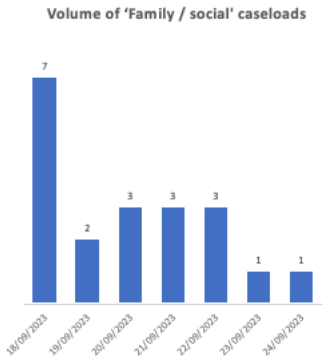
Patient on the books for longer than 6 weeks: *Due to some kind of delay. E.g., equipment is taking longer, patient unwell during pathway, family may have caused a delay in discharge for various reasons.*

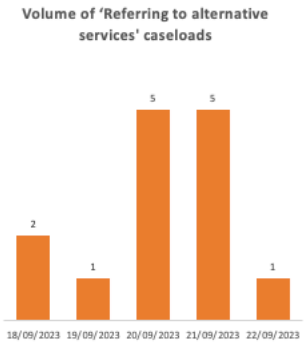


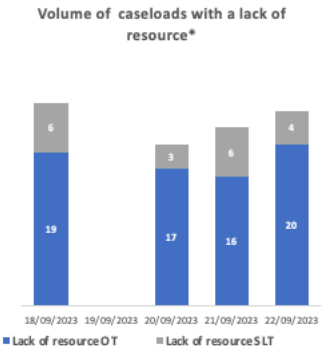
Categories of the SRUs

The below 3 graphs look at additional category volumes across the ESD service, on a day-by-day basis.

Note that Southwest's ESD service does not operate on weekends and hence reduces volumes for the 23rd and 24th







Stroke Audit Summary

Key numbers for the Acute

- Total bed numbers: **111 beds** including 2 funded by medicine, and 2 emergency beds
- Daily range of **56 – 65 beds** 'Appropriately used'
- Daily range of **2 – 8 beds** 'Empty'
- Daily range of **4 – 12 beds** 'Medical'

- Daily range of **30 – 43 beds** 'Referral / awaiting care / assessment' (average of 38)
- This final group is where we should be focusing on process and aiming for bed reductions by tackling flow improvements / tightening up on pathways

Bed numbers range for the Acute

- If there were no improvement to the 'Referral / awaiting care' grouping, we could use the top range value of **43 beds**
- Considering this with the 'Appropriately used' grouping, i.e., people who should be such beds, we want to consider a range of 56 – 65:
    - (Bottom range) 56 + 43 = **99 beds**
    - (Top range) 65 + 43 = **108 beds**

However, through discussions with the stroke stewardship group and leads on the acute wards, a target reduction of 20% (collectively across the 3 sites) to the 'Referral / awaiting care / awaiting assessment' grouping is seen as a good goal to work towards, as there is an awareness of potential process and flow inefficiencies n these area.

Considering a 20% reduction to the average (38) volume of this grouping gives a target goal of **30 beds**

- Considering this in line with the 'Appropriately used' beds data, this gives a range of:
- (Bottom range) 56 + 30 = **86 beds**
- (Top range) 65 + 30 = **95 beds**

Key numbers for SRU

The data suggested for SRU beds to be very well utilised. They are 80-90% occupied each day with patients experiencing ongoing stroke treatment, with an expected, infrequent occurrences of family / referrals etc. (approx. 10%). This supports the argument that additional stroke rehab beds would be beneficial and is currently a well used service.

For the week of September 18th – 24th the outlier data is as follows:

Basildon:

- 5 stroke patients on the stroke pathway were moved to medical wards from the stroke unit to make capacity for other patients.
- 1 patient was an outlier but eventually got to the stroke unit.
    - This patient was at an inpatient acute stroke ward and waited 8 days for the bed.

Broomfield:

- 5 stroke patients on the stroke pathway were moved to medical wards from the stroke unit to make capacity for other patients.
- The 5 patients didn't make it to the unit at all.

Southend:

- There were no outliers for Southend.

IMC Audit Summary

Over the past few years there have been several IMC audits conducted in order to establish a greater understanding of the demand and segmentation of the IMC patient pathways:

1. National Audit of Intermediate Care (NAIC)
2. 4213 IMC Model Audit
3. IMC Bed Deep-Dive Clinical Audit and Outcomes 2019

Each of these audits has revealed its own set of valuable observations and recommendations. However, despite their individual merits they have looked at different criteria and methodologies at different times, and therefore the results have had limited impact on the overall assessment of required bed numbers.

The following slides provide a high-level summary of each IMC audit and its key findings.

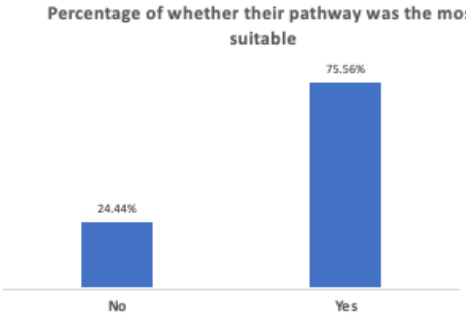
4213 IMC Model Audit

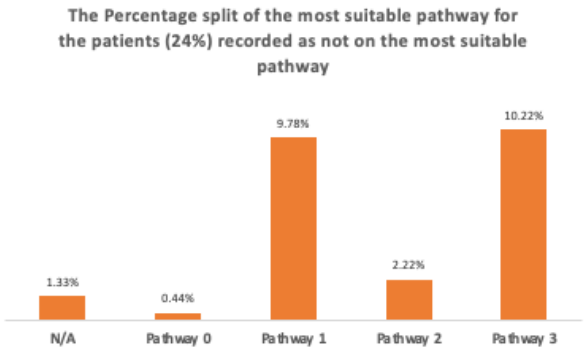
What is it?

An IMC audit was conducted between November 2022 and April 2023, with 255 responses collected. The audit recorded the date and location of each patient, their pathway assignment, an assessment of the accuracy of their pathway, their frailty score, and their BARTHEL score.

What are the key findings?

The report found the following key findings:





IMC Bed Deep Dive Clinical Audit and Outcomes 2019

What is it?

An audit reviewed all patients admitted to an IMC unit during a 10-week period (August – October 2019). It recorded their Clinical Frailty Score (CFS), End of Life GSF (Gold Standards Framework) Stage, final discharge outcomes, D2A pathways that should have been applied and the number of hospital readmissions,

What are the key findings?

The report found the following key findings:

1. Overall, only 40% of the cohort were deemed appropriate to have been requiring further rehabilitation in an IMC health bedded facility and gaining benefits from that.
2. 11% of the total cohort could have immediately returned home from the referring acute hospital via pathway 0 or pathway 1 and had no inpatient rehabilitation needs.
3. 1 death occurred on the IMC unit and 3 died very soon (within days) after return to acute hospital. All of the known deaths occurred within 3 weeks of admission to the unit and all deaths were seen in those with clinical frailty score of 7 or more (and at GSF stage amber or red).
4. Overall Readmissions to acute hospital occurred in 28% of the patients (with 11% requiring 2 admissions)

National Audit of IMC

What is it?

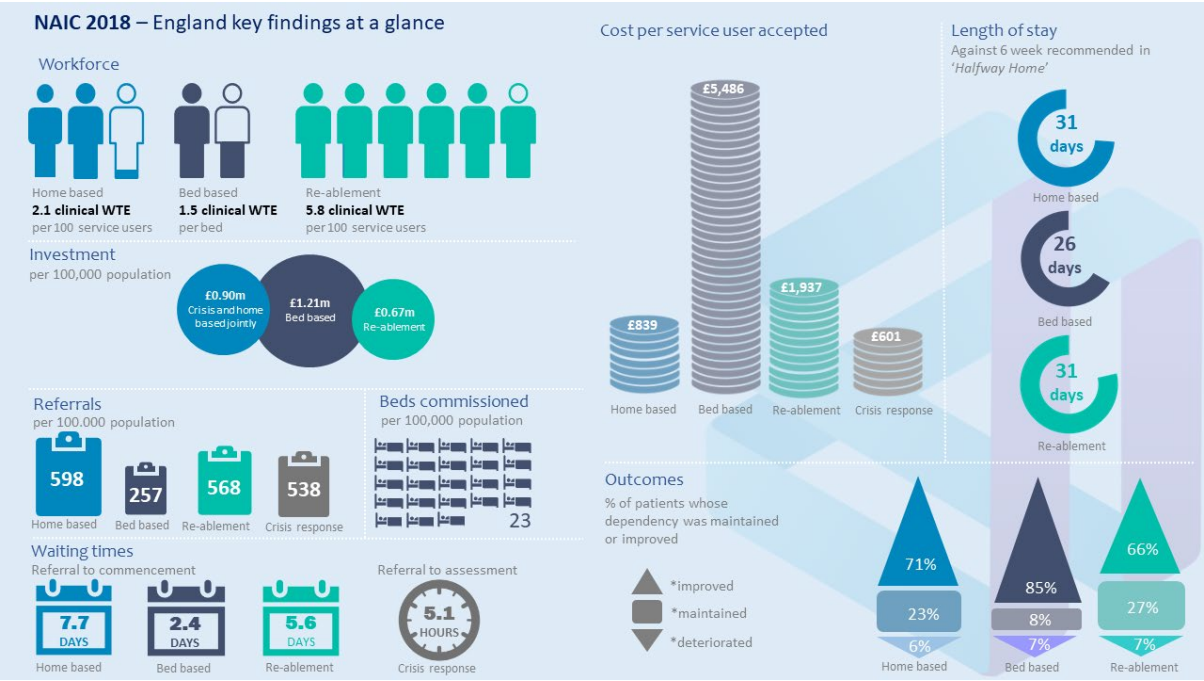
The National Audit of Intermediate Care (NAIC) aims to review intermediate care as a whole system and develop quality standards, assessing local performances against an agreed, national standard. The last NAIC (2018) reviewed intermediate care services in England, Wales, and Northern Ireland and collected data from providers for the following four intermediate care service categories; crisis, home based intermediate care, bed based intermediate care and re-ablement services.

What are the key findings?

The report found the following key findings.

Key factors with regards to our piece of work are:

1. Beds commissioned per 100,000 population is 23
2. Bed-based referrals per 100,000 population is 257
3. Bed-based length of stay is 26 days on average
4. Bed-based investment per 100,000 population is £1.2m



Appendix 11

Roadmap of IMC across Mid and South Essex

Appendix Eleven - IMC Pathway Map for Mid and South Essex ICB

National Pathway Targets:
Pathway 0 = 50%
Pathway 1 = 45%
Pathway 2 = 4%
Pathway 3 = 1%

Note that the below sections are broken down by pathway of service rather than where the pathway's funding is from.

	Southend LA	**Thurrock LA**	**Essex County Council**
Pathway 0	1. Pts return home 2. Welfare call	1. Pts return home 2. Welfare call	1. Pts return home 2. Welfare call
Pathway 1 H / S	1. D2A Therapy	1. D2A Therapy 2. RAFT	1. D2A Therapy 2. RAFT
Pathway 1 H	1. Continuing Health 2. CCT	1. Continuing Health	1. Continuing Health 2. CCT
Pathway 1 S	SEDS	1. Bridging 2. Thurrock Reablement 3. Direct to Domiciliary Care	IDT referral to ECL / ARC / bridging
Pathway 2 H	1. Community Hospital 2. Nursing Residential	1. Community Hospital 2. Nursing Residential	1. Community Hospital 2. Nursing Residential
Pathway 2 S	Brook Meadows / residential care	Collins House / residential care	Recovery to Home Beds Project
Pathway 3	24 hour bedded care	24 hour bedded care	24 hour bedded care

S = social
H = health
H / S = health / social

Pathway 0 – this pathway has a consistent approach across the patch

- Patient returns home with no/no new additional support needs.
- There is first a welfare call, which either directs a patient towards a community hub, or which links them back into IDT / ToCHs i(Integrated Discharge Team / Transfer of Care Hubs).
- Community hubs (set up by the voluntary sector) catch people who have gone through Pathway 0 but then may need community support or linking to community groups.

Pathway 1 / 2 – Health / Social – D2A Therapy – this pathway has a consistent approach across the patch

- The D2A Therapy team is a supplementary service to both Pathway 1 and 2, both Health and Social, that is supportive of the services provided by the patient's pathway, it is not independent or a replacement of that service but additional to, and hence sits across all pathways.
- It assess all patients discharges (new or increased POC), at home, between 0-3 days post-discharge.
- The assessment includes a review of function, equipment needs and care needs.
- Where staffing capacity allows, and is clinically required, some patients receive follow up-visits, e.g., if short term goals can be achieved with intensive input, or if the home situation and/or equipment needs are complex.
- This is currently non-recurrently funded.
- Referrals are also received from:
    - Ward/A&E Therapy staff when they have specific concerns that need to be assessed when the patient gets home.
    - Bridging/Social Workers/Community Services where patients recently discharged are struggling with their function at home and require an urgent therapy review.
- There is a slight variation in the provision across MSE:
    - **Thurrock/Basildon and Brentwood/Mid**: all Pathway 1 patients are reviewed by D2A within 48 hours of discharge home and referrals are received from wards/community.
    - **Southend (SEDs):** the D2A Therapy team are the therapy component of the SEDs service. All SEDs patients are reviewed by D2A within 72 hours of discharge home and referrals are received from wards/community. The D2A Therapy team jointly fulfil case management role alongside the SEDs Nursing team.
    - **Castle Point and Rochford**: there is limited D2A provision here at present. Currently, they are only providing assessment for high-risk discharges on a case-by-case basis. It will align with Thurrock/B&B/Mid once staffing allows.

Pathway 1 – Health – Continuing Health – this pathway has a consistent approach across the patch

- Able to return home with either new, additional, or a re-started package of support from health, and or social. This includes people requiring intensive support or 24 hour care at home. If the primary needs fall under the health criteria, then it would be pathway 1 – health over pathway 1 – social.
- Managed under the AACC team (All age continuing care).
- This is health funded.
- This pathway isn't used often as if someone has a health need at this point of discharge, they generally will be assigned to either Pathway 2 – Health, or Pathway 3, it is very rare to have a singular need that is health-funded and can be treated at home.
    - Whilst not used often now, Pathway 1 – Health was opted frequently when ED2A was in place at Thurrock. This was because the ED2A option was primed at enabling and supporting people to go home, it provided an option to go home with provisions setup, but as ED2A is no longer in place, this happens far less.

Pathway 2 – Health – Community Hospital – this pathway has a consistent approach across the patch

- People likely to benefit from and who are requiring intensive daily therapy-led input for a time limited period of active rehabilitation in an inpatient 24-hour bed-based setting- to support personalised therapeutic goals, before returning home AND who are both willing and deemed immediately able to participate in a programme of intensive rehabilitation in a 24 hour bedded setting for a time limited period.
- Whilst we try to discharge patients to the facility that is closest to where they live there may not be available resource and so they may be allocated to a facility further away within the patch.

Pathway 2 – Health – Nursing – Residential – this pathway has a consistent approach across the patch

- People deemed unable to immediately return home to their prior place of residence who do NOT require intensive therapy-led inpatient rehabilitation and/or who are unwilling/unable to participate immediately in a daily intensive inpatient rehabilitative therapy programme, but who could still potentially benefit from a period of general recovery/general convalescence, before determining their longer-term functional needs.
- There is now a consistent approach across the patch secondary to the decommissioning of the ED2A model in Thurrock (see Thurrock section for details). Therefore, there is not a dedicated discharge to assess service, or consistent discharge to assess approach, in place within this pathway now. Patients are discharged and may or may not receive community therapy/health input which is all dependent on whether a referral has been made into those services or not. In addition, the assessment of long-term needs (CHC assessment) is now conducted between 6-10+ weeks and is largely driven by AACC capacity rather than patient need. This is leading to a relatively low conversion to 'not eligible for CHC' at the point of CHC assessment compared to the ED2A model that was in place.
- This is health funded.

Pathway 3 – this pathway has a consistent approach across the patch

- People who have experienced a life-changing event and now require 24-hour bedded care (for the first time), on an ongoing basis. This new level of care is likely to be required for the rest of their life.
- For Pathway 3 – Health, discharges are managed by the AACC (All age continuing care) or to Hospice(s) under RADS (rapid access discharge service)
- For Pathway 3 – Social, discharges are managed by the local authority (these happen far less than the health discharges). As a system, there is work to be done to create a shared understanding of the category 'Pathway 3 – Social', to ensure that it is being used consistently across the patch.

Additional community services

- It is worth noting that across all pathways, across the patch, there may or may not be additional intermediate health and care provided by community services, e.g., specialist service AHP, district nurses.

The 3 authorities are split into the following sub ICB locations, with their relevant facilities listed:

1. **Southend on Sea County Council**
   Sub ICB: Southend
   IMC Facilities: Southend University Hospital (Paglesham)

2. **Thurrock Council**
   Sub ICB: Thurrock
   IMC Facilities: Thurrock Community Hospital (Mayfield)

3. **Essex County Council**
   Sub ICBs: Basildon and Brentwood (B&B), Castle Point and Rochford, Mid Essex
   IMC Facilities: Mountnessing Court, Brentwood Community Hospital, CICC (Cumberlege Intermediate Care Centre), St Peter's Hospital, Halstead Hospital

Southend on Sea County Council

SOUTHEND

Pathway 1 – Social – SEDS: Southend Enhanced Discharge Service

- SEDS picks up every patient in Southend who need a new package of care. The patient undergoes a D2A Therapy assessment (delivered by D2A Therapy Team) and then are either:
    - Directed to a Southend reablement service.
        - Enter a mainstream domiciliary care service where they leave the IMC stream and enter a chargeable service.
        - No longer require further care (and hence also leave the pathway)
- The core commission capacity is 25 slots (where 1 slot equals 1 patient requiring single-handed care) but through winter funding this increased to 50 slots. The current reality is closer to 80 – 90 slots, capacity has been greatly exceeded. This is predominantly due to delays in back-door flow of SEDS (adult social care assessments): the average length of stay should be 14 days but is currently 28.
- Within SEDS, you are the responsibility and accountability of health until you're referred to social care.
- It is joint funded.

Pathway 1 – Health – Collaborative Care Team (CCT)

- This is a domiciliary rehab care team that is provided by EPUT.
- Any patients that have had a Stroke, unstable fracture or have complex neuro needs are referred in to this service in place of reablement services.
- Note that SEDs will not take patients who meet the CCT criteria, i.e., they won't take a patient that has had a new Stroke and is having ESD input, or won't take a patient that has an unstable fracture.

Pathway 2 – Social - Brook Meadows / different residential care settings within Southend

- People who require recovery, rehabilitation, assessment, care planning or short-term intensive support, in a 24-hour bed-based setting before returning home.
- People deemed unable to immediately return home to their prior place of residence who do NOT require intensive therapy-led inpatient rehabilitation and/or who are unwilling/unable to participate immediately in a daily intensive inpatient rehabilitative therapy programme, but who could still potentially benefit from a period of general recovery/general convalescence, before determining their longer-term functional needs.
- If a patient is assessed (whilst in hospital) as requiring a Pathway 2 social placement but also has a degree of reablement potential, then those patients are ideally discharged into Brook Meadows residential home. Brook Meadows has in-reach Therapies provided by Adult Social Care therefore those patients do get a discharge to assess offer that supports a 'return home' approach. Adult Social Care conduct their Care Act assessment at c. 6-8 weeks and patients are either discharged home with domiciliary care provision, or are assessed as continuing to require 24 hour care which would then be processed via brokerage.
- However, if a patient is assessed (whilst in hospital) as requiring a Pathway 2 social placement but is not deemed as having reablement potential then they discharged into one

of a number of different residential care settings within Southend. Within these settings there is not a dedicated discharge to assess service, or consistent discharge to assess approach, in place within. Patients are discharged and may or may not receive community therapy/health input which is all dependent on whether a referral has been made into those services or not. As above, Adult Social Care conduct their Care Act assessment at c. 6-8 weeks and patients are either discharged home with domiciliary care provision, or are assessed as continuing to require 24 hour care which would then be processed via brokerage. In this pathway, a low percentage of patients are discharged home following their care act assessment at 6-8 weeks so in effect we're only applying the recover, assessment and care planning elements of the guidance in this pathway without a structured delivery of D2A which would cover off the rehabilitation and short-term intensive support elements.

Thurrock Council

THURROCK

Pathway 1 – Social

- Social workers (still) visit hospitals in Thurrock and provide an assessment on the ward.
- They will suggest a pathway, bridging is then used until the transfer of care is ready, and then the initial assessment is sense checked and the transition to the pathway is confirmed/progressed.
- This differs to Southend where social workers are not involved in the process anymore: health will cover the discharge, and the initial assessment and pathway. Social workers will only provide their assessment after discharge in Southend.
- This setup is probably out-dated (far more common pre-COVID) and is only needed because of the reliance on bridging. If SEDS was set up, this social worker initial assessment would likely not be needed.

Within Thurrock Pathway 1 - Social, there are 3 potential routes:

1. **Bridging**
   - This is where someone is medically optimised and are ready to leave but their care package is not ready, and hence the gap between where they are and need to be is 'bridged'. The pathway has been decided already but there is a delay in accessing it, so this 'bridges' that gap between the acute and pathway destination.
   - Capacity for bridging is approx. 200 hours per week in Thurrock.
   - Started in 2016 (in Thurrock) introduced to assist with the delays in transfer of care.

2. **Thurrock Reablement**
   - Caring For Thurrock (used to be called JRT (Joint Reablement Team)).
   - This aims to prevent hospital admissions and facilitate earlier discharges from hospital by enabling people who have had a crisis to return home or stay at home and maintain their independence.
   - Each service user is provided with an outcome-based reablement plan to meet their needs.

3. **Direct to Domiciliary Care**
   - Refers to the mainstream domiciliary care market where providers provide support to individuals with their personal care.
   - Key difference to Bridging/Reablement services is mainstream domiciliary care providers generally do not take a reablement approach to providing care.

Pathway 1 / 2 - Health / Social - Rehabilitation and Frailty Team (RAFT)

- Two services have been brought together and are now the Rehab and Frailty Team (RAFT). The two services were previously known as the Intensive Rehabilitation Service (IRS) and the Frailty Virtual Ward (FVW). The Rehab and Frailty Team continue to deliver both of these service offers as one team.

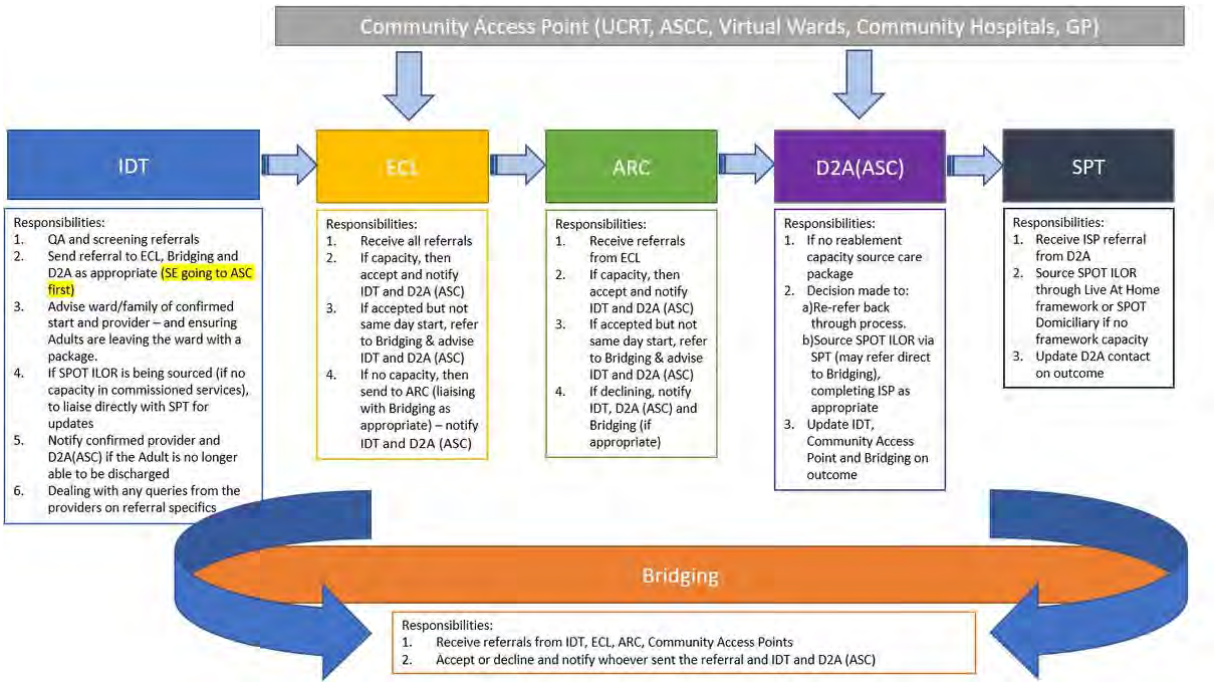
- RAFT services can be provided as a stand alone service, or as a supplementary service; whilst a very small number do experience it as the stand alone service, it is an option.
- This service aims to provide safe care in the patient's own home or care home to avoid admission into the acute hospitals and facilitate earlier timely discharges for those patients where ongoing management can be provided with clinical and care support in their place of residence. It also provides rehabilitation support in patients homes via a multidisciplinary team. Each service user has personalised, goal-based rehabilitation or personalised care plan(s) in place.
- The Rehab and Frailty Team provides safe and optimal care to adults with frailty, who may be presenting with urgent or emergent care needs due to intercurrent illness and /or presenting with a frailty syndrome and/ or to manage an exacerbation in an underlying pre-existing long-term condition in their usual place of residence. Those admitted to the Rehab and Frailty Team are medically optimised whilst on the ward and overseen by the consultant geriatrician and referred on as appropriate.

Pathway 2 – Social

- The Pathway 2 – Social setup in Thurrock is almost identical to the Pathway 2 – Social for Southend Council.
- They key difference is the name of the residential care setting that a reablement focus: this is Collins House for Thurrock vs Brook Meadows for Southend.

Essex County Council

Pathway 1 – Social



- Pathway 1 referrals begin with the IDT (Integrated Discharge Team) who are the co-ordinating function.
- The IDT will usually refer firstly to the ECL, if they have capacity, they will accept, and that transfer will begin straight away. If they don't have capacity on the day of referral but do soon, then bridging is setup, and the patient then goes to ECL once the capacity is free.
- If ECL have no capacity (in the immediate or near future) and hence decline the referral, then the patient is sent to ARC. The same process occurs: if ARC has capacity immediately, they are transferred, if they have it soon but not instantly, bridging steps in until this capacity is free.
- If neither ECL or ARC have capacity (and both decline the referral), the patient will go into bridging. They will stay in bridging until either ECL or ARC have capacity.
- After a patient has gone through their reablement (either ELC or ARC), the D2A ASC (Adult Social Care) assessment begins.
- In the instance where there is no capacity within ECL, ARC or bridging, then a patient will go into Spot ILOR (spot in lieu of reablement). However, this is a very expensive alternative and so is aimed to be used as little as possible.
- Depending on capacity and flow demands, sometimes bridging will also be informed at the very first stage, alongside ECL, to understand capacity demands across the board as quickly as possible.
- As well as IDT referrals (which is the majority of instances), there is also the Community Access Point for the pathway. In these instances, the process is the same as when IDT co-ordinates: ECL referral first, the ARC, then bridging, depending on capacity, or the D2A ASC assesses.
- At the exit point of ECL, ARC or Bridging (bridging instances where there was no confirmed care), if further services are still required at the end of this period, then the patient will have

a further social care assessment, and referrals will go to SPT. If a patient requires no further ongoing care at the end of their pathway (usually 6 weeks) they are discharged, but if additional ongoing care is required, rather than re-entering the ECL / ARC pathway, the patients further care is sourced by SPT.

BASILDON AND BRENTWOOD

Pathway 1 – Social is the same across the local authority (process map above)

Pathway 1 / 2 - Health / Social – Rehabilitation and Frailty Team (RAFT)

- Same as per Thurrock.

Pathway 2 – Social

- People who require recovery, rehabilitation, assessment, care planning or short-term intensive support, in a 24-hour bed-based setting before returning home.
- People deemed unable to immediately return home to their prior place of residence who do NOT require intensive therapy-led inpatient rehabilitation and/or who are unwilling/unable to participate immediately in a daily intensive inpatient rehabilitative therapy programme, but who could still potentially benefit from a period of general recovery/general convalescence, before determining their longer-term functional needs.
- Recovery to Home Beds Project. Aiming in Basildon and Brentwood to have 1 dedicated residential care setting with (min.) 5 beds that have an option to flex to 15, that can receive access to therapy/additional support.
- All patients who meet criteria for Pathway 2 – Social to be discharged into the Recovery to Home Beds pathway, ensuring all patients receive a standardised discharge to assess offer of post-hospital discharge therapy input (this therapy input is delivered by the D2A Therapy team) as well as dedicated adult social care to ensures the Care Act assessment is conducted in line with patient need instead of always between 6-8 weeks.

CASTLE POINT AND ROCHFORD

Pathway 1 – Social is the same across the local authority (process map above)

Pathway 1 – Health – Collaborative Care Team (CCT)

- This is a domiciliary rehab care team that is provided by EPUT.
- Any patients that have had a Stroke, unstable fracture or have complex neuro needs are referred in to this service in place of reablement services.
- Note that SEDs will not take patients who meet the CCT criteria, i.e., they won't take a patient that has had a new Stroke and is having ESD input, or won't take a patient that has an unstable fracture.

Pathway 2 – Social

- People who require recovery, rehabilitation, assessment, care planning or short-term intensive support, in a 24-hour bed-based setting before returning home.
- People deemed unable to immediately return home to their prior place of residence who do NOT require intensive therapy-led inpatient rehabilitation and/or who are unwilling/unable to participate immediately in a daily intensive inpatient rehabilitative therapy programme, but who could still potentially benefit from a period of general recovery/general convalescence, before determining their longer-term functional needs.
- Recovery to Home Beds Project. Aiming in Castle Point and Rochford to have 1 dedicated residential care setting with (min.) 5 beds that have an option to flex to 15, that can receive access to therapy/additional support.
- All patients who meet criteria for Pathway 2 – Social to be discharged into the Recovery to Home Beds pathway, ensuring all patients receive a standardised discharge to assess offer of post-hospital discharge therapy input (this therapy input is delivered by EPUT) as well as dedicated adult social care to ensures the Care Act assessment is conducted in line with patient need instead of always between 6-8 weeks.

MID ESSEX

Pathway 1 – Social is the same across the local authority (process map above)

Pathway 2 – Social

- People who require recovery, rehabilitation, assessment, care planning or short-term intensive support, in a 24-hour bed-based setting before returning home.
- People deemed unable to immediately return home to their prior place of residence who do NOT require intensive therapy-led inpatient rehabilitation and/or who are unwilling/unable to participate immediately in a daily intensive inpatient rehabilitative therapy programme, but who could still potentially benefit from a period of general recovery/general convalescence, before determining their longer-term functional needs.
- Recovery to Home Beds Project. Aiming in Mid Essex to have 3 dedicated residential care settings with (min.) 5 beds in each that have an option to flex to 15 each, that can receive access to therapy/additional support.
- All patients who meet criteria for Pathway 2 – Social to be discharged into the Recovery to Home Beds pathway, ensuring all patients receive a standardised discharge to assess offer of post-hospital discharge therapy input (this therapy input is delivered by PROVIDE) as well as dedicated adult social care to ensures the Care Act assessment is conducted in line with patient need instead of always between 6-8 weeks.

Appendix

Pathway 2 - Health – Enhanced D2A (ED2A): *now decommissioned*

Similar to the Recovery to Home Beds project being established across Essex County Council under Pathway 2 – Social. However, ED2A (Thurrock only) covered both Pathway 2 – Health and Pathway 1 – Health where all patients discharged on these pathways received discharge to assess Therapy input and AACC case management +- standardised domiciliary care offer for those on Pathway 1 Health, with weekly MDTs held to discuss progress of all patients and jointly determine best onward care provision. Therefore, the assessment of long-term needs (CHC assessment) was conducted in line with patient need rather than a set timescale.

- Previously in Thurrock, the patient's case is managed throughout their recovery journey, and when the patient is considered to be "optimised", they will then be assessed, at which point they could be stepped down into Pathway 2 Social, Pathway 2 – Health – Community Hospital, Pathway 1 – Health or Social, or Pathway 0.
- This model has now been decommissioned (despite a 60% conversion to 'not eligible for CHC' at point of CHC assessment) due to funding. The aim was to maximise independence which arguably worked very well given assessment conversion has now dropped to 10% in the new setup, which now matches the above of Southend, where there is no wrap around care. This drop in conversion highlights how the lack of support initially means there is no improvement at time of assessment.

Appendix 12

Bed Calculations

Demand and Capacity Calculation of IMC beds

1. **IMC**

The below working calculates 4% of non-elective discharges, the average stay length, and an occupancy level of 92%, 95% and 98%.
The 4% figure is taken from the 'Hospital discharge and community support guidance', stating that it is likely to be a **"maximum of 4% of people discharged: recovery, rehabilitation, assessment, care planning or short-term intensive support in a 24-hour bed-based setting, before returning home"** on **Pathway 2**.

Raw MSE data is utilised for the non-electives figure alongside the NAIC audit's average LOS.

The non-elective discharges data excludes anyone with a discharge method "died" – "NHSID 4". Data from previous financial years (2020 – 2021, and 2021 – 2022) have been removed due to the impact of Covid.

	April 2022 – March 2023
NEL discharges:	52,590
4% of NEL discharges:	2,104

The National Audit of Intermediate Care (2021) found an average LOS in a bedded IMC destination as 25.3 days.

Expected bed days = 4% of NEL admissions x Average LOS
2,104 x 25.3 = **53,231.2 bed days**

Expected beds = expected bed days / 365
53,231.2 / 365 = **146 beds**

Beds	**92% Occupancy**	**95% Occupancy**	**98% Occupancy**
146	158	154	149

Taking the projected population growth for MSE's IMC demographic (the 65+ age group), an 8.59% increase in population is anticipated in the next 5 years. Considering these growth figures, the below updates the bed figures to accommodate for project numbers up to 2029:

Avg. NEL admissions with an 8.59% increase:	57,107
4% of the increased NEL admission volume:	2,284

Expected bed days = 4% of NEL admissions x Average LOS
2,284 x 25.3 = **57,785.2 bed days**

Expected beds = expected bed days / 365
57,785.2 / 365 = **158 beds**

Beds	**92% Occupancy**	**95% Occupancy**	**98% Occupancy**
158	172	166	161

With a target bed occupancy level of 95%, the total required number of P2 IMC beds to cater for the next 5 years (until 2029) is within the range of **154 – 166 beds.**

Mid and South Essex's local authorities provide several P2 IMC funded beds:

1. Basildon and Brentwood have 1 site with 5 beds that can flex to 15

2. Castle Point and Rochford also have 1 site with 5 beds that can flex to 10
3. Mid Essex has 3 sites, each that can flex 5 to 10
4. Southend has 30 beds
5. Thurrock has 15 beds

Using the max value of each site with flex beds, and total bed count for other sites, this gives:

1. Basildon and Brentwood: 10 beds
2. Castle Point and Rochford: 10 beds
3. Mid Essex: 30 beds
4. Southend has 30 beds
5. Thurrock has 15 beds

Totalling the P2 local authority funded IMC beds at 92.

However, it's important to incorporate the difference in the average LOS between these types of P2 IMC beds:
The NAIC audit identified an average LOS of 25.3 days for community P2 IMC beds
LA-funded P2 IMC beds currently has an average LOS of 42 days, but a target of 28 days, and hence we will using a midpoint of 35 days.

To consider the difference in LOS for the two types of P2 IMC beds, the following calculation is used:

(Community beds ALOS / LA beds ALOS) x no. of LA beds
(25.3 / 35) x 92 = **67 LA beds** to be deducted from the overall P2 IMC volumes calculated above.

The range of P2 community beds specifically that is required is therefore:
154 (bottom range total IMC volume) – 67 (LA volume) = 87
166 (top range total IMC volume) – 67 (LA volume) = 99

A range of 87 - 99 community IMC P2 beds.

2. Stroke Rehab

As part of the Stroke rehab beds case presented to EoE Clinical Senate in 2022, our modelling showed that 23% of acute stroke admissions required rehabilitation in a community stroke rehab bed. The below working calculates 23% of acute stroke admissions, the average stay length, and an occupancy level of 92%, 95% and 98%. The 23% is taken from previous work provided by MSE to understand the conversion rate of stroke acute admissions to community beds. MSE data is also utilised for the stroke acute admissions figure as well as for the stroke rehab average LOS.

If we apply the calculation to MSE's stroke admission data below:

Data includes all admissions with a primary or secondary diagnosis of stroke (I60-I64), regardless of age. 2020 – 2021 and 2021 – 2022 data removed due to Covid.

	April 2022 – March 2023
Stroke admissions:	2530
23% of stroke admissions:	582

Location	**Total Discharges**	**Total LOS**	**Average LOS**
St Peter's	214	4830	22.57
CICC	63	2526	40.09

Average LOS across the two sites for April 2022 – March 2023: **26.56 days**

Expected bed days = (23% of stroke admissions) x Average LOS
582 x 26.56 = **15,457.92 bed days**

Expected beds = expected bed days / 365
15,457.92 / 365 = **42 beds**

Beds	**92% Occupancy**	**95% Occupancy**	**98% Occupancy**
42	46	44	43

Taking the projected population growth for MSE's stroke rehab demographic (also the 65+ age group), an 8.59% increase in population is anticipated in the next 5 years. Considering these growth figures, the below updates the bed figures to accommodate for project numbers up to 2029:

Avg. Stroke admissions with a 8.59% increase:	2747
23% of the increased stroke admission volume:	632

Expected bed days = (23% of stroke admissions) x Average LOS
632 x 26.56 = **16,785.92 bed days**

Expected beds = expected bed days / 365
16,785.92 / 365 = **46 beds**

Beds	**92% Occupancy**	**95% Occupancy**	**98% Occupancy**
46	50	48	47

With a target bed occupancy level of 95%, the required number of stroke rehab beds to cater for the next 5 years (until 2029) is within the range of **44 - 48 beds.**

There is also a case for change for 3 additional beds to be required, to provide support for Level 3a Neuro Rehab services. These beds aim to be used flexibly, with 0-3 beds available to provide Level 3a care at any point. With this addition, the overall range will thus increase to **47 – 51 beds**.

Appendix 13

UK Levels of Neuro-rehabilitation

Appendix 13 - UK Levels of Neuro-rehabilitation

In 2009 the Department of Health defined four categories of patient need (A,B,C,D) and three levels of specialist service (1,2,3) of which category A and category 1 are for the most complex cases. The National Service Framework for Long-Term neurological Conditions emphasises the need for provision at all levels, planned and delivered through coordinated networks in which specialist neuro-rehabilitation services work both in hospital and the community to support local rehabilitation and care support teams.

The proposal for Mid and South Essex is that a Level 3a service of up to three beds is made available at a Stroke Rehabilitation Unit as stroke patients essentially have neuro-rehabilitation needs similar to those of category C and D patients with different conditions. These characteristics are set out below:

Level 3:	**Local non-specialist services.** Includes generic rehabilitation for a wide range of conditions, provided in the context acute, intermediate care and community facilities, or other specialist services (eg stroke units)

Level 3a Other specialist services led or supported by consultants in specialties other than RM - eg services catering for patient in specific diagnostic groups (eg stroke) with Category C needs.
Therapy / nursing teams have specialist expertise in the target condition

Level 3b Generic rehabilitation for a wide range of conditions, often led by non-medical staff, provided in the context acute, intermediate care and community facilities, for patients with Category D needs

Patients with Category C rehabilitation needs

- Patient goals are typically focused in restoration of function / independence and co-ordinated discharge planning with a view to continuing rehabilitation in the community
- Patients require rehabilitation in the context of their specialist treatment as part of a specific diagnostic group (e.g. stroke)
- Patients may be medically unstable or require specialist medical investigation / procedures for the specific condition
- Patients usually require less intensive rehabilitation intervention from 1-3 therapy disciplines in relatively short rehabilitation programmes (i.e. up to 6 weeks)
- Patients are treated by a local specialist team (i.e. Level 3a service) which may be led by consultants in specialties other than Rehabilitative Medicine (e.g. neurology / stroke medicine) and staffed by therapy and nursing teams with specialist expertise in the target condition.

Source: British Society of Rehabilitation Medicine. Specialist Neuro-rehabilitation services. Updated 2019.

It was noted at the engagement with the Council of the East of England Clinical Senate on December 5th 2023 that a community stroke service should have an associated neuro-psychology team as recommended by the British Psychological Society Guidelines. This service would also be essential for neuro-rehabilitation patients.

Patients with Category D rehabilitation needs

- Patient goals are typically focused in restoration of function / independence and co-ordinated discharge planning with a view to continuing rehabilitation in the community if necessary
- Patients have a wide range of conditions but are usually medically stable
- Patients require less intensive rehabilitation intervention from 1-3 therapy disciplines in relatively short rehabilitation

  programmes (i.e. 6-12 weeks)

- Patients receive an in-patient local non-specialist rehabilitation service (i.e. Level 3b) which is led by non-medical staff.

Appendix 14

Feedback from Clinical Congress, Clinical Senate and Regional Chief Midwife

Appendix 14 – Summary of Formal Clinical Feedback

Clinical Congress

A meeting of the MSE Clinical Congress was held on the 29th November 2023 to discuss and clinically assure the PCBC. The following were present:

- Matthew Sweeting, interim ICB medical director – Chair
- Peter Scolding, assistant ICB medical director, Deputy Chair
- Krishna Ramkhelawon - Director of Public Health for Southend
- Donald McGeachy - Group Chief Medical Officer of Provide, clinical lead for integrated urgent care for MSE
- Fatemeh Leedham - head of pharmacy at Basildon
- Gerdalize Du Toit - physiotherapist, Congress member for community and AHP
- Feena Sebastian - deputy medical director for community services in EPUT
- Rebecca Boyes- nurse, assistant clinical operations director for Provide
- Sarah Zaidi - GP, ageing well stewardship group, alliance clinical director for southeast Essex
- Olugbenga Odutola – GP, alliance clinical lead
- Carolyne Dawson- stroke matron, stroke stewardship group
- Georgina Stickings - head of midwifery/gynaecology at Broomfield
- Jonathan Dunk - chief commercial officer for MSE FT
- Helen Chasney - governance officer for ICB, taking minutes
- Gavin Tucker- senior clinical fellow ICB
- Ruth Harrison – Moorhouse Consulting
- Chigozie Akinyemi – Moorhouse Consulting
- Claire Routh - head of communications for ICB

Outcome:

- The Clinical and Multiprofessional Congress supported the proposals in the business case going out to public consultation.
- The summary of this discussion and the recording will be sent to the East of England Clinical Senate Council, for discussion at Senate Council on 5th December 2023.
- A list of specific recommendations on the business case will be drawn out from this discussion shortly.

1. **Engagement:**

- Suggested that in future, broader engagement, to be careful to avoid jargon and acronyms– for example with regards to models of care (Integrated Neighbourhood Team etc).
- Consider early engagement with political bodies and committees within the system.
- Include examples of success from implementation of the models of care or their underlying principles – either from our own system or from elsewhere.
- Clarity on the condition of St Peter's estate - don't assume that the audience will have previous knowledge.

- Include primary care fora within engagement plans, particularly after decision-making phase and prior to implementation.
  Actions: Carolyne to pick with Stewards, Sarah to engage with ECC team.

2. **Ambulatory services:**

- Implementation needs close consideration, including the potential impact on waiting lists for the respective specialties e.g. radiology, T&O, rheumatology, eyes. There is a risk here without smooth implementation and transition. Close engagement with MSE FT regarding the management of this dimension would be beneficial.
- Could consider phasing implementation of OP transition in order to mitigate risks here.
  Actions: escalate to taskforce

3. **Maternity:**

- Consider how far it may be possible to include data from the winter arrangements (e.g. services moved to WJC from St Peters) into presentation and PCBC i.e. how many deliveries? How many times has it had to close? How do those things compare with the last few months at St Peters
- **Actions**: escalate to taskforce

4. **Equalities impact:**

- This should feature more prominently within the PCBC it was felt that this did not come through strongly.
- **Actions**: escalate within taskforce discussion

5. **Neuro rehab:**

- Endorse principle of bringing some provision into the system, taking advantage of synergies of Level 3A with stroke rehab care.
- May be useful to highlight how Level 3A is differentiated from Level 1/2/3b etc.
- Actions: include appendix within PCBC – definitions of neuro-rehab levels

6. **Stroke/ IMC**:

- Further discussion or acknowledgement of the potential impact and mitigation of any risks relating to services (either stroke rehab or IMC) would be useful.

East of England Clinical Senate Council

Dr Matt Sweeting (Interim Medical Director), Dr Pete Scolding, chair of the CCTF clinical sub-group, Dr Sarah Zaidi and Dr Gavin Tucker presented to the East of England Clinical Senate on the 5th December 2023 to gain assurance around the clinical engagement, processes and advice to the PCBC.

Feedback from this meeting was received on the 13th December 2023 as follows:

Dear Matt,

Pre-Consultation Business Case (draft v8) for the Future Configuration of Community Inpatient Beds in Mid & South Essex

Many thanks to you and your team for providing comprehensive evidence of the local processes applied to the above-mentioned business case and for joining the Clinical Senate Council meeting via Teams on 5th December, 2023 to answer questions. The Council welcomed the opportunity to support Mid and South Essex ICB by providing an independent view of the Clinical Governance and Assurance Processes followed to date.

I am pleased to formally confirm that the East of England Clinical Senate Council agreed that the Mid and South Essex ICB's Clinical Governance and Assurance Processes were followed for the Pre-Consultation Business Case for the Future Configuration of Community Inpatient Beds.

In addition, the following observations were made at the East of England Clinical Senate Council meeting on 5th December 2023:

1. There needs to be further work on the workforce plan for these proposals.

2. There should be further work on analysing travel times; especially the impact on areas of deprivation and the patient groups already identified as experiencing health inequalities.

3. While there was consultation with the public in forming these proposals, more extensive public consultation and engagement may have been helpful.

4. When doing further patient and public consultation in the future, Mid and South Essex ICB should ensure that enhanced patient involvement and the voice of underserved groups is especially targeted and heard so that a more inclusive and diverse range of feedback is received.

5. Mid and South Essex may wish to consider the recommendations of The British Psychological Society for integrated community stroke services.

6. It was suggested that clearer diagrams that depict how different governance groups relate to each other within the context of this proposal would be helpful.

We hope that the additional feedback regarding the future configuration of Intermediate Care and Stroke Rehabilitation community beds, the location of the freestanding Maternity Led Birthing Unit and the transfer of residual Ambulatory Services from the St Peter's Hospital site, will prove helpful in moving these services forward.

However, should you need any further information or independent clinical advice on the transformation of any other services, please don't hesitate to contact us.

Yours sincerely,

Dr Hazel Stuart
On behalf of Bernard Brett
East of England Clinical Senate Chair

Regional Chief Midwife

A meeting was held on 29th November 2023 with Wendy Matthews OBE, the Regional Chief Midwife, Georgina Stickings, Head of Midwifery and Gynaecology, Dr Pete Scolding, chair of the CCTF clinical sub-group and Ruth Harrison, Moorhouse to discuss the PCBC.

Outcome as emailed by Wendy Matthews:

In principle I am in agreement with the option 2b with the following caveats:

1. The proposed facility that will undertake a range of services (the local Library) can be made fit for purpose as a clinical area including IPC measures.
2. The facility is of sufficient capacity to undertake all the services that are required for maternity services e.g., antenatal clinics, parent session, scanning, phlebotomy.
3. There is adequate parking at the facility for mothers.
4. There is a good working lift.
5. That Georgina and Debbie are happy with the facility.
6. That WJC is kept open at all times except in exceptional circumstances and closure can only be agreed by the Director of Midwifery or executive Team.

I also strongly encouraged you to be more inclusive with a selected service user and also that their voice should be on the decision-making group and not just a separate group. It is so important that the user voice is represented at the highest level.

Appendix 15

References

Appendix 15 - List of References

Reference	Web source	Section in PCBC
National Clinical Guideline for Stroke for the United Kingdom and Ireland (2023)	National Clinical Guideline for Stroke (strokeguideline.org)	3.2.3
Discharge to Assess guidance	Quick Guide: Discharge to Assess (www.nhs.uk)	3.3.2
National stroke service model	NHS England » National Stroke Service Model: Integrated Stroke Delivery Networks	3.4.4
Better Births: Improving Outcomes for Maternity Services in England – A Five Year Forward View for Maternity Care	NHS England » Better Births: Improving outcomes of maternity services in England – A Five Year Forward View for maternity care	5.6
Three Year Delivery Plan for Maternity and Neonatal Services	B1915-three-year-delivery-plan-for-maternity-and-neonatal-services-march-2023.pdf (england.nhs.uk)	5.6
The National Service Framework for Older People, Ageing and Age-associated Disease and Disability (2001)	National service framework: older people - GOV.UK (www.gov.uk)	6.8.1
Improving Access to intermediate care' - David Oliver (2017)	David Oliver: Improving access to intermediate care (bmj.com)	6.8.1
The effects of locally based community hospital care on independence in older people undergoing rehabilitation: randomised controlled trial' Green J et al (2005)	Effects of locality based community hospital care on independence in older people needing rehabilitation: randomised controlled trial - PMC (nih.gov)	6.8.1