Thurrock - An ambitious and collaborative community which is proud of its heritage and excited by its diverse opportunities and future

Health and Wellbeing Overview and Scrutiny Committee

The meeting will be held at **7.00 pm** on **3 September 2020**

Due to government guidance on social-distancing and COVID-19 virus the Health and Wellbeing Overview and Scrutiny Committee on 3 September 2020 will be held virtually online. The press and public will be able to watch the meeting live online at the following link: https://www.youtube.com/user/thurrockcouncil

Venue: You can watch this meeting at YouTube: Thurrock Council, either live whilst in progress or later as a recording.

Membership:

Councillors Shane Ralph (Chair), Victoria Holloway, Fraser Massey, Sara Muldowney, Joycelyn Redsell and Elizabeth Rigby

Kim James (Healthwatch Thurrock Representative)

Substitutes:

Councillors Alex Anderson, Tom Kelly, Cathy Kent, Sue Sammons and Sue Shinnick

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Agenda

Open to Public and Press

Page

1. Apologies for Absence

2. Minutes **5 - 16**

To approve as a correct record the minutes of the Health and Wellbeing Overview and Scrutiny Committee meeting held on 18 June 2020.

3. Urgent Items

To receive additional items that the Chair is of the opinion should be considered as a matter of urgency, in accordance with Section 100B (4) (b) of the Local Government Act 1972.

4.	**Declarations of Interests**	
5.	**HealthWatch**	
6.	**2019/20 Annual Complaints and Representations Report - Adult Social Care**	**17 - 32**
7.	**Temporary reconfiguration of NHS Community Beds across Mid and South Essex including Mayfield Ward from Thurrock Hospital to Brentwood Hospital**	**33 - 82**
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9.	**Procurement to provide Autism Specialist Support - Medina Road**	**91 - 98**
10.	**Memorandum of Understanding across Mid and South Essex STP and update on CCG Merger and Single CCG Accountable Officer**	**99 - 142**
11.	**Work Programme**	**143 - 146**

Queries regarding this Agenda or notification of apologies:

Please contact Jenny Shade, Senior Democratic Services Officer by sending an email to Direct.Democracy@thurrock.gov.uk

Agenda published on: **25 August 2020**

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DECLARING INTERESTS FLOWCHART – QUESTIONS TO ASK YOURSELF

Breaching those parts identified as a pecuniary interest is potentially a criminal offence

Helpful Reminders for Members

- *Is your register of interests up to date?*
- *In particular have you declared to the Monitoring Officer all disclosable pecuniary interests?*
- *Have you checked the register to ensure that they have been recorded correctly?*

When should you declare an interest *at a meeting?*

- **What matters are being discussed at the meeting?** (including Council, Cabinet, Committees, Subs, Joint Committees and Joint Subs); or
- If you are a Cabinet Member making decisions other than in Cabinet **what matter is before you for single member decision?**

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Does the business to be transacted at the meeting

- **relate to; or**
- **likely to affect**

any of your registered interests and in particular any of your Disclosable Pecuniary Interests?

Disclosable Pecuniary Interests shall include your interests or those of:

- your spouse or civil partner's
- a person you are living with as husband/ wife
- a person you are living with as if you were civil partners

where you are aware that this other person has the interest.

A detailed description of a disclosable pecuniary interest is included in the Members Code of Conduct at Chapter 7 of the Constitution. **Please seek advice from the Monitoring Officer about disclosable pecuniary interests.**

What is a Non-Pecuniary interest? – this is an interest which is not pecuniary (as defined) but is nonetheless so significant that a member of the public with knowledge of the relevant facts, would reasonably regard to be so significant that it would materially impact upon your judgement of the public interest.

Pecuniary

If the interest is not already in the register you must (unless the interest has been agreed by the Monitoring Officer to be sensitive) disclose the existence and nature of the interest to the meeting

If the Interest is not entered in the register and is not the subject of a pending notification you must within 28 days notify the Monitoring Officer of the interest for inclusion in the register

Unless you have received dispensation upon previous application from the Monitoring Officer, you must:

- **Not participate or participate further in any discussion of the matter at a meeting;**
- **Not participate in any vote or further vote taken at the meeting; and**
- **leave the room while the item is being considered/voted upon**

If you are a Cabinet Member you may make arrangements for the matter to be dealt with by a third person but take no further steps

Non- pecuniary

Declare the nature and extent of your interest including enough detail to allow a member of the public to understand its nature

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You may participate and vote in the usual way but you should seek advice on Predetermination and Bias from the Monitoring Officer.

Our Vision and Priorities for Thurrock

An ambitious and collaborative community which is proud of its heritage and excited by its diverse opportunities and future.

1. **People** – a borough where people of all ages are proud to work and play, live and stay

    - High quality, consistent and accessible public services which are right first time
    - Build on our partnerships with statutory, community, voluntary and faith groups to work together to improve health and wellbeing
    - Communities are empowered to make choices and be safer and stronger together

2. **Place** – a heritage-rich borough which is ambitious for its future

    - Roads, houses and public spaces that connect people and places
    - Clean environments that everyone has reason to take pride in
    - Fewer public buildings with better services

3. **Prosperity** – a borough which enables everyone to achieve their aspirations

    - Attractive opportunities for businesses and investors to enhance the local economy
    - Vocational and academic education, skills and job opportunities for all
    - Commercial, entrepreneurial and connected public services

Minutes of the Meeting of the Health and Wellbeing Overview and Scrutiny Committee held on 18 June 2020 at 7.00 pm

Present:	Councillors Victoria Holloway (Chair), Shane Ralph (Vice-Chair), Fraser Massey, Sara Muldowney and Elizabeth Rigby Kim James, Healthwatch Thurrock Representative
Apologies:	Councillor Joycelyn Redsell
In attendance:	Roger Harris, Corporate Director of Adults, Housing and Health Ian Wake, Director of Public Health Tom Abell, Deputy Chief Executive Mid and South Essex NHS Foundation Trust Les Billingham, Interim Director of Adult Social Care and Community Development Andy Brogan, Andy Brogan, Executive Chief Operating Officer, Deputy CEO EPUT Lynnbritt Gale, Associate Director, Community mental health services Mid and South STP Anthony McKeever, Interim Joint AO for Mid & South Essex CCGs Mark Tebbs, Deputy Accountable Officer: Thurrock NHS Clinical Commissioning Group Jenny Shade, Senior Democratic Services Officer

Before the start of the Meeting, all present were advised that the meeting may be filmed and was being recorded, with the audio recording to be made available on the Council's website.

The Chair welcomed Members back to the Health and Wellbeing Overview Scrutiny Committee and stated that although there had not been an Annual General Meeting with Members having the opportunity to move around committees the Chair was personally honoured to be able to continue to chair this committee. The Chair continued to state that the committee was a very important part of health and social care in Thurrock and was happy to have the members who she believed contributed to this strong and productive committee.

The Chair made the following tribute to Ian Evans, the Health and Wellbeing Overview and Scrutiny Committee co-opted member, who sadly died on the 1 June 2020.

"Before starting the meeting people will notice that sadly we are missing an extremely valuable member of the committee. Sadly Ian Evans was recently diagnosed with an aggressive bladder cancer and sadly passed away surrounded by his family on 1 June 2020.

As Chair of this Committee over the years, Ian has attended and been a passionate advocate for so many issues. I knew he was extremely well respected at work, at the council, by everyone he met really however I didn't know about him outside of this. I asked Neil Woodbridge to let me know a bit more about him and he sent such a lovely response I wanted to share it just in case, like me, you didn't know Ian very well.

Ian worked for Thurrock Coalition for the past ten years, a User-Led organisation, and was an extremely passionate advocate for the disabled residents of Thurrock; he worked closely with many local, regional and national organisations.
He delivered training, consultations and events to promote equality, human rights and the Social Model of Disability – raising awareness of people's rights, responsibilities, duties and entitlements and to remove physical, environmental and attitudinal barriers that disable people face, empowering others to have choice and control in their lives and the community.

As an independent member of Thurrock's Health and Wellbeing, Overview and Scrutiny Committee, he looked at all the decisions of the Council that related to his areas of expertise and passed comment or suggested amendments.

He occasionally ran local campaigns for issues dear to his heart – for example he organised the community response to Network rails proposal to close the crossing at Grays. Now still open!

Indeed, from leaving Essex University Ian began his legal career at the United Nations in the Hague, followed by a period working for Refugee Migrants Justice in Bedford, representing refugees with asylum applications and appeals, before joining Thurrock Coalition where he built an unrivalled reputation through hard work and diligence, and was admired and respected by many local professionals and residents alike.

Ian was loved by many and made a memorable impact on everyone he met. He was softly spoken with a dry sense of humour, but nothing was ever too much trouble, he was generous with his time and would assist anyone if he possibly could.
He proudly promoted equality and independence and worked hard to ensure the local community had a voice; he was a very proud and dignified man, who hated asking for help as he valued his own independence and having control in his own life too.

Ian showed empathy and compassion to everyone. He loved his music, especially jazz music and often went to concerts and the occasional festival; his passion was to play the drums having obtained his first set as a young boy (not good when owning a VW Scirocco as it's a struggle to get a full drum kit inside). He was an enthusiastic member of a local band and would look forward to their practice sessions and jamming with friends.

Although Ian will be sorely missed by his family, friends, work colleagues and many Thurrock residents, his legacy to us all will be the confidence and belief he instilled in the local community - that everyone is equal and valued and their voice should be heard and respected when shaping the Thurrock Community for the future.

He bore the diagnosis with dignity and courage, as was the nature of this remarkable young man, and he will be sorely missed by all who knew him.
The family have chosen a local charity called 'Temple Springs' - Based in the old post-office in Grays. They teach young people how to play music. Amazingly, they set a crowdfunded target of £500 and as of this morning it had achieved £8,700!

A family funeral will take place soon, but a memorial event is planned once lockdown is eased to celebrate Ian's life and achievements and to allow everyone to pay their respects and remember him in their own way with fondness. Details of the event will be shared in the local media in due course.

Our thoughts are with Ian's family."

51. Minutes

Minutes of the Health and Wellbeing Overview and Scrutiny Committee held on the 5 March 2020 were approved as a correct record.

52. Urgent Items

The Chair agreed to receive an urgent item of business in regards to the Cabinet announcement made on the 17 June 2020 that there would be a £1.5 million reserve for social care. The Chair stated this was the first time that she had heard this mentioned and asked for an update.

Councillor Halden stated an announcement had been made by Cabinet on the 17 June 2020 for an extra £1.5 million into a reserve for social care. This reserve would be designated for exceptional use and needs of social care services. Councillor Halden stated an important message for anyone who are concerned for themselves or concerned about others they should come to the Council for help. In the current situation, the Council social care services were fully operational and still functioning. That additional work was being carried out to ensure the safety of residents in this time and services would be maintained.

The Chair stated that in the last 20 plus years there had been a hugely underfunded social care service and it was known that there was going to a greater demand on services. The Chair questioned how this money could be fed into that and questioned how the Council would deal with the competition of Thurrock's neighbouring boroughs who were paying more to their care workers. Councillor Halden stated that the money put into the reserve was a one hit pot for those services identified by Officers for social care needs of Thurrock residents. Councillor Halden agreed that there needed to be important conservations on the funding of long term social care and gave assurances and commitments to Members that nothing would be proposed until reports had gone through scrutiny. Councillor Halden then extended an invite to the Chair to attend the economic vulnerability task force that had been set up to which the Chair accepted.

53. Declarations of Interests

No interests were declared.

54. Healthwatch

Healthwatch had no matters to raise.

The Chair welcomed Anthony McKeever, the interim Accountable Officer for Mid and South Essex to the meeting and thanked him for his time this evening and asked that he introduced himself and provide members with an update on the work undertaken since he started his role and on the merger of the five Mid and South Essex Clinical Commissioning Groups into one regional Clinical Commissioning Group.

Anthony McKeever stated that he was the interim accountable officer for the five Clinical Commissioning Groups which included Thurrock and was leading the work on the integrated care partnership across the Mid and South Essex and started in this post in March 2020. His first five days was meeting 500 new colleagues and had the opportunity to have a handover with Mandy Ansell and other colleagues. The next five days he was redeploying those 500 so that they could work remotely and then spent time in an incident room under national arrangements to manage the emergencies, linking with officers through the Essex Reliance Forum and working in partnership when dealing with problems such as those with COVID-19.

Councillor Muldowney asked for an update on the mismanagement of funds taken from Thurrock's Clinical Commissioning Group to bail out Peterborough and Cambridge Clinical Commissioning Groups. Councillor Muldowney questioned referred to the services required by Thurrock residents that had been delayed because of this and asked for assurances that the money would now be repaid and this would not happen again. Anthony McKeever agreed to provide a specific update in writing to Members and agreed to pursue the handling of the repayment/debt.

The Chair stated that Thurrock's Clinical Commissioning Group had managed their budgets well and had not overspent which the Thurrock Clinical Commissioning Group and Members had been very proud of. In this case Thurrock Clinical Commissioning Group had supported another Clinical Commissioning Group that had got into difficulties and questioned now that the merger had taken place would this be the case in the future. The Chair had concerns that although Thurrock would continue to manage their budgets, some other Clinical Commissioning Group may not and may continue to take resources away. Mark Tebbs, Director of Commissioning, NHS Thurrock Clinical Commissioning Group stated the Chair had expressed her concerns well and stated that all overpayment and business as usual work had stopped so that the NHS could give all their attention to the COVID-19 crisis. Mark Tebbs addressed members concerns that some services would be delayed in particular the Mental Health Crisis Services. Mark Tebbs confirmed that this

service had now gone live during the COVID-19 crisis and there was now a 365 24/7 day mental health service available through 111.

Before moving onto the next item on the agenda, the Chair thanked everyone on the virtual meeting this evening, the NHS, healthcare workers, social care staff, officers and volunteers. The Chair stated that everyone had worked around the clock, day in and day out, working long hours over the last few months had meant that probably not much sleep had been taken. The Chair expressed her thanks and how grateful she was, as was everyone that had worked so hard to keep Thurrock's residents safe and well during this pandemic.

55. Health and Adult Social Care System COVID-19 Response

Ian Wake, Director of Public Health, started this item by presented a PowerPoint to Members on the latest update on COVID-19 in Thurrock. This provided Members with details in regards to epidemic curve of laboratory confirmed number of cases and when these were reported and ICU Bed occupancy; data on the number of deaths; the impact of lockdown on health and wellbeing; the economics of lockdown; the current situations on positive test results and the R Value; exiting lockdown and future policy implications, Test and Trace and the next steps. This PowerPoint can be found from the following link:

https://democracy.thurrock.gov.uk/documents/b17838/COVID-19%20HOSC%20Presentation%2018th-Jun-2020%2019.00%20Health%20and%20Wellbeing%20Overview%20and%20Scrutiny%20Committe.pdf?T=9

Councillor Ralph questioned whether there was a link between the number of excess deaths compared to the number of general practitioner and hospital appointments that had been cancelled. Ian Wake stated he was unable to answer that question in great detail but there had been an unexplained level of non COVID deaths but this would be known more once analysis of the data had been carried out.

Councillor Ralph questioned whether there was the capability to lockdown one particular area. Ian Wake stated he did not have the answer but potentially there could be powers attributed to local authorities to implement local lockdowns/settings but there was no clarity with Government working on decision frameworks at this time with clarity being available shortly. Ian Wake stated that local lockdowns would be difficult to manage for example identifying where a resident worked on the border and monitoring the transport and infrastructure going through that area.

Councillor Muldowney asked for more detail as to why the excess death rate was around +30-40% above what would be expected from the five year average. Ian Wake said he did not have the answer to that question but more readable data was being issued from the Office of National Statistics. The reasons were unclear but could be down to greater prevalence within the

community, underlining health problems, transmission of settings, ethnicity or deprived areas. That a huge amount of work on the data was required to get those answers.

The Chair questioned what would the practicalities be if a school had an outbreak and staff and pupils were told to isolate for example due to the numbers of teachers sharing a staff room. Ian Wake stated that school's protocol would play an important factor and advice would be set out with details of social distancing within settings such as staff rooms. Schools were currently operating in bubbles, with one bubble having 15 children and one teacher and would remain in their own social bubble. If there was to an outbreak that bubble would isolate on its own.

The Chair questioned how effective Test and Trace was when the news was reporting that a quarter of those identified from the 45,000 people told to self-isolate as a result of track and trace but could not be reached. Ian Wake stated this was one tool with a range of things to do to try and slow the spread.

Councillor Massey stated that Ordnance Survey geographical map of COVID-19 death showed a drop in Thurrock compared to the number of deaths in London and questioned whether this could be due to less density and more green space. Ian Wake stated that he would have expected a higher death rate in London due to the population and density but stated until this crisis was over this may change and was still an ongoing risk for Thurrock and caution must be adhered to at this point.

Councillor Ralph referred to the technical problems the Track and Trace App had experienced and questioned why an App that was already available was not used. Ian Wake stated that information had not been shared with Directors of Public Health.

Roger Harris stated the report covered how the local systems had work with the whole of the Mid and South Essex system responding well and how locally Thurrock should be proud with those responses. Under the Thurrock Integrated Care Partnership umbrella the work carried out was the partnership around organisations, the swift response, over £1 million had gone to the residential care home providers, the care homes protocol had been put in place quickly and the step-down facilities put in place. Roger Harris paid tribute to all Thurrock's partners as the system response had been very strong and also the partnership with the Mid and South Essex had been very good and highlighted that the swift response had saved lives in Thurrock.

Members were referred to the Annexes of the Agenda that provided individual summaries of the key elements from partners and trusts across the Health and Social Care System. The Chair thanked all partners for their contribution and update.

Councillor Muldowney stated how proud she was of residents and volunteers of Thurrock who stepped up to help with providing Personal Protective

Equipment to those that needed it. Councillor Muldowney referred to reports of lack of Personal Protective Equipment and asked for assurances that should there be a second wave there was confidence that this would not be an issue going forward.

The Chair referred to a Panorama Programme entitled “Has the Government failed the NHS” which had named Thurrock’s local trust and had reference to lists of items that had been delivered to a number of hospitals and questioned the reasons for there to be a lack of Personal Protective Equipment, what was being carried out to fix it and how sure staff could be assured that there was sufficient Personal Protective Equipment now. Tom Abell thanked all those that had contributed and stated that the Government took control of all supplies of Personal Protective Equipment and organised the distribution which was based on the calculation of need. That this was not an order system, the hospital received a certain amount of products but in some cases there was not sufficient of some items. Tom Abell stated the hospital had been supported by local communities, the hospital had looked at different alternatives such as a suitable substitute for a gown. The hospital also worked with local businesses who had stock available and donations. That there had not been any shortage of Personal Protective Equipment at Basildon but very tight on some days. There was confidence that stock levels were now way in excess and would be best placed if a second wave happened.

The Chair questioned whether this was the same process for care homes. Roger Harris stated they had different arrangements with each provider had their own source of suppliers, MHCLG deliveries and from system and mutual aid which had been organised locally. Roger Harris stated that although it had got very tight no supplies had ran out and supplies were now more regular and more reliable. Roger Harris also stated that the guidelines had changed and had got tighter over the last couple of months as more was known about the pandemic.

Councillor Muldowney asked for reassurance that following the COVID-19 crisis the Mayfield Ward would return from Brentwood hospital into its normal unit in Thurrock hospital and questioned whether the specialist equipment would also be placed. The Chair agreed with Councillor Muldowney’s question and if time had allowed this item would have been brought to the committee for scrutiny. Anthony McKeever stated that all the moves that took place during the COVID-19 crisis were essential and temporary and it would be the intention for services to be re-established back to local level. The Chair thanked Anthony McKeever for his comments and stated that it was important that Thurrock services stayed in Thurrock.

Tania Sitch stated that equipment that was old and no longer required had been disposed of, with other equipment being stored and new equipment purchased. That the move from Thurrock to Brentwood hospital had been a challenge undertaken within a quick timeframe and Brentwood had received compliments on how exceptional the service had been.

At 9.15pm the Chair called Standing Orders.

Councillor Ralph thanked Kristina Jackson and her team for the all hard work undertaken within the community undertaken during the COVID-19 crisis. Councillor Ralph also thanked those involved with the work undertaken within care homes in the borough they had done an amazing job. Councillor Ralph asked for clarification on the number of deaths in care homes during this time compared to other years. Les Billingham stated there had sadly been 35 deaths of people who had been in care homes of which six had died in the care home with the others unfortunately had passed away in hospital. The figure was being recorded this way to help identify whether a second outbreak would occur that could potentially run through care homes. Les Billingham stated that this was how the figures were being recorded across the country. Ian Wake stated there had been an increase of non-COVID-19 deaths in care homes over this period when compared over a five year average. Ian Wake agreed to take the action point away for clarify.

Councillor Ralph stated in regard to mental health what more could have been done in the community as there was now a backlog seeking help and questioned whether lack of early intervention had impacted more cases into hospitals. Andy Brogan stated that there had been a lack of demand but that further down the line this may have an impact on services and had concerns that people were not accessing these services. Mark Tebbs stated that monitoring had identified a drop in IAP services but services such as 1-2-1 or group therapy were up and running and capable but the demand had not been there. That demand had started to pick up again and it was noted that referrals for key workers were now being received and although temporary the aim would be for the services to be accessed as at previous levels.

Councillor Ralph raised his concern that once the restrictions of COVID-19 had lifted the services may not be able to cope with the demand of mental health referrals. The Chair stated that the mental health of residents and NHS staff would need massive support as did domestic violence and sexual abuse victims and questioned the Portfolio Holder for Health how he had intervened to ensure that these services would now have the resources to manage when we come out of lockdown. Councillor Mayes stated that mental health and the fewer number of referrals had been a concern, he reported that a Deep Dive Report on focusing on status of mental health would be undertaken with a recommendation to set up a working partner taskforce to focus on mental health in its own right. Working with partners and the workforce to look at how the service was working and what support could be provided. Councillor Mayes stated that this report would be presented at the Health and Wellbeing Board in July 2020 and to also look at the financial implications when the restrictions of lockdown had been lifted to monitor the referrals and need if there were to be another spike.

The Chair stated that funding was essential for domestic violence and sexual abuse and asked for reassurance from the Portfolio Holder for Heath that services would have financial support going forward. Councillor Mayes agreed and confirmed that resources and funding would be available. Andy Brogan stated the focus on mental health had raised the profile but the major

challenge could be further down the line. That long term investment and a cost delivery plan with the Clinical Commissioning Group would be put in place. The Chair stated that it was vital that services locally received everything they needed. Mark Tebbs stated that a national bid was in process for domestic violence and sexual abuse and worked had been undertaken with SERICC to get that bid. That the outcome was not known at this time but would continue to chase. Mark Tebbs confirmed that transformation plans were up and running and back on track. The Chair stated that Members would be looking for that reassurance that those services were in place.

Councillor Ralph questioned whether there was funding available for male domestic abuse victims and was the closest shelter in East Ham. The Chair stated that services were available to support both female and male domestic abuse victims. Ian Wake agreed to take the action point away for further clarity.

The Chair questioned how much money had been received from the Government and how much of that money had gone into the social care. Roger Harris stated there had been two tranches of funding from the Government which had not been ring-fenced with the Thurrock allocation being £9 million which had to support businesses, support social adult care and a whole range of services. That £1.5 million had been paid as resilience payments to care homes. That all hospital discharges since the 19 March had been paid for by Health as part of the accelerated discharge programme and would continue at least to the end of July but the long term plan was still unknown. The Council had received significant financial support with around £9 million in cash.

The Chair questioned why the General Practitioner service would cease from Orsett and although the Chair was mindful the hospital would close it had to be right time to move services out at the right time. Tom Abell stated that a change of operations would be undertaken and further details would be known over the next couple of weeks. Mark Tebbs stated that this was a temporary trial to provide a general practitioner service essentially for the winter pressures. Monitoring the Minor Injuries Unit had shown numbers had decreased and a decision had been made to increase the general practitioner presence into the hubs. The hubs would provide weekend and out of hour primary care services.

RESOLVED

That the Health and Wellbeing Overview and Scrutiny Committee noted and commented on the contents of this report which sets out the response of the Health, VCS and Adult Social Care systems in relation to the challenges faced during the COVID-19 Pandemic.

56. Progress Update on Major Health and Adult Social Care Projects

Roger Harris, Corporate Director of Adults Housing and Health, referred Members to the agenda which detailed the current status of the four

Integrated Medical Centres and the work continuing on the 21st century residential care at Whiteacre/Dikes Wood.

Tom Abell, Mid and South Essex NHS Foundation Trust, stated that COVID-19 had significantly shifted the way services operated and could not go back to the way that it was. The COVID-19 pandemic had given them the opportunity to review the services and therefore service models were being prepared with more services being moved to Orsett. The Chair agreed that local services should be kept in Thurrock and that Thurrock residents would want to see this.

Tania Sitch, North East London NHS Foundation Trust (NELFT), and Les Billingham, Assistant Director Adult Social Care, updated Members on the key wider transformation projects as referred to in the agenda that supported the Council's place based support model, provided services within the community and had been tailored towards those needs.

The Chair thanked Officers for the update and requested that an update be provided at a future committee to identify what the Council would change and how it would adopt in doing so.

Councillor Ralph raised his concern on the proposed parking arrangements at the Corringham Integrated Medical Centre due to the close proximity of the school. Councillor Ralph questioned whether the Integrated Medical Centre would be fit for purpose based on the area and the services needed and also questioned why there was a rush to have this facility ready when there was no plans to close Orsett Hospital. Tania Sitch stated that each Integrated Medical Centre would have different services and these would be presented to Members. A Stakeholder Group would be set up to include residents, school, highways and transport to which Councillor Ralph would be more than welcome to attend or to meet Councillor Ralph separately to discuss his concerns. Tom Abell stated that services had come out of Basildon Hospital into Orsett over a number of years and confirmed that Orsett would not close until the four Integrated Medical Centres were open.

Councillor Muldowney highlighted that the Council's Consultation Portal would probably be the main channel of consultation to engage with residents going forward but had received feedback that the consultation portal was not easy to use. Les Billingham thanked Councillor Muldowney for the useful information and would direct to the appropriate team.

Councillor Ralph questioned whether the Orsett Hospital Task and Finish Group should be reinstated. The Chair reminded Members that the decision had been made to incorporate this item back into the scrutiny of the Health and Wellbeing Overview and Scrutiny Committee.

RESOLVED

That the Health and Wellbeing Overview and Scrutiny Committee considered and commented on the report.

57. Work Programme

Members discussed the work programme.

The Chair requested a report to be presented at the 3 September 2020 committee in regards to the Mayfield Ward moving from Thurrock Hospital to Brentwood.

The Chair requested a report to be presented at the 3 September 2020 committee in regards to the COVID-19 Response.

The meeting finished at 10.06 pm

Approved as a true and correct record

CHAIR

DATE

Any queries regarding these Minutes, please contact Democratic Services at Direct.Democracy@thurrock.gov.uk

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3 September 2020	ITEM: 6
Health and Wellbeing Overview and Scrutiny Committee	
2019/20 Annual Complaints and Representations Report – Adult Social Care	
Wards and communities affected: All	**Key Decision:** Non Key
Report of: Lee Henley, Strategic Lead, Information Management	
Accountable Assistant Director: Les Billingham, Assistant Director, Adult Social Care	
Accountable Director: Roger Harris, Corporate Director of Adults, Housing & Health	
This report is public	

Executive Summary

The annual report on the operation of the Adult Social Care complaints procedure covering the period 1 April 2019 – 31 March 2020 is attached as an appendix. It is a statutory requirement to produce an annual complaints report on Adult Social Care complaints.

The report sets out the number of representations received in the year, key issues arising from complaints and the learning activity for the department.

1. Recommendation(s)

1.1 That Health and Wellbeing Overview and Scrutiny Committee consider and note the report.

2. Introduction and Background

2.1 This is the annual report covering Adult Social Care complaints for the period 1 April 2019 – 31 March 2020.

3. Issues, Options and Analysis of Options

3.1 This is a monitoring report for noting, therefore there is no options analysis. The annual report is attached as an appendix and includes consideration of reasons for complaints, issues arising from complaints and service learning.

3.2 **Summary of representations received during 2019/20**

The following representations were received during 2019-2020:

- 106 Compliments
- 34 Initial Feedback
- 19 Complaints
- 8 MP enquiries
- 59 Member enquiries
- 4 Local Government Ombudsman enquiries

Further detail on the above is outlined within the appendix.

3.3 **Local Government Ombudsman**

There were 4 cases received from the Ombudsman's office for the reporting period. Further detail on these cases are outlined within the appendix.

3.4 **Learning from Complaints**

Complaints and feedback provide the service with an opportunity to identify things that can be improved; they provide a vital source of insight about people's experience of social care services.

Upheld complaints are routinely analysed to determine themes and trends and services are responsible for implementing learning swiftly. Further details are outlined in the appendix.

4. Reasons for Recommendation

4.1 It is a statutory requirement to produce an annual complaints report on Adult Social Care complaints. It is best practice for this to be considered by Overview and Scrutiny. This report is for monitoring and noting.

5. Consultation (including Overview and Scrutiny, if applicable)

5.1 This report has been agreed with the Adult Social Care Senior Management Team.

6. Impact on corporate policies, priorities, performance and community impact

6.1 All learning and key trends identified in the complaints and compliments reporting has a direct impact on the quality of service delivery and performance. The reporting ensures that valuable feedback received from service users and carers is captured effectively and regularly monitored with the primary focus on putting things right or highlighting and promoting where services are working well.

7. Implications

7.1 Financial

Implications verified by: Jonathan Wilson
Assistant Director Finance

There are no specific financial implications arising from the report.

7.2 Legal

Implications verified by: **Lindsey Marks**

Deputy Head of Legal Social Care and Education

There are no legal implications as the report is being compiled in accordance with complaint regulations.

7.3 Diversity and Equality

Implications verified by: **Natalie Smith**

Strategic Lead Community Development and Equalities

There are no specific diversity issues arising from this report.

7.4 **Other implications** (where significant) – i.e. Staff, Health, Sustainability, Crime and Disorder)

None

8. Background papers used in preparing the report (including their location on the Council's website or identification whether any are exempt or protected by copyright):

None

9. Appendices to the report

Appendix – Adult Social Care Complaints and Representations Annual Report 2019/20.

Report Author:

Lee Henley
Strategic Lead, Information Management, HR, OD & Transformation

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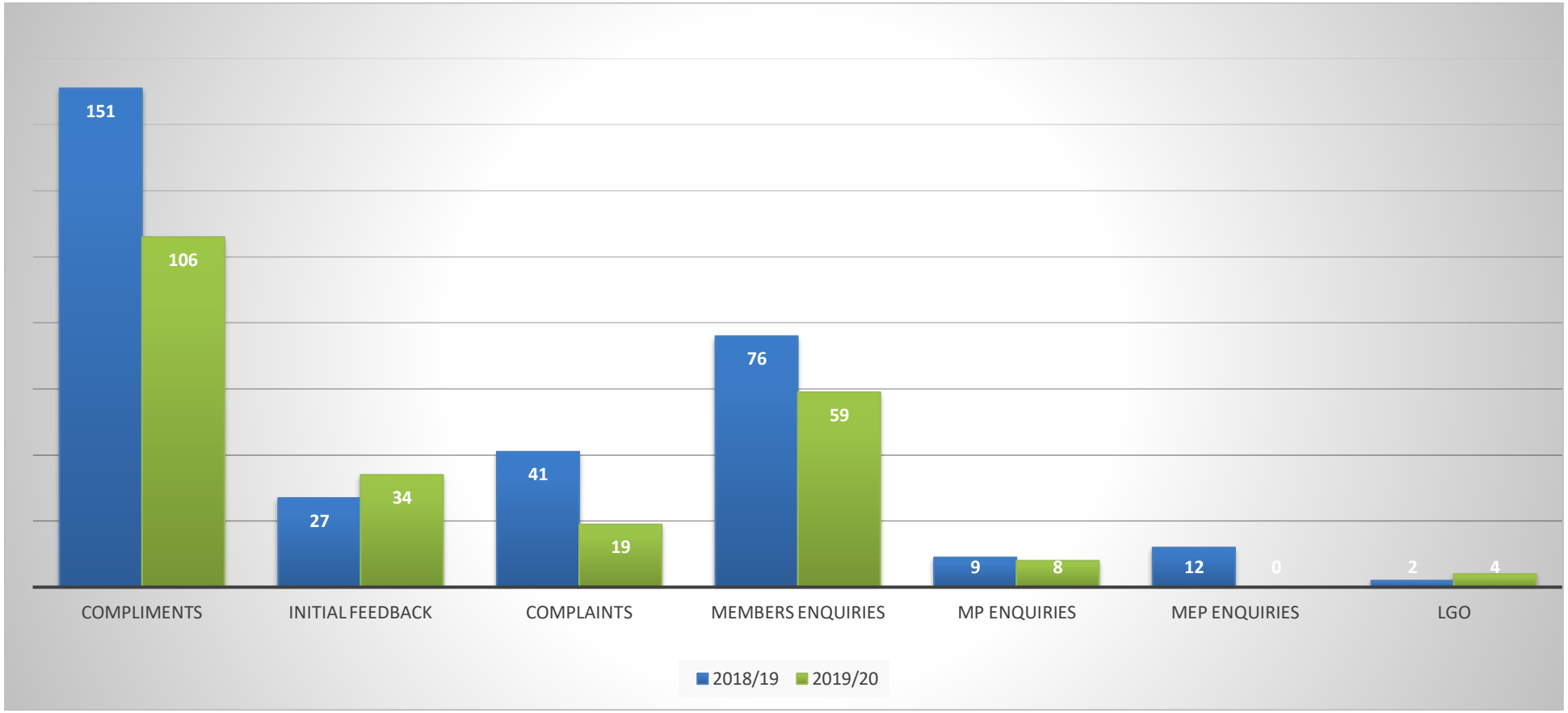
Appendix – 2019/20 - Adult Social Care Complaints & Representations Report

Volume of Representations 2019/20 vs 2018/19

Below is a comparison of representations received for both years. During 2019/20, **230** representations were received, compared with **318** for 2018/19.



Complaints – 2019/20 vs 2018/19

Below is the comparison between the two years broken down into more specific detail including those complaints involving both internal and external providers.

Feedback:	Initial Feedback	Low Intervention	Medium Intervention	High Intervention	No. withdrawn / Cancelled	Total to be investigated	Cases closed in period*	% of complaints upheld in period	% timeliness of response for those due in period*
2019/20	34	17	2	0	2	17	18	61%	79%
2018/19	27	37	3	1	2	39	38	56%	93%
Difference	+7	-20	-1	-1	0	-22	-20	+5%	-14%

* **For 2019/20, of the 18 closed complaints, 17 relate to the period 2019/20 and 1 relates to 2018/19 (but this was closed in 2019/20).**

* **2019/20 % timeliness is based on 19 complaints being due in the period (15 from 19 within timeframe).**

Root cause analysis and associated learning:

Complaints are analysed and the top themes are identified below. Learning from upheld complaints is recognised by the service as part of complaint resolution.

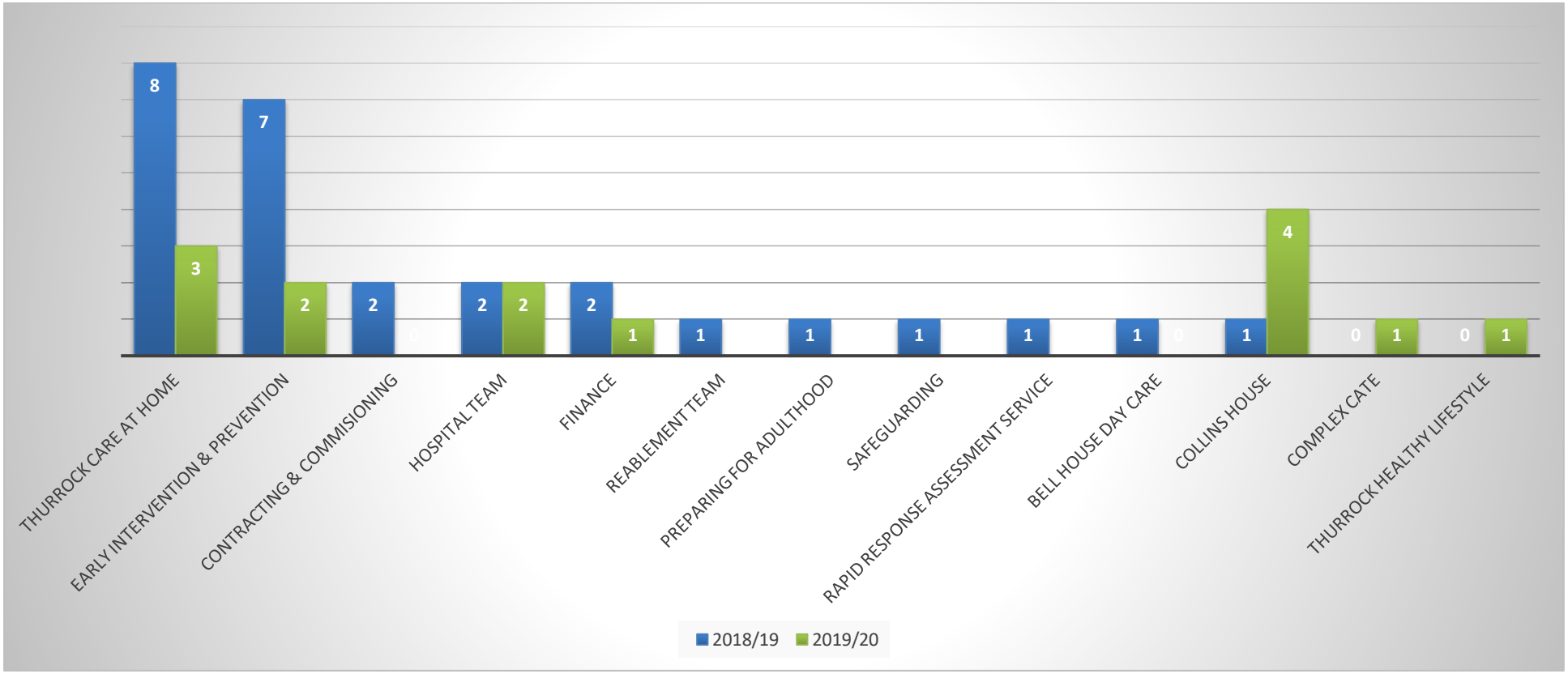
Root cause analysis and learning from upheld complaints:	Root Cause 1 and associated learning	Root Cause 2 and associated learning	Root Cause 3 and associated learning
2019/20	Quality of Care	Assessment	Communication
Learning	• Medication Audits changed from weekly to daily and Senior Carers will be undertaking further medication administration training • Staff member (carer) reminded of professional standards required during all visits • Staff reminded to provide additional support during meal times and ensure rooms are regularly cleaned • Staff reminded of the importance of the correct use of protected personal equipment • Staff reminded to dress service users appropriately • To ensure residents security by allowing them to lock doors	• Prior to the admission of a resident, ensure all information regarding potential safeguarding issues is gathered.	• Ensure documentation is fully recorded and the family are notified regarding changes in a resident's condition. • Ensure the family are always informed when an injury occurs to a resident. • Staff reminded to ensure questions from the family are directed to the duty manager to formally respond to. • Communication between staff for handovers to be improved and if delays occur these are communicated to all affected parties.

	• Ensure recording of information is accurate and ensuring medication is always provided		
2018/19	Missed Appointments	Quality of Care	Finance
Learning	• Providers to maintain consistency in carers call times • Staff reminded that all care calls must be provided and support plans followed at all times	• In-house system to be monitored to ensure quality & length of calls. • Additional training for carers provided • Staff to ensure that all available contacts for Clients are documented within ISP and are regularly checked and updated. • Medication policy updated	• Direct payments provider to review internal processes for payments • Funding decisions to make clear reasoning for outcomes (legal advice etc.)

Complaints regarding internal teams and staff:

14 of 18 complaints responded to within this period are for internal teams/services. This compares with **27** of **38** during 2018/19.

Note – From 1 April 2020, complaints data will also be captured and reported upon for the Essex Partnership University NHS Foundation Trust, for those areas where services are jointly managed with the council.



Commissioned Providers:

4 of 18 complaints responded to within this period are for commissioned providers. This compares with **11** of **38** during 2018/19.

Provider Name	Volume 2019/20	Volume 2018/19
Bennett Lodge	1	0
Hollywood Rest Home	1	0
Leatherland Lodge	1	0
Willow Lodge	1	0
Lodge Care Group	0	2
Guardian Homecare	0	1
Purple	0	6
Cedar House	0	1
Bluebell Court	0	1

Upheld Complaints:

- Percentages for upheld complaints for the services below appears high. This is due to the low volume of complaints that are in-scope of this report. Figures in brackets below represent the numbers of upheld complaints for those received and closed in period.

Complaint Area	Volume 2019/20	% Upheld	Volume 2018/19	% Upheld
Finance	1	100% (1)	2	50% (2)
Early Intervention & Prevention	2	0%	7	29% (2)
Thurrock Care at Home	3	100% (3)	8	100% (8)
Hospital Team	2	0%	2	0%
Collins House	4	100% (4)	1	100% (1)
Bennett Lodge	1	100% (1)	0	N/A
Hollywood Rest Home	1	0%	0	N/A
Leatherland Lodge	1	100% (1)	0	N/A
Willow Lodge Care Home	1	0%	0	N/A
Thurrock Healthy Lifestyle	1	0%	0	N/A
Complex Care	1	100% (1)		

Contracts & Commissioning	0	N/A	2	50% (1)
Safeguarding	0	N/A	1	100% (1)
Preparing for Adulthood	0	N/A	1	0%
Reablement Team	0	N/A	1	0%
Guardian Homecare	0	N/A	1	0%
Lodge Care Group	0	N/A	2	50% (1)
Bell House Day Care	0	N/A	1	100% (1)
Bluebell Court	0	N/A	1	0%
Cedar House	0	N/A	1	100% (1)
Rapid Response Assessment Service	0	N/A	1	100% (1)
Purple	0	N/A	6	67% (4)

Local Government Ombudsman (LGO) Complaints:

There were 4 LGO complaints/enquiries received during the reporting period. See below:

Area	Issue Nature	Ombudsman Findings	Financial Remedy

Finance	Regarding the council charging for 15 weeks of respite care which should only have lasted 6 weeks and delays in returning home.	No Maladministration	N/A
Finance	The council has not backdated all Disability Related Expenditure and not refunded money owed from 2013.	Maladministration Causing Injustice	N/A
Finance	The complainant disagrees that she should have to pay money to the council for her late mother's care costs.	Discontinue investigation	N/A
Finance	Resident complains the council reduced her direct payments without good reason.	Maladministration Causing Injustice	N/A

Alternative Dispute Resolution (ADR):

Complainants are seeking resolution and welcome the involvement of a neutral third person who will be able to assist both the complainant and the service in negotiating a settlement to their complaint. ADR is implemented as a mechanism to resolve complaints swiftly should the complainant request escalation. This involves assessment of the presenting issues by the Complaints Team**.** It can also include mediation with the complainant and the service area.

There have been no ADR cases in the reporting period.

Enquiries:

In the reporting period the following was received:

- 8 MP Enquiries
- 59 Member Enquiries

MP Enquiries	Total
Blue badges	1
Commissioning	1
Complex Care	1

Contract Compliance	1
Finance	1
Leatherland Lodge	1
Customer Finance	1
Thurrock First	1

Members Enquiries	**Total**
Thurrock First	18
Public Health	8
Safeguarding	7
Extra Care	5
Blue badges	4
Finance	3
Local Area Coordination	3
Thurrock Care at Home	2
Preparing for Adulthood	2
Early Intervention & Prevention (East)	1
Catering	1
Merrie Loots Farm	1
Older People Mental Health	1
Grays Court Care Home	1
Commissioning	1
Early Intervention & Prevention (West)	1

External Compliments:

A total of 106 compliments have been received during this period.

Note – These relate to compliments that have been sent to the Complaints Team to record on the complaints system.

Service Area	Number of Compliments
Joint Reablement Team	34
Thurrock Care at Home	10
Hospital Team	10
Collins House	8
Disabled Facilities Grant	8
Older People Mental Health	6
Extra Care	6
Rapid Response Assessment Service	5
Local Area Coordination	5
Early Intervention & Prevention (East)	4
Safeguarding	3
Blue badges	2
Careline	2
Day Care	1
Complex Care	1
Preparing for Adulthood	1

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3 September 2020	ITEM: 7
Health and Wellbeing Overview and Scrutiny Committee	
Temporary reconfiguration of NHS Community Beds across Mid and South Essex including Mayfield Ward from Thurrock Hospital to Brentwood Hospital	
Wards and communities affected: All	**Key Decision:** Non-key
Report of: Tania Sitch, Partnership Director, Adults Health and Social Care Thurrock (NELFT and Thurrock Council)	
Accountable Divisional Manager: Brid Johnson – Divisional Manager NELFT	
Accountable Director: Roger Harris, Corporate Director of Adults, Housing and Health	
This report is public	

Executive Summary

In response to the need to create additional Community Hospital Beds quickly to respond to the Covid Pandemic, Brentwood Community Hospital (BCH) was reconfigured and Mayfield Community Hospital Beds were moved temporarily to BCH in April 2020. The Mid and South Essex partners now need to agree a medium-term solution to manage the demand for community inpatient beds during surge over the winter period.

Following a review by all partners of 19 possible options for delivery of community beds over winter, four options are now being given full consideration, based on operational delivery, to manage the medium-term demand for community inpatient care from September 2020 to March 2021. Additional queries have been raised by a health planner brought in as part of the considerations that need to be addressed. The outcome of the four options being considered should be available to update verbally at the meeting on 3 September 2020, but was not available at the time of writing this report.

Creating a medium-term solution is to allow time for the system to reset following COVID-19 and system wide plans to be developed to understand the permanent capacity needed and full potential of the model post March 2021. A full business case for community beds for the MSE, considering the whole intermediate care pathway, will need to be produced by end January 2021 and there will be opportunities to comment and be engaged in that business case.

1. Recommendation(s)

1.1 For the Health and Wellbeing Overview and Scrutiny Committee to note and comment on the updated position of the Temporary reconfiguration of NHS Community Beds across Mid and South Essex including Mayfield Ward from Thurrock Hospital to Brentwood Hospital.

2. Introduction and Background

2.1 The provision of Community Beds moved from Thurrock Community Hospital to BCH in April 2020. This was at short notice and to respond to the need for additional beds to meet the demands of the pandemic. This was always intended as a temporary position. The MSE partners are now planning for winter and considering the best options to meet demands on Community Beds.

2.2 Modelling of the demand for Community Beds over the period identified has been carried out by Newton Europe, a piece of work commissioned by the MSE system. The modelling shows that to ensure we have enough capacity to meet demand we need 239 community beds:

Bed Type	Bed no's.	Additional Information
Acute (BTUH)	70	Beds that need to move out of BTUH to allow BTUH to become the critical care centre for the MSE over winter.
Stroke	26	Ideally would have one location for all stroke beds.
Step down/up	143	
Total	**239**	
Step down/up capacity at Brentwood	77	Bed capacity available is 147. 70 beds will need to be acute beds moving from BTUH.
Extra Step down/up needed addition to Brentwood	66	Gap between the Step down/up beds identified as being needed to cope with demand and the number of beds available at Brentwood.
Extra Step down/up needed including stroke	92	Beds needed in addition to Brentwood.

This modelling, and the information and options set out in this paper, considers the context we are currently working in – we are still in the middle of a global pandemic, operating under the COVID-19 context guidance. There is a significant amount of 'unknown' on whether there will be a second wave of COVID-19 and further lockdown, and the impact of the winter months and the usual problems they bring on the health and care system. As a system we must be prepared and do what we can to ensure we are in the best possible position to cope with surge if and when it happens.

2.3 The MSE system made the decision to consolidate the community wards in phase 1 of COVID-19 and the beds are currently in that consolidated position. The key reason for doing so was to focus available staffing resource onto two central sites for the 1.2million population of Mid and South Essex in order to support as many patients as practicable. It was recognised then and must be now, that staffing is the greatest risk there is to being able to cope with the anticipated demand and whatever sites are decided upon for the beds; we cannot open them if the staff are not in place. It's important to note that operating under the context of COVID-19 the service offer has changed and requires a higher acuity of care provision as patients are discharged when medically optimised (as opposed to medically fit); discharges occur 7 days a week often within hours of the decision to discharge being made and the ability to offer a step-up model to reduce acute admissions.

There was already a staff challenge prior to COVID-19 with vacancy rates. There is now the added risk of a second COVID-19 wave, additional sickness (potentially due to burnout where staff have been working tirelessly over the last few months dealing with phase 1 of the pandemic), BAME staff and other at-risk staff who we know are more at risk from COVID-19 and the associated mitigation and the impact of staff wanting to take annual leave that they haven't taken over the last few months.

There has been a significant benefit of the increased medical input in the community hospitals, particularly overnight and this has meant a reduction of 13% in the number of patients being readmitted to the acute hospital.

It is acknowledged that staff who worked at Mayfield when it was in Thurrock have all transferred to working from Brentwood. Their support has been greatly appreciated during this time. They have been supported with travel where required and this would continue if the decision is for Mayfield to remain at BCH for the winter period.

2.4 The four options that are being taken to full consideration are:

		Bed numbers	**No. of sites**
Option 2 Total - 239	Maximum beds at Brentwood	147	3
	In Mid Essex 49 Braintree beds move to a single facility that can also offer additional capacity for the rest of the beds needed. Location TBC. Howe Green site is an option that has been explored	70	
	Beds return to CICC	22	
Option 8	Maximum beds at Brentwood	147	4
	Keep one ward at Braintree (stroke)	26	

Total - 239	Move back to Halstead and maximise capacity to meet additional requirements needed	44	
	Beds return to CICC	22	
Option 18 Total – 239	Beds all return to previous locations pre COVID-19	139	6
	Additional capacity needed remains at Brentwood as wards already in place	100	

The fourth option is as option 18 but with no additional beds at Brentwood.

3. Issues, Options and Analysis of Options

3.1 This paper sets out the options that are being considered for this winter period. Two of the options will leave Mayfield at BCH for the winter period and two options will see Mayfield return to Thurrock Community Hospital site. The consideration for the options is taking into account the financial impact, staffing required and operational and clinical safety issues.

4. Reasons for Recommendation

4.1 To update the Committee on Phase 2 of the Community Beds and decisions regarding Mayfield Community Hospital location this winter.

5. Consultation (including Overview and Scrutiny, if applicable)

5.1 Partners in the MSE group are being consulted on the options for Phase 2 of this programme. More extensive consultation will take place in regard Phase 3 and the longer term provision of Intermediate Care and Community Hospital beds.

6. Impact on corporate policies, priorities, performance and community impact

6.1 The staff working at Mayfield are NHS staff and will be supported through NELFT processes and procedures.

6.2 Mayfield only provides short term care for patients and therefore there are no long term residents to be considered. In order to manage the demands and capacity of Community Beds, all patients across the Mid and South Essex Area are being cared for at the provision that has vacancies, and choice of where short term care is provided is not a requirement under new Discharge Requirements. Therefore all provision may have patients from across the Mid and South Essex Area and Thurrock patients may be placed in a facility in the MSE area. Patients, relatives and carers of Thurrock patients therefore may need to travel further to see their families.

7. Implications

7.1 Financial

Implications verified by: **Mike Jones**

Strategic Lead – Corporate Finance

Any decisions around future funding of these health beds is being made through the System Leaders Finance Group where Thurrock Council is represented at a senior level.

7.2 Legal

Implications verified by: **Lindsey Marks**

Deputy Head of Law

There are no legal implications for Thurrock Council as part of this decision.

7.3 Diversity and Equality

Implications verified by: **Natalie Smith**

Strategic Lead Community Development and Equalities

There could be temporary implications that affect some members of the community of Thurrock, in that they may need to travel to Brentwood to visit patients. This will be considered as part of the impact analysis of the options

7.4 **Other implications** (where significant) – i.e. Staff, Health, Sustainability, Crime and Disorder, or Impact on Looked After Children)

None

8. Background papers used in preparing the report (including their location on the Council's website or identification whether any are exempt or protected by copyright):

MSE Community Beds – Medium Term Options paper, attached as appendix.

9. Appendices to the report

Appendix 1 - MSE Community Beds – Medium Term Options paper.

Report Author:

Tania Sitch, Partnership Director Adults Health and Social Care, NELFT and Thurrock Council

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Appendix 1 - MSE Community Beds
Options paper for medium term

Contents

1 Executive Summary

This paper has been written to support the system in agreeing a medium-term solution to manage the demand for community inpatient beds during surge over the winter period. This paper summarises the progress to date on the creation of two temporary Community Inpatient facilities across Mid and South Essex (MSE) in response to the first phase of COVID-19 and proposes 5 options for full consideration, based on operational delivery, to manage the medium-term demand for community inpatient care from September 2020 to March 2021. The paper should aid discussion and support system leaders in deciding on which option should be implemented. It is important to note that over the last few weeks all system partners have agreed the Intermediate care beds are a standardised 'do once' offer across the system and that any decisions made should be taken with that in mind.

Creating a medium-term solution allows time for the system to reset following COVID-19 and system wide plans to be developed to understand the permanent capacity needed and full potential of the model post March 2021. A full business case for community beds for the MSE, considering the whole intermediate care pathway, will need to be produced by end January 2021.

Modelling of the demand for community beds over the period identified has been carried out by Newton Europe, a piece of work commissioned by the MSE system. The modelling shows that to ensure we have enough capacity to meet demand we need 239 community beds

Bed Type	**Bed no's.**	**Additional Information**
Acute (BTUH0	70	Beds that need to move out of BTUH to allow BTUH to become the critical care centre for the MSE over winter
Stroke	26	Ideally would have one location for all stroke beds
Step down/up	143	
Total	**239**	
Step down/up capacity at Brentwood	77	Bed capacity available is 147. 70 beds will need to be acute beds moving from BTUH
Extra Step down/up needed addition to Brentwood	66	Gap between the step down/up beds identified as being needed to cope with demand and the number of beds available at Brentwood
Extra Step down/up needed including stroke	92	Beds needed in addition to Brentwood

This modelling, and the information and options set out in this paper, considers the context we are currently working in- we are still in the middle of a global pandemic, operating under the COVID-19 context guidance. There is a significant amount of 'unknown' on whether there will be a second wave of COVID-19 and further lockdown and the impact of the winter months and the usual problems they bring on the health and care system. As a system we

must be prepared and do what we can to ensure we are in the best possible position to cope with surge if and when it happens.

The MSE system made the decision to consolidate the community wards in phase 1 of COVID-19 and the beds are currently in that consolidated position. The key reason for doing so was to focus available staffing resource onto two central sites for the 1.2million population of mid and south Essex in order to support as many patients as practicable. It was recognised then and must be now that staffing is the greatest risk there is to being able to cope with the anticipated demand and whatever sites are decided upon for the beds we cannot open them if the staff are not in place. It's important to note that operating under the context of COVID-19 the service offer has changed and requires a higher acuity of care provision as patients are discharged when medically optimised (as opposed to medically fit), discharges occur 7 days a week often within hours of the decision to discharge being made and the ability to offer a step-up model to reduce acute admissions.

There was already a staff challenge prior to COVID-19 with vacancy rates. There is now the added risk of a second COVID-19 wave, additional sickness (potentially due to burnout where staff have been working tirelessly over the last few months dealing with phase 1 of the pandemic), BAME staff and other at-risk staff who we know are more at risk from COVID-19 and the associated mitigation and the impact of staff wanting to take annual leave that they haven't taken over the last few months.

There has been a significant benefit of the increased medical input in the community hospitals, particularly overnight and this has meant a reduction of 13% in the number of patients being readmitted to the acute hospital.

There are a number of other key assumptions and factors that need to be considered (full list can be found in Section 4). These were all correct at the time of writing this paper -

1) Due to the merger of the 3 local acute trusts and the formation of the MSE acute group, and the acute hospitals response to COVID-19, we will see changes within pathways therefore there is a need to streamline as much as possible across community service provision to reduce the variability which results in confusion for acute staff.
2) Based on the requirement to recommence elective surgery and the limitations presented by managing hot/cold patients, Braintree Community Hospital is no longer a viable option.
3) As part of Phase II of the COVID-19 response, a clinical model and business case is being developed to relocate part of the Department of Medicine for Older People (DMOP) (currently two wards and an assessment area) currently sited on the Basildon and Thurrock Hospital site. Brentwood Community Hospital is the only facility that is capable of accommodating the re-provision of the DMOP services.
4) COVID-19+ positive patients are still unable to return to care homes without a negative swab prior to discharge, we currently don't have confirmation that this will change.
5) Wherever the beds are located, the same process must be followed for accessing the beds
    a. Must meet acute discharge criteria to discharge within 3 hours
    b. Use Discharge to Assess process
    c. Access is agreed via the bed bureau
    d. Meet access criteria for community beds- step up and step down
    e. Provide ability to admit and discharge 7 days a week, maximum hours per day

Based on the context we are currently operating in and staffing risks highlighted above, we believe that the safest way forward is to deliver services over the winter period on a minimum number of sites so that the scarce staffing resource can be consolidated and supported to deliver the level of care required and ensure an element of resilience in the service model. Options have been developed to take this into consideration. The more sites that are in place, the higher the risk that we will not be able to staff them and therefore the capacity will not be available to meet the demand.

2 Introduction

This paper summarises the progress to date on the creation of two temporary Community Inpatient facilities across Mid and South Essex (MSE) and proposes a number of options to manage the medium-term demand for community inpatient care from September 2020 to March 2021. The paper should aid discussion and support system leaders in deciding on which option should be implemented.

This discussion paper describes the current position, modelling on the anticipated number of beds needed for surge and goes on to describe a number of options for consideration in the medium-term phase and makes a recommendation. In preparing the plan it was evident that the financial costs will be different depending on the short-term vs long term use of facilities therefore we have discussed proposed costs under the different options shown in this paper.

Having a medium-term solution in place allows time for the system to reset following COVID-19 and system wide plans to be developed to understand the capacity needed and full potential of the model post March 2021. A full business case for community beds for the MSE, considering the whole intermediate care pathway, will need to be produced by end January 2021.

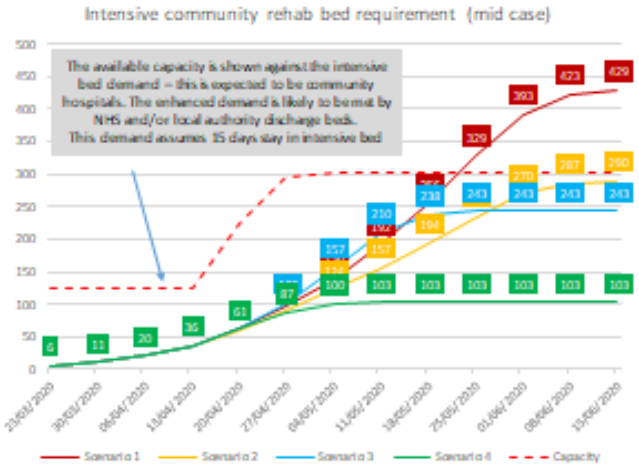
3 Background

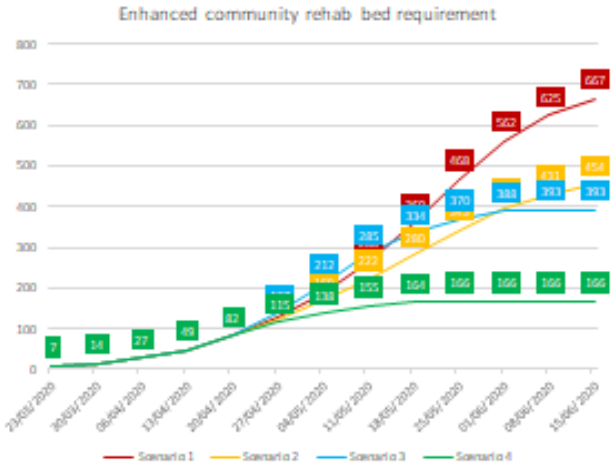
During the initial phases of COVID-19 it was necessary to rapidly complete an options appraisal and agree a plan to expand current community inpatient facilities following initial modelling predications on community care demands.

After a review of options, the decision was made by the Central Incident Team (CIMT) to create two central facilities to manage the anticipated demand for phase 1 of the COVID-19 outbreak. A key driver around the decision to create the two central facilities from six previous units was the availability of staffing resources and the ability to source additional equipment and consumables within reasonable timescales, as well as the need to continue to achieve compliance of the 2m bed space Health Technical Memoranda regulation when additional beds were added to facilities.

4. Demand and Supply in the four scenarios: Community Rehabilitation

The latest modelling from NHSE includes two types of step down bed for COVID patients – intensive (community hospitals) and enhanced (care homes, hotels etc.)
This discharge model has been applied to admissions expected in the 4 scenarios described.





Note: Stroke beds, Dementia beds and hospice beds are excluded from the available capacity

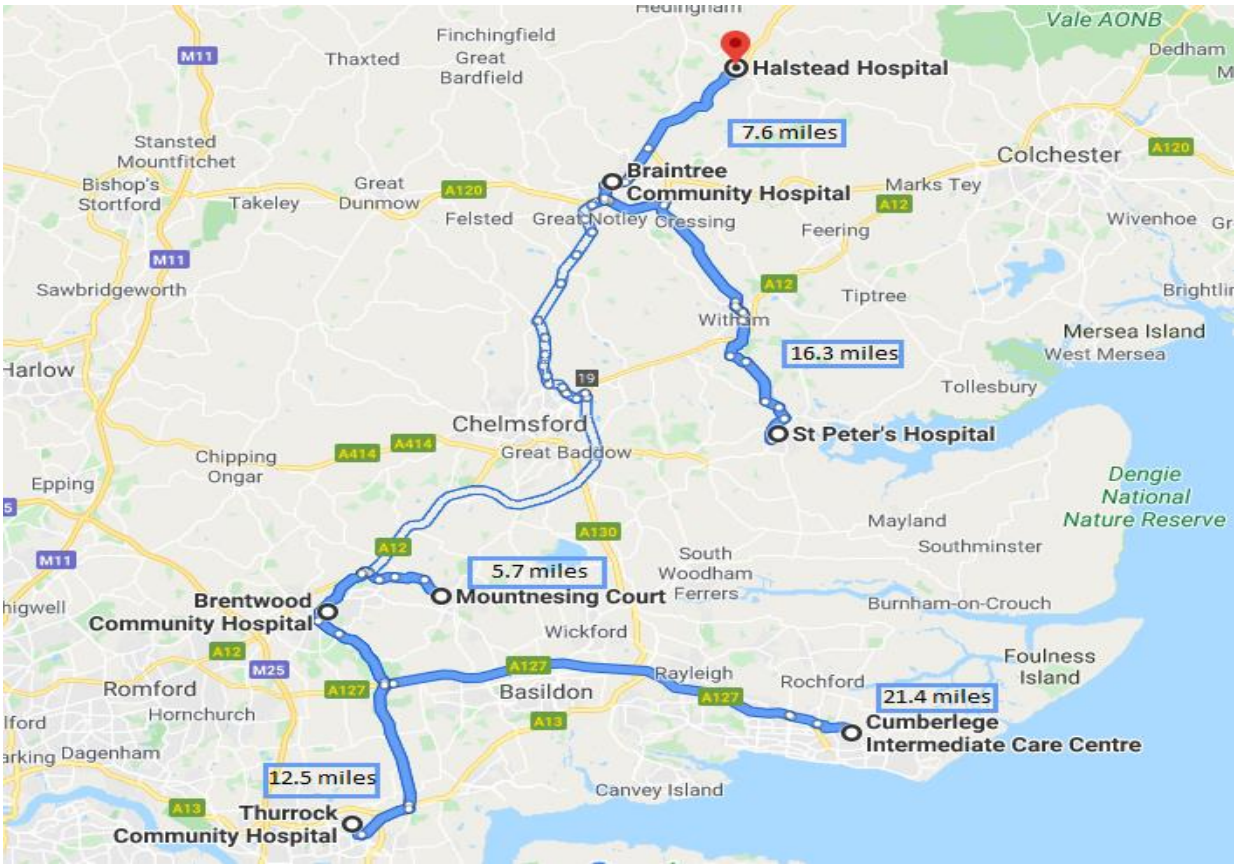
Ward areas	Location	2019 capacity	2019 stroke capacity	Change	New locations
Cumberlege (CICC)	Rochford	22	6*	Moved	Brentwood
Halsted	Halsted	20		Moved	Braintree stroke
Mayfield	Thurrock	24		Moved	Brentwood
Mountnessing Court	Billericay	22		Moved	Brentwood
St Peter	Maldon	26	10	Moved	Braintree
Thorndon	Brentwood	25	8	Remained	
Final bed numbers incl stroke		139			207
Final bed numbers		**115**			**181**

**not including the stroke rehabilitation in Southend Acute*

In June 2020 a paper was developed on the short-term plan for community inpatient beds and an agreement was reached to retain the inpatient community beds in Braintree and Brentwood until end September 2020. A short-term plan was needed to ensure staff, providers and other stakeholders had some clarity on the length of time the beds would remain in the two community facilities as a minimum whilst a medium-term plan was worked up. The current bed location/capacity is set out below:

Location:	Name of unit/service:	Number of current beds:
Brentwood Community Hospital	**Bayman Ward**	33
	Thorndon Ward	32
	Tower Ward	27
	Gibson Ward	32
	Courage Ward: phase 1	23
	Courage Ward: phase 2	11
	TOTAL BRENTWOOD	**158**
Braintree Community Hospital	**Courtauld**	26
	Crittall	23
	TOTAL BRAINTREE	**49**
	TOTAL COMMUNITY BEDS	**207**

Location of Sites



Sites	Travel time between hospitals
Brentwood Community Hospital – Thurrock Community Hospital (Mayfield)	30 minutes (12.5 miles)
Brentwood Community Hospital – CICC	38 minutes (21.4 miles)
Brentwood Community Hospital – Mountnessing Court	13 minutes (5.7 miles)
Braintree Community Hospital – St Peters Hospital	30 minutes (16.3 miles)
Braintree Community Hospital – Halstead Hospital	18 minutes (7.6 miles)

Due to the need to meet the continuing predicted demands for additional community beds there is urgency in agreeing the plans for capacity from September 2020- March 2021. As a system we need to recognise that reset and recovery work is ongoing. Having a medium term plan in place allows us to be prepared for surge whilst giving more time for reset and recovery to happen across the system and therefore consideration of additional changes that are needed in light of developments achieved during recent months. This will then inform future models of care across MSE which will impact the number and type of community beds needed. Although this work is happening at pace, the reality is that it will take a number of months to agree future models and these will be fed into the full business case.

There is an understanding that a full business case will need to be completed by the end of January 2021 to clarify the capacity needed and full potential of the intermediate care model post March 2021 across the MSE. This case will include:

- Strategic context: The compelling case for change including consultation and stakeholder engagement
- Economic analysis: Return on investment based on investment appraisal of long-term options
- Commercial approach: Derived from the sourcing strategy and procurement strategy
- Financial case: Affordability to the system in the time frame

4 Current position

National

The NHS and social care sectors are experiencing unprecedented pressure due to increasing demand from people living longer, often with complex needs or impairments and 1 or more long-term conditions. Admission to hospital and delays in hospital discharge can create significant anxiety, physical and psychological deterioration, and increased dependence. Multidisciplinary services that focus on rehabilitation and enablement can support people and their families to recover, regain independence, and return to or remain at home.

Intermediate care uses a range of service models to help people be as independent as possible. It can prevent hospital admissions, facilitate an earlier, smoother discharge, or be an alternative to residential care. It can also offer people living at home who experience difficulties with daily activities a means to maintain their independence.

The NICE Guidance NG74 Intermediate Care guideline focuses on the 4 service models included in the 'National Audit of Intermediate Care summary report 2014' (NHS Benchmarking Network):

- bed-based intermediate care- covered in this paper
- home-based intermediate care- being considered as part of the joint working between community providers, Primary Care Networks, Social Care and Voluntary sector
- crisis response- currently a separate work stream
- Reablement- currently being monitored/reviewed in all localities

These services are for adults aged 18 years or over and are delivered in a range of settings, such as community settings, residential and nursing care homes, dedicated intermediate care and rehabilitation facilities and are best planned and delivered alongside voluntary and independent sector providers. The guideline draws on the evidence base to highlight best practice, making recommendations that aim to provide equity of access and a more integrated approach to provision. It also aims to bring greater coherence, parity and responsiveness to service delivery, reducing duplication of effort and clarifying responsibilities for service providers. It is therefore essential that we underpin any service delivery model with this guidance and ensure that the interface between the 4 service models is clear and transparent in the model. In order to ensure there is a clear plan for all 4 service models the full business case will summarise the plan for all 4 models above alongside the interdependency with the bed bureau and the discharge teams.

National evidence shows that well-designed intermediate care can*:

- improve people's outcomes and levels of satisfaction
- reduce admissions to hospital and long term social care services
- reduce delayed discharges.

92% of people who used home-based or Reablement services maintained or improved their dependency score (a measure of the help they need with activities of daily living).

93% of people who used bed based services maintained or improved their dependency score.

70% of people who received intermediate care following a hospital stay, were able to return to their own home.

72% of people did not move to a more dependent care setting.

88% of people using health based intermediate care services meet their goals (wholly or partially).

90% of people said they were treated with dignity and respect. There is room for improvement about communicating with and involving people who use services and managing expectation about the short-term nature of the service.

*NHS Benchmarking (2015) National Audit of Intermediate Care Network Report

The NHS Long Term Plan will give patients greater control over the care they receive, with more care and support being offered in or close to people's homes, in summary aiming to:

- Promote a **multidisciplinary team approach** where doctors, nurses and other allied health professionals work together in an integrated way to provide tailored support that helps people live well and independently at home for longer
- **Give people more say about the care and support they receive**, particularly towards the end of their lives
- Offer **more support for people who look after family members, partners or friends** because of their illness, frailty or disability
- Develop more **rapid community response teams**, to support older people with health issues before they need hospital treatment and help those leaving hospital to return and recover at home
- Offer **more NHS support in care homes** including making sure there are strong links between care homes, local general practices and community services.

A full copy of the NHS Long Term Plan can be viewed via this link:
https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/

Local

Surge Planning

During the initial phase of COVID-19 following the completion of local modelling there was an immediate need to increase the bed based intermediate care capacity to manage the predicted patient needs and ensure the flow of patients from the acute services was managed effectively.

As we enter into phase 2-3 of COVID-19 and begin surge planning for the winter months the number of beds needed for intermediate care outside of hospital for those patients requiring an element of health input and rehabilitation (that can't be delivered at home) but that don't need acute care has had to be identified. Without this additional capacity the health and care system will not be able to cope with demand resulting in longer lengths of stay in acute hospitals and therefore the risk of developing a hospital acquired infection, becoming dependent on high levels of care. There is a lot of unknown in the system at the moment regarding COVID-19 and whether there will be a second wave and how tough winter will be on heath and care services. Acute hospital's restarting their elective programmes and the discharge criteria in place to discharge within 3 hours form the acute will also have an impact on the system. We need to ensure we are as prepared as possible.

In addition to health surge planning a number of areas of additional social care step-up/step-down capacity was secured during the last few months.

- **Thurrock:** secured Piggs Corner (10) this is now reduced to 5 if needed (others were handed back as not needed), Collins House (10) now scaled back to 7, Oak House (9). The LA have extended Oak House for a further 12 months. The maximum needed to date is 15.

  In addition Thurrock LA have been looking into securing CQC registration for use of Mayfield Unit as a care home if required, but it is unlikely it will be needed, and has

not been progressed to date. They also continue to monitor the care home and domiciliary care capacity to ensure community resilience can be strengthened.

- **South East Essex (CP&R, Southend):** secured Priory (13) for COVID-19+ patients. The LA have extended these beds for Winter 2020 and will require the continuation of the support currently received from the community nursing, Pall Mall and CCG continuing healthcare team.

  The LA are also currently building a new assessment facility on the Priory site which has been delayed (45). This unit will need the support of social care and therapy to ensure it can deliver high quality step-up/step-down social care including Reablement.

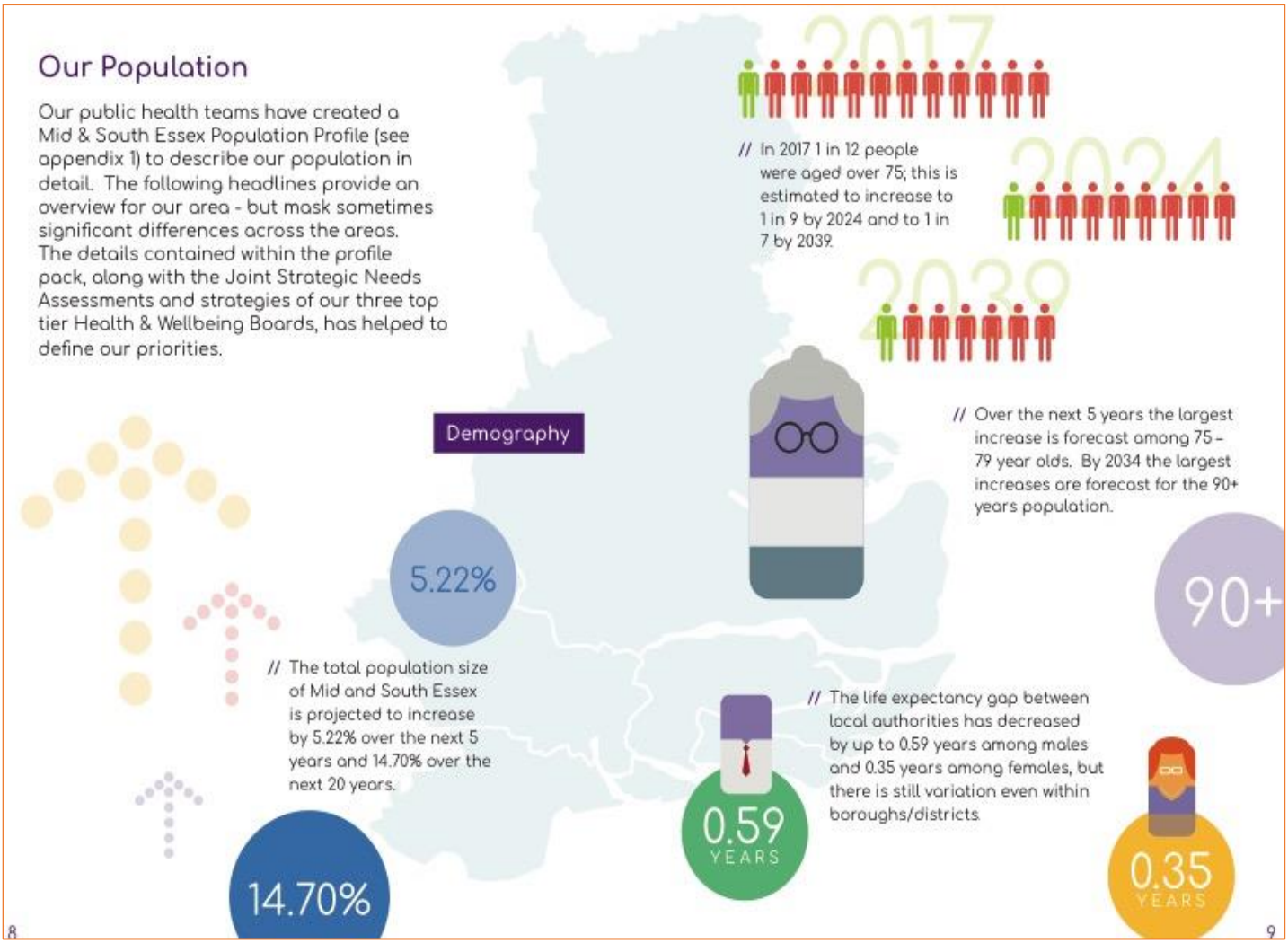
  The CCG and EPUT are currently reviewing the use of Rawreth and Clifton Dementia care home units.

- **Basildon/Brentwood and Mid Essex:** secured Howe Green (76) for COVID-19 patients. This has been decommissioned due to the low usage and the associated high costs. £250k was required to prepare this building prior to use.

  The LA now have an oversupply of residential home places, adequate supply of domiciliary care and have the ability to increase the Reablement capacity as needed. They are currently reviewing a care home in mid Essex with isolation units that is already staffed, further information will follow when more plans agreed.

Ageing Population/Frailty

Older People's Care is a key part of the NHS Five Year Forward View triple aim of better health, better care, and better value and is central to the ambitions of the MSE Health and Care Sustainability Transformation Plans and a vision to shift more care closer to home.



Our local health and social care system faces major challenges arising from reduced budgets, rising demand, increasing costs, greater transparency about the quality of care, and rising public expectations. Levels of hospital activity especially admissions continues to rise in addition to the new demands that COVID-19 has placed within the system including the COVID-19 aftercare requirements. Community health services, working together with other providers of physical and mental health care will need to support the increase in patients who have recovered from COVID-19 and who, having been discharged from hospital, need ongoing health support that rehabilitates them both physically and mentally. Meeting these challenges will be a joint endeavour, working seamlessly together including through, for example, multidisciplinary teams and/or neighbourhood team arrangements.

The full business case will address this growing demand and propose options for consideration in all 4 intermediate care service models listed above to meet demand.

Older People Service Re-provision

In Mid and South Essex, the overall aim is to be able to meet the needs of our local population requiring Older People Services. The MSE Acute Group are in the process of defining a recovery reconfiguration state that ensures short-medium term requirements are met including COVID-19 and additional critical care demands (70 beds), winter pressures and the planned care demands that need to be addressed. Key principles of the acute reset and recovery plan are:

- Building stronger links with community services for more effective triage, increased treatment out of hospital and faster discharge processes
- Create additional respiratory beds in the acute
- Move frailty older people's care to an out of acute area. In the medium term this will enable the 70 beds for the additional critical care demands to be created- Brentwood is the only suitable site that has been identified
- Additional step up capacity needed to avoid acute hospital admissions

A clinical pathway group and a Project Board has been set up and are currently meeting to agree the clinical model and the full implementation plan, it is anticipated that the service will move by November 2020.

A high quality acute admission avoidance offer needs excellent clinical leadership supported by highly skilled specialist support. The staffing of the 70 beds is being considered as part of the project plan but anticipate that the staff already working with the Older People acute pathway in MSE will transfer with the service.

Locality/Place based working summarised under stakeholder engagement on page

5 Factors to Consider

Staffing

In order to be able to meet the additional demand on the system, both in terms of bed numbers and acuity of patients being discharged into community beds, there are a number of things that need to be considered:

Staff numbers/availability

The ability to manage and staff the additional capacity identified is the biggest risk. The lack of available staffing resources remains and therefore there is a need to consider how we deliver the additional capacity within the resource constraints. Good health facilities need well-trained and motivated staff consistently available to provide care.

Prior to the transfer of wards

All the wards had long term staffing gaps and continued to struggle to appoint to all vacant posts. Internal temporary staffing (bank) and agency staff were covering gaps as available on the existing wards.

Vacancies rates January-March 2020

	% Mountnessing Vacant	% CICC Vacant	% Mayfield Vacant	% Thorndon Vacant	% St Peters Vacant	% Halsted Vacant
Ancilliary	0.0%	36.4%	0%	0%	18%	33%
Medical & Dental	16.7%	0%	0%	0%	0%	0%
Occupational Therapists	25.9%	31.2%	66%	24%	4%	
Physiotherapists	50.0%	0%	0%	0%	10%	
Registered Nurses	39.0%	39.7%	19%	45%	44%	16%
Nursing Support Workers	8.0%	42.4%	19%	5%	29%	0%
January Total	22.8%	39.1%	23.4%	17.3%	19%	
Ancillary	0.0%	36.4%	0%	0%	18%	33%
Medical & Dental	16.7%	0%	0%	0%	0%	0%
Occupational Therapists	28.9%	31.2%	66%	24%	7%	
Physiotherapists	50.0%	0%	0%	0%	7%	
Registered Nurses	42.0%	33.4%	22%	41%	44%	16%
Nursing Support Workers	16.2%	42.4%	31%	9%	29%	0%
February Total	27.7%	35.2%	20.7%	15.1%	19%	
Ancillary	0.0%	36.4%	0%	0%	18%	33%
Medical & Dental	16.7%	0%	0%	0%	0%	0%
Occupational Therapists	22.8%	2.6%	66%	24%	7%	
Physiotherapists	50.0%	0%	0%	0%	7%	
Registered Nurses	42%	33.4%	26%	38%	44%	16%
Nursing Support Workers	22%	42.4%	23%	9%	29%	0%
March Total	29.2%	32.0%	23.6%	17.3%	19%	

During the Pandemic phase (two locations)

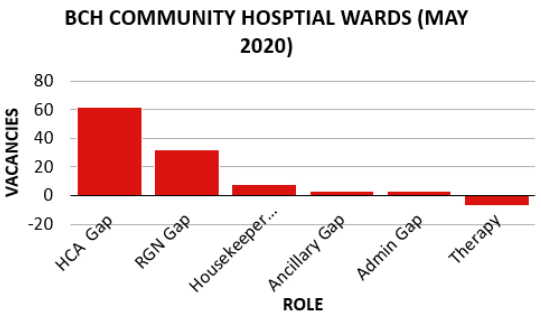
The community beds were staffed during the pandemic with a combination of staffing that transferred in from the relocated wards and redeployed staff from local NHS and private care providers. It is fair to say that the staffing remained a challenge and required on a daily basis a review of planned staff on the rota, against the staff in attendance, patient needs and staff competency to meet patient needs. We also had an additional challenge that as well as internal redeployment of NELFT/Provide staff to the wards, support was received from a number of other local providers (MSK Connect, MSE Acute, St John's ambulance, Virgin Care) and we have to constantly review capacity in light of their plans to re-open their services.

The chart below shows the changes in vacancy rates since ward moves. It is difficult to be certain on the changes/source due to the mix of staff working in Brentwood but there is clarity that the vacancy rate has increased in the EPUT Cumberledge centre staff.

Has our CH staff vacancy changed?

NB – data in the table show vacancies when redeployed staff are still included. When staff return to previous setting these values will change.

Provider	EPUT	NELFT	NELFT	EPUT	NELFT	NELFT	Provide	Provide
Previous Ward (March 2020)	Mountnessing	Thorndon	Mayfield	CICC	Courage (1)	Courage (2)	St Peter IMC & Stroke Rehab	Halstead
Current Ward (May 2020)	Bayman	Thorndon	Tower	Gibson	Courage (1)	Courage (2)	Courtland	Crittall
#/% Vacancies March 2020	11.91	7.59	11.46	9.84	No data	No data	Nursing - 36% AHP - 6.8%	Nursing - 7% AHP - 6.8%
#/% Vacancies May 2020	16.19	1.74	9.09	27.36	33.4	21	Nursing - 41% AHP 8.86%	Nursing 7% AHP - 8.86%
# children's staff redeployed to this ward	29.28						-	-
% Vacancy Increase between March and May 2020	36% Increase	-77% Decrease	-21% Decrease	178% Increase			Nursing – 14% Increase AHP – 30% increase	Nursing – 0% change AHP – 30% increase



The role with the largest number of vacancies is HCAs. The data above is just for BCH

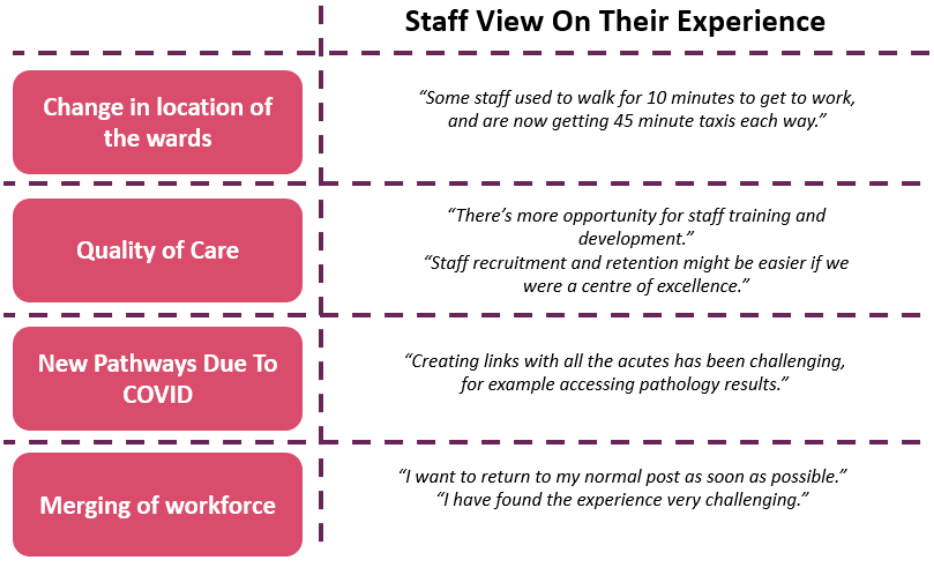
We still have vacancies in EPUT NELFT and Provide wards. In some wards the vacancies have increased, whereas in others it has decreased.

STRICTLY PRIVATE AND CONFIDENTIAL 3

Staff feedback from conversations and surveys.

Community Hospitals – Staff

Staff have had a big disruption to the status quo, having to work in different locations and in different teams. A lot of changes implemented quickly has meant there are new ways of working staff have had to adapt to, some of which have been challenging but some of which have been positive, and could be the first steps in becoming a centre of excellence.



STRICTLY PRIVATE AND CONFIDENTIAL 1

Staffing model

The service delivery model was scoped in April 2020 by Viv Barker, Deputy Director of Nursing Mid Essex and William Roberts, Professional Lead with input from medical and nursing teams across all inpatient wards in Mid and South Essex. The key driver was to ensure that all patients were offered safe, compassionate care delivered with dignity by skilled and knowledgeable staff.

The case mix and acuity that was initially defined was end of life care, rehabilitation/intermediate care, respiratory step-down and sub-acute care and was understood that would likely change over time. It's important to note that operating under the context of COVID-19 the service offer has changed and requires a higher acuity of care provision as patients are discharged when medically optimised (as opposed to medically fit), discharges occur 7 days a week often within hours of the decision to discharge being made and the ability to offer a step-up model to reduce acute admissions. This required a number of areas of change to facilitate the mode the following was implemented:

- Increased the staff knowledge and skills in areas such as venepuncture and cannulation, Catheterisation, manual handling, IV fluids and drugs, care of tracheostomy, advanced respiratory assessment.
- Increase the knowledge and skills of staff in the use of an electronic patient record (SI)
- Increase oxygen capacity for all area
- Provision of appropriate palliative medicines
- Increased medical leadership and skills
- Enhanced transport services

- Access to diagnostic services

The ratio of registered/unregistered staffing was reviewed and a new model was created to ensure we could staff the bed numbers and the additional capacity as required. Initially the available Safer Staffing tool indicated staffing ratios of 1:7 however when new national guidance was issued our numbers were revised. In the absence of local guidance local options were considered (Appendix 1) and Option 4 was selected. When there was a rise in patient safety incidents during June 2020 in Brentwood we reverted back to the Registered Nurse 1 RN to 8 patients ratio and 1 HCA to 4 patients (Safer staffing for Older People RCN).

A significant challenge to achieving this level of care consistently was the merging of staff with varying levels of skill and competency, in tandem with a reduced Nurse/Carer to patient ratio. To mitigate against poor care delivery and minimise risk, core induction and competency training was offered to all Registered Nurses and Support Workers.

Once all wards were combined onto two central sites Brentwood and Braintree there was a need to ensure we could manage the care appropriately and therefore a number of new wards were created led by a Ward Manager and overseen by a Matron and supplemented by a therapy and medical team.

A centre management and administrative function was created at Brentwood Community Hospital that holds operational oversight and access to senior Nursing support. This is staffed 24 hours 7 days a week. The purpose of this was also to ensure that some of the administrative and admission/discharge functions usually undertaken at ward level are now undertaken centrally due to the reduced registered nurse ratio. This was only feasible in the larger bedded facility in Brentwood.

Standard access criteria for all wards was also developed.

<u>Additional costs</u>

In addition to relocation/mobilisation costs (which have been charged to the COVID-19 budget) all community providers have accumulated additional operating costs per month, this includes costs for additional workforce (over and above funded staff from existing wards and redeployed staff) to deliver the enhanced model to meet higher acuity of patients with a multi-skilled team of Pharmacy, Medical and Therapy staff:

- £600k per month for NELFT (Brentwood)
- In supporting NELFT to deliver beds at BCH, whilst services at CICC and MNC were suspended in 20/21 EPUT has not incurred costs over and above those that it would have running CICC and MNC. However, EPUT have identified that £480k of costs in M1-2 relate to staff temporarily relocated to Brentwood and represent a notional saving to EPUT from the closure of the two units and a cost of supporting Brentwood.
- Provide CIC monthly recurrent costs for Nursing and AHP is £123,644 and Medical cover is estimated at a further £10 -15k per month

The full business case will need to clarify the full costs associated with delivering the preferred options as the redeployment of staff is a short-term measure. There will need to be triangulation of costs from multiple agencies to ensure all facilities management, catering etc are included.

Sickness and Annual Leave

As COVID-19 is a new virus, the lack of immunity in the population and the absence as yet of an effective vaccine means that COVID-19 has the potential to spread extensively including in our workforce across MSE. Given that data is still emerging, we are uncertain of the impact of an outbreak on the community inpatient workforce, it is therefore possible that a portion of our workforce could be absent from work during the next few months in addition to the increased sickness that arises during the winter period.

There is also a chance of a higher than usual level of staff 'burnout' over the next few months as staff have been working harder and with less time off during the COVID-19 crisis.

We are also acutely aware that there is evidence of disproportionate mortality and morbidity amongst black, Asian and minority ethnic (BAME) people, including our NHS staff, who have contracted COVID-19. We are all currently working with individual members of staff to quantify individual risk so we can take concerted action to protect them. We cannot currently quantify the effect that this will have on our current staffing capacity but will be able to quantify in the full business case.

We know that staff have not taken as much annual leave as they may usually have and this may cause an issue later in the year when staff want to take leave now the COVID-19 crisis is beginning to slow down and travel is opening back up.

There are also members of staff both in Brentwood and Braintree who have been moved from their original location and remain dissatisfied due to the additional travel distance. In some instances, we have had to fund a taxi to ensure staff can attend work in a timely manner due to the lack of local transport arrangements.

Staff training and capabilities

As stated above there was a need to provide additional training to ensure staff have adequate knowledge and skills to meet the patient needs. In addition, staff were provided with a competency framework to self-assess to ensure that at any time they could seek additional support as needed. We continue to work closely with staff as capacity and capability fluctuates depending on varying patient need. Where additional training is needed it is provided.

In Brentwood we have continued to need to monitor staff capabilities closely due to the feedback on standards of care. Feedback from the Matrons and the Assistant Director has stated that the lack of knowledge and skills is confined to groups of staff therefore in hindsight it would have been more appropriate to mix staff across the wards on transfer in according to knowledge and skills rather than keeping staff together with their initial team. A decision was made to keep ward teams together to maintain consistency of leadership and maintain the team working and camaraderie already in existence.

Medical model

On an initial review of the clinical model including consideration of the anticipated patient needs we reviewed the medical model with Dr Vivana Porcari and the existing small medical team that was employed on all the wards.

We were required to ensure implementation of the 'COVID-19 Hospital Discharge Service Requirements'. This document sets out the Hospital Discharge Service Requirements for all NHS trusts, CICs and health and social care services to adhere to this from 19 March 2020.

Based on these criteria, acute and community must discharge all patients as soon as they are clinical safe to do so. Discharge from hospital should happen as soon after that as possible, normally within 2/3 hours. In order to facilitate the implementation of these requirements in both the MSE Acute Hospitals and both Braintree and Brentwood Community Hospitals there was also a requirement to ensure that discharges and admissions could be facilitated 24 hours a day. To ensure we had the ability to meet the 7 days a week/24 hours a day need and to deliver end of life care, rehabilitation/intermediate care and sub-acute care including the care required post-acute phase of COVID-19 we had to extend the working hours and the capacity/capability of the team already in existence.

In order to meet the enhanced medical model agreed the following medical staffing was required per week:

Medical staff transferred or redeployed

New wards medical cover Mon-Fri	Doctors rota Brentwood	Transferred from original ward/funded team		Additional costs attributed to NELFT
TOWER 09:00-21:00	32 PA Spec. Dr 5 PA Cons	10 PAs Spec Dr from Mayfield	5 PAs Cons. from Mayfield	22 PA Spec. Dr
THORNDON 09:00-22:00	32 PA Spec. Dr 5 PA Cons	12 PA Spec Dr existing 4 PA Spec Dr from OA Health & Wellbeing team Thurrock	5 PA Cons. existing	16 PA Spec. Dr
BAYMAN 09:00-22:00	30 PA Spec. Dr 6 PA Cons	10 PA Spec. Dr from Mountnessing	6 PA Cons from Mountnessing	20 PA Spec. Dr
COURAGE 1 09:00-22:00	30 PA Spec. Dr 10 PA Cons			30 PA Spec. Dr 10 PA Cons.
Sat/Sun all wards 0900-22.00	24 PA Spec. Dr	0.5 PA from Mayfield 0.5 PA from Thorndon		27 wte
Total	148 PA Spec. Dr 26 PA Cons.	37 PA Spec. Dr	16 PA cons.	111 PA Spec Dr 10 PA Cons.

1 Dr is accessing free accommodation as per the COVID-19 staffing offer. If this were to cease it would have a cost implication

In addition to strengthening the medical model and extending the operating hours of the medical team we also needed to enhance the night medical cover as there was varying medical cover across all units that didn't facilitate a comprehensive night medical offer:

- Mayfield and Thorndon Ward — Out of Hours provider 111
- Mountnessing Court and Cumberledge Centre — Out of Hours provider 111
- St Peters and Halsted — Out of Hours provider 111

The additional cover was agreed and facilitate with input from William Guy, Deputy Accountable Officer BB CCG and included:

Commisceo are paid a retainer fee for the provision of an on-call service at £60.00 per shift, plus telephone support at £90.00 per hour and for each GP visit to Brentwood Community Hospital or Braintree a fee of £100.00 per hour. Invoices have been received to date for approx. £3,600.

Community beds: Admissions

- MSE Community hospital admissions per month are shown from April 2019 to May 2020.
- Community hospital admissions pre-Covid, from April 2019 to March 2020 were relatively consistent with just over 150 admissions per month.
- However, throughout COVID, in May 2020 the number of admissions per month has been upwards of 270.

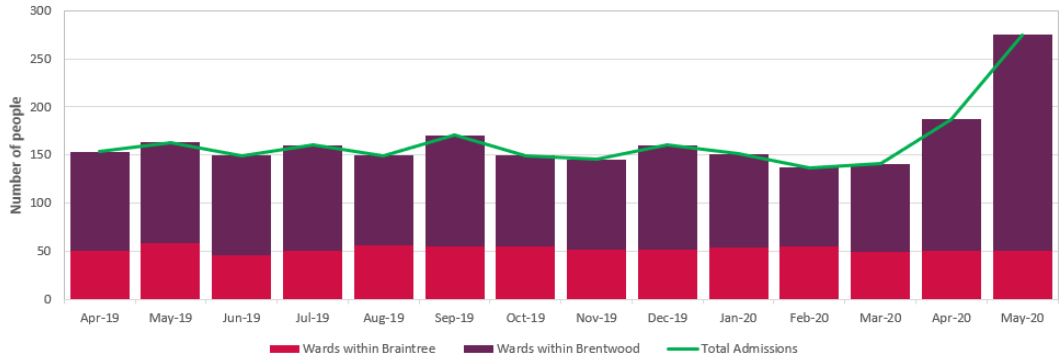
Wards labelled as Braintree and Brentwood include all those now who were separate before consolidation

Wards included:

Braintree:	Brentwood:
St Peters	CCIC
Halsted	Mountnessing
	Thorndon
	Mayfield
	Bayman
	Courage
	Gibson
	Tower

MSE: Community Hospital Admissions

April 2019 to May 2020



Data for Braintree for May assumed to be same as April as data not available.

Community beds: Length of stay

- Despite the sharp increase in community hospital admissions there has been a slight reduction in the average occupancy.
- This has been as a result of a much lower average length of stay throughout the last two months as compared with period before. April 2019 to March 2020 the average weighted community bed **length of stay was 25.2 days**, in the last two months this figure has **dropped to 8.02 days.**

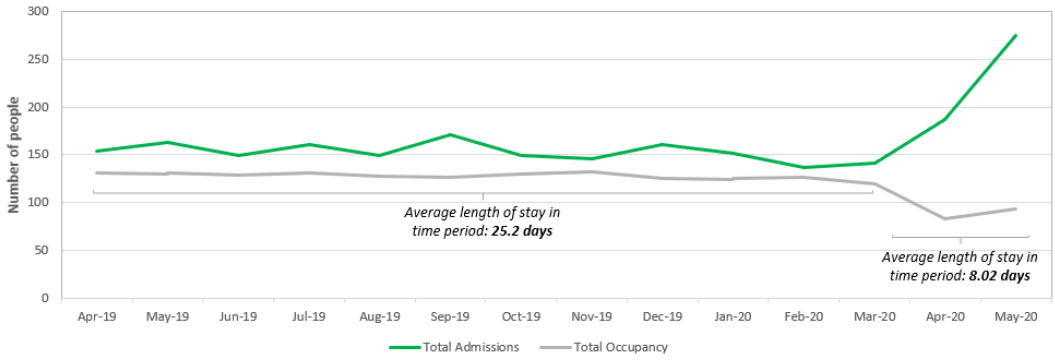
Wards labelled as Braintree and Brentwood include all those now who were separate before consolidation

Wards included:

Braintree:	**Brentwood:**
St Peters	CCIC
Halsted	Mountnessing
	Thorndon
	Mayfield
	Bayman
	Courage
	Gibson
	Tower

MSE: Community Hospital beds admissions and average monthly occupancy

April 2019 to May 2020

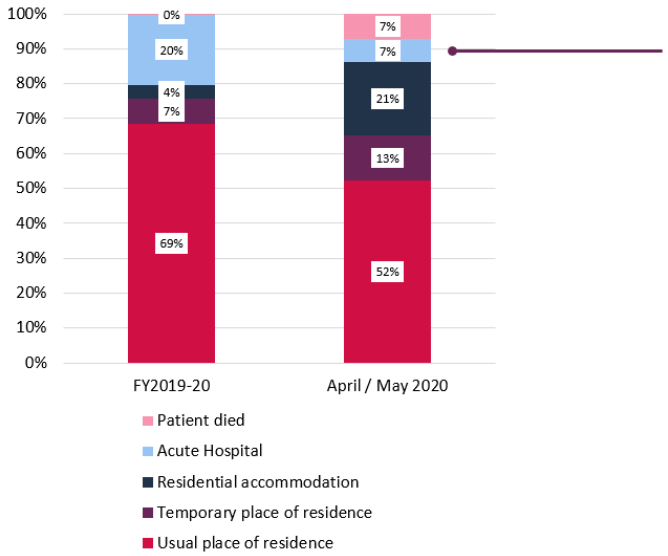


Data for Braintree for May assumed to be same as April as data not available.

Where do people go after Community Beds?

Data from Brentwood Community Hospital

DISCHARGE DESTINATIONS



Returned to acute hospital – 20% to 7%

There has been a significant decrease in the number of patients being readmitted to acute hospitals. This is likely to be because of the extended medical provision available at the community hospitals. For example, there is now out of hours medical cover until 10pm every evening and at weekends. Brentwood now has on-site radiology, and the pathology laboratory is operating a faster turnaround for diagnostic tests.

This means we are able to manage more patients in a community hospital rather than sending them back to an acute when their needs escalate.

We need to decide if this is a change we want to continue.

COVID-19 Red and Green sites

There is also a national requirement to deliver services in COVID free sites/create separate sites. We also have to ensure that we currently manage patients within units safely who are COVID-19+, COVID-19- and Pending results. This puts a strain on staffing levels/agency staff that can be used as we haven't yet been able to fully separate the sites into positive and negative sites (Brentwood currently takes both).

Step Up

At the initial phase we did not offer step up in the community beds, this was developed and we now offer this opportunity in Brentwood Community Hospital only with referrals being received through Urgent Care Response Teams, Senior Community Clinicians and General Practitioners. There is an agreed step up access criteria, and medical staff on site to ensure patients are assessed in a timely manner and have access on site to x-ray twice weekly at present due to low demand.

Stroke requirements

In January 2019, NHS England announced its Long Term Plan, in which stroke has been named as a new national priority. The Long Term Plan puts them as key vehicles for delivery of improved and transformed services across wider population areas.

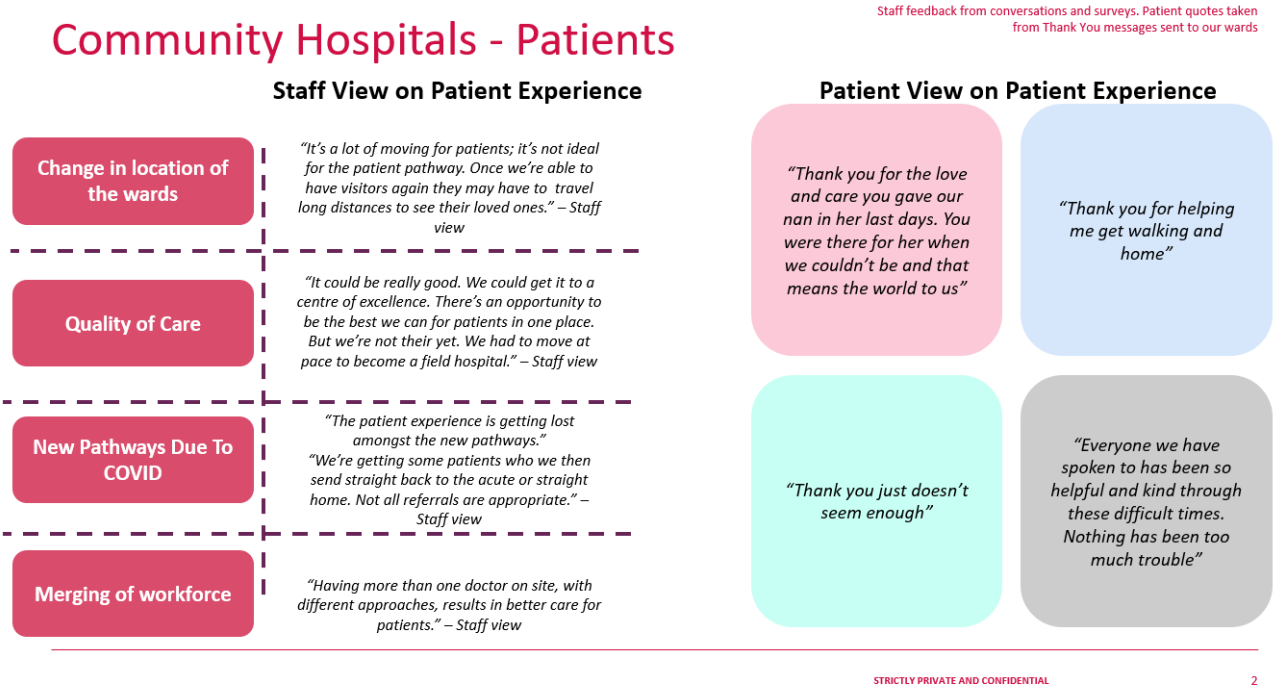
Because it is both a medical emergency and a long-term condition, stroke embodies the need for integrated, joined-up health care and community services. Only with this approach can local systems embed and achieve the stroke programme ambitions, ensuring stroke survivors and their families experience tangible improvements.

At present we have dis-joined delivery of stroke services although all teams are working to the national quality stroke specification. We have 3 early supported discharge teams (SW, Mid, SE) and, pre COVID-19, 4 areas where stroke inpatient rehabilitation was offered (Brentwood (8), St Peters (10), Cumberledge (6) and Southend hospital (13). Currently all community-based stroke beds are amalgamated in Braintree Community Hospital. It is felt that 26 stroke beds are the right number of beds needed at this point in time for the system. There is a need to consider the consolidation of the 26 community based inpatient stroke rehabilitation beds on a single site to ensure the highest quality of care is offered with support from a range of highly skilled staff. The early supported discharge teams will be taking part in a review of their model of service provision as part of the 'Service Prioritisation' workstream.

Patient feedback

Due to the limited time available (1 month to prepare this paper) we were unable to secure the support of an organisation to gather patients' feedback from inpatients in both Brentwood and Braintree. The full business case will include a patient feedback section (Healthwatch will support this development of the evaluation.

In the absence of a survey we asked each of the wards at Braintree and Brentwood to share any staff or patient/carer feedback good or bad from March 2020 onwards.
We are aware due to the lack of access to visitors on the ward there was limited carers visiting the sites during phase 1 of COVID-19.



Formal Complaint numbers

Ward	Jan 2020	Feb 2020	Mar 2020	Apr 2020	May 2020	Reasons
Mountnessing	0	2	0			1x Unhappy with treatment, 1 discharge related
CICC	0	0	0			
Mayfield	0	0	0			
Thorndon	0	0	0			
Bayman				0	0	
Tower				0	0	
Gibson				0	0	
Courage 1				0	0	
Halsted	1		1			1x discharge, 1x environment/premises/facilities
St Peters	2					2x Clinical treatment/care received
Braintree				0	0	

Informal complaints are addressed immediately and are not routinely recorded.

In addition, in both Brentwood and Braintree there was poor experience for patients (reported by staff) due to their swift discharge from the Acute and the need to move them quickly to an interim place while a longer-term plan was agreed for them.

Patient safety incidents

Ward	Jan –Mar 2020 Datix and (SI)	April-May 2020 Datix and (SI)
Mountnessing	47 (0)	
CICC	58 (0)	
Mayfield	59 (0)	
Thorndon	55 (0)	90 (0)
Bayman		41 (0)
Tower		52 (0)
Gibson		3 (0)
Courage 1		13 (0)
Halsted	49 (0)	
St Peters	39 (0)	
Braintree		74(1)*

Note that there are 3 'Category 3' pressure ulcers and 1 # humerus (Tower ward) currently pending a decision re Serious Incident status in Brentwood. *1 medication related Serious Incident

Datix incidents include pressure ulcers, medication errors, clinical queries, falls, and admission/discharge issues for all wards. The April onwards includes a rise in the number of admissions with pressure ulcers and the COVID-19 positive patients admitted.

Gibson/Courage data is variable as patients moved between wards and both were only partially open

Thorndon was the only existing ward in Brentwood and therefore had a full complement of permanent staff and the ward was used to its maximum.

Suitability of premises

St Peters Maldon

The need to improve the current facilities at St Peter's Hospital (26 including 10 stroke beds), has been a priority for the NHS for a number of years. There have been a number of attempts to identify options for the site and to produce a business case. Due to the complexities of the project and an historic issue with site value, a business case has never been fully developed to approval stage. This has been to the disappointment of the local community and the local council who have supported these past attempts and have expectations and requirements for improved facilities and services for their community. The work to develop this project has focused collective minds and has provided the basis for a Programme Business Case that is currently in development.

The project has significant political interest and support. Importantly, this had prompted the decision previously to retain inpatient beds, comprising intermediate care, stroke rehabilitation provision and some maternity care. The total project capital cost of £26m includes the costs of a newly built intermediate care ward.

The focus in the CCG was on the provision of primary care and non-acute activity, delivered in local community settings so as to provide access to sub-acute care locally and thereby releasing capacity within the acute hospital settings for acute care provision.

The current building built in the 1870s is not fit for purpose as the facilities do not enable good quality care with dark corridors, poor and potentially unsafe flooring and the inability to manage heavy weight materials and patients.

The backlog maintenance burden continues to increase with the buildings' age and deterioration, leading to operational failures requiring closure of beds to effect repairs. The condition of the premises makes them unsustainable from an obsolescence, compliance and maintenance perspective. Estimated CIR Backlog maintenance cost at this site is currently £7,261,740 (18/19 ERIC returns).

Halsted

This is a 20 bedded unit with a mixture of open bays and side rooms. It is a well-liked building by some members of staff who live locally. However due to its remoteness it is not easily accessible for patients and relatives. It is also difficult to recruit new staff due to its location. It doesn't have piped oxygen.

Mayfield

This is a 24 bedded unit based on the Thurrock Hospital site in Grays, Essex, 13 miles from Brentwood Community Hospital. The unit has been refurbished in recent years to facilitate a move of the previous ward (AFC) to allow them to deliver a service in a more suitable location.

This unit has a male and female side with 24 single rooms. We reviewed the building and established that the maximum number of beds that could be located on the ward (by changing the use of the day room) was 29 beds. The ward doesn't have piped oxygen.

Mountnessing Court

This is a 22 bedded unit based 6 miles from Brentwood community hospital in Billericay. This unit is made up of all single rooms and is set up as a good rehabilitation centre. There is no piped oxygen on site.

Cumberledge Centre

This is a 22 bedded unit including 6 stroke beds based in Rochford 21 miles from Brentwood community hospital. This unit is made up of all single rooms and doesn't have piped oxygen.

We reviewed the building and established that the maximum number of beds that could be located on the ward (by changing the use of the day room) was 30 beds.

Brentwood Community Hospital

Brentwood is a modern community hospital where Thorndon Ward (25 beds including 8 stroke beds) was based. There was an additional 25 bedded ward (Bayman) that was unused for a number of years. The remainder of the facility housed a range of community teams and outpatient type services delivered by a range of health partners across the acute and community systems.

During March/April the majority of the rooms were converted to bedded areas with a total of 158 beds available for use at a cost of £260,000. 11 beds (Courage 2) were sighted in the previously used OPD just by the entrance to Brentwood Community Hospital. Due to the size of the rooms and their location we propose that this ward areas is not used in the future for quality and safety reasons, e.g. unable to use profiling beds due to narrow door access,

away from the main ward area, poor visibility for ward team as all rooms are based in a small location.

The speed of the creation of the wards resulted in a number of areas that staff raised concern around- where possible we have resolved them asap

- Additional office space
- Additional IT outlets as all staff were required to use an electronic patient system
- Environmental changes e.g. curtains, additional curtain rails etc.
- Confusion re the variability of paperwork across 5 CCG areas, 3 LA areas and 3 Community Providers
- Access to pathology/biochemistry/microbiology/radiology results
- Staff breakout area- received charitable funds and have ordered a temporary marquee
- Transport via taxi for staff with difficulties

There are some remaining changes required that are not cost effective unless the facility is going to be used longer term, and at least until March 2021 or onwards including the following at a cost of between £15-20k.

- Air conditioning- temperature regulation
- Dirty Utility refurbishment x2
- Shower adjustments x2

Braintree

Braintree is a PFI hospital run by MSE Acute Group. Prior to 2019 the facility was used by Mid Essex Hospital for endoscopy and they had planned to use the inpatient wards for Orthopaedic surgery. In April 2020 Halsted moved to Braintree and early May 2020 St Peters moved from their current locations. In order to ensure it was fit for purpose it was necessary to make adjustments to the existing Coultauld ward and a newly created ward following adjustments made to an operating theatre/recovery suite at a cost of £18,500. The MSE Acute group have given notice of their intention to use this unit for surgery end September 2020.

Stakeholder Engagement

Due to the short timescales in creating this mid-term paper it was difficult to achieve good stakeholder engagement. However, a number of areas were achieved including discussions with:

- CCGs
- Local Authority via the Director of Adult Social Care
- Clinical Cabinet 30/6/20
- Community Providers
- Hospices

We need to ensure as part of any plans that links to locality focused developments, including the Thurrock Better Together programme, South East Essex Alliance, Mid Essex Live well Partnership and Basildon and Brentwood Alliance priorities. Contact and connection with

local system is key to the sustainability of any changes/development and therefore a discussion was held with the 5 Deputy Accountable Officers and the 3 Directors of Adult Social Care or their representatives across Essex, Thurrock and Southend.

In addition to the national and health and care priorities mentioned above some key local priorities that were raised include:

- the desire to maximise the clinical capacity available to manage the predicted demand which differed in local areas
- provision of care at home as first priority
- delivering care as close to home in each of the local areas
- offering a high standard of care linked to national NICE guidance
- offering a cost effective service

The specific options have been discussed and included under the Options section.

Hospice support

A high proportion of Hospice income is achieved through fundraising and this took a massive hit during COVID-19 with a loss of fundraising income, and a loss in charity shop income. This will affect the hospice services ability to deliver a full service.

In addition a recent meeting with St Luke's hospice has established that a new end of life unit is planned to open in Thurrock in October 2020 with no firm plans for usage at present. This could pose an opportunity for a further option to deliver care in Thurrock during 2020/21.

Fair Havens Hospice in South East can currently take up to 10 in-patients who require end of life care or symptom control. They are working with Southend and CPR CCGs to review the service specification and make it more patient outcome focussed. During COVID-19 CPR CCG funded extra capacity on a patient bed stay basis but this has now ceased. Fair Havens has 16 beds (all single rooms with bathrooms) and plan to run up to 10 inpatient beds to the end March 2021 (subject to discussion and fundraising ability). They cannot operate at full capacity until they recover some fundraising stability income. They are willing to support the system with palliative care support if demand increases but would need to be fully funded and they would need a lead in time to recruit or redeploy staff.

Provide CIC continue to work closely with Farleigh Hospice to ensure high quality palliative care for patient. During the pandemic Farleigh Hospice closed it's 8 bed inpatient unit, to minimise cross infections and offered the beds to MEHT to support demand. All but two end of life patients from April to July have been supported in their own homes by the hospices 'hospice at home team' which has seen an increase in demand and boost of staffing from reallocating those who would normally support the inpatient unit. The inpatient beds are being planned to opened from August, but Farleigh are reviewing this model of care and with lessons learnt over the last few months, reviewing if 8 beds are needed, and how to staff them whilst ensuring they meet the needs of patients.

Engagement with HOSCs

Due to the short timescales and the absence of a full business case we were unable to consult with local HOSCs at this time. This will be completed in line with the full business case development. Attached in Appendix II is the latest communication from Mr Anthony

McKeever, Executive Lead Mid and South Essex Health and Care Partnership & Joint Accountable Officer for its five CCGs (interim) which was sent to all HOSC leads.

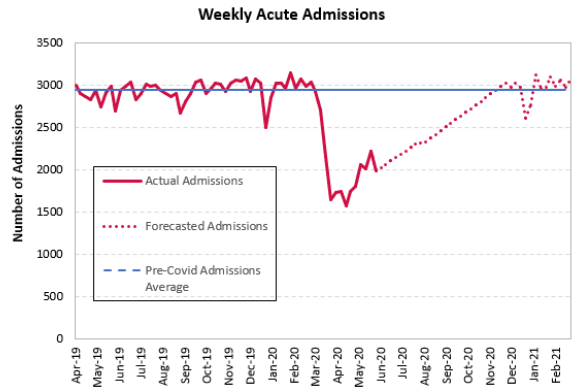
6 Modelling

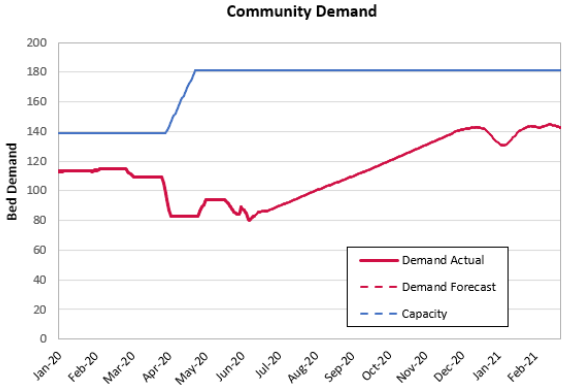
This modelling has been reviewed and refreshed by Newton Europe and includes the surge/winter planning predications and has identified that we will need an additional 100 community care beds up to March 2021.

To understand future community bed requirements, modelling was carried out to forecast patient referrals into community hospital settings as acute activity increases in the coming months. This combined with the length of stay within community hospital settings gives an indication of the required number of beds. Through analysis of historic data, we found that ~1% of acute discharges entered community setting in pre-COVID-19 time (discounting stroke patients). This rose to ~3.2% during the COVID-19 period. However, the increase in admissions was offset by a large LOS reduction from ~25 days to ~8 days.

Using the assumption that acute activity will return to historic levels by November 2020 we have modelled three scenarios. We have taken a mid-point assumption for discharge flow at 2% and produced the scenarios based on varying LOS. The first scenario represents the target LOS at 21 days, which produces a maximum bed demand of 143 beds by December 2020. The second scenario is a stretch target at 18 days, where bed demand is pushed down to 130 beds in the same time frame. Finally, we have an upper limit with LOS set at 25 days, which raises bed demand up to 155 beds by December 2020. This bed modelling only accounts for IMC beds. There are 26 beds allocated for stroke patients in addition to this and 70 beds being transferred from BTUH. This gives a total bed requirement of 239 beds (using scenario 4).

Scenario 4: Target mid-point (without stroke)



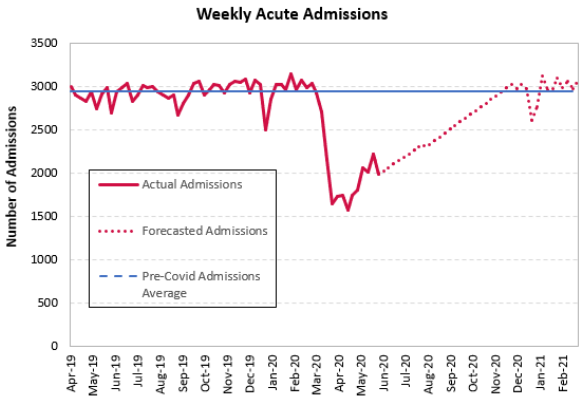


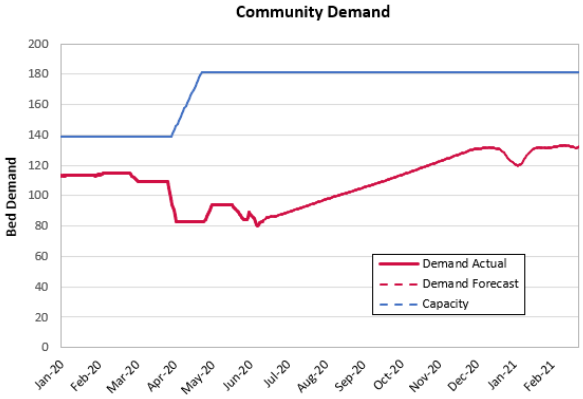
1. **Discharge Pathway** – Without stroke, discharge % into community hospital ranges from 1% (Pre Covid) and 3.2% (Post Covid). **Therefore Mid-point taken at 2%**
2. **ALOS – Set at target level of 21 days**
3. **Acute ramp up** – Non-elective and elective admissions ramp up to 100% of previous year's levels by November 2020

Output

The community bed demand ramps up to a higher level than last year reaching just over 140 beds by December 2020 before plateauing at this level. **26 beds ringfenced for stroke patients**

Scenario 5: Stretch (without stroke)



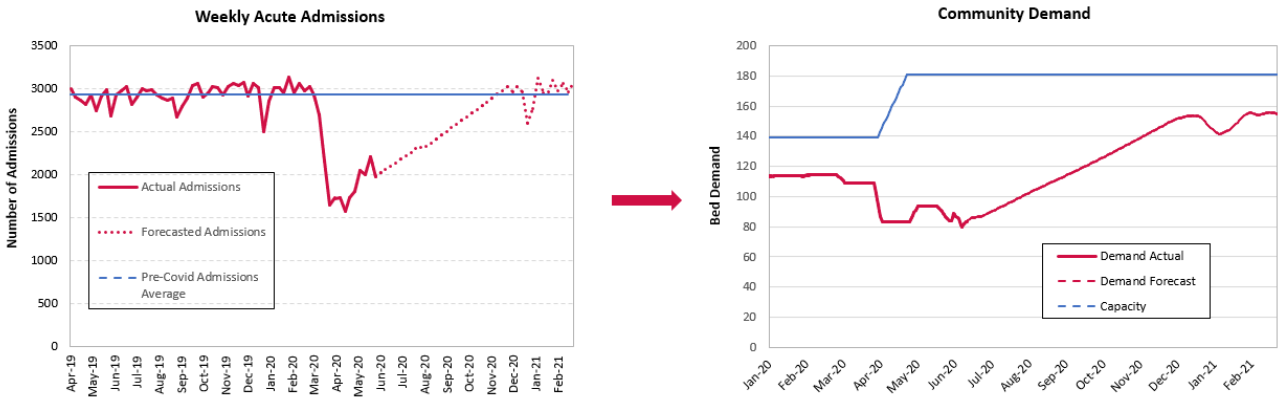


1. **Discharge Pathway** – Without stroke, discharge % into community hospital ranges from 1% (Pre Covid) and 3.2% (Post Covid). **Therefore Mid-point taken at 2%**
2. **ALOS – Set at stretch level of 18 days**
3. **Acute ramp up** – Non-elective and elective admissions ramp up to 100% of previous year's levels by November 2020

Output

The community bed demand ramps up to a higher level than last year reaching 130 beds by December 2020 before plateauing at this level. **26 beds ringfenced for Stroke patients.**

Scenario 6: Upper Limit (without stroke)



1 **Discharge Pathway** – Without stroke, discharge % into community hospital ranges from 1% (Pre Covid) and 3.2% (Post Covid). **Therefore Mid-point taken at 2%**

2 **ALOS – Set at upper limit of 25 days**

3 **Acute ramp up** – Non-elective and elective admissions ramp up to 100% of previous year's levels by November 2020

Output

The community bed demand ramps up to a higher level than last year reaching 155 beds by the end of December 2020 before plateauing at this level. **26 beds ringfenced for Stroke Patients.**

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The plans are based on what we know we need now, and will need to adapt as the system continues to reset and recover and agree transformative plans for the future.

4.1 Known Assumptions/Key Points

1) Based on the Newton Europe modelling the Mid and South Essex system requires an additional 100 community beds during this next phase of the COVID-19 response including stroke.

2) Due to the merger of the 3 local acute trusts and the formation of the MSE acute group we will see changes within pathways therefore there is a need to streamline as much as possible across community service provision to reduce the variability which results in confusion for acute staff.

3) Based on the requirement to recommence elective surgery and the limitations presented by managing hot/cold patients, Braintree Community Hospital is no longer a viable option. However, we have approached Mid Essex Hospital to see if keeping one ward would be possible and this is one of the options below. We are waiting for confirmation either way.

4) St Peters is not fit for purpose.

5) As part of Phase II of the COVID-19 response, a clinical model and business case is being developed to relocate part of the Department of Medicine for Older People (currently two wards and an assessment area) currently sited on the Basildon and Thurrock Hospital site. Brentwood Community Hospital is the only facility that is capable of accommodating the re-provision of the DMOP services from the BTUH site.

6) There is a requirement to enhance the admission avoidance model alongside the Frailty unit re-provision, the Urgent Care Response Team and Primary Care Network developments.

7) The health and care partnership ambition to deliver care closer to home to a high standard and to strengthen the stroke care offered to local residents.

8) The lack of staffing resource and the potential of this to reduce even further during Phase II COVID-19 over the winter period.

9) Some staff who have been relocated remain dissatisfied. For the full business case we need to undertake staff consultation.

10) COVID-19+ positive patients are still unable to return to care homes without a negative swab prior to discharge, we currently don't have confirmation that this will change.

11) Additional costs required regardless of location but varies per option (see specific options).
There may be an opportunity to secure money through the seacole bidding process.

12) Wherever the beds are located, the same process must be followed for accessing the beds
    a. Must meet acute discharge criteria to discharge within 3 hours
    b. Use Discharge to Assess process
    c. Access is agreed via the bed bureau
    d. Meet access criteria for community beds- step up and step down
    e. Provide ability to admit and discharge 7 days a week, maximum hours per day

13) A discussion was held at the Clinical Cabinet 30 June 2020 where a recommendation was considered regarding the maintaining of a single stroke rehabilitation facility during Winter period.

14) We have excluded the provision of 'neuro-rehabilitation beds' as the procurement exercise has now paused and a further review will be included. This should be completed for the Full Business Case.

7 Overarching benefits and risks

Benefits of consolidated sites

- Joint delivery in two locations allowed for the maximising of staff capacity from existing wards
- Cross cover on wards could be achieved due to the volume of staff on site
- Single bed criteria delivered

- Discharge pathway was embedded with a skilled discharge team on two sites
- Enhanced medical model created which facilitated the setting up of a step-up model
- Enhanced medical model facilitated admissions/discharges 7 days a week
- FY2 rotational Dr could begin again with an enhanced medical model
- Single consumables, equipment stock on each of the two sites
- Single facilities management on each site
- Increased patient flow through sites
- Ability to manage increased admission rates from the acute
- Reduced length of stay (casemix changed also)
- Re-admission rate to Acute hospitals reduced

Risks of disaggregating sites

- Services will be delivered differently if fragmented again- variability in leadership
- Discharges may be delayed without a focused discharge team who can link across MSE
- Admissions may be delayed from the acute if full access to a medical team is not made available
- It will be challenging to manage lack of staff due to absence/vacancies- when staff are on a single site you have the ability to move staff within wards on a daily/regular basis as they are on site. If they were off site the travel would cause an issue and prevent this occurring
- Potential greater staffing absence if some staff remain relocated and need to travel to work outside their local residential area
- Potential greater negative feedback from relatives who have to travel out of area
- The lack of a strong medical team on all sites could prevent the step-up offer being delivered
- Brentwood is not suitable for medium term occupation without further refurbishment
- Braintree needs to be vacated and St Peters is not fit for purpose
- If a decision results in the longer-term cost of decommissioning or repurposing the historic sites from where the wards originally came from. These are real costs and can be mitigated over time but they are a cost to the system in the short to medium term.
- Potential reduction in length of stay and throughput of patients
- Potential readmission rate to Acute hospitals increases again

The risk that the redeployed staff will be recalled to their permanent location remain depending on what the decision is. The current staffing costs are lower in Brentwood and Braintree as a number of staff are redeployed from other teams/organisations (St John Ambulance, Virgin Care, MSK Connect, MSE Acute, EPUT. NELFT- Mayfield). These costs will increase when redeployed staff return to the substantive roles.

While improving facilities comes at a financial cost, the benefits of such investments often surpass the initial costs. Therefore, the long-term plan/Full business case will focus greater attention on the impacts of facilities and adopt a long-term cost-benefit perspective on efforts **to** improve facilities.

8 Options

The overall objective of whichever option is decided upon is to ensure that the MSE System has enough community bed capacity in place to meet the demand identified in the modelling for surge over winter months. Capacity relates to the number of physical beds in place but also capacity in terms of staff available to open all beds.

There were 19 possible options identified for the configuration of community beds for the medium term. 5 of these options were identified as being most suitable based on the key assumptions and risks identified within the paper.

All 19 options can be found in Appendix 1.

Options are ordered based on number of sites (smallest to largest) as this has a significant impact on ability to staff the number of beds needed which is the highest risk to managing surge between September 2020 to March 2021.

With all options, there is a need to consider whether all surge capacity would need to be in place at once or whether there are some sites identified that could be 'switched on' quickly as needed.

Option 1 (Option 1 in options table Appendix 1)

Option 1	**Bed no's.**	**No. of sites**	**Beds per site ratio**	**Locality**	**Location**
Maximum beds at Brentwood	147	2	120	South West Essex	Brentwood
Find a site large enough in the MSE to accommodate the additional beds needed (Chelmer Valley is an option)	92			Mid Essex	TBC
Total	**239**				

Pros

Staffing

- This option is the best for being able to manage the identified staffing risks. Having staff consolidated into just two sites means there is the ability to move staff between wards based on patients' numbers, acuity of patients and staff experience
- Having just two sites mitigates the risks of being short staffed due to sickness and leave
- Working on a larger site is an attractive prospect for new staff that we may be able to recruit prior to winter

- The medical model that has been in place could continue. There has been a significant reduction in the number of patients being readmitted to the acute whilst wards have been consolidated because of the increased medical support, including out of hours

Premises

- Having two larger sites would allow for red and green wards or sites to manage COVID-19 over winter and particularly if there is a second surge
- Brentwood has already been developed during the first phase of COVID-19
- An additional larger site could be used in the future for a rehab centre across MSE

Location

- Brentwood is a central location in South Essex
- Developing a second site in mid Essex (if that was the chose location) would mean there would be two sites well placed to support the MSE area

Finance

- Minimal costs to developing Brentwood as the site has already been renovated

Other

- Being able to consolidate facilities, equipment and consumables on two sites means there is a benefit from economies of scale
- In terms of logistics there would just need to be one move from Braintree to the new site rather than numerous moves
- Developing clear and consistent processes for accepting patients stepping down from the acute, stepping up from the community and discharging patients has been a lot easier across less sites. This will impact outcomes for patients and is key to keeping flow across the system and in the acute being able to deal with surge over the winter months
-

Cons

Staffing

- There may be an impact on staff satisfaction as some staff are keen to return to their previous locations and do not wish to travel. There is a chance some staff could resign if they did not return to their original work place

Premises

- Second site currently unknown. A second site will need to be found urgently
- There may be an issue with timings as developing a new site could take longer than the timeline set out- Braintree beds need to move in September

Location

- There would be no ‘local’ beds in South East Essex and Thurrock
- Relatives/Carers may be impacted by the distance to the nearest hospital

Finance

- A new site is likely to need a significant amount of work to develop it and make it fit for purpose for intermediate care beds and stroke beds

Other

- There is a political challenge in consolidating beds and taking beds out of local areas

Option 2: a (Option 2 in options table Appendix 1)

Option 2	Bed no's.	No. of sites	Beds per site ratio	Locality	Location
Maximum beds at Brentwood	147	3	80	South West Essex	Brentwood
In mid Essex 49 Braintree beds move to a single facility that can also offer additional capacity for the rest of the beds needed. Location would need to be found. Howe Green site is an option	70			Mid Essex	Chelmsford
Beds return to CICC	22			South East Essex	Southend
Total	**239**				

Option 2: b (Option 4 in options table Appendix 1)

Option 4	Bed no's.	No. of sites	Beds per site ratio	Locality	Location
Maximum beds at Brentwood	147	3	80	South West Essex	Brentwood
In mid Essex 49 Braintree beds move to a single facility that can also offer additional capacity for the rest of the beds needed. Location would need to be found. Howe Green site is an option	68			Mid Essex	Chelmsford
Beds return to Mayfield	24			South West Essex	Thurrock Community Hospital
Total	**239**				

Pros

Staffing

- Having staff consolidated into just three sites means there is the ability to move staff between wards based on patients' numbers, acuity of patients and staff experience, but you don't get the same economies of scale as with just two sites (see cons)
- Having three sites still mitigates the risks of being short staffed due to sickness and leave just to a lesser degree than with just two sites
- Working on the two larger sites is an attractive prospect for new staff that we may be able to recruit prior to winter
- The medical model that has been in place could continue across the two larger sites. There would need to be the same level of support to the smaller site. There has been a significant reduction in the number of patients being readmitted to the acute whilst wards have been consolidated because of the increased medical support, including out of hours
- Developing clear and consistent processes for accepting patients stepping down from the acute, stepping up from the community and discharging patients will be easier across less sites. This will impact outcomes for patient and is key to keeping flow across the system and in the acute being able to deal with surge over the winter months
- This option would allow for some staff to return to their original work site
- Option 2: a- CICC- Mayfield site is run by NELFT staff. Therefore, Mayfield staff remaining at Brentwood would be easier than CICC remaining at Brentwood as they already work to NELFT governance and policies and are used to the culture of NELFT, whereas CICC is run by EPUT. Staff satisfaction if Mayfield staff remain at Brentwood is likely to be higher than CICC staff remaining at Brentwood.

Premises

- Having two larger sites would allow for red and green wards or sites to manage COVID-19 over winter and particularly if there is a second surge
- Brentwood has already been developed during the first phase of COVID-19
- Mayfield and CICC are already an established wards
- Opening CICC or Mayfield would mean the second larger site needed would be smaller than the additional new site in option 1 which will impact with both time and cost
- An additional larger site could be used in the future for a rehab centre across MSE

Location

- Brentwood is a central location in South Essex
- Option 2: a- CICC- Local beds in all locality areas- Mid Essex, South Essex and South East Essex

Finance

- Minimal costs to developing Brentwood as the site has already been renovated
- No costs other than removal costs in moving back to CICC or Mayfield unless additional beds are needed
- Potentially lower costs of additional site in mid as less beds needed for this site in this option

Other

- Being able to consolidate facilities, equipment and consumables on three sites will still mean there will be a benefit from economies of scale
- In terms of logistics there would just need to be two moves from Braintree/Brentwood
- Developing clear and consistent processes for accepting patients stepping down from the acute, stepping up from the community and discharging patients has been a lot easier across less sites. This will impact outcomes for patients and is key to keeping flow across the system and in the acute being able to deal with surge over the winter months
-

Cons

Staffing

- There may be an impact on staff satisfaction as some staff are keen to return to their previous locations and do not wish to travel. There is a chance some staff could resign if they did not return to their original work place
- There would need to be an increase in medical cover in line with that at the other two sites. This means additional staff would be needed at a smaller site at a time when cover is already stretched
- Additional ask on CICC or Mayfield staff to work in line with the new criteria and processes but from their standalone site without the support of a wider staff group and additional senior nursing and admin support that has been available through the nerve centre at Brentwood

Premises

- Second site currently unknown. A second site will need to be found urgently. Howe Green is an option but initial costs for developing the site are high
- There may be an issue with timings as developing a new site could take longer than the timeline set out- Braintree beds need to move in September

Location

- Option 2:a- CICC- There would be no beds in Thurrock
- Option 2: b- Mayfield- There would be no 'local' beds in South East Essex

Finance

- A new site is likely to need a significant amount of work to develop it and make it fit for purpose for intermediate care beds and stroke beds
- Howe Green has been identified as a potential site but costs to develop are approx. £1.4million, however, there is an outline business case in development for St Peter's hospital which includes intermediate care wards at a significant cost. Developing a current site rather than building a new site would be considerably cheaper and this needs to be considered

Other

- There is a political challenge in consolidating beds and taking beds out of local areas

Option 3 (Option 5 in options table Appendix 1)

Option 5	Bed no's.	No. of sites	Beds per site ratio	Locality	Location

Maximum beds at Brentwood	147	4	60	South West Essex	Brentwood
In mid Essex increase Halstead to nearly maximum capacity and move all Braintree beds there (-1)	48			Mid Essex	Halstead
Beds return to CICC	22			South East Essex	Southend
Beds return to Mayfield	24			South West Essex	Thurrock Community Hospital
Total	**241**				

Pros

Staffing

- Some staff have expressed that they would like to return to their original work place and this would help in some cases

Premises

- Wards already in place and facilities set up to function as they did before

Location

- Local beds in all locality areas- Mid Essex South Essex and South East Essex, and in all Council/Unitary areas- Essex, Thurrock and Southend

Finance

- Costs will be minimum as there would be no additional estate/facilities needed, other than to one location- see cons

Cons

Staffing

- There would be 4 separate sites for hospital beds. Staffing is the biggest risks to being able to open additional capacity. Having staff split between sites means losing the benefit of economies of scale; there would not be the ability to share staff between wards based on the acuity of patients, number of patients on each ward and ability/experience of staff. Having staff across just two facilities has allowed for this to happen.
- The medical model across previous sites was not equitable and there is a risk this would continue. There has been a significant reduction in the number of patients being readmitted to the acute whilst wards have been consolidated and there is a risk this would increase again, particularly out of hours if there are a number of sites again

- Issues of disparity in outcomes for patients, patients being accepted into the different wards and how rapidly this happens. This is key to keeping flow across the system and in the acute being able to deal with surge over the winter months
- Recruiting to Halstead site could be an issue because of its rural location
- Learning from the consolidation of wards already has shown there is more likely to be more of a variance in competence and expertise of staff across numerous smaller units

Premises

- High number of individual sites
- Halstead hospital would need to be developed to take the additional capacity

Location

- Halstead Hospital is at the very north of the MSE area and is closer to North Essex and Suffolk than South Essex and central mid Essex

Finance

- There would be removal costs involved with moving wards back to 3 sites
- Costs to developing Halstead site

Other

- Moving wards to 3 sites would need to be planned to ensure there wasn't any issues in services delivery whilst this happened. It is likely that each ward would need at least a couple of days to move and reset themselves up and this could impact system flow
- Added complexity where there are numerous sites of the discharge process, however this could be mitigated by the integrated discharge teams
- There is a political challenge in consolidating beds and taking beds out of local areas

Option 4: a (Option 8 in options table Appendix 1)

Option 8	Bed no's.	No. of sites	Beds per site ratio	Locality	Location
Maximum beds at Brentwood	147	4	60	South West Essex	Brentwood
Keep one ward at Braintree (stroke)	26				
Move back to Halstead and maximise capacity to meet additional requirements needed	44				

Beds return to CICC	22				
Total	**241**				

Option 4: b (Option 10 in options table Appendix 1)

Option 10	Bed no's.	No. of sites	Beds per site ratio	Locality	Location
Maximum beds at Brentwood	147	4	60	South West Essex	Brentwood
Keep one ward at Braintree (stroke)	26				
Move back to Halstead and maximise capacity to meet additional requirements needed	42				
Beds return to Mayfield	24				
Total	**241**				

Pros

Staffing

- Some staff have expressed that they would like to return to their original work place and this would help in some cases

Premises

- Wards already in place and facilities set up to function as they did before

Location

- Option 4: b- CICC-Local beds in all locality areas- Mid Essex South Essex and South East Essex

Finance

- Costs will be less than other options as 3 sites already in place and would require no additional work

Cons

Staffing

- There would be 4 separate sites for hospital beds. Staffing is the biggest risks to being able to open additional capacity. Having staff split between sites means losing the benefit of economies of scale; there would not be the ability to share staff between wards based on the acuity of patients, number of patients on each ward and ability/experience of staff. Having staff across just two/three facilities has allowed for this to happen.
- The medical model across previous sites was not equitable and there is a risk this would continue. There has been a significant reduction in the number of patients being readmitted to the acute whilst wards have been consolidated and there is a risk this would increase again, particularly out of hours if there are a number of sites again
- Issues of disparity in outcomes for patients, patients being accepted into the different wards and how rapidly this happens. This is key to keeping flow across the system and in the acute being able to deal with surge over the winter months
- Recruiting to Halstead site could be an issue because of its rural location
- Learning from the consolidation of wards already has shown there is more likely to be more of a variance in competence and expertise of staff across numerous smaller units

Premises

- High number of individual sites
- Halstead hospital would need to be developed to take the additional capacity

Location

- Halstead Hospital is at the very north of the MSE area and is closer to North Essex and Suffolk than South Essex and central mid Essex
- Option 4:a- CICC- There would be no beds in Thurrock
- Option 4: b- Mayfield- There would be no 'local' beds in South East Essex

Finance

- There would be removal costs involved with moving wards back to 3 sites
- Costs to developing Halstead site

Other

- Added complexity where there are numerous sites of the discharge process, however this could be mitigated by the integrated discharge teams
- There is a political challenge in consolidating beds and taking beds out of local areas

Option 5 (Option 18 in options table Appendix 1)

Option 18	Bed no's.	No. of sites	Beds per site ratio	Locality	Location	Ward	Ward capacity
Beds all return to previous locations pre COVID-19	139	6	40	South East Essex	Southend	Cumberlege (CICC)	22

				South West Essex	Thurrock Community Hospital	Mayfield	24
				South West Essex	Billericay	Mountnessing Court	22
				Mid Essex	Maldon	St Peters	26
				Mid Essex	Halstead	Halstead	20
Additional capacity needed remains at Brentwood as wards already in place	100			South West Essex	Brentwood	5 ward areas	
Total	**239**						

Pros

Staffing

- Some staff have expressed that they would like to return to their original work place. Changes to location of wards was a temporary move to support during the first phase of COVID-19

Premises

- Wards already in place and facilities set up to function as they did before. One ward would require additional work before it could return- see cons

Location

- Local beds in all locality areas- Mid Essex South Essex and South East Essex, and in all Council/Unitary areas- Essex, Thurrock and Southend

Finance

- Costs will be minimum as there would be no additional estate/facilities needed, other than to one location- see cons

Other

- There would be no political challenge as beds would be back in local areas

Cons

Staffing

- There would be 6 separate sites for hospital beds. Staffing is the biggest risks to being able to open additional capacity. Having staff split between sites means losing the benefit of economies of scale; there would not be the ability to share staff between wards based on the acuity of patients, number of patients on each ward and ability/experience of staff. Having staff across just two facilities has allowed for this to happen.
- The medical model across previous sites was not equitable and there is a risk this would continue. There has been a significant reduction in the number of patients being readmitted to the acute whilst wards have been consolidated and there is a risk

this would increase again, particularly out of hours if there are a number of sites again
- Issues of disparity in outcomes for patients, patients being accepted into the different wards and how rapidly this happens. This is key to keeping flow across the system and in the acute being able to deal with surge over the winter months
- Learning from the consolidation of wards already has shown there is more likely to be more of a variance in competence and expertise of staff across numerous smaller units

Premises

- High number of individual sites
- St Peter's would need work doing to the ward before moving back as there are numerous ongoing issues with the site. As explained earlier in the paper the current building is not fit for purpose as the facilities do not enable good quality care with dark corridors, poor and potentially unsafe flooring and the inability to manage heavy weight materials and patients. There is already work underway for a new build St Peter's hospital in the future as there are significant backlog maintenance costs already in the region of £7,261,740.

Location

- Mountnessing Court is just 6 miles away from Brentwood Community Hospital, so is very close to a large site to have a separate standalone ward
- Halstead Hospital is at the very north of the MSE area and is closer to North Essex and Suffolk than South Essex and central mid Essex

Finance

- There would be removal costs involved with moving wards back to 5 separate sites
- Costs highlighted above of moving the ward back to the St Peter's hospital site

Other

- Moving all wards back to 5 sites would need to be planned to ensure there were no issues in services delivery whilst this happened. It is likely that each ward would need at least a couple of days to move and reset themselves up and this could impact system flow
- Added complexity where there are numerous sites of the discharge process, however this could be mitigated by the integrated discharge teams

9 Next Steps

In the first instance this paper will be taken to the System Community Workstream Group for initial discussion and to agree next steps. These will be added to the paper following this meeting on the 3rd July 2020.

Appendix 1

All Options for Consideration

Options for beds v4.xlsx

Appendix 2

HOSC letter from Anthony McKeever, Executive Lead Mid and South Essex Health and Care Partnership & Joint Accountable Officer for its five CCGs (Interim)

8th June 2020

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3 September 2020	**ITEM: 8**
Health and Wellbeing Overview and Scrutiny Committee	
Proposed Consultation on Adult Social Care (Non-Residential) Fees and Charges 2021/22	
Wards and communities affected: All	**Key Decision:** Key
Report of: Catherine Wilson, Strategic Lead Commissioning and Procurement	
Accountable Director: Les Billingham, Director Adult Social Care and Communities	
Accountable Director: Roger Harris, Corporate Director Adults, Housing and Health	
This report is Public	

Executive Summary

This report outlines a very real issue where the gap between what we charge for domiciliary care and the actual cost we pay providers, has grown in recent years. This puts the stability of the service, certainly in the post COVID world, in doubt. Our preferred option – to phase an increase – brings us in far greater parity with Essex and Havering and allows residents to adapt to change over the three year period.

Providers are facing increased costs through the rises in the National Living Wage (NLW) and other cost pressures e.g. PPE requirements – in order for the Council to meet these very real increases in costs it is essential that we look at ways such as charging increases to maximise our ability to meet these pressures providers face.

Each year, as part of the budget setting process, the Council considers the level of fees and charges in those areas where there is local discretion. This is to ensure that we maximise resources to the Council but also that they are set fairly so as not to discourage service users from accessing services they need.

The strategic ambition for Thurrock is to adopt a policy on charging that aligns to the wider commercial strategy and ensures that all discretionary services will full cost recover. However, at the same time certain duties are placed on Local Authorities by the Department of Health and Social Care, the most important being the requirement to assess the individual's ability to pay.

This report looks at different charging options for internally provided and externally commissioned domiciliary care.

1. Recommendation(s)

1.1 For Health and Wellbeing Overview and Scrutiny Committee to review the three options for charging regarding the services in scope detailed in section 3.1

1.2 For Health and Wellbeing Overview and Scrutiny Committee to support the three options going out to public consultation.

1.3 For Health and Wellbeing Overview and Scrutiny Committee to support consultation with providers, as soon as possible, over the rates the Council pays with the presumption of an above inflation increase to stabilise the market and reflect the increased costs arising from COVID.

2. Introduction and Background

2.1 The Adult Social Care market remains fragile and the COVID-19 Global Pandemic has accentuated this fragility. In 2016 Thurrock experienced significant market failure within Domiciliary Care taking back into the Council 3 external providers resulting in the development of Thurrock Care at Home our in house domiciliary provision. Charging for services allows income to be generated to support the delivery of those services. Charges for the services in scope have remained fixed for 4 years at the then unit cost price of £13 an hour. Adult Social Care has given an increase in rates to our domiciliary care providers each year however, we have not increased the maximum amount we charge those who access these services.

The current unit cost for domiciliary care is £17.06 an hour. We apply equity in our charging policy the charge per unit cannot exceed the cost of the provision of the cheapest unit cost price. For example, internal domiciliary care declares a rate of £18.80 per hour for single-handed care, whereas the same service purchased externally is as stated £17.06. We cannot therefore charge in excess of £17.06 per hour.

Regionally our contracted price of £17.06 compares well to our neighbouring Local Authorities and as an Adult Social Care service we want to ensure that we support the market to remain sustainable by paying providers a realistic rate to provide responsive and high quality service. The table below illustrates rates for domiciliary care across four Local Authorities these rates are comparable across the Country.

Regional Comparison	
Authority	**Charge Per Hour**
Essex	£17.96
Havering	£17.50
Kent	£14.65 up to £16.24
Hertfordshire	£20.64

It is important to note that charging for other non-residential services provided by and commissioned through adult social care are not currently being considered within this consultation and so charges will remain at current levels. Those services are:

- Day Care as this service is currently under review in light of COVID
- Careline as this was a Member decision for the service to remain free of charge
- Respite Care as this is an essential preventative service that supports some of our most complex service users and their families
- Transport to services
- Meals on Wheels recently brought in house

2.2 The projected income from charging for services is influenced by a number of factors, this forecast is dependent on the number of individuals and the current levels of contribution that they are making. This is guided by:

- The person's financial situation.
- The benefit systems as a whole.
- The person's current living arrangements and circle of support.

The estimate is subject to fluctuation on a daily basis. Based on figures from the end of June and beginning of July 2020 the following details the projected income and number of people contributing to their care costs.

The first table indicates that by increasing the maximum charge to the current £17.06 hourly rate Adult Social Care would receive an additional income of approximately £243,969 a year.

	Estimated Income Per Annum By Per Hour Charge	
Hourly Rate	**£13.00**	**£17.06**
Estimated Income	**£1,772,808**	**£2,016,777**
Additional Income Per Annum		**£243,969**

The table below illustrates the number of service users receiving a service, detailing how many of those contribute in part or in full to their care costs.

Charging Assessment Band	Service user numbers	Detail
No charge	399	The person has a financial assessment and based on income and saving levels is assessed as not having to make a contribution to their care costs.
Opted out	109	The person does not have a financial assessment, as they do not want to disclose their income and savings. They therefore have to pay full cost for the service.
Section 117	32	The person receives after care under Section 117 following a period of inpatient treatment for mental ill health, the care is free of charge under Mental Health legislation.
Override band	6	This is when exemptions are made under very special circumstances and individuals are not charged for services.
Manual no charge	11	The person has very high disability related expenditure (DRE) due to the complexity of their condition and so are not charged.
Variable charge	589	The person has had a financial assessment and is assessed as being required to contribute to their care costs. The amount of the contribution varies according to each individuals financial circumstances.

Full charge	160	The person has had a financial assessment and has been assessed to pay the full cost of their care.

2.3 The process to ensure that charges are fair and equitable is as follows. When an individual is assessed under the Care Act 2014 and as a result of that assessment Adult Social Care provides care, a financial assessment takes place carried out by one of our Finance Assessment Officers. The assessment is to ascertain if the person will be required to make a financial contribution to the cost of their care and at what level that contribution will be. The financial assessment is usually undertaken through a visit to the person at home an assessment form is completed detailing the person's financial circumstances, level of income and savings together with any other assets. The Finance Assessment Officer will also detail any Disability Related Expenditure (DRE) this is anything that is required as a result of the person's condition or care needs that helps or supports them within their daily life. The DRE is deducted from outgoings before the calculation regarding any contribution is undertaken. All our Finance Assessment Officers have national benefit training once a year to ensure they are up to date with benefit changes.

3. Issues, Options and Analysis of Options

3.1 There are three options to be considered for charging within Adult Social Care for the services in scope.

The first is that the charges remain the same and we charge only to a maximum of the £13 an hour rate.

The advantage of remaining at the maximum level of £13 is that it would cause the least disruption and concern to people who use our services.

The disadvantage of remaining at a £13 maximum charge would be the loss of income to the Council an approximate £243,969 per year.

The second option is to implement the maximum charge of £17.06 an hour in one step and re-establish that link between what we pay providers and what we charge users.

The advantage of doing this is that the maximum income is generated to offset the increasing costs of care to the Council, realising a potential additional £243,696 per year.

The disadvantages of doing this in one step is that it is a significant increase as we have not raised the contribution for a number of years. The external hourly rate is now £4.06 more, for some people who receive services and pay full or almost full cost it would be a significant increase. People may feel they cannot afford such an increase and may reduce the amount of care they are receiving which longer term may have an impact on their wellbeing and may

mean that adult social care has to fund additional input when a service user's circumstances and wellbeing deteriorate.

The third option which is recommended, is to introduce an increase in charging incrementally over 3 years to enable the charges to keep pace with increases given to providers; this would be proposed as follows:

- Year 1 – £14.50 per hour.
- Year 2 – £16.00 per hour.
- Year 3 - £17.06 per hour : or up to the maximum being paid to external providers (NB this re-establishes the link between what we pay and what we charge and is likely to be a higher figure depending on what increases are agreed for providers over the next two years)

The advantage of taking a staged approach is that it will be more manageable for service users and not such a significant change from £13 to £17.06 and will be more affordable. People will be less likely to withdraw from care and may be more willing to pay the increase.

The disadvantage is that the income realised will be incremental and will not off set as fully each year the increased cost of care.

4. Reasons for Recommendation

4.1 The current maximum charge for the services in scope is £13 an hour which means that Adult Social care is losing potential income to off set the cost of care. It is important that we review our charging arrangements and we have increased the hourly rate that we pay to our external providers. To review this we want to ask those people who receive services now and the wider community their views through a consultation process. This consultation will help inform the final recommendations we would make to Cabinet regarding any potential increase in charge to our service users.

There are considerable financial pressures on adult social care now and increasingly likely so for the next few years. Care providers are facing increased costs through the rises in the National Living Wage, new infection control requirements and increased use of PPE. A separate consultation exercise with providers will be undertaken to confirm the rate we pay providers in future years but by increasing our income through this charge increase it will increase our ability to pay an appropriate increase to providers next year.

5. Consultation (including Overview and Scrutiny, if applicable)

5.1 We will undertake a formal consultation process regarding the 3 options outlined above. This will be in the form of a questionnaire, which will be sent to everyone who receives one of the services in scope. The questionnaire will also be place on the Consultation Portal. Usually we undertake consultation events across the Borough to enable as many people as possible to express

their views. In the light of COVID 19, we will need to ensure that our consultation adheres to social distancing guidelines together with exploring the use of interactive forums using technology to ensure that people are able to give us their views.

5.2 Following presentation at Health Overview and Scrutiny Committee and any recommendations, this report will be presented to Cabinet for final agreement to go out to public consultation.

5.3 The period of Public Consultation will start once final agreement is given to move forward. The results and recommendations from the consultation will be presented to Health and Well-Being Overview and Scrutiny Committee on the 14 January 2021 and then, including any recommendations, be presented to Cabinet on the 10 February 2021.

6. Impact on corporate policies, priorities, performance and community impact

6.1 The consultation regarding proposed charging options for the services in scope effects the following priority:

People *– a borough where people of all ages are proud to work and play, live and stay*

7. Implications

7.1 Financial

Implications verified by: **Mike Jones**

Strategic Lead – Corporate Finance

The effect of any changes to fees and charges will be determined as part of the budget setting process in which Corporate Finance and service areas will review anticipated level of demand, fee increases, previous performance and potential associated costs.

7.2 Legal

Implications verified by: **Courage Emovon**

Principle Lawyer/Contracts Team Manager

The Care Act 2014 provides a legal framework for charging in respect of Care and Support under Clause 14 and 17 and enables a local authority to decide whether to charge a person when it is arranging to meet a person's care and support needs or a carer's support need. The charges are primarily to cover the costs incurred by the local authority in providing the service. In arriving at what charges to be paid, service users are means tested and financially assessed. Thurrock Council has a duty to consult on any proposed changes

to charging. The process outlined within this report meets the duties under the Care Act 2014. A charging consultation must contain 4 elements as follows;

1. It must be at a time when proposals are still at a formative stage.
2. It must give sufficient reasons for any proposal to permit consideration and response from those to be affected.
3. Adequate time must be given for any consideration and response.
4. The result of the consultation must be taken into account in finalising any proposals.

7.3 **Diversity and Equality**

Implications verified by: **Roxanne Scanlon**

Community Engagement and Project Monitoring Officer

It is important to consider any potential impact to vulnerable people within Thurrock of any proposed changes to charging for services. Any approach to reviewing charges needs to be fair and equitable to ensure that people who really need services are able to access them and are not negatively impacted. A Community and Equality Impact Assessment is being undertaken by the lead officers on this work and will be carefully monitored to ensure that the impact of any potential changes is minimised.

7.4 **Other implications** (where significant) – i.e. Staff, Health, Sustainability, Crime and Disorder)

N/A

8. Background papers used in preparing the report (including their location on the Council's website or identification whether any are exempt or protected by copyright):

None

9. Appendices to the report

None

Report Author:

Catherine Wilson

Strategic Lead Commissioning and Procurement

Adults Housing and Health

3 September 2020	**ITEM: 9**
Health and Wellbeing Overview and Scrutiny Committee	
Procurement to provide Autism Specialist Support – Medina Road	
Wards and communities affected: All	**Key Decision:** Key
Report of: Catherine Wilson, Strategic Lead, Commissioning and Procurement	
Accountable Interim Director: Les Billingham, Interim Director, Adult Social Care and Community Development	
Accountable Director: Roger Harris, Corporate Director, Adults, Housing and Health	
This report is Public	

Executive Summary

The purpose of this report is to outline the proposal for the service model of care at the Medina Road development and the next steps for the delivery of this new service.

Medina Road is a housing scheme which contains 6 self-contained units of specialist designed accommodation to support individuals who have a diagnoses of Autism Spectrum Disorder.

As the development of this specialist autism unit progresses the report details the options that have been considered for the care and support provision enabling adults with autism to remain in Thurrock and maximise their independence within the community.

1. Recommendation(s)

1.1 For Health and Wellbeing Overview and Scrutiny Committee to review the future design of the service model to support people living at Medina Road.

1.2 For Health and Wellbeing Overview and Scrutiny Committee to support the proposal to commence the procurement of the support for Medina Road.

2. Introduction and Background

2.1 Thurrock Council's Adult Autism Strategy detailed the lack of long term residential or supported housing services for adults with autism within Thurrock often resulting in people being supported outside of the borough away from their families and communities resulting in an increase in financial cost to the authority.

2.2 Due to the outstanding Ofsted reports for the local specialist schools attracting families to move to the area the numbers of young people with autism are increasing. Thurrock's Adult Social Care's Market Development Strategy demonstrated a growth in people living with moderate/severe Learning Disabilities compared with the national average. There is an expected 13% increase in the number of people aged 18-64 with autism in Thurrock over the next seventeen years with high numbers of younger people coming through the transition process from Children's Social Care.

2.3 A "Care and Support Specialised Housing Fund (CASSH Fund)" bid to develop a specially designed housing scheme within borough for young people with autism was successful and in partnership with Peabody Trust (formally Family Mosaic) a site was identified at Medina Road, Grays.

2.4 The development of the scheme at Medina Road includes:

- 6 self- contained units of autism friendly designed accommodation
- Access to a private outdoor space (patio/garden) for each unit
- Small lounge/common room for residents
- 1 unit of accommodation for the on-site care and support team.

2.5 The scheme is nearing completion and the focus has turned to confirming those individuals who are suitable and wish to live within the scheme. To be eligible to live in the scheme the resident must be 18 years or older, have a diagnosis of Autism and have a local connection or live within the borough.

2.6 Adult Social Care are working alongside adults and young people approaching transition who meet the criteria and have shown an interest in moving into the scheme. This includes those currently living in residential or supported housing outside of the borough who would like to be repatriated to Thurrock.

2.7 The vision for the scheme is to support people with Autism to live a full and independent life. This will be achieved through a detailed assessment which will include specialist care and support service and where appropriate, education, vocational and employment opportunities. The assessment of need will result in an individualised care plan for each person; this will cover every aspect of the person's life. The services detailed below illustrate the range of options that will be available to meet those identifies needs. It will be expected that the person, their family and individual support will link together to ensure that the right service is accessed or bespoke services are developed. Bringing

together different services such as Inspire, specialist day opportunities and the World of Work will encourage the development of life skills and support community presence for each individual.

Inspire is the integrated education and skills offer working to provide educational pathways for Thurrock residents. There are a range of learning opportunities available linked closely to the adult education offer. This supports local residents to gain employment and training opportunities and recognise that learners have a range of challenges that makes learning difficult. The individuals who will live at Medina Road will be able to access a person centred pathway, as appropriate, which addresses their individual learning needs. Everyone living at Medina Road will be offered access to Inspire and will have the opportunity to be assigned a skills / life coach who will produce an Education and Health Care Plan specific to their needs to focus on independence with the right levels of support.

Specialist day opportunities support individuals to gain life skills which will complement the support delivered at Medina Road and provide opportunities to access the local community, participate in social activities and build relationships. Those who access this service will have individual 'All About Me' sessions to develop a response programme of support to enhance life skills and opportunities for independence

The World of Work enables people, where appropriate, to become ready for work through individual learning, support with volunteering and work opportunities together with links to Jobcentre Plus. The courses and service offered enhance the person's confidence understanding of work and volunteering, support to write a CV together with individual job coaching.

Supporting people with Autism can be complex, the people living within Medina Road will require significant levels of support. It is important therefore to ensure that each person, through their individual assessment has every opportunity to develop life skills and independence as fully as possible with the right levels of support.

3. Issues, Options and Analysis of Options

3.1 The Care Act 2014 promotes individuals rights to choice and control over their day to day life including where and whom they live with. This autonomy allows those who require support from social care to maximise their own potential and achieve a good life by choosing what is important to them within a safe environment. This is reflected in the aim of Medina Road for people living with autism to live as independently as possible within their own home for life.

3.2 To ensure that the service is successful, there will be two elements to support those who live within the scheme, housing related support and care and support. The housing related support will assist the tenants with housing related matters such as rent, paying utility bills, upkeep of their homes and

accessing their entitlements whilst the care and support will provide personal and emotional support where needed.

3.3 The vision for Medina Road is to support adults with Autism within the Thurrock Community. As Autism is a spectrum condition, this means that it can affect people in different ways. Some people with Autism also have a dual diagnosis including Learning Disabilities and Mental Health. To maximise inclusion for those who meet the criteria a specialist care and support provider will be required.

3.4 The specialist team will be required to adapt and flex to the needs and wishes of those who will live within the scheme. As some of the nominated individuals might have previously lived within a residential care or never lived on their own the support required will need to adapt to complex and challenging behaviours which might include the requirement for 24 hours a day support whilst the individual builds confidence and life skills.

3.5 To support the vision for Medina Road, the design of the care and support will need to achieve the following:

- Work alongside each individual to achieve pre-determined goals such as life skills.
- Increase independence for service users.
- Assistance to access the local community for those who are socially isolated.
- Become part of the community that they work in and are aware of the resources locally.

3.6 As the support required for Medina Road will be specialist, the cost of this service will depend on the needs and complexity of each individual who lives there. The care will be structured to include a model based on core care hours and individualised hours. The core care hours will be included as part of the tender process, while the individualised hours will be commissioned based on need. The model is as follows:

Core tenancy support costs, which are paid for through Housing Benefit, supporting each individual to maintain their tenancy and day to day living.

Core care costs which will provide care hours to each person, the people who will live at Medina Road will have high levels of care needs, the core care hours will be shared across all six service users and this will be procured for the whole service. The core care hour's model is based on 1 member of staff to support 2 Service Users will have an estimated cost for two units of £116,000 per year therefore the predicted annual cost of 3 x £ 116k i.e. £348,000. In addition to this, there will be a requirement for a sleep in night staff member at an estimated cost of £58,000. The total cost of the procured contract will be estimated at £406,000 per annum (approx. £65k per unit), **this is considerably less than the cost of residential care** there

might also be a need to top up individual costs but these will be determined dependent on need.

Individual care hours will be based on the individual need of each service users where there is a specific requirement for high-level specialist support for example where people may require one to one support to support their complexity of need. These hours will be individually commissioned either through a spot contract or Direct Payments.

By commissioning the model of support in this way, we will be able to control the impact of voids within the scheme. The final cost for the support element of the service will be arrived at through a competitive tender process based on quality and price.

3.7 We know from previous years and future demands that the numbers of people with autism coming into adult social care are growing. The projected growth in the prevalence of Autism is anticipated to be 13% over the next 17 years. We have reflected this in our Market Development Strategy 2018-2023. The range across the Autistic spectrum is from low level needs that do not require intervention from Social Care to very complex needs, where individuals require high cost packages. Most people with a diagnose of Autism who access Social Care also have Learning Disabilities or Mental Health challenges as well. Over the past five years we have seen the number and complexity of the condition has increased. In developing Medina Road, we are establishing a cost effective alternative for out of borough residential support for people who have autism. Due to the success of local schools such as Treetops and Beacon Hill, it is important that Thurrock responds and ensures there is local provision to deal with this demand. We have undertaken some further modelling work regarding future placement costs and the expected growth. We would anticipate therefore that if we do not create Medina Road as a viable alternative the budget pressures will increase over the next 3 to 6 years approximately by £225,848 per annum.

4. Reasons for Recommendation

4.1 For Health and Wellbeing Overview and Scrutiny Committee to review the future design of the service model to support people living at Median Road.

4.2 For Health and Wellbeing Overview and Scrutiny Committee to support the proposal to commence the procurement of the support for Median Road.

5. Consultation (including Overview and Scrutiny, if applicable)

5.1 The Autism Strategy was subject to extensive consultation with partners, users and carers.

6. Impact on corporate policies, priorities, performance and community impact

6.1 The care and support provision of Medina Road impacts on the following priority:

People *– a borough where people of all ages are proud to work and play, live and stay*

6.2 The scheme will help deliver one of the objectives of the Autism Strategy, in particular;

Continue to encourage the development of a range of new and innovative housing options offering care and support.

7. Implications

7.1 Financial

Implications verified by: **Michael Jones**

Strategic Lead – Corporate Finance

The funding for the project will be contained within the existing and future budget allocations as it forms part of the overall financial strategy for the departments.

This is part of the demographic growth requirements identified within the Councils medium term financial strategy, as the service should provide a more dynamic support model that focuses on improving independence, and therefore reducing costs overtime for individuals with very complex care needs.

7.2 Legal

Implications verified by: **Lindsey Marks**

Deputy Head of Law Social Care and Education.

The Care Act 2014 came into effect in April 2015 and replaced most previous law regarding carers and people being cared for. It outlines the way in which local authorities should carry out carer's assessments and needs assessments; how local authorities should determine who is eligible for support; how local authorities should charge for both residential care and community care; and places new obligations on local authorities. The Care Act 2014 imposes a duty on local authorities to undertake an assessment where there is an apparent need for care and support. The Care Act 2014 also required local authorities to undertake transition assessments if a child, young carer or adult caring for a child is likely to have needs when they , or the child in their care turns 18. This is regardless of whether the individual currently receives any support from Children's Services.

Procurement of the service model as stated in the body of this report requires compliance with the Public Contracts Regulations 2015

7.3 **Diversity and Equality**

Implications verified by: **Roxanne Scanlon**

Community Engagement and Project Monitoring Officer

Medina Road enables some of our borough's most vulnerable residents to live as independent as possible. The specially designed scheme, and care and support will assist residents of Thurrock to remain local, supporting their dignity and respect by recognising their diverse needs and significantly increase the offer of choice

7.4 **Other implications** (where significant) – i.e. Staff, Health, Sustainability, Crime and Disorder)

N/A

8. Background papers used in preparing the report (including their location on the Council's website or identification whether any are exempt or protected by copyright):

- Thurrock Health and Wellbeing Board Papers, 15 June 2015 item 16 – Bid to the Care and Supported Specialised Housing Fund for housing for young people with autism.
- Thurrock Council's Adult Social Care Market Development Strategy.

9. Appendices to the report

None

Report Author:

Michelle Taylor

Commissioning Manager

Adults, Housing and Health

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3 September 2020	ITEM: 10
Health and Wellbeing Overview and Scrutiny Committee	
Memorandum of Understanding across Mid and South Essex STP and update on CCG Merger and Single CCG Accountable Officer	
Wards and communities affected: All	**Key Decision:** N/A
Report of: Roger Harris, Corporate Director of Adults, Housing and Health and Mark Tebbs, Interim Deputy Accountable Officer, Thurrock CCG	
Accountable Assistant Director: N/A	
Accountable Director: Roger Harris, Corporate Director of Adults, Housing and Health	
This report is Public	

Executive Summary

The purpose of the Memorandum of Understanding (MoU) being considered by members at today's meeting is to formalise and build on our existing partnership arrangements and relationships across the Mid and South Essex footprint. It does not seek to introduce a hierarchical model; rather it provides a mutual accountability framework, based on principles of subsidiarity, to ensure we have collective ownership of delivery. It also provides the basis for a refreshed relationship with national oversight bodies.

The MOU defines an agreed governance framework that specifies the functions that will be delivered at:

- Locality (i.e. Sub-place footprint/Primary Care Network) level
- Place (i.e. The four places agreed across Mid and South Essex – Basildon, Thurrock, Mid-Essex and South East Essex)
- System (i.e. Health & Care Partnership/Mid and South Essex) level

The MoU recognises that accountability for the System and Places would be through Health Overview and Scrutiny Committee, with scrutiny undertaken by Health Overview and Scrutiny Committees, and further acknowledges that the MoU needs also to recognise the role and expectations of NHS regulatory functions.

The MoU shall commence on the date of signature of the Partners. It shall be reviewed within its first year of operation to ensure it remains consistent with the evolving requirements of the Partnership as an Integrated Care System. It shall

thereafter be subject to an annual review of the arrangements by the Partnership Board.

The MoU has been supported at the MSE Partnership Board and the Thurrock Health and Well-Being Board. It is currently being considered by the respective CCGs and Trust Boards.

1. Recommendation(s)

1.1 That Health and Wellbeing Overview and Scrutiny Committee members note and comment on the Memorandum of Understanding.

2. Introduction and Background

2.1 Since the creation of the Mid and South Essex Health and Care Partnership, the way system partners work has been further strengthened by a shared commitment to deliver the best care and outcomes possible for the 1.2 million people living in our area. We have recently published our 5-Year Strategy and Delivery Plan which outlines our vision and ambitions and refreshes our commitment to working together for the benefit of our residents.

2.2 The Mid and South Essex Health and Care Partnership have a number of lines of accountability – to each other, as partners, to our residents and service users and, for NHS partners, to government through NHS England and NHS Improvement. Through that route, two key expectations for systems have been identified:

- That we will work together to agree and deliver a **coordinated programme of transformational change,** to secure the long-term sustainability, ensure local delivery of the NHS Long Term Plan (LTP) and to support transformation of health and care at System, Place and Locality.
- That we will **collectively manage system performance**, noting that individual organisations retain individual statutory accountabilities.

2.3 The Memorandum of Understanding (MoU) has been created, at **Appendix 1**, to strengthen existing joint working arrangements and support our future development. This document is in two parts:

- Memorandum of Understanding – that provides an overview of the Partnership, its vision and priorities, principles for integrated working and a description of the functions at System, Place and Locality/Primary Care Network.
- Ways of working - that provides an overview of the governance arrangements and expectations for mutual accountability and collective agreement.

2.4 The recent Simon Stevens letter (31 July 2020) was clear that as part of the re-start / reset process it is the ambition of the NHS that every area become a fully-fledged ICS by 1st April 2021. The recruitment process for the Single Joint Accountable Officer is taking place in early September and again an update will

be provided at the HOSC meeting. These processes, along with the MoU are seen by NHS England as key components to becoming an Integrated Care System.

2.5 As a result of the COVID pandemic, work was paused on the proposal to establish a single CCG across Mid and South Essex. That work has not formally restarted although this remains the nationally direction of travel. The recruitment process into the CCG Joint Executive Team is currently underway and again an update will be provided at the HOSC meeting. Any application to merge the CCGs will not happen until September 2021.

3. Issues, Options and Analysis

3.1 The MOU provides a commitment across strategic partners to work together and undertake the planning and commissioning of services at the most appropriate geographical level.

4. Reasons for Recommendation

4.1 The MOU provides a commitment across strategic partners to work together and undertake the planning and commissioning of services at the most appropriate geographical level.

5. Consultation (including Overview and Scrutiny, if applicable)

5.1 The following partners have been engaged and consulted during the development of the MOU:

- Local Authorities and Health Overview and Scrutiny's across Essex, Southend and Thurrock
- NHS Commissioners representing Clinical Commissioning Groups across the Mid and South Essex Health and Care Partnership
- NHS Service Providers including NELFT, Essex Partnership University NHS Foundation Trust and East of England Ambulance Trust
- Other key partners including the local Healthwatch service within Thurrock, Southend and Essex and the CVS

6. Impact on corporate policies, priorities, performance and community impact.

6.1 The MOU helps to establish roles and responsibilities of local partners and will inform the future planning, commissioning and delivery of health and care services within Thurrock and across the wider Mid and South Essex Health and Care Partnership footprint.

7. Implications

7.1 **Financial**

Implications verified by: **Roger Harris**

Corporate Director Adults, Housing and Health

This report sets out a governance arrangements across Mid and South Essex and as such there are no direct financial implications.

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7.2 **Legal**

Implications verified by: **Roger Harris**

Corporate Director Adults, Housing and Health

The MoU is not a legal contract. It is not intended to be legally binding and no legal obligations or legal rights shall arise between the Partners from this MoU. It is a formal understanding between all of the Partners who have each entered into this MoU intending to honour all their obligations under it.

7.3 **Diversity and Equality**

Implications verified by: **Roger Harris**

Corporate Director Adults Housing and Health

None.

8. Background papers used in preparing the report

None

9. Appendices to this report

Appendix 1 - Memorandum of Understanding and Ways of Working

Report Author:

Roger Harris, Corporate Director of Adults, Housing and Health

Mark Tebbs, Interim Deputy Accountable Officer, Thurrock CCG

Appendix 1

Memorandum of Understanding & Ways of Working

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Foreword

Since the creation of our Partnership, the way we work has been further strengthened by a shared commitment to deliver the best care and outcomes possible for the 1.2 million people living in our area. We have recently published our 5-Year Strategy and Delivery Plan which outlines our vision and ambitions and refreshes our commitment to working together for the benefit of our residents.

As a Partnership we have a number of lines of accountability – to each other, as partners, to our residents and service users and, for NHS partners, to government through NHS England and NHS Improvement. Through that route, two key expectations for systems have been identified:

- That we will work together to agree and deliver a **coordinated programme of transformational change,** to secure the long-term sustainability, ensure local delivery of the NHS Long Term Plan (LTP) and to support transformation of health and care at System, Place and Locality.

- That we will **collectively manage system performance**, noting that individual organisations retain individual statutory accountabilities.

The challenge for the Partnership is to manage these expectations while also working together as equal partners. This document sets out how we will do this. We have aimed to:

- Put people at the heart of our approach, and not organisations.
- Honour the principle of subsidiarity
- Be respectful of the statutory functions and accountabilities of individual organisations
- Be as "light touch" as possible, while recognising the requirements placed upon us as outlined above, and that collectively, we are stewards of public services and funding.

We have agreed to develop this Memorandum of Understanding (MoU) to strengthen existing joint working arrangements and support our future development. This document is in two parts:

1. Memorandum of Understanding – that provides an overview of the Partnership, its vision and priorities, principles for integrated working and a description of the functions at System, Place and Locality/Primary Care Network
2. Ways of working - that provides an overview of the governance arrangements and expectations for mutual accountability and collective agreement.

The Covid-19 emergency has accelerated transformational change across the system. We have learned just how much can be done when led from the front line. The emergency has led to even closer working between organisations and sectors at place level and we realise that there is thereby still greater potential for change which is beneficial to all.

While we have made great strides, we know there is a lot more to do. The health and care system will continue to be under significant pressure, and we must address health inequalities. We all agree that working more closely together at System, Place and Locality level will enable us to tackle these challenges and achieve our ambitions. This MoU demonstrates our clear commitment to do this.

Professor Michael Thorne CBE, Independent Chair, Mid & South Essex Health and Care Partnership

Part 1: Memorandum of Understanding

Overarching Principles:

This MoU:

- Is based on an ethos that the Partnership is a **servant of the people** in Mid and South Essex.
- Seeks to ensure **collective decision-making** to **improve the health and wellbeing of our residents.**
- Has a **central principle of subsidiarity**.
- Commits to **supporting Place** as the primary planning footprint for both delivery of population health and integration of NHS, and adult and children's social care services.
- Recognises the **pivotal role of our Health and Wellbeing Boards** in setting joint health and wellbeing strategies to reduce health inequalities.
- Recognises the central role of **Local Authority Health Overview and Scrut**iny arrangements with responsibilities for holding health and care organisations to account and for scrutinizing major service changes
- Recognises the **regulatory functions of the NHS**.

This MoU is **not**:

- A legal contract. It is not intended to be legally binding and no legal obligations or legal rights shall arise between the Partners from this MoU.
- Intended to replace or override the legal and regulatory frameworks that apply to our statutory NHS organisations and Local Authorities.

1. Parties to the Memorandum

1.1 The members of the Mid and South Essex Health and Care Partnership (the **Partnership**), and parties to this Memorandum of Understanding (MoU), are:

Local Authorities

- Essex County Council* #
- Southend-on-Sea Borough Council #
- Thurrock Council #

NHS Commissioners

- NHS Basildon & Brentwood CCG
- NHS Castle Point & Rochford CCG
- NHS Mid-Essex CCG
- NHS Southend CCG
- NHS Thurrock CCG

NHS Service Providers

- East of England Ambulance Services Trust *
- Essex Partnership University NHS Foundation Trust *
- North East London NHS Foundation Trust *
- Mid & South Essex NHS Foundation Trust
- Provide CIC *

Heath Regulator and Oversight Bodies

- NHS England
- NHS Improvement

Other Partners

- Healthwatch Essex*
- Healthwatch Southend
- Healthwatch Thurrock
- Community & Voluntary Sector Network
- University College London Partners (UCLP)*
- Eastern Academic Health Science Network*

* These organisations are also part of neighbouring Integrated Care Systems.

\# The policy agenda and priorities for Local Authorities are set out by democratically elected councilors and cabinet and these are subject to scrutiny alongside management of finance and performance.

1.2 As members of the Partnership all of these organisations subscribe to the vision, principles, values and behaviours stated below, and agree to participate in the governance and accountability arrangements set out in this MoU.

1.3 Certain aspects of the MoU are not relevant to particular types of organisation within the partnership. These are indicated in the table at **Annex 1**.

Definitions and Interpretation

1, 4 This Memorandum is to be interpreted in accordance with the Definitions and Interpretation set out in Schedule 1, unless the context requires otherwise.

Term

1.5 This MoU shall commence on the date of signature of the Partners. It shall be reviewed within its first year of operation to ensure it remains consistent with the evolving requirements of the Partnership as an Integrated Care System. It shall thereafter be subject to an annual review of the arrangements by the Partnership Board.

2. Purpose

2.1. The purpose of this MoU is to formalise and build on our existing partnership arrangements and relationships. It does not seek to introduce a hierarchical model; rather it provides a mutual accountability framework, based on principles of subsidiarity, to ensure we have collective ownership of delivery. It also provides the basis for a refreshed relationship with national oversight bodies.

2.2. The MOU defines an agreed governance framework that specifies the functions that will be delivered at:

- Locality (ie. Sub-place footprint/Primary Care Network) level.
- Place (ie. The four places linked to respective Health and Wellbeing Boards)
- System (ie. Health & Care Partnership/Mid and South Essex) level

2.3. The MoU also outlines how partners will discharge the two key roles for the Integrated Care System, as defined by NHS England and Improvement. These are to;

- Work together to agree and deliver a **coordinated programme of transformational change,** to secure the long-term sustainability of the system, ensure local delivery of the LTP and to support transformation of delivery of health and care at System, Place and Locality.

- **Collectively manage system performance**, including the overall NHS financial and operational performance of the system, noting that individual organisations retain individual (and statutory) accountabilities

2.4. Partners to this MoU recognise that the system needs to move from a transactional model of commissioning /provision to a model of collaboration between health and care providers based on population health outcomes; and to transform healthcare services from a focus purely on treatment to one that also prevents ill health from occurring and has a strengths-based approach.

2.5. Our 5-year Strategy and Delivery Plan has outlined how we will take a Population Health System approach by working together to a common set of health and wellbeing outcomes.

2.6. We wish this MOU to provide pragmatic solutions to integration and partnership working and to avoid adding extra unnecessary layers of governance, bureaucracy or complexity. We aim to avoid creating rigid long term structures that are unable to evolve over time or which undermine the existing governance and statutory responsibilities of our individual organisations.

2.7. The MoU is not a legal contract. It is not intended to be legally binding and no legal obligations or legal rights shall arise between the Partners from this MoU. It is a formal understanding

between all of the Partners who have each entered into this MoU intending to honour all their obligations under it.

2.8. Nothing in this MoU is intended to, or shall be deemed to, establish any partnership or joint venture between the Partners to the MoU, constitute a Partner as the agent of another, nor authorise any of the Partners to make or enter into any commitments for or on behalf of another Partner.

3. Our Vision & Ambitions

3.1 We have worked together to develop a shared vision for health and care services across Mid and South Essex. All proposals, both as Partner organisations and at a Partnership level should be supportive of the delivery of this vision:

"A health and care partnership working for a better quality of life in a thriving Mid and South Essex, with every resident making informed choices in a strengthened health and care system"

We are committed to supporting:

Healthy Start – helping every child to have the best start in life
- Supporting parents and carers, early years settings and schools, tackling inequality and raising educational attainment.

Healthy Minds – reducing mental health stigma and suicide.
- Supporting people to feel comfortable talking about mental health, reducing stigma and encouraging communities to work together to reduce suicide

Healthy Places – creating environments that support healthy lives.
- creating healthy workplaces and a healthy environment, tackling worklessness, income inequality and poverty, improving housing availability, quality and affordability, and addressing homelessness and rough sleeping.

Healthy Communities – spring from participation
- making sure everyone can participate in community life, empowering people to improve their own and their communities' health and wellbeing, and to tackle loneliness and social isolation

Healthy Living – supporting better lifestyle choices to improve wellbeing and independent lives
- Helping everyone to be physically active, making sure they have access to healthy food, and reducing the use of tobacco, illicit drugs, alcohol and gambling.

Healthy Care – joining up our services to deliver the right care, when you need it, closer to home
- From advice and support to keep well, through to life saving treatment, we will provide access to the right care in the best place whether at home, in your community, GP practice, online or in our hospitals.

3.2 Our priorities for improving health outcomes, joining up care locally, and living within our financial means were set out in our 5-year Strategy & Delivery Plan and this MoU should be read in conjunction with the Strategy.

3.3 We have agreed through our 5-Year Strategy that our focus as a partnership should be to **reduce health inequalities** by seeking to shift resources to address the "inverse care law". We will do this by:

4 Principles for integrated working

This MOU, and more widely the way we plan, commission and deliver a Population Health System through an ICS is based on the following principles which all signatories to this MOU agree to:

1. **Prevention.** We will transform services from ones that react to health and care need, to ones that play a proactive part in keeping our residents as healthy and independent for as long as possible. We will intervene earlier to help people remain well. We recognise that this approach is both good for our population's health and wellbeing, and saves money in the longer term.

2. **Partnership.** *Progress occurs at the speed of trust.* We will ensure that future transformation and integration builds upon the strong relationships and partnerships at System, Place and Locality/PCN level and see to protect and nurture these relationships. We will ensure that future partnership arrangements include the widest possible range of stakeholders. As partners, at every level we will act for the benefit of the population we serve, and not for organisational self-interest. We will ensure that our residents are engaged as equal partners in decision making on future transformation activity at the most appropriate level.

3. **Whole Systems Thinking.** We recognise the value of coordinated action across all providers at each level of the system, as the best way to address the health and wellbeing challenges that our residents face. We have developed a single outcomes framework that operates across System, Place and Locality footprints. We seek to define population outcomes based contracts that coordinate action across multiple providers to ensure our system becomes sustainable over the long term.

4. **Strengths and Asset Based Approach.** We believe in a 'strengths and solutions' based approach. We see the individual as a whole person with differing needs and wants, not a passive recipient of "top down" services. We will harness and empower individuals to solve their own problems, with service providers support to 'fill the gaps'. We will leverage existing community and third sector assets in care delivery, connecting individuals with support outside of traditional NHS or Social Care interventions. This strengths based approach to delivering care will generate positive and varied solutions tailored to the wider wellbeing needs of each resident, not a 'one size fits all' option.

5. **Subsidiarity.** We believe in 'building from the bottom up'. We want to plan and deliver care in the heart of our communities. We recognise that PCNs and localities are the building blocks around which integration best occurs. We will devolve planning and delivery down to the lowest possible level where it makes sense to do so. Our starting point for service delivery, transformation and integration will be locality/sub locality level and we will only plan, commission and deliver services over wider geographical footprints where a clear case can be made that this is necessary.

6. **Empowering front line staff to do the right thing.** We believe in 'distributed leadership'; harnessing the creativity and energy of staff. We will move from a transactional model of commissioning to an approach that focuses on outcomes.

7. **Pragmatic Pluralism**. We recognise that across the system and our places there is a considerable heterogeneity of need between populations. We recognise that there are some actions that it makes sense to do once at system level, whilst others that need to be done differently in different places and localities. We will respect this diversity and develop pragmatic solutions that respond to it.

8. **Leverage Health Intelligence and the evidence base.** We recognise the importance of health intelligence and published evidence to fully understand and then best respond to ensure a high quality of care. We will use our JSNA programmes to understand the needs of our residents and improve their outcomes. We will look for opportunities for joint working between the three Public Health teams on shared health intelligence products. We know that different population groups have different care needs and we will use Population Health Management techniques like risk stratification and predictive modelling developed from our integrated health and care record system to identify and segment 'at risk' cohorts in our population and design targeted, tailored and proactive evidence based interventions to keep people well.

9. **Innovation.** Transforming the way we work means trying new and innovative approaches. To make process we will try and test new approaches, evaluating as we go, keeping the best and not admonishing ourselves where we fail and not being afraid to stop things that have not worked.

5. Expected Functions at Locality, Place & System Level

Subsidiarity is our guiding principle as a Partnership and everything we do together aims to ensure this. The following section describes the functions that may be carried out at each level in the system – at locality/PCN level, at Place and at System. The functions listed are not exhaustive. **Annex 4** provides a high level description of the spectrum of relationships between the various sectors and partners, and the functions that will be delivered within each.

Locality / Primary Care Network Level

5.1 Localities are the footprint upon which we can ensure that social care, welfare, advice, physical and mental health services collaborate to provide seamless care and support to residents. To support this approach, 28 Primary Care Networks (PCN) have been formed; these are groups of practices collaborating around populations of 30-50,000 residents.

5.2 We recognise the critical and increasing importance of localities and PCNs and support the principle of *subsidiarity;* that the starting point for planning, transforming and delivering services should be at the most local level practicable.

5.3 We have an aspiration to deliver Community-Led Commissioning/Resource prioritisation. We wish to shift power from organisations to communities, allowing them to drive what is commissioned, what it looks like, and to be part of the decision-making process.

5.4 At **Locality / PCN level** we commit to the following where practicable:

- Forming **locality/PCN based Steering Boards** to manage development and implementation of new models of integrated care within each locality
- Devolving the maximum number of programmes possible to create a coherent and integrated **locality offer**, moving services closer to communities.
- **Empowering front-line staff** to design and deliver a service offer that responds to local need and engages the third sector and residents in the wellbeing agenda.
- Through the **Better Care Fund**, identifying and protecting a local locality budget
- Developing **locality-based commissioning arrangements** where partners agree it makes sense to do so (eg locality/PCN based contracts for long-term condition case finding/management, LES services with GP, voluntary sector services)
- Delivery of locality based **healthy lifestyle services** (eg. self-care/patient education, smoking cessation, sexual health (spoke services), cervical screening, weight management)
- Supporting service delivery with a **mixed skill workforce** including integration of community healthcare, mental health, and social care.
- Delivery of a **wider range of services closer to people's homes**. This may include, but is not limited to:
    - Minor operations coordinated across GP practices (eg. lumps and bumps, vasectomy services)

- Phlebotomy services
- Long Term Conditions case-finding programmes including hypertension, AF and depression screening.
- Support for carers
- End of Life care
- Delivery of dental care and improved oral health programmes
- Delivery of MSK services
- Wound Care
- Single, integrated 'one stop shop' clinics for the management of diabetes, cardio-vascular disease and respiratory long-term conditions with input from secondary care consultants.
- New model of care for Common Mental Health Disorders and some mental health services for patients with SMI including IAPT, Dementia and Psychiatric Nursing
- Clinical models including diagnostics (eg. 24 hour blood pressure monitoring) and some secondary care outpatient clinic provision
- Consultant-led integrated primary/secondary care specialist clinical provision (eg. gerontology, community paediatrics, diabetes, neurology/epilepsy, community cardiology)
- Proactive clinical outreach to residential care homes
- Adult Social Care assessment/fieldwork services
- Social Prescribing
- Asset Based Community Development approaches including community assets and community resilience building
- Locality housing and employment support
- The Schools Wellbeing Service (defining a school as a community)
- Children's Centres – a wide range of services and support for families with young children.

Place (Integrated Care Partnership) Level

5.5 We have four defined Places across the system and will form four Integrated Care Partnership Boards with representation from all key local authority, NHS, Healthwatch, and community and voluntary sector stakeholders, aligned to the relevant Health and Wellbeing Board(s). These are:

- An Integrated Care Partnership for **Thurrock** encompassing the geographical footprint of Thurrock Council, Thurrock CCG ,Thurrock Joint Health and Wellbeing Board, Thurrock Healthwatch and Thurrock CVS
- An Integrated Care Partnership for **South East Essex** encompassing the geographical footprint of Southend-on-Sea Borough Council, part of Essex County Council, Castle Point Borough Council, Rochford District Council, Castle Point and Rochford CCG, and

Southend CCG, linking to both Southend Health and Wellbeing Board and Essex Health and Wellbeing Board.

- An Integrated Care Partnership covering for **Mid Essex** encompassing the geographical footprint of Mid Essex CCG, Chelmsford City Council, Maldon District Council, Braintree District Council and part of Essex County Council, linking to Essex Health and Wellbeing Board.
- An Integrated Care Partnership for **Basildon and Brentwood** encompassing the geographical footprint of Basildon and Brentwood CCG, Basildon District Council, Brentwood Borough Council, part of Essex County Council and linking to Essex Health and Wellbeing Board.

5.6 The work within each Place will reflect local priorities and relationships, and provide a greater focus on population health management, integration of services around the individual's needs, and a focus on care provided in primary and community settings.

5.7 We recognise *Place* as the primary planning footprint for both delivery of population health and integration of NHS, and adult and children's social care services. We also recognise the Kings Fund Research finding that 70% of integration activity occurs at Place or Locality level.

5.8 Appropriate resources will be made available to ensure our places can deliver agreed transformation programmes.

5.9 We acknowledge the pivotal role of Local Authorities in delivering integrated care and population health through their functions to address the wider determinants of health including housing, employment and economic growth, education, planning, regeneration and transport, their role in commissioning of primary and secondary prevention activity from the Public Health Grant, and their responsibility to commission and deliver Adult and Children's Social Care.

5.10 We further recognise the statutory role of the three Health and Wellbeing Boards, with responsibility for joint strategic needs assessments, and setting joint health and wellbeing strategies to reduce health inequalities. The Health and Wellbeing Boards also hold a requirement to approve plans for the Better Care Fund.

5.11 We also acknowledge the key roles of local Healthwatch in representing the views of patients and the community and voluntary sector in delivering wider health and wellbeing programmes.

5.12 Each place will have formal arrangements for engaging with local communities.

5.13 Political leadership for each ICP will be provided through the relevant Health and Wellbeing Board.

5.14 Each ICP will be accountable to the Health and Wellbeing Board for delivery of its locally agreed plan.

5.15 Each ICP will also have a line of accountability to the System (Partnership Board) for delivery of agreed system transformation, finance, quality and performance priorities.

5.16 We recognise the statutory role of Health Overview and Scrutiny Committees., with responsibilities for holding health and care organisations to account and for scrutinizing major service changes. Political scrutiny of proposals and decisions made at all levels of the system will be undertaken through Essex, Thurrock and Southend Health Overview and Scrutiny Committees and Cabinets. For some issues that have system-wide implications a Joint Overview and Scrutiny Committee will be established.

5.17 At each **Integrated Care Partnership** we commit to the following:

- **Developing and leading delivery of an Integrated Care Partnership Population Health Strategy** and outcomes framework aligned to wider Health and Wellbeing Strategies and the agreed system Outcomes Framework.
- Developing a single **ICP Integrated Care Alliance Contract** between all health and care stakeholders including the third sector with arrangements for sharing population health outcome metrics, and (where relevant) budgets and mechanisms to share financial risk and reward.
- **Gathering the views of our residents and engaging them** in re-design of services and commissioning decisions through Healthwatch and other consultation mechanisms.
- **Leading capital regeneration programmes** that impact on health and wellbeing and that are distinct to each ICP geography
- **Integrating planning and regeneration strategic programmes** that impact positively on wellbeing and wider determinants
- Developing and **implementing new models of integrated preventative care** encompassing NHS, adult and children's social care, education, housing, health improvement and prevention, community safety and third sector services/community assets.
- **Where appropriate, integrating Health and Social Care commissioning in a single function, managed through the Better Care Fund** as the financial delivery mechanism for integrated out of hospital health and care services.
- Development and **strategic leadership of local prevention programmes** eg tobacco control, smoking cessation, weight management.
- Delivery of **integrated Frailty Pathways** between hospital, community and primary healthcare, adult social care and the third sector.
- **Discharge planning from secondary to adult social care** including programmes to reduce/eliminate Delayed Transfers of Care
- Delivery of planned care activity including **Continuing Health Care.**

In addition, and depending on the footprint of the ICP, they may also undertake:

- **A Joint Strategic Needs Assessment and Healthcare Public Health Offer** to assess need/demand/supply and drive commissioning priorities
- **Management of integrated contracts / agreements** between providers eg. Section 75
- **Commissioning ICP wide primary prevention services** as appropriate, including local stop smoking, weight management, services that promote physical activity, services that improve nutrition, drug and alcohol treatment services, sexual and reproductive health services, public health nursing
- **Strategic commissioning Adult and Children's Social Care** where provision is borough wide

System (ie. Mid and South Essex) level

5.18 We recognise that there are some tasks and integration activity that it makes sense to do once, at scale, at *System* level for our 1.2m population. We also recognise the planning footprint of Mid and South Essex will become increasingly more important as the geography recognised by NHS England & Improvement for strategic financial and planning activity in their oversight of the NHS Long Term Plan implementation.

5.19 At System level, we commit to:

- Keep up to date our **Strategy & Delivery Plan**
- Agree and monitor a set of high level **population health outcomes** meaningful to the population of Mid and South Essex.
- Plan for and secure the right **workforce.**
- Use **digital technology** to drive change and ensure systems are inter-operable, including the development of the **integrated shared care record.**
- Place **innovation** and best practice at the heart of our collaboration, ensuring that our learning benefits the whole population,
- Develop and shape the **strategic capital and estates** plans across Mid and South Essex.
- Develop a shared **information, data, and intelligence function** to drive system-wide change.
- Operate as an Integrated Care System and progressively to build **population health management** capabilities required to manage the health of our population, keeping people healthier for longer and reducing avoidable demand for health and care services.
- Manage our **financial resources** within a shared financial framework for the NHS across the constituent CCGs and provider organisations to maximise system-wide efficiencies necessary to manage within the NHS financial control total. (See Annex 1 for organisations subject to the NHS control total)
- **Allocate resources in** line with the need to address health inequalities, re-investing savings in areas where this will have the largest impact for residents.
- Strengthen **strategic planning and commissioning arrangements** for the system.
- Own and resolve **system-wide challenges** (to be agreed between partners) through partnership working.
- Integrate, over time, the **regulatory functions** that have historically sat with NHSE/I as part of a single ICS.

Greater Essex

5.20 It is recognised that some services are planned, commissioned and delivered at the Greater Essex level – for example mental health and learning disability services. Nothing in this MoU seeks to undermine these arrangements.

NHS Region /National

5.21 It is recognised that some specialised NHS services are planned, commissioned and delivered at regional or supra-regional level. Nothing in this MoU seeks to undermine these arrangements.

Part 2: Ways of Working

This section of the document describes in more detail the ways of working and governance groups that exist.

6. Partnership Governance

6.1. The Partnership does not replace or override the authority of the Partners' Boards and Governing Bodies. Each of them remains sovereign and Councils remain directly accountable to their electorates.

6.2 The Partnership provides a mechanism for collaborative action and common decision-making for issues which are best tackled on a wider scale.

6.3 A schematic of our governance and accountability relationships is provided at **Annex 3** and terms of reference of the Partnership Board, System Leadership Executive, System Finance Leaders Group and Clinical & Professional Forum will be developed separately.

Partnership Board

6.4. A Partnership Board is in place to provide the formal leadership for the Partnership. The Partnership Board is responsible for setting strategic direction. It will provide oversight for all Partnership business, and a forum to reach collective agreement as Partners which neither impact on the statutory responsibilities of individual organisations nor have been delegated formally to a collaborative forum.

6.5. The Partnership Board is made up of the chairs of each organisation (NHS and upper tier Health & Wellbeing Board chairs), the Executive Lead for the Partnership (who is also the Joint Accountable Officer for the 5 CCGs), Chief Executive Officers of NHS provider organisations, lead officers for the three Local Authorities, Place-based leads, representatives from Healthwatch, Public Health, Community and Voluntary Sector organisations and the Local Medical Committee. Over time, membership will evolve to include identified system leaders for specific programmes eg. workforce, quality, performance.

The Partnership Board is independently chaired. It will meet at least 4 times each year in public.

6.6 The Partnership Board has no formal delegated powers from the organisations in the Partnership. However, over time our expectation is that regulatory functions of the national NHS bodies will increasingly be enacted through collaboration with our leadership. It will work by building agreement with leaders across Partner organisations to drive action around a shared direction of travel.

System Leadership Executive Group

6.7 The System Leadership Executive (SLE) Group comprises Chief Executive Officers and Accountable Officers of NHS organisations and lead officers from the Local Authorities. It is responsible for:

- Overseeing delivery of the Partnership's strategy, receiving reports from the Transformation Programme Delivery Group on priority programmes and agreeing action to resolve any issues arising.
- Taking advice from the System Finance Leaders Group and the Clinical and Professional Forum as appropriate.
- Regularly reviewing a dashboard of key performance, quality, finance and transformation metrics and taking appropriate action where required.
- Building leadership and collective responsibility for our shared objectives.
- Act as the interface with NHS regulators on system performance and assurance on behalf of the Partnership.

6.8. Members of the SLE will be expected to recommend that their organisations support agreements and decisions made by SLE (always subject to each Partner's compliance with internal governance and approval procedures).

Clinical & Professional Forum

6.9. Clinical and professional leadership is central to all of the work we do. Clinical and professional leadership is built into each of our work programmes and governance groups.

6.10 The purpose of the Clinical & Professional Forum is to drive clinical and professional leadership and provide support, advice, guidance and challenge to the Partnership, and to assist the Partnership in both setting and achieving its stated priorities.

6.11 The Clinical & Professional Forum ensures that the voice of professionals from across the range of partner organisations, drives the development of new models and proposals for the transformation of services. It also takes an overview of system performance on quality.

System Finance Leaders Group

6.12 Financial stewardship is key to the Partnership's work. The purpose of the System Finance Leaders Group is to provide financial support, advice and guidance to the Partnership and to assist the Partnership Board by providing collaborative financial leadership for all programmes.

6.13 The System Finance Leaders Group will develop a system-wide governance framework and work towards the system control total for NHS Partners, support the development of data analytics and financial modelling for the system, ensure financial plans are up to date, and develop a financial investment process to include the operation of an investment advisory group.

Transformation Programme Delivery Group

6.14 Delivery and transformation programmes have been established to enable the Partnership to achieve its agreed priorities. Cross-system programmes are overseen by a central Programme Management Office to ensure a consistent methodology of managing complex programmes.

6.15 Each programme has a Senior Responsible Owner, typically at executive level, and has a structure that builds in clinical and other stakeholder input, representation from each of our four places and each relevant service sector. All programmes will adopt the agreed system Design Principles and Target Operating Model described at **Annex 2**.

6.16 The Transformation Programme Delivery Group will comprise programme leads. It will meet bi-monthly to track progress of agreed priority programmes, manage risk and ensure interdependencies are managed. Programmes will provide regular updates to the System Leadership Executive.

Other governance arrangements between Partners

6.17 The Partnership is also underpinned by a series of governance arrangements specific to particular sectors (eg commissioners, providers, local authorities) that support the way it works.

The Joint Committee of Clinical Commissioning Groups

6.18 The five CCGs in Mid and South Essex are continuing to develop closer working arrangements within each of the four Places that make up our Partnership.

6.19 The CCGs established a Joint Committee in 2017, which has delegated authority to take decisions collectively on matters relating to:

- Acute hospital services
- NHS 111 services
- Ambulance services
- Patient transport services
- Acute mental health services

The Joint Committee comprises representatives from each CCG and has one lay member. To make sure that decision making is open and transparent, the Committee meets in public on a bi-monthly basis. The Joint Committee is underpinned by a memorandum of understanding and a work plan, which have been agreed by each CCG.

6.20 The CCGs have commenced work to engage with partners on a formal merger.

6.21 The Joint Committee is a committee of the CCGs, and each CCG retains its statutory powers and accountability. The Joint Committee's work plan reflects those partnership priorities for which the CCGs believe collective decision making is essential. It only has decision-making responsibilities for the Mid and South Essex programmes of work that have been expressly delegated to it by the CCGs.

6.22 The three acute hospital trusts in Mid and South Essex have been working closely together for several years and formally merged in April 2020 to become the Mid & South Essex NHS Foundation Trust.

Essex Partnership University NHS Foundation Trust (EPUT)

6.23 EPUT provides adult mental health and learning disability services across mid and south Essex. EPUT also provides Community services in south east Essex. For the purposes of NHS planning, EPUT aligns with the Mid and South Essex footprint. EPUT provides services across three STPs/ICS in Essex and is part of the New Models of Care Provider Collaborative with other mental health trusts for specialist mental health services in the region.

North East London NHS Foundation Trust

6.24 NELFT provide adult community services in south west Essex and children's community services across the footprint and children's mental health services across greater Essex. For the purposes of planning, NELFT aligns with north east London.

Provide CiC

6.25 Provide is a community interest company (social enterprise), providing health and care community services across the East region.

Joint Approach

6.26 NELFT, Provide and EPUT are currently exploring opportunities for joint working, sharing best practice and integration of services to achieve better outcomes for residents. This work is on-going with a view to a potential joint venture contract arrangement. NHS commissioners have indicated that they wish to pursue a single contract with the three providers.

Local Government

6.27 The Partnership includes three upper tier local authorities. Together, they work with the NHS as commissioning and service delivery partners, as well as exercising formal powers to scrutinise NHS policy decisions. At Place level, the district councils of Basildon, Brentwood, Castle Point, Rochford, Rayleigh, Maldon, Chelmsford and Braintree play a key role.

6.28 Within the Partnership, NHS organisations and Councils will work as equal partners, each bringing different contributions, powers and responsibilities to the table.

6.29 The four Places have accountability to the upper tier Health and Wellbeing Boards for delivery of locally agreed plans.

6.30 Local Authorities are subject to the mutual accountability arrangements for the partnership. However, because of the separate regulatory regime, certain aspects of these arrangements will not apply - most significantly, Local Authority partners would not be subject a single NHS financial control total and its associated arrangements for managing financial risk. However, through this MoU, Local Authorities agree to align with the spirit of joint planning, investment and performance improvement with NHS partners where it makes sense to do so. In addition, democratically elected councilors will continue to hold the partner organisations accountable through their formal Scrutiny powers. It is recognised that Essex County Council interacts with three ICS' and therefore must take a pragmatic approach to its interactions with each.

Current statutory requirements

6.31 NHS England has a duty under the NHS Act 2006 (as amended by the 2012 Act) to assess the performance of each CCG each year. The assessment must consider, in particular, the duties of CCGs to: improve the quality of services; reduce health inequalities; obtain appropriate advice; involve and consult the public; and comply with financial duties. The 2012 Act provides powers for NHS England to intervene where it is not assured that the CCG is meeting its statutory duties.

6.32 NHS Improvement is the operational name for an organisation that brings together Monitor and the NHS Trust Development Authority (NHS TDA). NHS Improvement must ensure the continuing operation of a licensing regime. The NHS provider licence forms the legal basis for Monitor's oversight of NHS foundation trusts. While NHS trusts are exempt from the requirement to apply for and hold the licence, directions from the Secretary of State require NHS TDA to ensure that NHS trusts comply with conditions equivalent to the licence as it deems appropriate. This includes giving directions to an NHS trust where necessary to ensure compliance.

6.33 NHS England and NHS Improvement are working more closely together and expect, over time, to merge. This means that NHS regulators will increasingly be taking a joined up approach to regulation of NHS partners, taking a "system first" approach. Our Partnership needs to be able to respond to this while respecting that non-NHS partners have separate lines of accountability.

7. A new model of mutual accountability

7.1. Through this MoU the Partners agree to take a collaborative approach to, and collective responsibility for, managing performance, resources and the totality of population health.

7.2 This MoU has no direct impact on the roles and respective responsibilities of the Partners which all retain their full statutory duties and powers.

7.3 The Partnership approach to system oversight will be geared towards performance improvement and development rather than traditional performance management. It will be data-driven, evidence-based and rigorous. The focus will be on supporting the spread and adoption of innovation and best practice between Partners.

7.4. Peer review will be a core component of the improvement methodology. This will provide valuable insight for all Partners and support the identification and adoption of good practice across the Partnership.

7.5. System oversight will including the following elements:

- Monitoring performance against key standards and plans in each place;
- Ongoing dialogue on delivery and progress and areas for improvement;
- Identifying the need for improvement support through education, sharing of best practice and peer review;
- Agreeing the need for more formal action or intervention on behalf of the Partnership; and

- Consideration of regulatory powers or functions.

7.6. A number of Partners have their own improvement capacity and expertise. Subject to the agreement of the relevant Partners this resource will be managed by the Partner in a coordinated approach for the benefit of the overall Partnership, and used together with the improvement expertise provided by national bodies and programmes.

Taking Action

7.7. The SLE will prioritise the deployment of improvement support across the Partnership, and agree recommendations for more formal support and intervention when needed. These may include:

- agreement of improvement or recovery plans;
- more detailed peer-review of specific plans;
- the appointment of external support where required; and
- restrictions on access to discretionary funding and financial incentives.

7.8 Where financial performance is not consistent with plan, the System Finance Leaders Group will make recommendations to the SLE on a range of support and, where required, intervention, including any requirement for:

- financial recovery plans;
- more detailed peer-review of financial recovery plans;
- external review of financial governance and financial management;
- organisational improvement plans;
- enhanced controls for deployment of transformation/capital funding held at Place

7.9 Mutual accountability arrangements will include a focus on delivery of key actions that have been agreed across the Partnership and agreement on areas where Places require support from the wider Partnership to ensure the effective management of financial and delivery risk.

National NHS Bodies – Support, Oversight and Escalation

7.10 As part of the development of the Partnership and the collaborative working between the Partners under the terms of this MoU, NHS England and NHS Improvement will look to adopt a new relationship with the Partners (which are NHS Bodies) in Mid and South Essex in the form of enacting streamlined oversight arrangements under which:

- Partners will take the collective lead on oversight of providers, commissioners and Places in accordance with the terms of this MoU;
- NHS England and NHS Improvement will in turn focus on holding the NHS bodies in the Partnership to account as a whole system for delivery of the NHS Constitution and Mandate, financial and operational control, outcomes and quality (to the extent permitted at Law);
- NHS England and NHS Improvement intend that they will intervene in the individual provider and commissioner partners only where it is necessary or required for the delivery of their statutory functions and will (where it is reasonable to do so, having regard to the nature of the issue) in the first instance look to notify the SLE and work through the Partnership Board to seek a resolution prior to making an intervention with the Partner.

7.11. To support Partnership development as an Integrated Care System there will be a process of aligning resources from Arms Length Bodies to support delivery and establish an integrated single assurance and regulation approach.

7.12. National capability and capacity will be available to support Mid and South Essex from central teams including governance, finance and efficiency, regulation and competition, systems and national programme teams, primary care, urgent care, cancer, mental health, including external support.

8. Collective Arrangements & Resolving Issues

8.1 We aim to make collective decisions as a partnership, respectful of the statutory obligations of each partner. Our approach to collective decision-making arrangements will follow the principle of subsidiarity and will be in line with our shared values and behaviours. We commit to taking all reasonable steps to reach a mutually acceptable resolution to any issue that arises.

8.2 Both the Partnership Board and SLE have no formal powers delegated by any Partner. However, they will increasingly take on responsibility for coordinating agreements, based on a "Best for Mid and South Essex" basis. The Partnership Board will initially have responsibility for reaching agreement on:

- The objectives of priority work programmes and work streams
- The apportionment of transformation monies from national NHS bodies
- Priorities for capital investment across the Partnership.
- Operation of the single NHS financial control total (for NHS Bodies)
- Agreeing common actions when Places or Partners become distressed

8.3 The Partnership Board will receive recommendations on the above from the SLE. The SLE will aim to reach agreement by consensus. If agreement cannot be reached, then the matter may be referred to the Partnership Board for wider discussion and resolution.

8.4 In respect of priorities for NHS capital investment or apportionment of transformation funding, if a consensus cannot be reached at the SLE meeting to agree this then the Partnership Board may make a decision provided that it is supported by not less than 75% of the eligible Partnership Board members. Partnership Board members will be eligible to participate on issues which apply to their organisation, in line with the scope of applicable issues set out in Annex 1.

8.5 The Partners understand any decision about service change that requires consultation will be undertaken in accordance with the relevant statutory obligations of partners.

Issue resolution

8.6 Partners will attempt to resolve in good faith any issues between them in respect of Partnership-related matters, in line with the principles set out in this MoU.

8.7 The Partnership will apply an issue resolution process to resolve any issues which cannot otherwise be agreed through these arrangements.

8.8 Subsidiarity will be the overarching principle when resolving issues. Therefore, where appropriate, Place-based arrangements will be used to resolve any issues which cannot be

dealt with directly between individual Partners, or which relate to existing schemes of delegation.

8.9. As agreements made by the Partnership do not impact on the statutory responsibilities of individual organisations, Partners will be expected to apply shared values and behaviours and come to a mutual agreement through the issue resolution process.

8.10. The key stages of the issue resolution process are

1. The SLE will discuss issues openly and transparently and seek to find resolution to the mutual satisfaction of each of the affected parties. The SLE will take appropriate advice from the System Finance Leaders Group, the Clinical and Professional Forum, Place/Alliances and other relevant groups in pursuit of a resolution.
2. The SLE will come to a majority decision (ie. a majority of eligible Partners participating in the meeting who are affected by the matter under discussion, determined by the scope of applicable issues set out in Annex 1) on how best to resolve the issue through applying the principles of this MoU and taking account of the objectives of the Partnership. SLE will advise the Partners of its decision in writing.
3. If the parties do not accept the SLE decision, or SLE cannot come to a decision which resolves the issue, the matter can be referred to an independent facilitator selected by SLE. The facilitator will work with the Partners to resolve the issue in accordance with the terms of this MoU.
4. In the unlikely event that the independent facilitator cannot resolve the issue, it will be referred to the Partnership Board. The Partnership Board will come to a majority decision on how best to resolve the issue in accordance with the terms of this MoU and advise the parties of its decision.

9. Financial Framework

9.1. All Partners are committed to working individually and in collaboration with others to deliver the changes required to achieve financial sustainability and live within our resources.

9.2. A set of financial principles have been agreed. They confirm that we will:

- aim to live within our means, and develop, for the NHS, system financial governance and risk management arrangements to deliver the system control total.
- develop a Mid and South Essex system efficiency plan in response to the financial challenges we face; and
- develop a shared approach to investment, including the establishment of an Investment Advisory Group
- develop payment and risk share models that support a system response rather than work against it.

9.3. We will collectively manage resources so that all Partner organisations will work individually and in collaboration with others to deliver the changes required to ensure financial sustainability.

Living within our means and management of risk

9.4. Through this MoU the collective leaders at System level and in each Place commit to demonstrate robust financial risk management. This will include agreeing action plans that will be mobilised across the Place in the event of the emergence of financial risk outside plans. This might include establishing a Place risk reserve where this is appropriate and in line with the legal obligations of the respective partners involved.

9.5. Subject to compliance with confidentiality and legal requirements around competition sensitive information and information security the Partners agree to adopt an open-book approach to financial plans and risks at System level and in each Place, leading to the agreement of fully aligned operational plans. Aligned plans will be underpinned by common financial planning assumptions on income and expenditure between providers and commissioners, and on issues that have a material impact on the availability of system financial incentives

NHS Contracting principles

9.6. NHS partners are committed to continuing the adoption of payment models which are better suited to whole system collaborative working and are outcome focused. The Partners will look to adopt models which reduce financial volatility and provide greater certainty for all Partners at the beginning of each year of the planned income and costs.

Allocation of Transformation Funds

9.7. The Partners intend that any transformation funds made available to the Partnership will be allocated through collective agreement by the Partnership, in line with agreed priorities. The method of allocation may vary according to agreed priorities – for example, funds may be allocated on an equitable basis in order to address the inverse care law. Any savings accrued through demand management functions will be re-invested where they can have maximum impacts for the population. Decisions will be guided by the Partnership population health management work.

9.8 Funds will not be allocated through expensive and protracted bidding and prioritisation processes and will be deployed in those areas where the partners have agreed that they will deliver the maximum leverage for change and address financial risk.

9.9. The funding provided to Places (through formula agreed by the partners) will directly support Place-based transformation programmes. This will be managed by each Place with clear and transparent governance arrangements that provide assurance to all partners that the resource has been deployed to deliver maximum transformational impact, address financial risk, and to meet efficiency requirements. Funding will be provided subject to agreement of clear deliverables and outcomes by the relevant Partners in the Place through the mutual accountability arrangements of the SLE and Partnership Board, and be subject to on-going monitoring and assurance.

9.10. Funding provided to the Programmes will be determined in agreement with Partners through the SLE, subject to documenting the agreed deliverables and outcomes with the relevant partners.

Allocation of ICS capital

9.11. The Partnership will play an increasingly important role in prioritising capital spending by the national bodies over and above that which is generated from organisations' internal resources. In doing this, the Partnership will ensure that:

- the capital prioritisation process is fair and transparent;
- there is a sufficient balance across capital priorities specific to Place as well as those which cross Places;
- there is sufficient focus on backlog maintenance and equipment replacement in the overall approach to capital;
- the prioritisation of major capital schemes must have a clear and demonstrable link to affordability and improvement of the financial position;
- access to discretionary capital is linked to the mutual accountability framework as described in this MoU.

Allocation of Provider and Commissioner Incentive Funding (Financial Recovery Funding)

9.12. The approach to managing additional funds set out by NHS planning guidance and business rules is not part of this MoU. A common approach to this will be agreed by the Partnership as part of annual financial planning.

10. Variations

10.1. This MoU, including the Schedules, may only be varied by written agreement of all the Partners.

11. Charges and liabilities

11.1. Except as otherwise provided, the Partners shall each bear their own costs and expenses incurred in complying with their obligations under this MoU.

11.2. By separate agreement, the Parties have agreed to share specific costs and expenses arising in respect of the Partnership between them in accordance with a "Contributions Schedule", developed by the Partnership and approved by the Partnership Board.

11.3. Partners shall remain liable for any losses or liabilities incurred due to their own or their employee's actions.

12. Information Sharing

12.1 The Partners will provide to each other all information that is reasonably required in order to achieve the objectives and take decisions on a "Best for Mid and South Essex" basis.

12.2. The Partners have obligations to comply with competition law. The Partners will therefore make sure that they share information, and in particular competition sensitive information, in such a way that is compliant with competition and data protection law.

13. Confidential Information

13.1. Each Partner shall keep in strict confidence all Confidential Information it receives from another Partner except to the extent that such Confidential Information is required by Law to be disclosed or is already in the public domain or comes into the public domain otherwise than through an unauthorized disclosure by a Partner. Each Partner shall use any Confidential Information received from another Partner solely for the purpose of complying with its obligations under this MoU in accordance with the principles and objectives and for no other purpose. No Partner shall use any Confidential Information received under this Memorandum for any other purpose including use for their own commercial gain in services outside of the Partnership or to inform any competitive bid without the express written permission of the disclosing Partner.

13.2. To the extent that any Confidential Information is covered or protected by legal privilege, then disclosing such Confidential Information to any Partner or otherwise permitting disclosure of such Confidential Information does not constitute a waiver of privilege or of any other rights which a Partner may have in respect of such Confidential Information.

13.3. The Parties agree to procure, as far as is reasonably practicable, that the terms of this Paragraph (Confidential Information) are observed by any of their respective successors, assigns or transferees of respective businesses or interests or any part thereof as if they had been party to this MoU.

13.4. Nothing in this Paragraph will affect any of the Partners' regulatory or statutory obligations, including but not limited to competition law.

14. Additional Partners

14.1. If appropriate to achieve the agreed objectives, the Partners may agree to include additional partner(s) to the Partnership. If they agree on such a course the Partners will cooperate to enter into the necessary documentation and revisions to this MoU if required.

14.2. The Partners intend that any organisation who is to be a partner to this MoU (including themselves) shall commit to the principles, governance arrangements and ways of working.

15. Signatures

15.1. This MoU may be executed in any number of counterparts, each of which when executed and delivered shall constitute an original of this MoU, but all the counterparts shall together constitute the same document.

15.2. The expression "counterpart" shall include any executed copy of this MoU transmitted by fax or scanned into printable PDF, JPEG, or other agreed digital format and transmitted as an e-mail attachment.

15.3. No counterpart shall be effective until each Partner has executed at least one counterpart.

Signed: Print:	Position	Organisation	Date
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Schedule 1 - Definitions and Interpretation

1. The headings in this MoU will not affect its interpretation.

2. Reference to any statute or statutory provision, to Law, or to Guidance, includes a reference to that statute or statutory provision, Law or Guidance as from time to time updated, amended, extended, supplemented, re-enacted or replaced.

3. Reference to a statutory provision includes any subordinate legislation made from time to time under that provision.

4. References to Annexes and Schedules are to the Annexes and Schedules of this Memorandum, unless expressly stated otherwise.

5. References to any body, organisation or office include reference to its applicable successor from time to time.

Annex 1 – Applicability of Memorandum Elements

	CCGs	NHS Providers*	Councils	NHSE & NHSI	Healthwatch	Other partners
Vision, principles, values and behaviour	✓	✓	✓	✓	✓	✓
Partnership objectives	✓	✓	✓	✓	✓	✓
Governance	✓	✓	✓	✓	✓	✓
Collective agreement and issue resolution	✓	✓	✓	✓	✓	✓
Mutual accountability	✓	✓	✓	✓		
NHS financial framework – risk management	✓	✓		✓		
Financial framework – Allocation of NHS capital and transformation funds	✓	✓		✓		
National and regional support	✓	✓	✓	✓		

*All elements of the financial framework for Mid & South Essex, eg the application of a single NHS control total, will not apply to all NHS provider organisations, particularly those which span a number of STPs. Provide CIC is a significant provider of NHS services. It is categorised as an 'Other Partner' because of its corporate status and the fact that it cannot be bound by elements of the financial and mutual accountability frameworks. This status will be reviewed as the partnership continues to evolve.

Annex 2 – Design Principles & Target Operating Model

Design Principle	Description

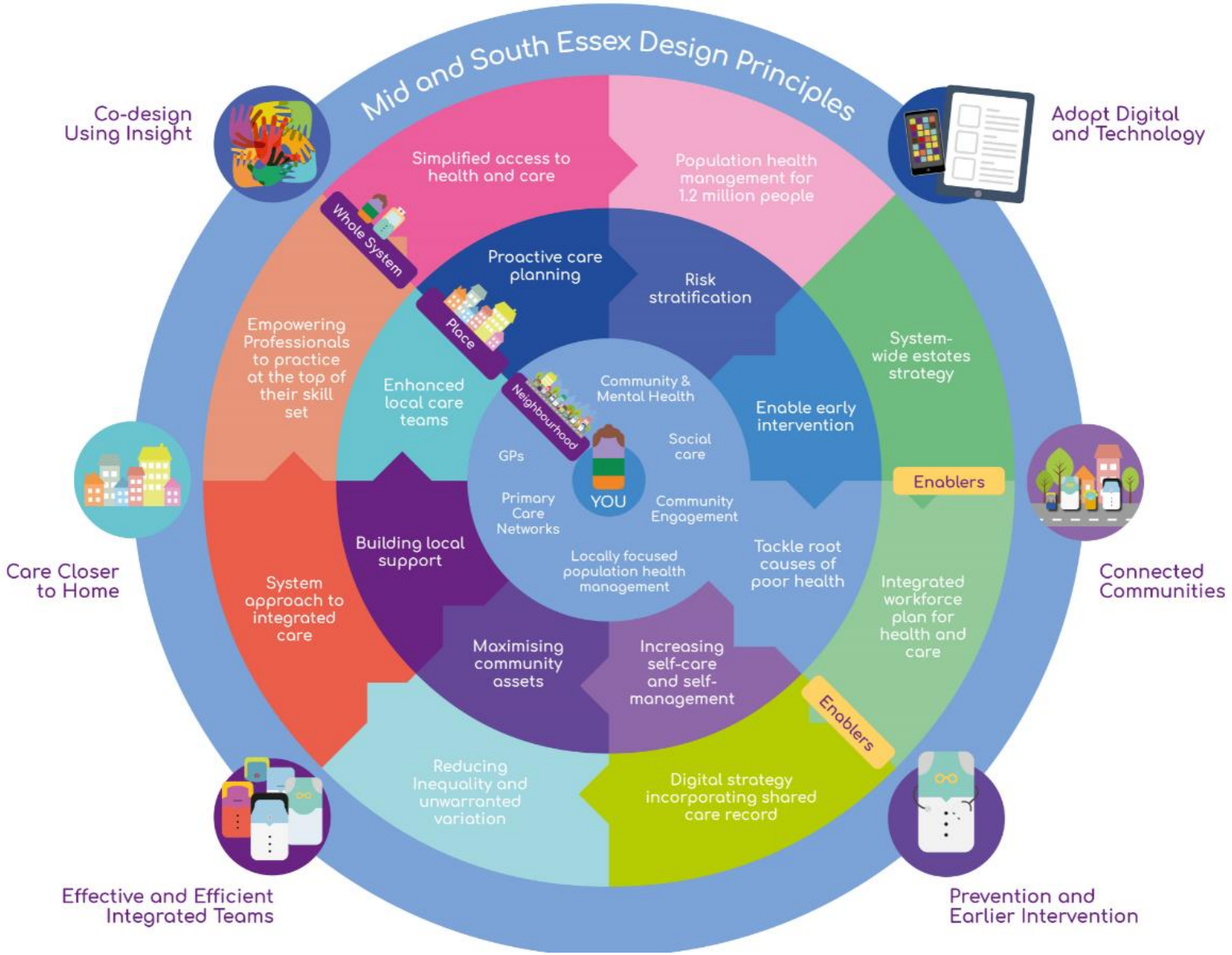
We will co-design with insights and intelligence, putting residents at the centre 	// We will work with our residents and staff to shape services that are focussed on better outcomes, long-term sustainability and continuous improvement driven by a feedback culture.
	// We will use data that is connected and evidence to ensure we understand fully the challenge and opportunity.
	// We will ensure we have the right resources to enable us to get an accurate view from shared and collective knowledge, insight and data, which will inform our plans and actions.

We will connect people together, delivering integrated care in the community 	// Services are designed to put residents in control – providing high quality information that is accessible online at any time and supporting them to make informed decisions. // We will ensure different organisations work together, meaning people get the right care more quickly and easily.
We will support people to stay well through prevention, self-care and independence thus building resilient communities 	// A shift from the reactive transactional model currently in place, to a responsive, proactive and sustainable system that focuses on keeping residents well and supports them through all stages of their life. // We will reduce inequalities by acknowledging and investing in the wider determinants of health and ensuring pathway design begins with prevention.

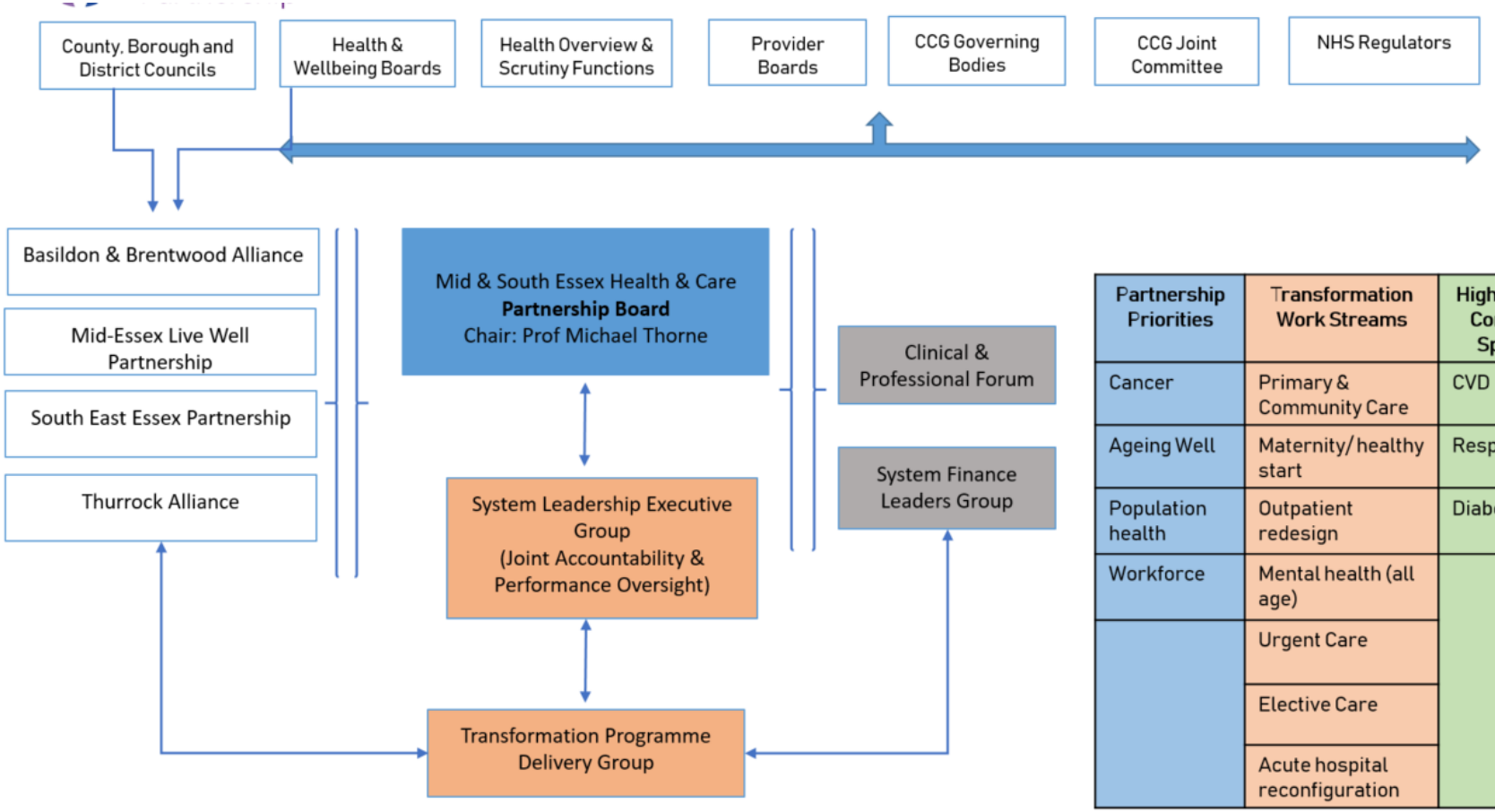
We will adopt digital and technology by default 	// Services will seek to optimise the use of technology consistently e.g. digital channels will be adopted as the primary and preferred method for communication and patient interactions.
	// Other channels will remain available but used only when most appropriate.
	// Staff and residents are supported to adapt to new ways of working and champion innovation.

We will enhance local care teams, led by multidisciplinary teams, that optimise the skills of a diverse workforce 	// Partners adopt a system-wide view and approach to delivering high quality, integrated services that are multidisciplinary team led. We will adopt best practice across the system, supporting all professionals to work at the top of their skillset.
	// Local teams will have ownership for helping deliver clinically, operationally and financially sustainable services.
	// We will support GP practices to work more closely together and to work with other care providers, sharing skills and resources.

 We will deliver services as close to the home as possible	// Community based provision of services is the default position, unless necessitated by clinical need. This ensures residents are able to access health, care and wellbeing services in the most appropriate setting for their needs; including online.

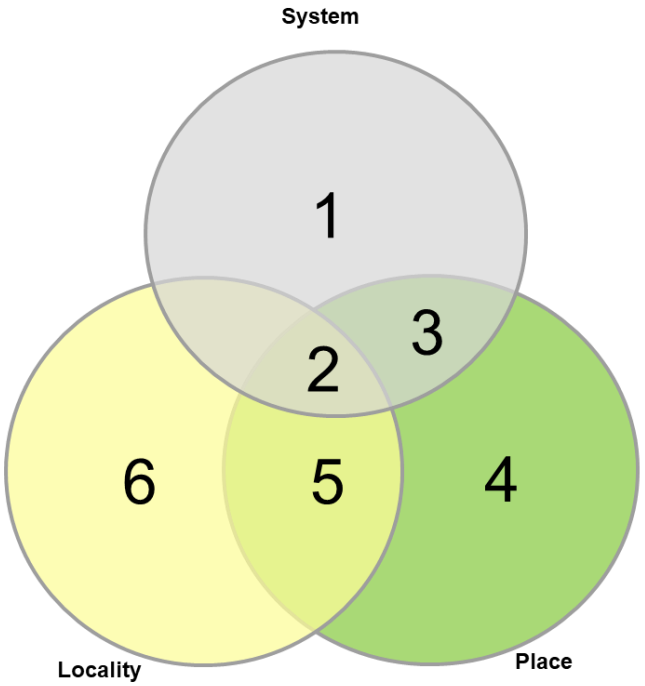

Mid and South Essex Design Principles
Co-design Using Insight
Adopt Digital and Technology
Simplified access to health and care
Population health management for 1.2 million people
Whole System
Proactive care planning
Risk stratification
Place
Empowering Professionals to practice at the top of their skill set
Enhanced local care teams
Neighbourhood
Community & Mental Health
Social care
GPs
YOU
Primary Care Networks
Community Engagement
Locally focused population health management
System-wide estates strategy
Enable early intervention
Enablers
Tackle root causes of poor health
Integrated workforce plan for health and care
Building local support
System approach to integrated care
Maximising community assets
Increasing self-care and self-management
Reducing Inequality and unwarranted variation
Digital strategy incorporating shared care record
Enablers
Care Closer to Home
Connected Communities
Effective and Efficient Integrated Teams
Prevention and Earlier Intervention

Annex 3 – Partnership Overview



Partnership Priorities	Transformation Work Streams	High-Impact Condition Specific	Enabling Programmes
Cancer	Primary & Community Care	CVD	Digital
Ageing Well	Maternity/healthy start	Respiratory	Innovation & Improvement
Population health	Outpatient redesign	Diabetes	Communications & Engagement
Workforce	Mental health (all age)		Estates & Capital
	Urgent Care		Business functions
	Elective Care		
	Acute hospital reconfiguration		

Annex 4 – Spectrum of Relationships



1

Shared vision and purpose for Population Health

System wide health intelligence

Population Health Outcomes Framework

Integrated Data Solution procurement/management

Workforce

Owning and resolving system wide challenges e.g. A&E

NHS Capital Programme

System wide population health activity e.g. Ottawa stop smoking model within hospitals

Single ICS contract for activity that it makes sense to do once at system level:

- Primary Care contracting and performance management
- Secondary Healthcare commissioning across more than one hospital site
- NHS Specialist commissioning
- System wide MH commissioning including inpatients, crisis care, ANLS, suicide prevention, RAID

Strategic oversight of STP Primary Care Strategy

2

Allocation of system wide finance/resources based on need/inequality
Use of integrated data
Local planning/implementation to support system wide priorities

3

Frailty Care pathway
Planned care commissioning
Secondary care implementation of prevention programmes

4

Integrated Care Partnership of all key stakeholder agencies with a single Alliance Contract and outcomes framework aligned to wider Health and Wellbeing Strategies, single capitated budget and mechanisms for risk/reward share between partners

Joint Strategic Needs Assessment to drive commissioning priorities

Engaging resident views in re-design of services through Healthwatch

Capital regeneration programmes that impact on Health and Wellbeing

Developing and strategic oversight of integrated care models

Integrating planning/regeneration and housing functions to impact positively on wellbeing

Integrating Health and Social Care commissioning managed through the BCF as the financial deliver mechanism for integrated out of hospital health and care

Strategic leadership of prevention programmes including Tobacco Control, Whole Systems Obesity, children and young people's wellbeing, public mental health

Management of integrated contracts/agreements between providers e.g. Section 75

Commissioning of lifestyle modification services including smoking cessation, weight management and drug/alcohol treatment

Commissioning planned care including continuing care

Minor Injuries

5

Developing single integrated population outcome based contracts encompassing LTC case finding/clinical management, PH lifestyle services, LESs, NHSE dental, PCN contracts, and provision of MH and community services
Single locality budget within BCF
Devolution of current place based services to locality level e.g. Community Led Solutions
Market development of locality based services

6

Formation of Local Based Steering Boards to manage implementation/delivery
Empowering front line staff in service re-design
Co-commissioning with residents
Implementation of integrated locality contracts care models including lifestyle modification, mixed skill clinical workforce, minor ops, LTC case finding/management, end of life care, wound care, CMHDs, IMC clinical models, proactive outreach to care homes, wellbeing teams, ASC fieldwork, social prescribing, community hubs/development, children's centres, edge of care services, locality housing offices

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Health Overview & Scrutiny Committee
Work Programme
2020/2021

Dates of Meetings: 18 June 2020, 3 September 2020, 5 November 2020, 14 January 2021 and 4 March 2021

Topic	Lead Officer	Requested by Officer/Member
18 June 2020		
HealthWatch	Kim James	Members
Health and Adult Social Care System COVID-19 Response	All	Members
Progress Update on Major Health and Adult Social Care Projects	Roger Harris, Mark Tebbs, Les Billingham	Officers
3 September 2020		
HealthWatch	Kim James	Members
2019/20 Annual Complaints and Representations Report – Adult Social Care	Lee Henley	Officers
Proposed Consultation on Adult Social Care (Non-Residential) Fees and Charges 2021/22	Catherine Wilson	Officers
Temporary reconfiguration of NHS Community Beds across Mid and South Essex including Mayfield Ward move from Thurrock Hospital to Brentwood Hospital	Tania Sitch (NELFT)	Members
Memorandum of Understanding across Mid and South Essex STP and update on CCG Merger and Single CCG Accountable Officer	Roger Harris / Mark Tebbs	Members
Procurement of Autism specialist Support Services - Medina Road	Les Billingham / Catherine Wilson	Officers

5 November 2020		
HealthWatch	Kim James	Members
Update on Orsett Hospital / IMCs	Roger Harris	Members
Verbal Update Targeted Lung Health Checks	Mark Tebbs	Members
Mental Health – Presentation from Providers	Providers	Members
14 January 2021		
HealthWatch	Kim James	Members
Adult Social Care - Fees & Charges Pricing Strategy 2021/22	Roger Harris	Officers
Update on the Whole Systems Obesity Strategy Delivery and Outcomes Framework	Helen Forster / Faith Stow	Members
Personality Disorders and Complex Needs Report	Mark Tebbs / Andy Brogan	Members
Worklessness and Health Joint Strategic Needs Assessment	Helen Horrocks / Sue Bradish	Officers
4 March 2021		
HealthWatch	Kim James	Members
Update on Orsett Hospital / IMCs	Roger Harris	Members

Clerk: Jenny Shade

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