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 **1 September 2022**

Committee Room 2, Civic Offices, New Road, Grays, Essex, RM17 6SL.

Membership:

Councillors Shane Ralph (Chair), Terry Piccolo (Vice-Chair), Tony Fish, Georgette Polley, Jane Pothecary and Sue Sammons

Kim James (Healthwatch Thurrock Representative) and Neil Woodbridge (Chief Executive Officer, Thurrock Lifestyle Solutions)

Substitutes:

Councillors Alex Anderson, Victoria Holloway, John Kent, Elizabeth Rigby and Graham Snell

Agenda

Open to Public and Press

Page

1. Apologies for Absence

2. Minutes **5 - 12**

To approve as a correct record the minutes of the Health and Wellbeing Overview and Scrutiny Committee meeting held on 7 June 2022.

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. To agree any relevant briefing notes submitted to the Committee.

4. Declarations of Interests

5.	**HealthWatch**	
6.	**Grays Integrated Medical and Wellbeing Centre (IMWC) Engagement Update - (PowerPoint)**	
7.	**Community In-Patient Beds**	**13 - 56**
8.	**2021/22 Annual Complaints and Representations Report - Adult Social Care**	**57 - 84**
9.	**Contract for Occupational Therapy and Independent Mobility Assessment Service**	**85 - 90**
10.	**Contract to Supply, Install, Maintain & Repair Telecare Equipment**	**91 - 102**
11.	**Work Programme**	**103 - 106**

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: **24 August 2022**

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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?**

↓

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.

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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;**
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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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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 7 June 2022 at 7.00 pm

Present:	Councillors Terry Piccolo (Vice-Chair), Tony Fish, Georgette Polley, Jane Pothecary, Sue Sammons and Graham Snell (Substitute) (substitute for Shane Ralph)
Apologies:	Councillor Shane Ralph (Chair), Kim James, Neil Woodbridge and Ian Wake
In attendance:	Ceri Armstrong, Senior Health and Social Care Development Manager Les Billingham, Interim Director of Adult Social Care and Community Development Jo Broadbent, Director of Public Health Tiffany Hemming, NHS Basildon and Brentwood CCG Ian Kennard, Adults Contract Management Team Catherine Wilson, Strategic Lead Commissioning and Procurement Jenny Shade, Senior Democratic Services Officer

Before the start of the Meeting, all present were advised that the meeting was being recorded, with the audio recording to be made available on the Council's website. In the absence of the Chair the Vice Chair, Councillor Piccolo, chaired the meeting.

1. Minutes

Minutes of the Health and Wellbeing Overview and Scrutiny Committee held on the 3 March were approved as a correct record.

2. Urgent Items

No urgent items were received and no discussion on briefing notes took place.

3. Declarations of Interests

There were no declarations of interest.

4. Healthwatch

Due to Kim James sending her apologies, the Chair moved onto the next item.

5. Integrated Medical Centres Update (PowerPoint Presentation)

Tiffany Hemming presented a PowerPoint on the update of the Integrated Medical Centres (IMCs). This PowerPoint can be found from the following link:

(Public Pack)Item 6 - Integrated Medical Centre Update Presentation Agenda Supplement for Health and Wellbeing Overview and Scrutiny Committee, 07/06/2022 19:00 (thurrock.gov.uk)

Councillor Piccolo thanked Tiffany Hemming for the update and referred to the extended deadline of the Tilbury IMC and questioned whether those additional costs for the redesign work would be looked at from another source. Tiffany Hemming stated that the savings for the redesign had come back, and they had saved relatively little and that work was now underway to ensure the design actually worked as it currently did not. Work would be undertaken to determine how much space was in the building which in turn would predict the overall costs for the building. A decision would be made once the district valuation costs had been determined and whether this cost would be affordable to the NHS. Councillor Piccolo continued to question what the fall-back position would be if this was not affordable and the additional funding was not available from NHS England. Tiffany Hemming confirmed that currently there was not a fall-back position but work continued by sending strong linkages to the towns regeneration scheme which highlighted significant additional benefits that might help to persuade NHS England to allow for the work to move forward.

Councillor Piccolo referred to the services moving out of Orsett Hospital into the Corringham IMC and questioned how many of those services would be available from day one to which Tiffany Hemming stated there would be a soft launch, moving services over a few weeks and expected to have everything operating out of the Corringham IMC in the space of about six weeks.

Councillor Fish questioned what the parking arrangements at the Corringham Health Centre second site would be, as he had experienced problems parking and felt the parking arrangements were dangerous. Tiffany Hemming stated at this time no car parking plans had been made for that site and as the strategy was developed for that site this would include a travel plan which would include parking.

Councillor Polley referred to fellowship general practitioners and the extended appointment times and questioned whether 111 would have access to these out of hours appointments or would these only be available through resident's general practitioner. Councillor Polley raised her concerns on the lack of primary care appointments and to the lack of progress being made to the Purfleet, Grays and Tilbury IMCs and asked for reassurance that Orsett Hospital would not close until all four IMCs were up and running and all services were available to residents. Tiffany Hemming stated that extended appointments and general practitioner appointments would be open to 111 to book and for residents to book via their general practitioner as the systems were electronically linked. It had been recognised that Thurrock was under doctored and was being prioritised for the general practitioner fellowship scheme, to recruit 12 newly qualified general practitioners to be based at the

Corringham IMC from September 2022 and provide a minimum of 500 appointments across the whole of Thurrock. Members were reassured that Orsett Hospital would only close once all services had been relocated from where they were currently provided into the IMCs.

Councillor Pothecary stated that the process so far had not inspired her with confidence that the plans would move quickly enough to have those three IMCs opened by 2024 and questioned what plans were in place should these sites not be delivered before the scheduled closure date of Orsett Hospital. Tiffany Hemming acknowledged Councillor Pothecary's concerns and stated that in her new role as executive director she would be bringing in three people who would be dedicated to work on the program as permanent management officers to ensure everything was undertaken in a timely manner and everything happened as it should. A part time lead person to lead on the program would also be brought in to ensure work actually happened when it should and to ensure activities would be delivered on time. Members were also informed that the closure of Orsett Hospital would also be work streamed into the program so that it would be linked with the opening of the four sites.

Councillor Sammons also raised her concerns that Orsett Hospital should not close until all the services were available in the IMCs.

Councillor Snell raised his disappointment that general practitioners offering services would not now be physically present in the IMCs to which Tiffany Hemming stated it was still the plan to put general practitioner services into the four IMCs alongside primary care network services which would be open to all residents. Also appointments at IMCs would be offered by general practitioners for residents who may need to see a general practitioner who specialised in a particular area.

Councillor Piccolo thanked Tiffany Hemming for the presentation and the responses provided to the questions raised this evening.

Tiffany Hemming left the meeting at 7.47pm.

6. Integrated Community Equipment Service Reprocurement

Catherine Wilson presented the report that outlined the duty under the Care Act 2014 and the Children and Families Act 2014 to supply Community Equipment for those with eligible need. The report detailed the current arrangements and the options that had been explored for future procurement.

Councillor Piccolo thanked Catherine Wilson for the report and questioned whether the department had actively looked for more cost-effective options rather than extending the current arrangements to which Catherine Wilson stated the market was extraordinary limited with only a few providers able to provide contracts of this size and over the next three years would look into how this could be undertaken in a different way. Councillor Snell agreed that there was a very limited number of suppliers and not much choice but what was important was the stability of supply.

Councillor Pothecary questioned why there had not been a consultation with users to establish whether service users were happy with the service they received and how the service was currently performing and felt this was relevant to the report. Ian Kennard stated the service performance was performing very well and had been consistent during Covid. The contract had financial pressures and were looking to make savings on the contract but to also improve service delivery. In terms of resident's satisfaction, in relation to KPI indicators and complaints the performance was very good.

Councillor Polley praised the work undertaken by the discharge planning team and had the privilege of visiting the team as part of the National Social Workers Week. Councillor Polley welcomed the report and referred to the equipment that was no longer needed by service users and how the collection of these items could be improved.

Councillor Fish fed back to the committee as a service user and questioned why there were delays on more bespoke items of equipment.

RESOLVED:

1. **Health and Wellbeing Overview and Scrutiny Committee reviewed and commented on the content of the report.**

2. **Health and Wellbeing Overview and Scrutiny Committee supported a proposed recommendation to Cabinet that the procurement of Community Equipment should move forward under the current Collaborative arrangements.**

Catherine Wilson and Ian Kennard left the meeting at 8.03pm.

7. Adult's Integrated Care Strategy

Ceri Armstrong introduced the "Better Care Together Thurrock - The Case for Further Change – Thurrock's new adults' Integrated Care Strategy" to members. The Better Care Together Thurrock - The Case for Further Change had set out the ambitious and detailed plans for transforming Thurrock's health, care, housing and wellbeing services and provided a blue-print for service integration to form one place-based and integrated care system, designed to deliver better outcomes for individuals that would take place close to home and make the best use of health and care resources.

The following PowerPoint was presented to Members:

(Public Pack)Item 8 - The Case for Future Change Presentation Agenda Supplement for Health and Wellbeing Overview and Scrutiny Committee, 07/06/2022 19:00 (thurrock.gov.uk)

Councillor Piccolo thanked Ceri Armstrong and Les Billingham and welcomed the report which had thoroughly proven that we understood what worked well.

Councillor Piccolo questioned whether the changes would jeopardise the effectiveness of the services and how this would affect the number of staff to which Ceri Armstrong stated there would not be any difference in the number of staff just that they would be working in a very different way. Moving services to a position where they would work together could reduce the number of times people would have to be assessed. There would be additional resources in terms of numbers as capacity would be freed up by reducing some of the work that would get in the way of the right action being taken. There would be the opportunity to learn from one another, have a more diverse knowledge of what was going on rather than being specialised in one particular area.

Councillor Fish stated the report had emphasised on the word “learning” a lot and had concerns on how that learning might take place. Ceri Armstrong stated that learning was used in a sense on how to empower staff to think about doing things differently and for members of staff who worked across different thresholds and functions to get together to look at cases differently. Les Billingham commented that the council were currently looking at using a technique called Human Learning Systems to help with this. The word learning had been mentioned a lot in the report deliberately as the aim was for a learning culture but in terms of how this would be done would definitely not be designed to be bureaucratic.

Councillor Polley referred to the primary care population lead area and questioned what the data was based on, how up to date this data was and how would this be updated with the expansion of growth in the borough. Councillor Polley stated this would be amazing when delivered but relied on all those partnerships involved working together and some learnings had to come out of that.

Councillor Pothecary thanked officers for the detailed, well researched and ambitious report and asked for clarification on Thurrock Integrated Care Alliance (TICA) and the accountability structures that ran alongside that. Ceri Armstrong stated this was the integrated health partnership that sat across the transformation programme of all services. TICA would have the same responsibilities as that of officers and made decisions in an integrated manner. In terms of accountability to committees would continue to scrutinise and be called to overview and scrutiny committees, health and wellbeing board and cabinet. Les Billingham stated these were a condition of the new health landscape with each place having some form of partnership agreement that would consist of local health providers.

Councillor Sammons thanked officers for the very good report.

Councillor Snell agreed this was a good report however had concerns over how these services would be measured and with the plan there were a lot of parts that could cause a lot of problems. Ceri Armstrong stated there would be parameters around learnings, decision makings and working within

frameworks. To also look at what changes to services would need to be made to deliver a better response for residents and to keep people safe.

Councillor Piccolo thanked Ceri Armstrong and Les Billingham for the good report.

RESOLVED

The Health and Wellbeing Overview and Scrutiny Committee endorsed the Better Care Together Thurrock - The Case for Further Change – Thurrock's new adults' Integrated Care Strategy.

Ceri Armstrong and Les Billingham left the meeting at 8.49pm.

8. Thurrock Health and Wellbeing Strategy Refresh 2022-26

Jo Broadbent acknowledged and thanked all those that had been involved in the process which had been a real team effort to develop the strategy. Members were briefly referred to the executive summary of the report which informed them there was a statutory duty to produce this strategy which was a whole system plan for health and wellbeing and a means to engage all partners in the wellbeing agenda, co-ordinating strategic thinking of all elements of the council and all system partners to deliver quantifiable gains in health and wellbeing of residents. Members were also referred to the goals and actions across the six broad domains that were set out in the strategy and that a comprehensive engagement process had taken place throughout the autumn with over 1300 different comments received from various stakeholders. Members were referred to the appendix to the report that referred to the Thurrock's Vision for Health and Wellbeing – Levelling the Playing Field, Wider Determinants of Health, Strategic Fit, People Place and Prosperity and the six domains of Health and Wellbeing in Thurrock were comprehensively detailed.

Councillor Piccolo thanked Jo Broadbent and all those involved for the very well-presented report.

Councillor Pothecary referred to the issues of air quality in the borough and the link to people's health and questioned why the goal had not highlighted the need to take an approach to improve air quality across Thurrock and not where there might be new regeneration or new redevelopments. Jo Broadbent stated this had been referred to in domain 5 but not referenced in detail as they did not want to pre-empt work that was going on in the strategy that had not yet been developed. Members were informed that following the consultation period a link was made with the climate change strategy which highlighted the work that was going on in the council and in the borough. Some work was being undertaken to underpin developing a new air quality strategy and that new air quality monitoring officer had now been recruited.

Councillor Fish referred to access to services, in particular primary care services and had noticed the section of the report that referenced

improvements made to telephony which would be very helpful. Councillor Fish stated that a lot of the primary care surgeries could not be accessed independently by wheelchair users and these were the type of issues that needed to be addressed.

RESOLVED:

The Health and Wellbeing Overview and Scrutiny Committee reviewed and commented on the final draft Strategy at Appendix 1 and considered the proposed domains and goals.

Jo Broadbent left the meeting at 9.06pm.

9. Work Programme

Members discussed the work programme and had concerns that there were too many reports for the next two committees. Democratic Services would work with officers to address this.

Councillor Pothecary requested a report on Health and Air Quality to be linked with the Air Quality Strategy and suggested this be added to the January 2023 committee.

Councillor Pothecary also requested a briefing note on the Underdoctored position in Thurrock.

The meeting finished at 9.10 pm

Approved as a true and correct record

CHAIR

DATE

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1 September 2022	ITEM: 7
Health and Wellbeing Overview and Scrutiny Committee	
Community In-Patient Beds	
Wards and communities affected: All	**Key Decision:** None
Report of: Mid and South Essex ICS - James Wilson, Transformation Director and Andy Vowles presenting	
Accountable Assistant Director: n/a	
Accountable Director: n/a	
This report is Public	

1. Introduction

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

2. Action required

The committee is asked to:

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

3. Background

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

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

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

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

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

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

4. Update and Next Steps

Development of the options

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

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

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

- Projected travel times for patients, carers and families.
- The proposed staffing models for intermediate care and stroke rehabilitation.

- The condition of the existing estate.
- The likely capital and revenue requirements.
- The connections between the beds and other services (for example, the hospital-based stroke pathway).
- An initial integrated impact assessment.

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

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

Clinical Senate

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

The Panel conducted its review in March and April 2022. The Panel included patient representatives as well as clinical leaders for stroke, intermediate care and frailty services. The questions the Senate was asked to consider were:

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

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

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

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

The Senate report – which is owned by the Senate, not the ICS programme - will be published later in 2022. An early version has however been shared and is broadly positive in its assessment of the models of care, the work to date and the clinical pathways and the emerging options. The final report will

include recommendations on how the proposals might be further developed or strengthened, which will be addressed prior to any public consultation.

Pre-consultation Engagement

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

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

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

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

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

Highlights from the engagement report

Some of the key themes from the engagement were.

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

- Challenges around transport cost and availability was a recurrent theme and 10-20 miles away, was considered a long way. There was an overwhelming consensus that the location of community beds provision should be as geographically close to patients' homes as possible.

- Community in-patient settings provided an opportunity for more holistic, personalised care, compared to the pressures of acute hospitals, which was seen as a positive benefit.

- Negative impact of failed discharges was a significant theme.

- There were concerns about whether the in-patient community care workforce has the skills and training to support patients with increasingly complex needs, along with the right facilities to support those patients. It was also important to ensure that the settings are appropriate for stroke rehabilitation and that the patients have speed of access to those services. And finally; the ‘home first’ approach was widely seen to be the best approach where the relevant skills and capacity were available.

Key themes around staffing

Key messages from the staff workshops included;

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

Conclusion

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

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

5. Appendices to the report

Appendix 1 - Community Inpatient Beds in Mid and South Essex

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Appendix 2 - Improving community bed-based care in Mid and South Essex - Report from pre-consultation engagement with community, staff and patient stakeholders - April 2022

Engagement
report_ Improving c

Report Author:

James Wilson
Transformation Director
Mid and South Essex Community Collaborative

Tina Starling
Head of Communications and External Affairs
Mid and South Essex Integrated Care System

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Community Inpatient Beds in mid and south Essex

1. Introduction

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

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

2. Action required

The Committee is asked to:

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

3. Background and key issues

<u>Overview</u>

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

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

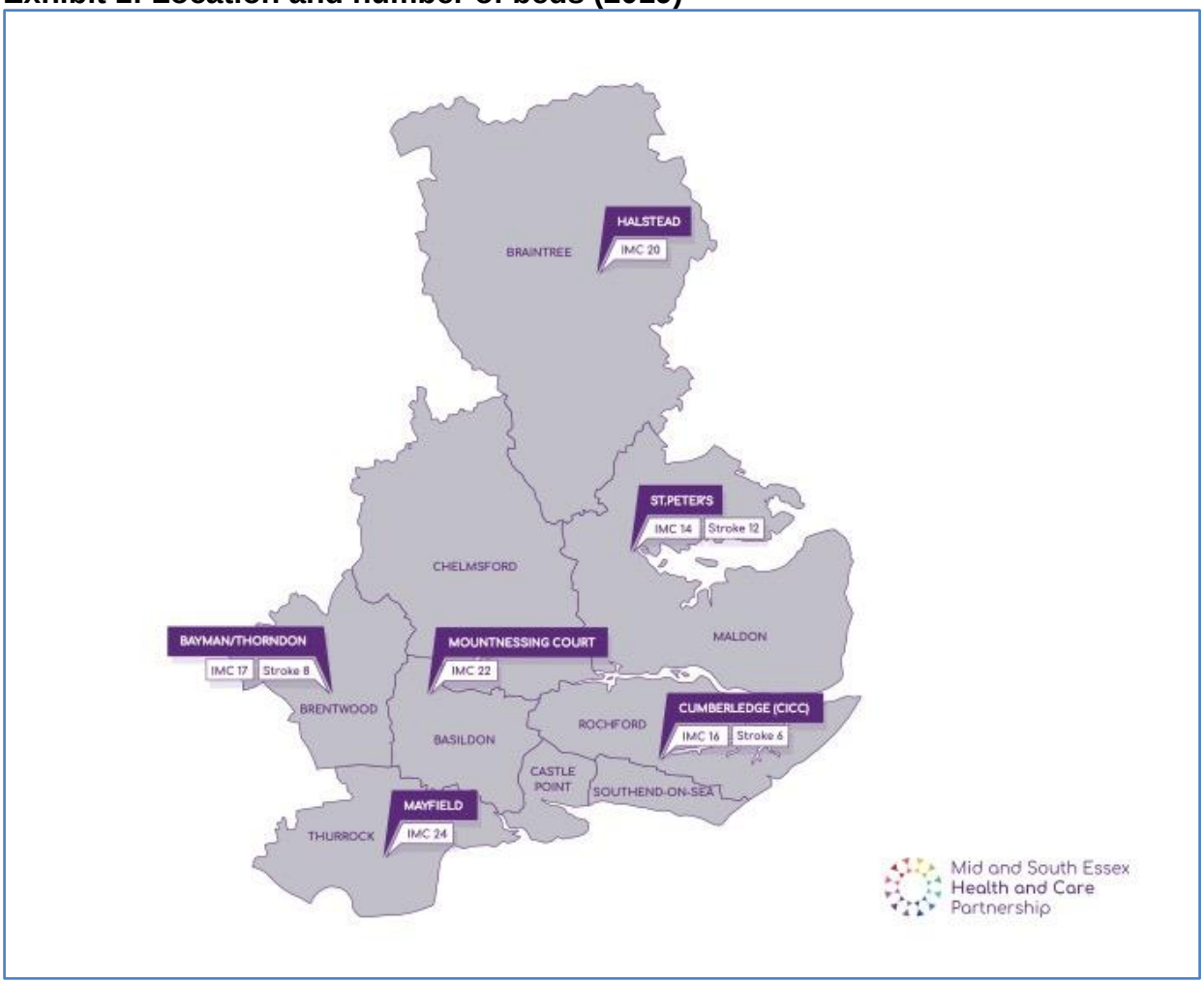
- Billericay
- Brentwood
- Halstead
- Maldon
- Rochford
- Thurrock

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

Configuration of community beds – 2019

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

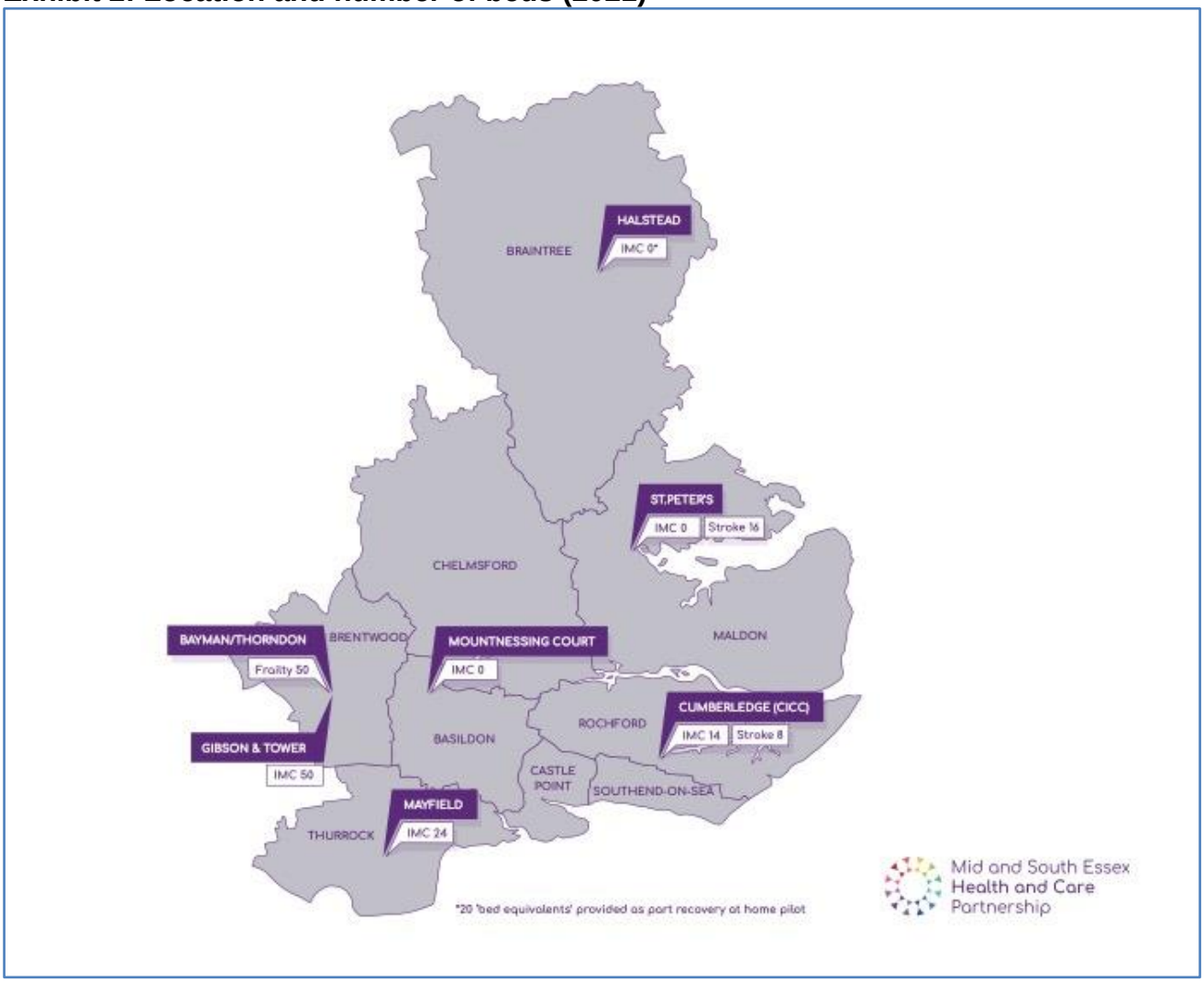
Exhibit 1: Location and number of beds (2019)



Configuration of beds - 2021

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

Exhibit 2: Location and number of beds (2021)



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

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

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

<u>The case for change</u>

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

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

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

Overall bed capacity and flow

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

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

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

Stroke

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

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

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

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

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

Intermediate Care

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

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

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

Frailty

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

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

<u>Timetable</u>

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

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

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

Proposed engagement process

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

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

We will examine themes and insight from our existing engagement work, with particular reference to the conversations had around the develop of our local response to the NHS Long Term Plan.

The main focus of our approach will be on the patients and people who represent patients that could be directly affected by the potential changes in the provision of community beds. We plan to do this through targeted engagement, with a strong emphasis on the views of carers.

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

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

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

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

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

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

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

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

- We will fulfil our statutory duties to inform staff, the public, patients and stakeholders about proposed changes in service delivery

- We will be transparent and accountable in the rationale for the current situation and future proposals
- We will consider all suggestions put forwards in the development of options
- We will seek to maintain the reputation of the NHS as a whole; and
- We will respond to questions raised by those with concerns in a timely and informative manner.

Joint HOSC

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

4. Update and Next Steps

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

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

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KALEIDOSCOPE Health and Care

Mid and South Essex Health and Care Partnership

Improving community bed-based care in Mid and South Essex

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

April 2022

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About this report

The engagement

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

Acknowledgements

Kaleidoscope Health and Care would like to thank all project team stakeholders and participants, who gave up their time to share their experiences and insights.

Errors and omissions are the responsibility of the authors alone and maybe queried by contacting chloe@kscopehealth.org.uk

Background & Introduction

Background

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

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

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

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

A map of these changes can be found in appendix 1

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

Aims of this engagement

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

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

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

Methodology

Community engagement

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

Table 1: Summary of activities and outputs

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

Table 2: Stakeholder breakdown (community engagement)

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

Staff engagement

Alongside a programme of community engagement (facilitated by Kaleidoscope Health and care) Mid and South Essex Health and Care Partnership internally led

a programme of engagement for staff. Staff were invited to three one-hour sessions to share their thoughts and views around the future provision of community beds in mid and south Essex. Staff members were provided with a programme narrative beforehand to explain the purpose of each session. There was a good representation of staff professions and groups at each session, including clinical and non-clinical.

Each session focused on four key questions:

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

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

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

Table 3: Summary of staff engagement

Activity	**Estimated number of staff engaged**
Intermediate Care Workshop (24th February 2022)	20
Stroke Rehabilitation Workshop (24th February 2022)	20
Acute Care of the Elderly Medical Wards (23rd February 2022)	10
Mentimeter Survey	20 respondents

Patient engagement

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

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

Community Engagement

General themes

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

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

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

The importance of the community care inpatient setting

Across the interview process, respondents emphasised the importance of community inpatient settings as a valuable point along the pathway. Some respondents discussed how community beds create an environment where patients feel safe and able to get care in a place that works for them. Stakeholders highlighted that not everyone has suitable accommodation to care for people in their own homes and that it can create a stressful or potentially unsafe environment, preventing patients from getting the right care.

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

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

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

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

Local access and getting care at the right time

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

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

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

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

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

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

Alongside local accessibility, temporal access and getting the right care at the right time were continually highlighted as important factors in people's experiences of community bed-based care. Stakeholders highlighted how timely access to community bed based care is particularly important for a patient's rehabilitation or enablement journey. Many highlighted this is particularly significant when patients are being discharged from an acute setting, as while they wait for a community bed they may lose strength and are unable to access the care they need. Stakeholders identified the particular resources that are more available in community bed-based care including, physiotherapy and getting people moving again to improve mobility, getting the correct medication and accessing additional professional support including psychologists. One

stakeholder described the tension between wanting community beds to free up more quickly to take in stranded A&E patients but recognising the longer community patients have within their bed the better their outcomes in terms of mobility and independence.

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

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

Ensuring great quality care

Across our engagement, accessing high quality, compassionate and responsive care was continually highlighted as one of the most important factors in people's experiences. Interviewees identified community inpatient facilities providing good care, including St Peters and Cumberlege. As previously discussed, it was largely considered that community inpatient settings provided an opportunity for more holistic, personalised care, compared to the pressures of acute hospitals. A community action stakeholder group representing a recently closed community hospital emphasised the value of 'low-tech, high nursing care', which focuses on time, enabling independence, and providing the best quality of life for terminally ill patients.

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

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

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

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

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

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

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

Developing and supporting the workforce

Thirdly, there were concerns about whether the inpatient community care workforce always has the skills and training to support patients with increasingly complex needs. Stakeholders noted while the staff are highly capable of delivering great rehabilitation and enablement care they have varied experience in working in acute settings and managing patients with more complex needs. This poses a risk to their ability to provide the right care needed for this new cohort of complex patients.

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

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

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

Personalised care and patient and carer activation

A major theme across the engagement is the importance of taking a personalised approach throughout community bed-based care. Stakeholders spontaneously

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

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

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

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

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

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

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

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

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

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

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

Discharge from community bed-based care

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

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

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

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

access a variety of services to support their needs and build resilience and connection.

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

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

Stroke

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

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

Personalised care

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

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

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

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

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

The role of the VCSE sector

Stakeholders representing VCSE organisations emphasised the importance of stopping stroke survivors from feeling like ‘they had been dropped off a cliff’ following discharge from community rehabilitation. This included utilising resources through commissioned services, providing an informal community response such as befriending services, linking to other individuals with lived experience (both for carers and stroke survivors) and promoting self-management to enable patients to take action on their own health. These stakeholders, local to Mid and South Essex, highlighted the negative impact Covid-19 has had on these services, warning that provision was ‘patchy’ across the area as a result of the pandemic.

Holistic approach to care & maintaining a sense of self

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

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

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

Bed locations & Accessibility

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

Accessibility was another key theme highlighted by stroke care stakeholders. This was firstly in regards to speed of access to stroke rehabilitation, helping to make progress as quickly as possible following a stay in an acute setting (and the associated impacts of immobility). Accessibility was also raised in relation to the location of stroke services; stakeholders reported the negative impact of relocating stroke rehabilitation beds where this has an impact on the ability of friends and family to visit. This was reported both in relation to the negative impact this has on the family and carers (the pressures of being further away from loved ones), the difficulty of VCSE organisations to keep track of clients when they have been moved out of the area, and also the impact on the stroke survivor; as connection with family was seen as an integral determinant of health and part of the rehabilitation journey.

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

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

"The pandemic heightened access issues…people didn't want to, or couldn't use public transport and private taxis are too expensive. When services are reconfigured, if it's explained properly to communities (that

it's so patients can get the right care, in the best place with the best team) they understand that…but if the transport systems don't underpin that it becomes a massive emotive issue for everyone".

Increased acuity in community settings and the impact on rehabilitation

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

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

The biggest challenge we face is that we are taking on more complex patients in community rehabilitation settings. The patients have their primary issue dealt with, which may be their stroke…but they now have unmet needs that the acute hospital could have picked up before they send the patient to a community hospital. Their problem isn't making them critically ill but it's impacting their ability to participate in the therapy.

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

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

Care for elderly patients

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

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

Accessibility

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

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

The impact of care settings

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

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

Effective communication

Stakeholders reported that effective communication was a core component of providing great care to elderly patients. This point was raised particularly in

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

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

Holistic approach to care (understanding the whole picture)

Stakeholders reported that taking a holistic view of the patient and their situation at home was key to avoiding 'failed discharge'; where patients are discharged home without ensuring there is adequate support for them in that setting. Failed discharge means that patients are at (avoidable) risk, there is a higher likelihood of them returning to hospital which has negative consequences for the patient (morale, poorer outcomes) and for the system as a whole due to the financial implications. Stakeholders reported that the realities of a patient's home situation may be different to what is recorded, effective communication between clinicians, patients and families/carers (that enables choice and input) was seen as paramount to ensure that patients are not discharged into unsafe environments or stuck in hospital settings for longer than is necessary.

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

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

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

Stakeholders also noted that community care teams and local community support groups should be deployed on a wider scale following discharge, to ensure adequate care for these patients. Stakeholders also reported the need to ensure that support was offered to carers after discharge, particularly for older carers.

These stakeholders highlighted the potential negative impact of carers putting off their own health needs to prioritise their caring responsibilities, both on the carer themselves and the person they are caring for.

Staff Engagement

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

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

Workforce

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

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

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

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

Up to date training and development (both personal and professional development) opportunities were also important to staff as an enabler for delivering great care. One member of staff suggested increasing shadowing

opportunities for both development and cooperation to increase understanding between teams and their differences or challenges.

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

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

Patient Care

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

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

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

patient can be safely managed at home. It was also noted there is a current lack of social care provision following rehabilitation.

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

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

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

Environment/location, facilities and equipment

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

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

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

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

It was also strongly felt that the location of community beds should ideally be easily accessible by public transport to enable visitors as transport to community hospitals is seen as a long term problem. Patient transport services can also a barrier to preventing care with staff reporting long waits for the patient to be

transferred and the time of transfers often happening too late in the day to give the patient adequate time to acclimatise to the new setting before it is time to go to bed.

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

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

The optimal scenario for community bed provision was described as a dedicated community hospital or purpose-built rehabilitation unit, with the wrap-around community services working in partnership with this. It should cover a wide range of patient needs including non-weight bearing patients and be able to cater for recuperation prior to rehabilitation. The community beds at place level should have seven days a week therapy provision with the Frailty Virtual wards co located.

Communication

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

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

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

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

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

Patient engagement

When asked what great community care should look and feel like, patients described a number of factors that contributed to their experience. The importance of delivering care with kindness was noted by patients, ensuring that they are provided with emotional support as well as physical support. The provision of empathetic care was noted by some patients as being reliant on staff having more time, or not 'being rushed off their feet' to deal with emergencies. These patients also made direct comparisons with the care they received in an acute hospital setting, explaining that staff in those settings had less time for person centred care.

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

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

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

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

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

- providing patients with haircuts,
- providing quiet spaces for patients,

- providing opportunities to be sociable,
- providing amenities such as television, and computer access,
- access to natural light,
- good food,
- access to a chaplain

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

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

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

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

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

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

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

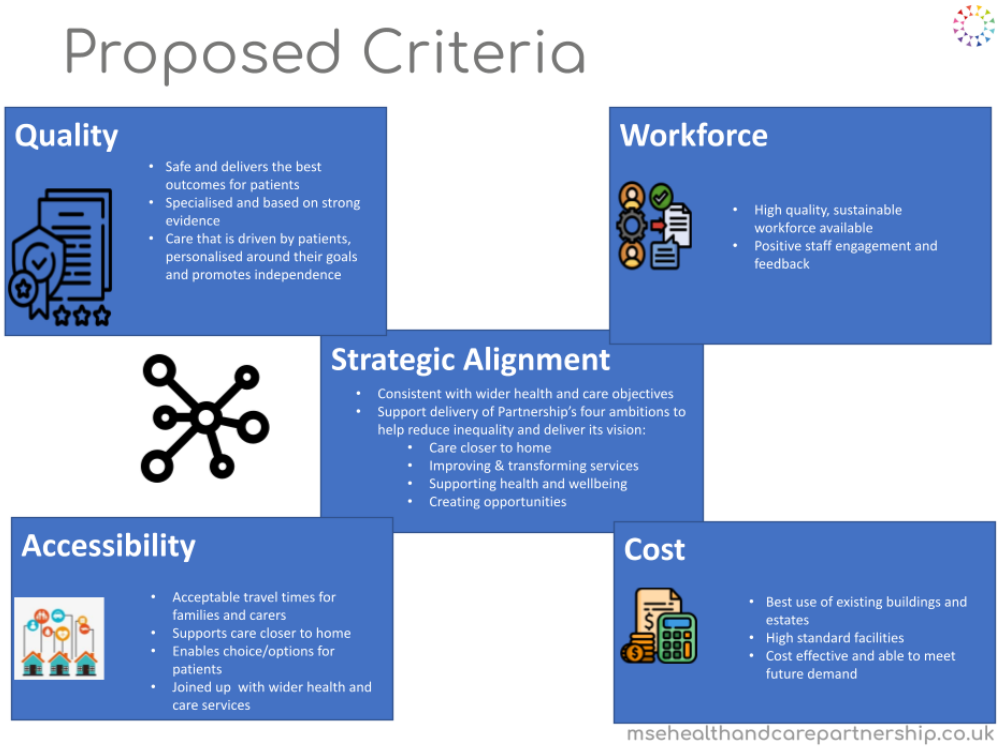
> *I have been waiting to go home for weeks. I was told it's because there is a delay in my care package…It would be good if there was better communication with social services and me and my son were told what was happening.* ***Patient***

Testing decision making criteria

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

The slide is shown in figure 1:

Figure 1: Proposed criteria slide



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

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

Overall

Stakeholders were receptive to the necessary simplification of the slide, which presents a complex and interlocking decision framework as a single, static set of criteria. One stakeholder noted that it was difficult to assess the criteria in isolation from the governance process within which they would be used. A well-designed governance process, with appropriate participation from stakeholders, would locate the criteria within a conversation. Such a conversation would bring

the criteria to life. It would develop and interpret them using a range of perspectives - place and system, patient and professional, intermediate care and rehabilitation. Without this context, aspects of the slide raised several questions and concerns, even while participants recognised the individual criteria as well-intentioned and appropriate.

They also observed that the criteria are not mutually exclusive. In other words, they do not represent a menu of choices from which some elements can be selected or prioritised, and others rejected or deprioritised. Rather, all elements are needed to produce a viable configuration of services. Across both community and patient stakeholder groups “quality” was identified as the pre-eminent criterion, recognising the offered description of quality as valid. One stakeholder felt that investment should prioritise quality and the workforce, while recognising that the one leads to the other, as means to ends. Among patient groups, accessibility was also recognised as a leading decision-making criterion.

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

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

Patient perspective

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

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

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

Composition of the workforce

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

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

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

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

The varied, evolving and complex needs of patients in community settings require an equally varied range of skills. Stakeholders recognised, and valued, the contribution of and care provided by nursing staff, but noted that, as intermediate care beds are occupied by patients who are still in the early stages of their recovery, access to specialist skills becomes necessary. These skills include but are not limited to, appropriately trained medical staff.

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

Local flexibility and patient choice

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

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

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

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

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

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

Finally, some stakeholders stressed the need to respect local variation in the configuration of services. This reflected both variation in the services currently

available, and also the need to integrate with health and social care services in the patient's own locality, which will inevitably vary.

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

Value as opposed to cost

Reacting specifically to the cost criteria, some stakeholders agreed strongly with the intention to make the best use of existing resources. But others felt that an emphasis on cost as a proxy for value was misplaced. One argued for the capability to assess the "longitudinal" or lifetime cost of patient care as part of decision-making.

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

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

Conclusion

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

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

Similarly, there is clear agreement across stakeholders on the major challenges facing community bed-based care in Mid and South Essex. Particularly, the issues relating to access, the geographical location of beds and access closer to patients' homes. While this is a challenging issue to address, especially in the context of external, transport and cultural factors in Mid and South Essex, our findings demonstrate good communication and carer and family activation can help alleviate some concerns. Additionally, the pressure of the pandemic and its strain on community bed-based care and the broader system is a major

challenge identified in this engagement. As a consequence, the increased complexity of patients has had strong implications on care delivery and patient outcomes. This engagement identified potential areas to address this challenge including good MDT working, ensuring the workforce has the relevant training, development, systems and infrastructure to support them deliver care and strong connections to other parts of the system for effective admission and discharge in and out of community inpatient settings.

1 September 2022	ITEM: 8
Health and Wellbeing Overview and Scrutiny Committee	
2021/22 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: n/a	
Accountable Director: Ian Wake - 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 2021 – 31 March 2022 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 the 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 2021 – 31 March 2022.

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 the reporting period**

The following representations were received during 2021/22:

- 99 Compliments
- 5 Initial Feedback
- 53 Complaints
- 14 MP enquiries
- 123 Member enquiries
- 2 Ombudsman findings

Further detail on the above is outlined within the appendix.

3.3 **Learning from Complaints**

Complaints and feedback provide the service with an opportunity to identify areas 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 within 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: **Gina Clarke**

Governance Lawyer

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 Inequalities, 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):

- None

9. Appendices to the report

Appendix – Adult Social Care Complaints and Representations Annual Report 2021/22.

Report Author:

Lee Henley

Strategic Lead, Information Management

HR, OD & Transformation

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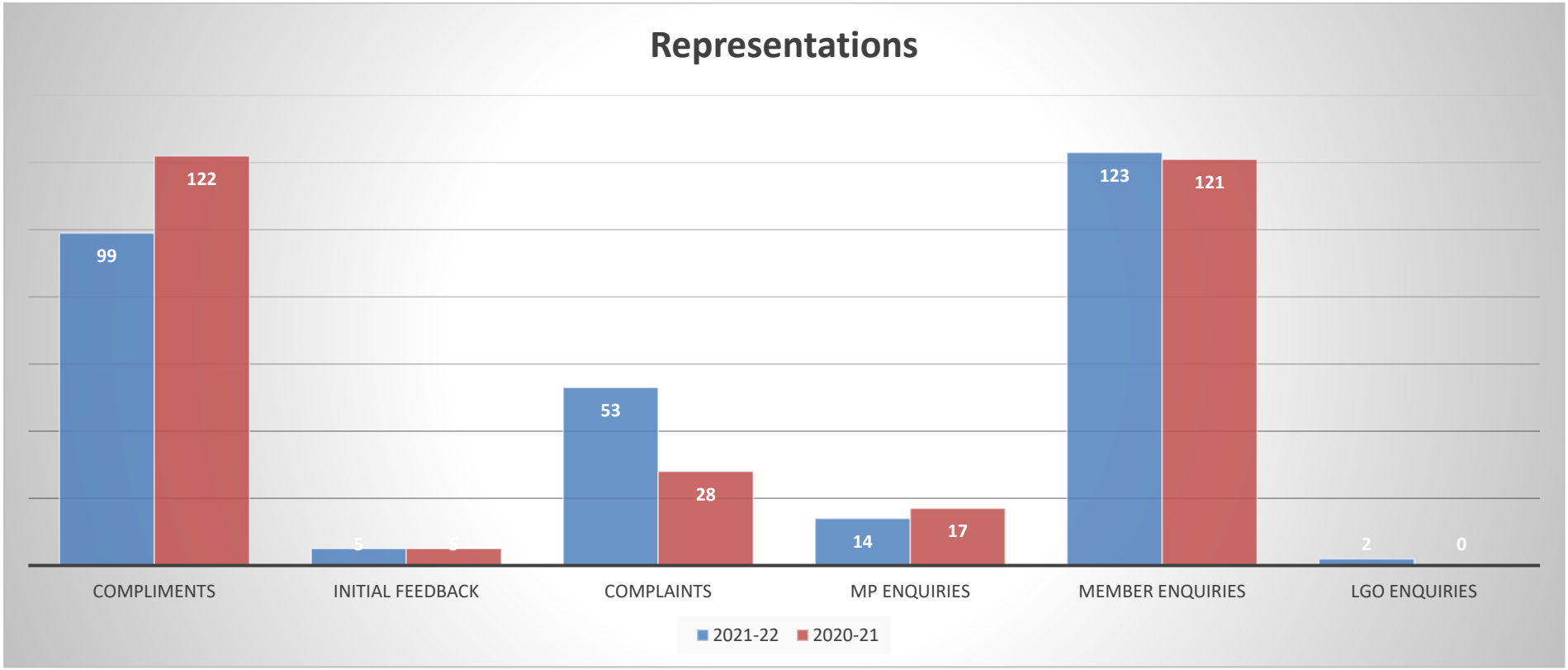
Appendix – 2021/22 - Adult Social Care Complaints & Representations Report

1.Volume of Representations 2021/22 vs 2020/21

Below is a comparison of representations received for both years. During **2021/22**, **296** representations were received, compared with **293** for **2020/21**.



2.Complaints – 2021/22 vs 2020/21

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
2021/22	5	53	0	0	1	52	44	66%	84%
2020/21	5	27	1	0	0	28	28	57%	81%
Difference	0	+26	-1	0	+1	+24	+16	+9%	+3%

For 2021/22:

- **53 complaints were received in the reporting period. Of these 53 received 1 was cancelled. These are shown within section 4 (pages 14-15)**
- **45 complaints were due a response in this period. 38 of 45 (84%) were responded to within timeframe.**
- **44 complaints were responded to within this period. These are shown in section 5 (pages 16-17).**
- **29 of 44 complaints responded to (66%) were upheld. These are shown in section 5 (pages 16-17) and the learning is detailed within section 3 (pages 3-13).**

3.Learning from upheld complaints:

Root cause analysis and learning from upheld complaints:	Root Cause 1 and associated learning Quality of Care	Root Cause 2 and associated learning Potential Safety Concerns	Root Cause 3 and associated learning Communication
Learning	**Complaint 2:** Complaint that the care worker is not following care plan. Examples provided were not making the bed or not closing the curtains (Thurrock Care at Home). **Learning:** Care plan updated to ensure that specified requests are clear to all care workers. **Complaint 3:** Concerns that the care worker had not followed the care plan, as the service user's washing had not been undertaken (Leatherland Lodge). **Learning:** To ensure that new staff are fully aware of any care plans that are in place for a service user.	**Complaint 7** Complaint that the care worker left bedroom lights, hob and the fan on (Guardian Care). **Learning:** Care staff reminded to ensure that prior to leaving the property, they must check everything is turned off and that the service user is happy. **Complaint 11:** After showering, the showerhead fell and hit the service user on their arm (Collins House).	**Complaint 1:** The family was not immediately informed about the service user being unwell (Leatherland Lodge). **Learning:** Change of procedure to ensure that in the event of any sickness, the family is informed with immediate effect and that this is documented and recorded. **Complaint 9:** Concern raised by the service user's daughter that there has been a breakdown in communication, and she is not provided with updates regarding her mother's care (Hospital Team).

Root cause analysis and learning from upheld complaints:	Root Cause 1 and associated learning Quality of Care	Root Cause 2 and associated learning Potential Safety Concerns	Root Cause 3 and associated learning Communication
	Complaint 4: Complaint regarding: • No Activities Coordinator in post • Food served cold (Willow Lodge Care) **Learning:** • Activities Coordinator post will be advertised • Staff reminded to ensure that plates are warm prior to serving • The temperature of food will be spot checked by the manager of the service **Complaint 5:** Concern that the service user's call times are inconsistent and are sometimes after the agreed time of 9am (Thurrock Care at Home).	**Learning:** • The member of staff was advised to be more careful when placing the showerhead back into its holder and to ensure it is secure. • An incident report was completed and forwarded to Health & Safety • The incident report has been placed on both the service user's and member of staff's file	**Learning:** Staff have been spoken to and reminded of the importance of ensuring that family members are kept updated on any changes to care plans. **Complaint 12:** Complaint that the care worker's call time was too early, and the service user was concerned their appointment had been missed as a result (Collins House). **Learning:** • Carer was asked to return to complete the call later that day • Ensure that in the event of any changes to AM call times, the care coordinators will ring the service user to ensure that they are made aware of the change

Root cause analysis and learning from upheld complaints:	Root Cause 1 and associated learning Quality of Care	Root Cause 2 and associated learning Potential Safety Concerns	Root Cause 3 and associated learning Communication
	Learning: An alert has been placed on the service user's care plan, to ensure all calls take place prior to 9am. **Complaint 6:** The service user had requested no male carers, however male carers were allocated (Homecare). **Learning:** Going forward, if any client is unable to accept a carer of a certain gender, this must be communicated to all staff and/or individuals involved. **Complaint 8:** Complaint regarding a service user not being provided with their medication (Homecare).		**Complaint 14:** The daughter of a service user complained that her father had a black eye and that she had not been informed. Checks by a GP confirmed that it was not a black eye, but instead an infection. (Leatherland Lodge). **Learning:** Training provided to staff to ensure that families are informed of sickness or wellbeing matters in a timely manner. **Complaint 16:** Complaint that a service user had received an injury that had not been reported by a social worker (Homecare). **Learning:** Staff reminded that all incidents/accidents are to be reported immediately and that all home visit notes must be updated with all details. Family members are also to be

Root cause analysis and learning from upheld complaints:	Root Cause 1 and associated learning Quality of Care	Root Cause 2 and associated learning Potential Safety Concerns	Root Cause 3 and associated learning Communication
	Learning: • The medication error was investigated, and retraining has been provided to the staff involved with this matter • Monthly audits are carried out to identify any repeat issues **Complaint 10:** Call times were agreed to take place early morning and late evenings; however, this is not being followed (Thurrock Care at Home). **Learning**: When taking on a new care package, the service must ensure that all parties are clear on the agreed times to avoid any confusion.		contacted as soon as practicably possible. Photos are to be taken at the initial incident for family and medical information purposes. **Complaint 17:** Concerns that the service user received correspondence relating to outstanding money owed and that this was incorrect (Finance). **Learning:** Ensure that social care cases are reviewed on an annual basis by social workers, to ensure that service users are receiving the correct care packages and that these are invoiced correctly. **Complaint 21:** Concerns that the family have had difficulty in contacting the service user and have to wait to be connected by the Care unit (Willow Lodge Care). **Learning:**

Root cause analysis and learning from upheld complaints:	Root Cause 1 and associated learning Quality of Care	Root Cause 2 and associated learning Potential Safety Concerns	Root Cause 3 and associated learning Communication
	Complaint 13: Concern that the care worker did not follow appropriate PPE guidance by not wearing gloves in the property (Thurrock Care at Home). **Learning:** Regular monitoring has been put in place, to ensure that the required standards for wearing appropriate PPE are being always followed. **Complaint 15:** Complaint from service user's son regarding a missed lunchtime call (Thurrock Care at Home). **Learning:** The missed call was due to a system error, causing calls due that day to not be displayed correctly to the care worker.		A new telephone system has been implemented to assist with ensuring that all calls to or from family members are recorded. This will help facilitate contact and minimise difficulties. **Complaint 22:** Concerns that the cost of the package of care had not been communicated to the service user and that a letter stated that Thurrock Council would handle the funding (Finance). **Learning:** Amendments have been made to letters issued upon the arrangement of a care package, to ensure that they are more clearly worded with regards to the costs of the package and responsibility for those costs. **Complaint 27:** Concerns that the service user was registered to a different GP

Root cause analysis and learning from upheld complaints:	Root Cause 1 and associated learning Quality of Care	Root Cause 2 and associated learning Potential Safety Concerns	Root Cause 3 and associated learning Communication
	Monitoring measures have been put in place, to ensure any system errors are identified and addressed promptly in the future. This will include ensuring that the individual monitoring the system, only has monitoring set as their task for the day, to ensure full attention can be focused on this task. **Complaint 18:** Concerns that care calls are being attended to by different carers each time (Thurrock Care at Home). **Learning:** Schedulers are to ensure that where possible calls are being arranged with the same carer for consistency. **Complaint 19:** Concerns that care calls are not long enough for carers to read the care plan and undertake required tasks (Thurrock Care at Home).		than usual without their consent. (Collins House). **Learning:** Collins House office staff members have been informed that they must request a signature of consent from the service user or their next of kin if registration with a local GP is required.

Root cause analysis and learning from upheld complaints:	Root Cause 1 and associated learning Quality of Care	Root Cause 2 and associated learning Potential Safety Concerns	Root Cause 3 and associated learning Communication
	Learning: Care calls have been extended by 15 minutes as per the commissioning plan to allow for all tasks to be completed fully. **Complaint 20:** Concerns that night staff did not offer assistance to the service user (Grays Court Care Home). **Learning:** Ensure that any new Night Staff read the care plans for any service users so that they fully understand the service user's needs. **Complaint 23:** Concerns that the service user's care plan is not being followed by the carer (Thurrock Care at Home). **Learning:**		

Root cause analysis and learning from upheld complaints:	Root Cause 1 and associated learning Quality of Care	Root Cause 2 and associated learning Potential Safety Concerns	Root Cause 3 and associated learning Communication
	To ensure more consistent care is provided, spot checks will be undertaken on a regular basis with notes then added to the system. **Complaint 24:** Concerns regarding missing items (Merrie Loots Farm). **Learning** • Staff reminded that all belongings must be entered on the full inventory, along with photographs of items if necessary for the purpose of identification. • For items of monetary or sentimental value, it should be considered if these items should remain with the individual due to risk of loss or damage and for alternative options to be considered.		

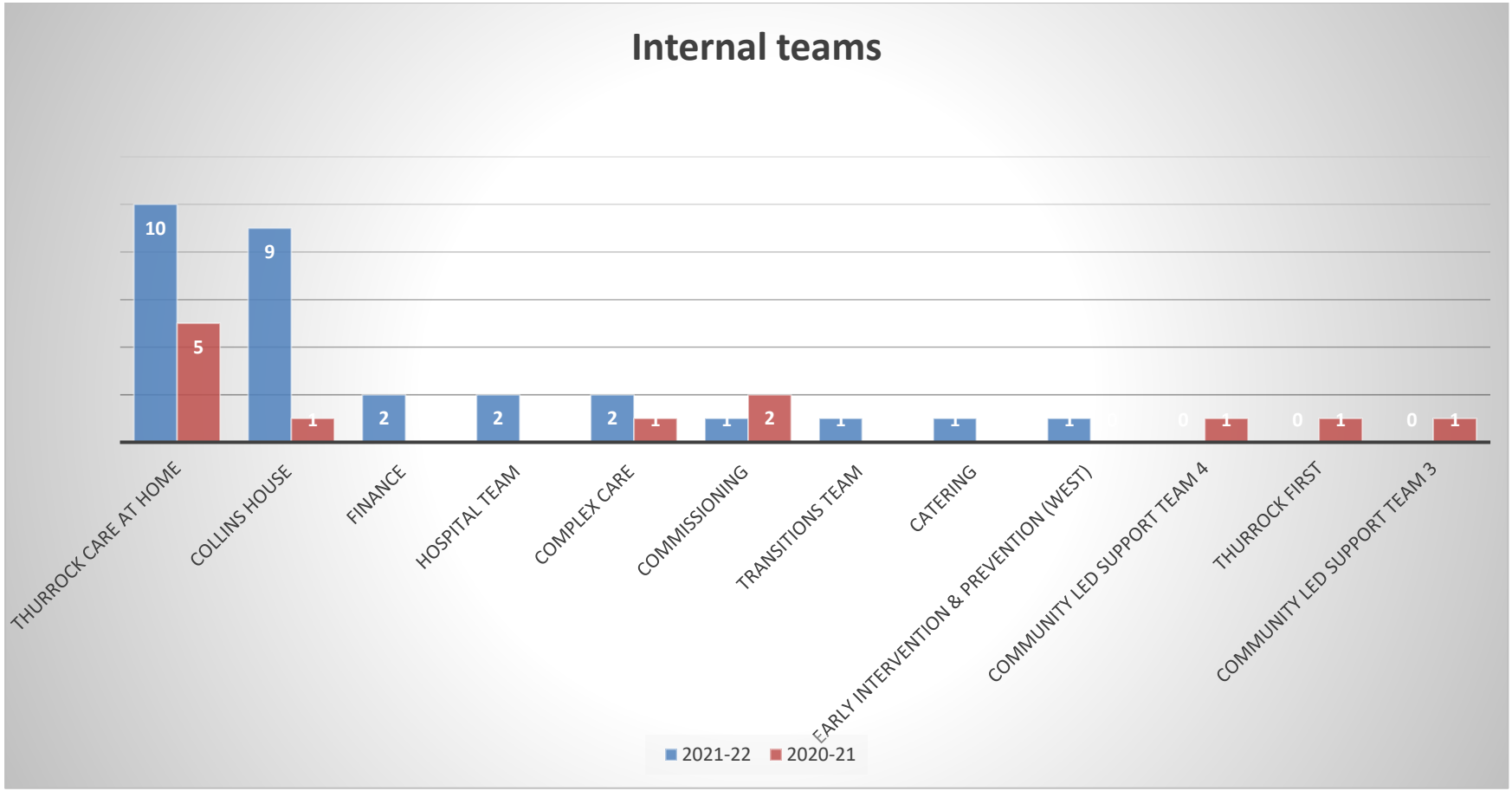
Root cause analysis and learning from upheld complaints:	Root Cause 1 and associated learning Quality of Care	Root Cause 2 and associated learning Potential Safety Concerns	Root Cause 3 and associated learning Communication
	• Breakages/damages to any personal items will be documented and family/friends/advocate to be informed immediately. **Complaint 25:** Concerns that the carer did not follow the care plan, as evening sandwiches were not prepared, and worktops were not wiped down (Thurrock Care at Home). **Learning:** Carers have been reminded to follow the tasks in the care plan and to complete tasks accordingly. Carers have also been informed to continue to use the system put in place (Mobizio) so that visit can be monitored for any issues. **Complaint 26:** Concerns that the carer is not following care plan (Thurrock Care at Home).		

Root cause analysis and learning from upheld complaints:	Root Cause 1 and associated learning Quality of Care	Root Cause 2 and associated learning Potential Safety Concerns	Root Cause 3 and associated learning Communication
	Learning: Carer reminded of expected standards when it comes to care visits. **Complaint 28:** Concerns that the carer did not prepare service user's evening sandwich or leave it in the correct location (Clarity Homecare). **Learning:** Care staff reminded that they need to prepare the sandwich and not just prepare the ingredients. Staff also reminded that the sandwich should be left on the kitchen worktop and not on the hob. **Complaint 29:** Concerns that the carer was completing written visit notes before the visit had begun **(**Clarity Homecare).		

Root cause analysis and learning from upheld complaints:	Root Cause 1 and associated learning Quality of Care	Root Cause 2 and associated learning Potential Safety Concerns	Root Cause 3 and associated learning Communication
	Learning: Carer reminded that they should not start completing their attendance notes before a visit and that going forward, they should only be started and completed when all tasks during a visit are completed.		

4A. Breakdown of complaints received - Internal teams and staff:
This may be different to figures shown within the upheld complaints section below, as the upheld section is based on closed complaints (not complaints received). The figures shown below will also exclude cancelled complaints.

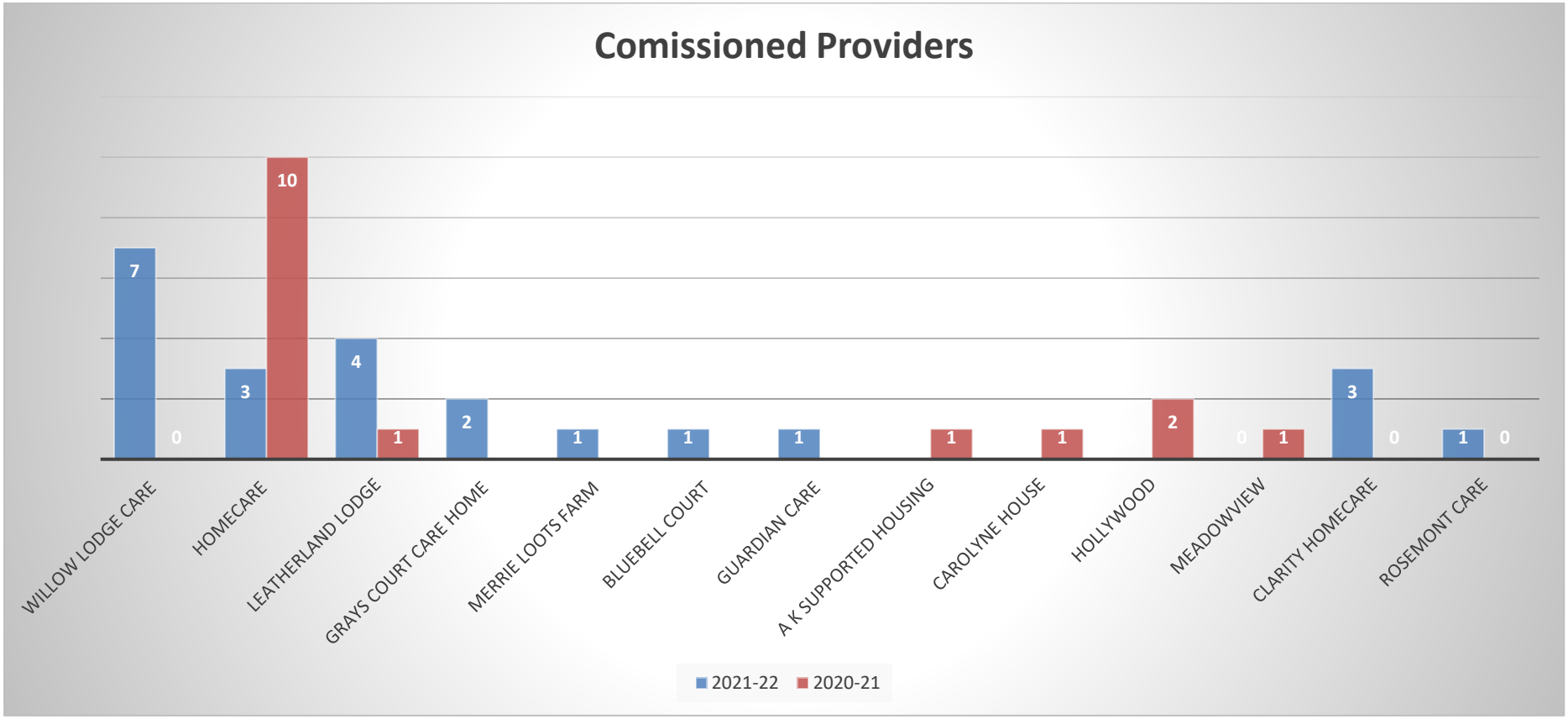
30 of 53 complaints received within this period are for internal teams/services (**1** was cancelled and this related to the Hospital Team). This compares with **12 of 28** during 2020/21.



4B. Breakdown of complaints received - Commissioned Providers:

This may be different to figures shown within the upheld complaints section below, as the upheld section is based on closed complaints (not complaints received). The figures shown below will also exclude cancelled complaints.

23 of 53 complaints received to within this period are for commissioned providers. This compares with **16** of **28** during 2020/21.



5.Upheld Complaints:

This may be different to figures shown above within the complaints received section, as the figures below are based on closed complaints (not complaints received).

Complaint Area	Volume Closed 2021/22	Upheld	Volume Closed 2020/21	Upheld
Thurrock Care at Home	10	10	5	5
Collins House	8	3	1	1
Willow Lodge Care	6	2	0	0
Homecare	3	3	10	4
Leatherland Lodge	3	3	1	1
Clarity Homecare	3	2	0	0
Finance	2	2	0	0
Hospital Team	2	1	0	0
Rosemont Care	1	0	0	0
Commissioning	1	0	2	1
Complex Care	1	0	1	0
Bluebell Court	1	0	0	0

Grays Court Care Home	1	1	0	0
Guardian Care	1	1	0	0
Merrie Loots Farm	1	1	0	0
Hollywood Rest Home	0	0	2	0
Community Led Support Team 4	0	0	1	1
Community Led Support Team 3	0	0	1	1
Thurrock First	0	0	1	0
Carolyne House	0	0	1	1
Meadowview House	0	0	1	0
A K Supported Living	0	0	1	1

6.Local Government and Social Care Ombudsman (LGSCO) Complaints:

There were 2 enquiries from the Local Government and Social Care Ombudsman (LGSCO), where they reached a final decision on any cases within the reporting period.

Area	Issue Nature	LGO Findings	Financial Remedy	Learning where relevant	Did the council respond to the LGSCO or HO timeframes
ASC – Willow Care Lodge	Complaint that the Care Home failed to allow the complainant to see their mother who was in the home's care due to COVID restrictions	Finding of fault / Service failure	£200	To review the visitors booking system to ensure double bookings are identified to avoid any visits being cancelled	Yes
ASC – Community Led Support Team 4	Complaint that the council did not provide details of a safeguarding referral and those restrictions were not clearly communicated.	Finding of fault / Service failure	N/A	Ensure that when managing any Safeguarding enquiries going forward, the reasons for any restrictions imposed through a safeguarding management plan should be clearly recorded. These restrictions must also be discussed and agreed with the person at risk, where appropriate, and their views should be clearly recorded	Yes

7.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 0 ADR cases in the reporting period.

8.Enquiries:

In the reporting period the following was received:

- **14** MP Enquiries
- **123** Member Enquiries

MP Enquiries	Feedback total
Thurrock First	3
Blue Badges	2
Community Development	2
Public Health	2
Finance	2
Community Led Support Team 3	1
Day Care	1
Collins House	1

Member enquiries	Feedback total
Public Health	36
Community Development	31
Thurrock First	19
Safeguarding	7
Thurrock Healthy Lifestyle	4
Finance	4
Local Area Coordination	3
Joint Reablement Team	3
Blue Badges	3
Community Led Support Team 1	2
Disabled Facilities Grant	2
Contract Compliance	1
Hospital Team	1
Thurrock Care at Home	1
Catering	1
Collins House	1
Community Led Support Team 3	1
Complex Care	1
Early Intervention & Prevention (West)	1
Day care	1

9.External Compliments:

A total of **99** compliments have been received during this period compared to **122** within the same period last year. A breakdown of the areas that these relate to is shown below.

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

Service Area 2021/22	Number of Compliments	Service Area 2020/21	Number of Compliments
Thurrock First	26	Disabled Facilities Grant	30
Joint Reablement Team	20	Thurrock First	24
Disabled Facilities Grant	10	Hospital Team	7
Blue Badges	6	Joint Reablement Team	7
Community Led Support Team 1	6	Community Led Support Team 1	6
Community Development	5	Barn & Coach House	5
Hospital Team	3	Blue Badges	5
Local Area Coordination	3	Day Care	5
Community Led Support Team 3	3	Extra Care	5
Thurrock Care at Home	3	Local Area Coordination	5
Careline	3	Collins House	3
Community Led Support Team 2	2	Rapid Response Assessment Service	3
Collins House	2	Careline	2
Rapid Assessment Service	2	Catering	2
Safeguarding	2	Community Development	2
Extra Care	1	Older People Mental Health	2
Complex Care	1	Safeguarding	2
Preparing for Adulthood	1	Bennett Lodge	1
		Commissioning	1
		Community Led Support Team 2	1

		Complex Care	**1**
		Grays Court Care Home	**1**
		Hollywood	**1**
		Public Health	**1**

10.Examples of External Compliments

Disabled Facilities Grant

I was helped and the team were so kind and couldn't do enough for me. If I needed to get in touch, they talked to me and gave me their phone numbers, nothing was too much trouble. They have made me safer in my home and given my daughter and son peace of mind about my safety.

Joint Reablement Team

During review visit the service user and her brother was very complementary of reablement service and the support they have received. The service user commented on how pleased she has been with all the support, staff have been cheerful and encouraging, and kept her motivated when she has been feeling low. She said she cannot fault the support she has received, and her brother stated the staff have been brilliant.

Thurrock First

Thurrock First were an excellent starting point as we were introduced to other agencies via them. This is the first time in my life that I have used Social Services and I cannot thank everyone involved in mums care enough. Mum has gone through several health crisis in under a year and the support provided was invaluable, both for mum and me.

Blue Badges

I have received an email informing me that my Mum's Blue Badge has been ordered. I just wanted to say a huge thank you to the staff who were so kind, calm, and knowledgeable and helped me with what I thought was going to be a very stressful complicated process. I really appreciate the help they gave me. Also, thank you to anyone else in the team that may have been involved.

Careline

Just received a lovely call from a husband thanking the ladies who assisted with his wife on Thursday. His words to me were ‘ he doesn’t know what he would of done without you.’ His wife had fractured her pelvis and the team called an ambulance, notified the next of kin and helped to keep the husband calm.

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1 September 2022	ITEM: 9
Health and Wellbeing Overview and Scrutiny Committee	
Contract for Occupational Therapy and Independent Mobility Assessment Service	
Wards and communities affected: All	**Key Decision:** Key
Report of: Cllr Deborah Huelin Portfolio Holder for Adults and Health	
Accountable Assistant Director: Les Billingham, Assistant Director, Adult Social Care and Community Development	
Accountable Director: Ian Wake, Corporate Director Adults Housing and Health	
This report is Public	

Executive Summary

The Occupation Therapy and Independent Mobility Assessment Service was commissioned to facilitate high quality outcome focused assessments for individuals eligible for non-specialist Occupational Therapy (OT support) and Independent Mobility Assessments (IMAs), via one-to-one assessments and clinics, for the Passenger Transport Services.

The Authority is compelled to undertake assessments of individuals for OT support as a statutory function under the Care Act (2014) and for Independent Mobility Assessments pursuant to the Chronically Sick and Disabled Persons Act (1970) and the Equality Act (2020) when Local Authorities were passed the responsibility for administering the Blue Badge schemes in August 2019.

1. Recommendation(s)

1.1 That Health and Wellbeing Overview and Scrutiny Committee supports the recommendation to go to market to reprocure the contract to provide an Occupational Therapy and Independent Mobility Assessments service.

2. Introduction and Background

2.1 The current contract is held by Inclusion.Me for the last 5 years costing £99,360 per annum, and the contract price has not increased during this period. During 2021/22 504 assessments were undertaken from 594

referrals, of which 96.5% had outcomes completed and submitted within 2 working days.

2.2 This is despite an increase focus on early intervention and prevention via the use to OT equipment, as well as the additional impact that the pandemic has placed upon the service.

2.3 Adult Social Care adopts a strength-based approach, focusing on the strengths and abilities of the individual and aims to connect them to support from friends, family and the wider community. By adopting an ethos of providing the right care at the right time in the right place, this equipment services enables individuals to remain at home and part of their local communities.

2.4 Consideration must be given to Digital Transformation as more than 95% of current base units and peripherals deployed are reliant on the Public Switched Telephone Network (PSTN) which is being phased out, as a national initiative, by December 2025.

3. Issues, Options and Analysis of Options

3.1 Do nothing – let the contract expire on 30 September 2023 (not recommended).

3.1.1 This would, without any subsequent action, result in a significant backlog of OT assessments as previous restructuring of internal services reduced retained OT specialist employed by the Authority to 4 FTE. Therefore, assessments would be significantly delayed, potentially placing individuals at risk or forcing the commissioning of more costly alternatives.

3.1.2 Additionally, without the IMA service in place Authority's would either breach its statutory requirements under the legislation detailed earlier in this document, or source this service on a spot provision they may result in a more costly solution for the Authority.

3.2 Extend current contract (not recommended).

3.2.1 The contract has utilised all extension options and has been extended up to 50% of the contract value. Therefore, unless the procurement regulation changes this is not a viable option to pursue.

3.3 Bring the service back inhouse (not recommended).

3.3.1 This would require the Authority to recruit OT specialists on Thurrock Council terms and conditions to undertake the same function. This would result in a greatly inflated staffing budget and undo the previous savings exercise that restructured the OT offer.

3.4 **Procure the services via a tender process in the open market (recommended)**

3.4.1 The previous decision to restructure and take this service to market seems to have delivered the desired outcomes in that staffing overheads were reduced providing savings and quality levels were maintained. During the lifecycle of this contract performance has been consistently high, only seeing dips in assessments carried out within 10 days KPI dropping during the pandemic but maintaining positive rates of outcome indicators level above 90% during the same periods.

3.4.2 Additionally, feedback from frontline staff regarding the quality and quantity of assessments is extremely positive. The Provider has been flexible, and solution focused on its approach during the pandemic which has built frontline confidence in this market sourced solution.

3.4.3 The Authority has, and continues, to lean on OT solutions to promote and create a greater level of independence for eligible individuals. It is likely that demand will increase during the lifecycle of the contract therefore consideration should be given to the budget levels as there have been no uplifts in the last 5 years despite significant external pressures (ie. NLW, NI).

4. Reasons for Recommendation

4.1 The current contract with the provider, Inclusion.Me, is coming to an end and a new contract to fulfil the statutory duty is required.

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

5.1 Engagement has taken place with Occupation Therapy Leads as well as Thurrock's Principle Occupational Therapist who have reviewed the quality of the service as well as fitness for purpose of the current service specification. It is felt the current quality of service is high, which is reflected in KPI indicators, and value for money.

5.2 Service User feedback was limited, however compliments for the service have increase over the last financial year to 1 per quarter compared to 1 for the entirety for 2021/22.

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

6.1 The contract for Occupational Therapy and Independent Mobility Assessment Service

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 Finance Corporate Finance

The funding for the provision of the contract will be contained within the directorates existing budget allocation.

7.2 Legal

Implications verified by: **Mark Bowen**

Interim Head of Legal Services

The recommendation if agreed is for a procurement process to enable a statutory duty to be discharged and is legally sound.

7.3 Diversity and Equality

Implications verified by: **Rebecca Lee**

Team Manager Community Development Adults Housing and Health

The executive summary of the report sets out the responsibilities of the authority to provide the Occupational Therapy and Independent Mobility Assessment service in line with the Care Act (2014), Chronically Sick and Disabled Persons Act (1970) and the Equality Act (2010).

Social value has been considered as part of the commissioning process for this service and will be monitored as part of the standard contract review cycle with the agreed supplier.

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

N/A

8. Background papers used in preparing this report (include their location and identify whether any are exempt or protected by copyright):

N/A

9. Appendices to the report

N/A

Report Author:

Ian Kennard
Commissioning Manager
Adults Housing and Health

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1 September 2022	ITEM: 10
Health and Wellbeing Overview and Scrutiny Committee	
Contract to Supply, Install, Maintain & Repair Telecare Equipment	
Wards and communities affected: All	**Key Decision:** Key
Report of: Cllr Deborah Huelin Portfolio Holder for Adults and Health	
Accountable Assistant Director: Les Billingham, Assistant Director, Adult Social Care and Community Development	
Accountable Director: Ian Wake, Corporate Director Adults Housing and Health	
This report is Public	

Executive Summary

This report outlines the statutory duty under the Care Act 2014 to supply Assistive Technology those with eligible need to help support people live independently in their own home while minimising risks such as falls, gas leaks etc. Under the Care Act (2014) the Authority has an obligation to provide equipment, including telecare and adaptations costing less than £1000.

This report seeks views from the Health and Wellbeing Overview and Scrutiny Committee on a proposed recommendation to Cabinet that the procurement for this service should go to market as an open tender.

1. Recommendation(s)

1.1 That Health and Wellbeing Overview and Scrutiny Committee supports the recommendation to go to market to reprocure the contract to supply, install, maintain and repair telecare equipment.

2. Introduction and Background

2.1 The current contract is held by Red Alert for a cost of £107,364 per annum and issues over 700 pieces of telecare equipment per annum, while having over 2600 pieces of actively used pieces of equipment at any one time.

2.2 The contract price for these services have remained static for the last 5 years, this is despite an increase focus on early intervention and prevention via the Technology Enabled Care (TEC) programme, as well as the additional impact that the pandemic has placed upon the service.

2.3 Adult Social Care adopts a strength-based approach, focusing on the strengths and abilities of the individual and aims to connect them to support from friends, family and the wider community. By adopting an ethos of providing the right care at the right time in the right place, this equipment services enables individuals to remain at home and part of their local communities.

2.4 Consideration must be given to Digital Transformation as more than 95% of current base units and peripherals deployed are reliant on the Public Switched Telephone Network (PSTN) which is being phased out, as a national initiative, by December 2025.

3. Issues, Options and Analysis of Options

3.1 Do nothing – let the contract expire on 31 August 2023 (not recommended)

3.1.1 This would, without any subsequent action, result in a breach of the Authority's statutory requirements. This would result in an increase in demand on traditional services and / or a reliance on spot arrangements for individual pieces of equipment that would reduce the purchasing power of the Authority and present challenges to maintaining the supply chain for telecare equipment.

3.2 Extend current contract (not recommended)

3.2.1 The contract has utilised all extension options and has been extended up to 50% of the contract value. Therefore, unless the procurement regulation changes this is not a viable option to pursue.

3.3 Procure the services via a tender process in the open market (recommended)

3.3.1 While this niche market is expanding and diversifying quickly, the mass purchase, storage and installation of TEC systems is not a resource the Authority presently has nor has the money to invest in and develop as a commercial model. Additionally sourcing a specialist Provider via a tender process will enable access to skills and knowledge that will assist in directing the digital transformation solutions in TEC the Authority will have to undertake in the next few years.

3.3.2 Additionally, the current level of funding should be given consideration given the increased focus and demand of these services to achieve savings upstream. Also, the Authority will have to factor in the impact of digitalisation and the increase on base costs that our outlined by our current Provider, Red Alert, using our current levels of demand and existing market solutions available in Appendix 1.

4. Reasons for Recommendation

4.1 The current contract with the provider, Red Alert, is coming to an end and a new contract to fulfil the statutory duty is required.

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

5.1 Engagement has taken please with Thurrock's TEC leads around Provider performance and have reviewed the current contract specification's fitness for purpose. Feedback around the Providers responsiveness and professionalism was very positive, and the TEC leads feel this specification and what is provided under the contract is suitable and appropriate.

5.2 June 2022 customer satisfaction survey, which is a 25% sample of monthly activity, returned another 100% rating across 6 key measures. This is in keeping with the results seen for the financial year 2021/22 which saw an overall satisfaction rating of 99.92%.

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

6.1 The contract to Supply, Install, Maintain & Repair Telecare Equipment:

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 Finance Corporate Finance

The funding for the provision of the contract will be contained within the directorates existing budget allocation.

7.2 Legal

Implications verified by: **Mark Bowen**

Interim Head of Legal Services

The recommendation if agreed is for a procurement process to enable a statutory duty to be discharged and is legally sound.

7.3 **Diversity and Equality**

Implications verified by: **Rebecca Lee**

Team Manager Community Development
Adults Housing and Health

The provision of this contract will support Council to uphold responsibilities set out in the Equality Act 2010 and Public Sector Equality Duty. The supply of equipment to support residents is also in line with regulations set out in the Care Act (2014) and the Children and Families Act (2014).

Social value has been considered as part of the commissioning process for this service and will be monitored as part of the standard contract review cycle with the agreed supplier.

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

N/A

8. Background papers used in preparing this report (include their location and identify whether any are exempt or protected by copyright):

N/A

9. Appendices to the report

Appendix 1 – Digital TEC Costing and Log Analysis

Report Author:

Ian Kennard
Commissioning Manager
Adults Housing and Health

Digital TEC Costing and Log Analysis

Dom Watkins – Stock Control Manager

Logistic Challenges

SEMI-CONDUCTOR SHORTAGE:

- COVID-19 Pandemic – plant closure – inventory depletion
- Fires at facilities in Japan and Germany
- China-US Trade War – alternative suppliers in Taiwan already at maximum capacity
- Severe Weather – plant closures
- Russia-Ukraine War – 50% of Global Neon from Ukraine | 40% of Palladium from Russia

"…any prediction of a resolution to the chip shortage by the end of 2022 is optimistic…the issue will not be fully solved until 2023 or 2024"

- IBM CEO Arvind Krishna

AVAILABILITY FOR TESTING | APPELLO SMARTLINE & TUNSTALL DIGITAL LIFELINE not currently available for field tests

EXISTING PERIPHERAL COMPATABILITY | Most manufacturers have their own peripheral ranges with limited x-compatibility and backwards compatibility with analogue peripherals.

TRAINING BURDEN | Integrating new equipment is costly in point of time and resource

DEPLOYED ANALOGUE DISPERSED ALARMS | 620+ Dispersed Alarms in ASC alone

SIM CARD MANAGEMENT | Repeating subscription costs and SIM Card Management

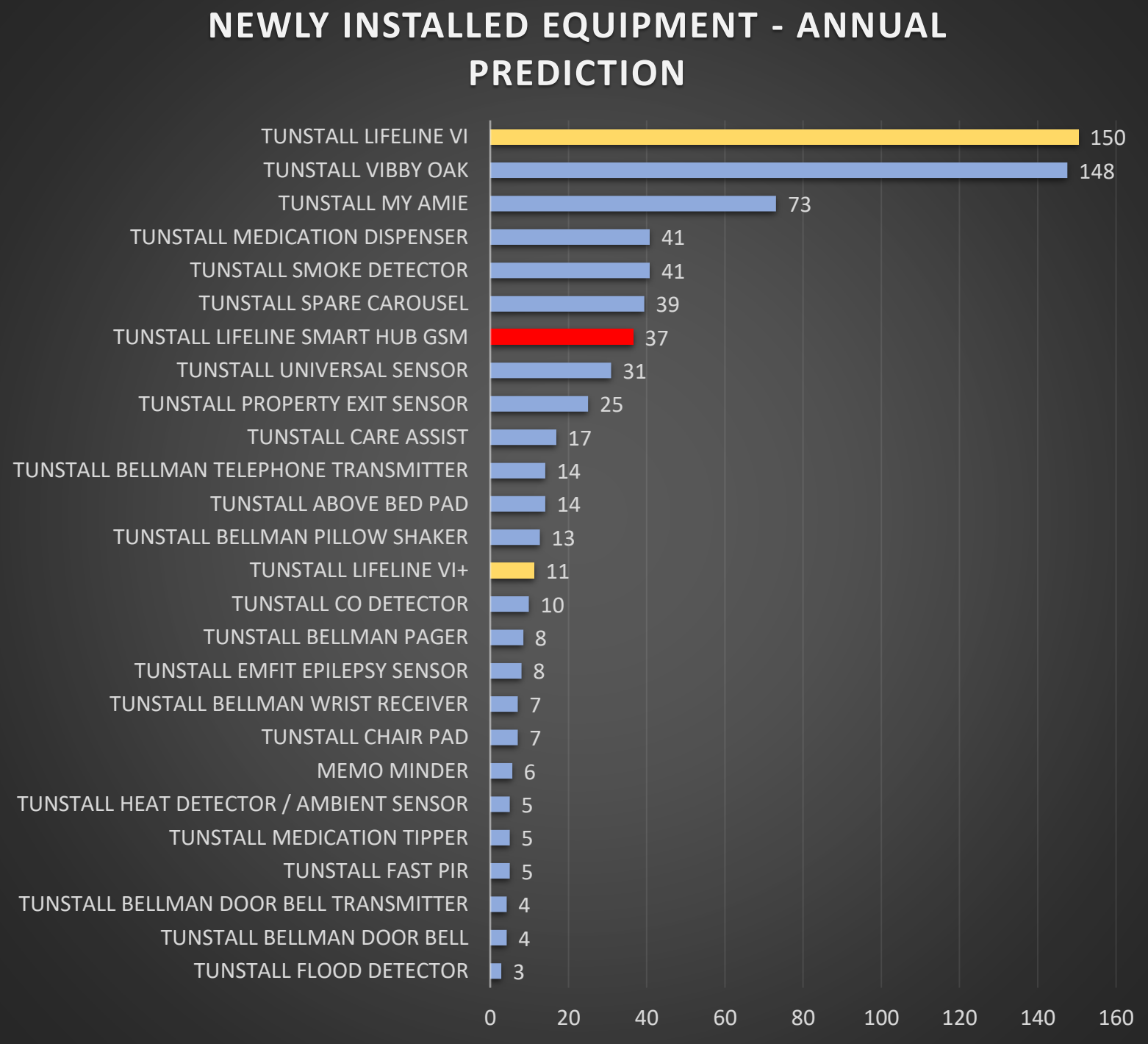
CURRENT USAGE* – ANALOGUE / DIGITAL

TUNSTALL SMARTHUB / LIFELINE / LIFELINE VI

~18% Dispersed Alarms are digital

TUNSTALL SMARTHUB

*New Installs Only



CURRENT COST – ANALOGUE / DIGITAL

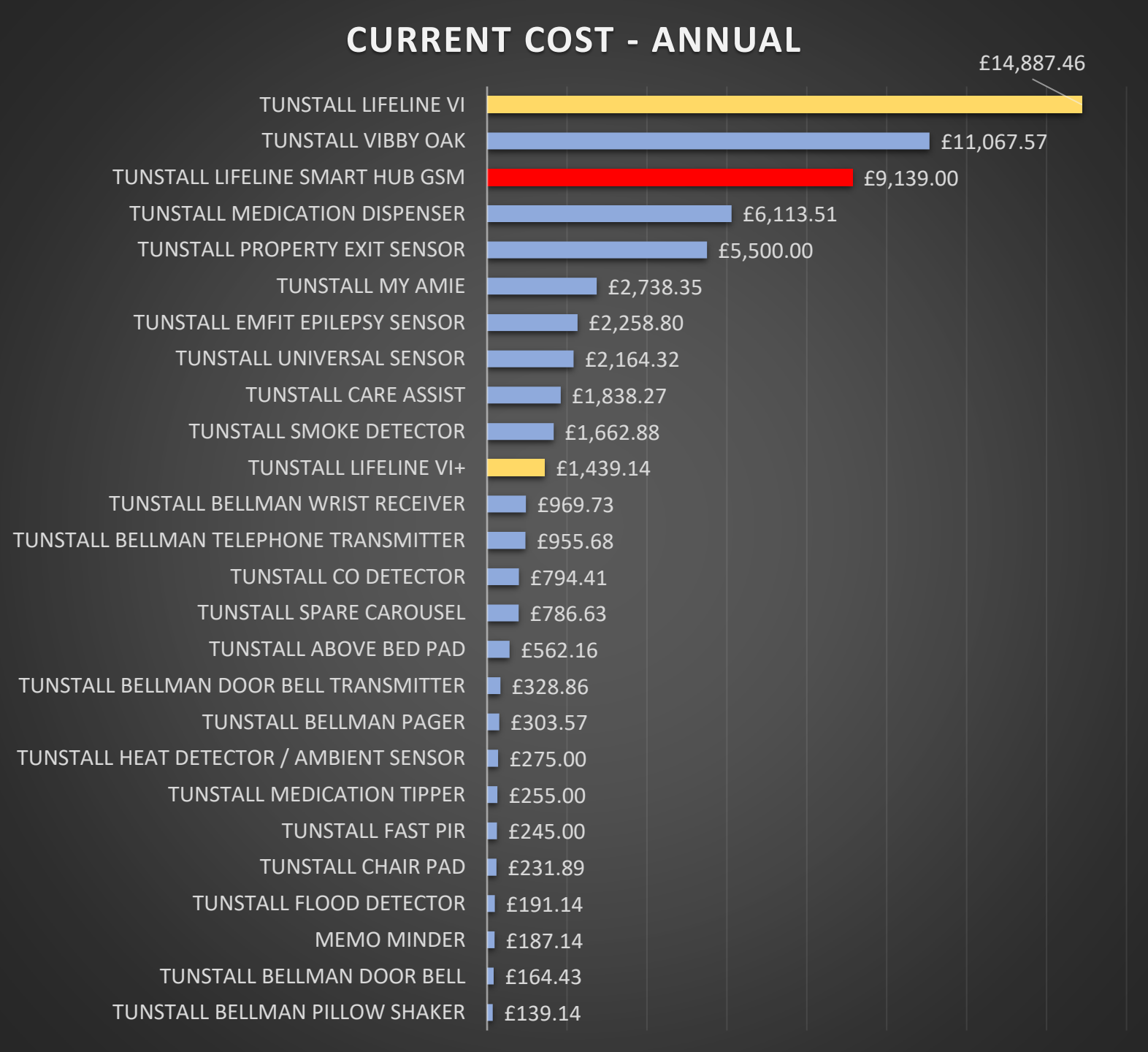
TUNSTALL SMARTHUB

~18% Dispersed Alarms are digital

Cost of New Equipment*

£65,199

*assumption of no recycling



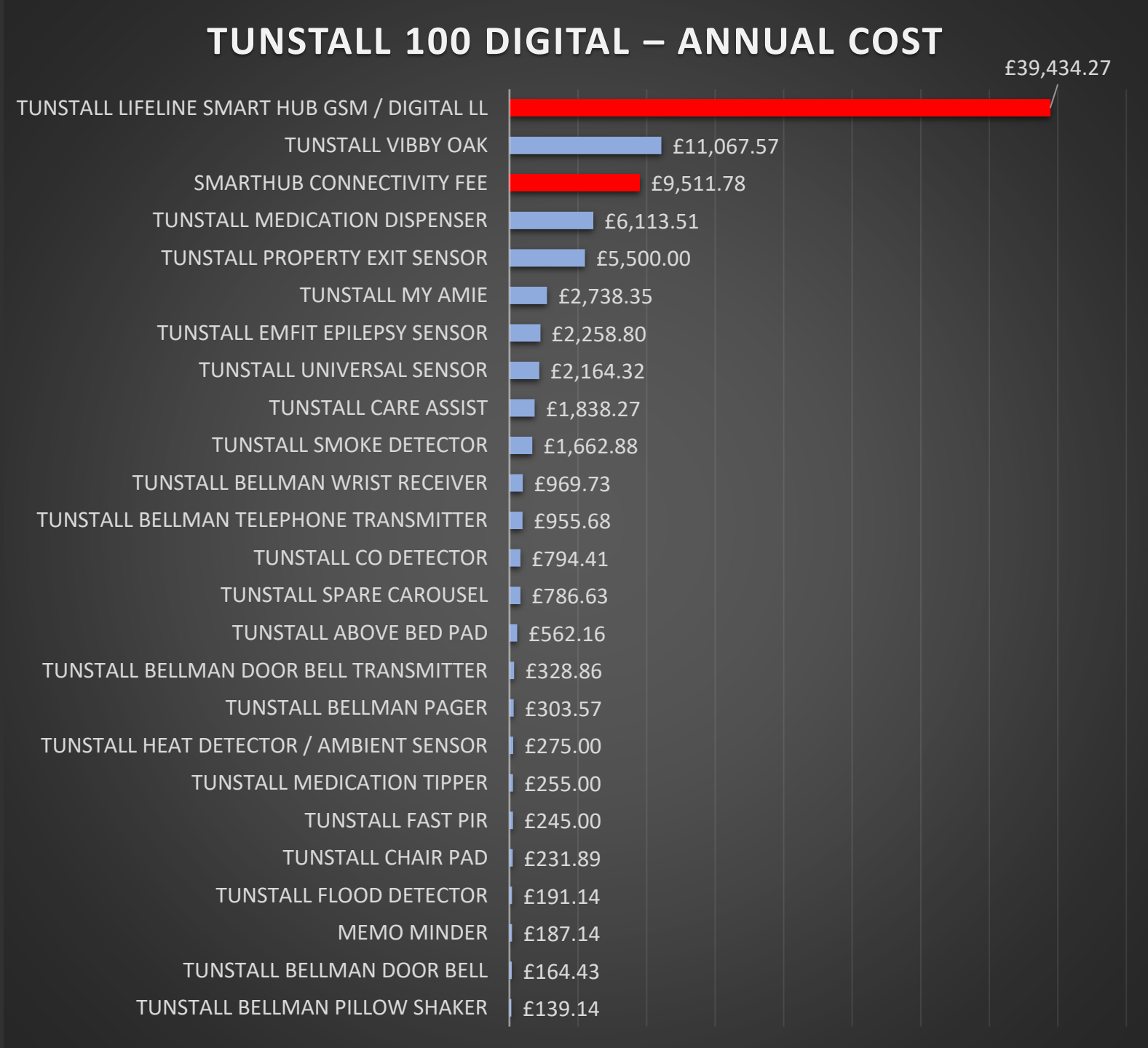
FULL DIGITAL

TUNSTALL SMART HUB

100% Dispersed Alarms are digital

Cost of New Equipment

£88,679



FULL DIGITAL

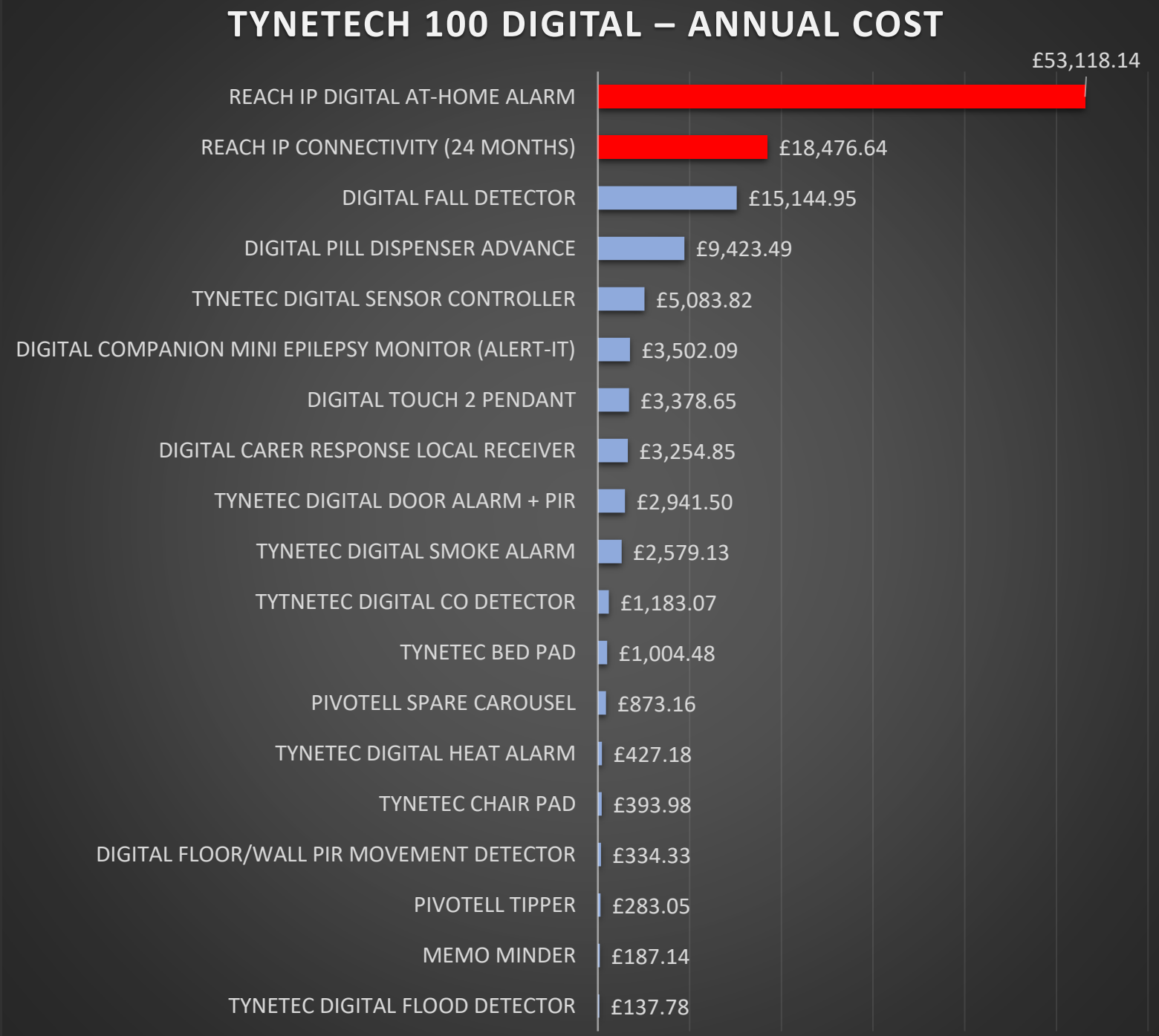
TYNETECH REACH IP

100% Dispersed Alarms are digital

Cost of New Equipment

£121,727

*Limited ‘sensory equipment’



FULL DIGITAL

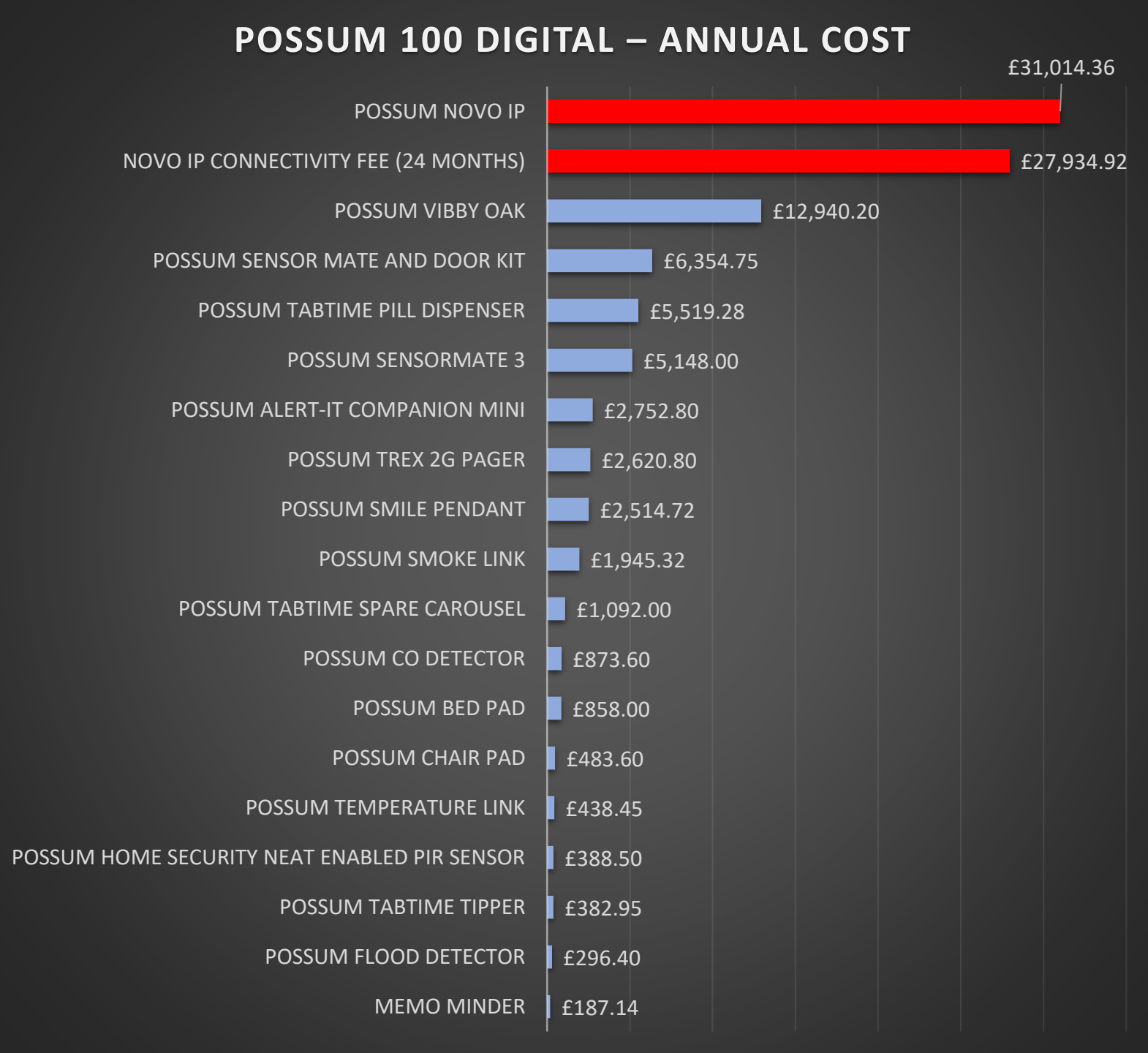
POSSUM NOVO IP

100% Dispersed Alarms are digital

Cost of New Equipment

£103,745

*Limited ‘sensory equipment’



Health and Wellbeing Overview & Scrutiny Committee
Work Programme
2022/2023

Dates of Meetings: 7 June 2022, 1 September 2022, 3 November 2022, 12 January 2023 and 9 March 2023

Topic	Lead Officer	Requested by Officer/Member
7 June 2022		
HealthWatch	Kim James	Members
Thurrock Health and Wellbeing Strategy 2022 - 2026	Jo Broadbent	Officers
Integrated Medical Centres Update (PowerPoint)	Tiffany Hemming	Members
Adult's Integrated Care Strategy	Les Billingham / Ceri Armstrong	Officers
Integrated Community Equipment Service (ICES)	Ian Kennard	Officers
Work Programme	Democratic Services	Officers
1 September 2022		
HealthWatch	Kim James	Members
Community In- patient Beds	James Wilson and Andy Vowles	Officers
2021/22 Annual Complaints and Representations Report – Adult Social Care	Lee Henley	Officers
Gray's IMWC Engagement Update (PowerPoint)	Tina Starling and Stephen Porter	Members
Contract for Occupational Therapy and Independent Mobility Assessment Service	Ian Kennard	Officers
Contract to Supply, Install, Maintain & Repair Telecare Equipment	Ian Kennard	Officers
Work Programme	Democratic Services	Officers

3 November 2022		
HealthWatch	Kim James	Members
Annual Public Health Report	Jo Broadbent	Members
Active Travel Needs Assessment	Jo Broadbent	Officers
Mental Health Supported Living Spec	Levi Sinden	Officers
Self-Care Joint Strategic Needs Assessment	Monica Scrobotovici	Officers
Adults, Housing and Health - Fees and Charges Pricing Strategy 2022/23	Catherine Wilson	Officers
Under Doctoring in Thurrock	Steve Porter	Members
Integrated Medical Centres Update (PowerPoint)	Tiffany Hemming	Members
Work Programme	Democratic Services	Officers
12 January 2023		
HealthWatch	Kim James	Members
Health and Air Quality	tbc	Members
Developing a New Residential Care Facility in South Ockendon	Christopher Smith	Officers
Integrated Medical Centres Update (PowerPoint)	Tiffany Hemming	Members
Portfolio Holder Report	Cllr Huelin	Members
Work Programme	Democratic Services	Officers
9 March 2023		
HealthWatch	Kim James	Members
Personality Disorders and Complex Needs Report	Mark Tebbs	Members

Dementia Strategy - Thurrock Implementation Plan –	Sarah Turner	Officers
Integrated Medical Centres Update (PowerPoint)	Tiffany Hemming	Members
Work Programme	Democratic Services	Officers
Briefing Notes		

Items for 2023/24 Work Programme:

Portfolio Holder Report

Clerk: Jenny Shade
Last Updated: July 2022

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