Appendix 1 - MSE Community Beds
Options paper for medium term

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1 Executive Summary

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

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

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

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

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

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

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

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

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

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

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

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

2 Introduction

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

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

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

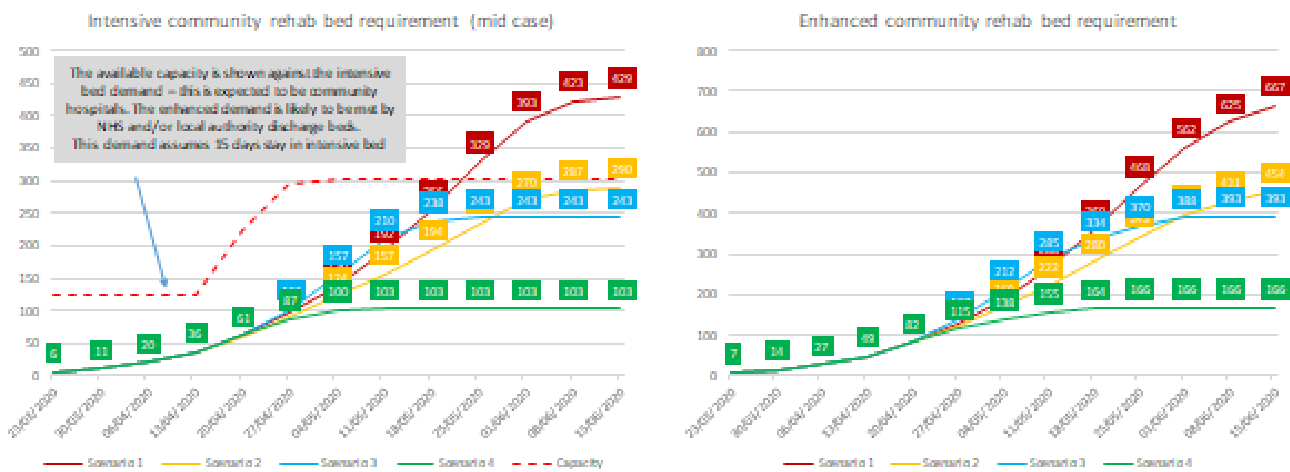
3 Background

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

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

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

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



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

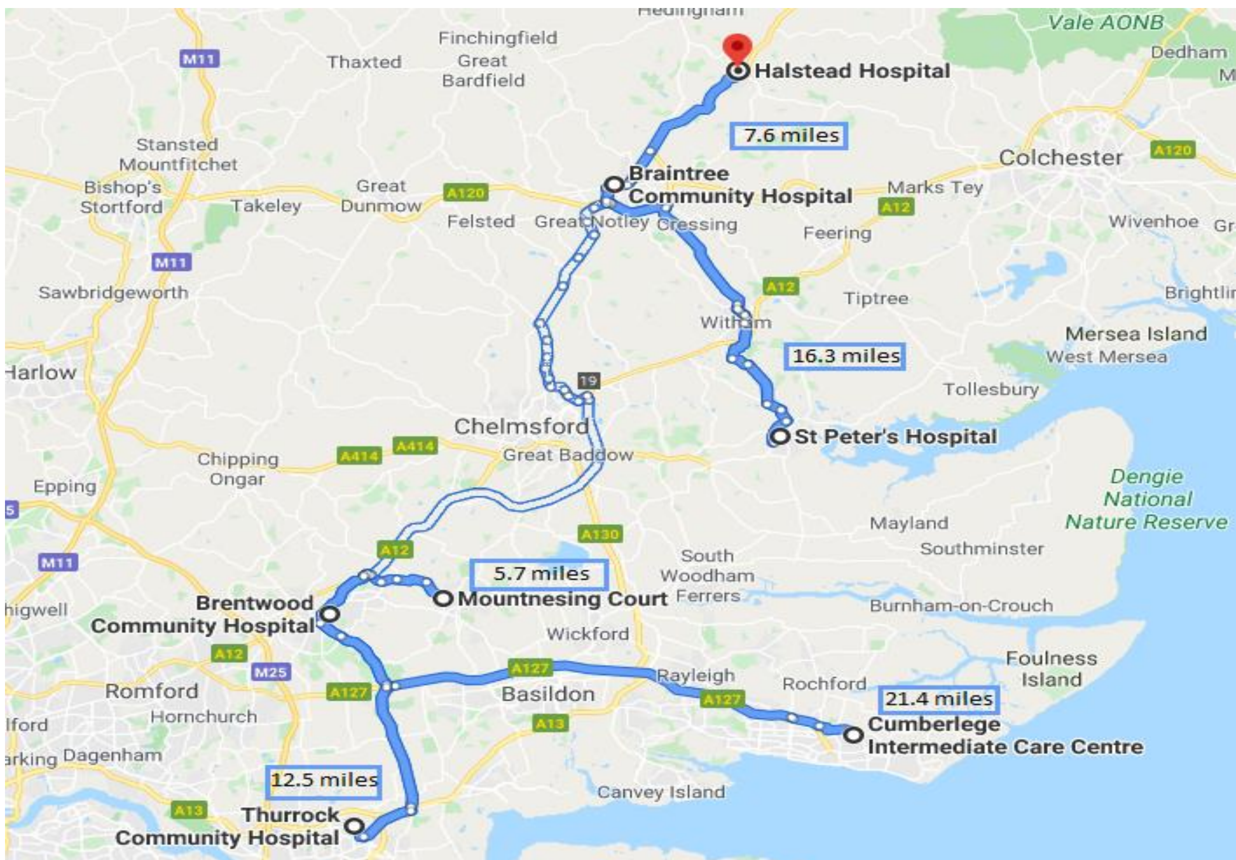
Ward areas	Location	2019 capacity	2019 stroke capacity	Change	New locations
Cumberlege (CICC)	Rochford	22	6*	Moved	Brentwood
Halsted	Halsted	20		Moved	Braintree stroke
Mayfield	Thurrock	24		Moved	Brentwood
Mountnessing Court	Billericay	22		Moved	Brentwood
St Peter	Maldon	26	10	Moved	Braintree
Thorndon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

**not including the stroke rehabilitation in Southend Acute*

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

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

Location of Sites



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

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

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

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

4 Current position

National

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Local

Surge Planning

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

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

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

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

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

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

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

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

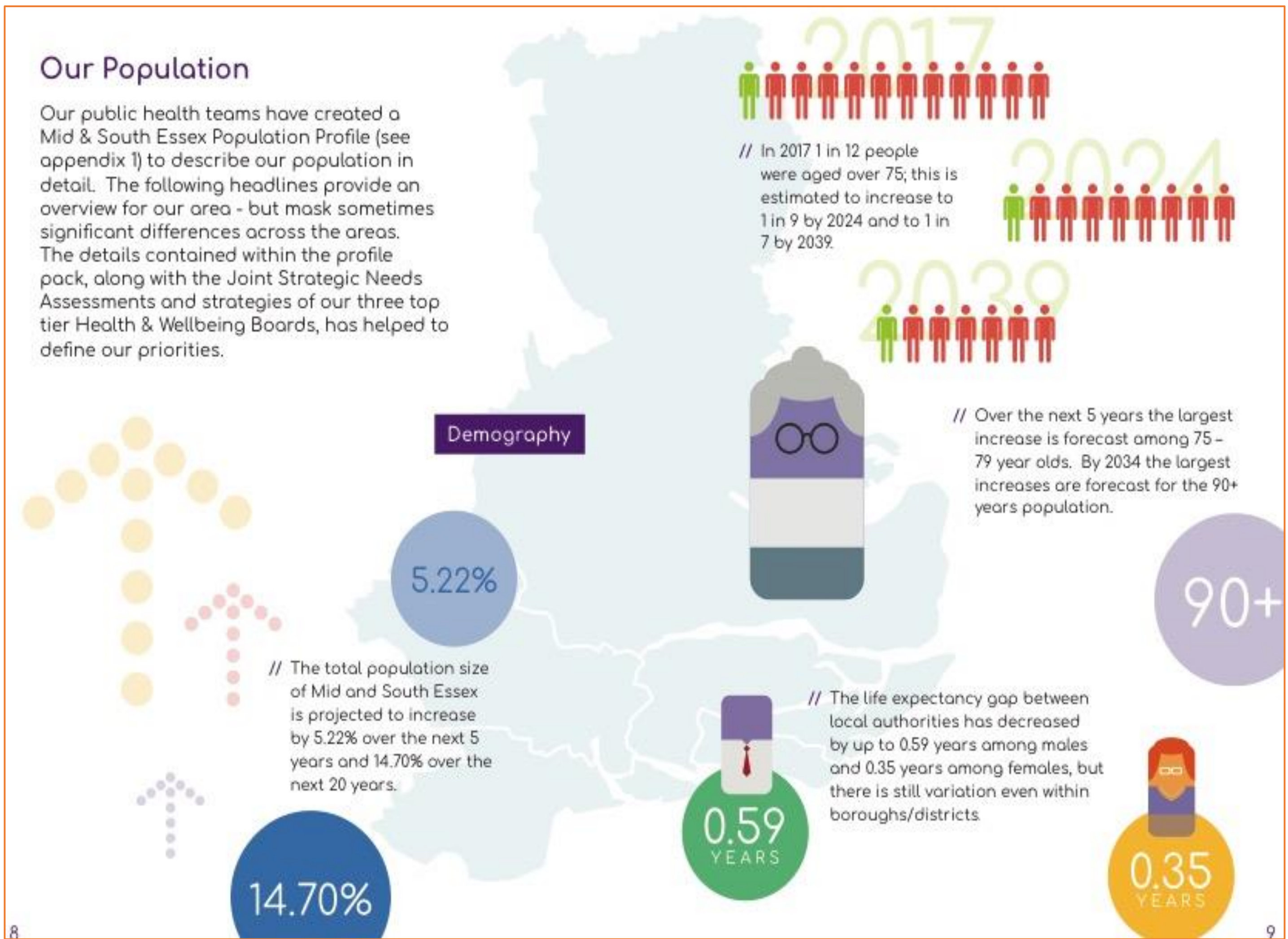
  The CCG and EPUT are currently reviewing the use of Rawreth and Clifton Dementia care home units.

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

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

Ageing Population/Frailty

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



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

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

Older People Service Re-provision

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

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

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

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

Locality/Place based working summarised under stakeholder engagement on page

5 Factors to Consider

Staffing

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

Staff numbers/availability

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

Prior to the transfer of wards

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

Vacancies rates January-March 2020

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

During the Pandemic phase (two locations)

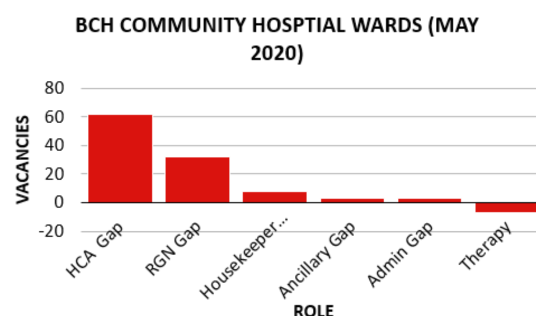
The community beds were staffed during the pandemic with a combination of staffing that transferred in from the relocated wards and redeployed staff from local NHS and private care providers. It is fair to say that the staffing remained a challenge and required on a daily basis a review of planned staff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

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

Has our CH staff vacancy changed?

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

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



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

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

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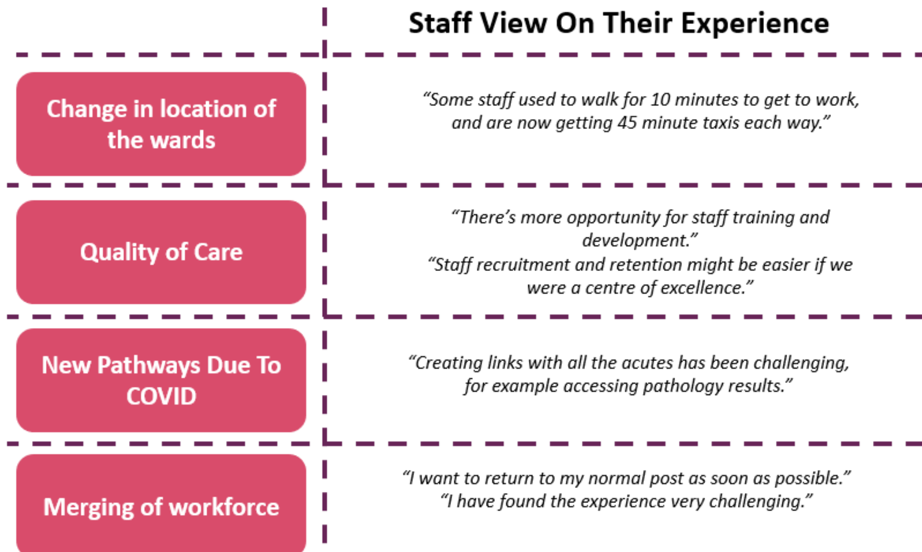
Staff feedback from conversations and surveys.

Community Hospitals – Staff

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



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Staffing model

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

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

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

- Access to diagnostic services

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

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

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

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

Standard access criteria for all wards was also developed.

<u>Additional costs</u>

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

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

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

Sickness and Annual Leave

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

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

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

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

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

Staff training and capabilities

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

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

Medical model

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

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

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

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

Medical staff transferred or redeployed

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

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

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

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

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

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

Community beds: Admissions

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

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

Wards included:

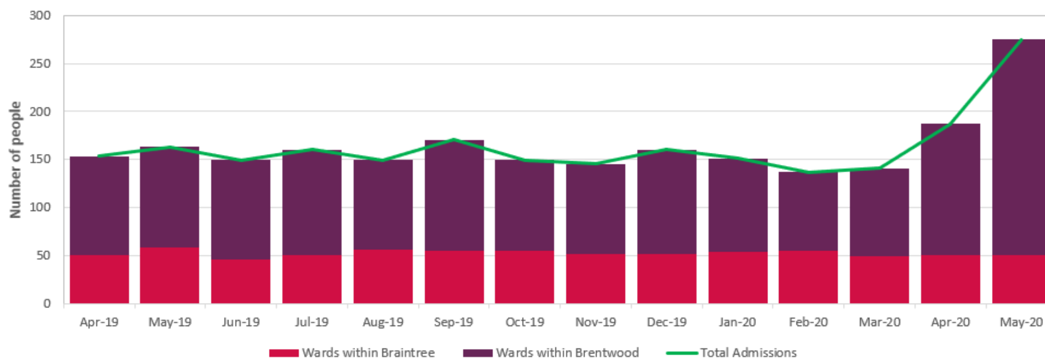
Braintree: St Peters, Halsted

Brentwood: CCIC, Mountnessing, Thorndon, Mayfield, Bayman, Courage, Gibson, Tower

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

MSE: Community Hospital Admissions

April 2019 to May 2020



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Community beds: Length of stay

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

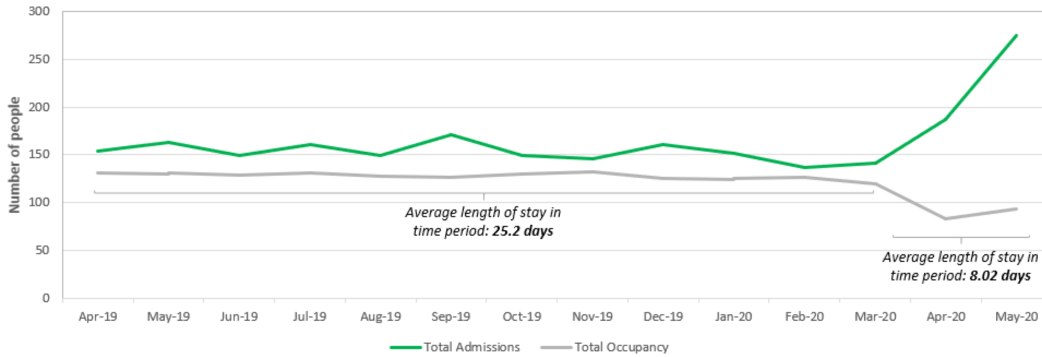
Wards labelled as Braintree and Brentwood include all those now who were separate before consolidation

Wards included:

Braintree: St Peters, Halsted

Brentwood: CCIC, Mountnessing, Thorndon, Mayfield, Bayman, Courage, Gibson, Tower

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



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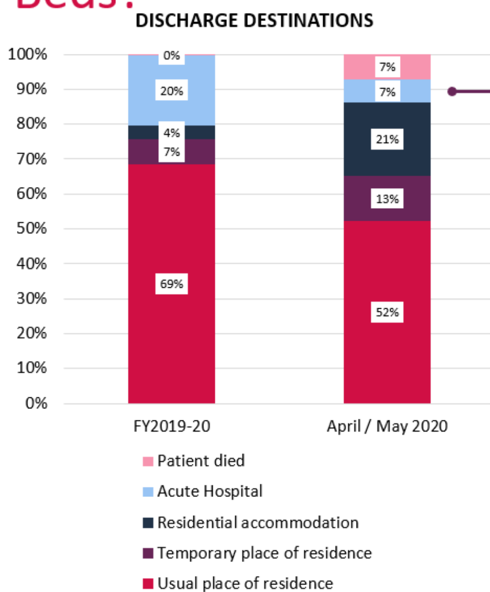
Where do people go after Community Beds?

Data from Brentwood Community Hospital



Returned to acute hospital – 20% to 7%

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

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

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

COVID-19 Red and Green sites

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

Step Up

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

Stroke requirements

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

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

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

Patient feedback

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

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

Staff feedback from conversations and surveys. Patient quotes taken from Thank You messages sent to our wards

Community Hospitals - Patients

Staff View on Patient Experience

Change in location of the wards

"It's a lot of moving for patients; it's not ideal for the patient pathway. Once we're able to have visitors again they may have to travel long distances to see their loved ones." – Staff view

Quality of Care

"It could be really good. We could get it to a centre of excellence. There's an opportunity to be the best we can for patients in one place. But we're not their yet. We had to move at pace to become a field hospital." – Staff view

New Pathways Due To COVID

"The patient experience is getting lost amongst the new pathways."
"We're getting some patients who we then send straight back to the acute or straight home. Not all referrals are appropriate." – Staff view

Merging of workforce

"Having more than one doctor on site, with different approaches, results in better care for patients." – Staff view

Patient View on Patient Experience

"Thank you for the love and care you gave our nan in her last days. You were there for her when we couldn't be and that means the world to us"

"Thank you for helping me get walking and home"

"Thank you just doesn't seem enough"

"Everyone we have spoken to has been so helpful and kind through these difficult times. Nothing has been too much trouble"

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Formal Complaint numbers

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

Informal complaints are addressed immediately and are not routinely recorded.

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

Patient safety incidents

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

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

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

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

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

Suitability of premises

St Peters Maldon

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

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

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

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

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

Halsted

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

Mayfield

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

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

Mountnessing Court

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

Cumberledge Centre

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

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

Brentwood Community Hospital

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

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

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

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

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

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

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

Braintree

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

Stakeholder Engagement

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

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

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

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

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

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

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

Hospice support

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

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

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

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

Engagement with HOSCs

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

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

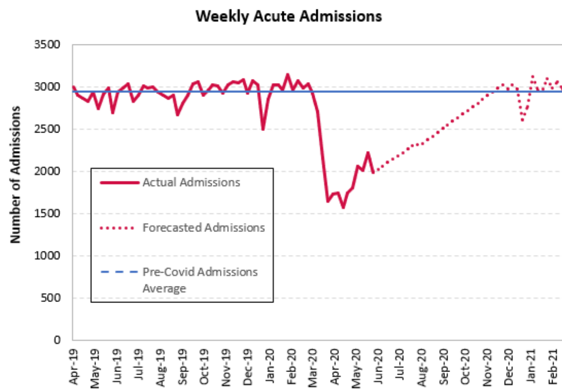
6 Modelling

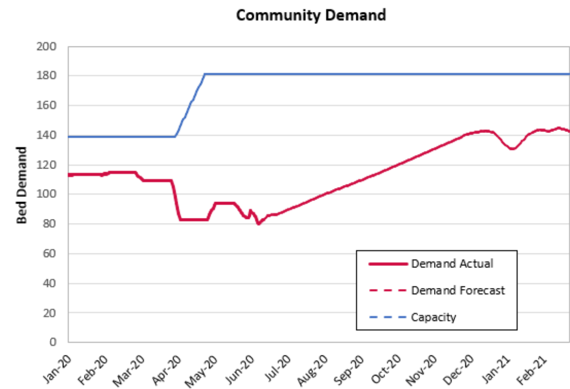
This modelling has been reviewed and refreshed by Newton Europe and includes the surge/winter planning predications and has identified that we will need an additional 100 community care beds up to March 2021.

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

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

Scenario 4: Target mid-point (without stroke)



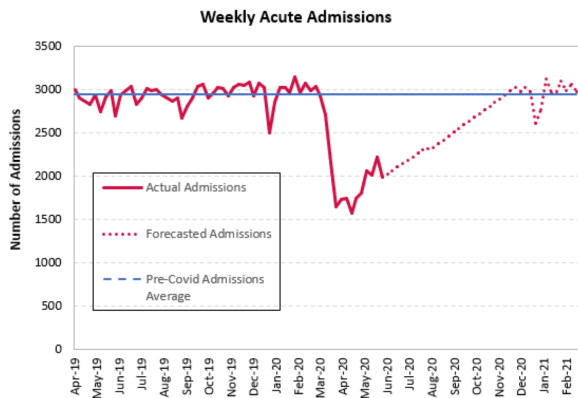


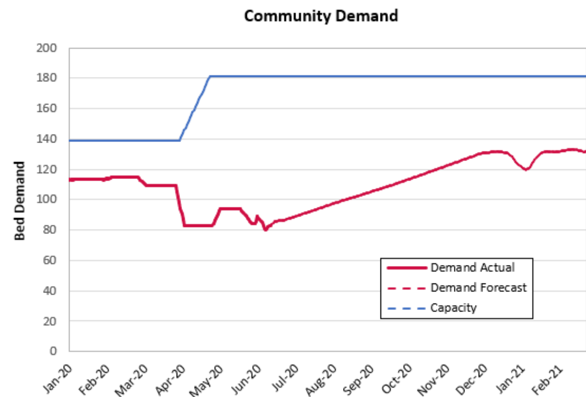
1. **Discharge Pathway** – Without stroke, discharge % into community hospital ranges from 1% (Pre Covid) and 3.2% (Post Covid). **Therefore Mid-point taken at 2%**
2. **ALOS – Set at target level of 21 days**
3. **Acute ramp up** – Non-elective and elective admissions ramp up to 100% of previous year's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

Output

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

Scenario 5: Stretch (without stroke)



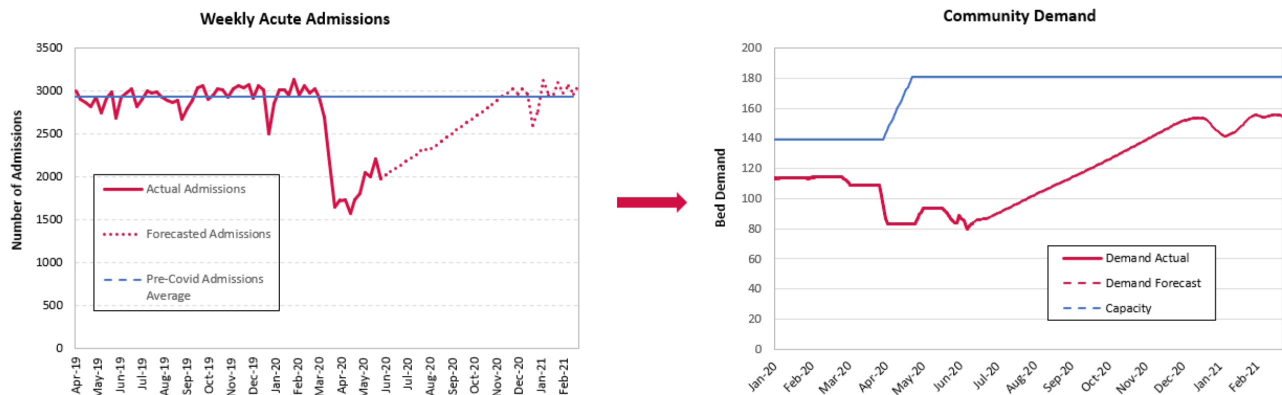


1. **Discharge Pathway** – Without stroke, discharge % into community hospital ranges from 1% (Pre Covid) and 3.2% (Post Covid). **Therefore Mid-point taken at 2%**
2. **ALOS – Set at stretch level of 18 days**
3. **Acute ramp up** – Non-elective and elective admissions ramp up to 100% of previous year's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

Output

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

Scenario 6: Upper Limit (without stroke)



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

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

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

Output

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

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

4.1 Known Assumptions/Key Points

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

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

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

4) St Peters is not fit for purpose.

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

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

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

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

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

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

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

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

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

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

7 Overarching benefits and risks

Benefits of consolidated sites

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

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

Risks of disaggregating sites

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

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

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

8 Options

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

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

All 19 options can be found in Appendix 1.

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

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

Option 1 (Option 1 in options table Appendix 1)

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

Pros

Staffing

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

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

Premises

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

Location

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

Finance

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

Other

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

Cons

Staffing

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

Premises

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

Location

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

Finance

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

Other

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

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

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

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

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

Pros

Staffing

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

Premises

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

Location

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

Finance

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

Other

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

<u>Cons</u>

Staffing

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

Premises

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

Location

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

Finance

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

Other

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

Option 3 (Option 5 in options table Appendix 1)

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

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

Pros

Staffing

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

Premises

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

Location

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

Finance

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

Cons

Staffing

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

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

Premises

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

Location

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

Finance

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

Other

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

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

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

Beds return to CICC	22				
Total	**241**				

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

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

Pros

Staffing

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

Premises

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

Location

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

Finance

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

Cons

Staffing

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

Premises

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

Location

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

Finance

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

Other

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

Option 5 (Option 18 in options table Appendix 1)

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

Additional capacity needed remains at Brentwood as wards already in place	100
Total	**239**

		South West Essex	Thurrock Community Hospital	Mayfield	24
		South West Essex	Billericay	Mountnessing Court	22
		Mid Essex	Maldon	St Peters	26
		Mid Essex	Halstead	Halstead	20
		South West Essex	Brentwood	5 ward areas	

Pros

Staffing

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

Premises

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

Location

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

Finance

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

Other

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

Cons

Staffing

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

this would increase again, particularly out of hours if there are a number of sites again

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

Premises

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

Location

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

Finance

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

Other

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

9 Next Steps

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

Appendix 1

All Options for Consideration

Options for beds
v4.xlsx

Appendix 2

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

8th June 2020