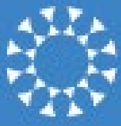

Mid and South Essex

Pre-Consultation Business Case on services in mid and south Essex for the future configuration of community inpatient beds, midwife-led birthing and ambulatory services at St Peter's Hospital

January 2024

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List of Acronyms / Abbreviations

Organisational acronyms

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

Further used Acronyms/Abbreviations

Acronym	Meaning
AHP	Allied Health Professions
BGS	British Geriatric Society
BMJ	British Medical Journal
CCORG	Clinical and Care Outcomes Review Group
DMBC	Decision-making Business Case
D2A	Discharge to Assess
ESD	Early Supported Discharge
FOI	Freedom of Information
HASU	Hyper-acute stroke unit
HDU	High Dependency Units
HOSC	Health Oversight Scrutiny Committee
HWBB	Health and Wellbeing Board
I&E	Income and Expenditure

ICU	Intensive Care Unit
IDTs	Integrated Discharge Teams
IMC	Intermediate Care
IPC	Infection Prevention and Control
JFP	Joint Forward Plan
MLBU	Midwife-led Birthing Unit
NAIC	National Audit of Intermediate Care
NICE	National Institute for Health and Care Excellence
NPEU	National Perinatal Epidemiology Unit
OP	Outpatients
P2	Pathway 2
PCBC	Pre-Consultation Business Case
PCNs	Primary Care Networks
PFI	Private Finance Initiative
POCT	Point-of-Care Testing
PROMs	Patient Reported Outcome Measures
ShCR	Shared Care Record
SOAC	System Overview and Assurance Committee
SRU	Stroke Rehabilitation Unit
SSNAP	Sentinel Stroke National Audit Programme
ToCHs	Transfer of Care Hubs
UCL	University College London
UCLP	University College London Partners

1. Executive Summary

1.1. Introduction

1.1.1. For several years, the contribution and performance of community hospital beds in mid and south Essex has been under review. Covid-19 interrupted this work and caused an emergency redistribution of community beds, which was gradually reversed in 2022/23. During 2022 the East of England Clinical Senate was asked to consider proposals from the Mid and South Essex Integrated Care System (MSE ICS) concerning intermediate care (IMC), stroke rehabilitation and frailty bedded care. The issues of the community bed clinical model and distribution remained under consideration primarily due to quality, capacity and estate issues. In early summer 2023, MSE ICS established a multi-agency Community Capacity Task Force (CCTF) to explore the extent to which community hospital provision needed to change. This has led to the development of proposals to improve community hospital services and the production of this Pre-Consultation Business Case (PCBC). The case details the recommendations made to the relevant boards and committees on the proposed options for service change. Its purpose is to:

- Set out the 'Case for Change' – the reasons decisions are being sought to make changes in order to secure better outcomes for patients and improved performance for the system of health and care. It explains why these changes are necessary.

- Demonstrate how the health and wellbeing needs of the local population affected by these changes will be better served. This includes how current inequalities will be tackled and how the model has been developed to meet the local needs of the mid and south Essex (MSE) population.

- Detail the clinical models which are the foundations of these changes and their basis in national guidance and best clinical practice.

- Describe the process that has been followed using clinical advice to generate the options for changes in community hospital bedded service, then determining which best meet the population needs through appraisal and evaluation of the options considered.

- Show how stakeholders and the public have been engaged in this preliminary process and their range of views captured. Should it be agreed that this case should proceed, there will be a public consultation for which proposed plans are also included.

- Provide an overview of the financial consequences of the shortlisted options and their affordability.

- Detail arrangements for the governance of the programme, how decisions will be made and the systematic approach to assurance which has been adopted.

- Provide an initial view of the necessary steps to be taken should the MSE Integrated Care Board approve the PCBC and agree to public consultation.

1.1.2. The programme has worked within the context of other local, regional, and national initiatives and will consider any further initiatives as they arise.

1.2. Temporary Service Changes

1.2.1. The CCTF initially focused upon the need to adjust the configuration of community beds to enable the system of health and care to respond to anticipated increased demand in the winter of 23/4. It became evident that the distribution and number of stroke rehabilitation beds required change. It was also apparent that the estate at St Peter's Hospital was not fit to continue to provide inpatient services there.

1.2.2. The CCTF therefore proposed transferring the 16 stroke rehabilitation beds at St Peter's Hospital to the Bayman Ward at Brentwood Community Hospital, increasing capacity there to 25 stroke rehabilitation beds and increasing the number of stroke rehabilitation beds at the Cumberlege Intermediate Care Centre (CICC) from 8 to 14.

1.2.3. In August 2023, the Boards of the constituent organisations comprising the ICS approved proposals to temporarily transfer the 16 stroke rehabilitation beds from St Peter's to Bayman Ward and to increase stroke rehabilitation capacity in MSE from 24 beds to a potential 39 in preparation for the expected surge in demand during the winter of 2023/4. Due to safety and quality issues, once the beds had been removed, the St Peter's inpatient Midwife-led Birthing Unit was also relocated leaving ambulatory services (outpatients, therapies, and diagnostic services) being provided at the St Peter's site. The inpatient transfers took place on October 9th, 2023.

1.2.4. As a result of the estates issues, the PCBC proposes that the transfer of beds from St Peter's should be made permanent and that the remaining ambulatory services should also be relocated. The hospital was opened in 1873 as a poor law institution. A recent survey showed that 78% of its gross internal area exhibited defects, 52% of which were high risk. The main building is prone to flooding with accompanying electrical and fire risks. The single bed lift is subject to breakdown. Overall the building is increasingly unfit to accommodate today's patient services and the cost of bringing it up to standard has been assessed as £18.7 million.

1.2.5. Figure 1 shows Maldon District and the location of St Peter's Hospital. The catchment for attendances at St Peter's varies according to the service provided.

Overall, approximately 35% of people attending St Peter's Hospital for ambulatory services reside in Maldon.

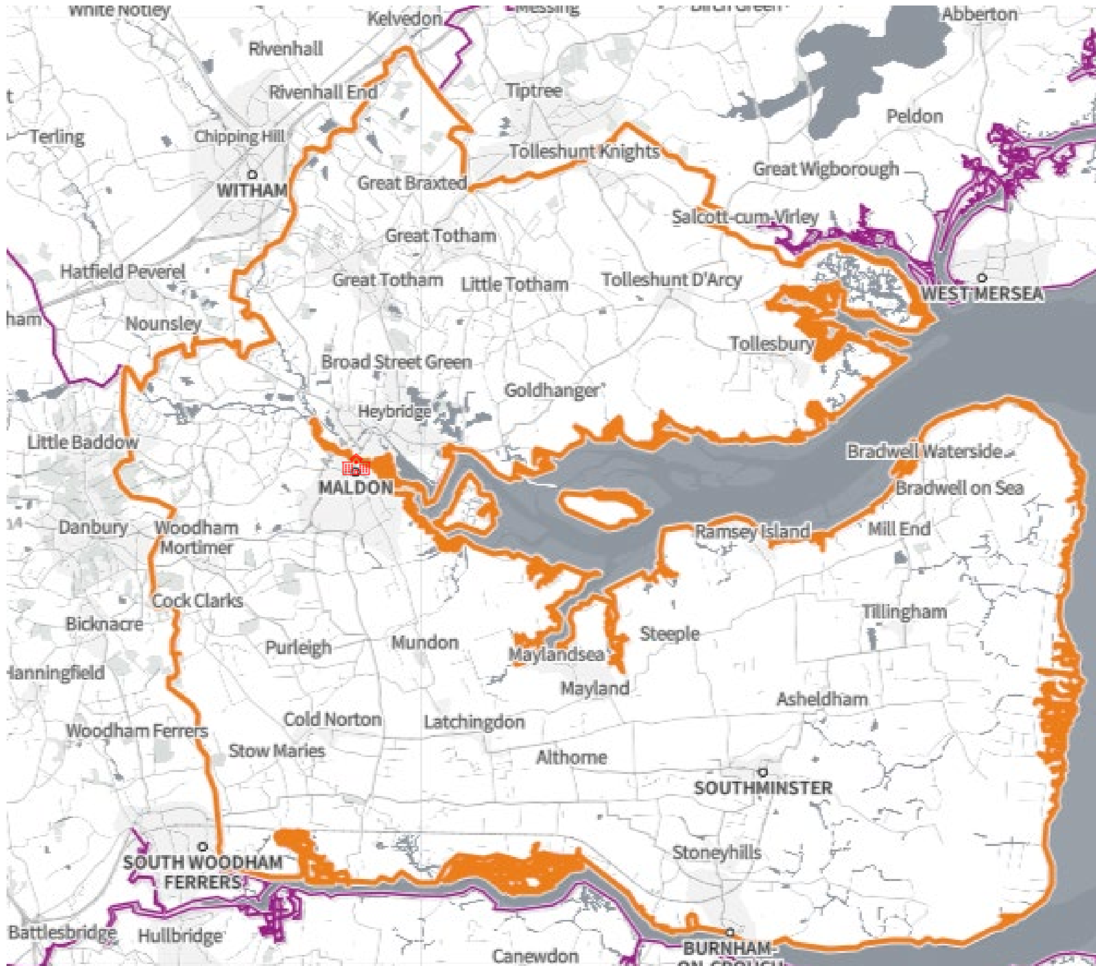

Figure 1, Map of Maldon District showing the location of St Peter's Hospital

1.3. Community Beds

1.3.1. Since 2020 because of COVID-19 and winter pressures, there have been several changes to the location of community hospital services in MSE which are described in Appendix 2. The most recent has been the October 2023temporary relocation of beds from St Peter's and changes to capacity at the CICC to enable MSE ICS to respond to the increased demand anticipated during the winter months of 2023/24.

1.3.2. Overall, for winter 2023, this enabled an increase in the number of stroke rehabilitation beds in MSE from 24 to 39, alongside a reduction in IMC beds from 105 to 99 to be available.

1.3.3. The CCTF continued its work to redesign the IMC and stroke rehabilitation services to accord with national guidance, best practice, and local clinical advice. The proposals contained in the PCBC reflect the aim of ensuring that the best possible outcomes are available for people needing hospital-based rehabilitation in MSE. This has resulted in two options for the configuration of community beds set out in paragraph 1.8 of the Executive Summary.

1.4. Midwife-led Birthing Unit (MLBU)

1.4.1. The condition of the St Peter's estate and the temporary move of the stroke rehabilitation beds meant that the MLBU at St Peter's Hospital would be isolated and its security at night and weekends compromised. Since it too was affected by the poor estate fabric and the attendant risks, it was decided that for the winter of 2023 inpatient services would be transferred to the William Julien Courtauld (WJC) Unit at St Michael's Health Centre, adjacent to the Braintree Community Hospital, which is equipped as a birthing unit. This therefore became the temporary alternative centre for the only freestanding MLBU in MSE serving a larger population.

1.4.2. The WJC Unit at St Michael's Health Centre, adjacent to the Braintree Community Hospital and the St Peter's Hospital Unit were both part of the maternity service based at Broomfield Hospital Chelmsford, ensuring continuity of care through the same midwives. A maternity outpatient service remains in Maldon. The PCBC therefore considers the future location of the system of health and care's freestanding MLBU following its temporary transfer from St Peter's Hospital, Maldon.

1.5. Ambulatory services

1.5.1. Ambulatory services include outpatient clinics, therapy, and diagnostic services, such as X-ray and blood tests. Following the temporary winter inpatient transfers in October 2023, ambulatory services have continued to be provided from St Peter's Hospital. Annually over 80,000 ambulatory care appointments, including approximately 39,000 outpatient appointments, are provided from St Peter's Hospital. That includes around 37,000 blood tests, 8,500 X-rays and 700 ultrasound examinations. Approximately 40% of the outpatient appointments were attended by people who live within the Maldon District. A list of ambulatory services provided on St Peter's is provided in Figure 6.

1.5.2. Most of the estate, which is 150 years old, was not designed to provide healthcare and is in need of extensive remedial work to be brought up to required standards. Continuing to provide ambulatory services and managing state risks is feasible only in the very short-term. If services are moved from St Peter's, the ICB is looking to ensure services continue to be accessible to Maldon residents. However, plans for ambulatory care must be developed in the context of other changes outside the scope of the PCBC are taking place in Mid Essex; such as the development of Braintree Community Hospital as an

orthopaedic centre, a Community Diagnostic Centre in Braintree, and the possibility of an ophthalmology diagnostic hub. These inevitably will influence the structure and function of some ambulatory services currently provided at St Peter's Hospital.

1.5.3. There are proposals to provide new NHS ambulatory accommodation, built by a developer and leased by the NHS in Maldon combined with primary care developments, but these are sometime away from fruition (at least 5 years) and so suitable interim accommodation, accessible to local residents, is needed.

1.5.4. Examination of local alternatives has identified several opportunities which are currently being explored. Continuing to provide NHS outpatient and diagnostic services from the St Peter's site until purpose-built accommodation linked to primary care becomes available is not practicable. This is due to the condition of the estate and the large sums of money that would need to be spent on a temporary basis to make the site safe enough for any sustained form of patient care which would represent poor value for the taxpayer. Alternative accommodation will need to be used until such time as the proposed development of new, replacement primary and community health facilities are completed. Estimated costs of securing local accommodation for ambulatory services are referred to in Section 11 of the PCBC.

1.5.5. The PCBC therefore proposes that the ambulatory services appropriate to remain in Maldon are transferred initially to suitable local alternative accommodation, ultimately transferring to purpose-built health facilities as and when they become available. This may be more challenging for some services, such as x-ray, where more specialist equipment is needed. However, options are being explored for this in Maldon and at Braintree Community Hospital. Services where there is an overriding clinical reason for co-locate with other clinical services to provide the best possible outcomes may need to be provided elsewhere. During the next few months, detailed proposals will be developed through a process of co-production involving service users, carers, residents, stakeholders and clinicians.

Figure 2, Map of Mid and South Essex, distances, and travel times between sites

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	To										
	Distance in miles	St Peter's Maldon	Mountnessing Court (MNC) Billericay	CICC, Rochford	Halstead	Mayfield, Thurrock	Bayman and Thorndon, Brentwood	William Julien Courtauld, Braintree	Broonfield Hospital, Chelmsford	Basildon Hospital, Basildon	Southend Hospital, Westcliff-on-Sea
From	St Peter's Maldon		16.2	19.7	19.2	27.4	20.3	16.3	15.4	20.6	21.2
	Mountnessing Court (MNC) Billericay	16.4		17.5	29.8	14.3	5.7	23.0	16.2	6.5	16.2
	CICC, Rochford	20	17.9		38.9	22.6	21.6	32.1	23.7	14.2	2.7
	Halstead	19.2	30.6	37.2		45.7	34.7	6.6	15.9	37.0	38.4
	Mayfield, Thurrock	27.6	14.1	21.1	43.7		12.7	36.9	28.5	9.0	19.8
	Bayman and Thorndon, Brentwood	20.6	5.7	21.0	36.4	12.9		27.2	14.2	10.2	19.7
	William Julien Courtauld, Braintree	15.0	23.3	29.8	6.2	37.3	27.4		9.2	30.4	31.0
	Broonfield Hospital, Chelmsford	15.3	12.7	27.4	15.9	28.8	14.2	9.1		22.0	26.1
	Basildon Hospital, Basildon	20.8	6.4	14.3	36.9	10.4	9.9	30.4	21.7		13.0
	Southend Hospital, Westcliff-on-Sea	21.8	16.9	2.7	37.9	20.0	20.2	30.1	22.7	13.2	

		To									
	Distance by car (minutes)	**St Peter's Maldon**	**Mountnessing Court (MNC) Billericay**	**CICC, Rochford**	**Halstead**	**Mayfield, Thurrock**	**Bayman and Thorndon, Brentwood**	**William Julien Courtauld, Braintree**	**Broonfield Hospital, Chelmsford**	**Basildon Hospital, Basildon**	**Southend Hospital, Westcliff-on-Sea**
From	**St Peter's Maldon**		35	45	45	50	40	40	35	40	45
	Mountnessing Court (MNC) Billericay	35		40	55	30	16	45	35	18	35
	CICC, Rochford	45	40		70	40	45	65	55	30	12
	Halstead	45	55	70		70	55	20	30	60	65
	Mayfield, Thurrock	45	30	40	75		30	60	55	18	40
	Bayman and Thorndon, Brentwood	40	16	45	60	30		50	35	24	40
	William Julien Courtauld, Braintree	40	40	55	16	55	45		18	50	55
	Broonfield Hospital, Chelmsford	35	35	50	35	50	40	18		45	50
	Basildon Hospital, Basildon	40	20	30	60	20	24	50	40		28
	Southend Hospital, Westcliff-on-Sea	45	35	12	70	40	45	50	50	28	

		To									
	Distance by public transport (minutes)	**St Peter's Maldon**	**Mountnessing Court (MNC) Billericay**	**CICC, Rochford**	**Halstead**	**Mayfield, Thurrock**	**Bayman and Thorndon, Brentwood**	**William Julien Courtauld, Braintree**	**Broomfield Hospital, Chelmsford**	**Basildon Hospital, Basildon**	**Southend Hospital, Westcliff-on-Sea**
From	**St Peter's Maldon**		121	120	146	151	80	89	59	159	116
	Mountnessing Court (MNC) Billericay	98		40	157	107	46	109	72	62	64
	CICC, Rochford	87	39		116	99	55	119	74	70	27
	Halstead	98	104	116		154	83	35	62	148	144
	Mayfield, Thurrock	161	115	126	175		115	162	132	55	109
	Bayman and Thorndon, Brentwood	90	39	50	113	66		94	60	70	77
	William Julien Courtauld, Braintree	111	110	123	52	170	98		30	152	130
	Broonfield Hospital, Chelmsford	58	79	85	72	106	55	29		93	90
	Basildon Hospital, Basildon	131	59	68	155	55	88	150	92		70
	Southend Hospital, Westcliff-on-Sea	67	58	23	133	95	75	130	93	73	

1.6. Emerging options

In constructing the PCBC, a long list of options for the distribution of IMC and SRU beds as well as the MLBU were developed, and clinical advice sought on each. These options were tested through an option appraisal that considered a wide range of clinical opinion. The final shortlist of options was then ratified by the CCTF. These options are described in Section 5 – Options for Change. Proposals for relocating ambulatory services need to be developed through coproduction with service users, staff providing the service and local stakeholders. Preliminary work has indicated that there are a number of opportunities in and around Maldon. It might also be clinically advantageous to co-locate some services which will be considered during this process.

1.7. Configuration of Community Inpatient Beds

1.7.1. MSE ICS is committed to tackling health inequalities and exists to deliver joined up services. Any solution for community beds should contribute to these fundamental acess for patients, relatives and carers is an important aspect when considering equality, but MSE is not in a position to enable equal geographical access for all since it is not proposing nor has the finance to build and operate new community hospitals. The eventual distribution of IMC and SRU beds will therefore be in existing premises which are themselves not distributed evenly throughout MSE. Indeed, for SRU beds the clinical requirement is that the beds are concentrated, thereby concentrating expertise to ensure that the best outcomes for patients are achieved. If this were not done, another inequality would be created by offering sub-optimal stroke rehabilitation services.

1.7.2. A recent (2023) NHS England (NHSE) publication ‘A New Community Rehabilitation and Reablement Model: Good Practice Guidance for Integrated Care Boards’ has emphasised that IMC can be provided in many care settings, not just community hospitals. These include care homes with visiting therapy staff and most commonly, peoples’ own homes, the aim being that 95% of people discharged from an acute hospital should go to their place of residence enabling achievement of the best possible health, well-being, and independence. The workforce should be multidisciplinary and can be multi-agency, with care being therapy-led, directed by qualified therapists, and often provided by rehabilitation assistants working under direction. Making the right decision as to which care setting is most appropriate for an individual is crucial. If this is done, services are aligned and skills deployed in the most effective manner whether provided in the community hospital, a local authority funded place in a care home or at a person’s place of residence. For NHS IMC beds, the modelling proposes 77 to 87 beds for MSE.

1.7.3. By contrast, national guidance strongly advocates that stroke rehabilitation should be provided in SRUs able to provide expertise and sufficient intensity of rehabilitation to achieve desired outcomes for patients who have been assessed as best being able to respond. The clinical sub-group of the CCTF has also suggested that consolidating and increasing SRU beds creates an opportunity to

provide some local NHS beds for some non-stroke patients requiring Level 3 neuro-rehabilitation. Currently access to specialist neuro-rehabilitation purchased from specialist nursing or care homes as and when it is needed, and these are often not within MSE. Patients, carers, and relatives would therefore have to travel distances outside the boundaries of MSE. The addition of some Level 3 beds in the local area will reduce this need to travel for some. With the specialist skills available in a larger stroke rehabilitation unit, MSE would be able to offer up to three beds for patients requiring Level 3 neuro-rehabilitation, something which has not previously been possible and could better meet the needs of the local population and help reduce inequalities based on diagnosis.

1.7.4. Only a proportion of all stroke patients will be rehabilitated in an SRU. Others, for example, might be more suitable to have an Early Supported Discharge (ESD) for stroke, a team working with them in their place of residence. This is the service offered to most people who have had a stroke, who might also need the support of social care services and benefit from the excellent voluntary organisations working with them.

1.8. Considerations

1.8.1. The key to effective rehabilitation is ensuring that the individual is properly assessed and whenever possible, participates in decisions about their future rehabilitation and care and then enters the most appropriate treatment regimen for them. The community hospital is therefore only one element in a spectrum of services and recovery pathways provided by a number of agencies, all of which function most effectively when the individual goes to the right care setting for their treatment.

1.8.2. MSE ICS is confronting a significant financial challenge as well as meeting the needs of an increasing and ageing population. Any course of action adopted must not significantly worsen the system's financial position and should ensure that services offers value, clinical quality, good outcomes and, within the limitations imposed by the existing building stock, reasonable access to patients, carers, and families. To that end, any option costing more than the existing service provision will need to deliver demonstrable efficiencies to ensure that the changes are at least cost neutral to the system as a whole. Any proposed changes would also need to be affordable within the system's capital allocation.

1.8.3. A vital related consideration is establishing services in locations accessible and attractive to the trained, skilled workforce who, in turn, can direct and train support workers. This also affects the financial position as the fewer temporary staff the system employs, the better it will be able to control its finances and the higher the quality of clinical care will be. Greater certainty about a more permanent distribution of facilities will help in this regard.

1.9. Options

1.9.1. IMC and SRU Beds

Based upon the firm advice from the clinical sub-group and stroke stewards that units should not provide both IMC and SRU services, two options are proposed to be taken to formal public consultation both of which propose an increase of 9 community beds, providing a total of 138 across MSE:

- Option 11 provides 88 IMC and 50 SRU beds. The SRU would be a single unit based at Brentwood Community Hospital occupying Bayman and Thorndon Wards. This hospital was built in the last 15 years and has space and facilities for rehabilitation as well as good parking and access. The advantage of this arrangement for stroke rehabilitation is that it would concentrate expertise in a single location enabling a consistent high-quality service to be provided with the aim of delivering excellent outcomes.

- A further advantage is that such a facility is likely to be attractive to skilled staff both in terms of recruitment and career progression.

- The SRU at Brentwood would also have sufficient beds to support a small number (up to 3) patients requiring neuro-rehabilitation for non-stroke conditions for which there are currently no permanent options available within MSE.

- However, locating the SRU in one place means that for some, care would not be close to home and visitors may have to travel some distance to Brentwood. There would not be IMC beds at Brentwood (currently 25), but in this option, they would be available at Mountnessing Court in nearby Billericay (22 beds).

- The Cumberlege Intermediate Care Centre (CICC) in Rochford would have 22 IMC beds accessible to the Southend population, an increase of 14 on the current capacity. The other facilities offering IMC beds would be the Mayfield Unit at Thurrock Community Hospital with 24 beds and Halstead Hospital in the north of MSE with 20 beds. These numbers would not be affected by the proposals. Overall, based on the national clinical model, the number of NHS IMC beds would be sufficient to meet the assessed bed requirement.

- Option12 provides 91 IMC and 47 SRU beds, the latter being located split between the CICC in Rochford (22 beds) and at Brentwood (Bayman Ward, 25 beds). The CICC was refurbished in 2019 and is in good condition but may need some bathroom alterations if it were to be used solely for stroke rehabilitation. For stroke rehabilitation, people living in the west and southeast of MSE would have good access, offering them choice. There is no suitable facility for an SRU in the north of MSE.

- Three more IMC beds would be available than in Option 11, but there would be three fewer SRU beds meaning that it would not be possible for this option to accommodate neuro-rehabilitation beds. No IMC beds would be available in the southeast of MSE, diminishing access to intermediate care for that population, with most IMC beds located in the west and south of MSE in Thorndon Ward at Brentwood Community Hospital (25 beds), Mountnessing Court, Billericay (22 beds), The Mayfield Unit, Thurrock (24 beds). The Halstead Hospital (20 beds) would provide the IMC beds in the north of MSE.

1.9.2. Maternity Services

Options for MLBU beds were much more limited. In the absence of St Peter's as an option, the remaining freestanding MLBU in MSE is the WJC Unit at St Michael's Health Centre, adjacent to the Braintree Community Hospital. Maintaining the alternative inpatient capacity at this site provides a more resilient service less prone to closure due to staff shortages. Options concerning the future arrangements for maternity outpatients are discussed in Section 5 – Options for Change, but the PCBC proposes that maternity outpatient services for Maldon, which include consultant and midwife clinics post-natal care, parenting and ultrasound scanning be provided locally in a maternity 'hub'. Therefore, the option to locate the MLBU at Braintree retaining a maternity outpatient service in Maldon is preferred since co-location with primary care services, while desirable is not yet available.

1.9.3. Ambulatory Services

The preferred option for ambulatory services, based upon the advice of the Clinical Congress, is to provide accommodation in Maldon where it does not need to be co-located with other services for clinical reasons. Patients who come from further away, such as Braintree and Chelmsford will, where possible, be offered access closer to their place of residence.

Until such time as purpose-built health facilities linked to primary care are available, a number of locations in central Maldon will need to be used for NHS services. Options are being explored across currently vacant buildings within the Maldon area, along with options for x-ray provision in both the local Maldon area and Braintree Community Hospital.

The determination of the configuration of ambulatory services needs to be co-produced with representatives of the local community ensuring that key services remain local. In the case of the Cherry Trees Unit similar co-production work with service users and staff will be required to identify suitable alternative accommodation.

1.10. Recommendation

1.10.1. The PCBC invites consideration of the future configuration of IMC and SRU community beds, the location of the freestanding MLBU in the WJC Unit at St Michael's Health Centre, adjacent to Braintree Community Hospital and options for the relocation of ambulatory services current provided at St Peter's Hospital in Maldon.

1.10.2. If these proposals are supported, the NHS will no longer commission services located at St Peter's Hospital, after which MSEFT may choose to dispose of the site. St Peter's has served the people of Maldon and surrounding districts before and since the inception of the NHS and so these changes will be difficult to adjust to. It is recognised that key local ambulatory services should remain local, where possible, and that MSE ICS needs to work with the local community to in developing the location of local services.

1.10.3. It is recommended that the MSE ICB undertakes a single public consultation in accordance with the s.14Z45 NHS Health and Care Act 2022-Public involvement and consultation by ICBs, consultation with the relevant local authorities under s.244 of the Act and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.

Specifically, this should seek views on:

- The options for reconfiguration of intermediate care and stroke rehabilitation services in community hospitals,
- The proposal to locate the freestanding midwife-led birthing unit at the WJC Unit at St Michael's Health Centre, adjacent to the Braintree Community Hospital, and
- The proposal to relocate ambulatory services currently provided at St Peter's Hospital Maldon.

2. Purpose and Scope of this Document

2.1. The Vision for the Future

2.1.1. The MSE Joint Forward Plan 2023-2028 (JFP) aims to enable every resident to make informed choices to achieve a better quality of life supported by a strengthened health and care system. Its focus is on equitable partnerships and reducing inequalities, prevention and early support from high quality health and social care services working together and being delivered where people need them. The system of health and care has identified priorities to:

- Reduce health inequalities.
- Offer local, personalised, coordinated services brought together by the four local alliances.
- Reduce preventable deaths from cancer, cardiovascular disease, and respiratory conditions.
- Increase activities which help prevent disease, for example, stopping smoking, healthy weight, and physical activity.
- Make investments to achieve better health outcomes and results guided by data and insight.
- Learn from and build up existing and future innovative practice.
- Amplify clinical and professional leadership
- Work side by side with local communities so that services meet their needs.
- Support the voluntary and community sectors.
- Place an emphasis on equality, diversity and inclusion for patients and the workforce.
- Ensure that services are accessible to all and deliver community services close to where people live.

2.1.2. These aims and ambitions guide the development and assessment of the options for reconfiguration of community services.

2.1.3. The practical challenges confronting the system of health and care also influence the choices and decisions which will be made. As a result, the growth in demand, recruitment and retention of the workforce, productivity and funding necessarily influences commissioning decisions, as does the system’s financial situation which means it is unable to build new hospitals.

2.2. Purpose of the Pre-Consultation Business Case

2.2.1. The purpose of this PCBC is to set out the context, the case for change and the proposed future volume, location and function of NHS run community inpatient beds in mid and south Essex. It also seeks to confirm the WJC Unit at St Michael's Health Centre, adjacent to the Braintree Community Hospital as the location for the freestanding MLBU for MSE. The transfer of inpatient beds from St Peter's Hospital, Maldon would leave ambulatory services as well as some community health offices on that site. The risks and challenges of the St Peter's estate has led to the conclusion that local alternative facilities are needed and that providing services for patient care from that site is not sustainable. In time these are intended to be superseded by a proposed purpose-built primary and community health hub in Maldon.

2.2.2. The PCBC acknowledges the long term health hub proposals, but any consultation will concern the community inpatient services, the transfer of the MLBU from St Peter's to Braintree and the proposed transfer of ambulatory services to alternative local facilities until such time as the purpose-built health hub is available.

2.2.3. This PCBC will be considered by relevant commissioner (Integrated Care Board) and Provider Boards prior to public consultation, which is planned for early 2024.

2.2.4. The PCBC therefore:

- Sets out a clear case for change.
- Describes the key elements of the proposed future model of care.
- Outlines and assesses the configuration options.
- Provides clinical and financial assurance.
- Describes how patients, the public and key stakeholders have been involved in the development of these plans.
- Outlines how the plans will be implemented if approved.

2.3. Scope of the Pre-Consultation Business Case

2.3.1. The scope of this PCBC is concerned with the future volume, location and function of NHS run community inpatient beds in mid and south Essex, the proposal to permanently relocate the freestanding midwife-led birthing unit to the WJC Unit at St Michael's Health Centre, adjacent to the Braintree Community Hospital and the proposal to relocate the ambulatory services currently provided at St Peter's Hospital, Maldon.

2.3.2. In this PCBC, reference is made to many other elements of out of hospital care – such as discharge to assess (D2A), recovery at home, virtual wards, and services (including beds) funded or provided by social care – but these are not a formal part of the proposed consultation.

2.3.3. Similarly, while the role of the three acute hospitals is considered, in recognition of the interdependency between acute bed capacity, community beds and supporting the flow of patients through different care settings, the principal focus is on community inpatient beds and the short-term future of residual services at the St Peter's site.

2.3.4. There are also some aspects of the existing community bed configuration that have been the subject of recent previous consultations (such as Orsett Hospital); these are also excluded, as is the use of Braintree Community Hospital, which is to be used mainly for orthopaedic surgery, helping to reduce waiting times for elective treatment.

2.3.5. The system of health and care in '*Your Care in the Best Place'* November 2017 consulted upon the distribution of acute hospital services, which included acute stroke services as well as the future of services provided at Orsett Hospital. It was concluded that the three acute hospitals would each continue to admit, assess and treat acute stroke patients. This PCBC is concerned with the rehabilitation of patients after the acute treatment of their stroke where intensive rehabilitation in the community is aimed at enabling the achievement of optimum function and the provision in a unit supports the medical needs of patients in a nurse/therapy led facility for those whose needs cannot be met at home.

2.3.6. Community beds have been subject to temporary changes since 2020. These were principally caused by the need to ensure acute beds were freed up for Covid 19 patients. Those changes were not consulted upon owing to the need to urgently to react to the pandemic. These changes are described in more detail in Appendix 2. More recently temporary changes were made to the configuration of community beds due to concerns around the quality and safety of the estate at St Peter's, and to enable the system of health and care best cope with the expected surge in demand for hospitalisation during the winter of 2023/24. These are described in the section of this document concerning reconfiguration options and are the starting point for any further changes to the distribution and number of beds.

2.3.7. As a result of these temporary changes, there has also been a focus on concerns about the condition of the estate at St Peter's Hospital, Maldon. Restricted floor loadings previously limited the number of stroke rehabilitation beds there to 16. In addition, the single bed lift is subject to breakdown, there is frequent flooding in the main building and people with limited mobility could not easily be evacuated from the second floor of the main building. The temporary changes effected in October 2023 have transferred the 16 stroke rehabilitation beds to Brentwood Community Hospital. At the same time the MLBU transferred

to the WJC Unit at St Michael's Health Centre, adjacent to the Braintree Community Hospital. Immediate changes within St Peter's have vacated the highest risk areas on the upper floors of the main building in order to manage the most immediate patient safety and estate risks there.

2.3.8. Within this context, the initial driver for the Community Capacity Task Force (CCTF) was to secure the best outcomes and performance from the two main elements of community inpatients beds use – NHS intermediate care (IMC) and stroke rehabilitation. The work then evolved into consideration of the future of all services at St Peter's Hospital owing to concerns about the quality and safety of St Peter's Hospital buildings which had originally led to the temporary transfer of inpatient services. As a result, proposals were developed for rehousing the ambulatory services currently provided at St Peter's to other locations.

2.3.9. The scope of the PCBC is therefore the configuration of the IMC and stroke rehabilitation beds, the relocation of the freestanding MLBU and proposals for future accommodation for the ambulatory services currently provided at St Peter's. The full scope includes:

- **Intermediate care** – beds which are primarily used to enable older people with complex care needs to be discharged from a main acute hospital for a short period of personalised, goal-based rehabilitation, where they are not yet well enough to return to their usual place of residence. These are provided by the NHS where there is primarily a health need requiring an intensive bedded rehabilitation programme and by Local Authorities commissioning residential care with therapy support where the need is primarily for convalescence and slower stream rehabilitation.

- **Stroke rehabilitation** – those patients who have had a stroke, have been assessed as being likely to benefit from a period of focused rehabilitation in a dedicated, bed-based facility.

- **Neuro-rehabilitation –** for the purposes of this document, includes patients with an acquired brain injury of traumatic or non-traumatic origin that is not ordinarily classified as Stroke (e.g. traumatic sub-arachnoid haemorrhage, Encephalitis, Meningitis) who would benefit from a period of focused rehabilitation in a dedicated, bed-based facility.

- **A freestanding midwife-led birthing unit** – offering choice to women within MSE which otherwise has midwife-led birthing units attached to the obstetric units at each of the acute hospital sites.

- **Ambulatory services –** annually there are over 80,000 ambulatory care appointments, including around 39,000 outpatient attendances, at St Peter's. Approximately 40% of those attending outpatient appointments live in the Maldon District. Ambulatory care services include a mental health outpatient service in the Cherry Trees unit, which is in a separate building near the site entrance, as well as plain film X-ray, ultrasound, phlebotomy, and office

accommodation for community staff. A full list of the ambulatory services provided at St Peter's is available in Figure 6. Alternative accommodation needs to be local and accessible, though some may need to be co-located with related clinical services where there is an overriding reason to do so.

2.4. Key Assumptions

2.4.1. In developing the possible options for the future configuration of community rehabilitation and maternity beds and replacement of ambulatory and office facilities, it should be recognised that there are constraints that will limit the range of options that are realistic.

2.4.2. For example, in common with other systems there is not access to large sums of capital funding, so any options that might rely on new or extensively refurbished buildings are unlikely to be practicable.

2.4.3. These wider parameters are treated as 'givens'; the principal ones being:

- No major new capital expenditure. A limited amount of capital may need to be spent on facilities to be retained e.g. Mountnessing Court and re-provision of x-ray services.
- Making best use of the existing estate where it is considered suitable.
- Contributing to wider system recovery post-Covid.
- Ensuring proposals are future proofed, able to accommodate new service models (for example, roll out of virtual wards) and aligned with best practice.
- Admission avoidance and appropriate discharge from acute hospitals will depend upon a combination of agreed urgent community response, clinical pathways, transfer of care hubs, development of virtual wards (there are already 172 virtual beds provided in MSE, 60 of which are for mental health), integrated neighbourhood teams and the community hospital beds.
- Ensuring proposals contribute towards meeting the MSE ICS four aims:
  - Improving outcomes in population health and healthcare
  - Tackling Inequalities in outcomes, experience and access
  - Enhancing productivity and value for money
  - Supporting broader social and economic development

3. Case for Change

3.1. Introduction and context

3.1.1. NHS Community beds have the primary function of seeking to rehabilitate patients many of whom no longer need active medical treatment. On occasion the beds are used to avoid admission to an acute hospital, but the majority are used by patients discharged after an acute episode of treatment and care, needing rehabilitation who are expected subsequently to go home or to a care or nursing home, depending upon their need. In the main the patients in community beds are from the older age groups and their subsequent care involves a number of statutory and voluntary agencies.

3.1.2. As described in Section 2: Purpose and Scope, consideration of the fabric of St Peter's Hospital and the need to increase capacity over winter 2023/24 led to temporary transfer of inpatient beds for stroke rehabilitation to Brentwood Community Hospital and the freestanding midwife-led birthing unit to the WJC Unit at St Michael's Health Centre, adjacent to the Braintree Community Hospital. It was then concluded that St Peter's is not a suitable location for long term provision of healthcare services including ambulatory services and proposals for alternative facilities would have to be developed.

3.1.3. Prior to the existence of the NHS, community hospitals were either built from public subscription or private benefaction. A number underwent a transition from Poor Law workhouse and infirmaries, as was the case with St Peter's Hospital. In 1948 the NHS inherited these institutions together with their historic distribution providing a service to some populations, but not to others. Since then, more modern community hospitals have been developed, particularly in the last two decades when government policy encouraged the use of private finance to fund capital developments.

3.1.4. Community beds in Mid and South Essex exhibit these characteristics derived from their development since the beginning of the twentieth century and earlier.

3.2. Reasons to change the community bed configuration.

3.2.1. **Respond to the increasing demand for care:** Demand for acute hospital treatment and care has been increasing principally because the total population of Mid and South Essex has been growing. The most pronounced increase has occurred in the age groups of those 75 and over. This older population often have multiple ailments and need a longer time and more help to recover from an acute episode of illness. They are the principal users of community hospital beds where they benefit from a programme of rehabilitation in what is described as intermediate care (IMC). The other significant users of community beds are patients undergoing rehabilitation after a period in an acute stroke unit. Some of these patients will be younger than patients in IMC.

Evidence from earlier MSE clinical reviews have indicated that outcomes locally for patients transferred do not meet national average performance (national audit of intermediate care NAIC) and there is a wide variation in demand for IMC beds across the system not explained by demographic or patient flow differences. Changes in performance are therefore essential if outcomes are to improve, future demand is going to be met and the population of MSE is to have access to IMC beds.

3.2.2. **Ensure that community beds fully perform their role in the spectrum of health and care services:** The community hospitals do not stand alone. They are an element in the health and care landscape working with the acute hospitals, primary health, and social care as well as the wide range of community health services supporting people in their home. As an example, local authorities also provide intermediate care services in nursing and care homes.

The health services now include integrated neighbourhood teams (INTs), the first nine of which in MSE were established in 2023. That landscape of health and care is constantly undergoing change.

Recently ‘virtual wards’ have been developed to support and treat patients in their place of residence. There are 180 virtual ward beds currently serving people exhibiting frailty, ‘hospital at home’ beds for people discharged from acute hospitals and ‘virtual’ beds for patients with respiratory conditions, as well as 60 ‘virtual’ beds for mental health patients. The virtual wards seek to provide better outcomes and enable patients to leave hospital earlier in their pathway of care but are not a replacement for community hospital rehabilitation services. Additionally, they support people to remain in their place of residence to receive treatment rather than going to hospital.

The Mid and South Essex system of health and care is developing transfer of care hubs (TOCHs) designed to streamline the processes which enable patients to move from one part of the system to another. The aim is to ensure that patients are assessed and are placed, with their agreement, on the correct recovery pathway for their needs. For people assessed as having health or social needs who would benefit from further step-down care the right care can be supported by the TOCH and made available.

Together with revised, agreed care pathways these services enable vulnerable people to be supported in the most appropriate care setting, preferably their own home, but if that is unsuitable, in sheltered or supported housing, or in interim residential homes as well as being able to have rehabilitation in a community hospital.

3.2.3. **Ensure that the stroke rehabilitation service is the right size and offers consistent high quality and is accessible to a high proportion of the population:** It is evident that according to national guidance not only have there been too few stroke rehabilitation beds in community hospitals in Mid and South

Essex, but patients undergoing rehabilitation have continued to occupy beds in acute hospitals which increases their risk of infection and is a less favourable therapeutic environment for recovery. With more community beds available and revised referral pathways, it should be possible to maximise the use of community facilities and 'free up' acute beds improving access to specialist acute stroke beds on admissions.

The National Clinical Guideline for Stroke for the United Kingdom and Ireland 2023 recommends that rehabilitation should be needs based and not time limited and proposes an increase in the amount of therapy patients would benefit from, citing international evidence supporting the approach. The Guideline also proposes specific levels of staffing for Stroke Rehabilitation Units (SRUs) which local services currently do not reflect and will take time to adjust towards. The evidence is that concentrating expertise and resource to provide intensive rehabilitation is more likely to achieve a better result for the patient.

The interim changes to the configuration of stroke rehabilitation beds created an opportunity to concentrate them in two community hospitals. Options for further changes to stroke rehabilitation for the future are to be considered as part of this business case.

3.2.4. **Increase access to local neuro-rehabilitation services**: Currently there are no permanent Level 3 neuro-rehabilitation beds available in MSE, with beds purchased as needed meaning patients may end up in more expensive Level 2b beds or, if they don't meet the criteria for bed-based rehab, they are managed by local community teams. Development of more extensive stroke rehabilitation facilities, especially where the beds are consolidated in a single unit, creates the opportunity for those needing Level 3 rehabilitation using up to three beds in local SRU capacity. There they may be treated by the local specialist teams with the aims of restoring function and independence; benefiting from therapy and nursing teams with specialist expertise led by consultants in specialties such as stroke and neurology. Currently neuro-rehabilitation patients may only receive these services outside the boundaries of MSE. The neuro-rehabilitation levels are described in Appendix 13.

3.2.5. **Meet the workforce challenge and in doing so assure a quality service:** In some cases, community beds have proved difficult to staff with skilled nurses and therapists. This leads to the use of agency staff who cannot sustain continuity of care or the use of the staff bank. In both instances the cost of staffing units increases, putting pressure on NHS expenditure. There is a need to ensure that community beds are such that the workforce can be attracted to them, and their services then retained. Greater certainty about the future and location of the hospitals is expected to support recruitment and retention of staff.

3.2.6. **Address the problem that some of the estate is unsuitable for continued use:** In St Peter's Hospital there are concerns about the safety and the suitability of the building as a location for providing clinical care as it does not

meet the required standards of accommodation and services. This has already resulted in the temporary transfer of inpatient services from the site, which would be followed by moving ambulatory services to alternative locations, subject to public consultation. The freestanding MLBU now in the WJC Unit at St Michael's Health Centre, adjacent to the Braintree Community Hospital which requires some minor works, but otherwise has the required facilities. There are other low-risk birthing units in MSE, which are all attached to the obstetric units on the acute hospital sites. The public consultation will seek views on permanently moving the freestanding MLBU from St Peter's Hospital to the WJC Unit at St Michael's Health Centre, adjacent to the Braintree Community Hospital, but it will not propose alternative locations for the service.

3.2.7. **Enable the system of health and care to offer services at best value:** Community beds are required to operate at best value while not compromising service quality. It is a seeming paradox that the cost per day of community beds tends to be relatively high as community hospitals offer beds in limited numbers on each site, meaning that the costs of overheads are a significant proportion of total costs.. Ensuring that the number of beds, their distribution and the essential workforce are best matched to meet population needs allied to recommended best practice principles will contribute positively to the efficient use of resources. It is also the case that where more modern or refurbished accommodation is used, it will contribute to cost efficiency and sustainability.

3.3. Meeting the evolving needs of MSE

3.3.1. The supply of community hospital beds is limited by the current premises, availability of a suitably skilled workforce and resources. It is neither possible nor desirable to keep building hospitals and putting people in institutionalised care if that can be avoided. It is also the case that the more recent development of virtual wards will help even more people receive more support in their own place of residence.

3.3.2. TOCHs are expected to promote optimal Discharge to Assess (D2A) performance, ensuring that patients enter the correct recovery pathway, enabling those admitted to community beds have been accurately assessed as to their needs and referred without delay. This requires that clinical pathways are agreed and applied consistently. In any event the underlying aim is to ensure that individuals, wherever possible, should be supported in their own home to support independence and wellbeing.

3.3.3. Until now there has not been a clear picture as to how many beds there should be to play their proper part in the system of health and care, whether they are located in such a way as to meet the needs of the population served, whether they are suitable for the standard of care provided and whether the public purse is receiving the best possible value for every pound spent. In dealing with the MSE focus on resolving health inequalities, the location of these facilities and their accessibility to populations in Mid and South Essex is an important factor.

This may need to be balanced against other equality factors such as the effectiveness of the services provided, and the patient outcomes achieved.

3.3.4. For the MSE system of health and care this is particularly important, as a national survey published in June 2023 showed that MSE had the lowest number of community beds of any system of health and care in the East of England. This should not be assumed to be a deficiency as the MSE system of health and care has recently been demonstrated to have the lowest percentage of delayed discharges from acute hospitals in England. Delay in discharging patients adversely affects recovery, slows their reablement and can diminish their ability to return home. In community intermediate care beds, active rehabilitation is required prior to the patient going to their place of residence. Housing large numbers of patients in community beds is not required and does not enable the best outcomes for this population. Effective use of the beds, provision of optimal home care services and community systems for early discharge as well as close working with public and voluntary social care agencies is necessarily the way forward. This promotes the improvement of population and system outcomes and is aligned to national best practice principles.

3.3.5. The PCBC examines the different ways these requirements might be met and proposes a range of solutions based upon the best available clinical advice which, it is believed, meets the needs of the population now and in the foreseeable future. It is clear that the current distribution and use of community beds needs to change if they are to play their proper part in the delivery of the health and care services of the future. The nature and extent of this change will be tested within the consultation processes initiated by the PCBC. Options for Change have been assessed by the clinical sub-group of the CCTF, Ageing Well and Stroke Stewards as well as the CCTF itself using criteria shown in Appendix 3 and shortlisted using a decision tree also to be found in the Appendix 3.

3.4. Making better use of community beds and improving pathways

In each of the areas within the scope of this business case concerned with rehabilitation– intermediate care and stroke rehabilitation – the PCBC seeks to assess at how many beds are likely to be needed in the future, where they might best be located and how the clinical pathways along which patients are expected to travel might be improved.

3.4.1. Intermediate care

3.4.2. There are several strands to the case for change that are specific to intermediate care:

- The number of NHS IMC beds required in the future has not previously been systematically modelled on an MSE footprint.
- There is evidence that the 'right' patients to go into IMC beds have not always been selected, which means that patient outcomes are not optimised.

- There is scope to improve overall outcomes for patients by further developing the intermediate care pathway with TOCHs increasing the number of appropriate admissions to community beds.

- The system of health and care is developing integrated neighbourhood teams comprising GPs and a range of other health care professionals initially in nine locations together with virtual wards.

- National guidance indicated that of the inpatients discharged from an acute hospital 50% should be able to go home without further reablement of support (Pathway 0), 45% may go home with some further support (Pathway 1), 4% are likely to need a community bed, which could be NHS or social care depending upon need (Pathway 2), and 1% will need to be accommodated where their needs can be met such as in a care or nursing home (Pathway 3). This is illustrated in the figure below:

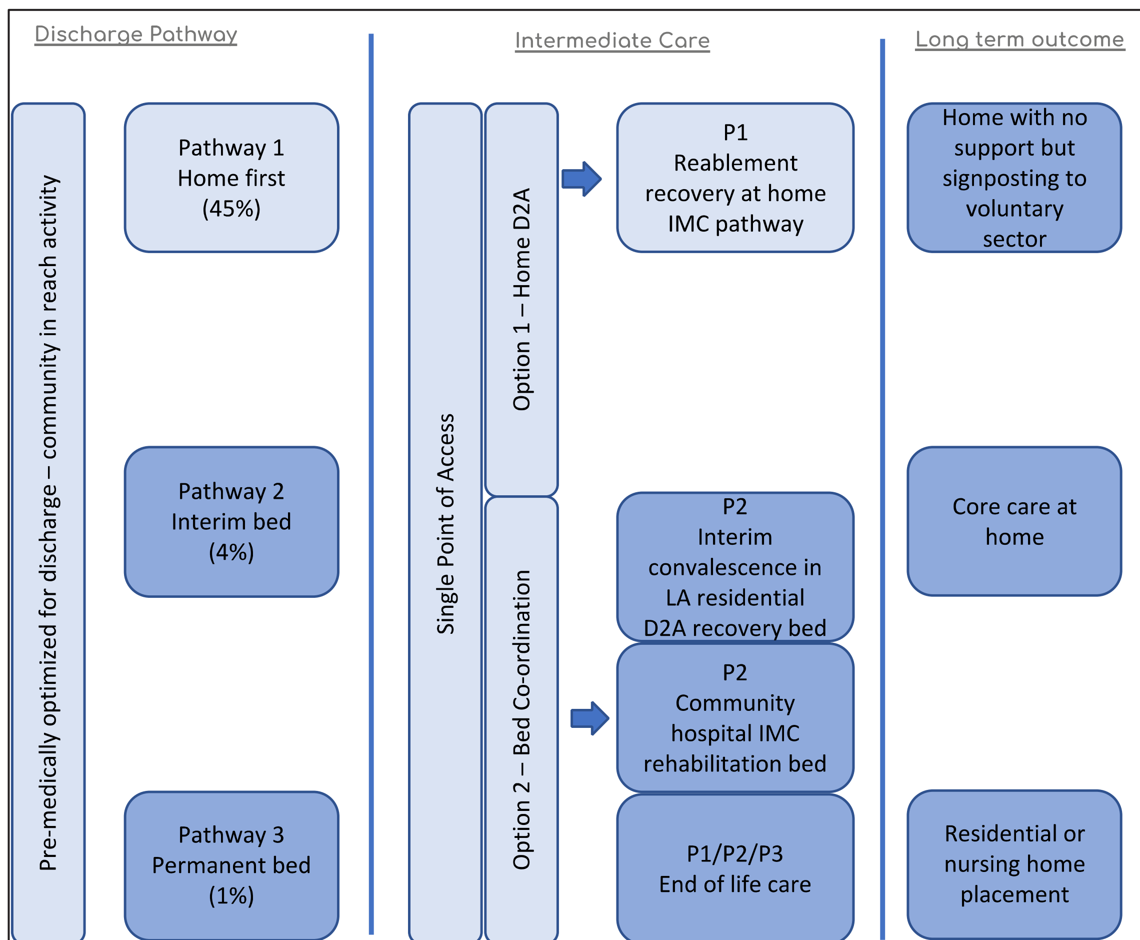


Figure 3, National IMC Pathway Guidance.

3.4.3. Clinical studies described as 'deep dives' in 2019 and 2020 to 2022 found that:

- That there was significant variation in in IMC bed use within MSE: There is differential use of IMC beds and unwarranted variation in the demand for IMC beds which cannot be explained by differences in patient population demographics, acute trust volume flows, or needs.
- Variations in the population demographics do not match the degree of variation in bed usage.
- Historic configuration of beds has not been optimally matched to the true bedded inpatient rehabilitation needs of the population.
- Evidence of the current outcomes for patients who are transferred to the current IMC community beds demonstrates a poorer than national average performance.
- Selection of patients specifically for P2 inpatient rehabilitation in the past has been far from ideal. A more recent audit in 2023 encouragingly found that 76% of IMC patients in community hospitals were on the correct pathway for their needs, which is expected to improve outcomes.
- A clinical audit in 2021 found that partly because of the numbers of patients selected properly to be on P2, outcomes for IMC patients in MSE were below the National Audit of Intermediate Care benchmark for those improving or at least maintaining function. The table below illustrates that the use of IMC beds in MSE and that patient selection for them needs to change. This suggests that discharge and referral processes need to improve, and it is expected that use of Discharge to Assess and Transfer of Care Hubs will support better targeting of patients and are expected to reduce delays.

%Patients whose dependency was improved, maintained or reduced	NAIC Benchmark performance (%)	MSE Intermediate care beds (%)
Improved	85	66
Maintained	8	24
Reduced	7	10

Figure 4, Extract from 2021 Clinical Audit Reviewing NAIC Benchmarking against MSE's IMC Bed Levels.

3.4.4. **Stroke Rehabilitation**

3.4.5. The National Stroke Service Model highlights that inpatient stroke rehabilitation is an essential ‘bridge’ for many stroke survivors between acute and community rehabilitation. These beds are key for patients who are medically suitable to be discharged from an acute site, but who require intensive stroke specific rehabilitation which cannot be supported by Early Supported Discharge (ESD) services.

3.4.6. Current arrangements are limited by:

- The lack of dedicated, ring-fenced inpatient stroke rehabilitation units.
- An inadequate number of stoke rehabilitation beds to meet projected future demand.
- Existing staffing levels being below recommended national standards.
- Intensive therapy is not currently provided at the level recommended in NICE guidelines and the 2023 National Stroke Guidelines.
- There is not currently a consistent MSE-wide pathway for inpatient stroke rehabilitation, mainly resulting from variation among predecessors’ organisations.
- The need for a clear ‘slow stream’ rehabilitation pathway for patients who need it.

3.4.7. **Refine** Stroke Rehabilitation Pathways

As with IMC beds there is a need to refine the stroke rehabilitation pathways since the current model of care and limited availability of community stroke rehabilitation beds results in rehabilitation patients being on wards in acute hospitals, which is less than ideal for all concerned. An approach in which stroke rehabilitation patients were in units dedicated to that purpose or at home, if that were more appropriate to their needs, is an aim of this PCBC.

3.5. **Stroke Audit**

An audit undertaken in September of 2023 showed that while most community hospital stroke beds were being appropriately used, stroke patients in acute hospitals needing rehabilitation were often awaiting referral and transfer. Others also were found to be ‘outliers’ on non-stroke wards. Details of the audit are available in Appendix 10.

4. Future Models of Care

4.1. **Community Hospitals:** Community Hospitals have been described by the Department of Health as ‘a service which offers integrated health and social care and is supported by community-based professionals who have direct access to its services’. They are often regarded as an effective extension to primary care with medical support provided largely from local GPs. In MSE the community hospitals have a variety of roles: stroke rehabilitation, intermediate care, some surgical care, and midwifery-led maternity services. Some, but by no means all, sites are able to offer a wide range of outpatient services from different service providers and imaging (X-ray and ultrasound) diagnostics.

4.2. **Key Principles**: The operation of intermediate care and stroke rehabilitation bed-based services should exhibit certain core principles:

- Patients stay in hospital only as long as is necessary to enable them to achieve the best possible level of personal independence.
- During their stay in hospital patients will be undergoing active rehabilitation.
- Patients’ social, psychological, health and well-being needs will be assessed and planned for before they leave hospital.
- Extensive engagement with community-based professionals while patients are in hospital and before their discharge will ensure a smooth handover of care.
- Agreed clinical pathways will be used for admission to and discharge from community beds.

4.3. Intermediate Care

4.3.1. This may be home, or bed based. This document is concerned with the NHS bed-based provision, but the principles of time limited rehabilitation for up to six weeks, but sometimes for as little as one to two weeks, remain the same. The majority of NHS community beds in MSE are designated for intermediate care with a focus upon promoting independence, avoiding admissions to an acute hospital, and reducing stays in an acute hospital. This latter - the ‘step-down phase’ is essential if the flow through acute hospital beds is to be maintained and the needs of sick patients at the hospital front door met.

4.3.2. The aim is to rehabilitate patients and enable them to move to their place of residence within a defined period. The services therefore must integrate with primary care, social care, and the community-based services. Evidence suggests that admission within 2 days of referral gives the best results, but performance on this metric varies across MSE. Maintaining a flow of patients through these beds serves to make them available for patients who otherwise might be admitted to an acute hospital or who have had an acute spell of illness

and while not ready to go home may leave the acute hospital to be rehabilitated in a community bed.

4.3.3. NHSE Discharge to Assess and national hospital discharge guidance indicates that 95% of patients admitted urgently to an acute hospital should be discharged home, with around 4% of discharges of patients needing rehabilitation going to an inpatient bedded setting which might be an NHS community hospital bed and could be a local authority funded place. The residual 1% of patients leaving acute hospitals are expected to require long-term residential or nursing home care. The services are principally nursing and various forms of therapy, with medical cover usually provided by general practitioners.

4.3.4. Data published recently has shown that between April and August 2023 the MSE system of health and care had the lowest percentage of delayed discharges in England at 5.8% compared to the national average of 13.7% and the worst performing system at 22.7%. The system improvement since the same period in 2022 has been attributed to the use of Urgent Community Response Teams (UCRTs), admission avoidance, Early Discharge Services (EDS), the development of Integrated Discharge Teams (IDTs) and 'bridging' where a person is medically optimised and ready to leave hospital, but their package of care is not available and so hours of support at home are provided to enable the discharge. This has demonstrated that the ability to have patients leave an acute care setting is not dependent upon there being a vast array of community beds to house Pathway 2 patients. Instead, a variety of community health and care interventions are needed.

4.3.5. The future model for intermediate care beds is primarily focused on addressing the shortcomings that have been identified and outlined in the Case for Change. These include:

- ensuring that the 'right' cohort of patients to be admitted to intermediate care beds is consistently identified. At present some patients who are transferred to these beds should be on other pathways – including being discharged home with appropriate support and dedicated end of life care. The actual locations for those assessed as requiring an NHS IMC bed are discussed in Section 5 of this business case.

- addressing unwarranted variation in the way in which intermediate care beds are used in the system. As MSE is a relatively recent construct as a health economy and includes a wide range of providers, there is considerable variation in the way in which intermediate care beds are used, including numbers, access criteria, and staffing levels.

- improving outcomes for the patients in intermediate care beds. Partly because there are not always the 'right' patients in community hospital beds, outcomes for MSE patients are not as good as they could be – for example earlier audit work suggested that MSE falls below the NAIC audit benchmark for intermediate care.

In summary, therefore, the approach to the future model of intermediate care beds is to introduce consistent pathways underpinned by common access criteria; broadly standardise staffing levels; and improved patient selection so that only people who really need and are most likely to benefit from intermediate care are admitted. In this manner outcomes for patients can be improved.

4.3.6. As outlined above, intermediate care beds form one part of a wider pattern of interconnected provision. MSE has a well-established programme known as 'Ageing Well' which considers many aspects of the pathways, from prevention through to rehabilitation. Some key elements of this wider programme which are relevant to this PCBC include:

- establishing a multidisciplinary single point of access across all three acute sites to ensure there is a consistent and rigorous approach to identifying patients' needs and matching this with the optimal pathway – for example home, interim, or intermediate care bed or end of life care.

- discharge to assess (D2A): moving to a model where discharge planning begins as soon as (or in some cases before) a patient is admitted to hospital and are then moved out of the acute environment whilst their individual needs are fully assessed. TOCHs are intended to facilitate this process.

- further development of community early response initiatives to prevent emergency admissions.

- development of alternative care settings to NHS and local authority IMC beds enabling people to avoid admission or be discharged appropriately from an acute hospital. Taken together, these measures are intended to prevent admissions where possible and, where someone is admitted to hospital, ensure that the system 'pulls' them out with the support that is best matched to their preferences and level of need.

4.4. Stroke Rehabilitation

4.4.1. Patients admitted to a stroke unit in an acute hospital, if assessed as being able to benefit from rehabilitation that cannot be provided in their own home may be eligible for a bed in a community stroke rehabilitation unit (SRU). They will have physio, speech and occupational therapy, assessment and treatment by a psychologist and overall medical supervision from a stroke specialist to enable them to attain their optimum level of function. As soon as it is possible for rehabilitation to be continued in their own home this will be arranged, but often a stay in a community stroke rehabilitation unit may be up to 6 weeks (the National Guideline indicates that this should be determined by need and not time). It is important to recognise that their age range is different from patients having IMC in that 1 in 4 people who experience a stroke are under 65 years of age and 1 in 10 are under 55. There are currently up to 39 stroke rehabilitation beds in Mid and South Essex. The National Clinical Guideline for Stroke 2023 states 'Well-

led, appropriately staffed and skilled multidisciplinary stroke unit is the cornerstone of holistic and comprehensive care for people with stroke.'

4.4.2. Mid and south Essex has beds, but not the type of specialised rehabilitation unit envisaged in the National Guideline. The aim must be therefore to develop one or two specialised units with a total of either 47 or 50 beds. Before autumn of 2023 there were only 24 community stroke rehabilitation beds which resulted in patients occupying beds in acute hospitals while requiring stroke rehabilitation. Increasing the number of community stroke rehabilitation beds should minimise numbers of stroke patients who are no longer acutely ill, accommodated in acute hospital beds.

4.4.3. A vital element in this model of service is to have consistent clinical referral pathways from the acute hospitals, ensuring correct case selection differentiating between patients who would benefit from a specialised rehabilitation unit and those who would better receive rehabilitation or support in their own homes.

4.4.4. The overall stroke service model is described in the figure below:

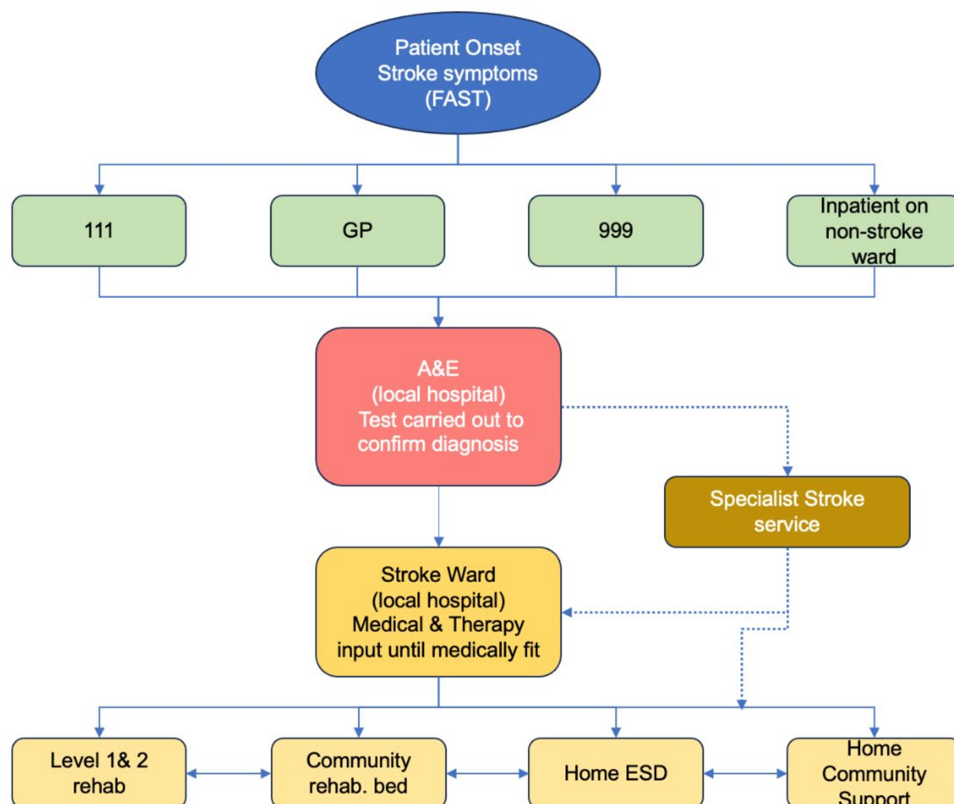


Figure 5, Stroke Service Model.

4.4.5. The future stroke rehabilitation service in MSE is intended to have the following characteristics:

- The right number of beds to meet future modelled demand.
- Accessible beds, whilst balancing the need to concentrate scarce clinical expertise.
- An increasing duration of therapy, aspiring to provide at least a 5-day service, and moving towards building staffing levels to meet standards set out in the National Guideline for Stroke 2023.
- A consistent pathway across MSE, including detailed access criteria for stroke rehabilitation beds (as recommended by the Clinical Senate).
- A clearly identified 'slow stream rehabilitation pathway for those patients that need it.

4.5. Neuro- Rehabilitation Provision

More extensive community stroke rehabilitation facilities offer the opportunity to create a limited amount of capacity (up to 3 beds) for patients who may be treated by a local specialist team for those requiring a Level 3 service led by consultants in specialties other than Rehabilitation Medicine (e.g., neurology/stroke medicine) and staffed by therapy and nursing teams with specialist expertise in the target condition. Patients usually require rehabilitation interventions from between one and three therapy disciplines. It is expected that this could be put in place if Option 11 were implemented.

4.6. Midwife-Led Birthing Units

4.6.1. Maternity Services in Community Hospital Midwifery-Led Birthing Units offer women with low-risk pregnancies choice to give birth with minimum intervention. Each of the maternity units at Basildon, Broomfield and Southend Hospitals offer this facility co-located with obstetric units, while there have been freestanding community birthing units at St Peter's Hospital, Maldon and WJC Unit St Michael's Health Centre, adjacent to the Braintree Community Hospital. Until recently only the freestanding unit at St Peter's was operational due in part to limited demand (77 births in 2022/23) and it was subject to periodic closure due to lack of staff. For the same reasons the WJC Unit at St Michael's Health Centre, adjacent to the Braintree Community Hospital was not operational. However, the condition of the estate at St Peter's was an increasing cause for concern. With the temporary transfer of the 16 inpatient beds for stroke rehabilitation to Brentwood Community Hospital, the birthing unit at St Peter's was left in an unsatisfactory estate and isolated, especially out of hours and so it was decided to transfer it to the WJC Unit St Michael's Health Centre, adjacent to the Braintree Community Hospital, which has two delivery rooms and a birthing pool. Maternity outpatient services were not transferred and alternative accommodation local to Maldon is considered to be the best available short-term option for maternity outpatients.

4.6.2. In addition to accommodating births, the freestanding midwife-led unit also admits several women pre-natally and women and babies after the birth has taken place elsewhere, relieving pressure on the maternity unit at Broomfield Hospital in particular. Following transfer from the St Peter's Hospital site the single freestanding midwife-led birthing unit is at WJC in Braintree. Until such time as formal decisions about service configuration are made following public consultation this will remain a temporary arrangement.

4.7. Ambulatory Services

4.7.1. The growing demand for outpatient services and the backlog caused by Covid-19 has led the NHS to develop a new strategy for outpatient services, recognising that outpatient attendance represents the highest volume of NHS provision. Even before the pandemic the 2019 NHS Long Term Plan had set out the need to transform the approach to ambulatory services. The NHS expects the MSE system to reduce follow up appointments by 25%, which for the St Peter's services is significant, since the majority of visits are outpatient follow ups, as opposed to first appointments.

4.7.2. It is assumed that the attendances for therapy and diagnostics will not diminish since these are driven by demand from population size and structure. However, a significant proportion of the patients attending St Peter's today travel from other parts of the county, notably Chelmsford and Braintree. Where possible these should be accommodated by more local and accessible ambulatory services than travelling to Maldon for their appointments.

4.7.3. The NHS is seeking to provide elective services where possible in sites other than acute hospitals where the demand for diagnostics, treatments and beds is at its most extreme. In MSE, Braintree Community Hospital is designated to provide orthopaedic services suggesting that in future orthopaedic and possibly rheumatology outpatient services might be co-located there. MSE is exploring options for an ophthalmic diagnostic 'hub' which would be able to offer extensive ophthalmic diagnostic services for the population of MSE. Community Diagnostic Centres which provide a range of endoscopy and imaging modalities are also being developed, such as the one at Braintree Community Hospital.

4.7.4. Nevertheless, many ambulatory services must remain local to Maldon for example, the maternity 'hub', clinics where co-location with other clinical services is not a requirement, therapy services, nurse-led clinics, mental health services and blood testing to ensure that local residents have access to services which are best provided locally. The table below in Figure 6 sets out where current services could be located in the future, noting that options for x-ray are being considered in both Maldon and at Braintree Community Hospital.

4.7.5. The use of technologies such as video consultation and remote monitoring are not assumed to be part of this business case, but they and related technologies will reduce the need for face-to-face assessment and enable patients to determine whether they need a follow up appointment and will also change the

ability of patients to communicate with clinicians. This will have a significant effect upon the provision of ambulatory and other services in the future. The PCBC does not attempt to speculate upon the extent of the changes this will cause, but further work at a national level and at pilot sites is continuing to illustrate the way forward for the wider NHS.

4.7.6. The actual configuration of ambulatory services will be undertaken working with the service users at St Peter's and the community in Maldon. This form of co-production is intended to reach the best possible solution, balancing clinical priorities with the need to ensure that ambulatory services are accessible to the wider community.

Service currently provided on St Peter's Hospital site	Proposed location
AAA Assessment and Rehab Unit (incl. COPD) Audiology Bladder and Bowel Mental health services provided in Cherry Trees Cardiology Catheter Clinic Children's continence Communication station initial assessments Day Therapy Dermatology Diabetes Dietetics District Nursing Endocrinology ENT Gastroenterology General Medicine Long Covid Maternity hub (including obs and gynae, paediatrics, neonatal and midwife OPs, scanning and classes) Nephology	Maldon

Service currently provided on St Peter's Hospital site	Proposed location
Neurology Optometry Orthoptics Out-of-hours GP Oxygen Parkinson's Phlebotomy Physiotherapy Podiatry Pulmonary Rehabilitation Speech and Language Therapy Spirometry Thoracic Medicine Tissue Viability Unscheduled Therapy Warfarin Clinics	
Orthopaedics	Co-located with radiology services
Rheumatology	
Radiology and Ultrasound	Maldon or Braintree Community Hospital
Ophthalmology	Maldon or Diagnostic Hub

Figure 6: Proposed locations for ambulatory services currently provided at St Peter's Hospital

4.8. Improving outcomes

4.8.1. A principal driver for this PCBC and the proposed consultation is to settle on a configuration for community beds that will enable patient outcomes to be improved. Most of the potential changes outlined in this case will contribute to this, for example by improving the way in which patients are selected for admission will improve patient outcomes.

4.8.2. Currently for stroke patients the lack of the right number of ring-fenced rehabilitation beds means that not all patients who have suffered a stroke and require inpatient rehabilitation are cared for in the best environment to meet their needs. Numbers remain on wards in acute hospitals. Addressing this – and moving towards national standards – will improve outcomes.

4.8.3. There is no direct effect upon the maternity outcomes from the transfer of the freestanding location of the Midwifery-Led Birthing Unit. Here outcomes remain based upon case selection and the skills of the supporting midwife.

4.8.4. In each of IMC and stroke rehabilitation in this PCBC a small number of indicators have been identified that will be tracked to ensure that there is a positive impact on outcomes. The baseline for most of these indicators is known and targets that were considered by both the Clinical Senate and the local Clinical and Care Outcomes and Review Group have been adopted.

4.9. Intermediate care

Across MSE an Ageing Well dashboard has been developed which gives a real time view on system performance. The intermediate care indicators and improvement targets fall within this broader context:

Indicator	Ambition	Source
Change in dependency (improved, maintained, reduced) Improved Maintained Declined	85% 8% 7%	Audit
Unplanned transfers back to acute (%)	<15%	Standard data set
Discharge destination / usual place of residence (%)	Usual place of residence: >75% year 2 >80% year 3 >85% year 4	Standard data set
Average exit delays (days)	Of those delayed, no more than 2 days	Standard data set
Patient recorded outcomes / satisfaction measure	At least equal to recovery at home	Patient survey

Figure 7, Intermediate Care – key outcome indicators and target levels.

4.10. Stroke

4.10.1. As a system, MSE collects and reviews a wide range of stroke data, and benchmarks using the Sentinel Stroke National Audit Programme (SSNAP) data.

4.10.2. However, as most of the SSNAP data is at an aggregate stroke pathway level – and not specific to inpatient stroke rehabilitation – as well as including many processes rather than outcome measures, a small number of indicators for bed-based rehabilitation have been identified.

Indicator	Ambition	Source
Readmissions to acute whilst on stroke pathway (%)	<10%	Standard data set
Change in dependency (%) Improve Maintain Reduce	 85% 10% 5%	Routine audit
Discharge destination (% who return to usual place of residence)	80%	Collation of community data
Patient survey outcomes Setting own goals Individualised care plans Family / carers involved in care planning	TBC	Survey tool to be developed

Figure 8, Stroke Rehab – key outcome indicators and target levels.

5. Options for Change

5.1. Intermediate Care

5.1.1. There are wide differences in the number and distribution of community beds across England. It has been calculated that MSE requires between 77 and 87 NHS beds if:

- 4% of hospital discharges of people conform to national guidelines and are on Pathway 2,
- The target population is to increase by 8% in the next five years,
- The current average length of stay is sustained,
- Assumed bed occupancy of 95%,
- Current Local Authority IMC capacity in each of Southend, Thurrock and Essex County Councils is appropriately used for Pathway 2 patients.

5.1.2. Should case selection for suitability for IMC beds improve further fewer beds might be needed, but that has not been factored in at this stage. More precise targeting of patients should improve performance and outcomes, potentially reducing the bed requirement. It is also the case that IMC can be provided in peoples' homes and in residential and nursing homes and so it should not be assumed that all IMC beds are in NHS accommodation and that community hospitals are the sole IMC resource for patients assessed as being suitable for Pathway 2.

5.1.3. Options for configuration of NHS community hospital beds could, in theory, include a central IMC facility, beds on two, three, four or five sites. In reality, a very small number of sites, while having the advantage of more efficiently covering overhead costs, creates difficulties of access for families and carers and would need investment capital and time. Since there is no sign that the capital would be available and the changes need to be made in the foreseeable future, use of existing sites, where they meet required standards, is the only feasible way forward. This has the advantage that large segments of the MSE population will have reasonable access to these facilities.

5.2. Stroke Rehabilitation

5.2.1. For stroke rehabilitation there is a pressing need to enable the development of a dedicated service on one or at a maximum, two sites. This will ensure that there is a clustering of specialist expertise and sufficient intensity of rehabilitation to offer tangible benefits to patients.

5.2.2. Based upon:

- 500+ admissions per year for rehabilitation,
- An 8% increase in incidence over the next 5 years,
- An average length of stay of around 35 days,
- Assumed bed occupancy of 95%.

5.2.3. MSE would ideally require 48-50 stroke rehabilitation beds. It should be noted that the average length of stay in Provide stroke rehabilitation beds is considerably shorter than 35 days which potentially reduces the bed requirement. However, the 2023 National Guideline for Stroke advocates that the duration of stay in a SRU should be on a 'needs' basis and not restricted to a fixed upper limit. Using the 35-day figure therefore allows for headroom in calculating the required bed number for SRU capacity. The figure of 48-50 beds is also supported by the MSE Stroke Stewards.

5.2.4. There are currently 39 stroke rehabilitation beds located at Brentwood Community Hospital and the CICC at Rochford Community Hospital. In addition, stroke rehabilitation patients are to be found in wards on acute hospital sites. Development of dedicated stroke rehabilitation unit(s) together with agreed, standardised clinical pathways creates the opportunity to cease the use of beds in acute hospital sites for stroke rehabilitation, conforming more closely to the National Clinical Guideline for Stroke. In September 2023 an audit of stroke rehabilitation patients in MSE highlighted the limitations of the current structure of the service and the need for change.

5.2.5. Initially the thirteen options shown below were developed by the Community Capacity Task Force (CCTF) established in the summer of 2023. Following a review by clinicians a short list of options was prepared and from it Option 4 was selected as clinically the most appropriate arrangement to enable the system of health and care to respond to expected demand over the winter of 2023/24 through temporary changes. This provided 99 IMC beds and increased the number of stroke rehabilitation beds from 24 to 39. None of the options considered continuing the use of St Peter's Hospital Maldon as its condition was considered to be unsuitable for continued use for inpatients.

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

Figure 9, Initial Longlist of Stroke Rehab / IMC Options. Note: Option 0 was the distribution of beds prior to the changes made in October 2023. Option 4 is the current distribution following those changes.

5.2.6. In preparation for the PCBC a further review of these and additional options was completed, using weighted criteria reviewed by clinicians. Recent audits informed the process and led to a shortlist of options for IMC and SRU services using the decision tree in figure 10 below. It should be noted that the Clinical sub-group of the CCTF was of the opinion that dedicated stroke rehabilitation units concentrating expertise, would create opportunities to have the best outcomes for patients, recognising that travel times for some relatives and carers would be increased. The shortlisted options are shown in Figure 11 below. They include two options added after the longlist had been first considered offering two stroke rehabilitation units (SRUs) 25 beds at Brentwood and 22 beds at CICC. Shortlisting has been undertaken using clinical opinion, decision trees and the options appraisal shown in Appendix 3. It should be noted that following transfer of the 16 bedded unit from St Peter's Hospital to Bayman Ward, Brentwood Community Hospital, this ward has a capacity of 25 beds which is shown in figures 8 and 9.

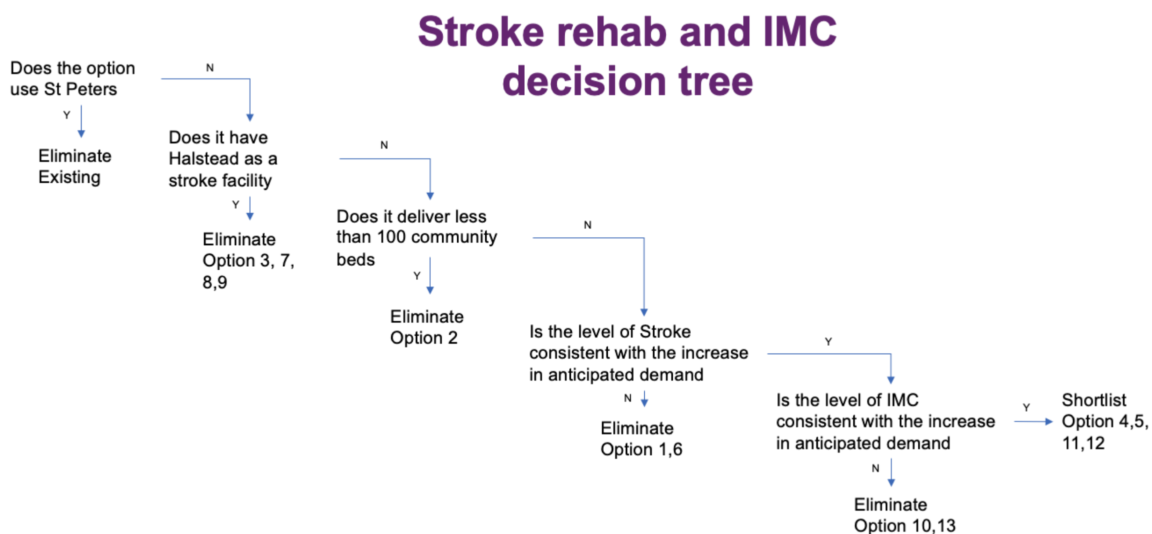


Figure 10, Decision tree to inform shortlist of stroke rehab / IMC options

	Option 0	Option 4	Option 5	Option 11	Option 12
	IMC/Str	IMC/Str	IMC/Stroke	IMC/Str	IMC/Str
St Peter's	0/16	0	0	0	0
MNC	22/0	22/0	0	22/0	22/0
CICC	14/8	8/14	8/14	22/0	0/22
Halstead	20/0	20/0	20/0	20/0	20/0
Mayfield	24/0	24/0	24/0	24/0	24/0

Brentwood	25/0	25/25	25/25	0/50	25/25
IMC/Str	105/24	99/39	77/39	88/50	91/47
Total	129	138	116	138	138

Figure 11, Shortlisted Stroke Rehab / IMC Options.

5.2.7. Within the shortlist Option 4, the temporary transfer of beds after October 2023 offers a spread of IMC beds which enables access for multiple centres of population in MSE, particularly in the south, west and east of the SE catchment, but provides only 39 beds in two locations for stroke rehabilitation. It is the current configuration with the Cumberlege Intermediate Care Centre (CICC) at Rochford as a combined IMC and SRU. National guidance indicates that all beds in combined units should be staffed at SRU levels to enable flexible use, which is a costly solution for the NHS. More importantly the consistent clinical view is that better outcomes are achieved where the SRU has the numbers and expertise to offer intensive rehabilitation therapy. As such, it is not considered to be a preferred option. Option 11 concentrates all stroke rehabilitation in a single specialised unit and provides 88 beds for IMC which requires the continued use of Mountnessing Court Billericay, as does Option 12. Option 12 splits the stroke rehabilitation between the CICC in Rochford and Brentwood Community Hospital in the west of the catchment providing 47 SRU beds. Clearly this is better for access from the east of the catchment for stroke rehabilitation but does not create a single specialised SRU and leaves the southeast of MSE without IMC beds.

5.3. The final configuration of IMC and SRU beds is an important decision which needs to be made following public consultation. The preferred options propose that the system retains 138 NHS community hospital beds, and the choice is whether there should be a single SRU or the stroke rehabilitation service should be in two units in separate locations. If the latter were preferred there is the residual issue as to whether the SRUs should be under a single management enabling expertise to be deployed flexibly across SRU sites. Both **Options 11 and 12** are viable options that improve care for patients and improve value compared with current services, and are therefore set out as options within the PCBC. . Within the constraints of available accommodation, both options respond to clinical advice by concentrating SRU beds and with them the clinical expertise needed to provide an excellent service with good outcomes for patients. In time, with precise case selection and use of supportive digital technology, a lower figure for NHS IMC beds could be achieved enabling the use of Mountnessing Court to cease, but for the time being it is proposed that it be retained and the necessary minor works to its bathrooms undertaken.

5.4. Option 11 offers the further potential benefit of the SRU accommodating a small number up to three neuro-rehabilitation patients needing Level 3 rehabilitation supervised by staff whose skill set in stroke rehabilitation could support these patients. There are no Level 3 neuro-rehabilitation beds in MSE currently and

such a facility could be used for patients leaving an acute setting needing Level 3 services or patients receiving a higher service out of area who are ready for Level 3. At the moment, these patients, their carers, and families are disadvantaged by having to be treated and travel some distance from their place of residence and out of county. Local facilities are expected to support discharge from acute hospitals, assisting with hospital flow.

5.5. Both option 11 and option 12 are viable options that would provide improved outcomes for patients and value to the health system, both are therefore included as options for consideration in the public consultation.

5.6. Midwifery Service

The system of health and care already has attached midwife-led birthing facilities in the maternity units of each of Broomfield, Basildon and Southend Hospitals and no change to those arrangements is being considered. This restricts options to consideration of the location of the freestanding MLBU or whether to have one at all. The system of health and care is committed to offering choice in accordance with the guidance provided in 'Better Births: Improving Outcomes for Maternity Services in England – A Five Year Forward View for Maternity Care'. Published in March 2023 by NHSE the Three Year Delivery Plan for Maternity and Neonatal Services places specific responsibilities on Integrated Care Systems and Boards to ensure that care is safe, personalised, more equitable, consistent and responsive. Because of the transfer of stroke rehabilitation inpatient service with the resultant out of hours safety and security issues together with the condition of the St Peter's Hospital estate, the MLBU was transferred to the WJC Unit at St Michael's Health Centre, adjacent to the Braintree Community Hospital in October 2023. This left the maternity outpatient and related services at St Peter's

Option 0	Option 1a	Option 1b	Option 1c	Option 2a	Option 2b	Option 2c	Option 3
	Broomfield			William Julien Courtauld unit (WJC)			Maldon Hub
Status Quo	Absorb into Bromfield	Broomfield+ Maldon Hub	Broomfield + WJC	WJC stand alone	WJC + Local Maldon facility	WJC + co-location with primary care	Maldon Hub
St Peters maternity services continues as a MLBU	Move St Peter's inpatient and outpatient Maternity services to Broomfield	Move St Peter's inpatient Maternity services to Broomfield and outpatient services to a Maldon Hub	Move outpatient Maternity services to Broomfield and leave inpatient services at WJC	Move St Peter's inpatient and outpatient Maternity services to WJC	Move St Peters inpatient Maternity services to WJC and re-provide outpatient services in Maldon	Move St Peters inpatient Maternity services to WJC and re-provide outpatient services in co-location with Maldon primary care development	Inpatient and outpatient in a Maldon primary care hub

Figure 12, Initial Longlist of Maternity Options.

- Options 1a – 1c were eliminated as the Broomfield Hospital Maternity Unit is already at capacity.
- Option 3 was eliminated owing to the capital cost and the time it would take to realise.
- Option 2a was eliminated as there would not be enough capacity for all the non-inpatient services at the WJC Unit at St Michael's Health Centre, adjacent to the Braintree Community Hospital.

- In reality, Option 2c is not realisable in the short term as there is not a short term plan to develop a primary care facility in Maldon, leaving 2b as the preferred option until such time as new health facilities are created in Maldon.

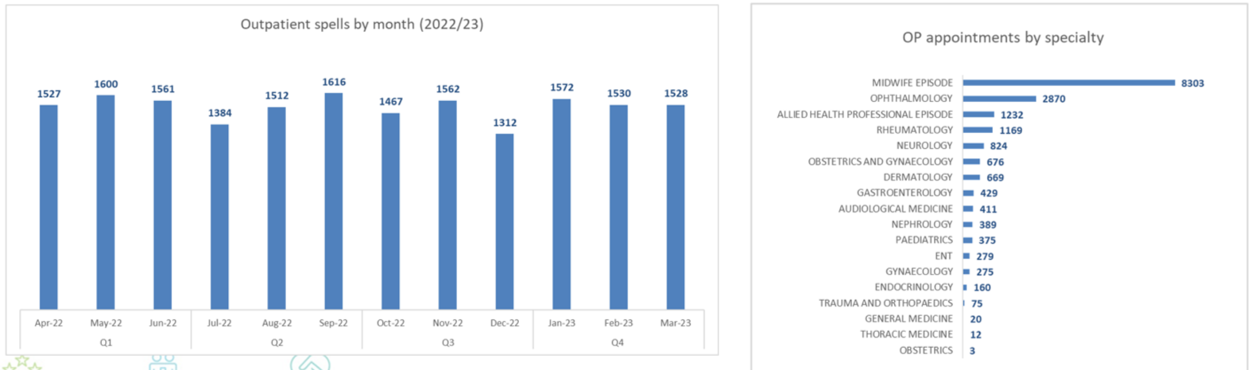
Option 2a	Option 2b	Option 2c
William Julien Courtauld unit (WJC)		
WJC stand alone	WJC + Local Maldon facility	WJC + co-location with primary care
Move St Peter's inpatient and outpatient Maternity services to WJC	Move St Peters inpatient Maternity services to WJC and re-provide outpatient services in Maldon	Move St Peters inpatient Maternity services to WJC and re-provide outpatient services in co-location with Maldon primary care development

Figure 13, Shortlisted Maternity Options.

5.7. Outpatient, day, diagnostic and related Services at St Peter's

5.7.1. Over 80,000 ambulatory care appointments take place at St Peter's hospital each year, including approximately 39,000 outpatient appointments. This includes around 8,000 for the maternity service, with significant numbers for ophthalmology, therapy, and rheumatology attendances. Diagnostic services such as testing of bloods (approximately 37,000 appointments a year), X-ray (approximately 8,500 appointments year) and ultrasound (approximately 700 appointments a year), are also provided. The specialty distribution of outpatient attendances for services provided by MSEFT is shown in Figure 14 below.

- There were 18,171 outpatient appointments in St Peter's Hospital in 2022/23, for 8,356 patients. On average, each patient had 2.2 appointments.
- 46% were Midwifery appointments, 16% were related to Ophthalmology.



Excellent Compassionate Respectful

Figure 14, Outpatient Attendances by Specialty at St Peter's Hospital 2022/23.

5.7.2. The patients attending MSEFT outpatients are mainly resident within the MSE catchment (95%) and of these over 40% come from the Maldon District, with 23% from Braintree and 19% from Chelmsford. The geography of the attendances by Primary Care Network is set out below in Figure 15.

5.7.3. Ambulatory provision at St Peter's as well as outpatient and therapy services includes the Cherry Trees Therapy Centre care for mental health patients, an X-ray facility, diagnostic ultrasound, and a blood test (phlebotomy) service. In order to vacate the site these will require alternative accommodation.

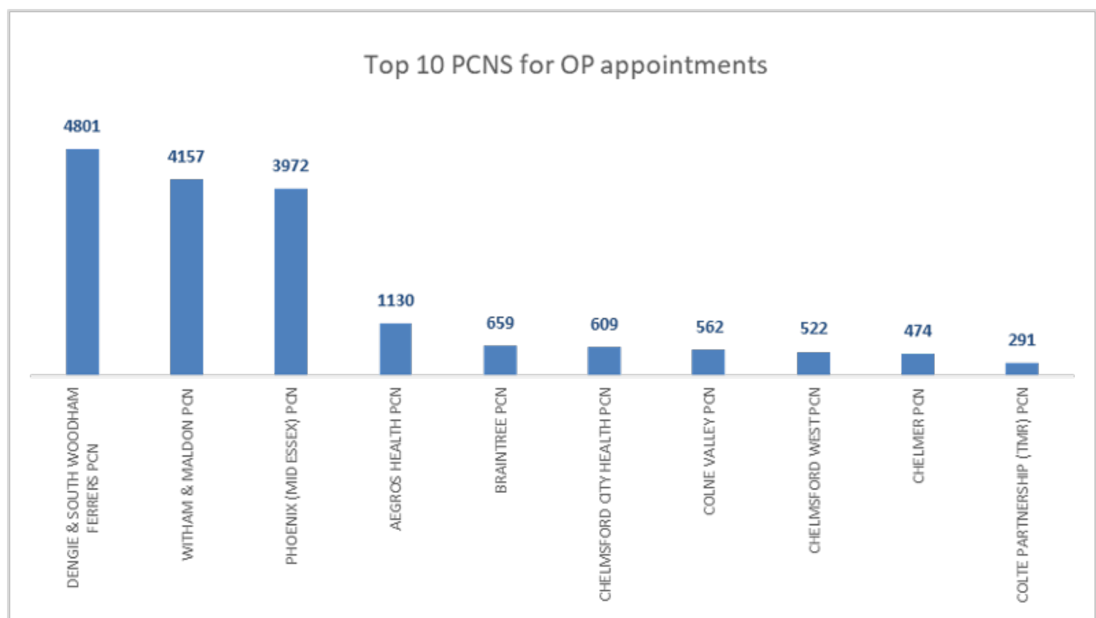


Figure 15, Distribution of MSEFT Outpatient Attendances by Primary Care Network (PCN) of Origin.

5.7.4. The age, condition and suitability of St Peter's had caused plans to be developed to provide purpose-built replacement local facilities. However, it is evident that any new development is some years away and that without a substantial injection of capital to deal with the all too obvious defects at St Peter's, continuing to provide health services from the current buildings is unsustainable. Alternative short-term solutions are needed if residents of Maldon and surrounding Districts are to continue to have accessible ambulatory services.

5.6.5 Options include:

- Locate alternative premises in and around Maldon and lease suitable premises where patients are best served by services remaining local. This will require some distribution of services and it might require some services to be co-located elsewhere for clinical reasons, where patients will benefit. In planning these alternative facilities decisions also need to be made about numbers to be planned for, as only around 40% of outpatient attendees are from Maldon District and patients from outside the immediate area could be accommodated elsewhere. Furthermore, the NHS Planning Guidance intends that follow-up appointments should be reduced by 25% and so like-for-like numbers of rooms and room sizes should not be needed in the future. Steps will need to be taken to develop a process of co-production with patients and staff of the Cherry Trees Unit to ensure that their needs are met in identifying suitable alternative accommodation.

- Undertake essential repairs on the elements of the fabric of St Peter's in order to manage the safety and security risks and enable outpatient services to temporarily continue there. This assumes capital is available to effect essential repairs and that doing so represents value for money. The condition and costs of operating retained buildings at St Peter's suggest that this is an unattractive option, particularly when the cost of running a large site and ageing estate is taken into account.

- Demolish the Villas and "C" Block to the rear of the St Peter's site and erect temporary accommodation for outpatient services there, bearing in mind that in the NHS temporary buildings have a tendency to become unintentionally permanent. This option would require a significant capital outlay for which there is not an evident source.

Of these options, the redistribution of ambulatory services to other locations is the most immediately realisable and does not require the expenditure of capital at St Peter's for what would only be a short-term extension of time for services on that site. Furthermore, patients who are not Maldon residents will have the opportunity to source services closer to where they live where that is possible. For those reasons, it is the preferred course of action.

6. Clinical Assurance and Evidence

6.1. Clinical leadership

The development of the clinical proposals set out in this PCBC have been led by and involved a wide range of clinicians. At a programme level, the CCTF clinical subgroup has a clinical chair (Dr Peter Scolding) as well as clinical and multi-professional input via the Ageing Well and Stroke Stewardship groups for both Intermediate and Stroke care. The MSE 'Stewardship' Programme brings together a broad range of clinicians and professionals to look at a particular service area and consider how delivery can be transformed, within the available resources.

6.2. Stroke

6.2.1. Improving the whole stroke pathway has been a priority for the system, as set out in the system's Long-Term Plan. As a result, there is a well-established and energetic Stroke Programme Board that includes a wide range of professionals to drive the improvement of each aspect of stroke care, from prevention right through to rehabilitation.

6.2.2. The proposals for bed-based stroke rehabilitation were developed and iterated by a sub-group of the Programme Board, led by Dr Peter Scolding. The proposed model of care developed was agreed by the Programme Board in 2021. This has been further updated following more recent national stroke guidance and further work by the Stroke Stewardship group to review the model of care, including admission and discharge criteria.

6.3. Intermediate care

The proposals for intermediate care have been developed and tested by the Ageing Well Stewardship Group, working with other Ageing Well-related clinical stakeholder groups spanning primary, secondary, community and social care within MSE, including the prior Ageing Well *Clinical Reference Group*. It has provided advice on the development of the overall approach to care for adults living with frailty, the needs of the population and, in recent months, has been specifically focusing on proposals for inpatient community beds for Pathway 2 rehabilitation. The group has ensured alignment with national Discharge to Assess (D2A) guidance and recommendations for estimated MSE population needs for Pathway 2 inpatient rehabilitation, based on 95% home first national best practice principles and recommendations.

6.4. Midwife-led Services

Clinical and Maternity sub-groups as well as maternity service leaders and midwifery staff have been engaged in developing the plan for the alternative location for the freestanding birthing unit and with executing the change of location on October 9th, 2023. The proposed preferred option has the support of the Chief Midwifery Officer for the East of England NHS.

6.5. Ambulatory Services

6.5.1. The CCTF clinical sub-group and the Clinical and Multi-professional Congress considered the future of ambulatory care and differentiated between services which would provide an improved clinical service if co-located with related clinical services, such as orthopedics, rheumatology, ophthalmology and imaging diagnostics, and those other ambulatory services better provided in Maldon, offering local access. The Clinical Congress advised that in making the changes to ambulatory services consideration should be given to ensuring that waiting times were not adversely affected and that phasing any changes might be appropriate.

6.6. Internal Clinical Assurance

6.6.1. Within MSE, there has been engagement with the Clinical and Care Outcomes Review Group (CCORG). This is a pan-MSE multidisciplinary group, focused on the Ageing Well population cohort, which brings together a wide range of clinical leaders from across the patch.

6.6.2. The CCORG and Ageing Well stewardship groups have considered evidence based best practice recommendations from sources of relevant national guidance and best practice policy such as national D2A policy guidance recommendations. Guidance from the National Audit of Intermediate Care (NAIC), British Geriatric Society (BGS) and the latest National Clinical Guideline for Stroke (2023) have also been considered.

6.6.3. Additionally, evidence was supported by findings from other local needs analysis and internal audit reviews ascertained by the Newton Connect program IMC review work of MSE Community Hospitals bed bases and MSEFT discharge processes 2021-2022

6.6.4. Several aspects of the clinical models set out in this PCBC have been tested with CCORG, including key pathways such as intermediate care, the selection of key outcome metrics and target levels, and the potential configuration options. Feedback from this group has helped to iterate and improve the proposed clinical models set out in this PCBC.

6.6.5. Early proposals, relating to the temporary changes made over winter 2023/24, were also reviewed and supported by the system Clinical and Multi-professional Congress. The PCBC was reviewed on 29th November 2023 by the Clinical Congress which endorsed the proposals concerning community beds especially the development of an SRU, as stroke is a major driver of disability in MSE and the potential availability of some local neuro-rehabilitation provision. The Clinical Congress also recognised that the midwife-led unit at the WJC Unit at St Michael's Health Centre, adjacent to the Braintree Community Hospital, allied to the provision of maternity outpatient and related services in Maldon provided a sustainable and resilient choice for service users.

6.6.6. On December 5th 2023 the East of England Clinical Senate Council met to review the processes of clinical assurance applied in the development of the PCBC. Their observations are highlighted in section 6.7.2 and their full report can be found in Appendix 14.

6.7. External Clinical Assurance

6.7.1. University College London Partners

At an early stage in the development of the clinical models, expert external advice was obtained from UCL Partners. Colleagues from UCLP reviewed the emerging proposals, and offered advice on the available evidence base and on how the proposals might be further developed.

6.7.2. East of England Clinical Senate

Many of the proposals contained in this PCBC were tested by the East of England Clinical Senate in 2022. The Senate considered that the then proposals had the potential to deliver good patient outcomes and support patient flow. The intermediate care clinical model and plans to enhance staff training were also supported as was the aim to improve home first performance towards national recommended best practice. The Clinical Senate Report from 2022 can be found in Appendix 6.

For stroke the Senate fully supported the introduction of dedicated ring-fenced stroke rehabilitation beds as a means of delivering ‘more consistent and more resilient care’.

Recommendations included digital solutions to facilitate communications and speed referral, development of an ageing well dashboard and use of the Patient Reported Outcome Measures.
In December 2023, the East of England Clinical Senate reviewed the updated proposals in the PCBC and agreed that MSE ICB’s Clinical Governance and Assurance processes were followed in developing the PCBC. The Senate supported the overall proposals and made a number of observations. These are set out, along with MSE’s response in Figure 16 below. The letter and full response are provided in appendix 6.

EoE Senate Council observation	MSE response
1. There needs to be further work on the workforce plan for these proposals.	This will be done as part of implementation planning once the estates configuration has been confirmed via public consultation and the system decision-making route described elsewhere. The Clinical and workforce subgroups will lead on this area.

EoE Senate Council observation	MSE response
2. There should be further work on analysing travel times; especially the impact on areas of deprivation and the patient groups already identified as experiencing health inequalities.	This has been further explored following this feedback in an updated inequalities and health inequalities impact analysis, including an updated travel analysis.
3. While there was consultation with the public in forming these proposals, more extensive public consultation and engagement may have been helpful.	At the time of meeting with the EoE Senate Council, the Pre-Consultation Engagement analysis report (containing the below information) was unfortunately not yet available. This was prepared by Kaleidoscope Health and Care, and endorsed by the Healthwatch organisations for MSE (Healthwatch Essex, Southend and Thurrock). This gained over 170 responses via two different surveys on the MSE Virtual Views platform. A further 120 people were engaged via survey groups online or in person. This is available as part of the appendices.
4. When doing further patient and public consultation in the future, Mid and South Essex ICB should ensure that enhanced patient involvement and the voice of underserved groups is especially targeted and heard so that a more inclusive and diverse range of feedback is received.	Pre-engagement, and public consultation plans have been based on the Integrated Inequalities impact assessment. They have included targeted engagement with the following groups who were identified as groups of interest who would be affected by the proposals: Maldon Stroke Club Thurrock Stroke and Carers Group Blackwater GP Surgery PPG (Patient Participation Group) Healthwatch Essex AIS (Accessible Information Standard) Working Group Slipper Exchange run by Age Concern Southend-on-Sea and hosted by Havens Hospices Carers First Canvey Community Supermarket Bus Brentwood Stroke Club Stroke Association SEE Alliance Winter wellness event Ad hoc engagement with women and birthing people at William Julien Courtauld at St Michaels, Braintree, and St Peter's Hospital
5. Mid and South Essex may wish to consider the recommendations of The British Psychological Society for integrated community stroke services.	Thank you, we will include this in our implementation work on the staffing model.

EoE Senate Council observation	MSE response
6. It was suggested that clearer diagrams that depict how different governance groups relate to each other within the context of this proposal would be helpful.	This is now present in the PCBC, Figure 34.

Figure 16, Summary of Senate's 2023 Recommendations and System Responses.

6.8. Evidence

6.8.1. Intermediate Care:

Much of the evidence in support of IMC has been long-standing. The National Service Framework for Older People, Ageing and Age-associated Disease and Disability was published as long ago as 2001. There has though been more recent work to evaluate intermediate care in its various settings. For example:

The NHS Benchmarking Network has undertaken audits of large numbers of patients. David Oliver in a 2017 article in the BMJ 'Improving Access to intermediate care' noted that a 2015 audit had shown that 90% of the 12,000 patients studied had demonstrated improved functional independence, but that there were significant delays from referral to acceptance.

In 'The effects of locally based community hospital care on independence in older people undergoing rehabilitation: randomised controlled trial' Green J et al compared the Nottingham extended daily living scores of 220 patients in Bradford who had transferred to community hospitals with those who remained in an acute hospital setting and found a statistically significant improvement in those being rehabilitated in community hospitals. A smaller randomised trial in Norway also found lower mortality among the community hospital cohort. Neither of these studies however compared care at home and care in a community hospital

Between 85% and 87% of patients in MSE are discharged to their place of residence on clinical pathways 0 or 1. The national standard is 95%. More patients are also discharged into local authority commissioned beds than would be expected. Improvements to the care pathway are expected to relieve pressure on local authority intermediate care beds. In common with other health systems this is likely to be a product of pressure to move medically stable patients out of acute beds, a need for standardised agreed discharge pathways and referral delays. A 2021 audit of 69 discharges from IMC beds in MSE indicated that up to 40% of patients admitted to community hospitals for IMC did not require a bedded pathway and that approximately 20% of IMC admissions to bedded care were appropriately selected and gained benefit from that pathway. This may appear extreme, but in the national Better Care Support Programme in 2018 a study of 10,400 cases found that between 32% and 54% of patients experiencing a delayed discharge were placed in a setting where the level of care was not suitable to their needs. Of those numbers 92% were receiving treatment

and care which was more intensive than they required, suggesting significant, endemic risk aversion in placing individuals.

More positively NAIC reported that 71% of patients having undergone 6 weeks of reablement had an improved dependency score and a 2023 audit within MSE indicated that up to 76% of patients in IMC beds were on the correct recovery pathway.

MSE has recently been shown to have the lowest percentage of delayed discharges from acute hospitals of any system in England at 5.8%, compared with the national average of 13.7% delayed and the worst performing system at 22.7%. This suggests that effecting discharge for Pathway 2 patients assessed as having primarily a health need, is not solely dependent upon the number and availability of NHS IMC community beds. It is believed to be affected by admission avoidance, better use of Pathways 0 and 1, giving priority to Home First, as well as bridging schemes to enable people to leave acute hospital sessions. The clinical sub-group has reviewed the requirement for NHS IMC beds and bearing in mind current stay length of stay and the availability of Local Authority IMC beds where residents stay for longer to achieve their rehabilitation goals.

There has been plenty of advice beyond the National Service Framework as to the most effective means of undertaking intermediate care. For example, the National Institute for Health and Care Excellence (NICE) produced National Guideline 74 in 2017 describing in detail optimal arrangements for all aspects of intermediate care.

6.8.2. Stroke Rehabilitation

The National Clinical Guideline for Stroke for the United Kingdom and Ireland 2023 sets out the evidence in support of effective rehabilitation, emphasising clinical leadership and concentrating available skills in stroke rehabilitation units. A major change was a shift in the intensity of rehabilitation recommending an increase in therapy per patient from 45 minutes per day to 3 hours per day for at least 5 out of every 7 days. The National Guideline cited international evidence in support of the argument that the increase in intensity had significantly improved outcomes. While it is likely that it will take some time for systems of health and care to adjust to these new demands for resources the indications are that MSE will either have one or at a maximum two stroke rehabilitation units, a question needing resolution as an outcome of consultation.

Calculations made previously indicated that of the 2000+ annual acute stroke admissions in MSE up to 500 would benefit from inpatient rehabilitation. Assuming an average stay length of 35 days and 95% occupancy, allowing for demographic growth it was considered that 48/50 beds would meet requirements in MSE. This also assumes agreed, effective pathways enabling stroke rehabilitation patients either to go to dedicated unit(s) or undergo rehabilitation at

home using Early Supported Discharge Teams. This should allow the use of beds for stroke rehabilitation on acute hospital sites to be minimised.

6.8.3. Maternity Service

Evidence from the National Perinatal Epidemiology Unit (NPEU) survey undertaken for the national maternity review ‘Better Births: Improving Outcomes for Maternity Services in England – A Five Year Forward View for Maternity Care has been cited in Section 5 Options for Change. In this consultation the configuration of maternity services is not being changed other than transferring the freestanding midwife-led Unit from St Peter’s Hospital, Maldon to the WJC Unit at St Michael’s Health Centre, adjacent to the Braintree Community Hospital.

Freestanding Midwife-led Birthing Units offer choice to those wanting a low intervention birth. The NPEU survey found in 2015 that while 6% of women preferred a freestanding unit there was no evidence of worse outcomes for women having a second birth or more. There was also a lower chance of intervention, which is the likely reason for the choice of the freestanding unit in the first instance.

6.8.4. Ambulatory Services

Increasing demand and the backlog caused by Covid-19 has focused national attention on ambulatory services. Long waits for appointments together with the need to achieve cancer targets has led to a series of documents providing guidance on improving performance, adopting patient-initiated follow-up, using digital solutions, and achieving the policy aim of reducing health inequalities. The NHS Long Term Plan 2019 first set out the intent and this has been followed by a Delivery Plan for tackling the Covid-19 backlog of elective care and principles and approach to deliver a personalised outpatient model 2022 together with toolkits and advice on transforming ambulatory services. In relocating ambulatory services, current policies and guidance will need to be considered along with the need to construct a personalised model of service.

There is also a need to distinguish between short-term and long-term care. In the former the service is provided for a defined period and then ceases, such as diagnosis and treatment of a cataract. Long term care may not have a defined end point as the problem is chronic. Many of the services provided currently at St Peter’s are of this type (see Figure 6). The Three-Year Delivery Plan for Maternity and Neonatal Services (2023) requires specific actions of an ICS including adherence to nationally defined best practice, investment in digital systems to enable patient access to their records and in the skills of the workforce to ensure that standards are consistently met. Transfer to a new site provides an opportunity both to seek to meet the requirements of the Delivery Plan and facilitate the participation of women and families in the decisions to be made about the future service.

Given the estate risks at St Peter's Hospital, provision of ambulatory care services on the site is only feasible in the very short-term. A preliminary assessment of local facilities has indicated that the majority of the current ambulatory services could be accommodated within Maldon in space which with some minor works will be much more suitable than that which is available at St Peter's. The Clinical Congress has advised that some services might offer an improved experience and outcome if co-located with like services elsewhere. An example is orthopaedics and rheumatology where there is an elective centre at Braintree Community Hospital and a Clinical Diagnostic Centre is being developed on the same site, which is due to open in December 2024, which can offer a range of imaging modalities including access to Magnetic Resonance Imaging and Computerised Tomography. However, it also has to be recognised that some of the patients in these services are likely to have difficulty with mobility. Plans for the future of ambulatory care will take this into account as options are co-developed, with input sought through the proposed consultation with the public, patients, staff and local stakeholders to inform any future decisions.

7. Alignment with Wider Strategic Plans

7.1. Overview

7.1.1. Even though this business case focuses principally on the future configuration of community beds across MSE, these beds form part of a much wider and interconnected pattern of health and care. Therefore, it is necessary to consider how this work aligns with the longer-term plans that have been developed across the catchment, including:

- The MSE Integrated Care Strategy 2023-33
- The Integrated Care Partnership Joint Forward Plan 2023-28
- The three Health and Wellbeing Board Strategic Plans as well as the County-wide Joint Strategic Needs Assessment
- Plans and capacity planning in adult social care
- The November 2017 to March 2018 consultation '*Your Care in the Best Place'* gave emphasis to the delivery of care out of hospital settings as well as changes to the distribution of acute hospital services across MSE.

7.2. The Integrated Care Strategy and the Joint Forward Plan

The Integrated Care Strategy 2023-33 sets out the ambitions of the MSE Integrated Partnership (ICP), a broad alliance of organisations comprising the MSE Integrated Care Board and the three upper tier local authorities – Essex County Council, Southend-on-Sea City Council and Thurrock Council to improve the health and wellbeing of the population they serve. The partners have developed a Joint Forward Plan for 2023-28 that sets out their collective ambitions and shared commitments, how those ambitions will be achieved by working with communities through cross-system leadership and their plans to deliver on the NHS Long Term Plan commitments and on their legal duties. Headline aims of the Joint Forward Plan include:

7.2.1. Improving the health of the population and reducing health inequalities – including in healthy life expectancy, in access to health and care and in addressing unwarranted variation especially in groups most likely to experience poor health outcomes through a Core20PLUS5 initiative. Efforts are to be concentrated on 20% of the most deprived communities, working with those with the poorer access to good health outcomes and focusing upon a number of clinical conditions affecting adults and children. For adults these include chronic respiratory disease, hypertension and maternity each of which has resonance within the programme of change for IMC, stroke and maternity services proposed in the PCBC.

7.2.2. Use data and insight to guide investment to achieve the best possible health and wellbeing outcomes. Continue to improve the quality of the care provided and learn from and build upon existing and future innovative practice.

7.2.3. Work in partnership to reduce preventable deaths, develop a shared view of the capacity required, build clinical leadership, and provide local personalised coordinated services.

7.2.4. Ensuring that operational performance is improved across a wide range of services including maternity, outpatient services, stroke services palliative and end of life services, cardiovascular and primary care services, each of which is likely to be influenced by the changes set out in the PCBDC

7.2.5. The plan also identifies four levels or 'anchor points' at which the system will operate in achieving these ambitions:

- The individual
- Neighbourhood – initially supported through the development of nine Integrated Neighbourhood Teams
- Place – reinforced by the four Local Alliances
- System-wide

7.2.6. This programme's work to determine how to best use community hospital beds is aligned with many elements of Integrated Care Strategy and the Joint Forward Plan. By encouraging the use of consistent pathways of care and reducing unwarranted variation, a core part of bringing care closer to home can be achieved. Helping to ensure patients are discharged from the acute setting in as smooth and timely a manner as possible into an appropriate care setting will improve services and outcomes. Retaining the choice of a freestanding Midwife-led Birthing Unit despite the need to transfer that service to Braintree also reflects the values expressed in the strategy and plans.

7.2.7. The more clearly defined pathways of care that are being developed support personalisation at the level of the individual; alignment of community intermediate care beds with local based health and care teams supports place-based working and some pathways – such as those for stroke – operate at a system level to make best use of scarce skills and expertise.

7.3. Health and Wellbeing Board Strategies

7.3.1. Each of the three Health and Wellbeing Boards to which MSE relates – Thurrock, Essex County and Southend – has produced wider ranging strategies for their areas which are 'owned' by their partners in producing and actioning their plans.

7.3.2. Even though each of these plans focus on the different characteristics, priorities and challenges faced by their own local communities and areas, there are some common themes:

Essex

- Improving mental health and wellbeing.
- Addressing obesity, improving diet, and increasing physical activity.
- Influencing conditions and behaviours linked to health inequalities.
- Enabling and supporting people with long term conditions and learning disabilities to achieve long term independence.

Southend

- Increasing physical activity.
- Tackling Health inequalities.
- Increasing aspiration and opportunity.
- Increasing personal responsibility and participation.

Thurrock

- Opportunity for all.
- Enhancing the identification and management of Long-Term Conditions.
- A healthier environment.
- Better emotional health and wellbeing.
- Quality care, around the person.
- Healthier for longer.

7.3.3. All three of these strategic plans identify meeting the needs of older people as an important issue, especially given the shifting demographic profile of the population. There is recognition, for example, of the need for all partners locally to regard frailty as a distinct long-term condition that needs an integrated response from health, care, and the voluntary sector. All three strategies include clear plans for responding to this priority, providing a clear context for any work on community beds.

7.3.4. Given the profile of this issue within all three plans, ensuring that best use is made of the system's community beds – and ensuring that they are appropriately linked into services and support provided by partners – forms an integral part of wider system planning.

7.4. Alignment with Adult Social Care Services

7.4.1. One of the most important inter-dependencies for community beds (and the wider system) is with the provision of adult social care across Thurrock, Southend, and Essex County. Decisions that the three councils make about social care capacity – for example the availability of reablement services, domiciliary and residential care – have a significant impact on admissions to and flow through NHS community inpatient beds. People discharged on Pathway 2 may be admitted to local authority funded places for reablement rather than a community hospital. People able to go home with support often require it from social services as well as health. Similarly, the capacity that is available in NHS beds needs to be considered alongside for the full range of services that are commissioned by social care.

7.4.2. In Essex County, for example, it is essential that plans are aligned with the Council's Transforming Intermediate Care programme and plans to expand domiciliary care capacity.

7.4.3. In Southend, the main area of focus has been reablement services, which are planned to expand by around a third on previous levels. There is now the opportunity to use Brook Meadow (a council owned and operated facility) to provide additional intermediate care capacity in designated places with agreed levels of therapy support.

7.4.4. In Thurrock, there is already a very high degree of operational integration between health and care services, enabled by geographic co-terminosity.

7.4.5. The commitment to partnership and joint working has resulted in consistency in planning and a sharing of priorities and values. The work of this programme of change in community beds to offer services focused upon individuals, enabling participation in decisions, minimising inequalities, and improving outcomes reflects the broader intent of the MSE system and its partners.

8. Enablers – Estates

8.1. Hospital sites for Intermediate Care and Stroke Rehabilitation

8.1.1. Community Hospitals vary widely in terms of their age and condition. Braintree and Brentwood were built as a result of the policy encouraging funding through the private finance initiative within the last 15 years. By contrast St Peter's Hospital main buildings are 150 years old. Several other units have been refurbished in recent years, but, with the exception of Brentwood, are relatively small with 24 beds or less.

8.1.2. Stroke rehabilitation beds are now located at CICC and Brentwood, with IMC beds distributed across the catchment enabling access for patients, carers, and relatives. There are no plans to increase bed numbers and the direction of travel is to enable further rehabilitation and reablement at people's place of residence, ensuring that only those who need a bedded stay use hospital and local authority facilities.

8.1.3. Brentwood Community Hospital

This is one of the newer facilities in MSE, having opened in 2008, and is centrally located with good transport links. There are diagnostic and outpatient facilities on the site, together with two permanent wards and extensive parking.

The facility was financed under the Private Finance Initiative, is managed by NHS Property Services, and leased by MSE in order to provide clinical services. Its 50 beds are operated by NELFT and Provide. A wide range of outpatient services are accommodated, mainly provided by the MSE Foundation Trust with some provided by Barking, Havering and Redbridge University Hospital NHS Trust (BHRUT). Some services on site are offered by private providers.

8.1.4. Mountnessing Court, Billericay

Mountnessing Court is located in Billericay and is close to both the town centre and local transport links. It has capacity for 22 intermediate care beds.

This facility is owned by EPUT and operated by NELFT with some staff seconded from EPUT.

8.1.5. St Peter's Hospital

St Peter's is a large site located in Maldon. It is one of the oldest facilities in MSE, with the majority of the buildings dating originally from its having started life as a Victorian Poor Law Workhouse in the 1870s. Until October 2023 inpatient services were provided from the site for stroke rehabilitation (16) beds and a MLBU. Increasing concerns about the condition of the estate caused the inpatient services to transfer. A recent survey showed that 76% of the gross

internal area exhibited defects, 52% of which were high risk. Outpatient services continue to be provided from the site and the options for replacing them with alternative local accommodation are discussed in Section 5 Configuration of Options. The site is owned by MSE Foundation Trust.

There are proposals to develop new primary care hubs in north and south Maldon, the latter offering the longer-term option of accommodating outpatient and some diagnostic services as well as local general practices. However, plans for the south Maldon development intended for Wycke Hill are at an early stage and it will be some years before they come to fruition.

8.1.6. **Cumberlege Intermediate Care Centre (CICC)**

CICC is located on the Rochford Hospital site, having moved there from its previous location in Southend-on-Sea in 2019. The unit is in good condition, having been refurbished prior to its opening in 2019. The unit has provided a mixture of intermediate care and stroke rehabilitation beds. In October 2023 the temporary changes led to stroke rehabilitation beds being increased from 8 to 14 and the IMC beds being switched from 14 to 8.

The services at CICC are provided by EPUT.

8.1.7. **Halstead Community Hospital**

The community hospital in Halstead is one of the older buildings in MSE, with several parts dating back to the 1920s, although others (including the rehabilitation facility) are much newer. A number of services are provided from the site, including IMC beds (20), outpatients and therapies.

The main community services on the site are operated by Provide.

8.1.8. **Mayfield Unit**

The Mayfield Unit is on the Thurrock Community Hospital site, to the north of Grays town centre. The unit was extensively refurbished in 2017, and as a result is in good condition. It provides 24 intermediate care beds, which are operated by NELFT, although the facility is owned by EPUT.

8.2. Key estate challenges

8.2.1. One of the constraints on this programme is that access to capital to either build new or upgrade existing facilities is limited. As a result, one of the 'givens' that has guided this work is an assumption that it is necessary to make the best use of existing facilities.

8.2.2. There are, however, three sites that pose challenges, for very different reasons:

8.2.3. **St Peter's Hospital Maldon**

The condition of St Peter's Hospital has for some time given rise to concern. The number of inpatient beds was reduced to 16 as a result of issues with the floor loading. The single lift able to convey patients in a bed was subject to frequent breakdown and during heavy rain floor areas were flooded as well as creating an electrical hazard. It was therefore concluded that the stroke rehabilitation beds could no longer be accommodated at St Peter's. This led to consideration of the safety of maintaining the MLBU at the hospital, which would be subject to some of the site hazards and vulnerable in terms of security especially out of hours if it remained at St Peter's. In October 2023 the stroke rehabilitation service transferred to Bayman ward in Brentwood Community Hospital and the MLBU transferred to the vacant, but fully equipped WJC Unit at St Michael's Health Centre, adjacent to the Braintree Community Hospital. Outpatient, diagnostic and some community services remain at St Peter's Hospital and work is continuing to find alternative interim accommodation for them, pending the development of purpose-built primary and community care facilities in Maldon.

8.2.4. Mountnessing Court Billericay

Despite offering ground floor accommodation Mountnessing Court has some need for improvement as a facility for IMC patients. Individual rooms are small and there is a need to widen doorways and ensure that each room has all necessary facilities. Some bathrooms need improvement. Access to the overflow car park also needs greater security and the IT and telephone need to be upgraded. The building though, is considered to be in sound condition and the necessary improvements do not involve major works. On the first floor there is accommodation for some mental health services. Mountnessing Court will be required for the foreseeable future, until patients on Pathway 2 are able to be assessed and identified with greater precision and the proportion of patients admitted to NHS IMC beds appropriately is closer to 100%.

8.2.5. **Brentwood Community Hospital**

Prior to Covid-19, only one of the two wards was operational, providing intermediate care and stroke rehabilitation beds. During the period of the pandemic, the capacity at Brentwood was rapidly increased, with a second 'permanent' ward opening, along with the creation of a further two 'temporary' wards. This enabled two wards to focus on intermediate care (run by NELFT), and two on sub-acute frailty (run by Basildon Hospital).

However, the two temporary wards were not fully compliant with all relevant regulations and standards; for example, they lacked piped oxygen, only had temporary washing facilities and were not well ventilated. Consequently, these temporary beds ceased to be used and the sub-acute frailty service moved back

into acute hospitals in early 2023. The vacated accommodation is being used instead for essential support services such as nurse education.

As a result, the potential to expand permanently the capacity at Brentwood to four wards has been examined. However, it has been concluded that it will not be able to expand the bed base beyond two wards. This is for two reasons: First, the total capital costs are very high – up to £20m. Second, the ownership structure of the site (it is a PFI building) means that there is in effect a cap on the total capital that can be invested in the facility before a change in accounting treatment is triggered. Expansion of the bedded capacity has therefore been ruled out as an option.

8.3. Future requirements

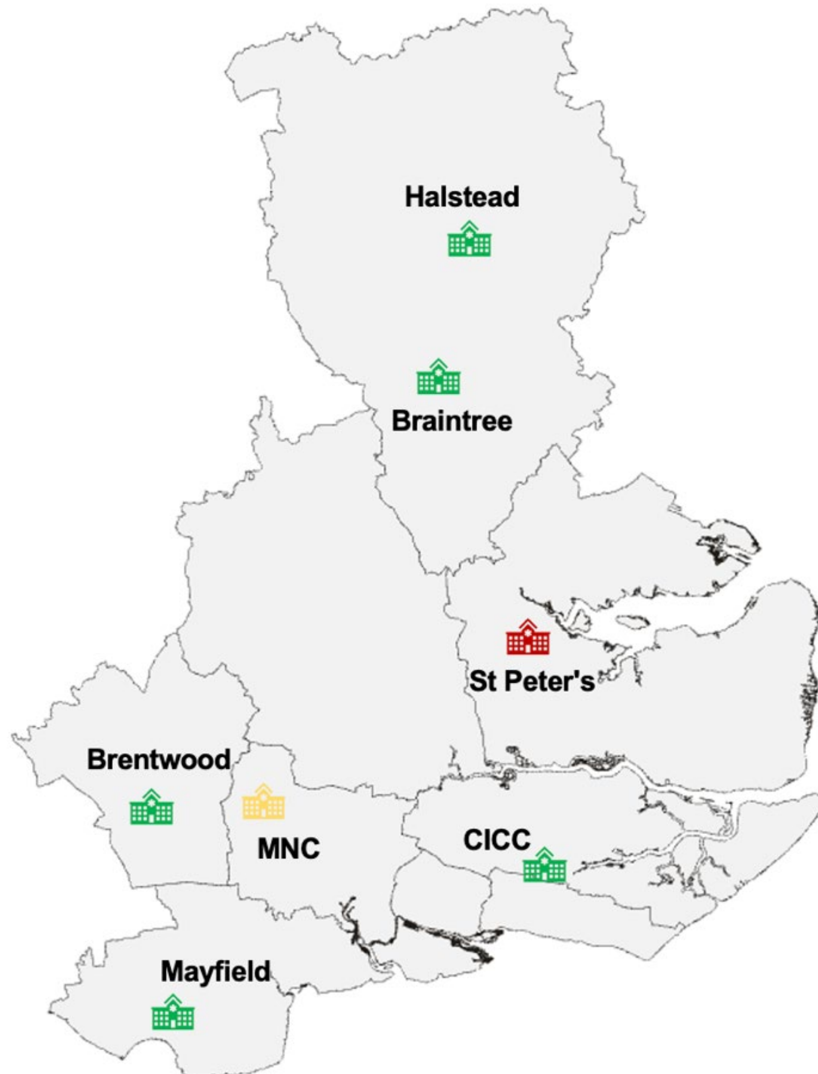
8.3.1. In developing the options set out in this PCBC, the changes that might be required to the estate to ensure that each site is fit for purpose have been considered. A list of criteria has been developed which have helped define levels that are ideal, and either acceptable or unacceptable.

8.3.2. This has enabled facilities to be categorised in terms of their suitability for inclusion in the longer-term provision of community beds which is shown below:

	Weighting	Category	St Peter's	MNC	CICC	Halstead	Mayfield	Thorndon	Bayman
	15	Fire risk assessment – outstanding red risks	0	2	2	2	2	2	2
	10	Water safety (Legionella Risk Assessment)	1	2	2	2	2	2	2
	15	Security assessment - outstanding issues	0	0	1	2	2	2	2
	10	IPC risk assessment	1	0	2	2	1	2	2
	15	Health & Safety risk assessment / condition survey	0	1	2	1	2	2	2
	5	Stability of IT systems to the building / Telephony	2	0	2	2	2	0	2
	5	Relevant maintenance and facilities contracts in place	0	2	2	2	2	2	2
	10	Oxygen storage (if relevant)	1	2	2	2	2	2	2
	5	Courier collections available / in place (e.g. bloods etc.) 7 days per week	2	1	2	2	2	2	2
	5	Patient transport accessibility	2	2	2	2	2	2	2
TOTAL	100		60	110	175	175	180	180	190

Per category:	*Red = 0* *Amber = 1* *Green = 2*
Overall:	*Red = 0 - 70* *Amber = 71 - 140* *Green = 141 - 200*

Figure 17, Suitability by Location of Community Beds in Mid and South Essex Assessment.



Braintree:
All green

Halstead:
Amber: several Health & Safety assessment risks

Brentwood Community Hospital:
Red: requires IT infrastructure to be put in place

CICC:
Amber: outstanding security assessment issues on CCTV systems

Mountnessing Court:
Red: stability of IT systems causing major issues on a daily basis
Amber: security assessment issues over the overflow carpark
Amber: lack of bathrooms impacting on the IPC risk assessment
Amber: courier collections only available weekdays

St Peter's:
Red: several fire assessment risks
Red: security risks over derelict building at rear of site
Red: £12 million backlog of maintenance issues outstanding
Amber: water safety issues
Amber: IPC compliance at 84%
Amber: oxygen storage requires review

Mayfield:
All green

Figure 18, Suitability by Location of Community Beds in Mid and South Essex Mapped Out.

9. Enablers - Workforce

9.1. The challenges faced within the community workforce at MSE are not unique. Across the NHS there are many vacant posts for skilled staff and competition for their services. At MSE these challenges have been aggravated by the adjustments made to the distribution of beds during and after the Covid-19 pandemic leading to uncertainty as to whether certain patient accommodation would be further reconfigured. In turn this meant that some posts were believed to be less attractive as job offers had to be made on a 'fixed term' basis. Uncertainty of employment and its location hinders recruitment and retention.

9.2. Recruitment and retention

9.2.1. Part of this consultation is to bring greater certainty to the system, which will help with recruitment particularly where uncertainty has led to significant use of bank and agency staff. For example, Halstead Hospital was reopened as part of the temporary changes for the winter of 2022/23 in order to initiate swiftly additional capacity. It was opened in December 2022, but had to be staffed using mainly bank and agency personnel. A community bed configuration for IMC that is more permanent is expected to cause available jobs to be more attractive to potential recruits and help to retain existing members of the workforce. It should reduce reliance on costly temporary staff.

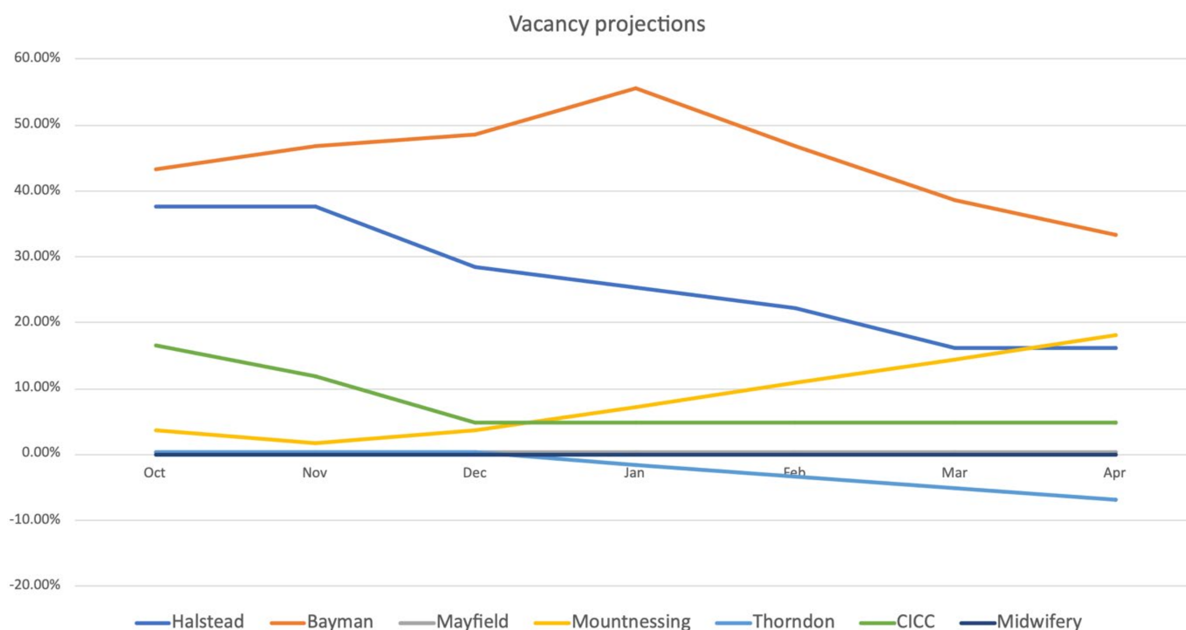


Figure 19, Projected Vacancy rates by Community Beds Ward Oct 23 – Apr 24.

9.2.2. Developing Stroke Rehabilitation Units (SRUs) as this PCBC proposes that conform more closely to the National Guideline is expected to be more attractive to potential recruits, while consolidating the service should help to retain trained health professionals, especially where services are considered to be excellent.

9.3. Stroke rehabilitation

The increase in stroke rehabilitation beds at CICC and the transfer of beds to Brentwood Community Hospital (BCH) has increased the overall number of SRU beds and the PCBC proposes to increase them further. There is a particular challenge for the system in the National Clinical Guideline for Stroke 2023 suggests a substantial increase in therapy time for each patient and sets out expectations of workforce increases which will have significant financial consequences. Plans will have to enable a gradual response to these new requirements which is practical and affordable for the Integrated Care System as well as responding to the national shortage of therapists. The PCBC does not propose hybrid IMC/SRU facilities partly because this dilutes the focus on the needs of two related, but distinct patient groups and because any such unit would have to be staffed to the higher levels required for stroke rehabilitation to enable the flexible use of the beds. For the system this is an avoidable and unnecessary cost penalty. Concentration of SRU beds, as proposed in the preferred options put forward in the PCBC, is expected to increase attractiveness of roles in such a facility to the range of professionals required for the service.

9.4. Intermediate Care

9.4.1. Current staffing levels for IMC changed in 2020 when hospital provision was consolidated onto a smaller number of sites. Nurse staffing ratios in response to the anticipated increased acuity of patients were increased (partially due to Covid-19) and this model is remains in place. The principal gap in the current staffing model is the absence of 7-day therapy across all wards. Establishing a level of staffing that is safe and likely to lead to the best possible outcomes for patients in addition to developing a consistent model for the system is a priority, which must be balanced by affordability.

9.4.2. IMC is provided in several care settings such as where people live, in care and nursing homes as well as community hospitals. Each of these require components of the workforce and to deal with the competition for key resources that this implies, coordination and planning of the workforce requirements at Alliance level will be essential.

9.5. Workforce considerations that will be assessed during consultation

9.5.1. The patient accommodation is to be in facilities that are in or will be made into an acceptable condition, able to support the delivery of high-quality care and providing an excellent working environment. This is intended to influence recruitment and retention, reduce rates of vacancy and the need to use agency and bank staff. An example is Brentwood Community Hospital where vacancy rates are low, and staff benefit from good facilities, parking, and access. As a unit close to London, Brentwood also attracts a London weighting allowance.

These factors are moderated by considerations of the extent to which staff must travel to reach their workplace and the effect of geography on access for families

and carers of patients. The benefits of concentrating services must be balanced against the need for reasonable access for staff as well as users.

9.6. Proximity to London

This factor affects workforce availability in several ways:

There is opportunity for staff members to work in healthcare in London at higher rates of pay, owing to London weighting. Transport systems are normally radial and so access to London by rail and road is relatively straightforward for those wishing to work there. To compete, local services need to be professionally and personally attractive.

London weighting creates pay differentials within the boundaries of MSE. In determining the location of services, the impact of London weighting upon the attractiveness of jobs needs to be taken into account.

9.7. Maternity Service

9.7.1. The St Peter's Hospital Midwife-led Birthing unit (MLBU) in Maldon has afforded women and birthing people who have low risk pregnancies the choice to have a birth without the expectation of intervention. However due to the difficulties in recruiting and retaining staff, the St Peter's MLBU was periodically closed. Staff engagement showed that midwives enjoy working within a community setting and therefore the options presented that keep a freestanding MLBU have received the most support.

9.7.2. In the context of a national shortage of midwives – removing options to work in low-risk community settings which are attractive to some could further compound vacancy rates and reliance on temporary staffing. "Growing your own" recruitment drives are underway to mitigate the impact of the national shortage offering opportunities to upskill staff and create a clearly defined career path.

9.7.3. The temporary transfer of the freestanding MLBU to the WJC Unit at St Michael's Health Centre, adjacent to the Braintree Community Hospital will enable the workforce consequences to be properly tested out, but it is the aim that greater workforce stability and elimination of the need to close the service because of staff shortages will be among the results.

9.8. Summary

9.8.1. In common with most other systems, MSE has challenges in recruiting to several staff groups including trained nurses and therapists. Since IMC and stroke rehabilitation services are expected to be therapy led, it is particularly important that local services can source and deploy skilled therapists.

9.8.2. Integrated Care Systems are now required to develop therapy blended roles and review the activity undertaken by therapists which could be given to support

workers as set out in the 2023 NHSE good practice guidance ‘Intermediate care framework for rehabilitation, reablement and recovery following hospital discharge’.

9.8.3. There is also a requirement to develop a single approach to demand and capacity planning for intermediate care. This will necessarily include a workforce plan setting out how sustainable staffing levels can be attained now and in the future.

9.8.4. Provision of the stroke rehabilitation service will need a similarly rigorous approach bearing in mind the expectation that more intensive therapy is provided, increasing the demand for suitably skilled staff.

9.8.5. Following consultation and decisions concerning service configuration a comprehensive workforce plan will need to be devised. In the meantime, the system of health and care will continue to ensure that short-term workforce planning continues to ensure that the system need for staff is met.

10. Enablers - Digital

10.1. Overview

There are four aspects of digital and data innovation which are not only relevant to the programme of change proposed in the PCBC but will enhance patient care and influence significantly the delivery of services in the future.

- Single patient record
- Remote care
- Support with self-care
- Insight and intelligence

10.2. Single patient care record

10.2.1. Introducing a single, integrated patient care record is a priority for the MSE system. As services become increasingly inter-connected, ensuring practitioners are able to easily access key information about people in their care is key. This work is also underpinned by the planned data lake, ensuring data can be used intelligently and pro-actively to bring benefits to services and their service users.

10.2.2. The MSE Community Collaborative (MSECC) which consists of EPUT, NELFT and Provide are working together to explore the shared use of digital records, making it easier to collaborate on the reduction of waiting lists, standardisation of services across MSE and giving greater choice to service users about where they can be seen. This will help patients to determine their response to ambulatory service changes as to where they attend for diagnosis and treatment. New EPUT/MSEFT shared patient record system procurement is under way, this will bring together the acute and mental health records for MSEFT and may be expanded to community.

10.2.3. The existing HIE Shared Care Record (ShCR) is being replaced with a new ShCR. This will enable greater functionality for services across both health and social care in MSE.

10.2.4. This is particularly important for work on community beds. As the Clinical Senate noted, most patients admitted to community beds will have received or required care from a number of settings, including primarily, community and often social care. A means of ensuring that key information is available is vital to providing seamless, high-quality care.

10.2.5. Patients rightly become frustrated at having to tell their story to health professionals multiple times. One reason for this is that there is not a fully integrated digital care record. As a result, when people are transferred between care settings, the quickest way to obtain essential information is to ask patients

or their families. A single patient care record accessible from any care setting will eliminate the need for the patient or their family to be asked repeatedly for the same information.

10.3. Remote care

10.3.1. MSECC are using voice-activated headsets so that clinicians can contact other remote clinicians and bring them into their consultation, allowing the remote clinician to see the patient and be part of the consultation. This can avoid delays in getting expert advice and works between different services. This technology is to be focused upon the virtual wards.

10.3.2. One of the factors considered as part of the development of intermediate care pathways in MSE is the potential contribution that new digital care tools can make. A number of evidence-based tools and devices are now available that enable patients to monitor their conditions from home, with the results being monitored by clinical staff. Examples include remote monitoring of respiratory conditions and heart disease.

10.3.3. Following the pandemic, it has also become increasingly common for consultations to take place online. Although this is not suitable for everyone, it can help patients and carers to be more confident in remaining at home, knowing that they have quick access to clinical and wider care advice if needed.

10.3.4. Digital tools are also making it easier for clinical and care teams to collaborate, and this too will benefit patients. Teams are now able to access key data and information – such as scans following a stroke – and work together on planning care for patients, without the need for either the patient or any team member to travel.

10.3.5. MSECC and MSEFT have worked in partnership to be able to offer Point of Care Testing (POCT) across MSE, a project that has recently gone live in the community.

10.3.6. POCT enables nursing staff in a variety of community services, including virtual wards to be able to take blood, test it and get the results in a matter of minutes, regardless of where they are. This avoids the need to send bloods to acute hospital laboratories for results and allows any required treatment to commence more quickly.

10.3.7. Community nurses are adding results into the community record, often supported by a mobile phone app. The results are then available both to community health services and the patient's GP.

10.3.8. These technologies have an indirect impact on the number of intermediate care beds needed in MSE. Taken together, they have the potential to contribute towards 'home first' becoming the default model of care, avoiding admissions and reducing length of stay.

10.4. Self-care

10.4.1. 'Patient Knows Best' is being introduced as a single front door for service users to be able to view their records and interact with MSECC and LA partners.

10.4.2. One of the main themes from the pre-consultation engagement work with both patients and staff was the importance of being able to help people care for themselves in their own homes, especially following a stay in one of the community hospitals. This included training carers, families and loved ones to continue to support patients post discharge (and is one of the reasons why having access to community inpatient sites was a priority for both groups).

10.4.3. Some of this support can be practical – such as training family members in wound care and changing dressings. However, by harnessing emerging digital technology and tools – such as home sensors, remote symptom monitoring and online advice and support – it will in future be possible to support further the drive to develop 'home first' as a preferred choice for patients.

10.4.4. While this work is not initially focused on community beds, it is clearly highly relevant to the future model for intermediate care and is therefore an important enabler for this programme.

10.5. Insight and Intelligence

10.5.1. In order to improve the planning approach to managing demand and capacity, MSE is working with partners to implement a system wide scenario planning tool which should enable future capacity challenges to be predicted. In doing so it can provide an insight into the impact of potential interventions.

11. Financial Assurance

11.1. System Financial Context

11.1.1. The system is operating at a financial deficit and significant efforts are underway to reduce, and ultimately eliminate the deficit. Part of that work includes improving patient flow from acute settings out into the community and home.

11.1.2. Ensuring that the community bedded capacity, particularly for Intermediate Care and Stroke Rehabilitation operates effectively is a key part of the system's ability to function. However, with the financial pressures faced, these changes are required to be at least cost neutral, for both revenue and capital. All changes in Provider revenue expenditure plans will need to be reflected as corresponding changes in income flow, transacted via the ICB.

11.2. Scope of financial analysis

	Option 4	Option 5	Option 11	Option 12
	IMC/Str	IMC/Stroke	IMC/Str	IMC/Str
St Peter's	0	0	0	0
MNC	22/0	0	22/0	22/0
CICC	8/14	8/14	22/0	0/22
Halstead	20/0	20/0	20/0	20/0
Mayfield	24/0	24/0	24/0	24/0
Brentwood	25/25	25/25	0/50	25/25
IMC/Str	99/39	77/39	88/50	91/47
Total	138	116	138	138

Figure 20, Costed options for Stroke Rehab / IMC

11.3. In-scope

- Incremental changes in revenue costs relating to the Intermediate Care and Stroke Rehabilitation and the MLBU
- Cost of delivery of the changes, where there is an interim solution enabling such.

- Mothballing of, and the associated benefits, of locations no longer proposed for use.

- Provision of alternative location for other ambulatory services (outpatients, x-ray, therapy, etc.) currently at St Peter's Hospital, to ultimately enable the site disposal.

- Financial impact on other acute hospital services and benefits from acute bed rationalisation made possible from improving patient flow through the system.

- Capital costs relating to all potential/proposed changes in site usage.

11.4. Revenue impact of options

11.4.1. Incremental change in service costs

The table below details the incremental changes in annual revenue costs, for each option, by both individual organisation, and the MSE system as a whole.

Summary Financial Options Appraisal							
Incremental Financial Changes per Anum (k) (Cost)/Saving							
Option	Provide £m	EPUT £m	NELFT £m	ICB £m	MSEFT £m	System wide £m	Bed movements (IMC/Stroke/Total)
4	(2.0)	(0.4)	0.0	(0.0)	2.2	(0.2)	-6/+15/+9
5	(2.0)	0.7	3.9	(0.0)	2.2	4.7	-28/+15/-13
11	(2.0)	0.1	(2.4)	0.2	3.9	(0.2)	-17/+26/+9
12	(2.0)	(0.5)	0.0	0.0	3.5	1.0	-14/+23/+9

Figure 21, Cost Increase Breakdown for MSE for Shortlisted Options (see Appendix 5 for detail).

11.4.2. Key points of Note

- Values reflect the recurrent* forecast incremental movements in annual expenditure, by Partner organisation, at the 2023/24 price base.

- Adjustments will be made, via the ICB, to income streams for Providers, equating to their movement in expenditure values.

*

- excludes forecast non-recurrent I&E/revenue gain on St Peters Hospital disposal, for all options,
- includes additional depreciation on capital investment for relocation of services, for all options,
- includes forecast saving from vacation of Mountnessing court, for option 5 only.

11.4.3. Statement of Comprehensive Net Income (SOCNI)

Below are the retained surplus/deficit positions from the Statements of Comprehensive Net Income, (SOCNIs), which consolidate the overall movements in cost and income across the system as a whole, for the eleven-year period 2024/25 to 2034/35.

11.4.4. Detailed SOCNIs for all four options are available within the appropriate appendices.

Summary Retained Surplus/ (Deficit) Positions													
Option	2024/25 £m	2025/26 £m	2026/27 £m	2027/28 £m	2028/29 £m	2029/30 £m	2030/31 £m	2031/32 £m	2032/33 £m	2033/34 £m	2034/35 £m	Total £m	Bed movements (IMC/Stroke/Total)
4	(0.2)	0.3	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.1)	(0.1)	(0.1)	0.2	(1.0)	-6/+15/+9
5	3.7	5.4	5.1	5.2	5.3	5.4	5.6	5.7	5.8	5.9	6.4	59.5	-28/+15/-13
11	(0.2)	0.3	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.0)	(0.0)	0.3	(0.2)	-17/+26/+9
12	1.0	1.6	1.1	1.1	1.2	1.2	1.3	1.3	1.3	1.4	1.7	14.1	-14/+23/+9

Figure 22, Statement of Comprehensive Net income (SOCNI)

11.4.5. Key points of note

- The model covers an 11-year period, given that the forecast capital investment associated with the relocation of services from St Peter's Hospital will be fully depreciated by year 10.
- Inflationary movements year-on-year are consistently calculated with reference to the assumptions made within the System-wide Medium Term financial plan.
- The less favourable position for Option 5 is in the 2024/25 financial year represents an assumption that the vacation of Mountnessing Court would not generate a saving until 2025/26.
- The less favourable position, for all options, in the 2025/26 financial year represents the forecast non-recurrent I&E/revenue gain upon disposal of St Peters Hospital.
- The favourable position, for all options, in the 2034/35 financial year reflects the forecast capital investment (see (1) above) will be fully depreciated by the end of 2033/34

11.4.6. Key assumptions

- Financial impacts are calculated on an annual basis, utilising inflationary movements which are consistent with the assumptions made within the draft Medium Term Financial Plans modelled at system-level.

- Increased costs relating to service delivery, are based upon existing service standards being maintained, and not enhanced.

- Savings associated with bed reductions in the acute setting are modelled on a proxy bed-day rate provided by MSEFT. Current modelling assumes that for every increase in Stroke Rehabilitation beds in the community there is a corresponding reduction in stroke beds on acute hospital sites.

- Utility savings, generated as a result of the mothballing of the St Peter's site, are based upon pro-rating existing total costs. The savings modelled assume that these will accrue based on proportional floor areas for ongoing use versus those which will no longer be operational and have been validated by MSEFT.

- Capital charge savings, comprising both depreciation and Public Dividend Capital (PDC), as a result of the rationalisation to the ground floor of St Peter's Hospital, have been modelled by the MSEFT finance team. Calculations have been based upon the values within the existing asset register, with valuations as at 31st March 2023, and using gross internal area to arrive at the resultant value.

- MLBU service delivery costs are assumed to be unchanged.

- Accommodation costs associated with any further potential relocation of MLBU are assumed to be cost neutral.

- All estate costs associated with the occupation of Brentwood Community Hospital (BCH) are considered a sunk-cost across the system but are part of a bigger piece of work pan-system, to understand liabilities by individual organisation (see specific section relating to BCH below).

- Implementation of Option 5 would involve the closure of Mountnessing Court as an operational facility. Such a change would lead to a reduction in cost equating to the stranded cost of the site, which is currently embedded within the EPUT contract with the ICB. It is recognised that the saving will only be fully realised upon the ultimate disposal of the site, and the financial model currently assumes this reduction will take effect in the 2025/26 financial year.

- Any future accommodation costs associated with the interim relocation of the residual services housed on the ground floor of St Peter's Hospital are assumed to be cost-neutral, i.e. the costs of alternative premises are expected to be equal and opposite to the savings generated by vacating the St Peter's Hospital site.

- The revenue consequences of the estimated capital investment required to relocate the services remaining on the ground floor at St Peter's Hospital to

alternative interim premises are included within the financial model. The estimated capital investment value is £3m (inclusive of a contingency sum of circa £0.5m), and asset lives are assumed to be 10 years in duration, commencing in 2024/25. The table below reflects the construct of the £3m investment proposal. Finalised costs will need to be agreed to support a Decision Making Business Case.

Proposed Capital Investment	£m
Light refurb (including on-costs)	0.6
Medium refurb (including on-costs)	0.7
Heavy refurb (including on-costs)	1.2
Contingency Sum	0.5
Total	**3.0**

Figure 23, the construct of the capital investment proposal

- Trajectories for the reduction of bank and agency usage have been worked-up by Human Resources Subject Matter Experts and have been quantified and included within the financial model.

- Costs which are time-limited in nature (e.g. excess travel payments) are included within the financial model only for the duration of them being incurred.

- A forecast non-recurrent gain, amounting to £0.5m, resulting from the proposed disposal of St Peter's Hospital, is included within the financial model in the 2025/26 financial year.

- Upon a final solution being agreed, changes in Provider revenue expenditure patterns will need to be reflected as corresponding changes in income flow, transacted via the ICB. All system partners are signed up to this principle, which will allow the necessary flow of funds around the system.

11.5. Brentwood Community Hospital PFI considerations

The Brentwood Community Hospital site was originally funded through a PFI contract which is now managed by NHS Property Services Limited. Individual providers using the facilities pay for the lease cost of the areas they utilise, whilst the rental value of any vacant or void areas become a liability which is underwritten by the ICB.

This leads to the principle that, where possible, maximising the use of the Brentwood site has a system financial benefit where it avoids estates costs

elsewhere. However, the financial implication of moving a service to the site for an individual provider may increase their direct costs of running the service.

There is a broader piece of work required regarding the use of BCH, current funding sources and future financial flows, by organisation. A specific group has been established to oversee this piece of work, with Estates and Finance colleagues. As noted above though, all estate costs associated with the occupation of the site are considered to be 'sunk' across the system and thus the outcome of this work is expected to be revenue neutral to the system as a whole.

To this end, such costs are ignored for the purposes the project.

It should be noted that the temporary changes, implemented over the 2023/24 Winter period, has brought Bayman ward back into operational use at no increase in cost to the system as a whole.

11.6. Capital impact of options

11.7. St Peter's Hospital

St Peter's Hospital is an ageing site with significant backlog maintenance investment required. To keep St Peter's Hospital open would necessitate significant backlog maintenance and other capital investment required to bring this Victorian site back up to the required standard for the delivery of NHS services. It is estimated that the required investment totals £18.7m and is not, therefore, considered a viable option.

If the proposals in this PCBC are approved, the NHS would no longer commission services from St Peter's Hospital, at which point MSEFT, as owners of the site, may look to dispose of it.

The current net book value for St Peter's Hospital within MSEFT's Statement of Financial Position is £6.2m.

The valuation for potential site disposal, based upon a recently commissioned valuation report, stands at £6.7m net of demolition costs, and excluding any associated fees.

While the technical financial impact of site disposal will need to be worked through via the Capital Team within the MSEFT Finance Department, in summary:

- The forecast gain on disposal (assumed to be £0.5m) will manifest itself as a non-recurrent Income & Expenditure/revenue impact, and this is currently assumed to come to fruition in the 2025/26 financial year.

- It is recognised that the proceeds of the future disposal of St Peter's hospital would need to be considered by reference to both MSEFT's strategic capital programme and the overall capital requirements within the system as a

whole. The current working assumption, however, is that the capital receipt will ultimately represent the funding source for the capital investment associated with the relocation of the ambulatory services currently occupying the ground floor of the hospital.

- The sale proceeds and capital investment requirements are likely to fall in different financial years, and therefore, any capital expenditure in the intervening period would likely need to be covered off via brokerage arrangements, either internal or external.

- By way of context, the proposed investment of £3m equates to circa 5% of the system's current annual allocation (see table below).

Organisation	2024/25 £000s	% age
MSEFT	43,544	77.7
EPUT	10,513	18.8
Provider Total	54,057	96.5
Primary Care	1,988	3.5
System Total	56,045	100.00

Figure 24, Construct of the system capital allocation

The system will therefore need to prioritise the investment from within its own CDEL limit in 2024/25.
The St Peter's Hospital sale proceeds will increase the system's available capital resource in the actual year of disposal, which is expected to be during 2025/26

11.7.1. Mountnessing Court, Billericay

The proceeds of any potential future disposal of Mountnessing Court would need to be considered by reference to EPUT's strategic capital programme and the overall capital requirements within the system as a whole.

For information, the current net book value of the site within EPUT's Statement of Financial Position stands at £3.3m, and the backlog maintenance costs to bring the site up to the required standard stands at £0.6m. Should Mountnessing Court be disposed, there is no anticipated revenue gain as a result.

11.7.2. System Financial Management

As noted above, MSE ICB will ensure that the financial impact to individual Providers is accounted for, via the amendment of contract income values accordingly.

12. Integrated Impact Assessment

12.1. Introduction

A key commitment for Mid & South Essex ICS is to deliver a comprehensive plan for community care across the system. An important component of this is delivery of an Integrated Impact Assessment of proposed solutions. A robust analysis over 76 pages can be found in the accompanying Annex document, including a literature review of over a hundred different sources of information.

12.2. Why an Integrated Impact Assessment?

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

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

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

12.3. What is included in an Integrated Impact Assessment?

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

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

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

12.3.2. This IIA is made up of 3 chapters:

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

12.4. Applicable Standards and Principles

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

12.4.1. **Equality**

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

12.4.2. **Health and health Inequalities**

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

12.4.3. **What is the scope of this IIA?**

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

12.5. Methodology

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

12.5.2. **Descriptive analysis** of the current patient population and health landscape within England. This analysis has been used to establish an understanding of the scale of impact. This ensures the response to the impact is proportional to its scale.

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

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

12.5.5. Each impact was prioritised based on:

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

12.6. Proposed Models

12.6.1. Mid and South Essex shortlisted 4 proposed options for Stroke and Intermediate Care following an options appraisal. The below refers to the number of beds available in each model. Option 0 is the configuration prior to the winter moves made in October 2023.

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

Figure 25, IMC and Stroke Rehab Model Options for the IIA.

12.6.2. As a result of the relocation of services from St. Peters proposed in all 4 models, there are impacts to maternity, which also takes place there. Therefore, the below outlines 4 future options for maternity. The models refer to the movement of maternity to WJC Unit at St Michael's Health Centre, adjacent to the Braintree Community Hospital.

	Option 2a	Option 2b	Option 2c
	Inpatient & Outpatient to WJC Unit	Inpatient WJC Unit. Outpatients in Maldon	Inpatient WJC Unit Outpatient co-location with Primary Care development
Inpatient Activity	6 beds	6 beds	6 beds
Outpatient Activity	8, 500 outpatient appointments	8, 500 outpatient appointments	8, 500 outpatient appointments

Figure 26, Maternity Model Options for the IIA.

12.7. Assessment of Impact

When assessing the impact of the proposed options green indicates positive, red indicates negative, and grey indicates a neutral impact.

		Option 4	Option 5	Option 11	Option 12
Equality Impact Analysis	Age				
	Disability				
	Sex				
	Pregnancy and Maternity				
	Marital Status				
	Race				
	Sexual orientation				
	Religion or Belief				
	Gender reassignment				
Health inequalities Analysis	Deprivation				
	Carers and Unpaid Carers				
	Homelessness				
	Mental Health				
	Substance Misuse				
	Gypsy, Roma and Traveller Communities				
Health Impact Assessment	Dementia				
	Falls				
	Stroke				
	Frailty				

Figure 27, Overall Assessment of IMC / Stroke Rehab Options.

		Option 2a	Option 2b	Option 2c
		Inpatient & Outpatient to WJC	Inpatient WJC, Outpatient to Maldon Hub	Inpatient WJC, Outpatient Primary care locations
Equality Impact Analysis	Age			
	Disability			
	Sex			
	Pregnancy and Maternity			
	Marital Status			
	Race			
	Sexual orientation			
	Religion or Belief			
	Gender reassignment			
Health inequalities Analysis	Deprivation			
	Carers and Unpaid Carers			
	Homelessness			
	Mental Health			
	Substance Misuse			
	Obesity			
	Gypsy, Roma and Traveller Communities			
Health Impact Assessment	Diabetes			

Figure 28, Overall Assessment of Maternity Options.

		Outpatients & Diagnostics Proposed locations			
		1. Midwife episodes & Obstetrics, gynaecology, Glucose Testing, Paediatrics and SLT within Maldon, with Midwife and neonatal in WJC	2 Phlebotomy, District Nurses, ESD and Cherry tree in Maldon	3 MSK Physiotherapy & AHP in Maldon	4 All other outpatient services potentially located within Maldon where clinically appropriate
Equality Impact Analysis	Age				
	Disability				
	Sex				
	Pregnancy and Maternity				
	Marital Status				
	Race				
	Sexual orientation				
	Religion or Belief				
	Gender reassignment				
Health inequalities Analysis	Deprivation				
	Carers and Unpaid Carers				
	Homelessness				
	Mental Health				
	Substance Misuse				
	Obesity				
	Gypsy, Roma and Traveller Communities				
Health Impact Assessment	Dementia				
	Falls				
	Stroke				
	Frailty				

Figure 29, Overall Assessment of Outpatient Options.

12.8. Positive Impacts

- The closure of St. Peters will allow for stroke patients to receive care in better equipped facilities and provide appropriate room for expansion to meet the population's needs.

- Increased opportunity for patients to be treated at home improves patient outcomes.

- For stroke patients who meet the criteria to be treated outside of the acute hospital, receiving care in community bedded setting both reduces risks associated with acute care (e.g., hospital-acquired infection etc), and provides access to dedicated rehab care, optimising patient outcomes.

- By improving the IMC offer and increasing stroke capacity in community, The population of MSE will have access to optimised community care which will keep care closer to home for patients and improve facilities, training for staff and rehab opportunity following a stroke.

- Models are not necessarily reducing IMC capacity, but rather right sizing the capacity to ensure that patients who can be cared for at home have the opportunity to go home which results in improved patient outcomes.

12.8.1. IMC and Stroke Models

- Options 4 and 12 ensure IMC bed numbers remain consistent with existing demand and keep an IMC presence across the MSE footprint, whilst accommodating the stroke expansion which is important to meet the future demands of the population.

- Option 5 may result in a reduced IMC bed base too quickly and reduce the geographical footprint for IMC offered to patients as there would be no IMC community beds in both Maldon and Basildon.

- Option 11 proposes dedicated IMC facilities across 4 areas in MSE. Dedicated IMC will enable development of specialist staff skill sets, care processes, easier audit and monitoring, and greater potential for research and innovation.

- Options 11 and 12 offer dedicated Stroke care options at Brentwood or Rochford. This will enable development of specialist staff skill sets, care processes, easier audit and monitoring, and greater potential for research and innovation.

- Analysis conducted, 95% of all patients attending any of the community hospital locations identified in the options, can get to these locations via car in 27-33 minutes. Public Transport does take longer for patients overall, with 67% of people in Mid and South Essex living within 45 minutes of any of the community hospitals and 91% living within 60 minutes.

12.8.2. **Maternity Models**

- All short-listed maternity models propose inpatient activity at WJC in Braintree. This will mean increase in access to maternity services for patients as St. Peters would often need to close due to the environment. Patients will have access to better, more modern facilities which are consistently open and available.

- Maternity option 2a proposes all maternity services moving to the WJC Unit at St Michael's Health Centre, adjacent to the Braintree Community Hospital allowing for all care to take place in one place.

- Maternity options 2b and 2c propose inpatient activity to move to Braintree, however, outpatient activity to remain closer to home in Maldon via a hub or primary care locations.

- Within Maternity, 95% of patients get to St. Peters in 29 minutes by car. This remains the same journey time to attend WJC. This is because just 31% of all patients who attend maternity at St. Peters are from Maldon. 95% of patients get to St. Peters in 102 minutes by public transport. This would reduce to 92 minutes to go to WJC. This is because just 31% of all patients who attend maternity at St. Peters are from Maldon.

12.8.3. **Outpatients and Diagnostic Model**

- The proposed models plan to keep outpatients in Maldon locally and more centrally located for those who use public transport, where it is possible to do so. The proposed locations are also familiar locations many patients may prefer and feel more comfortable in.

- By outpatient and diagnostics being located locally in the town centre, transport links are improved which could make travel cheaper and easier for patients.

- Some carers may find this easier as patients may be able to get to appointments alone and patients may have a greater independence due to this.

- Those with Mental Health conditions may have mixed responses to the proposed changes. Some patients may prefer a more familiar and less clinical environment.

- District nurses and early support discharge working in an integrated way in Maldon could impact all patient's pathways positively, allowing for an integrated approach to discharge and support at home.

- Having leisure centre facilities for MSK conditions could support optimised rehabilitation.

- 95% of all patients who are outpatients at Maldon live within a 23-minute drive of St. Peters. The new outpatient locations are up to 6 minutes by car from the original St. Peters site. There is a bus and coach station, and bus stops across Maldon.

12.8.4. **Environmental and social Impacts**

- Boosting Local Economy and Assets: By providing outpatient services in the local high-street of Maldon, local shops and may see the benefit of an increased population of customers which could help to sustain local businesses.

- Healthy travel: High streets are more accessible to people without cars than out-of-town centres and offer a chance to promote other sustainable forms of travel. In the longer term, car use is likely to decline and public transport, walking and cycling will be the normal way to access town centres, meaning high street design needs to evolve. Low traffic neighbourhoods have also been shown to increase life expectancy. By increasing outpatient and diagnostics locally in Maldon town, these benefits may be realised.

- Reducing Carbon Emissions: Not only could localised outpatient services in Maldon high street help to reduce carbon emissions to other hospitals and care settings but the closure of St. Peters could also reduce Mid and South Essex's carbon footprint as the building was originally built in 1872 and, despite improvement works being carried out since, does not efficiently use energy due to its vast size and likely it is difficult to isolate effectively.

- Local Community & Culture: The proposed model for outpatients and diagnostics could use local amenities to boost pride in the local community. The difficulty will be to sustain this if patients are not from the area, however, the majority do live near Maldon so this impact still could be seen.

12.9. Adverse Impacts

- Ensuring the right IMC capacity in community could have positive impacts long term as more patients will move to appropriate pathways, including home based care. Only those who need to be in inpatient intermediate care beds will be. This, however, will could have short term implications whilst the infrastructure is being put in place to ensure patients are on the right pathway.

- If outpatient services are moved across multiple primary care locations, then patients could find travel to these different locations difficult. Cohorts who may find this challenging are those who have difficulty with mobility or disability, those who rely on public transport, those with mental health conditions and carers or unpaid carers. The proposed models would, however, where possible try to promote more home-based care rather than inpatient care, optimising patients' outcomes and reducing travel when not necessary.

- For patients who could receive care at home rather than in IMC beds, this could put more responsibility on carers which could result in anxiety or fatigue. Virtual wards etc offer support to carers and relatives including training when needed and regular visits or support in line with patient need.

- Increased opportunity for patients to be treated at home improves patient outcomes but relies on appropriate infrastructure in place to allow MSE to move from 105 beds to a reduced number.

12.9.1. **IMC and Stroke Models**

- Options 4 and 5 allow for stroke beds in multiple places around MSE which could be beneficial for patients in terms of travel but offers 39 beds, which in a growing stroke population may be low in capacity in 5 years' time.

- Option 5 proposes the closure of Mountnessing Court in addition to St. Peters. Mountnessing Court Is located in Billericay, Basildon. Basildon has the high rates of complex needs such as deprivation, homelessness, substance abuse, unpaid carers, mental health conditions etc. Therefore, removing a care facility in an area of complex need could be challenging for people who live there.

12.9.2. **Maternity Models**

- In option 2a patients will need to travel to Braintree for at least their inpatient care, if not all care. This could result in patients travelling further for maternity services resulting in additional cost to them. This could impact patients with disabilities, living in deprived areas, those who are reliant on carers for transport etc.

- Maternity options 2b and 2c propose inpatient activity at Braintree but outpatient activity in Maldon. This could reduce feelings of consistency in care for patients who would feel more comfortable at one location and may result in more travel for patients between locations.

12.9.3. Outpatient & Diagnostic Model

- Ophthalmology and audiology patients may experience some sensory impairment which could mean some people may find attending an appointment in a busier high street setting more challenging or less comfortable.

- Those with a disability or any other conditions which could impact mobility, e.g., MSK, obesity etc, may find travel in local built-up areas more difficult as this may require more walking from local car parks.

- Some patients, particularly those with multi-morbidities, may find it difficult to keep track of where their appointment is if they attend multiple locations.

- Some carers may find travel easier, and others may find travel more difficult based on these proposed changes. It is important to note that as not all patients live in Maldon, therefore travelling to the local centre may be more difficult, e.g., to park or because more walking is required.

- Those with Mental Health conditions may have mixed responses to the proposed changes. Some patients may feel anxious about new locations in a busier setting.

12.9.4. Environmental Impacts

- **Carbon Emissions:** It is important to consider that only around 50% of patients who would attend St. Peters actually live in Maldon. Creating spaces in the high street for outpatient services may generate more pollution and traffic in the centre of Maldon as many may continue to drive. More work will be required to better understand these impacts, or any benefits, of proposals in line with the Climate Change Act prior to the Decision Making Business Case.

- **Parking Challenges:** By providing outpatient services in local leisure centres and high-street facilities, this could create a pressure on local car parks that are not equipped to deal with an increase in demand that may be generated.

12.10. Evidence Based Recommendations

12.10.1. Patients

- It is recommended to engage with residents in MSE from ethnic minorities as 29% of patients at St. Peters are from an ethnic minority.

- It is recommended to engage with those over 65 as the large majority of patients in IMC and stroke beds were over 65. When engaging on matters related to Stroke reconfiguration, 38% of stroke patients are aged 40-69, therefore, it is important to also consider this age group when engaging.

- It is recommended to engage with Males and Females proportionately. Some proposed changes impact Males more than females and vice versa, therefore engagement of both Males and Females equally is advised.
- It is recommended to engage with people living in deprived areas across MSE, particularly related to changes to outpatient services from St. Peters. If outpatients are spread across multiple locations, patients may be required to travel further which could be costly.
- It is recommended to engage with women and people of child-bearing age to understand how the proposed changes to maternity impact them.
- There will be plans to move outpatient appointments to virtual appointments where possible to save on unnecessary travel for patients. It is important to consider areas of digital exclusion when rolling this out.
- It is recommended to engage with patients with mobility and sensory conditions, such as, MSK, ophthalmology and audiology patients to understand their needs with regards to travel and the impact of navigating a high street setting.
- It is recommended to consider where services will be best co-located to reduce patient travel and ensure that facilities (e.g., X-Ray) are accessible and comfortable for patients.
- It is recommended to engage with patients who do not live in Maldon but attend Maldon outpatient services to understand how the proposed model of outpatient and diagnostic services in Maldon town would impact them.

12.10.2. **Staff**

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

12.10.3. Services

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

- It is recommended to engage with substance misuse services and service users to understand how they may be impacted. Basildon has the highest volume of people living with drug misuse and risk of alcohol related illness. Therefore, Option 5 would be reducing IMC services in that area.

- It is recommended to engage with mental health services and carers/ unpaid carers and/or services who support carers to understand the impact of travelling to a different location for IMC or Stroke care which may be further from their home. It is also important to understand the impact of increased home-based care on mental health. For patients who could receive care at home rather than in IMC beds, this could put more responsibility on carers which could result in anxiety or fatigue.

- It is recommended to engage with local authorities to understand transport links offered to primary care locations which may be used for outpatient appointments previously at St. Peters. This can be provided to patients who may be reliant on public transport to reach appointments.

- It is recommended to engage with those who live alone or those who provide home based services such as virtual wards to understand the impact of the proposed models on patients who do not have additional support at home.

- It is recommended to engage with pregnancy diabetes services and other complex conditions during pregnancy to understand how patients will be impacted by the proposed changes.

- It is recommended to explore if parking is more limited and the cost, if any, to park needs to be considered.

13. Assessment Against the Five Tests

13.1. Background

NHS England requires assurance that service changes are beneficial and there is guidance for systems developing proposals. It is therefore essential that changes meet the four tests of service change:

- Strong public and patient involvement
- Consistency with current and prospective need for patient choice
- Clear clinical evidence base
- Support from clinical commissioners.

In 2017 NHS England introduced a new, fifth test. This requires systems that are planning to “significantly reduce hospital bed numbers” to evidence that they can meet one of three conditions:

That there is sufficient alternative provision in place alongside or ahead of bed closures

They can show that new treatments or therapies will reduce specific categories of admissions.

That there is a credible plan to improve performance without affecting patient care. For example, increasing the precision of directing Pathway 2 patients to community IMC beds leading to better outcomes.

Some of the options under consideration will reduce NHS intermediate care bed numbers, but all shortlisted options increase the number of stroke rehabilitation beds. In addition, the system of health and care is well along its path to developing alternative care settings to bedded provision such as virtual wards and community reablement.

13.2. Test 1 – Strong Public and Patient involvement

13.2.1. The PCBC has been developed in conjunction with engagement with stakeholders. Following its approval by the MSE ICB, the system of health and care proposes to enter into a period of public consultation, enabling the Decision-Making Business Case to be developed in the light of the public responses. It is also intended that the solutions for replacing ambulatory services to be transferred from the St Peter’s Hospital site should be developed through a process of co-production with service users, clinicians, and the local community. The arrangements for engagement and consultation are set out in Sections 14

and 15 and at the time of the PCBC being formally agreed and issued the information gained up to that point will be included.

13.2.2. The draft plan for full, formal consultation is set out in Section 15 “Communication and Consultation Plan”, with the current plan provided in Appendix 8. It details a comprehensive approach to enabling patients, carers, the public, staff, and key stakeholders to be involved through a wide range of activities, events, and media which will start on 25 January 2024 and run for eight weeks to 21 March 2024. Following the consultation, analysis of insights from public and local government consultation will be undertaken and used to inform the development of a Decision Making Business Case (DMBC), which will be presented to the ICB Board in Q2 2024/25.

13.3. Test 2 – Patient Choice

13.3.1. Choice of location

The proposals within the PCBC continue to offer patients choice in where they access services, where it is clinically appropriate to do so, and aim to support patients to access care as close to home as possible. For example, the freestanding midwife-led unit at WJC provides choice to mothers with low-risk births, and maintaining ambulatory care services within Maldon supports patients wishing to receive outpatient care close to home.

13.4. Test 3 – Clinical Evidence

13.4.1. Clinical leadership and scrutiny

13.4.2. The proposed service changes set out in this PCBC have been led by a Community Care Task Force (CCTF) with clinicians in its membership, supported by a Clinical Sub-Group which reviewed in detail the long list of options, refining them to a short list which led initially to the interim changes to configuration to help the system of health and care manage winter demand. The system’s Stroke and Ageing Well Stewards have met regularly and have been fully engaged in the development of options and in September an audit of stroke services was undertaken which has informed this business case. The PCBC refers to several clinical audits of intermediate care services since 2019 which illustrated the need to improve outcomes.

13.4.3. Section 6 ‘Clinical Assurance and Evidence’ has set out the extent of clinical engagement and the extensive selection of national and other guidelines which support the approach being taken in the PCBC.

13.4.4. In addition, in preparation for consultation at an earlier date, the Clinical Care and Outcomes Review Group (CCORG) reviewed and challenged proposals as they have developed and sought to ensure that they were aligned with the evidence base and best practice across MSE. As well as commenting on the pathways and the configuration options, CCORG was involved in the selection of the key outcome measures as well as the targets that were established.

University College London Partners (UCLP) review
In 2022, at an early stage in the development of the clinical models, expert external advice was obtained from UCL Partners. Colleagues from UCLP offered advice on the available evidence base and on how the proposals might be further developed.

Clinical Senate
In April 2022 an East of England Clinical Senate Panel was convened to review in detail proposals under consideration at that time. A further review of the PCBC took place at the Clinical Senate meeting on 5th December 2023. The Panel's overall conclusion was supportive of the proposed service and made a series of recommendations, which were agreed by MSE clinical and operational leads. The headline recommendations can be found in Section 6 of the PCBC, and the full report is in Appendix 6

Clinical and Multi-professionals Congress
Since 2022, the ICB has strengthened its systems of clinical assurance. In September 2023, the temporary winter proposals were taken to the ICB Clinical and Multi-professional Congress (Clinical Congress) to ensure they were fully aware of the background to this PCBC. The PCBC was presented to the Clinical Congress in late November 2023 and their initial findings are to be found in Section 6 of the document. While providing valuable advice and comments the Clinical Congress endorsed the proposals to create SRU beds, enable timely access to IMC beds for appropriate patients, locate the MLBU at the WJC Unit at St Michael's Health Centre, adjacent to the Braintree Community Hospital to provide a resilient, sustainable service and to locate key ambulatory services in premises accessible to Maldon residents. The Clinical Congress also indicated that there were services which, for clinical reasons, would be better co-located in order to offer the best possible clinical quality.

13.5. Test 4 – Support from Clinical Commissioners

13.5.1. Since the Tests were devised, the NHS has undergone a fundamental change from a clear separation of commissioners and providers of services to the creation of systems of integrated care where organisations work cooperatively to deliver services to defined populations. In this system the commissioner role is primarily adopted by the Mid and South Essex Integrated Care Board (ICB), which has supported the development. The system of health and care comprises the ICB together with the local providers – MSE Foundation Trust, NE London Foundation Trust (NELFT), Essex Partnership University Trust (EPUT) and Provide a Community Interest Company.

13.5.2. The services referenced in the PCBC do not involve specialist commissioning and there is limited use by a very small number of patients living outside MSE. Nevertheless, specialist commissioning and neighbouring systems of health and care will be invited to participate in any consultation concerning the proposals.

13.5.3. The PCBC will be reviewed by each of the Boards of the constituent organisations of the MSE Integrated Care System, to confirm support from all NHS bodies in Mid and South Essex.

13.6. Test 5 – Bed Numbers

13.6.1. Total number of beds

At an aggregate level, the number of beds in the MSE system may not materially change because of the proposals set out in this document. This depends upon the decisions made about the number and distribution of the NHS beds. A summary of the main potential bed changes is set out below.

13.6.2. Several of the proposals will either directly or indirectly affect the number of beds across the system:

- Under either option 11 or option 12, MSE would have a total of 138 community inpatient beds across IMC and stroke rehabilitation. This is an increase of 9 beds from the 129 that were available prior to the temporary moves that took place in October 2023. The split of IMC and stroke rehabilitation beds varies across the two options, with option 11 also including the potential to accommodate up to 3 beds for Level 3 neuro-rehabilitation. In Section 5, *Options for Change,* calculations have been shown for the numbers of beds required. However, the number of beds is only one factor in the spectrum of service delivery of intermediate care, the majority of which takes place in care settings outside hospital.

- The priority in intermediate care is to enable people to live well in their place of residence. The purpose of an NHS IMC bed is to rehabilitate an individual as quickly as possible to achieve that aim. In the same way local authorities commission places in residential care where individuals on Pathway 2 with primarily social needs can also receive therapy to support their reablement and go home. The NHS and social care beds need to be thought of as a similar resource dealing with related, but somewhat different needs.

- The MSE system has been shown to have the lowest percentage of delayed discharges from acute hospitals in England with a percentage delay of 5.8% compared with the all-England average of 13.7%. This is believed to be a result of community Early Discharge Services, the development of Integrated Neighbourhood Teams, use of ‘bridging’ to provide practical support for individuals ready to leave hospital, but without their package of care not being in place as well as the recent development of ‘virtual ward’ beds enabling people to stay at home and receive treatment and care.

- The current proposals contain options to increase the number of community stroke rehabilitation beds further from 39 to 47/50 either in a single specialised unit or in two units in the east and the west of the system.

- The release of medical beds at the acute hospitals potentially freeing up beds at Paglesham Ward at Southend, which in the absence of appropriate community facilities, have historically been required to care for patients who need hospital stroke rehabilitation.

- Of the virtual ward beds now in operation 60 are for 'hospital at home' and 60 for 'frailty'. These do not replace community IMC and SRU beds but do provide a means of continuing to manage the medical needs of patients in people's place of residence. The development of integrated neighbourhood teams supported by remote technologies also potentially extends access to care and reablement at home rather than necessarily in hospital.

- For stroke rehabilitation patients the community Early Supported Discharge service supports their treatment and care in their place of residence. This service across MSE complements the bedded stroke rehabilitation units.

- The WJC Unit at St Michael's Health Centre, adjacent to the Braintree Community Hospital which could replace the St Peter's Hospital MLBU has sufficient beds for women giving birth there. Should more capacity be needed to relieve demand for ante and post–natal space at the Broomfield Hospital Maternity Unit, in the future it would be possible to increase the bed capacity in the WJC Unit.

14. Public, Patient and Staff Engagement

14.1. As this programme has developed, we have worked to ensure that the public, patients, community groups and staff already working in relevant services are engaged so that their views can influence our approach and help to shape the emerging proposals.

14.2. Public and stakeholders

14.2.1. We commissioned an external organisation to support us with our pre-consultation engagement with members of the public, carers and key stakeholder, partners from the voluntary sector. Together, we held several interviews and small focus groups. Some of the main questions and topics we explored in these discussions were:

- What does great care look and feel like to you?
- What works well in the services you or your loved one have experienced?
- What is not working so well now and why do you think that is?
- What one thing should we change to improve your experience?

14.2.2. We also shared and discussed some of the thinking about potential decision-making criteria that we could use to help narrow down the potential options.

14.2.3. The themes that emerged were:

- The importance of what was referred to as patient and carer ‘activation’, which encompasses several dimensions: co-designing care planning with each patient and their family; promoting independence by where possible including and training carers and family members; the development of personal goals and outcomes; and the importance of clear, consistent communication.
- The considerable value placed on community beds as an important part of a transition from hospital to returning home, and in providing a setting in which care can be much more personalised with care goals agreed with the individual.
- The importance of accessibility, both in minimising any wait to be referred into a bed and geographically, so that it is easy for relatives, friends, and carers to visit.

- A recognition that community beds are more and more frequently caring for people with greater needs, resulting in a strong emphasis on having the right staff with the right skills.

- The importance of both communication and integration with the wider health and care system – including acute hospital, primary and social care

14.2.4. Since this initial engagement phase took place , we have conducted further pre-consultation engagement to ensure that we incorporated the views of those relating to intermediate care and stroke rehabilitation, maternity and ambulatory services provided at St Peter's. There was particular reference to the temporary transfer of beds from St Peter's Hospital to Brentwood Community Hospital and the increase of stroke rehabilitation beds at CICC with the consequent reduction there in IMC beds.

14.3. We have developed a separate report that sets out in more detail the main things we heard as part of pre-consultation engagement, and how we plan to incorporate this feedback building on previous themes. This is attached at Appendix 9. As part of the pre-consultation engagement, this outcome report received independent ratification from Healthwatch Essex, Thurrock and Southend for ratification.

14.4. We will continue our programme of engagement through our proposed consultation process. We will aim to obtain a broad range of views from a wide variety of communities, services users, and their representatives on our proposals.

The consultation will seek to:

- Ensure the population of our combined geographies are aware of and understand the case for change and the proposals for change, by providing information in clear and simple language and in a variety of formats.

- Hear peoples' views on the proposed options for inpatient community based care and proposals linked to ambulatory services at St Peter's Hospital.

- Ensure the ICB as decision-makers are made aware of any information which may help to inform the decision-making process.

- We will commission an independent company to analyse the consultation responses and outputs from all engagement methods. On conclusion of the analysis the independent company will produce a final written report which will be publicly available. The report will be used to inform the Decision-Making Business Case, on which the final proposals will be put forward. We are clear that the results of consultation are an important factor in health service decision-making and are one of a number of factors that need to be taken into account.

14.5. Staff associated with community inpatient beds

14.5.1. We included all staff that are currently working on wards within the community hospitals, as well as other staff in closely related services (e.g., the recovery at home team). We held focus groups in addition to the face-to-face sessions, we used on online tool (Virtual Views) to enable staff to submit their views, observations, and comments.

14.5.2. Some of the key areas explored during the discussions were:

- 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, what would it be?

14.5.3. Some of the key themes emerging from these staff sessions and the feedback on virtual views were:

- Reinforcing the importance of delivering care as close to home as possible for patients, carers and families.
- The importance of communicating proactively with staff so that they can support the continuity of patient care.
- The need to consider transport services, particularly for family, carers, friends and staff.
- An emphasis on the critical role families and loved ones play in recovery and the need to fully involve them in decision-making and care planning.
- The need to continue to improve links with social care to ensure services are integrated.
- The pivotal role having access to regular, good quality therapy services plays in supporting rehabilitation and delivering the best possible outcomes.
- A recognition of the importance of having trained and skilled staff available at all times, and a desire to improve access to learning and training.
- A view that care should be personalised, needs based and not too restricted by overly rigid pathways or procedures.

14.6. Staff associated with Maternity Services

The staff associated with maternity had many overlapping themes with those working within community beds with particular distinctions as noted:

- The significance of patient choice and supporting women and birthing people to have the birth they desire.
- Ensuring consistent staffing levels that deliver equitable outcomes for women and birthing people across mid and south Essex.
- The importance of ring-fenced staff to create a network of support around families.

14.7. Staff associated with Ambulatory Services at St Peter's

We also spoke to staff working in non-inpatient areas at St Peter's Hospital to help capture their views to help influence our approach and help to shape the emerging proposals. As with the former staffing groups the following themes were of high priority:

- The key role having a warm, homely environment with modern well-equipped facilities is to deliver the best possible outcome and experience for patients.

Detailed feedback can be found in Appendix 9.

14.8. Patients

14.8.1. As part of our pre-consultation engagement, we were able to speak to a small number of current patients being cared for in one of our community hospital sites. These took the form of structured interviews conducted by members of staff from the local teams.

14.8.2. Some of the key themes highlighted by patients as being important to them in the care they were receiving (and how it could be improved) included:

- Having regular access to family and loved ones, either face-to-face or by phone, was highlighted as being key to making a rapid recovery.
- The importance of staff having time to offer emotional support and kindness, alongside the physical care and rehabilitation.
- The need to establish a positive atmosphere, including opportunities for group activities and other opportunities to socialise and break up the day and alleviate potential boredom.

- The potential to improve the wider environment has raised, including having better access to computer and television, and the provision of personal care such as haircuts/hairdressing.

- The provision of local based services where possible

14.8.3. A further survey to help gather insight to inform proposals around outpatient, day, diagnostic and related services at St Peter's was also carried out, See Appendix 9.

14.9. Decision making criteria

14.9.1. As part of the conversations, we held with the public and stakeholders, we asked them for their views on some of the criteria that we could consider using to help us with decision making, including moving from a long list of options to a short list.

14.9.2. The five key domains we asked people to think about and discuss were:

- **Quality:** optimise outcomes, based on strong evidence based/consistent with national frameworks, positive patient experience – user driven, personalised care, promoting independence.

- **Workforce:** High quality, sustainable workforce available, positive staff engagement and feedback.

- **Accessibility:** Acceptable travel times for families and carers, supports care closer to home, enables choice/options for patients, integration with wider health and care services.

- **Strategic alignment:** Consistent with wider health and care objectives, support delivery of partnerships for ambitions to help reduce inequality and deliver its volume, care closer to home, improving & transforming services, supporting health and wellbeing, creating opportunities.

- **Cost:** Best use of existing estates, facilities compliant with national standards, sustainable financial model able to meet future demand.

14.9.3. Some of the key views we heard as part of these conversations were:

- The need to consider accessibility in the round, considering carers and relatives as well as the patient themselves.

- The importance of thinking broadly about finance – not just the direct cost of services, but the wider benefit of (for example) maximising outcomes for individuals.

- The importance of being clear about the decision-making process itself and how this will operate.
- As part of workforce, emphasising the importance of consistency and continuity of care.

14.10. Conclusion

14.10.1. Although the pre-consultation engagement conversations all had their own features and nuances, there are a small number of clearly discernible themes that we have identified and which we can use to both shape the programme and to develop potential options for the future configurations.

These include:

Theme	Response
Involvement of carers, family and friends in planning and delivery of care	Prioritise physical access to sites with community beds, including transport options, with any options appraisal. Engage with councils on improving transport links based upon future location of care outlets.
The importance of having a workforce that has the right skills to meet the (growing) needs of the patients	Provider delivery plans must include robust workforce plans for staff that includes recruitment and retention, training, development, and 'upskilling' opportunities as well as clear career development pathways. Greater development of specialties due to economies of scale to attract talent. Ensure that best use is made of skills that are scarce, including supporting relevant staff to work across multiple sites if required.
The importance of good and early communication and engagement	Maintain engagement platforms that are easily accessible online or in person so that staff, patients and community groups can continue to share their thoughts.
The need to future proof the service for the increased need	Assess which services would be best for co-location and prioritise locally based solutions accordingly.

The importance of having the right physical environment that promotes recovery, rehabilitation and supports the achievement of personal goals	Complete a full assessment of the quality of the existing facilities, including explicit identification and consideration of the additional costs of areas of improvement.

Figure 30, Summary of Key Themes across Pre-Consultation Engagement.

15. Communication and Consultation plan

15.1. A dedicated engagement and communications steering group was established to oversee the delivery of our programme of early engagement as well as measure its impact. The group is composed of communications and engagement leads across the Mid and South Essex Health and Care System. This group ensures that clear and cohesive messages are presented and that stakeholders are engaged in a timely manner.

15.2. We are committed to ensuring:

15.2.1. Clarity about decisions

We will be clear in our documentation and in discussions with local people about:

- How is this a change from current arrangements?
- What are the potential benefits e.g., improved outcomes, service, efficiency, sustainability?
- What are the implications and disadvantages for patients and public e.g., number of people involved, access to services, issues for carers and family?

15.2.2. Clear and accessible supporting information to enable people to take a view.

We will ensure that there is an easily accessible library of background information that will include details on:

- Background and case for change
- Clinical evidence and relevant national guidance
- How the new service models would work in practice, including digital support, estates, transport.
- Equality
- Benefits for workforce
- Implications for staff
- Benefits for the system and implications for partners and cross-border issues
- Resource and financial issues e.g., costs, investment, savings

15.2.3. Clarity of debate

We will ensure that within the accessible library there are full details on how we have arrived at the current proposals, including:

- What the options were and how we assessed them

- How people have been involved

15.2.4. Effective opportunities for people to have a say.
We will ensure that our consultation process is fair and effective by providing:

- A reasonable period to access and respond to the information.
- Accessible channels and methods for feedback, including digital.
- Good access to information and further information
- Demonstrable "listening" and two-way discussion.
- Ensuring it is a view seeking exercise, not a vote/referendum.

15.2.5. We will be proportionate in our efforts.
We will ensure that our consultation is proportionate by:

- reaching out to mid and south Essex's geography, demography, and diversity.
- seeking fair representation across patients, carers and the public, groups, and organisations.
- include the views of equality groups potentially impacted by the proposals and their specific needs informed by the Integrated Impact Assessment (IIA).

15.3. Applying our principles

We are working with partners to ensure our preparations for consultation in the following ways:

- Continue to brief in private key stakeholder and opinion formers – such as MPs and influential council members – on the emerging proposals and likely issues, applying a 'no surprises' principle.
- Share draft versions of the consultation document with partners and service users to improve on style, content, and design in preparation for publication.
- Design with partners and service users the associated materials to support consultation, including an online feedback survey, short versions of the consultation document and other support materials that may be required.
- Set a comprehensive programme of meetings and workshops to ensure meaningful discussion and feedback. This will include attending existing groups and committees, such as Health and Wellbeing Boards and local authority scrutiny committees.

15.4. Consultation Objectives

The primary objectives of the public consultation plan are as follows:

- To inform the public about the proposed changes to both intermediate care beds and stroke rehabilitation beds and outpatient, day, ambulatory services located at St Peter's Hospital in Maldon.

- To provide staff, stakeholders, and the community with an opportunity to express their views, concerns, and suggestions regarding the proposed changes.

- To ensure compliance with all relevant legislation. These include the duties on NHS bodies to make arrangements to involve the public and are all set out in the National Health Services Act 2006, as amended by the Health and Care Act 2022:

  - section 13Q for NHS England
  - section 14Z45 for integrated care boards
  - section 242(1B) for NHS trusts and NHS foundation trusts.

- To demonstrate adherence to the five tests of the NHS England assurance process: clinical evidence, patient and public engagement, support from clinical commissioners, affordability, and bed numbers.

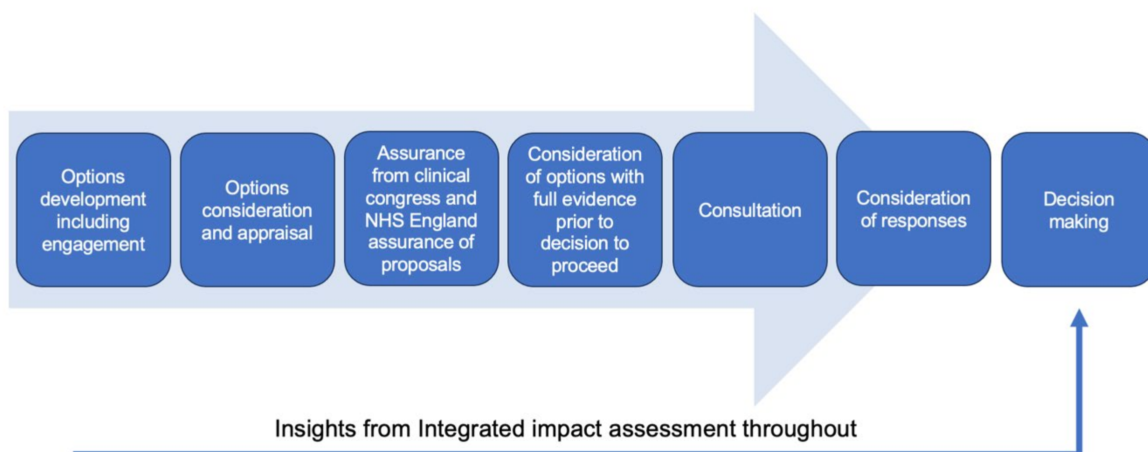


Figure 31, Process steps for consultation

15.5. Stakeholder Engagement

- Identify and engage key stakeholders, including patients, local residents, healthcare professionals, local authorities, Healthwatch, and community groups.

- Establish a consultation steering group consisting of representatives from various stakeholders to guide the process.

15.6. Communication Strategy

- Develop a comprehensive communication plan to ensure all relevant information is accessible to the public.
- Utilise a variety of communication channels, including local newspapers, websites, social media, public meetings, video content and information sessions.

15.7. Public Meetings and Events

- Organise public meetings in accessible locations and or online to present the proposals and answer questions.
- Host information sessions to provide in-depth information on the proposed changes and potential hospital closure.

15.8. Consultation Materials

- Create clear and concise consultation materials, including leaflets, brochures, audio/video and online resources.
- Translate materials into easy read and multiple languages where required to ensure inclusivity.

15.9. Feedback Mechanisms

- Establish multiple feedback mechanisms, such as online surveys, written submissions, and dedicated consultation email address.
- Encourage stakeholders to provide feedback through various platforms, making it convenient for them to participate.

15.10. Analysis and Reporting

- Thoroughly analyse all feedback received during the consultation period.
- Compile a report summarising the feedback and outlining any adjustments to the proposals based on stakeholder input.

15.11. Decision Making

- Consultation findings will inform the decision-making process.
- Decision-makers will consider the tests of the NHS England assurance process to reach a final decision.

15.12. Timeline

- Establish a clear timeline for the consultation process, including key milestones and deadlines.
- Ensure transparency by regularly updating stakeholders and the public on progress.

15.13. Evaluation

- After the consultation, evaluate the process to identify areas of improvement for future consultations.
- Share the results of the consultation, including any decisions made, with the public and with staff working in affected services.

15.14. Legal Compliance

Continuously review and ensure compliance with all relevant legislation as noted above and including the ‘triple aim’ duty in the Health and Care Act 2022 (sections 13NA, 14Z43, 26A and 63A respectively). This requires NHS bodies to have regard to ‘all likely effects’ of their decisions in relation to three areas:

- health and wellbeing for people, including its effects in relation to inequalities.
- quality of health services for all individuals, including the effects of inequalities in relation to the benefits that people can obtain from those services.
- the sustainable use of NHS resources.

15.14.1. The public consultation plan can be found at Appendix 8 will undergo further review and refinement before and during implementation, with input from relevant stakeholders and legal experts.

15.14.2. The accountable body for the consultation is NHS Mid and South Essex ICB. The services impacted by the proposals are provided by Mid and South Essex NHS Foundation Trust, Essex Partnership University NHS Foundation Trust and Provide. The consultation plan will be informed by a consultation reference group. This will include patient representatives, voluntary sector organisations, clinicians and our three Healthwatch organisations to guide the process.

15.15. Consultation approach

15.15.1. Subject to relevant approvals the consultation would commence on 25 January 2024 and will run for eight weeks. During this time there will be a number of ways for people to get involved including:

Survey

A survey about the proposals will be available on our involvement website - The survey is in four sections, so people can share views about the services that matter most to them.

Face-to-face discussion sessions

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

- Burnham
- Thurrock
- Southend
- Chelmsford
- Basildon

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

Online discussion sessions

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

- Stroke rehabilitation
- Intermediate care beds
- Midwife-led birth hub
- Outpatient services
- General session about the proposals as a whole

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

Consultation Hearing

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

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

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

There will be one Consultation Hearing event held in Maldon town.

Voluntary and Community Sector Organisation (VCSO)-led discussions

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

As mentioned previously, we will be proportionate in our efforts. We will ensure that our consultation is proportionate by:

- reaching out across mid and south Essex's geography, demography, and diversity
- seeking fair representation across patients, carers and the public, support groups and organisations

15.16. Outline consultation plan

Phase	Timing
Phase 1 – Consultation preparation • Pre-consultation engagement • Independent analysis report • Draft consultation plan	**Nov to Dec**
Phase 2 – Immediate Pre-Consultation Activities • Board approval for consultation launch – • Liaison with X3 HOSCs and HWBBs • Draft Stakeholder briefing • Prepare for discussions sessions and speakers/subject experts. • Prepare press and media updates. • Briefing and preparation with key spokespeople	January onwards
Phase 3 – Consultation • Publish consultation materials via website and distribution. • Formal launch and media programme • Ongoing stakeholder briefings and updates • Individual stakeholder discussions and meetings • Programme of workshops • Sessions with targeted groups • Feedback via survey, letters, notes from meetings and workshops	End of January TBC subject to relevant approvals

Phase 4 – Consultation outcome and decisions 1. Feedback collated and prepared for analysis. 2. Independent analysis and outcome report 3. Outcome report for consideration 4. Engagement and discussions with stakeholders 5. Decision-making process and post-consultation business case	April onwards

Figure 32, Outline of Comms Communication Plan.

15.17. Main production and management elements

Production materials
The consultation document is the anchor and centrepiece and will be available online, with video/audio explainers and in printed form.

Hard copies of the consultation document will be available from the libraries and is being supported by partners in Southend, Thurrock, and Essex.

We will make arrangements to provide different formats on request e.g., audio version, large-print, language versions, and easy-read for people with learning disabilities.

Supporting materials include:

- A short summary of the consultation
- Covering letters for different audiences
- Feedback survey
- Stakeholder briefing note
- Press notice
- Presentation slides for different audiences
- Speaker support materials – core narratives, lines to take, FAQs

15.18. Digital support and social networking

15.18.1. **Use of the websites**

Use of websites for the consultation will help to ensure accuracy of information and access to all available information e.g., background clinical evidence, links to other relevant information, more detailed documents.

15.18.2. **Feedback survey**

An online survey style feedback questionnaire will ensure an efficient collection of views and also offers analytics for monitoring and analysis.

15.18.3. **Social media**

Social networking is important as a channel for access to information and a means for feedback.

15.18.4. **Eventbrite or other meetings planner**

Eventbrite will support the management and promotion of events, including email distribution, booking system and analytics.

15.18.5. Handling communications and feedback

15.18.6. Press and media

The consultation period requires a detailed press and media plan with a series of releases at intervals over the period. We have established close relationships with key outlets and will ensure they are well-informed on most of the issues, ensuring accessibility to key clinical spokespeople.

15.18.7. FOIs and enquiries

There are likely to be increased workload for responses to questions that may come via the FOI route or just via email and post. This will require continual management and structured processes to ensure timely responses, often involving contributions from subject matter experts and senior management sign-off.

15.18.8. Horizon scanning and issue management

Controversy can escalate at any time, with a high risk of misinformation. The consultation programme requires a robust system of horizon scanning and alerts, with ability to take proactive and speedy action to avoid problems.

15.18.9. Relationship management and reporting

The consultation programme will need to respond to the needs of different audiences, anticipating where possible what these may be. This includes relationships within both internal and external audiences.
This requires continual management and liaison with subject matter experts, senior management, and organisational partners.

15.18.10. Management of feedback

There will be robust systems for receiving, acknowledging, and recording feedback, and responding where necessary, sometimes involving contributions from subject matter experts and senior management sign-off.

Feedback will be in multiple forms – online survey, written feedback, notes from meetings and file notes of conversations.

Feedback records will need to be organised in a way that enables effective summary and analysis to be compiled in a final feedback report with recommendations for decision-making.

15.18.11. Risks and mitigations

Risk	Impact of risk	Mitigating action
Lack of engagement from target audiences	targets not met, impacting overall programme and ability to deliver required outcomes	Regular, appropriate, and easily understood communications, driving awareness and understanding and makes links to other workstreams so not viewed as “another thing” Also engagement through local VCFSE partners to support engagement.
Lack of consistency in messaging. Potential for messaging to be too complex.	Confusion and misunderstanding among audiences, loss of reputation and credibility	Following central messaging and embedding this in local comms. Sharing this with partners for use in their own comms. Ensuring use of language is consistent and straightforward
Message fatigue	People start to ‘switch off’	Refresh comms content and creative in line with phases of the programme
Message overload	Confusion, ‘too much to take in’, start to ‘switch off’ or the opposite	Timed and considered comms that are relevant to that stage in the campaign
Poor channel selection	Low levels of engagement and understanding	Ensure channel(s) are relevant to the audience e.g., not everyone is online

Lack of credibility in the content	Low levels of engagement, people become suspicious	Remain consistent with messaging/content, use local/peer spokespeople to build confidence
Comms are not seen as relevant to the audience e.g., general public	Little notice is taken if people fail to see how this affects them	Case studies / examples using ‘real people’

Figure 33, Risk and Mitigation Plan.

16. Governance

16.1. Pre-Consultation Business Case

16.1.1. To plan and effect the temporary changes to community beds as part of the planning for winter 2023/24, the system through its Chief Executive Forum established the Community Capacity Task Force (CCTF).

16.1.2. The CCTF in turn developed more specialised sub-groups to advise on the plan and to detail implementation of the changes, which took place in October 2023. These were:

- Clinical
- Communications and Engagement
- Workforce
- Maternity Services
- Finance
- Strategy & Analytics
- Estates
- Outpatients
- Operations.

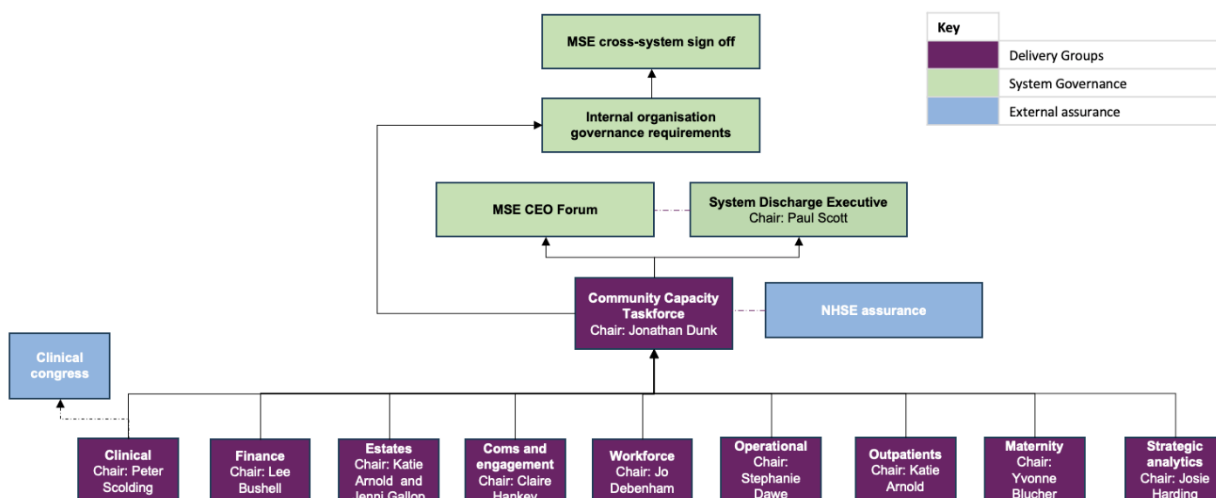


Figure 34, Governance Hierarchy.

16.1.2.1. Information generated by these sub-groups was used beyond the temporary changes to assist with the development of this PCBC. Care was taken to ensure that proposals were clinically validated through the clinical sub-group and by the Ageing Well and Stroke Stewardship groups. Account was taken of the views expressed previously by the East of England Clinical Senate and the MSE Clinical Congress has reviewed the PCBC at an advanced stage in its development. Within the system of health and care, reports from the CCTF have been considered by the System Overview and Assurance Committee (SOAC) which has widely drawn membership. The CCTF has also taken issues arising to the Chief Executive's Forum. Since the CCTF had knowledge and understanding of the NHS community beds and the options for their future, it was also given responsibility for developing this PCBC.

16.1.3. The decision to effect the temporary changes for the winter 2023 was supported by all organisations comprising the system of health and care – the Integrated Care Board (ICB), Essex Partnership University Trust, Provide CIC, North East London Foundation Trust and Mid and South Essex Foundation Trust.

16.1.4. It is also these bodies which will decide whether to agree the PCBC and enter a programme of formal public consultation. The Integrated Care Board is the body required to undertake the engagement and consultation processes.

16.2. Decision Making Business Case

The DMBC will, in part, be dependent upon the response to consultation and comments received during the consultation process. Analysis of the comments and information produced will help to shape the document and any resultant decisions. Again, decisions will be made by the constituent bodies of the system of health and care as described above, with the process of publication and consultation being managed by the ICB.

16.3. National Health Service England Assurance

16.3.1. Business cases involving changes to the provision of NHS services are subject to a process of rigorous assurance either by the NHSE Region concerned, or if the business case requires a substantial investment by the national NHSE. In this instance assurance will be undertaken by NHSE East of England. An initial Strategic Sense Check occurred in September 2023 which enabled MSE to be advised of the NHSE requirements and expectations of the PCBC.

16.3.2. At the point that the PCBC is substantially complete the NHSE will establish a Stage 2 Panel comprising the expertise to examine the business case against the Five Tests as well as the deliverability, affordability and value for money.

16.4. Public consultation and beyond

16.4.1. If the decision to move to public consultation is supported by the ICB and NHS England, the CCTF will evolve into the Community Capacity Programme Board,

with the same sub-groups reporting into it. The Programme Board will be led by Emily Hough, Executive Director of Strategy and Corporate Services in the ICB, who will oversee the public consultation on behalf of the system. The Programme Board will report into the ICB Executive, the MSE Chief Executives Forum and the ICB Board and the Boards of its constituent organisations.

16.4.2. The Community Capacity Programme Board will also oversee the development of the Decision Making Business Case (DMBC), ensuring that it takes account of all the ICB's legal duties, including those relating to addressing health inequalities, climate change and emergency preparedness, resilience and response (EPRR). The DMBC is expected to be developed for consideration in Q2 2024/45.

17. Next Steps

17.1. In deciding whether to approve this PCBC, the constituent NHS organisations and Community Interest Company that make up the MSE Integrated Care System will take into account the views of stakeholders expressed during a period of initial engagement in 2022 as well as the more immediate period of engagement in November and December of 2023.

17.2. Approval of the PCBC would lead to a period of public consultation before any changes could be agreed, which would require specific actions to take place:

- Agreement to the revised governance of the programme for this next phase.
- It is also suggested that the temporary configuration of beds instituted for the winter of 2023/24 is agreed to be kept in place pending the outcome of consultation and any subsequent decisions.
- Approval of the plan for consultation which is proposed to start on 25 January 2024 and run for eight weeks until 21st March 2024.
- Approval of the proposed consultation document and supporting materials.
- Following consultation, the results will be analysed and reported, and a DMBC prepared. The DMBC will take account of the analysis from the consultation, as well as ensuring that any recommendations take account of the ICB's duties. This is expected to be presented to the ICB Board in Q2 2024/25. The NHSE might choose to assure the DMBC, and time should be allowed in the programme for this activity.
- Subject to the outcome of the DMBC, further implementation planning to support delivery of any agreed recommendations would take place. Significant works to implement and agreed actions would therefore be unlikely to commence before October 2024.
- All future work will take account of any regulatory updates relating to service change.