Annex 10b

Written Evidence for consideration by Save Maldon's Medical Service Group

Submitted by Email: 19/3/24

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Guide

Points from author are in bullet form with evidence in hyperlinks and excerpts for your perusal and consideration

Stroke, Rehabilitation and Intermediate care

Evidence 1

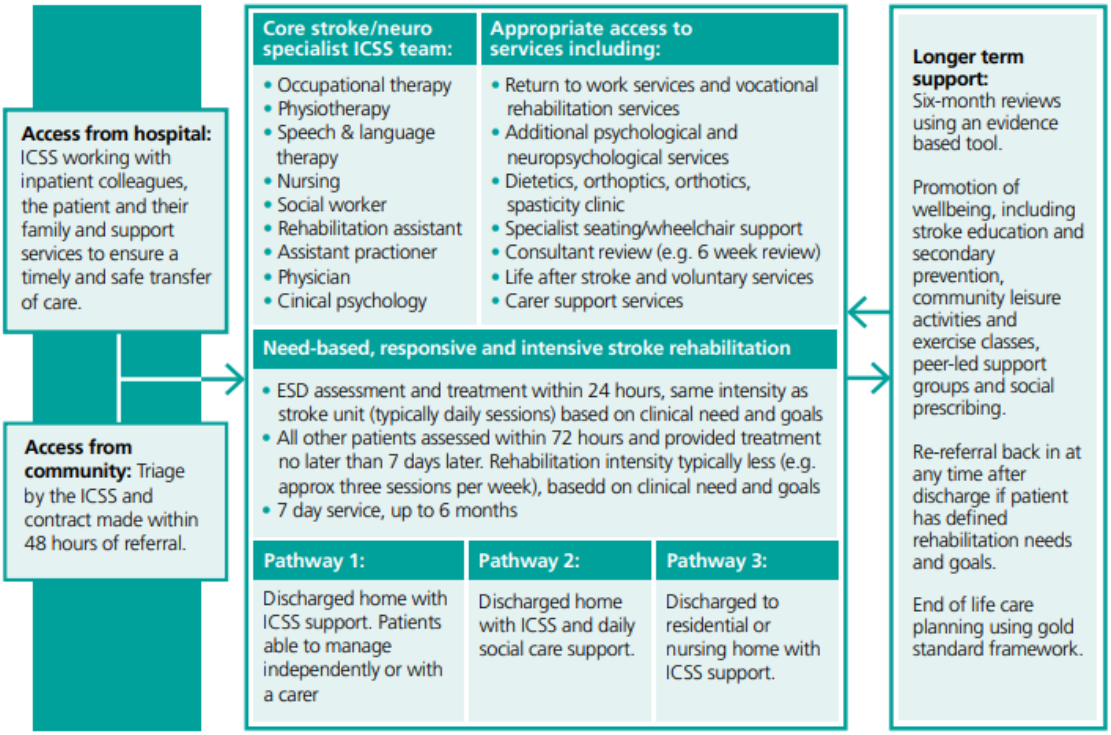
National service model for an integrated community stroke service February 2022

Needs-based stroke rehabilitation Evidence-based stroke rehabilitation, support and any appropriate management plans should be provided to address patient needs (Box 1 provides an overview as recommended in the National Clinical Guideline for Stroke). Rehabilitation should be provided either directly by the ICSS or **by seamless access to services** or onward referral where required. Therapy should be **provided up to six months** by the ICSS with the option for re-referral after discharge if rehabilitation needs and goals are defined, and with access to support services on discharge.

- Access to this for 6 months- is this logistically possible, financially possible to those I areas of deprivation, is it morally right that those after such a traumatic event travel such long distances on public transport, some up to 3 hours each way?

Patients with stroke who have mild-to-moderate disability and who have been identified as eligible for ESD should be offered assessment and treatment within 24 hours. Stroke rehabilitation should be offered at the same rehabilitation intensity as stroke unit care (typically daily sessions 9) 3,9

- Again 9 days of travel on public transport. Some areas do not have transport connections that last until the end of a typical working day.
- This diagram from the document is especially important. It shows all the services running under 1 roof at St Peters. The staff are already there. Until the community beds were removed residents could access this ICSS service already. Staff living here worked within this system already. Patients in the remote parts of the Dengie could book the Dart bus and be collected from their doorstep and dropped directly to the hospital and dropped back home. The same for outlying villages such as Wickham Bishops. This will not be the case now the beds have been moved to Roch ford and Brentwood.



https://www.england.nhs.uk/publication/national-service-model-for-an-integrated-community-stroke-service/

Evidence 2

- We have had many people contact us and comment on our group page on Facebook. We have also held events in the High Street, around the Dengie Peninsula and at local supermarkets to raise awareness of the MSE ICB survey and distribute paper surveys to those who have no access to a smart phone or computer. At these events we have been told heart breaking personal stories of spouses separated from their loved ones for many months whilst they have been in the stroke wards in South Essex. This is because they cannot drive, they are disabled themselves and cannot use public transport to get there. One lady and her husband married some 70 years had not been parted a day in their lives until this occurred. We have shared some of these stories on our PowerPoint. We have names for those who shared on Facebook. They are easily found across the many Community groups of the Dengie Peninsula and villages of the Maldon District too on our posts.

https://www.facebook.com/groups/savemaldonsmedicalservices/

Evidence 3 Broken heart syndrome

- Given the first-person evidence 2 we are asking you to consider the long-term impact of separating loved ones. It is a real phenomenon Broken heart

syndrome. I am a former head of Cardiac Department and echocardiographer so have seen cases myself. I have seen many instances where couples die within days of one another. My own Aunt and Uncle did after 70 years together. I present evidence 3

Takotsubo Cardiomyopathy - Broken Heart Syndrome - BHF

What is takotsubo cardiomyopathy?

Takotsubo cardiomyopathy causes your heart's main pumping chamber (the left ventricle) to change shape and get larger. This weakens the heart muscle and means it doesn't pump blood as well as it should.

It's usually triggered by extreme emotional or physical stress.

For some people, being emotionally or physically distressed can trigger takotsubo. This is why it's sometimes called broken heart syndrome. Our research is beginning to understand why some people's bodies react to stress this way.

Some examples of stressful triggers may include: bereavement and grief

Why elderly couples often die together: the science of broken hearts | Death and dying | The Guardian

But it turns out there is some actual science behind the phenomenon. There is a thing called broken heart syndrome, believed to occur when someone loses a close partner or spouse. Death of a spouse is recognised as one of the most stressful things that can happen to a person. But as well as the mental anguish and grief (which are themselves very debilitating and not to be dismissed), many forget that stress also has a physical component. Stress can cause numerous physical ailments, and if the stress is sudden and serious enough, such as if a spouse dies, then these ailments can be very serious, affecting the heart.

- With couples who are suddenly parted for an unknown period of time this can have the same effect. A wife or husband with their own co-morbidities is as vulnerable at home when their loved one is taken ill. To be then taken to the other side of the county out of reach is even more challenging, heart breaking and a massive cause of stress. As I have already mentioned the current transport systems such as the Dengie Dart, buses, taxi firms and community buses are already in place to ensure the vulnerable and elderly can reach St Peters. This cannot be replicated so far afield. This has already led to countless couples and indeed parents who have adult children who are vulnerable living with them still separated from them. This cannot be overlooked. We are a rural area of Essex, unlike South Essex. 21% rural, well over the national average with pockets of deprivation. Even more so with the Cost-of-Living crisis.

Maternity

Evidence 1

https://publications.parliament.uk/pa/cm5803/cmselect/cmhealth/115/report.html#heading-1

Recruitment locally, and services locally, need to reflect the population. For that, you have to be able to attract people appropriately into the profession. Midwives say, "They need people to look like them." That is so important … We are all committed to that.[61]

Evidence 2

https://www.nice.org.uk/guidance/ng235/chapter/Recommendations#service-organisation

1.2 Service organisation

1.2.1Commissioners and providers, including networks of providers, should ensure that all 4 birth settings (home, freestanding midwifery unit, alongside midwifery unit and obstetric unit) are available to all women (in the local area or in a neighbouring area). **[2014, amended 2023]**

1.2.2Ensure that all women giving birth have timely access to an obstetric unit if they need transfer of care for medical reasons or because they request regional analgesia. Audit and publish transfer times and reasons for delay in transfers so women can be informed of local service availability. **[2014, amended 2023]**

1.2.3Commissioners and providers, including networks of providers, should ensure that there are:

- robust protocols in place for transfer of care between settings (see also section 1.5)
- clear local pathways for the continued care of women who are transferred from one setting to another, including:
  - when crossing provider boundaries
  - if the nearest obstetric or neonatal unit is closed to admissions or the local midwifery-led unit is full. **[2014]**

Evidence 3

Maternity Transformation (rcm.org.uk)

- Developing the idea of Maternal Medicine Networks, which enable women to access the specialist care they need in pregnancy in the right places and as close to home as possible

- ## How is the RCM involved?

- The RCM is an active and vigorous campaigner for improvements to the pay and conditions of its members securing 3,000 more student midwives, supported by our reports on the State of Maternity Services. We have been key to shaping the workforce strategy in which the government acknowledges England needs more midwives to carry out the transformation programme. We have published guidance on apprenticeships and as long term advocates and supporters of MSWs, are leading the MSW career and competency framework and developing a midwifery career framework.
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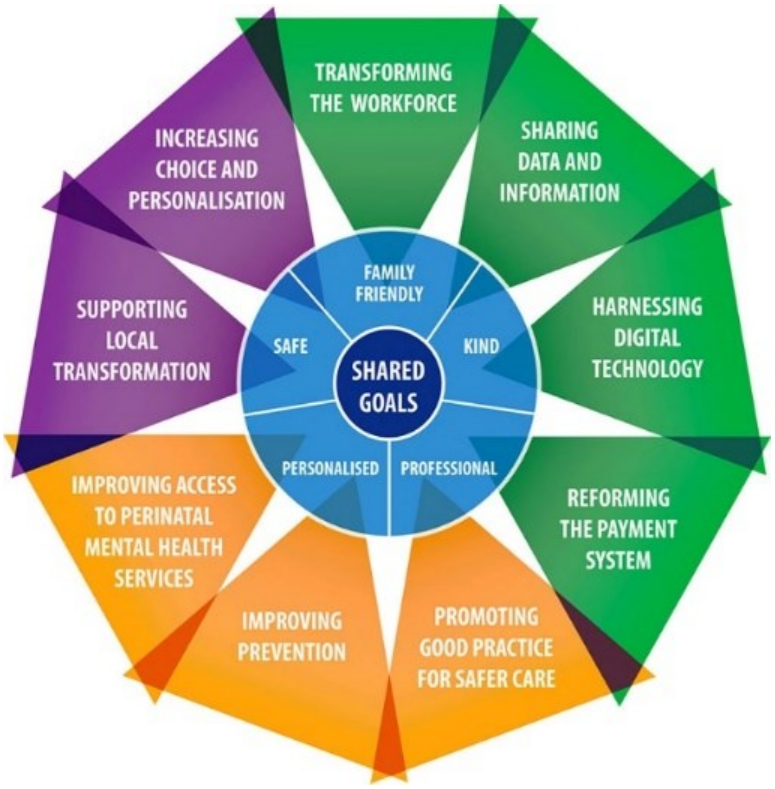


Evidence 4

Choosing maternity care - Care Quality Commission (cqc.org.uk)

Wherever you choose to give birth your experience should be a positive one. You can give birth at home, in a unit run by midwives (a midwifery unit or birth centre) or in hospital. Some hospitals have a labour ward run by doctors who work with midwives and also a separate midwifery unit. The choice you have about where to have your baby will depend on your needs and, to some extent, on where you live. Maternity staff should take account of your needs and wishes throughout your pregnancy, birth, and in the days after your baby is born.

When we inspect maternity services, we ask these five key questions:

- Is this service safe?
- Is this service effective?
- Is this service caring?
- Is this service responsive to people's needs?
- Is this service well-led?

Please consider the Duties of the ICB, The NHS Constitution when evaluating our evidence for Maternity.

- Maternity and Stroke/Rehabilitation have been closed due to safety concerns. We refute this position and hold MSE ICB accountable for allowing parts of the hospital to become unfit due to their lack of investment and more importantly compliance to annual Health and Safety maintenance. The safety concerns, due to the lack of annual maintenance to site, have now led to the breaches to health and Safety. This is reckless and gambles with people's lives. The work undertaken on site have only served to preserve its sale value such as reinforcing floors of wards they have closed and replacing the roof. Tarting up the asset to sell.

We have seen the grid below in the pre consultation business plan and ask the following

- What steps have you taken under the Health and Safety at work act to remedy the Fire risk assessment as the site is still active with staff and patients on site
- What steps have you taken under the Health and Safety at work act to remedy the Water safety as the site is still active with staff and patients on site

- What steps have you taken under the Health and Safety at work act to remedy the Security assessment as the site is still active with staff and patients on site
- What steps have you taken under the Health and Safety at work act to remedy the relevant maintenance as the site is still active with staff and patients on site and if not why not as these may present a potential risk to human life. I cite the recent fall of the ceiling at Princess Alexandra Hospital (https://www.bbc.co.uk/news/articles/cpw0j72723zo)
- Under HSE storage of flammable gases will have been a requirement for 40+ years. Why would this be only an issue now at St Peters? Presumably this also will have been dealt with as it could cause an explosion?
- All these points will be sent to the HSE. This then is an accountable reference for the CEO to answer to, although as risk assessments are an annual requirement by law, I remain baffled they should have occurred solely in just one Community site at all.

	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*

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

Outpatient Services (Ambulatory Care) and why Community Hospitals are important

- Currently St Peter's in a single site. It has capacity for growth and can expand to take on extra consultant clinics, new diagnostics and has land to build. In terms of outpatient services, it offers the benefit of being able to travel to the one site and have a range of diagnostics and Outpatient appointment in one day. It is on a bus route. It has free parking and plenty of disabled spaces in the front and back of the building. IT has ramps into the hospital and around the building to enable access throughout the site. It has disabled toilets and all the doors are wide to enable access to couches for scans or X-rays.
- Many people come to the hospital together with a spouse or relative for appointments. For example, a husband is at the eye clinic and the wife has a blood test and an X-ray. It is all on one site. Having Outpatient services and diagnostics in one place provides another site for Surgical Pre-Admission away from the Acute Trust. One staff member can travel from the Acute trust and this saves many hundreds of people travelling long distances over a year. This reduces the Carbon Footprint. It also enables those (now with cost of living) to travel using the Dart service on the Dengie from their front door to the Hospital and back.

Evidence 1

By way of first-person evidence, I present myself Michelle Olley. I am a retired NHS diagnostic service manager. I joined then ESSEX RIVERS HEALTHCARE TRUST now ESSEX and SUFFOLK HEALTHCARE NHS FOUNDATION TRUST

When I started there on 19th January 1999 I arrived to a cardiac department of 1 outpatient room. Having come from Broomfield Hospital where I trained. I set up the department they have today at Colchester, retiring in 2013.

My evidence is thus:

In creating my department, I attracted the appointment of the first Cardiologist Dr Kare Tang. I had already established diagnostics and pacemaker clinics at all Community Hospitals belonging to the trust. This enabled our new Cardiologist to immediately set up outlying Outpatient clinics alongside my diagnostic clinics and have same day diagnostics. This grew over the years and by the time I retired there were 6 Cardiologists running the same clinics in Community hospitals. My ethos and theirs was that the patients in rural Tendring- like the Dengie were older than the usual UK demographic and would have to travel further to the acute trust. Clacton has community stroke, Maternity and Rehabilitation wards just like St Peters. It ran a minor injury too, which makes complete sense. Parking at the acute trust is difficult, so sending 3 staff- a Cardiac Physiologist, Cardiographer and Consultant (possible another doctor if the clinic expanded) meant 30 to 50 patients would not park at the acute trust. It frees up clinic space at the acute trust and doubled capacity for diagnostics. I had the lowest waiting times consistently for my whole tenure.

Now my successor- my deputy- has established a replica department at Clacton running 7 days a week providing diagnostics for Cardiology and Respiratory services. This is mirrored in Ultrasound, MRI and X-ray.

My point here is everything is under one roof. IT is on a site owned by the trust. It does not only serve Clacton and Tendring. It is another diagnostic outlet for the trust. I myself have been offered it as an option for echocardiogram as a resident of Tiptree. It offers greater patient choice. But more importantly for those residents who cannot travel it keeps services local.

https://www.clactonandfrintongazette.co.uk/news/22311710.clacton-hospitals-new-diagnostic-centre-get-14-2m-boost/

https://www.neecommunity.org.uk/our-services/services-for-adults/integrated-community-cardiology-service/one-stop-assessment-and-diagnostic-clinic/

https://www.esneft.nhs.uk/drive-through-services-launched-for-heart-patients/

Evidence 2

- We would like you to consider why Community hospitals still are required. What is a Community Hospital? The second example comes from East Anglia. It is another rural area. Like ourselves it demonstrates the need to preserve community beds. Not only for the excellent care given by staff who live locally but because patients can be visited by loved ones.

http://communityhospitals.org.uk/what-are-community-hospitals.html

Community Hospitals are small local hospitals that provide a range of services to their local community. These can include community beds, maternity, clinics, minor injuries units, X ray departments and much more.

Community Hospitals have been part of our health care system for over 150 years and offer a strong tradition of care that local populations have known over generations. There are over 500 community hospitals throughout the UK.

Originally established as converted cottages offering inpatient beds, they have developed into hubs of services that have developed to meet changing needs. These services range from health promotion, diagnostics, treatments, rehabilitation and end of life care. The community hospital plays a particular role in intermediate care, and is a focus for integration for many staff and services in both health and social care.

Community hospitals vary considerably, as they have adapted to the needs of their local populations. They are typically highly valued by local people, and this support is shown through actions such as volunteering, fundraising, promoting and campaigning.

Swaffham Community Hospital, Norfolk

Swaffham Community Hospital was built to commemorate Queen Victoria's golden jubilee in 1887 and opened the following year. It now offers an 18-bed general rehabilitation ward, as well as clinics such as diabetes, anticoagulation, X-Ray, continence, speech therapy, podiatry, dermatology, physiotherapy, contraceptive and sexual health services. The hospital serves a population or around 148,000 people across west Norfolk. The community hospital is supported by an active League of Friends, who provide volunteers, and also fund equipment and improvements to the building.

Swanage hospital was built in 1894. The hospital has 15 in-patient beds, a Minor Injuries Unit, X-ray and ultrasound, day surgery, endoscopy services and physiotherapy. Clinics are offered from consultants from three acute hospitals. Support for the community is shown through the provision of a meals-on-wheels service, school meals service, and assistance given to community groups. The hospital is accredited for its end-of-life care and its surgery. The hospital is very well supported by a very committed Friends of Swanage Hospital. The Friends benefit from donations and legacies, and in 2017 spent £185k on equipment, building work and staff training.

"Swaffham is a perfect example of how you can provide excellent, high-quality care to people closer to where they live, helping to keep them out of busy and stretched acute hospitals. Not only is that good for the patient, but is also good for the NHS."
Michael Scott, CEO Norfolk Community Health and Care NHS Trust

Evidence 2

https://www.ncbi.nlm.nih.gov/books/NBK436702/

Community hospitals and their services in the NHS: identifying transferable learning from international developments – scoping review, systematic review, country reports and case studies

Headline

Community hospitals can provide a wide range of potentially integrative services, suggesting that a more strategic role for community hospitals in England may be timely

Results:

The evidence reviews found that community hospitals provide a diverse range of services, spanning primary, secondary and long-term care in geographical and health system contexts. They can offer an effective and efficient alternative to acute hospitals. Patient experience was frequently reported to be better at community hospitals, and the cost-effectiveness of some models was found to be similar to that of general hospitals, although evidence was limited. Evidence from other countries showed that community hospitals provide a wide spectrum of health services that lie on a continuum between serving a 'geographic purpose' and having a specific population focus, mainly older people. Structures continue to evolve as countries embark on major reforms to integrate health and social care. Case studies highlighted that it is important to consider local and national contexts when looking at

how to transfer models across settings, how to overcome barriers to integration beyond location and how the community should be best represented.

Conclusions:

At a time when emphasis is being placed on integrated and community-based care, community hospitals have the potential to assume a more strategic role in health-care delivery locally, providing care closer to people's homes. There is a need for more research into the effectiveness and cost-effectiveness of community hospitals, the role of the community and optimal staff profile(s)

Evidence 3

Outpatients - The future - Report

https://r.search.yahoo.com/_ylt=Awr.gm5sr_hlQzAArBZ3Bwx.;_ylu=Y29sbwMEcG9zAzQEdnRpZAMEc2VjA3Ny/RV=2/RE=1710825453/RO=10/RU=https%3a%2f%2fwww.rcplondon.ac.uk%2ffile%2f11479%2fdownload/RK=2/RS=Lm_zGEeTqErnpgFPXdFHcArwweY-

1.Demand for an outpatient service should be met by the available capacity. Capacity should take into consideration fluctuations in demand and staff availability throughout the year.

2 Interventions to reduce new patient demand should be targeted at all referral sources. They must not deter necessary referrals or damage professional working relationships.

3 Generic referrals should be pooled to minimise waiting times for appointments. Local consultants should review an agreed mix of generic and sub-specialty referrals according to demand.

4 All outpatient care pathways should aim to minimise disruption to patients' and carers' lives.

5 Clinic templates should allow for timing flexibility depending on case complexity and the needs of the patient. They should allow a realistic timeframe to conclude business and avoid frequent unsatisfactory visits.

6 Patients should be directly involved in selecting a date and time for an appointment. That can happen either in person, via telephone or electronically.

7 All clinical information should be available to both the clinician and patient prior to consultation. That includes notes, test results and decision aids.

8 Patients should be fully informed of what to expect from the service prior to appointments. That includes the aim of the appointment and expected waiting times.

9 Alternatives to face-to-face consultations should be made available to patients and included in reporting of clinical activity.

10 Patients should be supported and encouraged to be co-owners of their health and care decisions with self-management and shared decision-making.

11 Patients and community staff should be able to communicate with secondary care providers in a variety of ways, and know how long a response will take. This aids self-management, and provides a point of contact for clarification or advice regarding minor ailments.

12 Access to follow-up appointments should be flexible. Patient-initiated appointments should be offered, replacing the need for routine 'check in' appointments.

13 All care pathways should optimise their staff skill mix. Allied medical professionals and specialist nurses should be an integral part of service design.

14 Letters summarising a clinical encounter should be primarily addressed to the patient, with the community healthcare team receiving a copy.

15 All outpatient services should offer a supportive environment for training.

16 All outpatient-related services should promote wellbeing for staff and patients.

UK outpatient activity Outpatient appointments across the UK account for almost 85% of all hospital-based activity (excluding A&E). Demand for outpatient appointments continues to rise at a rate faster than the growth of the UK population.1 Outpatient appointments in England alone have almost doubled in the past decade, now reaching over 118 million per year.

20% of pensioners who attended an outpatient appointment reported feeling worse afterwards because of the stress involved in the journey alone.

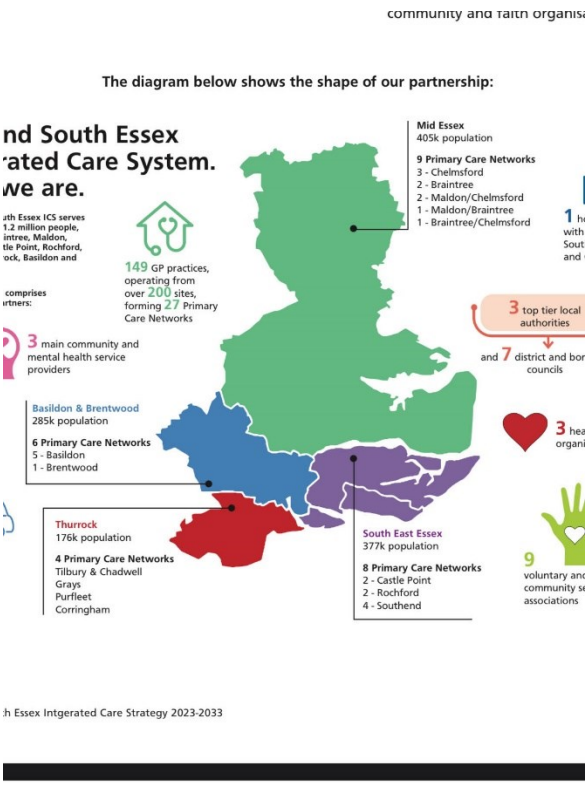
Care delivery should be personalised to the needs of the patient, and recognise the costs incurred by the patient, such as missed work, childcare, parking charges and travel time. These costs increase when appointments don't run to time, are unnecessary or require multiple attendances. These encounters offer low value if they don't progress care in a timely manner. Different styles of clinic that offer diagnostics and management consultations in one attendance offer improved efficiency from both the patient and provider perspective. These clinics may be designed around a symptom, e.g. breathlessness clinics, and include input from multiple specialties, or around a common condition, e.g. asthma clinics with lung function testing. Reducing the number of steps in a patient journey can minimise delays in care and improve patient experience by minimising disruption to their lives.9

All care pathways should optimise their staff skill mix. Allied medical professionals and specialist nurses should be an integral part of service design.

Voluntary and community sector programmes Community programmes and voluntary groups that promote healthy behaviours and improve health outcomes should be supported and utilised by secondary care teams. Programmes such as specialist singing groups for lung health can improve quality of life, remove social isolation, improve respiratory function and reduce healthcare utilisation, e.g. admission, acting as a form of pulmonary rehabilitation.27,28

- There are all these one-stop diagnostics and more available at St Peters and plenty more room to expand to create a local site to establish services to support the acute trust in the future. It also has many alternative therapies running onsite, keep fit classes etc. This is evermore important with Long Covid and other long-term conditions which benefit from community groups to run extracurricular activities to improve the health and mental wellbeing. The loss of this base in the district will have a catastrophic effect on many hundreds of regular visitors to those classes alone.

Transport- and the effects this has on access to services.



https://www.midandsouthessex.ics.nhs.uk/your-area/

Consider this with a mind for the ICB's duties for:

- Have regard to legislation on climate change (14Z44).
- Promote integration of health services where the ICB considers this would improve the quality of services and outcomes and reduce inequalities of access and outcomes for individuals. Promote the integration of health services with health-related services (those that may have an effect on the health of individuals but are not health or social care services such as housing accommodation) or social care services where this would improve quality and outcomes and reduce inequalities of access and outcomes for individuals (14Z42).
- Reduce inequalities between patients in relation to access to services and outcomes; promote the integration of health services where this would improve quality; and reduce inequalities of access and outcomes for individuals (14Z35).

assets for local people.

1.2 Maldon District

Maldon is one of the most sparsely populated districts in Essex and is one of only two in the county to be categorised as more than 80% rural by Defra. The district has 75 miles of coastline, much of it of international importance to nature conservation, which helps to attract 3 million visitors each year. It has 3,745 businesses including a growing range of local food producers, but its rural nature also ensures it has the highest travel time to key services, including GPs, hospitals, schools, and food stores, of any district in Essex, lower than average skill levels and a shortage of affordable housing. 25% of the population are aged 65 or over.

https://www.maldon.gov.uk/download/downloads/id/19542/applicant_guidance.pdf

Produced by SMMS. Distanced verified by Google maps and also by Public transport systems: Traveline

Travel distances from various Maldon District places to intended new facilities in Braintree/ Brentwood/ Rochford/ Halstead				
		Driving times	Public transport (train or bus)	
Burnham-on-Crouch to	Maldon	24 mins	1 hr 1 min	
	Braintree	51 mins	2 hrs 2 min	Including a 13-minute walk from Braintree bus station
	Brentwood	47 mins	1 hr 1 min	Including a 20-minute walk from Brentwood Station
	Halstead	59 mins	3 hrs 26 mins	Including a 7-minute walk from Halstead bus route
	Rochford	45 mins	50 mins	Including a 7-minute walk
Tillingham to	Maldon	24 mins	1 hr 23 mins	
	Braintree	53 mins	3 hrs 38 mins	Including 2 lengthily walks
	Brentwood	51 mins	2 hrs	Including a 20-minute walk from Brentwood Station
	Halstead	1 hr 1 min	3 hrs 31 mins	Including a 7-minute walk from Halstead bus route
	Rochford	50 mins	2 hrs 27 mins	Including a
Southminster to	Maldon	20 mins	34 mins	
	Braintree	49 mins	2 hrs 49 mins	Including a 13-minute walk from Braintree bus station
	Brentwood	46 mins	1 hr 8 mins	Including a 20-minute walk from Brentwood Station
	Halstead	56 mins	2 hrs 57 mins	Including a 7-minute walk from Halstead bus route
	Rochford	45 mins	55 mins	Including a 7-minute walk
Maldon to	Braintree	32 mins	2 hrs	Including a 13-minute walk from Braintree bus station
	Brentwood	33 mins	1 hr 30 mins	Including a 20-minute walk from Brentwood Station
	Halstead	39 mins	2 hrs 38 mins	Including a 7-minute walk from Halstead bus route
	Rochford	45 mins	1 hr 50 mins	Including a 16-minute walk

These all presume no traffic and seamless transfer between bus and rail connections.

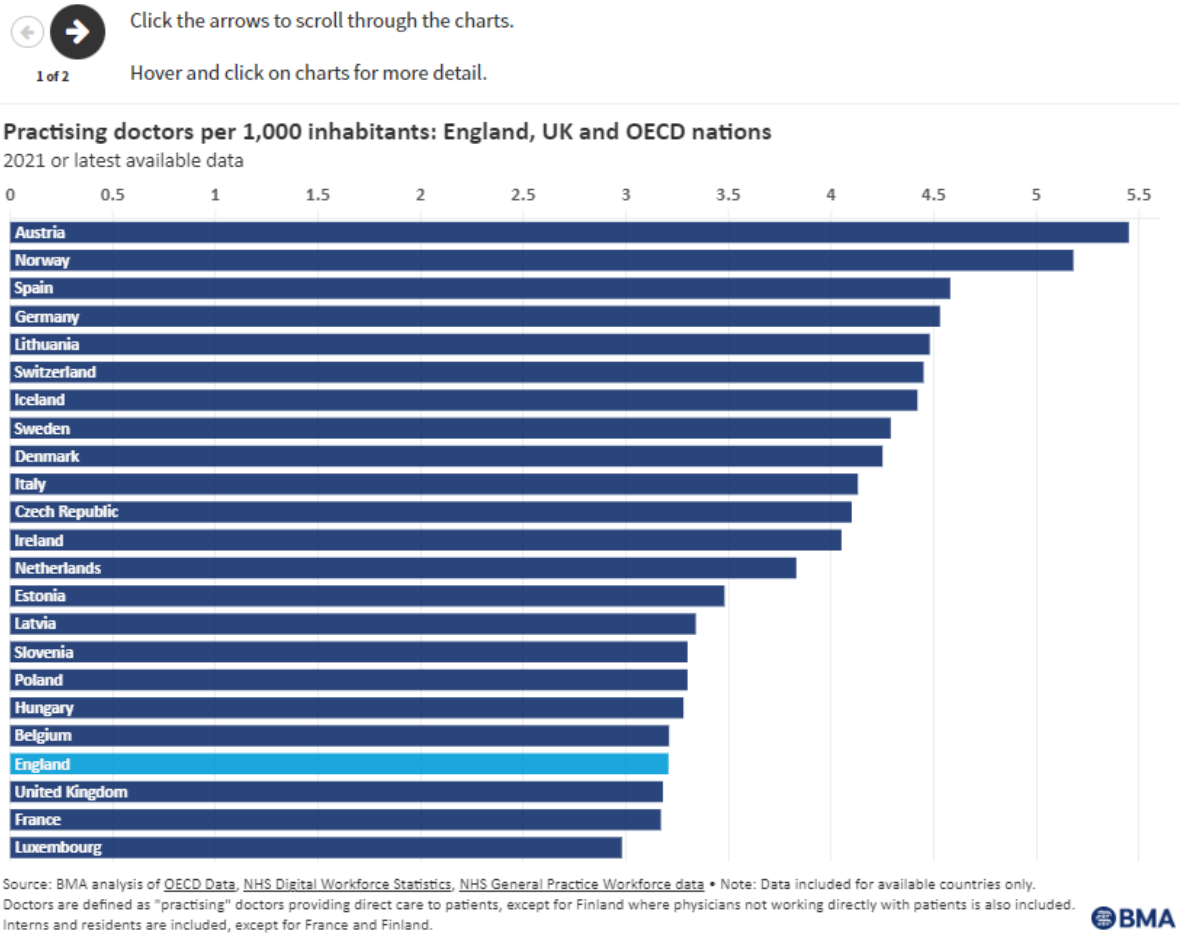
Please note many of the bus routes finish before clinic lists and visiting hours finish themselves. How will patients and visitors who do not qualify for patient transport reach clinics or visit loved ones?

Staffing and Visitors

Evidence 3

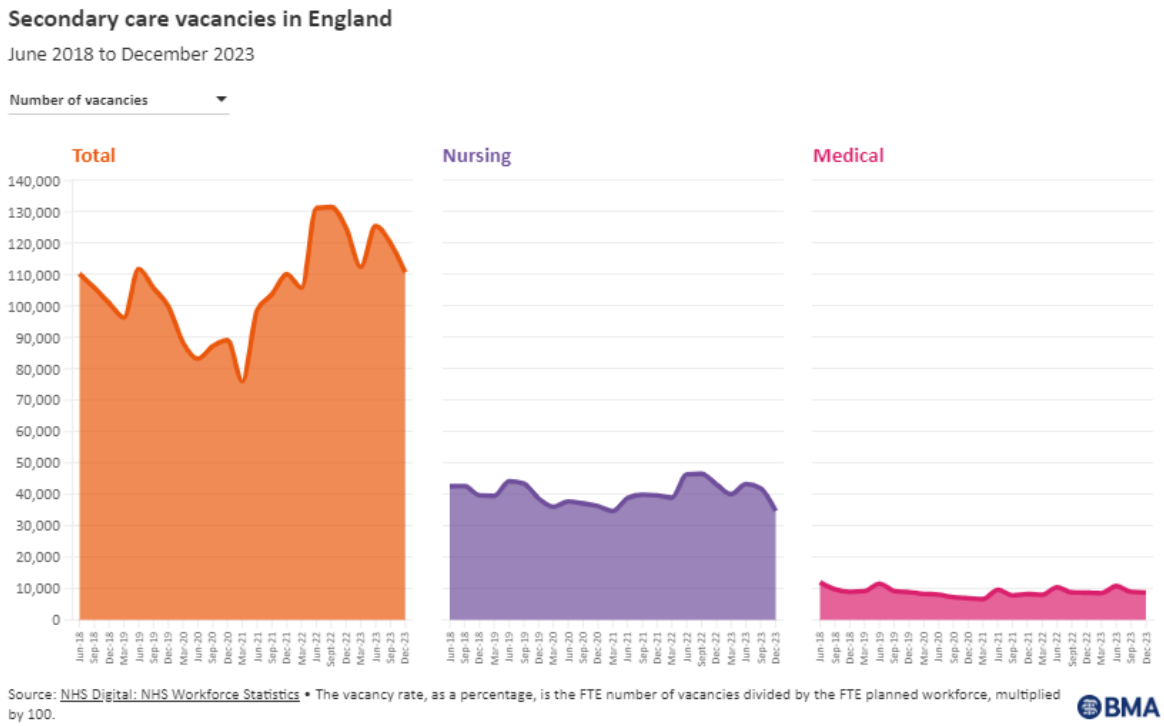
- We would like you to consider the impact that displacing family from inpatients will (has) now have on their well-being. This should be considered by you in conjunction with the national shortage of trained staff. We would like you to consider that the units in South Essex Rochford and Brentwood are in areas with Higher house prices than Maldon and the Dengie and are in the Commuter belt for London Hospitals. MSE has a poor recruitment and Retention staff history and these sites will be hard to recruit to with the prestige of London centres o close by. MSE ICB is also repeatedly a failing trust which is not attractive for recruitment of highly trained specialist staff.

https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/workforce/nhs-medical-staffing-data-analysis



In comparison to other nations, England has a very low proportion of doctors relative to the population. The average number of doctors per 1,000 people in OECD EU nations is 3.7, but England has just 2.9. Germany, by comparison, has 4.3.

England needs nearly 50,000 additional FTE doctors simply to put us on an equivalent standard with today's OECD EU average of 3.7 doctors per 1,000 people.



Evidence 2

https://www.gmc-uk.org/about/what-we-do-and-why/data-and-research/the-state-of-medical-education-and-practice-in-the-uk/workforce-report

Evidence 1 and 2

- We would like you to consider the lack of patient choice given in Option A and Option B of the consultation. It does not allow any consideration for patients to be regularly visited during their stay. MSE ICB is a consistently failing trust with difficulty retaining trained staff. As such on wards there is a reliance on visitors to fill the gaps in a working day. They help their loved one's wash, dress, eat their meals. They can be a chaperone to tests or accompany a porter to Physio. This is by no means a criticism to the great work undertaken at an acute trust but it is from my 20+ years' NHS service one I can attest to observing on a daily basis. What I can say though is a Community Hospital differs from an acute trust. The ratio of nurse to patients is greater and the culture in a Community Hospital is better for staff and patients alike. The outcomes are better too. The services work hand in hand and the visitors know the names of the staff. Whilst these seem small things, they give confidence to the patient and to those who are entrusting their care to the hospital. With 66K residents in Maldon and Heybridge many can walk to St Peters to visit their loved ones. Moving community beds to the other side of the county removes this option.

https://www.gov.uk/government/consultations/visiting-in-care-homes-hospitals-and-hospices/outcome/government-response-to-the-consultation-on-visiting-in-care-homes-hospitals-and-hospices

Excerpt 1

Foreword

We know that visiting loved ones in care homes, hospitals and hospices plays a vital role in maintaining health and wellbeing. Loved ones often play an essential role as 'care supporters', providing assistance, support and advocacy for those accessing care. We also know just how upsetting and distressing it can be to have those crucial visits restricted. Since the pandemic, we have been working hard to ensure visiting restrictions that were in place during the height of the COVID-19 pandemic cannot be commonplace again. We will move forward and learn to create a better environment for all when it comes to visitation.

Excerpt 2

Impact on residents and patients

The majority of respondents identified a range of positive impacts that requiring care homes to facilitate visiting would have on residents. The most commonly selected options from those provided were 'improvement in residents' wellbeing as they can receive visitors and make social plans' (78%) and 'residents who have difficulty advocating for themselves will be more able to share their wishes or raise concerns due to support from friends or family' (78%).

Several benefits to patients were identified by around half of standard consultation respondents including:

- patients receiving treatment sooner if their health changes
- having the benefit of advocacy
- improvements in patient wellbeing
- improvements in relationships with family
- improvements in mental stimulation
- a reduction in loneliness
- improvements in ability to communicate

Misinformation by the trust to staff and Service users

- The process has been advertised as a consultation in to proposed changes to St Peters Hospital. However, at meetings outside of the Maldon District they are advertised and spoken about as closure. They are also explained to the staff differently too. This is not complying with their duties of the ICB

- Promote the NHS constitution (14Z32).

Under the NHS constitution

https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england#nhs-values

NHS pledges

The NHS pledges to:

- provide convenient, **easy access to services** within the waiting times set out in the Handbook to the NHS Constitution
- **make decisions in a clear and transparent way, so that patients and the public can understand how services are planned and delivered**
- make the transition as smooth as possible when you are referred between services, and to put you, your family and carers at the centre of decisions that affect you or them

- This is what the staff were told in Maldon. This was the leaflet handed to all staff. You can clearly see the inference is that the services will be and I quote **'like for like and not reduced'**.
- Does the relocation therefore to the staff imply a temporary situation?
- Does it provide clarity to them on whether they should relocate or are safe to continue raising their families in the area?
- Does this scrap of paper give them an indication of job security or career progression?
- Is this clear and transparent?

IMPORTANT ANNOUNCEMENT

It has been announced that St Peters Hospital will be closing, and Outpatient services (Ambulatory care) will be moving to somewhere in Maldon when a place has been found that is suitable. There will be a purpose-built hub in Maldon, but this will take at least 5 years. In the meantime, we will be relocated locally until the Hub is completed.

There will be a public consultation commencing on the 25th of January for staff and public to get involved to ensure the services provided are like for like and not reduced, this will be for 8 weeks.

You can view the board papers for the Trust here: www.mse.nhs.uk/board-meetings

Board papers for the Mid and South Essex Integrated Care Board here: ICB - https://www.midandsouthessex.ics.nhs.uk/events/icb-board-meeting-14/

If you would like to feedback your thoughts both as staff and a local resident, or join the Consultation portal, please email the engagement team at the ICB on mseics.getinvolved@nhs.net

This is what the people of Basildon and Thurrock have been told
https://planetradio.co.uk/greatest-hits/essex/news/basildon-thurrock-residents-mse-consultation-services/?fbclid=IwAR1x7KGnWZEqsgDpVL27P80fIwEY8oybr3-RM7TY8QT8XMpz6wTLaPyW1XE

Basildon and Thurrock residents encouraged to have their say services ahead of St Peter's Hospital closure

- What is important to note is that both documents here are not in line with the public consultation document. They are a fait accompli. Take this alongside stealth closure of the wards and some services already this is all very underhand. It has left staff at the hospital very worried about their futures. The services are already reduced, District nurses have already been told they are going, Physiotherapy has gone, stroke ward has gone, Maternity has gone. The explanations are shifty. The lift has been cited. The excuse being it is not safe in the event of a fire. I am an NHS manager; no lift is used in the event of a fire. Staff are trained to take patients down stairwells. I was at Broomfield when there was a fire outside ITU!

- I overheard a discussion in the main Outpatients Department (I did not see the staff so cannot identify them) that the trust purchased the lift part required to mend the issue with the lift performance at a cost of £30K but for some reason the MSE trust returned the part. They took the decision to close the upper floors instead. Is it not a good narrative to have no access to the floors by lift? I think the public and staff would consider it a calculated and very underhand one. The roof and floors have been repaired, this increases the market value of the site, why repair these if the wards and services are not

going to be used? However, now they are repaired they are sound and therefore are not a valid excuse to not use the site. I would charge you with getting a FOI from the Trust and ask these points. This is a smokescreen at best.

Other

https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england#nhs-values

Access to health services

Your rights

You have the right to receive NHS services free of charge, apart from certain limited exceptions sanctioned by Parliament.

You have the right to access NHS services. You will not be refused access on unreasonable grounds.

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

You have the right to expect your NHS to assess the health requirements of your community and to commission and put in place the services to meet those needs as considered necessary, and in the case of public health services commissioned by local authorities, to take steps to improve the health of the local community.

You have the right to authorisation for planned treatment in the EU under the UK EU Trade and Cooperation Agreement where you meet the relevant requirements.

You also have the right to authorisation for planned treatment in the EU, Norway, Iceland, Lichtenstein or Switzerland if you are covered by the Withdrawal Agreement and you meet the relevant requirements.

You have the right not to be unlawfully discriminated against in the provision of NHS services including on grounds of gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity or marital or civil partnership status.

You have the right to access certain services commissioned by NHS bodies within maximum waiting times, or for the NHS to take all reasonable steps to offer you a range of suitable alternative providers if this is not possible. The waiting times are described in the Handbook to the NHS Constitution.

https://www.local.gov.uk/publications/get-act-health-and-care-act-2022

Duties of ICBs (1.25)

ICBs have the following general duties:

- **Promote the NHS constitution (14Z32).**
- Exercise functions effectively, efficiently, and economically (14Z33).
- Secure continuous improvement in quality of services and outcomes (14Z34).
- **Reduce inequalities between patients in relation to access to services and outcomes; promote the integration of health services where this would improve quality; and reduce inequalities of access and outcomes for individuals (14Z35).**
- Promote the involvement of patients and carers and representatives in decisions that relate to prevention or diagnosis of illness in the patients, or their care or treatment (14Z36).
- **Enable patients to make choices about their health services (14Z37).**
- Obtain appropriate advice to enable it to discharge its functions effectively (14Z38).
- Promote innovation, research, education and training (14Z30 – 41).
- Promote integration of health services where the ICB considers this would improve the quality of services and outcomes and reduce inequalities of access and outcomes for individuals. Promote the integration of health services with health-related services (those that may have an effect on the health of individuals but are not health or social care services such as housing accommodation) or social care services where this would improve quality and outcomes and reduce inequalities of access and outcomes for individuals (14Z42).
- **Have regard to wider effect of decisions – the triple aim (14Z43).**
- **Have regard to legislation on climate change (14Z44).**

https://www.eoesenate.nhs.uk/files/6317/0688/7892/Senate_Letter_to_MSE_-_Final_13_December_2023.pdf?fbclid=IwAR0yA9T4FUXaTz0ZOVR3NgJ3ZaDHZCF2rKdcRSI0EDwLZOkEAu5v6b1crsA

1. **There needs to be further work on the workforce plan for these proposals.**
2. **There should be further work on analysing travel times; especially the impact on areas of deprivation and the patient groups already identified as experiencing health inequalities.**
3. While there was consultation with the public in forming these proposals, more extensive public consultation and engagement may have been helpful.
4. **When doing further patient and public consultation in the future, Mid and South Essex ICB should ensure that enhanced patient involvement and the voice of underserved groups is especially targeted and heard so that a more inclusive and diverse range of feedback is received. Victoria House Capital Park Fulbourn Cambridge Cambridgeshire CB21 5XB England.clinicalsenate@nhs.net**
5. Mid and South Essex may wish to consider the recommendations of The British Psychological Society for integrated community stroke services.
6. It was suggested that clearer diagrams that depict how different governance groups relate to each other within the context of this proposal would be helpful.

- Point1. Most staff seem totally unaware what the workforce plan is.
- Point 2. What travel time analysis has been undertaken for the areas for deprivation and health inequalities. Especially those who are on public transport links that terminate before any hospital departments close themselves. Have visitors been considered in this especially as they have removed a ward with long stay patients. In the travel analysis did they consider travel interruptions or the type of patient travelling, i.e. disabled, pregnant, mental health etc. Did they consider length of appointment time and the ability to get home. Did they consider the impact of travel times on diabetic patients.
- Point 4. We note that at a very late juncture, In March some 4 months after this advice and 6 weeks into the consultation the MSE ICB offers micro grants of £300 to the underserved groups. It has also failed in its duty to reach any residents in Maldon District who do not have access to a digital platform. Evidence for this: post on Facebook Essex is United 6th March 2024

Essex Is United
6 March at 15:00 ·

LOCAL COMMUNITY GROUPS INVITED TO HELP TO CHAMPION LOCAL VOICES AS PART OF A CONSULTATION ON PROPOSED CHANGES TO NHS SERVICES

The NHS is looking for voluntary, community, and social enterprise organisations across mid and south Essex to run a focus group on proposals that impact services at local community hospitals.

Dr Matthew Sweeting, System Medical Director at NHS Mid and South Essex said: "It is important that we understand the diverse needs of all those living in mid and south Essex when considering making any changes to local services.

"We are keen to work with local community groups who can gather feedback from specific groups to make sure we hear from a range of people, for example carers, people with disabilities, or people with long term health conditions.

"To make it as easy as possible we will provide some small grant funding and provide a 'how to guide' which makes it as easy as possible to have a discussion and provide the feedback.

"We want to make sure everyone can receive the care they need in a safe environment, staffed by a highly skilled workforce, so that everyone has the best chance of a good health outcome.

"It's important we involve people in any decisions that might affect them. We're a long way from making decisions. Getting feedback from local people is vital."

An expression of interest form is available at
http://www.virtualviews.midandsouthessex.ics.nhs.uk/chang....

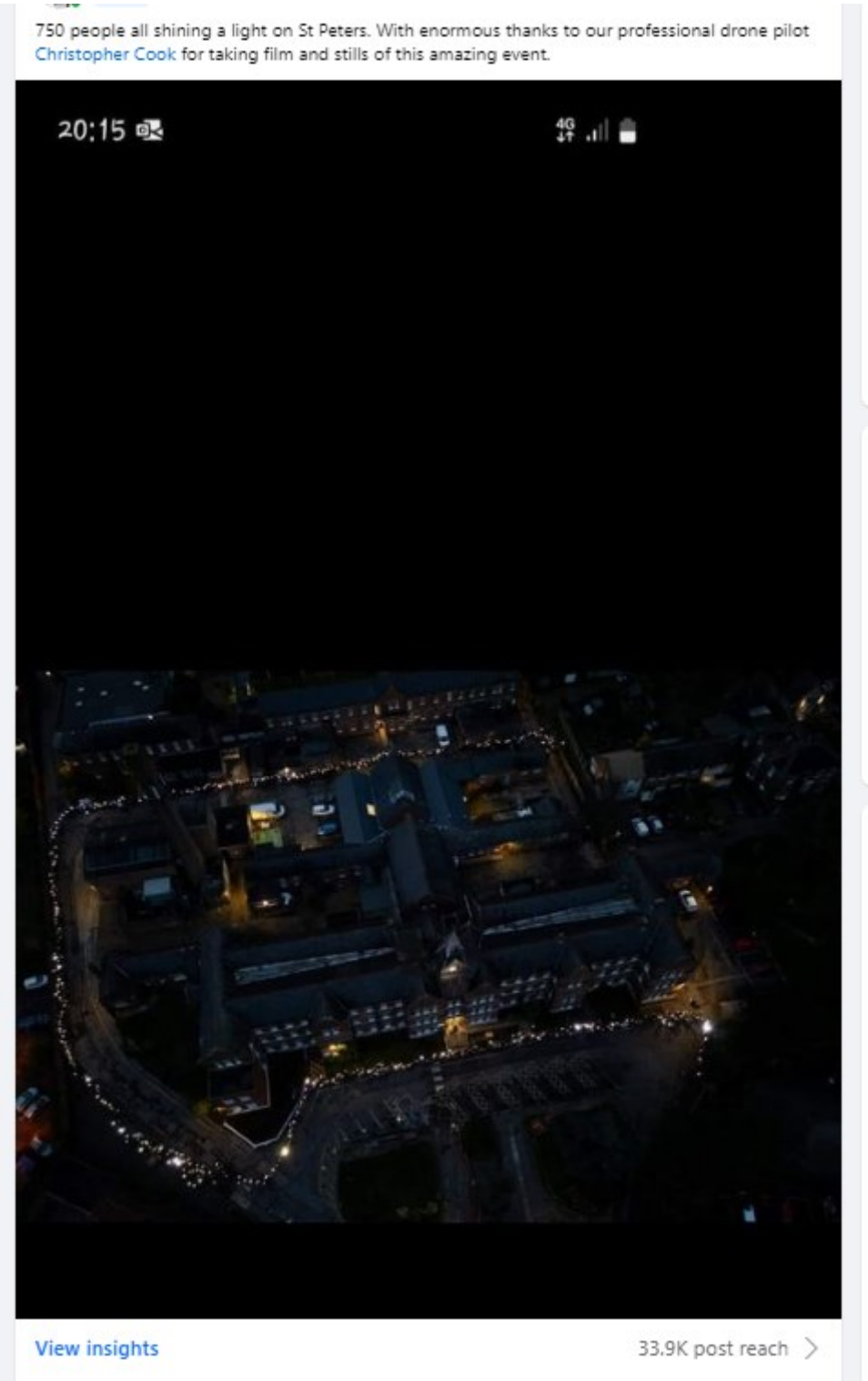
All forms need to be received by midnight on 12 March 2024 with a microgrant payment of £300 provided for their participation. A toolkit is provided with a step-by-step guide on what groups would need to do.

- SMMS have been out on the high street, in villages, at supermarkets, in care homes and sheltered housing with paper surveys to help as many residents as possible access paper surveys and have their say. This is a massive failing on the ICBs behalf. It is a discrimination of the old, infirm and quite frankly makes this whole process unjust. These are the very people who use St Peters and have not been able to have their say or be make aware it will close.
- It is our belief as a group that the ICB is failing to meet its duties, particularly the highlighted sections of the Duties of the ICB above. We have produced

evidence throughout this written submission and also within our PowerPoint. Potentially we believe there is evidence to substantiate a judicial review of this consultation.

Weight of feeling in the community

Shine a light on St Peters



https://www.maldonandburnhamstandard.co.uk/news/24193547.maldon-campaigners-hold-event-opposing-potential-hospital-closure/

750 residents came to St Peters on 17th March 2024. The event was watched virtually by 2500 more and has been seen now by a further 34,000 in support on Facebook.

Petition

We have an online petition against the closure of St Peters, over 6,300 have signed electronically and we have approximately 1000 more hand signatures.

https://www.change.org/p/prevent-the-closure-of-st-peter-s-hospital-or-ensure-investment-in-a-new-dengie-area-hospital?fbclid=IwAR1hOOTuOeiLMkosqgZ94B3nnFfOT6SjsL1slqMhHZ4odWpmVmTnEHU1RPw

- To conclude they have failed by:
    1. Not undertaking a travel analysis that considers all rural areas and the deprivation within our communities. Nor have they considered the public transport limitations.
    2. Their survey is not accessible and excluded many groups of people, vulnerable adults, those without access to computers, smartphones etc. We as SMMS have undertaken their work for them to plug some of the gaps.
    3. They are shutting down services at St Peters ahead of the outcome of the consultation
- We will submit further written evidence before 4th April 2024 as it presents itself