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Draft report of public consultation hearing

NHS Mid and South Essex Integrated Care Board

Community capacity public consultation January – April 2024

July 2024

This report has been authored by Stand, independent specialists in involving people and communities in health service transformation.

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The project was carried out in line with best practice industry standards for public consultation and applicable regulatory standards.

Thank you

The authors are especially grateful to every one of the presenters who took the time to prepare evidence and attend the event to present. And we are grateful to everyone who applied to present.

We would like to thank the people who attended to observe, watched live online, or watched one of the session recordings online.

We are grateful to Maldon Town Council and the staff at Maldon Town Hall for their support in hosting the event.

And we extend our thanks to everyone at NHS Mid & South Essex who contributed to running the hearing.

Contents

Introduction

From 25 January to 11 April 2024 NHS Mid and South Essex Integrated Care Board held a public consultation about proposed changes to services at local community hospitals. As part of its public consultation, the ICB held a public consultation hearing in Maldon on 19 March and online on 04 April.

This report has been produced by the independent organisers of the event. It describes the process behind the hearing and presents the evidence provided by participants, including a transcript of proceedings, the documents submitted, together with a record of presenters' discussions with the panel.

The event organisers and NHS Mid and South Essex ICB are sincerely grateful to everyone who applied to present at the hearing, and to the presenters for their time, effort and diligence in preparing and presenting the evidence they submitted.

This report will be shared in draft with NHS Mid and South Essex Integrated Care Board and uploaded onto the NHS Mid and South Essex Virtual Views webpage. Presenters are invited to feed back on the accuracy of the content.

Background

The public consultation

On 25 January 2024, NHS Mid and South Essex Integrated Care Board published proposals for changes to services at community hospitals in the area it serves.

The proposals published in the consultation were:

- potential changes to the places where some community hospital intermediate care and stroke rehabilitation services are provided.
- making permanent the temporary move of the freestanding midwife-led birthing unit from St Peter's Hospital, Maldon to the William Julien Courtauld Unit at St Michael's, Braintree.
- the possibility of moving all other patient services at St Peter's Hospital, Maldon to other locations, mostly in and around Maldon.

A consultation document and a range of supporting information was published to inform people and communities living and working in the Mid and South Essex Integrated Care

System area. Patients, carers, residents, community groups, organisations and other stakeholders were invited respond to the consultation in a range of ways, by:

- Completing the consultation survey online or on paper
- Attending one of a series of ten scheduled consultation events
- Attending events organised by partner and stakeholder organisations
- Providing a written response on email or by post
- Providing a response over the phone.
- Presenting evidence at a public consultation hearing.

The public consultation ran to 11 April 2024.

Public consultation hearings

A public consultation hearing is a formal, participatory event, where consultees can present directly to a panel of senior people from the consulting organisation information to add to the body of evidence for decision-makers to take into account, or to correct evidence published in the consultation.

Presenters are expected to prepare well and be able to back up the points they make with robust evidence. The process is designed to test the evidence presented by providing decision-makers with the opportunity to listen directly to the evidence presented and ask questions to test its veracity and aid their understanding of the points being made and the information provided.

This evidence might include:

- Information decision-makers need to consider in response to the consultation
- Alternatives to the information set out in consultation
- Detailed proposals for other ideas to solve the issues in the consultation
- Predicted impacts of the proposals

A consultation hearing is an invitation event held in addition to the public meetings which normally take place during a public consultation. They are held in public and often live-streamed for purposes of openness and transparency.

Organising this public consultation hearing

The date and venue for the public consultation hearing was published with all the consultation documentation on 25 January 2024. NHS Mid and South Essex ICB had appointed Stand (WeAreStand.co.uk), specialists in patient and public involvement, to independently organise and manage the event.

The consultation hearing was planned to take place over three sessions from 14:00 to 19:45 at Maldon Town Hall on 19 March 2024. This provided capacity for up to nine interested individuals or groups to present, with each presenter allocated 15 minutes to speak to their evidence and asked to be available for up to 15 minutes following their presentation to respond to questions from the panel. The organisers invited an experienced independent person to chair the event.

A general invitation was issued for individuals, organisations or groups to apply to present at the event evidence relevant to the issues highlighted in the consultation, or to attend the event to observe.

People interested in presenting were asked to complete and return to the organisers by Monday 4 March 2024 a short application form giving some brief information about the evidence they wanted to submit. Following feedback from potential presenters, the application window was later extended to 6 March.

People interested in attending to observe the hearing could book tickets via Eventbrite, or by contacting the consultation team via the contacts provided in the consultation document.

Twenty-five individuals and organisations expressed an interest in presenting evidence at the event. Eighteen applications were received.

The ICB agreed to the organiser's requests to add an extra presenting slot to the agenda on 19 March, and arrange on 4 April an additional session to accommodate applications to present from affected members of NHS staff.

The organisers sought, on the basis of the applications, to include as many presenters and as wide a range of viewpoints as possible. Some applicants who wanted to cover similar themes were asked if they would work together sharing a presenting slot. Applicants who had provided with their application no detail of the evidence they wanted to present were contacted and asked for more background. Organisers gave priority for presenting slots at the event to those applicants who were representing local people and communities and were clear about the evidence they wanted to submit.

Once the slots were allocated and invitations issued, some invitees decided to work together and share their time with people who hadn't been selected. One group decided not to present at the event, submitting their evidence in writing instead. That slot was accepted by one of the other applicants.

The first three sessions took place on Tuesday 19 March 2024 at Maldon Town Hall. The fourth session took place online on Thursday 4 April.

A final agenda for the first three hearing sessions was issued on Monday 18 March 2024. Authority to make changes to the agenda on the day was given to the event chair. A final agenda for the fourth session was issued on 3 April.

Interested people could book tickets to attend and observe proceedings at Maldon Town Hall. Fifty-seven people attended all or part of the event. Sessions 1, 2 and 3 could be viewed live online via YouTube. Technical issues prevented the intended livestream of session 4. Recordings of all four sessions are on YouTube:

Sessions 1, 2 & 3: https://www.youtube.com/live/CSqW0r0vRPw?si=VqREzDUz0Vk-kEWa

The livestream peaked at 65 viewers at any one time with an average of 41. The video had had 990 views at 10 May 2024.

Session 4: https://youtu.be/GkWoJsiaShI?si=JxGHHW_XD-VBhuQe

Technical problems prevented the planned live stream of the event. The video had had 261 views at 10 May 2024.

Next Steps

This report will be shared in draft with NHS Mid and South Essex Integrated Care Board and uploaded onto the Mid and South Essex Virtual Views webpage.

Presenters are invited to feed back on the accuracy of the document without incorporating any additional content by emailing publicconsultationhearing@wearestand.co.uk within two weeks of the draft document being published.

A final version of this document will be uploaded on the Virtual Views pages and linked to the full consultation report.

The final consultation report will be presented to the NHS Mid and South Essex Integrated Care Board to inform the decisions which will be made about the proposals.

Report of proceedings

Session 1

14:00, 19 March 2024, Maldon Town Hall

Chair's welcome and introduction

The Chair welcomed everyone and introduced the session, setting out that the purpose of this hearing is for members of the community and organisations to present information to the panel members today to influence thinking. He shared that he had been invited to act as an independent chair for the event by the organisers. And explained the role of independent chair is to encourage those who are presenting to provide information to the panel and to encourage the panel to extract information that will be useful in making decisions about the future of services for the area.

The panel members introduced themselves.

The Chair described the format for the proceedings and evacuation arrangements. Thanks were noted to people who had made written submissions to the hearing, including Judith and Roger Bond, Lindsey Wright and Councillor Emma Stephens[1], The chair reminded those present and those viewing online that responses to the consultation would be accepted until the 4th of April and encouraged everyone to respond.

	Speaker/s	Topic	Organisation	Page
Submission 1	Sara Poole	General	Healthwatch Essex	Page 9
Submission 2	Peter Blackman	General	South Woodham Ferrers Health & Social Care Group	Page 12
Submission 3	Steve Rogers	General	Maldon resident	Page 20

Panel:

- **Dr Matthew Sweeting:** Consultant Geriatrician at Broomfield Hospital, Mid and South Essex NHS Foundation Trust and Executive Medical Director at Mid and South Essex ICB
- **Emily Hough:** Executive Director, Strategy & Corporate Services at NHS Mid and South Essex Integrated Care Board
- **Claire Hankey:** Director of Communications and Partnerships at NHS Mid and South Essex Integrated Care Board
- **Chris Howlett:** Senior Director of Estates and Facilities, Mid and South Essex NHS Foundation Trust.

[1] Cllr Stephens was present and later invited by the chair to speak to her submission when proceedings were ahead of schedule.

Submission 1 - Sara Poole, Healthwatch Essex

Sara Poole presented a PowerPoint presentation, which is available at Annex 1.

Sara is one of the Information and Guidance Officers at Healthwatch Essex. Healthwatch is an independent charity which gathers and represents views about health and social care services in Essex. Their aim is to influence decision-makers so that services are fit for purpose, effective and accessible, ultimately improving service user experience. Their website is www.healthwatchessex.org.uk. They also provide an information service to help people access, understand, and navigate the health and social care system.

Sara presented the views and feedback that members of the public had given Healthwatch in various forms.

Presentation

Sara explained that Healthwatch Essex started to receive comments from members of the public regarding the proposed changes at St Peter's Hospital whilst carrying out a project in the Burnham on Crouch area. They had also had feedback via the Healthwatch England Have Your Say online submission forms.

Comments were sent to them directly via email and also via various ambassador groups that they run. Numerous residents had concerns regarding the general access to hospital care across the Maldon and Dengie Peninsula. The general feeling is that it is already difficult for some to access Broomfield Hospital due to the distance, difficult public transport links and lack of parking at the hospital.

The feeling is that moving the stroke rehabilitation beds further away from the area was a major concern. Again, the difficulties for people to travel was one of the main issues. The comments sent are highlighted in blue in this report and were reproduced in the PowerPoint presentation. The commentary between the comments is Sara's commentary.

> *Closure of hospital St Peter's Maldon Essex. The hospital is being closed despite our district population heading for 70k! Services are being scattered all over Essex making it very difficult to access healthcare. If you don't drive, you will not be able to get to hospitals! £65.00 for a taxi (each way!) to get to the nearest hospital or four changes of buses. If you have mobility problems you're sunk! Maternity/birthing unit has already been moved over 15 miles away and hours away by public transport. Stroke rehab 20 miles away and over two hours by public transport (no accessibility for disabled) two buses to railway station, train then another bus to hospital. Patients only accepted if there's room. If not there's another hospital which is even worse to get to. The wishes of our residents are being totally ignored and our welfare trashed!*

So, looking at this comment, the closure of Hospital St Peter's Maldon Essex, being closed despite their district populations heading for 70,000.

Services are being scattered all over Essex, making it very difficult to access healthcare. If you don't drive, you will not be able to get to the hospital. £65 for a taxi each way to get to the nearest hospital or four changes of buses. If you have mobility problems, you are sunk. Maternity and birthing unit has already been moved over 15 miles away and hours away by public transport.

Stroke rehab 20 miles away and over 2 hours by public transport. No accessibility for disabled. Two buses to the railway station, train, then another bus to hospital. Patients only accepted if there's room. If not, there's another hospital which is even worse to get to. The wishes of our residents are being totally ignored and our welfare trashed.

> *Our local outpatient hospital (St Peter's Maldon) stroke rehab/ maternity/ blood test etc. hospital is being closed down. It's the only one for at least twelve miles and our local population is heading for 65,000. The rehab is now over 20 miles away an would take around three hours to reach by public transport. Maternity is around 16 miles away (around 2 hours by public transport) X-ray, surgical, dermatology, oncology etc around 2 hours by public transport. St Peter's is maximum 30 miutes by public transport from outlying Maldon district and within 10 minutes public transport from Maldon town areas.*

St Peter's is a fantastic hospital, repair the parts of the building which have been DELIBERATELY neglected and leave us an ACCESSIBLE service. OR build the replacement hospital which was PROMISED BEFORE the population swelled by over 40,000!!!

Another comment very similar. Our local outpatient hospital and straight rehab maternity blood tests, etc. is being closed down. It's the only one for at least 12 miles and our local population is heading for 65,000. The rehab is now over 20 miles away and would take around 3 hours to reach by public transport.

Again, the distance regarding the maternity, X-ray, dermatology, etc. St. Peter's is a fantastic hospital. repair the parts of the building which have been deliberately neglected and leave us with an accessible service. Or build the replacement hospital which was promised before the population swelled by over 40,000.

> *Our local hospital is being closed down. Leaving us a 40 minute drive to get services. Our town has thousands of new houses but now no hospital. Very conflicting.*

Again, another one regarding distance and the amount of new houses being built, but no hospital.

> *"Maldon is now big enough to qualify for a small community hospital like Braintree, Broomfield is past breaking point, a good example is patients with cancer having to travel to Southend for chemo, we are talking just a nurse and an IV required."*

Another comment, Maldon is now big enough to qualify for a small community hospital like Braintree. Broomfield is past breaking point. A good example is patients with cancer having to travel to Southend for chemo. We are talking just a nurse and an IV required.

So our main summary are the residents' concerns, the continuing growth of the population, housing developments, and how services will meet that need. And I think one of the most important ones, transport links to services if they are moved further away.

And that is the presentation from Healthwatch Essex.

Discussion

Event chair: Okay. Thank you very much, Sara. That was nice and brief. Has anybody on the panel got, open with questions for Sara?

No? No? Okay. I was just interested, I was interested, Sara, for as somebody who, is from outside this area. Obviously, you cover, Healthwatch covers the whole of Essex. And in this case, we're talking mid and south Essex that the ICB covers. The population statistics there, obviously this was very related to Maldon.

How does it compare with similar sized towns across the area and their accessibility to services? Have you got any information that does a comparative?

Sara Poole: Not quite. Not immediately to hand. That is something that we could look into. Obviously Essex is a massive county. Healthwatch Essex does cover the majority of the county, but we don't cover Southend and Thurrock.

They have their own Healthwatch services. But it for us, this sort of just started to come up because we were already doing some work for a GP surgery in the Burnham area. So there was a lot of strong feeling around that anyway. And then just timing wise with the consultation for this coming up at the same time.

But I suppose. Sort of Clacton, Harwich and the Tendring area would probably be a comparable distance. A lot of those areas have to travel into Colchester, which is 45 minutes to an hour to get to a bigger hospital, especially that the Harwich area. But Clacton is having a new facility being built over there at the moment, so okay they are hoping that, obviously that will meet that need over there. But it's that geographical wide spread. We know we're a big county, and I think everyone understands that the pressures that everyone is under to try and meet that, that growing need. But, when people drive to the big hospitals like Broomfield and Colchester and they get there and they have struggled parking, it all adds to extra stress of that already stressful situation if someone is unwell. But we can also understand from the estate side of things that you can't produce land if it isn't there. and finding that balance between providing that parking but also providing services is obviously very difficult as well. So it, it's trying our job as well as representing the residents is also to try and explain factors that people might not always necessarily be aware of as well.

Event chair: Okay. And does, in this area, the area that this is covering, Mid and South Essex, does Healthwatch Essex feel that the people of Maldon would be more disadvantaged than people in other areas as a consequence of proposals?

Sara Poole: I think so, yes, especially when you look at Dengie Peninsula and Burnham on Crouch and Southminster and those sort of areas that, that, that trying to get to Rochford or Brentwood. I think was the other area where the stroke rehab beds are being moved to that that's really difficult. And by the nature of the condition, strokes are generally happening. Older people. So husbands or wives of people that have become ill may not drive anymore. They may not necessarily have friends or family around them who could support with being able to drive them to and from.

I think for us, that's our main concern that the transport links and that geographical nature of moving something like the stroke rehab beds so much further away.

Event chair: Okay. All right. I'm going to be consequently on to, yep.

Dr Matthew Sweeting: Sara, thanks so much for your clear presentation, which was really helpful. Do you think there is an understanding of the fact that there is a commitment to keep local services within the Maldon district? And the fact that stroke bed usage and rehabilitation. Really important, about one in five residents within the Maldon district at the moment. We will have, will need that and are using that at the moment. Do you think that was appreciated when you were going round, collecting your feedback?

Sara Poole: Don't think people really understand. I think people need to have that explained to them and websites and the internet are very good, but only on Friday I spoke to a lady who was like, I don't use the internet, I don't use social media. I've literally just found out about this consultation. She was not aware of it at all, and it was something that she would have really liked. She can obviously still get involved and I sent her the link to the website and she was going to get a family member to assist her with looking up, but I think, especially for the older generation who might not have it's all well and good having the online forums, but if they're not aware of that, and people don't necessarily have the confidence to feel or to attend a meeting like this or other meetings, they so there's got to be other avenues for people to be able to voice their views and opinions, but also to get information back as well. Thank you.

Event chair: No? Okay. Thank you very much, Sara.

Sara Poole: Thank you.

Submission 2 - Peter Blackman, chair South Woodham Ferrers Health & Social Care Group

This Group stated: Our evidence will be drawn from: our recent independent academic research project assessing the health and care needs in the Dengie & South Woodham Ferrers (SWF) Primary Care Network at https://swfhealthsocial.files.wordpress.com/2023/07/health-welfare-social-care-assessment-of-the-dengie-south-woodham-ferrers-pcn-jun23.pdf; our past and present experience of relevant activities; and, the views of SWF's people as expressed in a prior virtual consultation event that took place with MSE ICS from 1830-2000 on Tuesday 5 March 2024.

The evidence was presented by Peter Blackman, chair of South Woodham Ferrers Health and Social Care Group.

The PowerPoint presentation is available at Annex 2a and the evidence document is available at Annex 2b. Further information sent following the hearing can be found at Annex 2c.

South Woodham Ferrers is at the west edge of Dengie Peninsula, the north bank of River Crouch.

The spokesperson Peter Blackman is also Chair, Trauma East Voices, East of England Major Trauma Network, and was the first chair of Essex and South LINk (Local Involvement Network) and Chair of the Joint East of England LINks' Group. He brought with him Councillor Donna Eley, Mayor of South Woodham Ferrers and South Woodham Ferrers Councillor Ian Roberts.

Presentation

Peter Blackman: Okay. Good afternoon, everybody. I'm taking it that as we had to get our stuff in by 4.30 in my case on Friday afternoon, you've had the chance to look at our slides and presentation. So I'm going to follow your example of our public meetings and assume that you've read it all. So I'm going to just pull out the highlights.

I'm the spokesperson for the South Woodham Ferrers Health and Social Care Group. My name is Peter Blackman. I chair that group. Where is South Woodham Ferrers? For anyone who's not sure, it's on the west edge of the Dengie Peninsula and the north bank of the River Crouch. My particular interest in this is also that I chair the East of England Major Trauma Network's Trauma East Voices and there is a slight relevance to that which I will come to. South Woodham Ferrers Healthcare 2000 Group was a millennium project which started in 1999 and then amalgamated with the South Woodham Ferrers Town Council which ran care lunches up until 2016 when we amalgamated to become the South Woodham Ferrers Health and social care group, and we look after the health and social care interests of the people of South Woodham Ferrers, recognising the roles of health and social care related, professionals, volunteers and the patient participation groups.

You've got full details of our history, background, governance, etc., in the pack. So that's me. That's us.

South Woodham Ferrers Health and Social Care Group and Warwick Medical School published last summer our Health, Welfare and Social Care Assessment of the Dengie and South Woodham Ferrers Primary Care Network.

It was produced in conjunction with the Mid and South Essex Integrated Care System. And the Mid Essex Alliance, who collaborated in what the point of the research was, and the contributions. That's 6,000 plus words, possibly the most comprehensive report you'll have in the area, whose population of 45,000 is arguably the second largest users of the services in question after Maldon.

Primary care network staff started to turn up for our PCN, from April, and they found this extraordinarily helpful. And so the report and the mind map that I will show you, next, and commentary are drawn completely from our report and form the initial agenda for work of our primary care network.

It identified and confirmed some key issues.

There's a commentary and that's also helpful and I'll leave you to read that. Some key concerns. Accessibility. So on the Dengie, especially the geography, distance for services, and length of time for the arrival of things like ambulances on 999 calls and times to reach A& E are of particular concern in South Woodham Ferrers.

It's just lack of supply to meet the increasing demand for services and for everybody it's the distances to get to access acute services and the lack of supply to compare to demand of those. On the transport front, we're talking public transport, which is pretty absent as our colleague from Healthwatch has already pointed out, it's very poor.

There's the need for more public care and outpatient services, lack of appointments and poor roads and poor parking. Going on from that towards this, as we held a virtual consultation meeting on the 5th of March about this, it was kindly hosted by you, the NHS, and that meant that getting the recording was particularly difficult, but you've got access to it, and I can't give it to you, but you gave it to me, and hopefully you can give it to yourselves afterwards.

It was an interesting evening, and our mayor was one of the contributors to that. So when we get to the consultation questions, what are the things that we propose? Intermediate inpatient services. Both options A and B provide for 22 intermediate care beds at the Cumberlege Intermediate Care Centre in Rochford.

So that's common to both, so there's no argument about that one. And at that point, I'd point out that Billericay is pretty close to Brentwood. So when we come on to the second part, which is the stroke rehabilitation inpatient services, opinions differ. Now this is something where we feel very strongly.

There's, you'll hear a lot of popular requests for everything to be local and that is reflected in the consultation meeting. People want services to be close to home and this is an expectation that comes from the history of the NHS and it is based in 1948 and we have regularly suggested that there is a huge need for the NHS to mount an effective education and information campaign to bring the patients and public up to date with the nature of the present NHS.

We, as an organisation, always recommend that you want the best health care and the best outcomes. And as chair of the Trauma East Voices, I speak for that. Going to Addenbrookes is not the nearest, but it undoubtedly is the best. It saves twice as many lives, and it provides much better recoveries and quality of life.

As does the Basildon major hospital thoracic, head centre. So it's a very technical thing. Today's NHS. And if you want the best outcomes, you want it to be by the best people who are having regular experience of that. But you've got to be able to get there and you'll know that I was passionate about this when Addenbrookes was set up and we have a first class service there because you're getting traumatic, traumatized, friends, relatives turning up. They need a bed. They need a lounge. They need everything there. They need to be able to park without having to worry about paying a fee or getting in or finding one in an emergency. The same as if you're having a baby. We always recommend and support the best care and outcomes for survival and recovery, which are proved to come from maximizing expertise and experience.

So we want staff and specialists to be brought together in a single 50 bed stroke rehabilitation unit at Brentwood Community Hospital, as that will deliver the best outcomes. Strokes are well known as very serious emergencies. Thankfully, rehabilitation has advanced significantly, and we know the best rehabilitation is needed to deliver the best recovery standards of life, and least long term cost of health and welfare support.

It's got to be matched by good transport, parking, accessibility, resources for family and friends to visit. That, you'll see, will be a regular theme of what I say in my remaining seven minutes. An overall loss of three intermediate care beds is marginal, whilst that will remain well spread around mid and south Essex.

Freestanding midwifery led birthing unit, nearest or best, same thing, is about six births a month for critical mass. Again, opinions differ. Again, we always want the best care and outcomes, which come from maximising expertise and experience. So we think that bringing staff and specialists at Braintree Community Hospital will deliver the best health outcomes.

But that must be matched by good transport, parking, accessibility, and resources for the birthing partners. The distance between Maldon and Braintree is similar to distances to such units in many other parts of the country. And we must remember that these are bookings for low risk births with suitable pre planning.

Also, they're nearer to Broomfield if anything's going not so well.

Fourth outpatient services provided and I have underlined and put in red Cherry Trees. Cherry Trees is very important and must be remembered because the mental health services and the memory clinic services that are provided there, it's on the same site, so we mustn't lose sight of them.

And we mustn't stop the present services until alternatives in Maldon and the surrounds are up and running, providing at least the same numbers of appointments. And we know that we've already got a promise from the CEO that will happen, but we just emphasise that must happen.

Central Maldon joins with the Dengie and South Woodham Ferrers in the forthcoming Integrated Neighbourhood Team. So there is going to be another link with our PCN. Dengie and South Woodham has a 45,000 population in the peninsula and our major use is. This is a one off opportunity to bring all the locations of these services up to today's standards of compliance whilst maintaining the tremendous skill and care which has always been such a huge part of the experience of all services at St Peter's.

This must be matched by good transport, parking, accessibility and patient visitor facilities for all the new locations. I don't get a medal for a penny for every time I say that. Okay, you've actually come up with some potential sites for future things, and, they look as though, they appear to be potentially suitable for delivery, of those community services in question, except the X-ray services, which you suggest might go to Braintree, which is already fully used.

This is an opportunity to bring a modern X-ray and investigative centre, a new diagnostic and treatment centre to Maldon.

MSE, Mid and South Essex ICB has said there are bridging financial arrangements available, between setting up new premises and receiving the sale proceeds of St. Peter's, so part of that should be used to deliver a new X-ray and other scanning services in the Maldon area, which will help to meet the present situation of demand and waiting times and also provide for the future.

All new locations for these services must be accompanied by good transport, parking, accessibility, and facilities for patients and accompanying family, friends. It's a bit of a chorus, everybody could join in, couldn't they? Then we get to the animal.

There we are. The elephant in the room. Okay, so we've had 25 years of consultations and planning coming to nothing. I've been on an awful lot of them. South Woodham Ferrers has been represented on many task groups about a replacement for St Peter's, but they're never finalised and delivered. We're now in the context of today's NHS and I understand that things have changed over the years and we need to think about what works today, but St. Peter's is unfit for purpose, past its sell by date and unsafe. Plus we've got all the forecast increases, of housing developments and populations and demand that are widespread around the area Maldon, Chelmsford, the Dengie, etc. And that also needs to be thought about at this stage. We stand by our above recommendations about inpatient beds, because their priority is best outcomes.

And we stand by our above recommendations for outpatient services, which don't need specialist fixed equipment. But, we plead, beg, demand, whatever you want, strongly recommend that a new diagnostic and treatment centre be planned and built immediately in Maldon or its surrounds to meet today's and forecast growth of demand in the Maldon existing catchment area and also to help to serve South East Essex below the Crouch.

This is the least that can be done to ameliorate all the past broken promises. Thank you.

Discussion

Event chair: Okay. Thanks, Peter. Lots to take on board there. Questions? Anything you'd like to discuss with Peter?

Emily Hough: Peter, thank you very much. There was a huge amount in there and I think it's really helpful to hear from yourselves and those who live in South Woodham Ferrers. And thank you for your thoughts on the different options. I think we remain committed to thinking about what we do with outpatients, and I look forward to working with you. It'd be helpful to get your take, perhaps on how we can do that as we move forward and think about potential options. As you mentioned, we've highlighted a number of options. How can we work with you on that?

Peter Blackman: We'll be very happy to help with that. I think we have a good, very good understanding of our area and a reasonable one. And I'm sure in conjunction with somebody suitable from Maldon, who's familiar with here as well, we can do it. As I said, I think the main thing is that wherever we go, it's probably, you might well be able to provide better parking than at St. Peter's at times anyway, for a lot of these places, but I cannot get past, and obviously you're not actually stretching the locality challenge in these places, and people are already getting used to going to a place within a primary care network area rather than perhaps their own surgery, for example. And it all comes back to this specialism side.

We're much better having one specialist who's really familiar with doing something rather than a few who do it occasionally and make more errors. But you've got to have the best of the transport. You've got to make that work. Now, we've had difficulties, obviously, post COVID, during COVID etc. with things like getting just to the Crouch Vale Medical centre in South Woodham.

So we've got to find a way of getting something like the Dengie, whatever it's called, I'm sorry, but, sorry? Dart. Dart, yes. Something like that, which has accessibility. It's no good having a 52 seater bus. We know that contract doesn't work. It's no good having a four seater taxi, which hasn't got accessibility.

And it's got to have the flexibility to get around. And so that people can get there and back in a reasonable time, rather than taking two hours by bus to get to an appointment that gets delayed. That then means they've been out all day and at the same time they're a carer and somebody at home is being neglected or whatever.

So it really is important. I hope that anyone listening to this will accept that what I'm saying is we want people to get the best outcomes, but it's got to be done efficiently. And that doesn't mean that your responsibility stops at the door of that facility and service.

Event chair: Okay, thank you. And any further, yeah?

Claire Hankey: Thanks Peter. I just wondered if I could ask a little bit more about the role of carers. I know you yourself are a carer and there's a number of members of your group that provide care. I just wanted to get a bit more perspective on what it means for carers traveling to visit loved ones and how you think we can mitigate some of that concern around people getting the best care but then having to travel a little bit further.

Peter Blackman: Okay. My classic example of this is a carer who took one of the persons they cared for to an A& E in this area and they would treat the person with the injury was triaged, and it wasn't a highly urgent one, and no account was taken of the carer. By the end of the time that the person was seen the four hours, that person had become extremely agitated with their conditions, and the person being cared for at home had been completely neglected, had soiled themselves, needed all sorts of things.

There's got to be a recognition of unpaid carers. We're saving you billions of pounds by what we're doing. and the least you can do is actually put something in place. The same applies. I was speaking to somebody this morning who was trying to get an appointment for high blood pressure situation in one of the Maldon practices and she went on patches at one minute to eight and took a screenshot of it saying it'll open at eight.

She then got through at eight and they said, all the appointments have gone, come back at eight. 12 at one o'clock, and she took a screenshot of that, and then she went on at a minute to one and took the screenshot and then at one o'clock, it was saying you've got to go for eight o'clock the following morning.

That is absolute rhubarb and has got to stop. So we've got to have effective systems and we got to identify who it is on the other end of the call. And I can put it on loud speaker and wait while I go from 15 in the queue to one, and I can do that because I can still go around and do things for my wife, etc.

And then I know when I get to two, I've got to turn it on. Cause I know that if they answer it and I don't immediately speak, they'll cut off and go to somebody else. I don't blame them particularly, but anyway, I could be, I could have a starter. Or some, so there's, other things.

I think there's a big need for carers to have recognition within the system. So have their own access through some means that they're able to, again, people were talking about older people, perhaps not being so familiar with technology equally. I'm going tomorrow morning to the County Council's exhibition about digital services for carers, which will be very interesting, but they've got to be useable. So I think that there's got to be an understanding. You've got to have some way of identifying. We all register with our GPs, the NHS system should recognise that we're carers or that the person's being cared for.

And that needs to be taken into account with the accessibility, please. Does that answer your question? Thank you.

Event chair: Okay. Anything further? Yeah.

Dr Matthew Sweeting: Peter, thanks for your comprehensive review, which is really helpful for me. And I share your focus on best outcomes for our population. Absolutely. Particularly as the lead clinician for this process. I just wanted to pick up a bit on the research that you did, with university as well, just to understand that. I'm not familiar with the work myself, but it was a qualitative piece of research looking at local residents' voices about access to health services. Is that correct?

Peter Blackman: It was quantitative and qualitative. So there were four different questionnaires. A lot of it was in the aftermath of COVID, but we also ran a couple of workshops. It's Masters level. You've got, it is 6000 words. I would suggest that if you look at the mind map and the commentary of that, you'll get, that's a pretty good executive summary of it.

Given the limitations of the resource time, etc. we put out questionnaires and got surveys back. It was ethically approved. It was solid, non directional research. I think it, and it was interesting because the workshops confirmed the, and also the points that had come up from the PCN, from the Alliance people who help with it, and from the PPG leads, etc.

Every, everything that came out of it was confirmed, but it's so rich. We've got those lists of the 10 most important conditions and, but that sort of stuff. So it's…

Dr Matthew Sweeting: Just to confirm your kind of one of your big learnings around transport links, particularly access to local services.

Peter Blackman: That is huge. I was an ambulance responder for many years and the time it took. If we got call out someone having a cardiac arrest or a heart attack anywhere on the Dengie, it was a lot longer for an ambulance to turn up than it was even in South Woodham.

And also finding the places out there can be, I'll never forget one that we were looking for in the fog in November, in Fambridge. Yeah, that was an interesting experience. We, me and the two ambulance people nearly had the heart attacks because it took us half an hour to find the person who actually was, sadly, someone who suffered from dementia and was actually asking for one of us to make her a cup of tea. But that was quite a finish to it. I think that accessibility is the huge thing. The Dengie have a huge problem with transport. And accessibility and South Woodham has a huge problem with increased demand largely since COVID. And I know that all the staff are working their socks off, but they literally can't provide any more.

They're providing more appointments now than they were, etc. But it's just not enough. And I understand the constraints that you're under locally. And I wish that when I heard about the record amounts that were being spent or provided for things, were actually corresponding to the demand rather than last year's figures and inflation.

Event chair: Anything more? No? Okay. Thank you very much, Peter, for that detailed contribution there and engaging in responses to the questions as well.

Submission 3 - Steve Rogers, Maldon resident

Steve Rogers is a Maldon resident. He presented his analysis of the findings of his investigations into previous consultations and what he had heard from local people.

Steve provided a handout which is at Annex 3a and a PowerPoint presentation (Annex 3b) He also provided as background documents the following:

- St Peter's Community Hospital development brief (April 2012) (Annex 3c)
- A news story from gov.uk about Five major hospitals to be rebuilt as part of over £20 billion new hospital infrastructure investment (Annex 3d)
- A document dated 2018 with the government's consultation principles (Annex 3e)
- NHS Mid Essex Maldon Community Hospital Strategic Outline Case (May 2009) (Annex 3f)
- A Royal College of Physicians Report *The problems of smaller, rural and remote hospitals: Separating facts from fiction* (Future Healthcare Journal 2020 Vol 7, No. 1:38-45) (Annex 3g)

Presentation

Steve Rogers: I'm a resident from, Maldon and I was at the initial public meeting in on 9th of February [organised by Maldon MP, Sir John Whittingdale OBE,] and of those 450 odd people in the hall, I've spoken to quite a few of them and I've been in contact with various different groups of people on messages, etc., etc.

And so I've come to present my analysis, which is made up of my investigation plus what I've heard from local people. And is anyone here from Maldon on the panel?

Event chair: No, I'm from actually completely out of the area.

Steve Rogers: So I seem to be the only one from Maldon, so I think it's probably a good idea I came.

And I've brought, instead of a presentation, fantastic, I'm pleased to hear that. instead of a presentation, I've had enough presentations in my life to kill me a number of times over, so I've got a handout. So there's a bit of a theme, as you, there will be, I'm sure through today. So I want to start off by really just going through some of the historic situation regarding St Peter's, etc.

So the first question, are medical services necessary in Maldon? Well, in Maldon, sorry, in 2009, there was a community hospital strategic outline case, which was paid, I believe there was about 250,000 pounds paid by yourselves to create this, this report through a number of professionals, including yourselves are on the committee.

And it came out with the answer that all of the services here, GP services, outpatients, in fact, all of the ones which are in your consultation document were necessary within Maldon. It was also decided that a new hospital was needed and the best and cheapest option was to develop the existing site. Despite those decisions, unfortunately, a third of the services which I've listed here have already been or are being moved out of Maldon as

we speak and sit here today. If you go to the next page, continue Braintree Community Hospital was completed in 2010. During the planning stage, Maldon was next.

I've spoken to people who work at St. Peter's who were on that panel deciding exactly where the stuff was going to go. Plans were drawn up and still being reviewed in 2012, and there was an NHS development brief, St. Peter's Hospital April 2012, which detailed exactly what could be done on that site. The population of Maldon District is now well in excess of the 62,500 which was outlined at that particular point in 2009.

And as you've well pointed out, there are 300 appointments and 80,000 a year in St. Peter's. So it's not a quiet hospital, it's a busy hospital. Further, this report points out that in 2029, which is only five years away, there'll be two people aged 15 to 64 for every person over the age of 65. To me, that's a pretty shocking statistic, and it means that there'll be less carers, the carers will be older, and sending someone home for community care will not be possible, as you suggested at the public meeting.

Because there just won't be that facility. Now, that means there will be, and is, there is now, and will be in the future, a need for community based rehabilitation or intermediate care beds. If I carry on, in that same document in 2009, under the local context, there are 11 pledges and 10 service commitments from the NHS East of England.

Two of the pledges were to ensure healthcare is available to marginal groups. Closing St. Peter's will certainly not do that. The next one was working with partners to reduce the difference in life expectation between the poorest 20 percent of the communities and the average. I can tell you the poorest ones will not be going to hospital, because it will take too long.

St. Peter's is strategically placed to enable, mark, sorry, strategic, is strategically placed to enable access for Maldon and the rural Dengie Peninsula. Without St. Peter's drive times are impossibly long and virtually no public transport. I think you have to remember that some assets are strategic and some tactical and the NHS needs St. Peter's because of its location.

Unfortunately, because of time in this whole process, I felt completely under pressure to try and get information to you. And I've found a report only the other day. So unfortunately, you haven't got this background information, but I found an engagement report, entitled *Improving community based care in Mid and South Essex,* and it was done by the Mid and South Essex and Care Partnership in 2022.

And it demonstrates how important community based rehab is and not only in St. Peter's but in the community. For example, I've taken a few quotes out of there and you've got them in your pack [NB this is a set of PowerPoint slides]. The first one says,

One thing that comes out strongly when people speak about community based rehab is the difference it provides compared to being in an acute hospital setting.

People start to get their sense of self back through a more personalised level of care. I'll read another one.

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

And the next one, because this is particularly personal to me, and I'll explain why.

The process from hospital to home was traumatic for me. Failed discharge after failed discharge, we were at a loss. They said, come and collect your loved one and then get on with it. The emotional distress of the patient and the carer is immense. The transition could be a lot smoother, a link from inpatient to outside would make a huge difference.

And that's personal to me because my father had a stroke, he's 81, 82 when he had the stroke and my mother's the same age and he was playing tennis before he had the stroke.

He went into Broomfield and my mother lived just 15 minutes away in a car from Broomfield, but the stress of driving the 15 minutes to Broomfield, another 15 minutes to try and park, another 15, 20 minutes walking, and my wife will confirm this, 4,000 steps there and back to the ward, she ended up in a wheelchair.

Alright, now that's only 15 minutes away from the hospital. Your proposals, some people have 50 minutes by car, three hours by bus. And the last comment regarding the community-based care. One stakeholder working in the acute hospital described how they felt the constant need to make pragmatic decisions, to free up beds.

In community-based care, there is more time to support people through rehabilitation and enable them to meet their personal outcomes. And I can't stress that strong enough considering the demographic of the Dengie Peninsula and Maldon. So why are NHS Mid and South Essex determined to reduce medical services in Maldon?

We've been given a number of reasons at the meeting and on the video presentation that we've been invited to watch. So the first one was to improve quality of care in specialist units. I found a report from the London College of Physicians 2020 where there are many questions as the advantage in both quality of care and finances when closing small community hospitals, you've been provided with that.

There are clear cases where fatalities increase purely due to the extended travel. Both in terms of the time, travel time, and the direct disincentive to go to hospital appointments if they take more than two hours on public transport. There's a study which is that the paper from the College of Physicians quotes 109 different papers as part of its study process for one of those papers covers the closure of 112 hospitals from 1997 to 2006 and concluded that mergers had no impact across a broad range of outcomes, including financial performance, productivity, waiting times, and clinical quality.

In fact, there was little evidence of any of gains as a result and was instead a reduction in clinical capacity and an increase in financial deficit. Another reason we've been told they want to close St. Peter's is because of staff recruitment. You're saying that in specialist

units you can recruit better staff because there are more incentives for the people to go there.

I find that, I find staff shortages in the NHS and the community care are complex. I don't believe you can lay the shortage of staff on the NHS at the feet of St. Peter's. Is St. Peter's in a fit state? Sorry, St. Peter's is not in a fit state to accommodate service any longer. That's true and that's because there's been no investment for 32 years.

I'm on page 6 of the presentation now. Another reason we were given to close it is it would cost 18 million to rectify St. Peter's building and there is no money. I have a problem with this because I don't believe money is a reason. The government has allocated 20 billion for new hospitals before 2030.

In a population of 70 million, that's about £285 per person. There are around 70,000 people on the peninsula. That's £20 million which should be allocated to this community. Further, if St. Peter's is sold for redevelopment, then the funds generated should come to support the medical services in Maldon District.

That's been estimated at £6 million, I don't know if it's going to be possibly more than that. For over 32 years, Maldon has been plundered by the NHS, spending the money which should have been spent on St. Peter's on other hospitals like Broomfield, Basildon and Southend. Further, the reduction of services in St. Peter's and the adoption of NHS Plan B would generate savings of £14.1 million, they're your figures. This money should be allocated to the medical services in Maldon to invest in facilities in the future. On page seven, nothing in the consultation considers the St. Peter's site other than closure. The site was given to the people of Maldon before being transferred to the NHS. It's in a prime location with a good access. It's currently 8,000 square metres. A community hospital or an NHS hub could be supported between 2,000 and 4,000 square metres. That's just my research on looking at other community buildings which are being built around the country. But you guys know better than me. The cost of building hospital facilities is around 4,000 pounds per square metre. So a new building could be built for typically £10 to £16 million on half of the site, and the other half could be offered for redevelopment.

If Maldon agreed to option B for 11 years, it could raise £14.1 million. Okay, these are the figures which are out of your consultation document. There are options for example. Option one, sell St Peter's site, start phase one of a new hospital build with the £6 million from the sale, do phases two and three as savings are released from the £14 million.

Or you could sell half the site, use the funds from the £14 million to develop a small community hospital or NHS hub at the St Peter's site. I'm not saying the building has to stay. These options are long term options, but Maldon's been waiting 32 years. The options above would require commitment from both the NHS and the government and would need to be underwritten.

Further, if options one or two could provide a small increase in the number of beds for intermediate community based care. I think this area needs a small amount of beds. There are a lot of people that cannot be put back into the community straight after being to acute

ward. It would leave, after 11 years of not doing anything, if we adopted option B, it would at least leave us with some local beds.

Why would the consultation not leave services in Maldon? And I'm afraid this theme is common to a lot of people who are at that first meeting. The government's published a consultation guide in 2018 to do with public consultation. Why would NHS Mid and South Essex have not followed the guidelines in a number of areas.

Section B states, consult about policies or implementation plans when the developments of the policies or plans are at a formative stage. Do not ask questions about issues on which you have already final view. There's no consideration other than closing St. Peter's. The decision's been made. The stroke unit has already been closed, and the options available are options A, Brentwood and Rochford, or option B, Brentford and Rochford. The decision's already been made. The birthing unit, we're told, we are consulting on one option. I'm not quite sure what a decision on one option is, but the decision's already been made. Other patient services, we're told, we need to suggest where they can be put. But we're not told, sorry, but we are now told the X-ray and hence orthopaedic and rheumatology will be in Braintree Community Hospital.

You have provided some alternatives, which this gentleman showed a little while ago. I'm afraid, living in Maldon, I know a little bit more about these places. The, the first one, the council offices, they already have the council, the police, two busy doctor's surgeries, and assistance and advice.

And yesterday, they were putting up a new sign saying, Permit holders only, because they can't stop everybody parking there. Then there's retail premises. If anyone's been into the car park, which serves the high street, you'll realise a lot of the times you can't get parked. Then there's Wantz Chase.

Does anyone know where Wantz Chase is? Yeah, It's, a single lane, dead end road with no parking other than four spots for the NHS staff and a school opposite, which means it's extremely difficult to get into most of the time. I've asked the NHS ICB to give me an example of a town where medical services have been distributed in many buildings and it worked successfully.

They've not responded and I talked to GPs and medical staff and they believe this distribution model would not work. We need a single NHS hub.

Carrying on with the deviation from the government guidelines, section C, it says, give enough information to ensure that those consulted understand the issues and can give informed responses. Include validated impact assessment of the costs and benefits of the options being considered. Nothing has been provided about what money will be available, what work space area is required, how many staff, what parking requirements for medical services to remain in Maldon.

How can we suggest alternatives without information? Nothing has been provided about the options for St Peter's site. We have been told St Peter's is not fit for, suitable for beds,

which I understand. But it's been offering the other services we need. And there are documents which show that there is a certain amount of money for the critical part, and there is a certain amount of money for the less critical parts.

But nothing's been said about that whatsoever. Residents have not been informed of the impact or extent of the almost impossible public transport access to Brentwood, Rochford and Braintree. There's been no offers of support, transportation, which will make access to the National Health Service available only to the privileged. You're making it so unless you've got a car, you won't go. It's wrong. Section E. Consultation should last for the appropriate amount of time. I mentioned I feel under pressure all of the time, and I do because the consultation started on the 25th of January. The first public meeting was on the 9th of February.

But if you wanted to present evidence here, you had to do it by the 4th of March. Although the NHS may be claiming eight weeks consultation, if you wanted to provide evidence after the initial meeting, it's just four weeks. And by the way, Bradwell Power Station consulted for 12 weeks and provided literature to every single house.

And the final one, section B, which says take consultation responses into account when taking policy forward. I find that a little difficult because a lot of the policy decisions have already been made.

Finally, beds. I've asked the NHS and ICB to provide details explaining why option A in your bed analysis costs 2,000 over 11 years and option B saves 14.1 million over 11 years. They're providing approximately the same number of beds. In fact, it's the same number of beds, just slightly different allocation. I think there's three more stroke and two rehabilitation and the other way around. They've not provided this information. I believe the reason it's not been provided is because option A requires an investment in Brentwood to create the additional 25 beds, probably in excess of 14 million.

This money could be spent on Maldon. While doing this report one Sunday, this Sunday afternoon I did it, I used a travel plan to check how long it would take to get from Maldon, not Bradwell or Southminster, to various hospitals by public transport. So to get to Rochford, this was about 11 o'clock on a Sunday morning, to get to Rochford I had to take bus 332, then number 7, it would take 189 minutes, 3 hours 9.

Brentwood, I could take the bus 332, then the train, then I'd have to walk. And it'll take 139 minutes, 2 hours and 19. Braintree, I could take the bus 332, the 170 and the 370, and it'll take 141 minutes, 2 hours 21. Billericay, I could take the bus 332, 300, and it'll take 124 minutes, 2 hours and 4 minutes. Halstead I can take the bus 75, the X20 and the 370 and it will take 222 minutes, 3 hours and 42 minutes. Grays, I can take the bus 332, the 300, the train, C2C, and it will take 212 minutes, 3 hours 32 minutes.

You're making the NHS into two tier. I'm fortunate, I've got a car. But there's a lot of people in Dengie who either haven't got a car or they can't afford the petrol or the taxi to do this. Apart from the devastating impact on the Maldon District residents when they are in need, having extraordinarily long journeys to hospital, where it is likely that loved ones can't visit,

the environmental impact or carbon footprint of this decision, if 80 percent of the people drive, has not been considered.

Finally, in a conclusion on page 11. I believe I've demonstrated on the evidence provided that there's always been and has and is now requirement for strategic medical services in Maldon, e.g. a hospital or NHS hub. Further, there is money available if the NHS choose to use it to provide medical services in Maldon.

The NHS is not consulting correctly and this should be stopped. The NHS must stop making decisions with no consideration or care for the needs of the Maldon district. St. Peter's is a strategically important hospital for the community of the Dengie Peninsula. Community hospitals are being built in the UK.

NHS Mid and South Essex just don't want to build one in Maldon, where there is clearly a need now and in the future. Over 32 years is a long enough to wait to get what clearly is needed. The £6 million site money and the £14 million savings from closing St Peter's Bed should be ring fenced and allocated for the future medical services in Maldon.

Now I was going to stop at that point because I thought I'd made my point and come to my conclusion. Then I realised actually, you know this already, because there was a paper on February 2024 provided in an answer to a number of questions on this consultation process, which details the St. Peter's Hospital estate briefing, February 2024.

And section seven says: The need to develop suitable fit for purpose health care facilities in Maldon has been recognised by the NHS for several years. There have been previous attempts to identify options for sites to develop a Maldon health hub which would provide the Maldon district with modern and appropriate premises where health and well being services are provided on integrated multi agency basis delivering collaboration between GP services, the acute Trust, Maldon District Council, healthcare providers, organisations, social care and voluntary sectors.

And even further than that, if you read further down, it talks about further developments and it says, there is the option for a second phase for inpatient care and specialist services. So you agree with everything I've just said. Why is this not in here?

Event chair: We've actually gone a little bit over time with that, but I felt that what you could,

Steve Rogers: I was just using up the other time.

Discussion

Event chair: No, it's fine. Personally, I found there's some really interesting stuff in here and it's quite clear. You've put a lot of work into what you've contributed here and a lot of thoughts into it. I'm going to open up now to the panel to ask questions and talk with you further. Anybody want to start with questions?

Emily Hough: Thank you. Yep. Clearly a huge amount of, information and time that's gone into this. So really appreciate you presenting it to us today. I was wondering if you could

talk me through a little bit more about the options that you've set out on page seven. You suggest two options, around what you would think to be included in those?

Steve Rogers: Okay. In terms of what the health facilities or the actual money because I'm not a health person. I'm just an engineer, a retired engineer who's got frustrated with this situation. Number seven. So what do you want to know? You've suggested that if we agreed to option, and here you say if we agreed to option B, there are some options, and I'd just like to better understand what you're thinking about in terms of option 1 and option 2.

What I'm saying is that nothing in this consultation, although, in fact, I'll just pass this out, bear with me. The document I've just handed out (Annex 3c) is what was provided to me on a question, I asked a question about what the maintenance charges were within St. Peter's and they actually offered me this document which details all of the plans which were for a brand new site. And so my suggestion is first of all, you have in here two options A and B.

A clearly is 25 more beds at Broomfield, which clearly have to be paid for because B there's a £14 million saving. That £14 million saving is the cost which the public and the people on the Dengie Peninsula will have to pay for 11 years to get that money. But I'm suggesting that maybe that's the price worth paying.

Maybe we say we agree to be if that money is ring fenced and used for new facilities within Maldon. And I'm saying that if you're going to do that, you won't necessarily be able to keep St. Peter's. So you will also have a benefit from the sale of the site. That site was given to the people of Maldon, and so that money should also be added to that £14 million.

That would make around £20 million, which would pay for a small community hospital on a greenfield site.

Event chair: Okay, anybody else want to?

Audience: *Inaudible*

Steve Rogers: There isn't any analysis on it.

Event chair: Okay, can I, excuse me, can I ask audience members? Yeah, I need to keep the focus of the panel on the presenter. Okay. Okay. No worries. And next question.

Dr Matthew Sweeting: Yeah. Steve, thanks for your really detailed piece here. which was really clearly presented. I wanted to explore a bit. I guess the presumption around bed based units, say the idea of having units, whether it's for stroke, rehabilitation or for

Steve Rogers: The stroke... the acute hospitals need the specialist area. I understand that. But what I'm saying is that within Maldon within accessible distance, there needs to be a few beds for high nursing, low tech type recuperation.

Because there are so many older people that cannot get. My mother, I said, when my father came out of hospital, first of all, they stood him up and they said he can go out. He

couldn't even walk and he was playing tennis when he was in there. So I said, there's no way you're releasing him. So we forced him to stay in there for a little bit longer.

When he came out, he was in a wheelchair. My mum couldn't do anything with him. We had to pay for carers to come in and support them. We got nothing from the hospital whatsoever. All right now, that's us. Fortunately, they're in a position where they could afford to do that. I know dozens and dozens of older couples in Maldon and the peninsula who would not be able to do that.

And we need to have facility where at least they can come out of acute care. Spend two or three days with physio, building up their morale, building up their strength to go back home. Otherwise you're going to get into a repeat cycle

Dr Matthew Sweeting: And as an older person doctor, I completely appreciate that. I guess it's the moving the change of thought over the years on bed based units.

So some of the quotes you do is we started off, as you said, with lots and lots of beds 20, 30 years ago, but we know the outcomes for older people, particularly, were not always the best, particularly long lie beds. We know the evidence is quite poor for that now can be deep, can something called deconditioning, more confusion, lack of, and then obviously morale.

So I suppose it's. Is there an understanding, do you think, around the importance of home based rehabilitation as well to ensure that, because that's been a lot more focus in the last few years?

Steve Rogers: There's an understanding, but it's not possible with an older demographic in every case. And so there needs to be somewhere where they're out of your hair in terms of the acute stuff. I'm sure you have a fantastic job and you're the first person I've come to when I need support, but when you come out, you're, you've gone into an acute right there. There are some, bits in that report which I was reading. And it was saying that, one woman was left, she was an acute ward, but she was left to wet herself because I'm sure she had the appropriate underwear, etc. But the staff in the acute ward was so busy that they felt that was the right thing to do. They didn't want to get out of bed. They wanted to keep her there and do her bits and pieces. But that was so degrading to her. That whole mental state started to collapse. Now in a community based nursing environment, you can look after them for the few days they need to get out.

And I'm just saying that I don't believe we need a hub with everything that you're trying to, not you personally, please don't take it to everything the ICB are trying to take away. We want to stop all that. We need to keep it in Maldon. But I do think in the long term there will be a need for a few community beds.

I'm saying that Maldon should take the hit for 11 years. If you promise to put back that money that you're going to save,

Event chair: I'm interested to be interested to know whether you'd be interested in having further discussions.

Steve Rogers: Absolutely.

Event chair: About that balance of care in the community versus caring in the beds and explore that a bit further.

Steve Rogers: Absolutely.

Event chair: Yeah. I know Peter is committed to, was invited to have further discussions and things. Would you be interested in doing that as well?

Steve Rogers: Absolutely. Yeah.

Event chair: It might be worth everybody having further conversation with you. There are elements that I'm aware of within what you have said that are very much open to interpretation.

And I think you would benefit from hearing on a personal basis, some of the dilemmas that the clinicians and others have and the estates have.

Steve Rogers: I'm happy to do that. If you take seriously the fact that the money I've highlighted here needs to come back to Maldon. Because every time I mention it, they say, people say, Oh it's not NHS Mid Essex.

It's NHS England. I'm sorry, but you report to NHS England or whoever it is. To us it's NHS. Alright, it doesn't matter what flavour it is, it's NHS, and it's money which we're all paying for the NHS, and so that money needs to come back to Maldon, because they've been deprived for too long.

Event chair: I'm going to, yeah, if you want to come in, I'll come back to you Peter. Thanks.

Chris Howlett: Yep. Thanks very much for that, Stephen. It was a really, interesting presentation and there was a lot of sense in much of what you included within your presentation. I just wanted to pick up one on one point.

I'm also an engineer, so we're from a similar background. I tend to look at things from a very practical perspective. You talked briefly about whether there were any examples of where medical services have been distributed around town, rather than in one building. And you commented that you didn't think a distributed model would work.

Steve Rogers: That's correct.

Chris Howlett: Are there any specific reasons why you think that couldn't work?

Steve Rogers: I've just spoken to GPs and other medical staff, and they've said, if you take the services which currently work together, you take them out and put them into various different buildings. Then it's not going to work because you have to share resources from time to time. And that's very important. And I think you'll agree. It makes it far more complicated. Apart from also the fact that please don't take this personally. You couldn't look after one building. How the hell are you going to look after five?

Chris Howlett: So the point is really about the economy of having services co- located so you get the efficiency of sharing resources.

Steve Rogers: Yeah, you need to have those people working together. Not only for the good, for the health of the workers, let alone anything else.

Chris Howlett: Yeah, okay. I would also welcome a follow up discussion about some of the points that you've raised. Thank you.

Event chair: I'm going to break with protocol a bit and bring you back in, Peter. I know you wanted to say something. Go on.

Peter Blackman: I'd just like to say that I think that this highlights the point I made about the lack of information and education of the NHS compared to 1948 and today. And I welcome the discussion because I think if we start talking about the way virtual wards are coming in and the improvements that will come from the integrated neighbourhood team, I've been involved in these talks since probably about 20, 2000, and I admit that each time we've looked at it, we've needed to look at a different solution to fit where the NHS was then.

And we want a solution that fits where the NHS is today, not yesterday. But I hasten to add everything I said about the need for the best care.

Close of session

The chair thanked presenters and complimented their presentations. And, noting that the session was running 15 minutes ahead of schedule, the chair announced a 20-minute break in proceedings.

Session 2

14:00, 19 March 2024, Maldon Town Hall

Chair's welcome and introduction

The Chair welcomed everyone to the second session and invited new panel members Debbie Goldsmith and Nikki Abbot to introduce themselves.

The Chair described the format for the proceedings and evacuation arrangements and introduced himself to new arrivals. Thanks were noted to people who had made written submissions to the hearing, Judith and Roger Bond, Lindsey Wright.

The Chair reminded those present and viewing online that responses to the consultation would be accepted until the 4th of April and encouraged everyone to respond. He reminded observers in the public gallery that a consultation hearing doesn't take questions from the floor and advised that they could direct their questions to the consultation team.

	Speaker/s	Topic	Organisation	Page
Submission 4	Cllr Paula Spenceley	General	Heybridge Parish Council	Page 32
Submission 5	Cllr Phil Barlow	Outpatient (mainly)	Witham Town Council	Page 40
Submission 6	Holly Fry Nicola Dallinger	Midwife-led birthing	N/A	Page 44
Submission 7	Cllr Emma Stephens	General and midwifery	Maldon District Council (Tollesbury ward)	Page 51

Panel

- **Dr Matthew Sweeting:** Consultant Geriatrician at Broomfield Hospital, Mid and South Essex NHS Foundation Trust and Executive Medical Director at Mid and South Essex ICB
- **Emily Hough:** Executive Director, Strategy & Corporate Services at NHS Mid and South Essex Integrated Care Board
- **Claire Hankey:** Director of Communications and Partnerships at NHS Mid and South Essex Integrated Care Board
- **Debbie Goldsmith:** Midwifery Lead, NHS Mid and South Essex NHS Foundation Trust
- **Nikki Abbott:** Interim Managing Director, Women's & Children's Services, Mid and South Essex NHS Foundation Trust

Submission 4 - Cllr Paula Spenceley, Heybridge Parish Council

Cllr Spenceley presented statistical evidence/data related to deprivation levels in Heybridge linking to inequalities in access to health services, distances of travel and availability of public transport. Her evidence contained collated views from residents attending regular parish events for groups including the elderly and parents with young children and of parish councillors and residents.

Cllr Spenceley's PowerPoint presentation is available at Annex 4. Councillor Anne Beale, Councillor Simon Burwood and Councillor Colin Edmonds accompanied Councillor Spenceley to the event.

Presentation

Cllr Paula Spenceley: The evidence that I'm presenting today is on behalf of Heybridge Parish Council. I'm also a district councillor for Heybridge West, and I'm in fact the Maldon District representative on the Health Overview and Scrutiny Committee at Essex County Council. By representing Heybridge, I really want to highlight an area that needs perhaps, I know we, the whole district needs special consideration here, but I want to bring to your attention some particular points about Heybridge.

I think there is a certain view that, you know, Maldon's quite an affluent district, and it's not true everywhere, so Heybridge is an example of that. It's very sensitive, I've learnt that. Equality and accessibility to services. One of the key principles of the Integrated Care Board, as stated, is that it's to help ensure equality and access to the services that it provides.

For the residents of Heybridge, as well as the residents of the district more widely, the range of proposals in this consultation would promote inequality of access. This presentation aims to examine some of the reasons why. So if we look at the deprivation and age profile for Heybridge, Heybridge West particularly shows that on one side of the ward, there are indicators of high level deprivation in a number of different categories.

This data is taken from the indices of deprivation 2015 and 2019. It is split down into LSOAs and to explain that, there's smaller areas than wards because that enables a better view of the statistical data around deprivation. So Lower Layer Super Output Area is an LSOA and it's a geographical area designed to show data more correctly.

So here are some of the deprivation data headlines for Heybridge West Ward, and this is the right hand side of the ward where we have the greatest deprivation. Income deprivation is among the most deprived 20 percent nationally. Employment deprivation among the most deprived 30 percent. Health deprivation and disability, among the most deprived 40 percent.

Income deprivation affecting older people, among the most deprived, 40 percent. And this is one that absolutely breaks my heart. Income deprivation affecting children, among the most deprived, 20 percent nationally. On the other side of that particular ward, on the left hand side, barriers to accessing services, and that includes housing and health services,

transport, it is among the most deprived 20 percent and there's a heavily elderly population on that side of the ward and very, poor public transport, which I'll come to in a minute.

Connectivity to services Heybridge, as with much of the Maldon District, suffers from poor public transport infrastructure. The very famous thing that there is no train station in Maldon and Heybridge. And it is the central area of the district. Heybridge, interestingly, also has the largest, strategic, single strategic development site in the whole of Maldon District, which is the North Heybridge Garden suburb.

On the left side of Heybridge West, there is just one regular bus service, to Chelmsford, not to Broomfield Hospital itself. You require another journey at the end of that, and it's a two hourly service, and I can tell you from personal experience, it's not always a two hourly service. The one way fare for a taxi or cab to Broomfield is around £40.

Actually, it can be more than that. I've experienced that myself recently. Braintree would be around £30 to £40 and Brentwood up to £50 just for a one way journey.

Equality of access to services, both Mid and South Essex Integrated Care Board and the Mid and South Essex Foundation Trust have those key objectives, it's not just the ICB, focusing on equity for the population they serve. Any loss of medical services to Maldon District will be in direct opposition to these key objectives with regard to Heybridge, indeed to all of the residents of Maldon District. Other services currently offered at St Peter's. This part of the consultation is vague and in fact unacceptable in my opinion and that of the Parish Council. The options to answer the question will undoubtedly lead to the possible misinterpretation of data.

And there I'm talking about the question around the other services. You're asking, is it okay, basically, to close St. Peter's and put the services in and around Maldon? But there's a confusion there. There's no list provided. In fact, the list provided, as is only very recent.

There are no details about where any of those would go. What do you mean by in and around Maldon? And it turns out by the list that in and around Maldon is Braintree. Who would know that? I don't think Braintree is really going to be an answer, for people certainly living in my ward and for the rest of the Maldon district.

And so it's very misleading. And by not putting what was meant there and what was being considered, there's a danger that introducing that list so late on in the consultation is going to lead to very difficult data to properly interpret.

The consultation has been inadequate in targeting the most affected groups, including people with disabilities. We're going to come to that in a moment. The experience of Heybridge Parish Council with regard to this consultation has also been highly unsatisfactory. And I don't know if you've noticed everybody, but there aren't many parish councils represented here today.

And do you know that you didn't reach out to them? And I find that very strange because Heybridge is one of the biggest parish councils in the district and we have an elderly lunch

club. We have clubs for mums and dads with young kids We have all sorts of things there all sorts of ways. You could have come and engaged and you didn't even contact us.

In fact the reason I'm here is because I was quite on board with, St. Peter's and, what was coming to us from behind, from a long time ago because of HOSC, because of Health Overview and Scrutiny and because of my interest in it. And in point of fact, it was the contact to get me here was all from coming towards you, not you coming towards us, which I think is how it should have been.

And actually we asked, for example, for paper copies and it took us weeks to get them. Absolutely took us weeks to get them. So it's very unsatisfactory.

New GP facilities at Heybridge. I'm really looking forward to these, but I'm almost fed up of hearing about them. And the reason is, the planned new GP facility at Heybridge is not a compensation at all.

To the harm of these proposals for the residents of the parish. This is just a GP surgery that we're talking about. It was always planned. It's suddenly being heralded as some great achievement that somehow replaces what we've lost. I will now read a paragraph from a Maldon District Council 2010 report on the Plan U Health Hub to justify this statement.

In fact, I've got a little bit more than that. So I'll just pop my glasses on because otherwise when I leave them on the rest of the time I can't see anybody else. This report, was to Maldon District Council's it then had a community services committee. It doesn't now, but it did then. And it was an update on the community hospital, 30th of March 2010.

And at paragraph 2.3, informal consultation on a strategic services development plan, SSDP, was undertaken by the then PCT in March 2005. This set out a proposed model of a community resource centre, i.e. a hospital, in Maldon, with extended primary care centres in Danbury, South Woodham Ferrers, Mayland, Tollesbury, Tillingham, Southminster and Burnham on Crouch.

In addition, there was a proposal for a new primary care centre in Heybridge. The development plan set out a time scale of three to six years to complete all the facilities. And members of the District Council supported it. So we should have had the new health hub by 2013, according to that. But it went on.

In July 2016, the then Clinical Commissioning Group for Mid Essex wrote to the then Director of Maldon District Council and I've got that from a report, which is in the public domain. Thankfully, otherwise I'm in trouble, but it looks like it's in the public domain. So primary community development for Central Maldon CCG commitment.

It says the CCG remains committed to the development of an affordable primary community facility for Central Maldon to replace St Peter's Hospital.

We are currently applying for funding to support further development of the outline business case and to support the development of a feasibility financial appraisal for the Blackwater surgery.

We are also in the process of sourcing an experienced project manager to take the scheme forward.

I'm guessing they were never employed.

Data shows clearly that in fact access to primary care services from Maldon District, including Heybridge, have worsened since this time and they compare badly to both the national and Essex picture. So we haven't solved anything. It's difficult to understand why it was felt that this was needed then and it's not needed now.

This is very temperamental, isn't it?

Excuse me. I have to actually make sure that I've got the, a few words from Heybridge Parish residents. I thought what I really must do is, get to speak to some people, perhaps maybe even some, that wouldn't get to complete the consultation, As, without being funny, it didn't seem that the ICB was going to do that, so I thought I'd try.

So Nikki, she's a lifelong Heybridge resident and local care home worker. Been a care home worker for many years, speaking about her father.

> *"After 12 weeks of stroke rehab at St. Peter's, my dad was able to eat, talk and walk. Knowing I was going to be his sole carer, I was able to visit him at the hospital daily.*
>
> *And sit in on his physiotherapy and speech therapy sessions. This meant I could learn directly from the therapist what my dad needed, so I could continue their good work when he came home."*

As a care worker, she wouldn't have been able to do that with the distances that would now have to be travelled.

I'm all for a specialist centre for this kind of thing. Let's just have it in Maldon though.

Abbey, real name changed to protect her identity, direct and unchanged quote.

> *"I have a son aged six who has serious disabilities. I take my boy to St. Peter's a lot for speech therapy and for a few other things. I find this hard to talk about but I have to say something because I'm scared. I'm so worried I can't sleep.*
>
> *We can't make ends meet as it is. And I won't be able to take him to Broomfield or the other hospitals. They're too far away. I don't have the money to run a car. And it's so hard with him on the bus because it takes so long. What will I do?"*

Sarah, Heybridge resident speaking about her travel costs for crucial scans. Sarah is an older lady.

> *"I recently needed to attend an appointment at Broomfield for a DEXA bone density scan. The taxi cost me £36 each way from Heybridge. This is quite a common scam for retirees like myself."*

And of course, I think we know that, in all Mid and South Essex, Maldon District is the area that has the greatest aging population situation, which is, I believe, expected to continue.

So this one's quite important. So I'm not going to say much more about Penny than her name Penny, but what I will say is, and not everybody in this room will know this, that she was one of the people who actually, at the very start, initiated the Save Maldon's Medical Services campaign. And she's from Heybridge, so I'm very proud of her.

But she's homebound.

Where is the section of the ICB consultation specifically aimed at and about accessibility? Apart from a phone number to request an alternative versions of the survey.

Where are the invitations to the disabled, chronic illness, neurodivergent and special complex needs community and their carers? Ensuring their many complex needs are considered and met. One person has said they are terrified. Another that they will not cope with the proposed changes to medical provision.

I have asked MSE ICS more than once about the focus groups they are inviting people to.

And actually I've seen direct evidence of this from Penny.

They've refused to tell me if one is active in my locality or online. This is a disabled person who has been homebound for 20 years With compromised physical and cognitive capacity. My lived experience is of no interest to them. I find the process and attitude discriminatory and ableist.

And if you want more evidence from Penny of that, I can certainly put her in touch with you, but I believe she already is.

I've just got the views of the parish councillors, so I'll quickly go through those views of Highbridge Parish Councillors.

Moving any of the medical services provided at St. Peter's outside the town will have a significant indeed very serious negative impact on our residents, many of whom already suffer deprivation and or have very poor access to services.

Public transport is not sufficient from Heybridge to enable easy accessibility to services if services are moved away and will worsen the current situation.

No services should be removed for St Peter's until the long promised health hub is built in the town.

We as a parish council believe that the proposals of this consultation are a total departure from the previous plans and promises made to our residents over the last 30 years.

We feel that the needs of our residents are being overlooked in these proposals.

We urge the Mid Essex Integrated Care Board to submit firm proposals that resolve the claimed issues at St Peter's and retain all medical services provided there within Maldon.

Thank you.

Discussion

Event chair: Sorry have rushed you a bit there. Panel members, anybody want to start with any questions for the councillor?

Claire Hankey: Hello. Hi. I just was interested, you talk about Heybridge, West, right and left hand side. I was just interested to what size population are we talking about in the kind of, for that?

Cllr Paula Spenceley: Okay, so we have around, I think in that half of the ward around three and a half thousand residents and we have most, we have the North Heybridge Garden suburb mostly within our ward, which will be another 1,300 plus homes.

> **Cllr Spenceley clarified this answer on 25 March via email:**
> With regard to population figures, which one member of the panel asked for and I did not have to hand. At the last census (2021) there were 8,163 residents living within the Heybridge parish, encompassing both Heybridge West and Heybridge East. In addition, there are a further 744 residents living in Heybridge Basin Parish, which until recently was part of the Heybridge parish area and of course still in reality remains part of the Heybridge area.
>
> The North Heybridge Garden Suburb (known as Westcombe Park) will see more than 1,300 homes added to Heybridge, with the first 15 families having just moved in.
>
> Altogether, it means that within the next few years the total population of Heybridge can be expected to easily surpass 12,00 residents. I would like this added to my evidence, please, as the scale of population affected by the proposed loss of medical services to Maldon district is growing daily and perhaps more substantial than has been fully appreciated.

Chris Howlett: Thanks for that presentation, Councillor Spenceley. I was interested about your commentary about the difficulties with access to primary care services. Do you think that the ideal solution means co-locating primary care with those services that are currently provided from the hospital, or can you see that there are other viable solutions other than having that co-located hub?

Cllr Paula Spenceley: I think when you look back at what the original plans were, the idea of having these new super surgeries dotted around, the ones that I mentioned here, and the health hub at the middle was quite critical. One of the things that I recently heard at the, an overview and scrutiny committee from the ICB was that one of the reasons for our GP patient ratio being so poor is that doctors aren't attracted to come here.

A, because of the travel, probably, but also because we have some facilities which are, less than ideal. And I think this plan was to try to rectify that situation a little, so that there was a cohesive care system within, medical system within, Maldon and Heybridge and within that area, so linking primary care into intermediate care.

I think that what's being planned here with taking that central hub out of the middle and this strange idea of scattering services into buildings that many people who live here can't envisage at all is that it's really not going to improve that situation. And I could bet that if that happens. Who can say what'll happen in the future, but let's just say I wouldn't be surprised if 10 years' time I could be sitting here saying that those ratios are just as bad as they are now. Thank you.

Event chair: You'll have to excuse me for this because I'm ignorant of the local area. and the reason I ask this is because I see the interactions between ICB parish councils and councils, county councils, in other parts of the country. So I wanted to ask, is there, does the parish council and yourselves, do you ever get into a conversation with the county council and try and facilitate discussion around the transport services?

I can see that's obviously a theme that people have frequently looked at.

Cllr Paula Spenceley: I can help. So I'm a member of the quite newly established Maldon and Heybridge bus users group. And that often meets at the parish council hall. So there is really no way that you would jump because we're three, it's a three tier system here.

So you've got your parish councils, your district councils, obviously and the county council. Really, this group has been facilitated by one of our local county councillors to try and make that communication easier, but clearly it's failing. I'll give you just a little example, which is very quick.

I was tasked with going around and looking at the condition of the bus stops in Heybridge, asking if they had timetables. Most of them didn't even have any indication which bus stop there, let alone timetables. Some of them were overgrown and we couldn't actually find them. Some people had actually given up in one place in Heybridge, waiting at a bus stop, there was a nearby place where it was easier for the driver to pick them up. We don't have a public transport system here to speak of, any worth, particularly one side of Heybridge is better served by public transport, as you saw, than the other side. I have cases where I'm regularly emailed by either elderly, more usually friends of elderly, residents who were desperately worried because the one bus service we had that went into Maldon was cut quite recently and now they're totally socially isolated, they can't even afford to get into the town.

Event chair: I have to confess it's not really my place to say this, but maybe there's a case here also for trying to facilitate conversations with the council. The county council about solving some of these problems, whether or not you can achieve it is another matter, but you've got to keep trying, haven't you?

Yeah, and I don't know if that's something that resonates with, yeah, panel members. Yeah. Okay.

Cllr Paula Spenceley: The point is those services aren't there and these proposals don't recognise that fact. And I think that is a major flaw in this. We had somebody sitting here

earlier. But the proviso would be, there would have to be, good public transport and parking, but there won't be will there. And that's the issue, that is the issue.

Event chair: it's a conversation that should be extended outside of this, but I have some experience of other places that have actually come up with unique solutions and perhaps it's, I could have a conversation with you later. Okay, anything else that we want to, nope, okay.

Submission 5 - Cllr Barlow Witham Town Council

Councillor Phil Barlow summarised his presentation as follows:

Witham is a substantial population centre in Mid Essex bounded East and West by the Regional centres of Chelmsford and Colchester and North and South by Braintree and Maldon. The ICB is aware of the health deficits that exist in Witham and have done for years and are also aware that we rely on many of the services that St Peters currently provide. Maldon is the closest town and is the easiest in terms of access to health services for my residents. Your proposals for acute bed reprovision will move these much further away and midwifery isn't likely to be the same reprovision. However most importantly there are no details of any reprovision of the outpatient services let alone where they may be located. This is of great concern to my residents.

Presentation

Event chair: Councillor Barlow, could I ask you to come and present your evidence. Councillor Spenceley, you don't necessarily have to move from there if you prefer to stay.

Cllr Phil Barlow: thank you.

[The livestream froze at this point, leaving 39 seconds missing from the recording of Cllr Phill Barlow's presentation (video timestamp 2:24:19 to 2:24:58)]

At the public meeting which we arranged those facilities that we did have at New Ivy Chimneys, which was a mental health hospital, and Bridge Hospital, which was a care facility, and we were promised health services when they closed, and we never had them. I've lived here for coming up to 50 years, represented the town and the district across the years since 1989. I've also been a non exec director of Mid Essex Community Mental Health Trust. And then from 2002 to 6, a non exec director of what was then Witham, Braintree and Halstead Care Trust, which dealt with primary care services and elderly services.

Event chair: Sorry, Councillor, I think people are struggling to hear. Can you pull the microphone a bit closer if that's alright?

Cllr Phil Barlow: Yeah, I'll try to and I'll try to be a bit louder in that case. In 2002-6, our then Chief Executive, Paul Zollinger-Read, undertook a health services audit for Halstead, Braintree, Chelmsford and Maldon, which were our largest population centres, and they all had secondary care facilities. His conclusion was that we had hardly any, we had a significant deficit which needed to be redressed. When the care trust dissolved in 2006, our findings were sent to the Mid Essex Primary Care Trust, which took over facilities in all of those towns and we wrote to them more than once in the lead up to them taking over and subsequently when they came into being, we heard nothing and I think that part of that may well have been that this was the time when walk in centres were being devised by the then government.

And if you had looked at the clinical need for each of the population centres, you would have found that the walk in centre should have been based in Witham. The anecdotal evidence was that the deal had already been done with Sainsbury's in Chelmsford, and a walk in centre was built as an annex to Sainsbury's.

We have no corroborative evidence for that, but quite clearly rumour was rife, because if you'd have done the clinical need assessment, that would have fulfilled a lot of the deficit that we had. And so since 2006 practically, and going back a couple of years earlier, we have had a proven audited clinical need for secondary care services and they have not been delivered.

When we heard that St. Peter's was closing and there was a consultation to enable people to make those points, there was not one in Witham. I understand that John Whittingdale got a public meeting in Maldon, but there was one in Chelmsford, bizarrely, and in Thurrock. I went to the Chelmsford meeting and made very clear that I did not think that the ICB had done their homework sufficiently to understand the potential impact on health services that would accrue to Witham in the same way as they, they do for Maldon. We rely on Maldon, Braintree and Broomfield very largely for secondary care services.

Maldon is by far the closest. And at least we have a better bus service than you. But we have one bus that starts in the town centre and stops at the hospital. So for those people who cannot drive, Maldon is by far the easiest, the most obvious secondary care centre. When we did a little bit of canvassing ahead of our public meeting, and we spoke to 60, 65 people, over 60 percent of those go to Maldon Hospital for blood tests.

Because even though our GP surgeries offer blood tests to some of our patients, they don't offer them to all. And so there is a clearly a need for a phlebotomy service. In addition, people have gone there for X-ray, for physiotherapy, for hearing tests, and for a number of other outpatient services.

And so we clearly recognise and rely on the hospital services that Maldon provides. And we're very concerned that when we went to the public meeting in Chelmsford, there was absolutely no idea whether all of those services would be re provided and where. Our concern was also that and I'm sure that's true of Maldon, that the critical and secondary care beds, are going to move to Brentwood or Rochford.

Now, if you don't go by bus, it's impossible anyway, isn't it? But a bus service to Brentwood from Witham, there isn't a direct one. The A12 is dreadful, and when I asked the question about extra parking for those whose relatives may want to visit those care beds, we didn't get a satisfactory answer.

Rochford is probably even more complex for Witham people to get to than Brentwood. The maternity services, which were touched on, we, a number of our, residents have used them, including my wife and my daughter. The fact that home births were offered there, and I think I told you the story about my, my daughter not quite getting the birthing pool filled before my granddaughter arrived, but nevertheless, the offer was there, and we were not convinced that in fact the same offers would be made if they moved to Braintree.

And also, Braintree is at least two buses from Witham, whereas Maldon was only one. So we had some idea of where those facilities may go, but we had no idea of where the secondary care facilities would go. And since then, I understand that a number of places have been identified in Maldon, but I think you made the point that actually, is there parking in all of those areas? And if you're coming down from Witham, actually the bus goes to the hospital. It doesn't necessarily go to those other parts of Maldon. I appreciate entirely that the people in the Dengie Peninsula will have a bigger problem, but ours is still that we've been promised secondary care facilities.

Here was an opportunity for the ICB to consider whether they could actually re provide across an area. And the responses that we've got is that no, they're not really being considered. We had a public meeting and our MP arrived and we have one of the NHS representatives here. And we again made the point that we are really concerned that if Maldon closes, we will have fewer services available to us.

We also made the point that even though Witham is fairly well served by bus services, none of them go direct to a healthcare facility apart from Maldon. There are at least two buses that our residents have to get to William Julien Courtauld or the Braintree Community Hospital. And for the area that I represent, three buses are necessary to get to Broomfield.

We have to get one to get into town, one to get to Chelmsford bus station, and then another. We have lobbied for a considerable amount of time to get a direct bus service from Witham. And, once, First Group actually held the rail franchise and the bus franchise, and we said have a through ticket, and they said no.

We also have a difficulty in as much as, for much of Mid Essex, there are community transport facilities run by Community 360 and another organisation called DigiGo. If you look at the map of Mid Essex, you'll find that Witham isn't in either of those maps. And so we are also denied community transport to get to health facilities that was acknowledged by our MP last week who said that she would seek to work with the integrated care service which is the ICB and local authorities to see if that could be, I guess, improved but in fact invented would be helpful for us.

The Chelmsford meeting I went to actually had the leader of Chelmsford City Council there who acknowledged although the ICB is there to provide health facilities, access is just as important for people. And if the transport system and other people do not make it easy, then, in fact, it's much more difficult when you seek to find somewhere to provide them.

And that's the basis on which I went to the public meeting. That's the basis on which we organised our own public meeting. We were not I think satisfied that sufficient answers were given because we had no indication that the health deficit continued to be recognised and that anyone was doing anything about it.

The Member of Parliament did say that the District Council has set aside, as it has, a considerable sum of capital money, but that was 10 years ago. It might still be available, but there are no facilities for that capital sum to enable development of secondary care

facilities to take place. And so I might be a little bit of an interloper, but nevertheless, the closure of St Peter's is actually going to have an adverse impact on my residents as it has on Maldon's.

I better stop there, hadn't I?

Discussion

Event chair: Yes. Okay. Thank you for that. I guess anybody got questions? No, no, specific questions. Councillor, just one thing I would ask is that, if there was a no change scenario, I'm assuming there'd still be a transport problem effectively, wouldn't there? it's not a case of,

Cllr Phil Barlow: I'm sorry, I missed the first part of the question.

Event chair: No, I'm saying that if, there was, no change to the status quo with regards to services, you'd still have a transport problem, wouldn't you? No. It's not, it's still not ideal. What is the point I'm getting at, let, please, let the Councillor,

Cllr Phil Barlow: The reason that Maldon is so attractive to my residents, it is the closest and parking is not unreasonable. If these were transferred elsewhere, it would be a bigger transport problem.

Event chair: Okay. All right. Fair enough. I was a bit unclear as to whether you'd insinuated there was already a problem anyway, as well as if it's changed. Okay.

Cllr Phil Barlow: If the status quo remained, then I suspect most of my residents would still use the facilities that are currently available, because unless they have to, they would not go to Braintree, and they certainly wouldn't go to Broomfield unless they really had to.

Can I just also make the point that, there's a computerised diagnostic centre being built at one of the Braintree hospital sites and its phlebotomy service will close whilst that is being built. And so if Maldon closes and Braintree closes, the only option we have is for blood tests at Broomfield. And who would want to go there with a hassle with the cars, with the buses and whatever, just to have a blood test?

Event chair: Okay. Thank you. Nobody else got anything that they want to ask at the moment? No? Okay. Thank you very much then, Councillor.

There followed a short break in proceedings

Submission 6 - Holly Fry & Nicola Dallinger

Holly and Nicola summarised their presentations as follows:

Holly: Own experiences at St Peters and at the places proposed in the consultation. Increased Risks for Maldon and Dengie Area. Palmed off to an already oversubscribed service. St Peters staff pulled due to poor staffing at Broomfield and Braintree. Level of care reduced by becoming a number not a person. Cleanliness at an all-time low having to rely on Broomfield. Options for women removed. No consultation on the birth unit as this was removed in Oct 2023. Holly provided a document about transport Annex 6a, and a document presenting testimonies about the St Peter's maternity service Annex 6b.

Nicola: I would like to talk to the panel about postnatal care for women, labouring women and breastfeeding care, the lies that were put out in the media initially, and the pure lack of care for people in the Maldon District.

Presentations

Holly Fry: Thank you. It's been an emotional day, to say the least. My name is Holly Fry. I am a South Woodham and Maldon resident since birth. I'm a new mum and I'm speaking here today as a person. I'm not a number.

I had the absolute privilege on the 26th of July 2023, of giving birth to my beautiful son at St. Peter's Hospital under the safe and caring hands of the Maldon's own midwives, the St. Peter's midwives. The rooms at St. Peter's were immaculate, calm, clean, welcoming, and the perfect space to embrace the labour journey I had feared for nine months.

The facilities available were above and beyond expectation. Ali, Sarah RJ, Sophie and Jess made me feel empowered, reassured and safe. I remember their names because they became my team. After birth, the midwives monitored my son and weren't happy with his oxygen levels. After using the expert knowledge to try and resolve the situation, Broomfield insisted we were moved there and my son was put into neonatal.

At St. Peter's, I was given comfort, support, assistance and love as not only three hours ago I had birthed my son. I was blue lighted to Broomfield. Now, I've only been given seven and a half minutes to speak, so the next part is going to be brief and blunt about Broomfield. My husband was kicked out, even though we were neonatal.

We had planned to stay at St. Peter's that night. It took 16 hours and four times of asking the staff to get the bathroom cleaned with another woman's blood in it. I felt very unsafe. I wasn't given explanations to what was happening by the midwives or consultants with my son and we were on the time frame of giving them antibiotics.

We told them it's nine o'clock, my son needs to go for his antibiotics now. I was left alone. I was, as I was a natural birth, I can't remember the midwives names as I didn't really see him that much. Only obviously checking on my son.

In the next room, there was an abusive man in there. He was on his phone, he was using despicable language. He was talking about threats, about the police and what happens if

they catch me. He was hanging his head out the window, smoking. I did report at the time, but apparently nothing could have been done. I was the most unsafe, alone and scared I had felt my whole pregnancy and birth journey. My 12 week scan at Broomfield, the team wouldn't wait for my husband as he couldn't find a car space before they started the scan.

As a first time mum, with the fear of the outcome of this first scan, I needed my husband by my side. Broomfield is over subscribed and whilst I was there, I witnessed with my own eyes, sorry, women in active labour in waiting rooms as no beds were available. I had friends having c sections two weeks before my son, who was born, before he was born, sorry, that was sat on plastic chairs in a waiting room, heavily pregnant, waiting as there were no beds available for them.

I think the main issue here is management. Not scheduling rotas appropriately resulted in constantly closing a safe, fully equipped, amazing birthing unit in Maldon, as Broomfield are unable to sufficiently meet their operational needs. Send the midwife lead to St. Peter's to reduce the pressure off of Broomfield.

At Broomfield, I was a number, not a new mum, not even a person. I was a statistic. Braintree Community Hospital. I attended pelvic physio here. Natasha was phenomenal. Gave me confidence and great exercises. It took me an hour and ten minutes to get there from Maldon with horrific traffic and my son was in the car.

If anyone's been in the car with a six month year old for an hour and ten minutes in traffic, they'll feel my pain. But sat in traffic at the time, I noticed that the old St. Michael's Hospital has been sold and converted to houses and flats. And then after speaking to the receptionist, they said, yes, that used to be where we were, and then a brand spanking new hospital had been built next door.

Mid Essex deserves this here in Maldon, a community hospital to keep all our services, even the ones that have already been removed, like the birthing unit, all together in one place. You have set a precedent with this. Use your success stories and change the narrative here today. St. Peter's maternity unit is also halfway stop of birth in place for women in the Dengie area.

I did send over a transport document (Annex 6a) that had some times in that on it, but while I'll just pick out one. Southminster to St. Peter's is 26 minutes. Southminster to Braintree is an hour and 10 minutes. Without traffic, that is. That's door to door. How, I'll just leave that there. This is causing an increase of risk of complications for mothers and this is, sorry, this is causing an increased risk of complications for mothers and babies.

St. Peter's is a place where women in the Dengie, Maldon and South Woodham area can come with exceptional staff to assist, give birth or get the expert advice that the ambulance is needed should they see complications. These midwives have really seen it all. Women choose St. Peter's, they choose Maldon midwives, but you can take, sorry, but you've taken this choice away and also removed the joy of birthing babies from the most capable, cohesive team of midwives.

Just to clarify, I didn't know any of these midwives before walking in for my 12 week scan, my 12 week meeting at the antenatal. My passion and fight comes from the experience they gave me. I'm speaking today as one mum. For thousands of past, present and future mums that need this midwife led unit here in Maldon for the whole of Mid Essex.

I've got some testimonies here. I'll just pass them over to you. (Annex 6b)

This was a post back in 2023 in August. Me and my husband, after going through the birth experience, we wanted to donate robes to the ward because I didn't have anything to hide for my dignity from moving from bath to bed. So we were going to donate 10 robes, we were going to get them all embroidered and everything else so they can use them for future mums to be to come in.

They stopped us from spending our money as there was a rumour it was closing. So I went on the community for help and I'll let you read the help that we received. Maldon, Dengie and South Woodham Ferrers. Every town for under Mid Essex is rapidly growing with housing developments, meaning more residents needing these medical facilities.

Removing vital medical services from this area is just ludicrous, as this decision will have massive consequences, causing more stress for Broomfield, As Braintree is just too far away and public transport is literally non-existent. Finally, sorry, I will carry on quick because I haven't got long left.

The consultation process. Removed St Peter's Birthing Unit before the consultation had even begun. The guidelines say nothing will change until after the end. Dates have been constantly changed and only updated secretively on Facebook. If it weren't on socials, I would never have known this was even happening. You've relied on the committed volunteers to do your PR and get it out to the community.

The selection of today's guest speakers has been very intimidated and selective. I felt very intimidated out there. Even just standing there and being rushed in. And I'm so proud of myself that I'm nearly at the end, and [the organisers] hounded me on the phone whilst I was in France last week to join up with Nicola for this time.

I didn't know Nicola, we individually agreed, we met up at the weekend. We were then phoned yesterday, hounded yesterday morning that only one of us was able to speak and be heard. Trying to silence us and make our time less impactful and our evidence. Manipulating stats to be, to back your arguments.

We've all been to university, we've all wrote dissertations. It's been an absolutely disgraceful, disorganised, secretive, and underhanded consultation. This is our lives. This is our children's lives that we choose to fight for. My name is Holly Fry. I am a Southwood and Malton resident. I am a new mum and I am not a number and I will be heard.

Thank you.

Event chair: Just before you start Nicola, Holly, I'm really sorry that you're feeling the way that you do about how this has come about. I don't think it was the intention to put you in

that position and make you feel that way. Okay. I don't think people would intentionally have done it. However, it's acknowledged how you're feeling.

All right. Okay. Nicola, would you like to take the floor?

Nicola Dallinger: Hi everyone. I'm Nicola Dallinger. I am a maternity care assistant at St. Peter's Hospital. I have also been a resident of the Maldon District for my whole life. So I'd like to begin talking with a quick overview of my experiences within St. Peter's so that you can gauge why I'm so passionate about its importance. To begin with, I was born there. My mum and her eight siblings were born there. My husband was born there, as was his brother and both my brother and sister. I have also been fortunate to have the most amazing birth of my second child there, along with postnatal stays with my first and third, as well as all my antenatal care.

In addition to this, I've had X-rays, blood tests, CBT, physiotherapy and ultrasounds at this hospital. At separate points of my life, both my nans have been very well looked after as inpatients on the stroke ward too. The care they received was so much more individual and loving there than what they were at Broomfield.

I and my family would not have been able to visit them half as much as we did had they been in Brentwood. We are grateful that we had the time that we did with them. Lastly, as I mentioned, I now work there too and have been there for over three years. Even without working there, I would be seen standing here today in support of these much needed services.

However, as I do work amongst the most fantastic midwifery team, I'm going to focus my evidence today towards that. As one of the staff members who teaches expectant couples about infant feeding, and with a large portion of that being about breastfeeding, I'd like to continue that support that I and my colleagues give through to this consultation.

Did you know that we have an increased amount of women we are seeing postnatally who have had a lack of support with their feeding choice? Feeling so overwhelmed by those first few days and weeks that they feel they have no other choice but to give up breastfeeding, even though the qualities of it massively benefit the mother, the baby and even society.

For example, the reduction in the risk of ovarian and breast cancers for the mother, the reduction in childhood leukaemia and SIDS for babies and even society. This saves so much money. For the workforce, for the hospitals, for the NHS on the whole, because there's less sick time taken, and this is just one of the many points that I bring up in my infant feeding class.

It is a fact. Over time, this is impacting on the costs to the NHS. My dad has always said, if you look after the pennies, the pounds will look after themselves. This would fall into that statement, and doing something simple, such as keeping the midwife led birthing unit at St. Peter's, or reinstating it, would enable so many women the breastfeeding support and success that they so desire, therefore saving the NHS millions in the long run.

I'm just going to hand out a table of statistics that I prepared. So please take a look at the table of statistics I have given you. I compiled this to prove how the maternity department was indeed very much used and that by not eliminating or manipulating statistics, we can actually get a more wholesome and true picture. So in the first column are the amount of days that St. Peter's maternity was forced to be closed due to staffing levels at Broomfield. On average, over the five months of March to July 2023, St. Peter's maternity department was closed for 8.6 days per month, with the least being three days and the most being in July with 19 days of closure. This was all to staff Broomfield, and more often than not, this was for numbers, not actually because the staff members were needed.

Many times, midwives were called over there and were not needed to do any work at all. So they did this as well as using the on calls to staff it, often therefore suspending home births too. So no lady now has the choice of a low risk birth. Unfortunately, the way the Trust released information to the media, it came across as though St Peter's didn't have the staff, which is one of the many lies construed by MSE.

Sometimes these closures were from 4pm and other times they were from 8pm. Sometimes this even happened midnight shift in the early hours of the morning. Second column is the percentage of days actually open per month. And taking the above into account, the average percentage of times that Peter's maternity was open overnight was only 71.9%, which is a little over two thirds. In the third column, the average amount of births during these five months was 4.6. However, many women felt that the anxiety of not knowing whether St. Peter's would be open or not when they were in labour forced them to make the decision to reluctantly go to Broomfield anyway, without even trying St. Peter's first. This figure also does not reflect the women who the Trust forced to go over to Broomfield while in labour, misusing the ambulance service to transport them there, and all because Broomfield needed the numbers. The St. Peter's midwife, who was giving fantastic labour care in the beautiful, calm and oxytocin inducing St. Peter's, was tasked with caring for the very same labourer on labour ward after a bumpy and unnecessary ambulance ride and into a bright, loud and uncaring environment. The fourth column. Compared to the days actually open, St. Peter's still managed 20.9 percent of those days to have a birth, which, considering the hurdles faced, is actually quite the miracle.

Column number five. The problem with only using births in the statistics is that it doesn't show the true picture of the positive impact that St Peter's midwifery led birthing unit has on women and their postnatal journeys. Unfortunately, this was the only statistic that MSE felt necessary to include in the media announcements, quietly eliminating the fact that on average, 51.2 postnatal stays were had there per month, with an overall total of 256 stays across the five months. That's 256 days where intense and compassionate care was given to women, and more often than not, the reason was for help breastfeeding or just a little bit of TLC before they went home. Unfortunately, now women have not got this service available.

We're seeing an increase in readmissions, increase in feeding difficulties, infections and an increase in jaundice with babies with one known case of kernicterus. The argument that

having less than half the postnatal beds available to women if they travel for an extra 30 plus minutes is not a valid one when responding to these statistical facts.

Number six. On average, St. Peter's was used for postnatal stays at 221. 8 percent compared to days open, meaning that St. Peter's midwife led birthing unit certainly was used and certainly would be used if it is open. This is more than two postnatal stays per night open, meaning St. Peter's is making a positive impact in four lives a night, two women and two babies.

Number seven. One of the most shocking statistics that once again, MSE eliminated from their public information is that of the women and their babies who were sent home prematurely and against their wishes due to Broomfield taking the staff from St Peter's and therefore resulting in the closure of the unit.

Women who needed more care, more support and more time, none of which could be offered at Broomfield because of the lack of beds there and the lack of time that the staff were able to give them. A total of 29 women and their babies were sent home against their wishes and before they were ready and that's just the ones in those five months.

Number eight, the average percentage of women being unfairly discharged is 15.9 percent per month. That's 15.9 percent of times that MSE has failed its patients.

Finally, the last lie that was publicly announced by the MSE was that the practice at St. Peter's was unsafe when compared to the likes of WJC and Broomfield, which is a unfair, very insulting and very wrong thing to state as well as that WJC's maternity was allegedly built for purpose when in fact that is also incorrect.

It is clear to myself, my colleagues and my fellow residents of the Maldon district that the Trust wants to pass the closing of this hospital and its services for no other reason than to line the pockets of those at the top. Manipulating data to suit them, trying to sneak the consultation through without much promotion and giving weak reasons that change with the wind as to why it ought to go.

There is no doubt in my mind that Maldon District needs all of the services it offers. But to have unlawfully closed the maternity department without consultation is indeed a huge misservice to thousands of people. Again, a further lie that was transcribed by the MSE that the closure of maternity was temporary and just for the winter, giving massive but false hopes to hundreds of women.

Discussion

Event chair: Thank you, Nicola. Are you two okay with taking questions? You okay? Yeah. Thank you.

Debbie Goldsmith: Yeah, thank you. I haven't got a question as such, but it's nice to see you again, Nicola. We did meet before.

Holly Fry: Holly

Debbie Goldsmith: Sorry yeah. Yeah. So we did. We did meet before, didn't we? And another consultation meeting. It's really nice to see you again. And I'm sorry to hear that you had such a difficult time when you were transferred over to Broomfield.

There's always a reason why we transfer the care out, but to hear your story is very, emotive. And I wanted to apologise that you had such a difficult time.

Holly Fry: Thanks for the apology, but at the same time, I'm making it aware because how many other women's has happened to that aren't speaking up?

Audience: *Inaudible*

Event chair: Hello. If you. Do you mind if I let the panel have a go? No, it's alright. what I was going to say is, if you've got anything that you think is useful information of experience, and your family's experience, do put it in writing. Alright? It's important that it comes in writing as well. Alright? Okay?

Anyway, folks, let proceedings, please let us keep going. Okay? Anybody want to, got questions? Okay. Yeah.

Claire Hankey: Hi, Holly. I'm just interested in where you gathered these statistics from.

Nicola Dallinger: Hi there, I gathered from them from our own staff records of when we were closed. We DATIX every night that we were closed, so you'll also find the records on all the DATIXs, and obviously against the patients that were sent over or sent home that were affected as well. Those statistics are available.

Holly Fry: Sorry, just to clarify, I'm Holly and this is Nicola, just to clear that up.

Debbie Goldsmith: So obviously Nicola, we know each other quite well, we have met in the consultation process, but I think you've made some really strong issues, or you've raised some strong issues, so if we could meet outside of this, I'd really appreciate that. Are you happy to do that?

Nicola Dallinger: yes, I'm happy to, because we've got some third parties there as well, so yeah, awesome.

Event chair: Any more questions from panel members? No? Okay in which case, let me just check my schedule here. We're just past five o'clock, so we're well ahead of schedule.

Submission 7 - Cllr Emma Stephens - Maldon District Council (Tollesbury Ward)

Councillor Stephens had applied to present after the schedule for the hearing had been filled. As the hearing was progressing ahead of schedule, the chair invited Cllr Stephens to speak as an unscheduled presenter. Her evidence document is available at Annex 7.

Presentation

Cllr Emma Stephens: My name's Emma Stephens and I'm the Maldon District Councillor for Tollesbury. For those who don't know it, Tollesbury is the village on the peninsula in the Blackwater to the east of Maldon town.

Tollesbury residents are already 10 miles and half an hour from St. Peter's Hospital by car or bus. That's before you take into account the distances from St. Peter's to Braintree or Brentwood, which plenty of people have spoken of today. For much of what I'm just about to present, I will use Tollesbury as my example, but the facts apply to most of the villages in Maldon District, and it's the district I speak for, not just Tollesbury.

I'm going to cover five aspects of the proposal, first, the three sections that you have, which is the outpatients, the stroke rehab, and the birthing unit. I want to say a few words about the consultation survey and the process and the ultimate cause of this situation and what seems to me its obvious solution.

So looking at outpatient proposals, I'm broadly in favour of an outpatients being located in any suitable single site, provided it remains within Maldon Town. But the consultation refers to outpatient services as being relocated in and around Maldon, which wasn't at all clear where that meant when people have filled in the survey.

I don't know if that was meant to mean Maldon Town or Maldon District. And this latest announcement that says three of the sites being considered are in South Woodham Ferrers, Braintree and Burnham, well, none of those is in or around Maldon, never mind Maldon Town. That's just, it shows the consultation up as being untrue. If outpatient clinics are scattered, I think it will be far harder to manage staff. And it will probably require more staff, more reception staff for example. If outpatient clinics were scattered all over the town today, I think you'd want to build a new hospital to centralise them, so separating them feels like a backward step. It's also much easier for you to quietly drop a service when they're scattered all over.

We'd all notice if you close a hospital, but people might not notice so much if one service is quietly dropped. So within perhaps, I don't know, 15 years, as leases on various sites expire, Maldon could suddenly find it hasn't actually got any outpatient clinics left here at all.

On stroke rehab, I'll move on to the second section. I'm not in favour of moving stroke rehab beds away from Maldon because of the distance and journey times. It's 34 miles from Tollesbury to Brentwood and just 10 to Maldon. Looking at climate change, I think somebody did mention this earlier, the NHS states in one of its documents, which I can

find and submit when I send this in, for emissions we can influence, we will reach net zero by 2045, with an ambition to reach an 80 percent reduction by 2036 to 2039.

Tripling people's journey distances to hospital just doesn't match that statement, does it? Moving on to stroke rehab patients and their families, it's likely that many people could not visit their loved one in Brentwood every day from Tollesbury. Picture, if you will, a man who's had a stroke and is now in rehab at Brentwood. Let's say his wife has never driven, or as she's got older she's stopped driving, or perhaps she now only drives local familiar routes. She certainly doesn't do the A12. I know a lot of women in Tollesbury who fit this profile, and this will be replicated across all the small villages in the district. Now, our lady must travel to Brentwood by public transport to visit her husband.

If she were travelling just to St Peter's, it's one bus ride and it takes half an hour. To Brentwood, it's an hour and a quarter each way. She must get the bus to Witham, and then a train to Shenfield, and then a bus to Brentwood Hospital. Now, if the lady's a pensioner, the bus is free, but the off peak train fare is £16.80 a day if I have interpreted Anglia Rail's website correctly, which was a challenge in itself. But I think it's £16.80 a day. So that's almost exactly £100 a week. Which you can't do Sundays because there's no buses in Tollesbury. If the lady's not yet the age of 66, then she must also pay the bus fare. We all know that's only two pounds at the moment, but for a start, that won't last, but more importantly, that's two pounds per bus. So you've got to go from Tollesbury to Witham, and then from Shenfield Station to Brentwood Hospital. That's two buses, and the same coming back again. So four buses. It's another eight pounds. So another £48 a week. Buses and trains together, £148.80 a week. That's money most of us just don't have sitting about waiting to have to go visit someone in hospital. And compare that with the £24 a week it would cost to get to St. Peter's by bus or that would simply be free for a pensioner with a bus pass. And the train can be cheaper if you have a senior rail card but if my husband, if my resident and her husband have a two together rail card you can't use that to travel on your own.

I've said already that there are no buses on Sundays in Tollesbury. Now, of course, that's true for getting to St. Peter's as well, but actually, from a community like Tollesbury, you're very likely to get a lift to St. Peter's. Sooner or later, it would be around the village. Oh, so and so needs to get to St. Peter's every day. There's always someone going to St. Peter's. The person would probably get a lift from the community. That's not going to happen to Brentwood. Much too far, and nobody, it's not on anyone's way to anywhere. So let's say that my lady can only afford to visit her husband perhaps twice a week, I don't know.

So that's not just going to impact her and your patient. The staff in a busy hospital ward rely on visitors to help patients to feed, to take patients outside with some fresh air, to take laundry home. I've requested evidence from the NHS on the impact on a stroke rehab patient of their spouse being unable to visit every day. But I've had no response. So today's about evidence and I've asked for some evidence and I haven't got it. I don't think it's for me to find that evidence. I think it's for the NHS to provide that evidence and I don't

think the NHS has it. So we have adverse impacts on both the patient and their visitor in terms of time, money, and I think recuperation.

It just doesn't seem to have been thought through.

Moving on to the birthing unit. I am not in favour of moving the standalone midwife-led birthing unit away from Maldon Town because of the distance and journey times. It's 19 miles to WJC from Tollesbury, just 10 to St Peter's. Now it's likely that most people travel by private transport when they're in labour, but it is only 30 minutes by bus from Tollesbury to St Peter's. Given that the unit's for non-complex births, going by bus might be okay for some women. But to WJC, it's over two hours by bus, and it's three buses. I don't think many women in labour, even for a non-complex, would, I just don't think they would contemplate that. So most people will have to travel by private car.

Google says it's up to an hour. My experience at busy times in the rush, it's over an hour from Tollesbury to WJC. That's it. To St. Peter's, half an hour. To be in labour within the confines of a car can really be like torture. I'm speaking from experience. But the NHS is making this journey last at least twice as long for women in this district. This is a retrograde step. It's disadvantaging rural women. I wanted to know if the East of England Ambulance Service will take such women who are in labour to WJC. For weeks their website's been out of action for all but the most basic details. But three other ambulance service websites that I looked at say, normal labour is not an emergency, therefore it is not appropriate to call an ambulance for transport to the hospital. Should you call 999, you could be told to make your own way to the hospital. That's all. I ask if there will be any special arrangements by the Ambulance Service for women in labour in the Maldon district. I think I know the answer to that, but it's a question.

At one of your presentations, I think you mentioned offering more home births. So again, a question, has that started? Today is about evidence, so I'd like to know that, and I don't quite understand how you could be offering more home births if actually you need to take midwives to another unit. I've also requested evidence from the NHS about the impacts on a safe birth of being in labour in a car for over an hour.

Are the outcomes worsened by journey length? And again, I've had no reply yet. So those are your three proposals, and then I'd just like to look briefly at the survey itself and my conclusions. The online survey is amazingly hard to find. I know it's got easier as Google's algorithms have cottoned on to where it is. It has got easier, but it has been very hard to find. And people have said to me, Oh, I had to look and I couldn't find it. So I really wonder if you've actually got as many people responding as might have done, if they'd been able to get hold of it, if you do find it, it still says it closes on the 21st of March, but I understand it's been extended to April.

So I think if I hadn't, I looked at it today, I'd think, Oh, I just haven't got time for that. Put it away. I don't understand why that date hasn't been updated. On the paper surveys, I find repeatedly that residents may have digital access, but they only use it if they absolutely must, if there's no other option.

I sit at my computer all the time, it's like an extension of me. That's absolutely not the case for many people. Clearly, filling in a survey is not mandatory. It's just not something that they'll do. They want to have it on paper. And of course some people don't have any digital access. Not about choice, they just don't have the digital access.

Ofcom figures show 6 percent of people are completely digitally excluded. And it's a higher percentage than that amongst older people. And of course it's older people that predominantly use hospitals more. But despite this, paper surveys, as far as I'm aware, were not provided automatically to GP surgeries. They were put in libraries, but rural villages like Tollesbury don't have libraries.

They weren't put in cafes, village halls, clubs, schools. I don't think there's, correct me if I'm wrong, but I don't think there's been any effort to get piles of paper surveys out there and banners and to draw attention to it. I'm still meeting people that don't know anything about this. So I've done that bit for you in Tollesbury. I've put them out in cafes and put it on Facebook and all that stuff and maybe other members have done the same. I'm sure they have. But it's patchy. And there's no return address on the paper surveys, as somebody pointed out to me, so I was a bit taken aback to discover that. The second set I received had got reply envelopes with them, but, yeah, no return address on there. So I just don't know how you can rely on any of the survey results. For the stroke rehab choice, you've given people two unwanted choices. If they pick the lesser of two evils, it will allow you to say most people preferred option A or option B, but that's only because you haven't asked people what they would actually choose, which for Maldon district residents would certainly be keep it in Maldon.

And for the birthing unit I think someone said earlier, there's only one option, so that's not a consultation. It's just, it's in the bag, which it should not be. The ultimate cause of this solution, the prompt for all this, is an abject failure to maintain St. Peter's Hospital buildings. The situation we're in has not been driven by any strategy or policy or aim. It's just because patients, who will benefit. It's not because patients will benefit in the slightest from being treated in other towns. It's just a desperate last bid, last ditch reaction to old lifts, old sewers, old floors. The situation hasn't suddenly arisen through some terrible unforeseen disaster.

It's come about inevitably entirely predictably from always putting the needs of Maldon district residents last. And that's not good enough. I say you need to go back to the Department of Health, have the courage to demand enough money to deliver appropriate health care in appropriate accommodation to Maldon District residents.

Thank you.

Discussion

Event chair: Councillor, thank you for that. Just before we go to questions, I just checked on, you were saying about the response level to the surveys and things. So I asked the question, my understanding is there's over 3000 responses online at the moment and they don't know the exact number of paper, but there's a lot of paper copy responses as well. The distribution of them have mainly been through libraries, campaign groups and others. But I'm sure they'll be very interested in what they've heard from you and trying to improve that in the last part of the consultation. Okay. All right. Any questions from anybody for the Councillor? Yep.

Claire Hankey: Thank you, Councillor Stephens, and thank you for your submission. I was just wondering, was it clear that the options that were put up earlier around potential locations were what we've heard so far through the consultation. They weren't predetermined options that the ICB were considering, so I just wanted to understand whether that was clear enough that they were what we've heard through the consultation.

Cllr Emma Stephens: Yes, I think I understood that those were ideas that have come to light or that through conversations you've been having have become apparent. I don't know whether other people would have realised that but the shocking bit to me is that you're even considering South Woodham Ferrers, Burnham and Braintree as being around Maldon because they're not.

Event chair: Just as a matter of clarity, because you're not the first person to have raised this today, I was looking through the consultation document, and you mentioned about the two options with regards to the services that are under consultation, and then there's also the in and around service, extra services that are, what do we do with them in and around Maldon?

It is a little bit confusing on the basis that essentially speaking, the first two elements are things that are being consulted on. The other services it's a suggestions invitation and perhaps they don't sit together. And I realise why people are very confused about that format. Yeah. But I think that what you need to do is to, and it's all fine for us in this particular room and me talking about this, but obviously the general public won't be aware of it except for people watching what we're doing today is that, if they're unclear as to the purpose, ask the question, get some clarity. And then it makes it easier to respond and it is a bit confusing.

No, this is what I'm just, yeah, I know what is on there. It is a public consultation and there are firm proposals for some of the sections that they want you to make response to as firm proposals. This becoming what sounds like from what you people have been saying, a bit of misinterpretation as to what they mean by the other services and how can they be accommodated in and around Maldon.

Interjection from the gallery

Audience: But Dr. Sweeting in the Burnham consultation actually raised several of those areas as already under consideration, so I'm sorry, they were being talked about.

Event chair: Yep. Okay. Alright. I get and I think that there needs to be some clarity given to you about that possibly, and I'm going to suggest that may be something to be looked at.

Audience: *Inaudible* It needs to be stopped because there'll be an administrative review about this and you've got all the information, we have none, and you drip feed these. And there's no difficulty with posting stuff to residents in Maldon. Every householder in Maldon is interested in this. What's the problem? Instead of producing a glitzy load of brochures, just on the case of question A, what do you want?

The question isn't, the question that you put is, here are four or two predetermined, questions that other people have looked at that suits you. This is not what do the people in Maldon have now. And what do they need now? What do they want to keep? And do they need going forward from the developing environment that we have, that have been summarised in every consultation that I've received?

Are you listening?

Event chair: Yeah, I, and I understand the feeling.

Audience: You don't.

Event chair: No, I do. I, do.

Audience: Stop it now and start again. You need to start again.

Event chair: Okay. All right. Then I think that they're listening. This is the point here. This is about listening. So I'm sure that will be taken into consideration. Okay.

Audience: *Inaudible*

Event chair: And you've already put that in electronically.

Audience: *Inaudible*

Event chair: Yeah.

Audience: *Inaudible*

Event chair: For me or the panel?

Audience: For the panel. Okay.

Event chair: Alright. If you want to, if you want to bring it over then, because we're going to take a break now anyway, and then after the break, obviously, it can be part of what we talk about. Alright?

Close of session

The chair thanked participants, announced that proceedings would resume at 17:50 and closed the session.

Session three

17:50, 19 March 2024, Maldon Town Hall

Chair's welcome and introduction

The chair welcomed everyone to the second session and invited new panel members Dr Pete Scolding and Dr Ramanathan Kirthivasan to introduce themselves.

The chair offered thanks to people who had made written submissions to the hearing, Judith and Roger Bond, and Lindsey Wright.

The chair reminded those present that the event was being filmed and streamed live on YouTube and that if they had questions, they could direct them to the consultation team. He explained that responses to the consultation would be accepted until the 4th of April and encouraged everyone to respond. He reminded observers in the public gallery that a consultation hearing doesn't take questions from the floor and advised that they could direct their questions to the consultation team.

	Speaker/s	Topic	Organisation	Page
Submission 8	Veronica Sadowsky	Stroke and outpatients	Carers First	Page 58
Submission 9	Cllr Tony Fittock	General	Maldon District Council (Althorne ward)	Page 64
Submission 10	Les Flack Michelle Olley Tim Olley	General	Save Maldon's Medical Services	Page 72
Submission 11	Cllr Nick Spenceley	Consultation process	Save Maldon's Medical Services	Page 83

Panel

- **Dr Matthew Sweeting:** Consultant Geriatrician at Broomfield Hospital, Mid and South Essex NHS Foundation Trust and Executive Medical Director at Mid and South Essex ICB
- **Claire Hankey:** Director of Communications and Partnerships at NHS Mid and South Essex Integrated Care Board
- **Dr Pete Scolding:** Stroke Steward at NHS Mid and South Essex Integrated Care Board
- **Dr Ramanathan Kirthivasan:** Clinical Lead and Stroke Consultant, Mid and South Essex NHS Foundation Trust

Submission 8 - Veronica Sadowsky, Carers First

The summary of Ms Sadowsky's submission says:

As the currently ECC [Essex County Council] commissioned support service for unpaid carers aged 18+, I would like to feed back comments from those registered with us across Mid and South Essex, gained through informal conversations at peer support groups and events. We have promoted the consultation via e mail to carers who may choose to respond on an individual basis but many will not and it's important to also recognise wider national research around carer health outcomes.

Veronica Sadowsky's PowerPoint presentation slides are available at Annex 8.

Presentation

Veronica Sadowsky: Good evening everyone. My name, as you've heard, is Veronica Sadowsky.

Currently, I'm a manager within a charity called Carers First. and our mission is to support unpaid carers. I've come along this evening because, whilst quite rightly, a lot of the focus of the discussion today is on patients who access lots of different services at St. Peter's, it's really important that we don't forget that many of those patients actually have a carer for supporting them, whether it be a partner, whether it be a child, whether it be a sibling, or even a family friend.

So I just wanted to put that into context really and to say that we have sent the consultation out widely to carers who are known to us across mid and South Essex. I really hope that a lot of those carers will have taken the opportunity to respond individually, through the website, etc.

We've also had conversations at some of the groups that we hold locally but it's also really important to recognise that lots and lots of carers are not in touch with us, or with adult social care, or with their GP. They may not even, they may not live with the person that they support, and they may not see themselves as a carer.

And that's why it's really important that we come and advocate for them. I'm also aware that Healthwatch Essex were here earlier. I did watch some of the earlier submissions online and I can see that Healthwatch Essex came along and talked about feedback. And I know that some of our carers were involved through the carers voices project with Healthwatch Essex. So what I'd like to do is flag up that actually, the proposed changes impact on carers in two different ways. They impact on carers in their caring role, in helping the people that they support to access St. Peter's, and obviously those people have long term conditions, often multiple long term conditions, but actually the carers themselves can have long term conditions that mean they need to access St. Peter's while still maintaining their caring role. So I think it's important that we recognise that any changes impact on carers in potentially two different ways.

So just to give you some context, Carers First, we're currently commissioned by Essex County Council to support unpaid carers across all of Essex.

From April, there's a slightly new contract coming in, but Carers First will still be providing support in mid and south, which is clearly the localities we're looking at. We've worked with an excess of 5,500 carers since 2018 in mid and south. But that, as I say, is just a tip of the iceberg. I put on the bottom the definition of a carer within the NHS, and you can see it's fairly broad.

So just to give you some. In a more general national context, Public Health England actually produced a report and it said that being a carer is in itself a health inequality. It's actually been recognised that carers are twice as likely to experience poor health as non carers within the general population.

And that can be physical, mental, emotional ill health, or possibly all three. It could be related to their caring role. It could equally be related to the fact that we have enormous numbers of older carers. And in Braintree and Maldon, there are higher numbers of older people within the population than the regional and national average.

And therefore we're likely to see that magnified. So I've just put up there obviously that, there are 400,000 carers nationally aged 85 plus. We have lots of carers registered with us in their nineties, and they're trying to support other people in their nineties, which as you can imagine is quite a difficult role to fulfil.

Because of the aging population, we're going to see increasing numbers, both of people requiring support but also those providing that support in that age group. It's also important to say that Public Health England recognise there isn't enough research done on carer health outcomes. There are lots of gaps in the data. And actually we need to know more about carers in order to support them better in NHS decision making.

So I also wanted to flag up Carers UK. Carers UK is a national lobbying organisation who many smaller carer organisations are affiliated to. They do an annual survey called the State of Caring in the UK and they ask individual members, the vast majority of whom are carers to complete a survey. And you can see that huge numbers have reported that the caring role impacts on their own health - 82 percent. But actually more worryingly 44 percent put off their own health appointments because it was just too difficult to get appointments, or to undergo a procedure or a course of treatment. Impossible.

We need to make the services available to carers locally and we need to remove barriers so that people can keep themselves healthy and try and keep the people that they look after healthy. Interestingly, 42 percent felt they needed more help from the NHS to sustain their caring role.

These are some of the local considerations that carers have spoken to us about in one to one conversations and in group settings. I know that earlier on in the afternoon there was a lot of conversation around transport, the difficulties around public transport, people saying it's a three hour journey to get to Brentwood with multiple buses and multiple bus

and train interchanges. That's even if you could actually manage that with your mobility and the mobility of the person that you're supporting. Transport is clearly a huge issue in rural Mid Essex. I also talked about whether we perceive or put enough importance on the perception that carers need to actually visit people in hospital.

Because I think, as I said, the focus is quite rightly on patients because that's what a lot of the services are for. But actually, if people are supported by having frequent visits from somebody who supports them at home, that will actually aid their recovery. And it will actually also take away some of those negative things about being in a strange environment, about having people around you who don't know you.

Many people who are on the intermediate care and maybe the stroke rehab beds may have some form of cognitive deficit. And they are going to find that environment extremely challenging. But having somebody familiar come every day, if they possibly can, to keep some of those routines going, to help them with meals, to encourage them to do therapy, just for companionship, to sit and talk, look at books, do whatever it is that people want to do, but also, importantly, to actually help the staff with the decision making, because lots of carers are actually going to be lasting power of attorney and other things that actually need to be taken into account when you're making clinical decisions.

So you need to make it as easy as you can for carers to visit people in whatever setting that might be. I did actually talk about younger carers because it's been particularly noticeable over the last couple of years that with the cost of living issues it is working age carers who are perhaps not working or not working full time who are really struggling from a financial perspective because they are not obviously going to get free transport. They're not going to get free buses and they're not going to get reduced travel on rail, on railways, etc. but actually if they wanted to go somewhere every day, they've got to pay full cost and their income can be extremely low. We've really noticed that in the last couple of years.

So we've already talked about poor health outcomes and obviously moving some of these services from St. Peter's is likely to present another barrier to carers. We know that they struggle to get to things already. If we move further away, they will struggle more to get to things, whether it is around the transport, whether it is about the rurality, whether it is about respite, which is an enormous issue for carers, they don't come to appointments because they don't have anyone else to undertake their caring role and the further away they have to go to access some of those quite straightforward, sometimes outpatients appointments, even less likely that they'll go to them.

And even more likely that actually any conditions they do have, which might have been managed okay with an early intervention will go on to be more complicated than they needed to be because people haven't felt able to access things at the beginning when they needed to access them. So I've just put at the bottom there that it would be really helpful as a mitigation if the ICS could consider how they could move towards some more carer friendly processes.

We know there are some really good practice examples. There are lots of, unfortunately non mandatory standards, for instance, for GPs. But there are lots of NICE recommendations. There are lots of ways that health settings can support carers and I think this is a great opportunity for the ICS to look at how MSE could really become a beacon of good practice for carer friendly work.

Event chair: Okay. Okay. Thank you. Thank you very much, Veronica. Panel, anybody got questions or want clarity on anything that Veronica has said? Yeah?

Discussion

Dr Pete Scolding: Hi, Veronica, I'm Pete. I was really interested particularly your last point about some of the carer friendly processes measures that you'd like to see in place. I just wondered if you could enlarge on any of those and recommend some things you'd like to see.

Veronica Sadowsky: For instance, across the Acute Trusts we've had points where we've had carers passports and that was generally before the merger of the three hospitals. Basildon had its own passport, Broomfield had its own passport, but I think when there was a merger, then there was a feeling that obviously it had to be Trust wide, got a bit lost in translation somewhere, so there are, it is about putting those flags on people's records then it is about using those flags to actually support people and to be a bit more proactive in perhaps referral and signposting, because there are lots of organisations that are not just Carers First that would support carers.

The new contract that's coming in that's County Council commissioned, has some quite exciting initiatives that we've not had before. There's a possibility that we might be able to support people with payments around appointment breaks. Which we do in our, is done in other areas.

So it's about having those conversations level where change is actually going to happen because you can have a conversation with somebody and one clinic might change. And that would be great for the people who go to that clinic. But actually we need it to be wider because it's in no one's interest for carers not to access health appointments.

Respite is one issue, transport is another issue, having something that's not three hours on four buses is another issue. So it's just about how can we best support people to use the services.

Dr Pete Scolding: Yeah, and ditto, is that kind of same things you mentioned GP specifically? Is that the same kinds of things you'd like to see in place or anything different for the GP settings?

Veronica Sadowsky: Yeah, GP settings exactly the same. Obviously, the GPs have a carer's register. Some GPs are slightly more enthusiastic than others about having a carer's register but it's also about how do you use that register? Making sure that people have flu jabs, have COVID jabs, have all those things. Whether or not they qualify in their

own right, which many carers do because of their age and their own health conditions, but then there are other people who need to be identified and flagged up.

And again, it is around information. If every GP practice had something on its website about if you're a carer this is where you find support locally. If everybody had a really small notice board with a few things on it, that would be massively helpful for carers because it's somewhere that everybody goes apart from pharmacies, but it's really hard to squash a notice board on a pharmacy.

Dr Matthew Sweeting: Veronica, thanks very much for your clarity here. With our consultation, we are grappling with providing high quality care for individuals, particularly around bed based rehabilitation, so stroke and intermediate care, for a short period of time to get longer term gains for people to return home. I am very conscious, as an older person doctor, of the absolute need for carers' loved ones to be able to visit. But have you got an understanding around the use of technology, for example, during COVID, where essentially we need to balance those two. How do we, how do carers feel? How do they support with essentially using technology to support some of that caring role while in a bedded unit to have the longer term gain to be at home with their loved one? Have you got a feeling for that? Are there barriers there that we could think about?

Veronica Sadowsky: If I could actually take my Carers First hat off for a moment, and make a personal reflection, my late father had a stroke and wasn't able to use the stroke beds because of various other conditions and it didn't fit the pathway.

I know you were talking earlier about care at home and rehab at home. My personal experience of it wasn't really fit for purpose, the care at home. He, we didn't, use technology because he didn't have any internet. Because he was 93 and he didn't want the internet. So there are obvious barriers.

I think that things like the virtual wards are fantastic. There's so much potential in things like virtual wards and in technology at home. But some of the support services are in a very traditional, that traditional reablement model is maybe not right for every condition. So maybe there's something about a more nuanced approach to the kind of support you give people.

And, yes, there are barriers, I would have been, I did try and persuade him to have the internet on numerous occasions so that I could work from his house, but it was to no avail. And would have taken about three months probably to get BT to come around and put it in. So it's about recognising it will be great for some people, lots of carers do use a lot of tech.

Lots of people do use a lot of Alexas and lots of things that we have now. But everything else, it's not a one size fits all solution. Certainly got potential, but we're not quite there, are we?

Dr Ramanathan Kirthivasan: Hi Veronica, thank you. Currently we have a lot of travel. There's a lot of travel between, within MSE, footprint for individuals, be it clinics or clinical services. Now, providing more consolidated and higher spec service, which brings about

good outcome, would potentially keep a lot of individuals within the footprint of Mid and South Essex.

Have you worked out as to how to balance the benefits that we would get from that versus the other difficulties?

Veronica Sadowsky: It is a really difficult construct and, full disclosure, I was a worker in Broomfield Hospital for a number of years, and that really opened my eyes to, the benefits of maybe centralising some services to get those outcomes, because I think before I'd worked in a hospital, I probably had a perception that's more common amongst people that people should stay in hospital until they are well.

When actually you do realise that actually often that's probably not the right thing for people and they are better to go home with some of the technology and those sorts of things to have that really intense intervention in a place of excellence. But it is about that, we just need to make sure that we don't go too far down the road where it is such a long way for people to and this, to be honest, is not a new issue. I remember over 10 years ago, people being discharged from Chelmsford to Halstead. And having exactly the same difficulty and spending a whole day trying to find community transport for a gentleman in his 80s to visit his wife in what was then Colne Valley, I think. I had rehab there, so Colne View.

So this is not a new issue, and it's not an issue that's going to go away, but it is about just realising that it is a real difficulty for some people. It's not a difficulty for everybody, but it is a difficulty for a lot of people. And we just need to be mindful of that.

Event chair: Okay, good. Okay, thank you very much, Veronica. Thank you very much for that and for answering the questions. You're welcome to stay there for the minute if you want to, or rejoin the audience, whichever you prefer. All right. Okay.

Submission 9 - Cllr Tony Fittock - Maldon District Council (Althorne Ward)

Councillor Fittock's presentation/ evidence sheets is available at Annex 9a. Cllr Fittock followed up with some additional information available at Annex 9b.

Cllr Tony Fittock: Chairman, my name's Tony Fittock. I'm Councillor for Maldon District Council Althorne Ward, which encompasses Latchingdon, Mundon, Althorne, and Maylandsea so a significant part of the Dengie.

I'm also the chair of the Dengie Hundred Group of Parishes. That represents pretty much all of the Dengie, south of Maldon. And also chair of Latchingdon Parish Council. But obviously I'm here speaking as a resident, primarily. But obviously influenced by those positions. Okay?

I don't know if you've got an evidence pack. I sent across all of my sheets across. I don't know if you've got them or not. But it's, really more about data than anything else. But I'll do my best in the absence of that. Thank you.

I'd really like to start by just outlining where we've come from in the brief history that I've gone through. Back in 2009, a document was produced indicating that there would be a new health hub or community hospital in the Maldon District. It concluded that there were four options. The first option was do minimum. And that'll cost £9,563,000 over a 30 year period. Ranging up to option 3, or option 4, which was relocation to a new facility. Up to £35,592,000 over 30 years. By 2012, there was a development brief considered by the council that basically was proposing redevelopment of the existing site instead of relocation of the development.

During that period, there was obviously a local development plan. And for those that are not aware of what a local development plan is, it basically sets out your spatial growth for a period of 15 or 20 years. It decides, it determines where you're going to build and why you're going to build there and obviously infrastructure is a major consideration in that factor. And it's interesting that as we move through the history of this, by the time we get to the local development plan inspection, that is an agreement between the council, the Secretary of State for housing and all of the statutory respondees, which includes the NHS, the conclusion was reached that there was a need for a community hub within the Maldon District, and on the inspector's recommendation or an agreement with the statutory consultees, there was reference to this matter placed within the local development plan.

And here is the local development plan. And basically it sits under what we call Policy i2. Policy i2 is really to look at health and wellbeing of the district, and make sure that our growth plans are in accordance with both national policy and agreed policy amongst statutory consultees and the council, and to a large degree the residents, because they are consulted on this matter.

So we have a Policy i2, health and wellbeing, and it states the following: “The council will resist the loss of existing health facilities, including St. Peter's Hospital in Maldon, unless

appropriate new provision has been secured that meets a long term health needs of the district". That is the policy.

So in essence what that really means from a planning perspective is that if a development was to come forward on this site for anything other than the health hub the council should be in a position of pushing back on it to say no it's been agreed that there should be a site there, it's not appropriate to use it for something else. That will be something we'll consider in due course perhaps.

When we get to, up to 2021, there's been various things happen between then. One of the most significant was that, as part of the local development plan, there is some land that we refer to as Knowles Farm or Wycke Hill. This land was promoted on behalf of Essex County Council and it was proposed within that planning consent that land be allocated to either a community hospital or a health hub. Now unfortunately, in the local development planning it did indicate that would come forward in perhaps 2019, 2020. So up to that point we've still got intent to build a community hub. Health Hub or Community Hospital. Unfortunately, that development's stalled, so at the moment it hasn't come forward, for further development, but it's likely to in the very near future. In 2021, there's a press release within the Maldon News now, and basically it's reiterating that purpose.

And it basically could start to say the first part of the plan to build the hub, which describes a new community hospital for the area, will be to provide a new fit for purpose premises for Blackwater Medical centre in 2016, the target for the opening of the new facility of 2020. And it goes on. So at that point in time, we're still looking to try to develop a health hub of some sort within the district, or community hospital.

In February 2023 as Sir John Whittingdale quoted, there is also, there will also be a brand new health hub incorporating some services from the former St. Peter's Hospital to combine with one of the GP practices Blackwater. So we still appear to be on course to develop some kind of health hub in the district, okay?

And this goes on and on, up until this point in time. Now, I understand that the consultation is very much in principle about the relocation of the stroke beds and maternity units. But when you read through the evidence presented within the documents, in terms of the business case and you look at the comments that are made within the Senate findings of it, it's very clear that the intention is perhaps to move forward with these changes and then it puts the viability of St. Peter's into doubt, which I can understand why. I thought what I'll do is I'll go away and try to understand why the NHS or ICB, whatever it's called now, has concluded that it's in the best interest of the residents to depart away from the spectral growth pattern that we've agreed with them in the past, and how that will improve health outcomes.

So I thought how do I get this information? So I thought the first thing I'm going to do is going to try to start to understand the impact of the, impact on residents of the district by the potential removal of St. Peter's completely. And I noted within the reports that are produced in the business case, it does give some indicative timings of how long it would

take to travel to various locations that are proposed within the consultation. So I focused on the ones that are most obvious, and that would be Braintree birth time, Braintree for birthing, Brentwood Stroke Unit and Rochford Stroke Unit. And there are obviously some significant variations in timings but I looked at the average travel time and distance by car and public from St. Peter's existing residence. And the average distance that people would travel would be 7.4 miles in the Dengie across all of the areas. I say all of the areas, the most significant, areas. And when I look at the, this time it would take to travel from those same areas to Braintree Birthing Unit, it's something like, in the NHS assessment, it comes up with an average of 40 miles. The reality is, it's 55 miles, not 40 miles, in terms of the movement area. Because obviously, I think what's happening there is, you're presuming that the start point is Maldon, well the start point isn't Maldon, it'll be the furthest point away from Maldon, won't it? And we can go through, so basically what I've come up with is I've got a matrix that I can tell exactly how long it will take in principle to get from A to B.

I, A to B will be whether it be Brentwood, Braintree or Rochford. And in terms of statistics, there'll be a 170 percent increase in travel time for people travelling from Braintree and to Braintree, as opposed to from, St. Peter's. The most significantly where the variations are the widest, in the consultation report presented for the business plan, it's saying that the estimated travel time to birthing unit for Braintree is 89 minutes, by public transport. But in reality, it's 128 minutes, average time okay? and that will range from 160 minutes, 2 hours 40 from Tillingham, down to 82 minutes, best case scenario, in Wickham Bishops. And all of the statistics that we've got indicate there's significantly more time really than was put forward in the consultation documents.

And it was suggested that the ICB go away and look at that data in more detail, which they did in the form of heat maps on the consultation. But they're no different to these. There's not been any modelled study on the matter. So perhaps these are things you want to take away in the future. So basically, the distances that have been consulted upon and approved in principle to move forward are considerably different to the ones that are actually in reality for residents. And that's going to be the biggest problem. So what other data is there from a government perspective that we can use to assess what the benefits are of this development in terms of the deprivation index?

Councillor Spenceley spoke of that matter, in terms of deprivation. And we tend to think about that in terms of have people got enough money? How is their general living standard? There are a number of different deprivation indexes, and one of them is the barriers to housing and services domain. And I was quite astonished to find out what I found out within this data.

For example, Wickham Bishops, which is one of the most affluent areas perhaps in the district. They're within the 7.95 percent most deprived areas in the country. Now, that's LSOAs. There's 32,944 LSOAs. And they would rank at 2,620.

Maybe if I look deeper into this. I looked at Tolleshunt D'Arcy again, another very affluent area. They rank 354th out of 32,944, LSOAs in terms of deprivation to barriers between

housing and services. So 1.7%, they're the most 1.7 percent deprived community on that measurement. Really what you're hearing from the residents, it is very much substantiated by the data that the government produces inasmuch as that whilst an area might be relatively affluent and Maldon is, there are significant areas of deprivation in many different ways that need to be considered, which is the point that the Senate was making and I don't see any evidence of in the con in terms of the business case that properly assessed this level of detail.

Because it's all very well having a nice amount of money in the bank. But if you don't drive, and if you struggle to get a taxi, which you do in the Dengie area, how are you going to get anywhere? You can't. And moving backwards, the problem is, that our local development plan, our whole spatial pattern, our transport structure is based upon where things are now. So once we start moving them away, it completely disrupts that order. I then thought how is the general health care of the district doing? How are we doing with the GP to patient ratio and the health indicators published by government? And I know there's been discussion on this matter in various forms, whereby you're putting forward statistics. There seems to have been a little bit of a shift away from the old fashioned, we'll measure it against qualified GPs, to let's look at all GPs. And I know that [a resident] put some data forward to us at District Council, but that was on a constituency basis. We're not a constituency, we're talking about a bit of a district.

So basically what I did is I broke that data down into more actual district level to look at the GP facilities within the district, and where we sit against the national and Mid Essex averages. I also then looked at what the growth would be for the district in the next five years, which I've got access to the data, and as that you use a 2.4 multiplier to indicate what the number of patients would be, because that's how you get your S106 contribution to the GPs. So looking at that data, it indicates that within five years, we'll have a GP to patient ratio of 2,939 to one GP, unless we have more GPs. Now, I will add that I can't be certain of the number of GPs we've got, because there isn't any data that indicates the number of full time GPs at district level.

So basically what I did is I went through the health impact assessments that are provided by developers, who tend to look upon it here to have more favourable figures than detrimental. And I've used all of the numbers that they've used to assess the number of GPs. Okay. So that is in essence, 28.1 percent using the fully qualified GP number that the government used of 2295.

So we've got, we'll have a 28 percent deficiency in GPs. What does that mean in numbers? Basically it's looking at the current time that we're going to need 14 more GPs in the next five years to bring us up to the national target or BMJ of 1750. So then I thought I'll look back a little bit, I'll look at where we were in the past, at the last local development plan, which was adopted in, 2017.

The evidence at that point in time, using the same calculations, is that we had, deficiency of 4.7 GPs. So basically what I'm seeing here is a continual trend downwards in terms of

provision because a GP to patient ratio then was 2090 and we are predicting it to be up to 2939. Now I know obviously that there might be some benefit of not fully trained GPs in GP practices, but we don't know how often they're going to be there and we don't know how much benefit they will be.

I prefer to use what I do know, which is the fully qualified GPs. So basically what we're seeing there is that, at the moment, we're on a downwards spiral in terms of GP provision or primary care provision. And within the proposal, it's proposing that we actually use some of those facilities or leverage some of that asset to improve the outcome, in terms of the NHS perspective of reducing the amount of estate you need.

I don't see any evidence to indicate that you can achieve that. Moving forward, I also thought I'd look at the maternity side of things. Now, I don't know anything about maternity. I don't know. But I just looked at the statistics. So I looked at the statistics, and I thought let's make some sense of this. So I thought how can I compare something to something? So I picked on stillbirths. Okay? They're a relatively easy thing to measure. It's all recorded by the government in the statistics. And I looked at Maldon's. And Maldon's stillbirth ratio, and this is not meant to be detrimental to any service provider, it's a statistic.

So I thought the best way to do this is to look back over a period of time so I can actually get a balanced view on things. So I looked back over five years. And basically, at the moment, the average for stillbirths across the country is 4.1 per 100,000. [*Inaudible*] and Essex is 3.6. Maldon District is 5.5 on both indicators. So therefore we're 33 percent risk, there's a 33 percent risk above the mean of England and a 51.8 percent risk above the mean of Essex. So I thought okay, perhaps that's just because we're a small local authority. So what I do is I do a sample and a study across, just at random, areas that have got a similar birth rate to the Maldon district.

And I just went through alphabetically. And the first one I come to was Fylde. Their ratio 3.7, 3.7. The next one was Copeland, 4.1, 4.1. And I looked at Torridge, 4 2, 4.2. So basically what I'm gleaning from that statistic is that Maldon is not doing particularly well on that measurement. It's doing worse than the average of those three organisations.

So then I'm starting to think, okay, I can't really see any evidence in the consultation document looking at this type of measurement to see how the outcome will improve. These, I don't know. So then what I thought I'd do, as I look at the ONS doc data, on general health score indexes from 2015 to 2021, and compare us across the district and we can see in 2015, our health score index was 112.1. By 2021, it had fallen to 106.8. So there's no indication there that health outcomes improved according to or how it's measured by the government. So then I thought I'd look at some more data, item 6A of the table. And I'd look at the individual index that work at the deprivation, levels.

And so I go along it and I can see that actually Maldon District Council now have fallen from a relatively good number, to being second worst in the county of 87.3 score. But what sticks out more than anything are two areas, and that is difficulty in daily life and disability.

In difficulty in daily life we're the lowest in all of Essex, and when I look at disability we're far the lowest in all of Essex. And this is really speaking of the problems and, that the difficulty in daily life is really frail people. I had to find out what that was. So what we're saying is that some of the more elderly people, we have a very high proportion of them and it's reflected in the government data, which then goes on to be reflected in deprivation index at different levels.

So why are we where we are? There's obviously been a strategic decision to move the bed based units elsewhere. I can fully understand why, based upon the clinical evidence you presented. However, there's a bigger picture than this, isn't there? There is the future of St. Peter's. And I was looking at some press releases on the matter, and there was an item in the Essex and it says the following:

> *"NHS services in Essex set for impacts in face of spending cuts."*

It then goes on to say:

> *"Mid and South Essex ICS managers say the year to date position at Mid and South largely reflects the current shortfall in efficiency program delivery which was set to mitigate the impact of rising risk."*

It then goes on to say, I'm not entirely sure why this is in there, This is taxpayers' money we are overspending, and if we are overspending, then that means someone else cannot spend as much they need for their population. Obviously I'm here to represent the Maldon population as a resident of Maldon, so I'm not really concerned about the rest of the country. And I'm not entirely sure that I would accept the position that we should take one for the team, as it were, inasmuch as we lose our facilities in the absence of other people.

Why are we where we are? Now, I was interested to hear about this statement that we're not meeting our efficiency targets that we've got to meet. So I thought I'll look at some outside research on the matter. I looked at the Institute for Fiscal Studies, and basically what it's saying is here.

In June 23, NHS published its much awaited long term workforce plan, which was welcomed across the political spectrum. The plan aims to increase the number of staff employed by the NHS from around 1.5 million. Now, the problem is that the IFS have concerns about whether or not the productivity targets and gains that are expected to be achieved from the NHS are realistic.

They are NHS' own estimates, the staff increase in the training plan is not realistic. Will only be enough to meet NHS demand if productivity can increase by 1.5 and 2% per year. This is an extremely ambitious target, well above what the NHS is estimated to have achieved in the past. It's all very well to have ambitious plans, but I guess where we are at the moment in terms of the efficiency of the infrastructure, that we've clearly demonstrated from the statistics, that reducing capacity at further outlets, whilst it might improve your productivity in terms of the fact that you've got rid of administrative staff and support staff, so you appear more productive, you haven't increased your capacity.

And if you're not able to increase your productivity, then you won't be able to meet the demands that you've got. So I thought okay, they may do it. But again, within the document that I've I looked at it in terms of the business case before and I'm thinking okay, I can see that they're trying to find ways to be more efficient and save money and get better clinical outcomes.

But how are they planning for the future? How are they planning for future growth? You can't absorb it all by productivity. So I looked at the housing numbers for the areas around the district.

Event chair: Councillor, we're running well over time for the session. Can you conclude and give them a chance to ask you questions?

Cllr Tony Fittock: I looked at Braintree, Brentwood I looked at, Braintree, Brentwood, Chelmsford and Colchester and in summary, each year, that is going to produce 3,450 houses over a five year period. In the next five years, we're going to have something like 34,500 houses built in these areas, when you will look at the, in terms of the patient impact.

So there's significant growth happening, not just in Maldon, but more importantly around the other areas that I don't see any planning for. And we're already behind the curve in terms of infrastructure, so I think that there needs to be some more modelling done on impacts. Thank you.

Event chair: Councillor, just to check, all of that information, the data and things you're quoting is included in the report, the submission, isn't it?

Cllr Tony Fittock: Other than the reference to the Fiscal Studies, but I can send that.

Event chair: But could you actually let them have that as well? That would be quite useful for them. Okay. You okay to take questions? Absolutely.

Discussion

Dr Matthew Sweeting: Councillor Fittock, thank you so much. I've been, you've walked us through a tremendous amount in that period of time, including the history, of Maldon, health and St. Peter's. We've looked at health inequalities, we've looked at GP survey, and we've looked at rurality and the challenges of health inequalities in that zone.

We've looked at stillbirth and the challenges there as well. So I'm digesting that as we go along. I guess my question from all of those stats, which you so eloquently produce and thank you for the pack that you've done, do you still see in a sense, the benefits of keeping majority of outpatient services local and within the Maldon district because of those various stats you've outlined.

Cllr Tony Fittock: I would agree, but I wouldn't agree that if you like, the approach that's being taken is either is appropriate at the end of the day, if we're going to disperse those services across different areas. Looking at it very simply whenever you move something somewhere else, there'll be an impact. And there'll be an impact on traffic. Now, perhaps if

these developments were to come forward individually, they might end up being refused because the impact and parking facilities are not there. Now the problem we have from a planning perspective, I'm thinking about it that way, is that because they've already got that class granted, then we won't be able to do much about it.

But that doesn't mean to say that there won't be considerable detrimental impact on the area by doing so. So I think that, if I'm honest, my position is very simple, is that we've been, the residents were promised a health hub. I understand the financial constraints that the NHS are under, but we're not prepared to take one for the team. We expect to get a health hub if you want to relocate certain services because there's clear clinical benefit. I think we probably can't disagree with that too much, other than the fact that there is risk. If we're moving these things further and further away for people and I think you've got to consider the next step as well of the evolution of the healthcare system here.

If you keep getting growth, you're going to need new facilities at some point. Why not put them in Maldon? Where we've got land. It's difficult because the land there is, land allocated in principle within our local development plan. It's a strategic site and it does say that there could be a health hub there. Preferably, many people would like St Peter's to be completely refurbished. But I think, to be fair to you, you have to make that decision for yourselves.

If the cost of providing the facility in the Maldon district is better in a different location because it can be built to purpose. That's not for me to decide, that's for you to decide. But it's not for you to decide, I think, that you're just going to withdraw these services because it's more efficient, but doesn't really give you any scope to grow in the future.

Because, as I say, with all of this growth in these other areas, you're going to have a next step. I don't see a next step in the business case that's put forward. I just see consolidation, which I can understand why. But is that the right thing to do?

Event chair: Councillor Fittock, thank you very much for that contribution. Thank you. Okay we've come to our penultimate opportunity here, which is the Save Maldon's Medical Services Group, Tim Olley, Michel Olley, and Les Flack. Are we, everybody ready? Okay. Okay. Alright. So we'll give them a moment to get set up.

Submission 10 - Les Flack, Michelle Olley, Tim Olley, Save Maldon's Medical Services

The summary of this evidence said:

We have been working in the district with residents and also collecting statements from them too. So they will likely be on the PowerPoint. We will use excerpts from legislation in the NHS constitution ACT 2012 and other such documents.

Les Flack's submission, with links, can be found at Annex 10a. The PowerPoint presentation of all three presenters can be found at Annex10b. A document of evidence handed in on the day is at Annex 10c.

Presentation

Les Flack: I'm Les Flack. I'm just a regular resident. I have been involved in a campaign with, say, Moreland's Medical Services, but I speak as myself tonight. I'd asked for a slot on my own, but didn't get it, so I've come this way.

Event chair: Yeah, we're sorry it was trying to get, fit everything together in that, but, yeah, yeah, okay.

Michelle Olley: My name's Michelle Olley, I'm a resident as well, I'm also retired NHS. Okay.

Tim Olley: Tim Olley, local resident.

Event chair: Okay, who would like to open?

Les Flack: Hi. I'll rattle on since time is short. So I have consultation process concerns. I'll be grateful for any questions after this. I grew up in Epping with St. Margaret's and Harlow Hospital close by. I supported my ageing parents driving from the Dengie to Epping and accessed their medical care in under 20 minutes.

Although I was not nearby, local hospitals eased my supporting of my parents. Family support, aids, recovery, rehabilitation and wellbeing. With our own younger family, also not local, I fear my wife and I will be isolated and separated from each other and family care resulting in expensive taxis and paid carer support for medical visits.

The journey times and fragmentation proposed do not ease family care and are surely a threat to rehab and the mental and emotional wellbeing of both the patient and the family, perhaps causing more family health issues. My wife has Meniere's disease and COPD, which result in severe malnutrition.

Breathless, she can't walk far, which escalates distress and anxiety. It's an hour from the Dengie to St. Peter's by bus, with two hour gaps in the schedule. Moving a mobility scooter on buses is not always feasible. I drive, but I can't always be around or able to drive. Long delays from temporary traffic lights are a frequent feature on the Dengie.

My wife is in line for lung reduction operation and will be even more dependent on the support from the provide staff who operate from St. Peter's, a lifeline for her both physically and emotionally, such as at times of chest infections, which is common with COPD. St. Peter's is a community hospital and needs to remain so. My family and the community can't take more burden and stress of uncertain and varying locations, journey costs, and time for healthcare.

Shifting gear now, I submit that with our rapidly heating and collapsing ecosystem, we must strive to minimise unnecessary travel distances for less emissions, air pollution, congestion and resource extraction. These goals are not a nice to have. Every fraction of a degree saved in rising temperatures reduces risk of future pandemics and vector borne disease. Additionally, increasing air pollution is a harm to health, especially the vulnerable, the elderly, those with pulmonary diseases, and our children and babies.

St Peter's is central for public transport, car sharing, trip stacking, and future implementation of active travel routes. In net zero times, we hear talk of the need for 15 minute cities, or key services within 15 minutes. We should pursue rural local futures, not in force, but where reduced and easy low impact travel for healthcare benefits the whole community wellbeing.

We need a holistic approach to healthcare and that takes into account mental and social factors rather than just the symptoms and treatment of an illness. Action towards collective responsibility of our global home aligns with localisation and the needs of the most vulnerable in society.

We must look there towards the vulnerable for the primary goals in decision making. For example, to the lady, Anne, I met in Maldon, entirely dependent on travel for a mobility scooter, visiting St. Peter's 20 times in the last two months. Consultant, blood test, X-ray, all done, same place, same day, shopping on the way home.

The ICB stated X-rays unlikely to be relocated in town due to specialist equipment and is likely Braintree, not local. How will Anne get there on a mobility scooter? Another stressful and unnecessary journey with all the impacts I've described. Dismantling St. Peter's Medical Services and casting them asunder around Mid Essex flies in the face of localisation and the mental and emotional wellbeing of its served community and in turn has potential impacts on physical health.

In 2012, the MDC and Saville's development brief presented a perfectly feasible plan to have new build at the rear, merged with restoration of St. Peter's front section of building. When the ICB say there's no money for St. Peter's, that's a choice. The community deserves to be treated with respect and dignity.

My family and this community needs the NHS decision makers to look beyond short sighted outlook of cost saving, what's affordable, what's value for money, and take the more holistic approach to healthcare, look beyond essential medical care to include mental and social factors, treatment and respect of the whole person and the whole community, not just the illness or disease.

Slightly off track now, I propose that you should enhance St. Peter's medical services with a wellbeing centre of excellence so that GPs and social prescribers can signpost the public to St. Peter's. Why is it closed at night? why aren't we using that huge resource? We could have regular community and education groups with topics such as weight management, relaxation, pain management, menopause help, mindfulness, pace and plan, thrive and survive, even gardening club.

These create social network subgroups and build community networks, which are all excellent for health and wellbeing. People are under so much pressure. Around 20 percent of GP visits are said to be non-medical. That's a huge figure, such as loneliness, socialisation, social isolation, or issues with debt, relationships or housing.

Fragmentation of services and medical care to distributed locations and longer journeys will only exasperate these social issues, further burdening GPs. So dig deep, get serious about Maldon and District's healthcare, holistically. Thank you.

Event chair: Before we decide what's next, just going to check, are you guys going to talk about quite some different themes or is it a merged theme into some different themes? In that case, did the panel members want to ask Les questions now so that we keep it in context rather than later?

Discussion

Dr Pete Scolding: Yeah. Hi, Les, thank you for that. You raised quite a number of really good points. I wanted to ask you just a little bit more about your personal example you gave with your wife, and you mentioned she used some of the different services in terms of her COPD, her Meniere's disease, at St. Peter's. It was just what was the kind of different types of services she'd used to understand that example a little bit more.

Les Flack: I know the provide team are mobile, but they usually operate out of St. Peter's, so she knows where she's going, she's already under a huge amount of stress, so she knows the route, how to get there, so it's things like, she has sought a consultant there, about the possibility of a lung operation, it's an extremely stressful time for her.

So she goes there in the chapel for tests. They do a periodic test where they're getting her to do the bleep test and things like that. And on occasion, we've seen the nurses there, in the unit round the back, where I set the radio up from when I go there. But, yeah, so quite a lot of things, we drop off blood tests, we drop off sputum tests there, I know those things can all be mobile, but she knows where she's going, and her stress and anxiety is high with this condition, so coming out there, we pop into town, we get a coffee, we go for something to eat, we do a bit of shopping, being in town eases her stress and knowing that if I'm not around she could just jump on a bus. She knows where she's going.

Dr Matthew Sweeting: Les thank you very much for your story and the story of your wife. I just wanted to explore, we've heard quite a bit on our consultation journeys. We've gone around the whole of the 1.2 million population and the different areas around opportunities,

particularly in the Maldon district to, so I've heard around keeping local services absolutely local, i.e. In the town or as close to as possible.

Les Flack: Say that again, sorry.

Dr Matthew Sweeting: So keeping local services as local as possible, but at the same time, we've potentially offering something called a hub and spoke model where maybe a day a week, for example, in Burnham or in Witham or in Tollesbury, there may be a something mobile or a dedicated area. Do you think that would be an option we should explore as well, not taking away from a central hub, but also thinking how we support residents where transport is an issue?

Les Flack: Yeah, I think there's value in looking at that. But I would have to say that, the Dengie, the transport in a Dengie is quite unique. for example, you mentioned Burnham. We can't get a bus to Burnham. So that's just not an option. She recently had a pulmonary class in preparation for the operation, and that was in Latchingdon, which was convenient. So they brought that nearer to us. But that did come with the added uncertainty of how do I get there, so she was dependent on me, to drive her there, so obviously, I don't know. I've got a life as well. So it's an idea, but it's not without his problems.

Event chair: Thank you very much, Les. Thank you. We'll move over to Michelle.

Presentation

Michelle Olley: Okay, I'm just going to start to explain, obviously, that, as Save Maldon Medical Services, we comprise a variety of people. We are local residents, local councillors, and we are here just to speak, not just for ourselves, but for those who cannot speak today.

We feel that we have to cover the failings of the ICB in the consultation process. and what we are here to ask, is that we are here to say that we want to keep the medical services here in the Maldon District, ideally at St. Peter's. We want them to be contained within one single unit. and we want secondary care that is easy to access, which is our right under the NHS Constitution for England, 2023. What I mean by that, and I think that refers to actually the last question you've just asked, actually, is not to have one service sent out on a bus. It is really just to actually say that what we want to be able to do is that if you actually go for an appointment at a hospital, that you are able to actually have all your investigations done in one go.

It doesn't mean that you have to go around the county to have everything done if you break up everything that's at St. Peter's at the moment. You will have people traveling to various different parts of the county to have physio done in one area. They'll have everything being done in various different parts of the county. At the moment we have everything under one roof and I think as a Maldon district is our right to actually have that preserved in this area, an example could be that there's no future planning in your public consultation if you wanted to have for argument's sake, extra capacity from your acute trust. You might want to bring out more pre admission.

You would be able to have all of that undertaken in your local area. You can use your diagnostic corridor, which you have already, at St. Peter's. You have excellent blood facilities. You have excellent X-ray, excellent ultrasound. and your outpatient service runs very swiftly. All of that you're expecting to either put in a shop or spread out to Burnham or spread out wherever you'd like to do and you will be asking people to go from one to another and undertake extra journeys to do that. Extra days to do that. And that's just unacceptable for our area. Our area is actually built up, under DEFRA of 80 percent rural population, which means we have to travel further. And I don't think that's acceptable.

We've had a great deal of response on our Facebook page. Many people have given us personal quotes. We have these people's names. We can give this to you so you can verify these. And these are actual things that have happened. Some of these are since you've moved our stroke and rehabilitation ward. We've had examples that have been given to us on the street where elderly residents have been separated for up to three months.

You've heard stories, or at least heard evidence from Councillors today, where they've explained that their residents may not be able to drive. They have to take public transport and incur costs up to £148 in a week to be able to visit their relatives. And some of this is already happening. And as a consequence, we have submitted to you our 25 pages of evidence.

I would call upon you to actually look at this evidence because the evidence effects that this can have on elderly residents could well be broken heart syndrome. It could cause separation anxiety and also the impact is also there from the point of view that it will actually affect the ability for that patient to recover in hospital.

There should be some observation into what actually will happen in terms of the welfare of that patient. I have 20 years' experience in a hospital. I'm not blindsided to the fact that there is a huge shortage of staff. Mid Essex Trust is a failing Trust. It also has difficulties in its retention of staff.

If you're going to move your stroke services or you already have to Brentwood and to Rochford, these are areas where you are going to have difficulty recruiting. This is an area where staff are going to be far more attracted to move to London Trusts. I'm a former NHS manager. I would find it difficult to recruit there myself.

We organised a peaceful vigil at St Peter's. As you can see, 750 people turned up and peacefully showed their love for this building. A building that you can see is in pretty good condition actually. An awful lot of misinformation has been given out to the public, to the staff. There's been plenty of investment in the roof, in the floors.

It's a good asset to sell. There's been an awful lot of press on the television showing the wards that haven't been used for years. But as I say, it has a fantastic diagnostic corridor. It has a fantastic outpatient department and a plot size of a number of acres, which is absolutely perfect for development. We have a number of pieces of evidence to give to you. This is the Rural Health Care Inquiry Report. These pieces of evidence here help to

show you that the NSH, NHS constitution is founded on the principle of equal access to healthcare. The constitution states that the NHS is available to all and it is a social duty to promote equality through the services it provides and to pay particular attention to the groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population.

It emphasises that people should not be disadvantaged because of where they reside and that nobody should be excluded, discriminated against, or left behind. Despite these fundamental commitments, health and social care in rural areas has been raised as a concern in numerous reports over many years.

Evidence presented to the inquiry was clear. In essence, many rural residents are disadvantaged through their life course compared to the urban counterparts. Access to maternity care is more problematical. The wider community services for children and young people are less accessible. Primary and secondary care are not so readily available for people of working age, including preventative and screening services, and the provision of both health and social services for the growing population of older citizens is increasingly inadequate.

We are not offering equal care if we're all in England, despite the commitment to do if we take a look at this graph here, you can see very clearly that the population, the number of residents per kilometre here quite clearly shows that we have in our density for our population. Yeah.

I'll ask my husband to explain. I have aphasia.

Tim Olley: Yeah, it clearly shows the population density in South Essex. It does also suggest, Mid and South Essex isn't a London borough. It does stretch from Sudbury in the north of there to the edge of London and to the sea. It's not the centre of Chelmsford, which is the big pink blob in the middle for anybody who doesn't know. And clearly shows that Maldon is as least densely populated of all the districts.

Michelle Olley: What it actually does, help by moving down, all of our services down into South Essex is it does allow the Trust to be able to have attendances very nicely from all of our South Essex counterparts. But it means that everybody traveling from the Dengie will have to travel up to three hours on public transport, which is where we will all be having difficulties meeting our appointments, or you'll have an awful lot of DNAs on your hands from all the Maldon district, or they won't be able to visit their loved ones.

I missed one. We list here the duties that the ICBs have to follow and we feel that and then we've listed in the 25 pages of evidence at different sections that we feel that you have negated to comply with your general duties.

You'll feel you'll actually have that in your written evidence and obviously as time is short, I cannot go through each one of these now, but I would see the audience will be able to see that they have a duty to especially to comply and promote the NHS constitution. They fail on that on several, several counts.

But there is a great deal of wealth of evidence that we provided to you. And we've, we ask you to come back to us on each juncture where we have provided all this evidence to you. And obviously we haven't got that to produce to you. I'm sorry at this moment. But we have provided it to you to obviously come back to us at a later date.

One of the most important things that I've heard today keeps coming back about, visitors. And actually, there is, the DHSC Consultation Visiting in Care Homes, hospitals most importantly in hospices and the ministerial forward states visits from loved ones are vital to the health and wellbeing of people receiving care in care homes, hospitals and hospices.

We know how much these connections matter whether through practical care and an individual provides to a loved one supports and advocacy during a difficult medical appointment or the comfort provided from a held hand or a hug. It is not a nice to have, but a vital part of providing individuals with the high quality care everyone deserves.

We want everyone to be able to see and support the people they love in health and care settings. This is something that is going to be brought into law. This means that you don't have to just rely on a virtual way of seeing your loved one. The reason this is important is that a lot of our people in our area, come under, because as I've mentioned before, DEFRA have designated Maldon as 80 percent rural. That means, obviously in Essex, we are the most rural area. In the rural district, in the Maldon district. This means that we are going to have the most difficulty getting to south Essex areas and we will come on to those transport difficulties in a moment but I need that to be impressed upon you.

Tim Olley: Okay, to go to the various consultation paperwork, there's a general presumption which everybody's aware of that anything other than St. Peter's is better, although as we've learned this evening, the consultation is for suggestions on any, all the outpatients things, but what that means, who knows. There is an interesting comment regarding the maternity offer, with 95 percent of patients get to St. Peter's in 102 minutes by public transport, and this would reduce to 92 minutes to go to WJC. No, I couldn't work out what that relates to. Postcode plot of the mothers, or anything, the whole of the Mid and South Essex patch. So that includes people from Thurrock, who knows, but considering in the impact assessments, the majority of patients at St. Peter's come from CM1, which is central Chelmsford, CO9, Sible Hedingham and Halstead, which of course is north of Braintree, and CM7, which is Finchingfield and Braintree, it would appear that a lot of patients are making the active decision not to go to WJC and prefer to come to St. Peter's.

The integrated impact assessments also make a number of recommendations as to who to engage with to ensure relevant feedback is obtained. I think there's about 18 or 19. We'd love to find out how you've managed to achieve those 18 recommendations in the future. The impact assessment suggests that locating to unknown locations in Maldon town centre would improve transport links. As we've heard from various people, St. Peter's is very well connected and quite a short distance from town centre.

To go on to the maintenance costs, which have been mentioned repeatedly, the Mid and South Essex Foundation Trust presented an update to the County Council's health overview, privacy and scrutiny committee on the 4th of January this year which advised that there was a pre consultation business case due to be considered in 2024, which of course was decided to progress on the 18th of January. The total maintenance cost presented to that committee for various hospitals, Basildon £64.1 million, Broomfield £41.1 million, Southend £78.6 million.

Orsett, which according to other documents, or according to this report, has already been decided to be closed, fourteen and a half million [pounds]. And, dear St Peter's, twenty million [pounds]. If you're spending fourteen and a half million on Orsett, which is already marked to be closed, there's quite a saving to be made there.

The document also goes on to suggest that the Trust, which I know isn't the ICB, has a number of estate objectives, one of them being one public estate, optimising opportunities to support new models of care as part of a co-ordinated approach to deliver care closer to home, which I think you'll appreciate isn't what this is attempting to achieve. Also, the clinical principles of the trust merger business case, principle five, care, move closer to the patient's home.

As has been mentioned by a number of people so far today, there are a selection of alternatives that have appeared in the frequently asked questions, being Maldon District Council offices, the second floor of Carmelite House, which is the library, Blackwater Leisure Centre, retail premises in the High Street, the health facilities in Wantz Chase, and South Woodham Ferrers, Braintree and Burnham.

The consultation document does also suggest that there will be a number of, services co located at Braintree, but the document that provides the travel times on the consultation forgets to provide travel times to Braintree. Which, as you've heard from a number of people, from a number of, starting from a number of places, achieving arrival at Braintree will be a challenge.

The transport element of this, the documents submitted by the ICB, presumes all journeys start at Maldon District Council offices. Maldon isn't in the middle of Maldon District. It's very close, it's far closer to all the proposed destinations than most of Maldon District. Interestingly it asserts that Maldon has a bus and coach station, which, [LAUGHTER] I think the audience response has covered that. I don't know, don't believe anybody thinks we still do. It was closed and turned into housing many years ago. Yeah, not sure where the ICB have got their information from. So we've produced a little table of various journeys. I won't labour the point, as has been raised numerous times by numerous people getting to anywhere other than Maldon is an immense challenge. For a nine o'clock appointment in Braintree from Tillingham, of course you have to leave at half past six the day before. As Councillor Fittock has gone through, Maldon has expanded, continues to do. We've got the 11th least densely populated district in the east of England. We had a population of about 30,000 in 1950. We had two train stations and a hospital then. Now

we've got 66,000 and more, plus over two and a half thousand to be built around Maldon plus the rest of the district. No train stations, no bus station, but the hospital is no longer required apparently.

The capacity, the consultation document doesn't mention the capacity of the other hospitals to deal with the increased burden on them from directing Maldon residents elsewhere, or Maldon residents, South Woodham Ferrers residents, Witham residents. There's been, Tiptree residents, Maldon's the closest for a lot of things and easier to get to than Colchester Hospitals.

The impact assessments make great play of the issues of car parking in town centre, but don't mention the completely oversubscribed parking at Broomfield Hospital or parking availability at the various other options. However, the report to the County Council Overview and Scrutiny Committee does say that Broomfield suffers significant parking congestion.

And as mentioned already, there's no consideration of the London effect of attracting staff in that direction. This is just a list of services. I know we're over time.

Event chair: No, I was going to, I was going to say, Oh, you've got your conclusions. I was going to say, yeah. Okay.

Tim Olley: Conclusions. I think everybody who's spoken during the day has put forward hugely well researched and evidenced comments and conclusions about the issues with the proposals as put forward.

And the need to think again with different parameters, different thought process, and a proper consideration of the facts. I've got nothing else to say.

Event chair: Okay. Thank you Tim and Michelle. You happy to take questions?

Discussion

Dr Pete Scolding: Thank you for that. And may I ask just one clarifying question? Because I think you covered quite a lot within both of those presentations. So thank you. Mr. Olley, it was something you mentioned, which I didn't catch, I didn't spot on the slide, so that's why I'm just wanting to clarify it. I think you mentioned 18, 19 recommendations that you wanted to understand the role. Could you just expand on that one, just so we get it?

Tim Olley: Literally just over there, in the impact assessment. The executive summary. There are a whole list of recommendations that the trust or the ICB has made to itself regarding engagement with us.

Event chair: Thank you. Any more questions?

Dr Matthew Sweeting: Could I just go Tim, back to you? Just help me understand the 80,000 additional outpatient appointments oversubscribed hospitals. Just help me unpack

that because obviously there is a guaranteed to stay in the Maldon district. So I was trying to understand that statement, if that's okay.

Tim Olley: The 80,000 appointments is in the consultation. Yeah, are they guaranteed to stay in Maldon? Because the consultation document actually says that a whole load of things will need to be co located in Braintree. Which isn't in Maldon.

Dr Matthew Sweeting: So is that the clarity of, I was just trying to understand, so that's the reference to the 80,000, so phlebotomy, antenatal services, physio and consultant appointments, I imagine.

Tim Olley: We don't know where you're proposing to put it.

Michelle Olley: There's so much misinformation.

Tim Olley: Or information lacking. Where are the 80,000 appointments going to go? Because there haven't been any suggestions of where it's going to go in Maldon. But there is quite clear suggestion that certain things will have to be co located at Braintree.

Michelle Olley: The document I gave you earlier, actually the staff are under the impression that like for is going to be, is going to be implemented. Yeah.

That's what was given to every member of staff at St. Peter's.

Tim Olley: Turn your mic on.

Event chair: Sorry, I apologize. Yeah. just for the benefit of the others. Yeah, it's not an official staff communication apparently.

Michelle Olley: I was going to say, that was given to every member of staff. So that's, as I say, that there are many people at St. Peter's. They are running around. They do not know what's happening, and that's what was given to them.

So I say there's so much misinformation. In the Maldon district, we are under the impression it's a proposed closure. Anybody who lives outside of the Maldon district, they know that St. Peter's is closing.

Event chair: Can I make a suggestion? Obviously you've heard a lot of what people have said today and there's the different submissions. But is it a worthwhile exercise that you might produce a kind of like a listing of what you think you want in the way of information that you think is currently lacking. I know there's only a couple of weeks left, but the point about it is

Tim Olley: Well, can you extend it? You should extend the consultation.

Event chair: It's already been extended once and that's not down to me. That's not me and a decision has to be made elsewhere but there's a lot of people saying there's information missing on this or that and I think that it needs to be coordinated and pulled together and I'm sure that what will be happening after this is that will be looked at but from your perspective it might be worth you putting together your definitive list of things.

Michelle Olley: I'm sure we'd be quite happy to do that as a group but we have been discussing it with both the MPs who are taking it to Parliament because they actually feel there should be a Judicial Review with judicial review and actually stop this consultation. Okay

Audience: *Inaudible*

Event chair: Okay It's it just to where obviously you're off mic, so people won't have picked that up and just for the benefit of the others in the room. Yeah. yeah. that's been repeated several times today. So I think, the message has been heard. Okay. Yeah. In which, case it just leaves me to thank Tim, Michelle, and Les for your contributions today. Alright?

Submission 11 - Cllr Nick Spenceley – Maldon District Council (Heybridge East Ward)

Councillor Spenceley stated that he would talk about the Gunning Principles and how this consultation falls short. He also cited a report by Peter Levin PhD from Cornwall (formerly of the Department of Social Policy, London School of Economics and Political Science and member of West Cornwall Healthwatch). This is attached at Annex 11 and other material by Dr Levin is available at:

https://spr4cornwall.net/wp-content/uploads/Dont-close-community-hospitals-use-them-as-re-ablement-centres.pdf

https://spr4cornwall.net/wp-content/uploads/Closing-a-community-hospital-how-consultation-went-wrong.pdf

Event chair: I would like to move on to Councillor Nick Spenceley. Councillor, the floor is yours.

Presentation

Cllr Nick Spenceley: Thank you, Chair. I'm Councillor Nick Spenceley. I'm District Councillor for Heybridge East. and I'm speaking tonight generally for the community at large. And I have one question. works [unclear] with the save Maldon's medical services group as well.

So I intend to address the legitimacy of this consultation process or the alleged consultation process, and I'm not doing a PowerPoint. As an ex teacher, I've done enough PowerPoints in my day. So there's two sources. One is your, the ICB's own documents, the consultation documents, and the pre consultation business case.

And the other source is a report produced by a social policy researcher called Peter Levin, a PhD, Dr. Peter Levin, who operates in Cornwall. And who did a report into a similar exercise involving a hospital that was put up for closure in St. Ives in Cornwall. And he's very kindly responded to me reaching out to him when I saw this case study. And he's done his own independent scrutiny of the consultation process. What I want to do is go through some key principles now. Mr. Rogers did a fantastic presentation earlier on and I'm picking up some of the points he made about what to expect from a consultation and I know, chair, you're an expert on consultation law.

So I'm going to speak with a bit of caution on that one. But the consultations are governed by the Gunning Principles, which were established in 1985 and have been consolidated by case law since. And there's four basic principles. One is that proposals should still be at a formative stage. A final decision has not yet been made or predetermined by the decision makers. And we'll come to that in a minute.

Two, there is sufficient information to give intelligent consideration. It must be available, accessible and easily interpretable for consultees to provide an informed response.

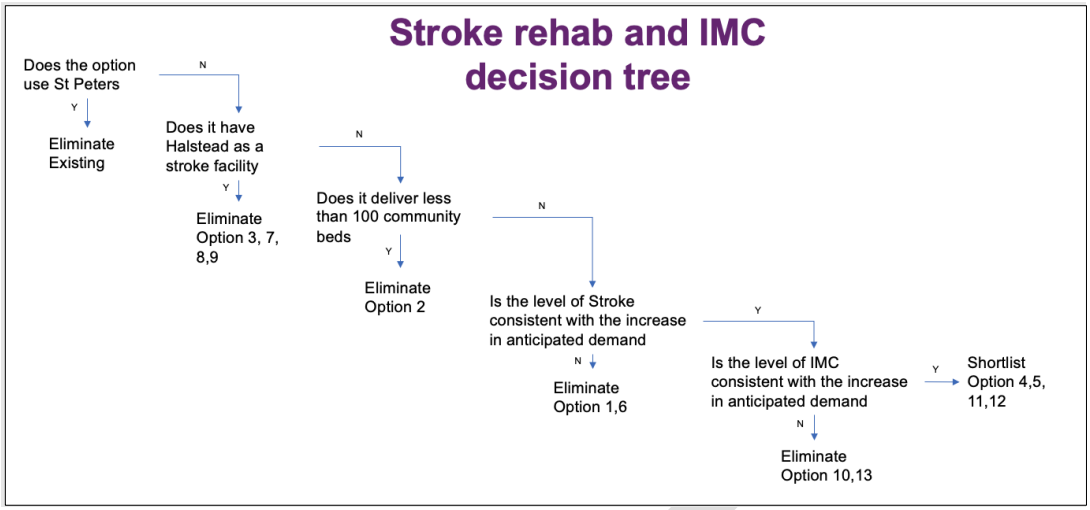
Three, there is adequate time for consideration and response. There's a kind of, norm that about 12 weeks is expected, but it's not law. This consultation has expanded from eight to 12 weeks, which is good to hear, or ten. Oh, okay. That's true. Good point.

Four, conscientious consideration must be given to the consultation responses before a decision is made.

Turning to Dr. Levin's reports, he did indeed see a lot of similarities between what's happened here and, the hospital in Cornwall. And he concludes, one, the consultation document amounts to an attempt to mislead the public into thinking that all possibilities remain open. He says, the proposals that we, the public has been told in the consultation document, the proposals that we are describing are just that, proposals.

We are asking local people to share their thoughts before we decide what to do. But prior to public consultation, Dr. Levin goes on, numerous possibilities, including all those that involve keeping St. Peter's Hospital going, have already been ruled out. Decisions have already been taken by default. And it reminds me of when I was putting my children to bed, I used to consult my children. I used to say, Do you want to go to bed with an orange drink? Or do you want to go to bed with a glass of milk? The real issue at stake, going to bed, was not subject to consultation at all. And to switch metaphors, we're looking at giving our views on the last three tumbling dominoes in a row that have been triggered by the decision to close St. Peter's Hospital. So we've got the decision already taken on a temporary basis to move stroke services away, followed by a decision taken as a result of that, and again it's, this is from the pre consultation business case, because of the transfer of stroke rehabilitation inpatient services, with the resultant out of hours safety and security issues, together with the condition of the estate, the midwife led birthing unit was transferred to the unit at St. Michael's in Braintree, So that's another domino that tumbles.

Then, of course, you've got all the inpatient services gone, so why are you providing outpatient services? So now we've got the very vague proposal to transfer outpatient services to unspecified locations in and around Maldon. But the elephant in the room is the decision to close St. Peter's, and Dr. Levin is very clear about this. In the pre consultation business case, page 49 of 128, there's a decision tree, which is a six stage flowchart looking at options for, in this case, stroke rehab.



Step one says, does the option use St. Peter's? If yes, eliminate. So basically, step one, does it consider St. Peter's? Get rid of it. St. Peter's was ruled out right from the start. That decision must have been taken in the summer or autumn of 2023 2024.

The task force that worked on this has been at work since the summer of 2023. But the business case, as others have said, has only just been published. It was led by clinicians, and they considered a whole set of options. None of them involved continuing the use of St. Peter's Hospital, as its condition was considered to be unsuitable for continued use for inpatients, section 5. 2. 5:

> *"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."*

So basically, you've got a track where clinicians are ruling out St. Peter's. And there does not seem to have been any consultation with the public.

Now, in case you come back on that, it does mention in this document, that there was some reaching out to a total of 290 people. Because, as Councillor Fittock has pointed out, the East of England Senate Council had some criticisms about the process. And they said, extensive public consultation and engagement may have been helpful.

The ICB's response is that they met with Healthwatch, and they did two different surveys on a virtual views platform, whatever that is, and reached a further 120 people via survey groups online or in person. So it's 170 on the virtual views, 120 on survey groups, which apparently includes the Blackwater patient participation group and the Maldon Stroke group, although nobody I've reached out to remembers this.

But hey, it says it's available as part of the appendices, but I can't find it in the appendices. So much for that. So also, if a consultation has been carried out, why is it called a pre consultation business case? The decision to close St. Peter's was taken before this consultation started.

Dr. Levin's third point, outlined as five, by the way, third point is that St. Peter's Hospital appears to have been deliberately allowed to run down. If that had not been the case, the faulty roofs would have been dealt with at a manageable cost, preventing disruption and damage caused by water ingress.

And part of the pre consultation business case, and I don't know if, yes, it is visible, is this little table [on page 70 of the PCB].

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.

The columns to the right show the other community hospitals, and they're RAG rated according to the state of various indicators. The one on the left is St. Peter's, and it's all red and amber.

The only green elements there are actually to do with IT systems and telephony, the availability of couriers and patient transport accessibility. The ICB would say that proves the case, we should close St. Peter's. Now, as a former principal responsible for an estate

that had maybe eight or nine blocks, all of which had separate building condition surveys from time to time, I would conclude two things for that.

One would be, I would order the immediate evacuation of this building because it would be a danger to my staff and students and the other thing I would think would be how on earth did I let it get to this state?

Another element of perhaps confused thinking is in the pre consultation business case page, section 8.1.5, it says there are proposals to develop new primary care hubs in North and South Maldon. We've already heard that a new GP facility on the Westcombe Park Estate does not a health hub make. It's just a focus for GPs. The latter offering the long term op, so this is the South Maldon one, the latter offering the long 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. At the moment, it's looking like decades, because this has been, this is the very development that's been discussed for a very long time indeed, but there seems to have been a false assumption that something would turn up during this pre consultation business case.

Point four in Dr. Levin's critique, no one seems to have asked, what do we see if we look at St. Peter's Hospital building and site as an opportunity? My friends from the previous presentation, particularly Les, were very eloquent about that. It seems, it appears, Dr. Levin says, that the minds of the management of the MSE NHS Foundation Trust have been closed to possibilities other than complete shutdown of the hospital.

It may be that lay members of the Trust board were unwilling to challenge the clinicians. The absence of open mindedness as to the hospital's future is perhaps suggestive of weak management on the part of the ICB.

Point five, the members of the task force have not properly understood the role of intermediate care in community hospitals. Community hospitals are not just elements in a spectrum, as the business case describes them, section 3. 2. 2. Rather, they provide essential stages for patients in a process, their care journey, the transition from the acute hospital where they have been treated to their home or other place of residence.

I don't profess to be an expert on this. I bow to my friend in Cornwall, but closeness to home and the sense of being on the journey there play a crucial part in keeping up patients' morale and keeping their need for institutional care at bay. And you've heard today many eloquent testimonies about that.

Dr. Levin also looked at the age profile of this area and felt that it particularly put in question the model that the board had adopted in terms of where they felt this care should be located. Where do we go from here? I feel a lot of sympathy for you guys on that side of the table.

But let's face it, this whole process could have been very different if this had been a genuine consultation from the start that looked at the substantive issue of the future of St.

Peter's and invited the community as mature people, with local knowledge, to contribute. It could have been so different.

As Dr Levin says, there's a wide gulf between the people running the current public involvement in events who insist that the proposals up for discussion are no more than proposals and the clinicians operating behind the scenes in the task force, who very early in the decision making process ruled out any options that would make use of St Peter's Hospital.

There has to be more to public participation than inviting lay people to have your say after critical decisions have already been taken. If you get a hostile reception, be aware of the reasons for it and be prepared to go back to the drawing board. You need to take the public with you in your thinking.

Most people understand dilemmas. And we'll appreciate the difficulties you face, but if you ask them to rubber stamp decisions that you have already taken, expect to be challenged.

Event chair: Councillor Spenceley, just interestingly, before we open this up to questions, obviously what you've done is you've provided effectively a critique. But is there, taking that aside, are there any specific things that you think that the panel should actually be considering from the perspective of influencing their decision making?

Audience: *Inaudible*

Event chair: No, don't misunderstand I think Councillor knows what I'm referring to,

Cllr Nick Spenceley: I feel that we are in the midst of a process that has come off the rails. I think it started for the ICB in the public meeting which I attended. I think, first of all, there was never going to be a public meeting in Maldon, which was a big miscalculation.

It was only pressure from the MP and the mayor and the town council that produced a consultation, a public meeting in Maldon. I think it was very clear that ICB reps were taken aback by the strength and vehemence of the public response. There have been responses since which the ICB could argue is them being flexible like extending the consultation and belatedly reaching out to specific community groups.

These have been triggered by specific representations from people. We've heard about the ableist approach that was initially adopted, various other things. So it has been some response. But again, that's evidence that it was ill thought out, rushed, didn't follow proper process. I feel the timescale has been governed by national election, rather than a mature consideration of how a major development like this can be approached.

I would go back to the drawing board. I really think we're in a position where the actual issue at stake has not been part of the consultation. And I question the legitimacy of the consultation process on that basis. There are many other flaws which people have eloquently portrayed today.

Event chair: Okay. Thanks. Any questions?

Discussion

Dr Matthew Sweeting: Thank you for your really comprehensive report. It's just a point of process, really, in terms of Dr. Peter Levin, a social researcher. So just, I just wanted to clarify that. Obviously sounds like an expert in his field. Is this published material? Did you approach as a commissioned piece? Or is this something that came with co correspondence and

Cllr Nick Spenceley: It's a bit of pro bono work on his part. I emailed him when I saw his reports on the closure of the hospital in St. Ives and said, Can you give me some advice? This looks a very similar case to ours and he responded almost immediately and said "Yes It does look very similar. Please give me links to any documents associated with this and I'll give you some feedback," and he very kindly wrote this report. So essentially his website is regularly updated with reports on various aspects of NHS activity, particularly in Cornwall. But I think he sees this as really something that strengthens the case for what's happening there as well.

And I think he's reaching out to the Community Hospitals Association. I don't know if it's and NHS England, raising this as an issue as well.

Dr Matthew Sweeting: And he's a social researcher with an interest in this area.

Cllr Nick Spenceley: Yeah, he was a former lecturer at London School of Economics, retired.

Dr Matthew Sweeting: Thank you very much as a really helpful with the, with your correspondence there. Obviously make that available so we can study that in depth, which sounds like you've tried to do for us today. No problem. Thank you.

Event chair: I've got a question. Dr. Levin, as a social researcher, are you aware whether or not he's got any practice law in the consultation field?

Cllr Nick Spenceley: I'm not aware of that.

Event chair: No. Okay. All right. Okay. I'm just going to, as a comment, I would say that if he hasn't engaged specialist consultation lawyers someone like Peter Edwards from Capsticks or somebody of that sort, I find that, what I read of that, I take, I, I didn't think it was very strong, I didn't think it was accurate, and I think he really should have sense checked what he wanted to write there with a proper lawyer, who practices in consultation law.

Cllr Nick Spenceley: Okay any advice on specialist consultation lawyers would be very welcome to us. I'm not sure if we could afford their fees, but and I have dabbled in that myself, looking at a law briefing. And you can perhaps help me here, because in terms of predetermination, the briefing I read said that there should be an open mind, but the consulting body can have a preference so they can have a preference for a solution. But their understanding of the law is that, it should not, so an open mind is not an empty mind. So clearly the ICB will have in mind their preferred solution but the term that this lawyer

used was that there, that the door should be ajar. So that other possibilities are open. Now, the impression I get here is that the door is not ajar, it's shut and it's triple locked.

And I bow to your much, much, greater knowledge of consultation law on that one.

Event chair: I'm going to say something I think that I appreciate because of the sentiment and the feelings here. That maybe what I'm going to say, you will probably get shouted down. But I think the fact that they are holding this type of event. Is part of that door being ajar? part of what part of...

Audience: Are you sure you're independent?

Cllr Nick Spenceley: No, hang on guys. In fairness, I think our chair has been a good chair, and I've read his record, and, from what I've read that you, actually worked for a charity that helps Israelis and Palestinians to reconcile. So you must have pretty good track record.

Event chair: I founded Salaam Shalom.

Cllr Nick Spenceley: There we go. So clearly you've got a track record of conciliation and independence. Yeah. I think the point, the proof will be that Point Four of the Gunning Principles. What will the ICB do with the feedback that we've given them?

Event chair: And I think it's really important because when we don't like proposals, right? what we forget is that it is actually the judiciary who determine the Gunning Principles... whether the Gunning Principles have been applied, not me, not anybody else. It's for the courts to decide that at the end of the day. And my experience of doing it is that the views of the courts can be much broader than we would like to sometimes think when we don't like the proposals, their views can be quite broad and they're ever changing.

Audience: Has the Trust taken legal advice on the consultation process and will they publish that advice? Because you, sir, as independent chair have gone further than you should have done. should.

Event chair: Okay. Fair enough.

Audience: Can I add something about Dr Levin?

Event chair: Yeah.

Audience: INAUDIBLE ...50 years, his main research has been government planning, policy making he has released books on the government planning processes INAUDIBLE and scheme in the sixties, making social policy mechanisms of government politics, INAUDIBLE on the committee of the West Cornwall Health Watch, voluntary community health watch that's been serving West Cornwall since 1987.

Event chair: I don't debate his credentials in social research. I don't debate it. Okay. So are we concluded? Anything further you'd like to add councillor?

Cllr Nick Spenceley: No. Fine. Thank you.

Conclusion of the event

The chair thanked everyone present for their participation and reflected some of the common themes shared across the three sessions:

- the importance of preserving facilities within Maldon itself
- the importance of understanding the implications of moving services
- many transport access issues and, the difficulties people from Maldon and the Dengie would face in accessing services elsewhere.

The chair reminded people that the purpose of these hearing sessions is gather and discuss evidence that will be available to decision makers to inform their decisions on these matters. And explained that the submissions and proceedings would be produced as a feedback report.

The chair informed the audience that the consultation was scheduled to be open for two more weeks and advised people watching online and in the audience still have time to respond to the consultation. He relayed the ICB's commitment to taking all the feedback received into account in decision making.

Finally, the chair thanked all the presenters again and asked the audience to give themselves a round of applause.

Session 3 closed

Session 4

18:00, 04 April 2024, online

Chair's welcome and introduction

The Chair welcomed everyone and introduced the session, explaining that it is an addition to the three evidence sessions which took place at the public consultation hearing event held at Maldon Town Hall on 19 March 2024, held to accommodate more of the people who applied to submit evidence.

The chair shared that there are three scheduled presenters who, in line with the format used on 19 March, would have been allocated 15 minutes to talk to their evidence followed by 15 minutes of related questions from and discussion with the panel.

A technical issue preventing the planned live-stream of the event was noted and apologies shared for those waiting to view online while the team worked to resolve it.

The panel members introduced themselves.

	Speaker/s	Topic	Organisation	Page
Submission 12	Lynda Peggs	Maternity		Page 93
Submission 13	Kirsty Jenkins	Stroke rehab & intermediate care beds	Community Stroke Staff Team Cumberlege Intermediate Care Centre	Page 98
Submission 14	Donna Murphy	Stroke rehab & intermediate care beds	Substitute presenter for slot allocated to Chartered Society of Physiotherapy	Page 106

Panel

- **Claire Hankey:** Director of Communications and Partnerships at NHS Mid and South Essex Integrated Care Board
- **Debbie Goldsmith:** Midwifery Lead, NHS Mid and South Essex NHS Foundation Trust
- **Carolyne Dawson:** Stroke matron, operational lead for SSE frailty virtual ward and collaborative care team and Joint Lead Stroke Steward, NHS Mid and South Essex NHS Foundation Trust

Submission 12 - Lynda Peggs, Resident and community midwife

Lynda's evidence document can be found at Annex 12.

Presentation

Lynda Peggs: My name's Lynda Peggs, I've been a Maldon resident for 21 years. My family are all service users of St Peter's. I have two children, childbearing age. My mother's had a stroke, my husband has regular blood tests, I've had physio so we're big users of St Peter's. I'm also a registered midwife, I work out of St Peter's as a community midwife. And today I mainly want to be talking about why I think the intrapartum and inpatient services at St. Peter's shouldn't be relocated or closed. And I'm here basically to advocate for women who are already pregnant or those that are planning to be pregnant in the future.

Women who I think their choice is being taken away by this proposal.

I just need to clear something up. First of all, and I'd like to be on record, which is why I'm going to say it now. I'm slightly disappointed in the way that my application to present at this public hearing was handled. I applied online and then was called in via my line manager at work. So someone from the board spoke to maternity.

I think that's very unprofessional, and I don't believe that's an appropriate way for that to have been handled. [The organisers have] been very helpful in making sure that I am able to speak now, but I think that was quite poor to start with. And I'd also like to apologise for my referencing when you get my presentation, because it's appalling and not, degree standard.

So the first point I want to make is about women's choice. Okay, so for a numbers of years, policy makers have recommended women have given a choice of setting in which to give birth in. So I've just picked out three examples from the last three decades about that. So *Maternity Matters*, 2007, identified key targets to provide choice, access and continuity of care in a safe service with a national choice guarantee for women.

Moving on 10 years, *Better Births* published in February 2016 by NHS England noted that women were not being offered that real choice in a service that they accessed as was promised in 2007. And in its vision for the future, the very, very first point that it noted was about personalised care and saying that women should have a genuine choice about care.

Decisions about where they could give birth, then jump forward another 10 years, 26th of February this year, MSE launched their new updated personalised care and support plan, lovely document that we can discuss with our women about all the choices, including their choice of where to give birth, which does mention the three choices, the places you can have your baby, at home, in a freestanding midwife led unit at St. Peter's or Maldon, in an alongside unit at Broomfield, Basildon or Southend, on an obstetric unit. So we're giving the women these choices, but on the other hand we're taking them away. There's been a number of other reviews, publications, initiatives, all agreeing with this main theme about women being able to choose where to give birth.

So my second point is about why we want women to give birth in a midwife led unit, why we don't want them to go to an obstetric unit, and the benefits for low risk birthing women. There's a huge amount of evidence out there that show it's safer and it's cheaper for healthy women with straightforward pregnancies to give birth in a midwife led unit.

In 2014, NICE confirmed that more women should be encouraged to birth at midwife led units, rather than traditional labour wards, because the rate of intervention is lower and the outcome is no different compared with an obstetric unit. Lots more research provides evidence that shows midwifery led care is a more evidence based strategy to improve maternity care. It finds the universal philosophy of midwives rather than consultant doctors, emphasises care that encourages normal physiological birth and supports women to birth with minimum or no routine intervention. Cohort studied in Denmark over 800 women at two freestanding midwife units with a matched cohort attending to obstetric units concluded there was no increase in any perinatal morbidity but there was a significant reduction in caesarean sections and other birth interventions like forceps. 2020, a study was undertaken by the National Institute for Health Research and it looked into factors that influence the use of freestanding and alongside midwifery led units in the UK. Worryingly, the study found that most Trust managers, senior midwifery managers and obstetricians did not regard their midwifery led units as being an important part of their obstetric sorry, as being an important part of their overall maternity package. The report also found strong evidence that midwife led units reduce caesarean rates by two thirds, are very safe, improves patient satisfaction and are 20 percent cheaper than obstetric units.

Despite all this evidence regarding the benefit of birthing in a midwife led unit, the research from the same study found that unconvinced about their actual value. And believed incorrectly that midwife led units are more expensive and less safe.

So the final point I want to make is about the proposal to relocate intrapartum and inpatient services to WJC. I'd like to say I disagree that you're planning to relocate, okay? WJC has been a freestanding midwife led unit as part of the Mid Essex facility for a number of years. Intrapartum care there was suspended in August 21, as it was at St Peter's, due to staffing levels at Broomfield. St. Peter's was reopened, WJC never was.

Therefore, we're not relocating our services, we're actually harming them. If we go back to 2021, there were four delivery rooms, two at WJC, two at St. Peter's. WJC has space for three postnatal women. At St. Peter's, there was a ward for five, plus the DAU which could be converted for two more postnatal if required. Considering the number of women that are coming through Broomfield currently, we're losing four, we're losing two low risk birthing units and seven postnatal beds. Broomfield already has less postnatal beds than St John's had. Okay, we're often bedblocked in the postnatal ward, and we know the effect that has on the whole unit.

Ultimately, this leads to delay at the beginning of people's journey with induction of labour, because we don't have the space to move those postnatal ladies on. I'd also like to

counter what you said in your proposal document. WJC is not a purpose built ward offering better facilities.

It's a converted ward. Two of the postnatal rooms currently don't actually have the correct beds. They have a double bed because the doors are not wide enough for them to put a postnatal bed in. This is a real problem for staff. So staff that are there to give breastfeeding support mainly for these ladies, these low risk ladies are having to bend over or kneel down because the beds won't raise because we can't get the real beds in because the doors are too small.

They also, the way the location there the way the layout is at WJC, postpartum women have to go through an outpatient waiting area to get to the toilet, which you can understand is not suitable for a lady that's just had a baby. Please don't misunderstand me. WJC is a fantastic facility and I want it to be kept open.

I had the joy of having my first birth there. The other day I went on call over to WJC and we had a lovely birth and it's a fantastic facility. But what is best for the women in our area, and for women who access care throughout our area, is that we can keep both WJC and St Peter's open. Then they've got a real chance of deciding where they can give birth.

Sorry, I've really rushed that, quite nervous reading it out. So thank you for listening to me, and giving me my opportunity to present my views. Thank you.

Event Chair: Thanks very much, Lynda. And apologies to hear about your build up to this. I'm sure that somebody will be talking to you about it and dealing with that. Um, panel members anybody would like to open with any questions or discussion with Lynda, Debbie,

Discussion

Debbie Goldsmith: Lovely. It's nice to see you, Lynda. So you're very welcome. And you didn't come across as nervous. You came across as very knowledgeable. Very confident. You'd obviously taken the time to do your research and you were really credible. Just a couple of things for me. I'm really sorry to hear about your application because I'm not aware of that. And maybe we can have a conversation after this meeting if you want to, so we can look and see exactly what happened. That's about that point. And I think that was it really. You just made some really valid points about WJC that I was not aware of. So things that I can take away from this in terms you said about the beds and the doors.

And so I can take that from this meeting and have a look at that. But I just want to say thank you for taking the time to come today. To do all the groundwork that you've done, all of your research and to be really credible to represent your personal life as well for your family, but also our midwifery workforce. So thank you very much.

Event Chair: Thank you, Debbie. Claire?

Claire Hankey: Thanks, Nick. And thanks, Lynda, just to echo what Debbie said. Thank you very much indeed for taking the time to come and advocate so strongly on behalf of the population across the Maldon district for this. I just had a couple of things and this is

partly my ignorance around kind of maternity practice and stuff but also just to unpick a little bit of the things you've said. I know Debbie will take back some of the things you've said around the location. I suppose for me it's understanding the workforce issues behind being able to open two units. Part of the struggle that we've been clear about is that we are not able to recruit enough staff to resource the units adequately across both the acute units and the freestanding units.

So I just wanted to understand a little bit from your perspective around how you think we could perhaps look at ways in which we could increase the population of workforce across those units.

Lynda Peggs: I've got to be honest, Claire, I'm not a manager. I'm talking in an ideal world. I just. If you think about the postnatal ward, for example, run ragged most days because we have a high section and induction rate and the pressure on the postnatal to get the women out of the building in a safe way. And I'm not suggesting anything happens unsafely at all, but there's a lot of pressure on the postnatal ward, which refers back all the way. The labour ward can't get ladies to the postnatal ward. DAU can't get ladies to the labour ward. I understand, you look back on statistics, how underutilised we were, but going forward, with the increase we have of people, a ward with seven postnatal beds, and one midwife and one MCA overnight, because that's all you have on the postnatal ward, when you're thinking about the allocation of how many midwives to members of to service users, would just free up the midwife there and enable that to work more efficiently. But like I said, I'm not a manager. I know that there is a real problem with staff numbers and things like that. Absolutely. I'm just, I suppose I'm in a perfect world of advocating what would be best for women. That would be to have both units open, and I understand if we can't, but if we do only have one, St Peter's was bigger.

That's all I can say. But WJC is a lovely unit as well, and I certainly don't want that to close.

Claire Hankey: No, and that certainly came across in what you were saying, and I suppose, and you're right, in an ideal world it would be fantastic if we could have everything for everybody as close to them as possible, but unfortunately we don't live in an ideal world, so we do have to sometimes make difficult decisions around this.

Lynda Peggs: Sorry, Claire, can I just say one more thing about that? The demographics of WJC and the people that live around it is a lot smaller than the demographics from the St Peter's area. I cover Witham, and I, a lot of our ladies are going to be able to go to WJC because they're not very far away.

But, when you look at the other side of Maldon, and you've got out to South Woodham Ferrers and you've got the Dengie and you've got Burnham, they're not going to go to WJC. They're going to go to Broomfield and they're going to increase then the numbers that are going at Broomfield, which is already, as we know, very stretched.

So the demographics between, unfortunately, WJC and St Peter's, we have more ladies within our area. Yeah. Then don't go see them.

Claire Hankey: That was going to be my question a bit around demographics actually. In your experience, are the people eligible for low risk birthing through a midwifery led unit? Is that still continuing? Is it dropping? Is it higher? What's your experience in terms of the numbers that are able to participate in a low risk birth? Because I know demographically the population are giving birth older, which often brings with it more risk.

Lynda Peggs: Absolutely. There is no doubt that our things are changing because a lot more because of medical management, a lot of women that are higher risk are now giving birth that were never giving birth before. And without doubt that is happening, but we still have a lot of low risk women, you've got to think childbirth is a natural thing that, unless there is a medical reason, shouldn't need any intervention. Low risk birth should be the ideal that we're striving for all women.

And I think, one thing, and it's not about Mid Essex, this is a national problem, but the way that we are medicalising maternity and childbirth in general, and we're inducing for more things, and we're then causing intervention and more sections. We're creating a higher risk demographic because then on subsequent pregnancies, those ladies that could have been low risk to start with that we have medicalised, then come back as high risk the second time.

So yes, our demographics are definitely changing without a doubt. But there's still a lot of low risk women out there that we need to facilitate births for them.

Claire Hankey: Okay, that's really helpful. Thank you so much, Lynda. And again, just to reiterate, I think you've come across really well and know your stuff and made some really valid and important points. So thank you.

Event Chair: Okay Caroline, did you want to say anything or?

Caroline Dawson: No, sorry, I'll have to say maternity's not my area and I haven't had children myself, so don't know very much about it at all.

Event Chair: Okay, all yeah. Lynda, I think that was really excellent. Thank you very much for that contribution.

Submission 13 - Kirsty Jenkins, Lead Speech and Language Therapist, Cumberlege Intermediate Care Centre (stroke rehabilitation)

Kirsty's PowerPoint presentation is available at Annex 13.

Presentation

Kirsty Jenkins:. My name is Kirsty Jenkins and I am the Lead Speech and Language Therapist at Cumberlege Intermediate Care Centre, which is a stroke rehab unit at Rochford and also in the ESD service in South East Essex as well.

So today I'm representing the staff at the Cumberlege Intermediate Care Centre and representing views that have been expressed and conversations I've had with the staff over the proposals to the option to either move all the stroke rehab beds to Brentwood Community Hospital or to keep stroke beds at Cumberlege Intermediate Care Centre and so to have some beds at Cumberlege Intermediate Care Centre and some at Brentwood.

Okay, so I just wanted to give you an idea of the day a bit of a day in the life of CICC. So I wanted to give you an insight as to what a stay on CICC looks like. Our staff dedicate themselves to providing care and rehabilitation for our patients. Throughout the week we run a variety of groups and activities, not only to work on their physical, cognitive and communication goals, but also activities that support their wellbeing and are fun.

We have craft groups which involves painting, sewing, mosaics, you can see some of the wonderful creations there. We have singing group and this is focused around carols at Christmas and you'll find staff, all staff joining in, patients singing and dancing as they are able. You can see some photos there of people being facilitated to stand and participate in those groups.

So as much as it is an enjoyable activity, it's also facilitating their therapy as well. We have a garden and we also celebrate public events. You can see the banner there that was created by the patients and sewn together by one of our members of staff to create that banner to celebrate the King's Coronation.

Staff give their time and their resources to provide positive outcomes for patients in line with our clinical guidelines. Patients have built longstanding friendships on the ward and continue to support each other once they're discharged. We have therapy dogs that visit regularly and this puts a smile on staff and patients' faces.

The goals are set at the beginning of someone's stay at CICC and a commitment to work towards those goals is established together between the staff and the patients and a full MDT work on the ward across the week to support the patients in their rehabilitation. Next slide, please. So I just want to talk about patient outcomes.

So the facilities that we have on CICC I just want to explain a little bit about what they are, because I think they differ to what's available at Brentwood. Facilities at CICC, we have direct access, so they are located on the ward to a gym and a rehab kitchen, which are used daily for rehab sessions.

The design of the unit means patients have their own rooms and access to a lounge, dining room and garden, which they are encouraged to help look after, especially if it's linked to one of their goals on returning home. We create more personalised step towards the return home rather than a clinical hospital style setting.

We facilitate a range of interventions such as one to one and group therapy sessions. Our breakfast group runs daily facilitating them to do as much as they can for themselves because it's linked to what they need to do going home. And even they might make something like eggs for a small group of people among, along with their therapy to target their limbs, their communication and their cognition, these therapies are run by all members of the team, qualified and non-qualified. We have singing like I've described, the therapy dogs, carols, celebrating public events. We also have direct access to local shops and the community, where patients can practice their outdoor mobility and social goals around shopping.

I also wanted to say that clinical excellence shouldn't look clinical so it should be needs led and goal directed by the patients. It involves creativity, passion and enthusiasm, which our staff demonstrate on a daily basis. We have a team of passionate and experienced staff that are very patient focused.

The goals that we work on just to select a few are around toileting independently, making a salad for lunch, which they can do on the ward because we have access to that kitchen right off the dining room, or helping someone to relearn how to use their phone in order to access communicating with the people that are important to them at a time that suits them and not waiting for someone else to facilitate that for them.

It should not be overlooked that it is cheaper to provide the services in the two locations rather than in one single location in Brentwood. This would therefore provide value for money. We still have further to go to develop the service to meet the new stroke guidelines and have projects in the pipeline to progress towards this.

But we have patient input into our monthly team meetings, which identifies what we've done well and what areas that we can improve on. Next slide please.

So looking at staffing there's a significant number of staff that would not be able to make the move to Brentwood as they live locally and maybe and use public transport to access work or would not be able to manage the work life balance and meet their commitments outside of work whether this be care of children, older people or their hobbies.

We will lose some experienced, highly qualified staff if the beds are relocated solely to Brentwood. Maintaining a workforce at both sites will support broader social and economic development due to the roles being available at both sites and therefore opportunities available to more people who need to work in their local area.

Working in large teams can be challenging to build strong relationships and good communication which is key to providing a positive work environment in which to provide the best care for our patients. The bigger the team gets, this can provide more challenges

in this respect. The whole team at CICC have worked really hard over recent years on the working relationships and opportunities now that staff take to support one another.

There's a quote there on the slide from one of our assistants. She just says:

> *"I feel that the skills mix at CICC has taken time, mutual support, respect and hard work from all the CICC team disciplines to achieve, creating an almost bespoke service, this also leads me into thinking about possible issues around staff recruitment and retention should CICC be relocated."*

Currently there is a project ongoing about stroke training and it's a project that is part of implementing the integrated community stroke service. This is to make training available to the whole stroke workforce and will enable sharing of expertise to upskill staff. Sharing skills across the MSE will help improve outcomes in population health and healthcare.

The sharing of skills and training will tackle inequalities in outcomes, experience and access. We have good communication links with the local services in South East Essex, both who feed into the unit at CICC and those services that continue to support on discharge. Staff meet with those services regularly and this creates a really important working relationship.

The consultation reports that staff and the public were consulted in November to December 23. CICC staff were not included on the list in the appendix for that, and I would suggest that they are a key staff group to be involved in such engagement. Individuals who are currently using the service are also a key group to consult.

They have real and present understanding on what's involved in supporting someone after a stroke in an inpatient unit and this may need to be done in person rather than online to increase participation. Next slide please.

So thinking about the accessibility which is a really key thing that came through in the consultation document and the engagement.

The importance of access to family and friends has been highlighted in all aspects of engagement for this consultation. This is for many reasons, for physical and emotional reasons. Significant others are key in the rehab process, and education and support for them also is important. Where there's an option to provide care in multiple locations, therefore closer to home for more people, this needs to be considered as an option that will meet the needs of those patients.

Stroke patients spend longer in an inpatient setting and therefore may be isolated from family and friends for longer if in a unit further from home. Discharges can be more challenging. Home and access visits will take longer and remove staff from the work environment for longer.

To facilitate discharges and check equipment is suitable in the person's home environment. We're experiencing a higher number of people who have less support around them and require staff to facilitate safe discharges. The travel time will increase if stroke

beds are moved to Brentwood. Rochford is on a bus route and directly opposite a train station.

Examples are that from Shoebury, one area in Southend, there would be a 43 minute increase in travel by public transport and between the 25 minute and one hour difference by car from Shoebury, the shorter, that's the time between going to Rochford or going to Brentwood. For Canvey, the difference between travelling by public transport to Rochford or Brentwood is that it's 32 minutes shorter to go to Rochford but it's about the same by car.

And for Westcliff, another area in Southend, it would be 52 minutes shorter to travel to Rochford by public transport, and again, quicker to go by car, 18 minutes versus 55 minutes to travel to Brentwood. It's not only the geographical mileage or the time that is important, it's how quickly you easily people feel they are, will be able to access a different area that's really unfamiliar to them.

So I've given you some examples of numbers there but it doesn't all come down to numbers. We have many visitors that visit their friends and family daily and this is really key. They're really involved in the rehab of these patients and it would be detrimental to their rehab not to have them visit.

Keeping the two sites provides local based solutions and improves accessibility. And again, there's a quote there which highlights how important the involvement of family and friends in the rehab is. So one of our therapy assistants says:

> *"I have seen first hand the positive impact that family and friends support has on patients' recovery, and the support that staff at CICC give to family members. This will most likely be more challenging logistically if the location changes, not just for older people but also those still raising their families and with work commitments or their own health issues, they will possibly be unable to give the time and support they would wish to….and that their family members deserve."*

Last slide please.

So my suggestion off the back of what I've presented here is that there should be more direct in person engagement with the current staff and the patients and their relatives to determine where the best outcomes can be achieved for patients and to consider other methods of joint working across the two sites rather than the possibility of staff being on one site providing the best outcomes.

Thank you.

Discussion

Event Chair: Thank you Kirsty. That was very informative and very good as well. Okay. You happy to take questions? Okay, who'd like to go first? Hands up with, so Caroline first then.

Caroline Dawson: Hi Kirsty, just want to say well done, that was brilliant, and I have to say I loved your quote that clinical excellence should not look clinical. I was like, that's brilliant, I think it should be a tagline, I really liked it, well done. I just want to confirm, and I'm pretty sure I know the answer to this, but you're advocating that CICC, you're advocating for option B, so CICC would have 25 stroke beds and lose the intermediate care beds. Can I?

Kirsty Jenkins: Yes.

Caroline Dawson: Yeah. Okay. Lovely. I just wanted to check that. Like I said, I was 99 percent sure that's what it was, but I just wanted to double check. Thank you.

Event Chair: Okay. Claire?

Claire Hankey: Thanks, Nick. And thanks, Kirsty. Again really great presentation, really well put together and really advocating on behalf of your patients and colleagues. So thank you for that. And really good insight there. It is a fabulous service. It absolutely is. And there's no question in any of this that the service and care provided by our staff across the system is any way detrimental. This is really about trying to build and increase the numbers of people that can benefit from these types of service. So I just wanted to make sure you could feed that back to your colleagues isn't we in no way is there any kind of detriment to the service they've been providing? We know that we haven't got enough beds for stroke, bed based stroke rehabilitation and hence why the kind of options were developed. I suppose in advocating for option B, that loss of local intermediate care beds, where actually it's slightly less specialised, but still a specialised form of care, would that not be better locally to then co locate the stroke specialist care, because that is the higher level of specialist care, does that make sense?

It's almost like a triangle, isn't it? You've got stroke rehab at the top, then intermediate care, and then the kind of general access to community services, so I was just wondering what your thoughts were on the removal of intermediate care from that location for the people of that population, where a stroke rehabilitation would be open to wider population across Mid and South Essex. So it's that balance, isn't it? Between who can access those very specialist beds versus the more kind of slightly less specialist, but still important intermediate care beds.

Kirsty Jenkins: Yes yeah, take your point on that. I think my response to that, sorry, I'm just, I can't, I've got the consultation document here, but I don't think I've got the maps on me, but so intermediate care patients tend to spend less time in inpatient settings than stroke patients. So on average, they would spend two to three weeks in an inpatient setting, whereas stroke patients would spend around six weeks in an inpatient setting. So there are also more sites available for intermediate care. So there is a bit more of a spread there. But I think it's really around the involvement of families.

So key for stroke rehab, it's less involved for intermediate care. And in order to have access to their relatives, I think it's more important that stroke beds are local because they are, would be isolated from their family and friends for longer, and they are more involved

in the actual rehab of those patients so not just visiting, but actually they perform part of the therapy, so to have them involved is yeah, there's slightly more need for that, them to be available.

Claire Hankey: Yeah, great. Thank you. That's really good kind of insight there. And so on the kind of converse, if you like if we had the option A it's, it allows us to have slightly more beds, but also to repatriate some of the neuro rehab work that goes elsewhere. Is that not a benefit to the population more than having it spread across two sites?

Kirsty Jenkins: There would, there obviously would be benefits to that. I think the problem with that is I see there could be an issue with staffing that as one unit. As I described, I think moving it to Brentwood means you will recruit staff from a smaller geographical area. Recruitment is a challenge already.

And I think that will be a challenge to staff that possibly because you're like pooling from a smaller area. In terms of the staffing, I think there's lots we can do in terms of upskilling staff in terms of using lower banded roles like the band four role and also using the apprenticeship route.

Cause a lot of the guidance, the clinical guidance is that there's lots of other people other than therapists that can perform really effective therapy. So we do need to be creative and yeah, use our best working models in order to staff places appropriately. My concern is if it was in one location, would bet the, that if you had a large number of stroke patients and you had a real difficulty recruiting, or you had issues within staff retention and things, that, that would be confined to one area and that would put pressure on staff and the outcomes that people could achieve.

Claire Hankey: So by having the two, you've almost got a bit of resilience there across the two units rather than having a single unit. Okay, thank you. That's really helpful. There was just one other thing I was gonna oh yeah, it was talking about you mentioned ESD at the beginning, and for those that aren't familiar with the acronym, it's Early Supported Discharge, that's right, isn't it?

Kirsty Jenkins: Yes.

Claire Hankey: I was just interested in, kind of, the move towards more, kind of, home based care. It is a general kind of move, isn't it, within healthcare to support people more in their own homes. And I just wondered if there is more opportunity to look at that in the round to make sure that we're not expecting people to travel more unnecessarily to fixed points, if you like. But the opportunity and ways we could perhaps do something different to support more people at home.

Kirsty Jenkins: Yeah, that's it. The criteria for the stroke rehab unit should be that someone is not able to return home for, look, for different reasons, whether their care needs are too high, whether their safety needs are not able to be met at home.

So really anyone that can go home after their acute stay at hospital with the early supported discharge team should be going home with a care package and that rehab

service, which just to explain that it provides the same level of rehab that's expected in the acute hospital, but at home. So yeah, the criteria of these units should be that these people can't go home and that they're needing higher levels of care or safety and support. So yeah, it's important to have good criteria. That's a really key thing that people come into the service are the right people going into that service. Going home is best for people who can because they can rehab best at home where they've got their own things and people around them and they can meet much more functional goals in that home environment. But for those who can't, we really try at CICC, we really try and create that step towards home from that acute hospital setting in a bedded unit. That, with those very medical aspects that need to be covered there at CICC it does, it is that one step home and we really try to make everything as functional as possible. I know over at Brentwood they don't have direct access to a gym and a kitchen. It's they have one, but it's not on the ward so it takes extra time and extra resource to facilitate people using that.

And with all our caseloads are high at the moment, so it is time pressure. So yeah, again, staff are being creative at how they facilitate that for people. But yeah, it's really important that step is a step towards home and not just another kind of clinical step in the process.

Claire Hankey: Brilliant. Thank you so much. That's really helpful insight and thank you for taking the time to come and present.

Event Chair: Okay. Thanks, Claire. Donna, unusual because you're another part, you're another presenter. Have you got a question or is it an observation?

Donna Murphy: Yes. I'm sorry. I know I'm not a panel member, but I did have a comment on the way that intermediate care beds are currently allocated. Okay. Patients are not allocated to the unit near where they live. They are allocated to the first available bed. So at Thorndon Ward, I have Southend patients at the moment. So where the units are it is good to have a spread of units across the area. But having a unit in your area does not mean you will get a bed in your area and hasn't done for a while. And I know there is part of the consultation document directed at maybe, pardon me, improving that. But at the moment, just because there's beds at Southend for IMC doesn't mean patients will get IMC in Southend. In that sense, right now, the beds could be anywhere. I'll talk a little bit more, but it was just to let you know that's how things are organised at the moment.

Claire Hankey: That's really helpful. Thanks Donna.

Event Chair: Thank you Donna. Okay. Kirsty, I've got a couple of clarification points, if I may. I think you made a statement where you said it's actually cheaper to deliver the services in two locations than one. Is that right?

Kirsty Jenkins: Yes.

Event Chair: With your submission, your written submission, have you got anything that illustrates how that works?

Kirsty Jenkins: In the consultation document it states that it will cost 14 million pounds less to provide the two units and 0.2 million more to provide the unit at Brentwood only.

Event Chair: Okay, so it's not, you're not contradicting anything in the document then? It's basically just reiterating. Okay, fine. All right. And the other one was your travel calculations and things.

Yeah. Were those different to those within the consultation materials or are you just, are you confirming them?

Kirsty Jenkins: I have to say, I hadn't seen them in the material myself. Were they in the main document or were they appendices?

Event Chair: I think they're appendices. Yeah. Okay. Okay.

Kirsty Jenkins: I took those from Google Maps because that's how I believe someone would determine how long it would take them to get there.

I feel like that's the most..., like the place people would go to, to determine how to get there and how long it would take. So that's where I got my information from.

Event Chair: Okay. All right. That's great. That just helps with clarity on how you got there. All right. Brilliant. Okay. Thank you very much. Any more questions for Kirsty?

Oh, in that case, Kirsty, thank you very much. You're welcome to stay, by the way. And it's Donna's turn.

Submission 14 - Donna Murphy, Therapy Lead Brentwood Community Hospital

Donna Murphy is the therapy lead at Thorndon Ward, the intermediate care ward at Brentwood Community Hospital. She asked to present on intermediate care beds in mid and south Essex. Donna's PowerPoint presentation is at Annex 14.

Presentation

Donna Murphy: My name's Donna. I am the therapy lead at Thorndon Ward at Brentwood Community Hospital, which is the intermediate care ward at Brentwood. And I wanted to talk to you about intermediate care beds in mid and south Essex. My slides have gone. I'll open up my own. Lovely. Next slide, please.

So I've just put below the number of intermediate care beds in mid and south Essex, and then the proposed number of intermediate care beds with either option A or option B, which are the two options on the table from the consultation. So at the moment we have 99 intermediate care beds across mid and south Essex, which across about five sites.

Option A proposes that we lose 11 of those and Option B proposes that we lose eight. Option B also involves the complete removal of intermediate care from Thorndon Ward at Brentwood Community Hospital. So if I tell you a little bit about Thorndon Ward as it is now and if we can go to the next slide. Sorry, I think there's one in between.

But we are a 25 bed rehab rehabilitation unit. We accept patients from Queens, Broomfield, Basildon, and Southend. And as I mentioned earlier, the patients are allocated to us, to the Mid South. By the Mid and South six bed bureau patients are allocated to the first available bed, not the bed nearest their house.

We predominantly take patients for a period of inpatient rehabilitation, but we also accept a small number of our criteria. Patients who come to us for social, health or nursing needs. Patients are accepted from the whole of Mid and South Essex, which includes Thurrock, and we accept patients with a high level of complexity, which are sometimes declined by the other units.

So the teams on Thorndon Ward so we are one of the only units that are fully staffed at present, and that's from nursing therapy and the medical side. We have seven day medical cover, including twice weekly consultant ward rounds, which is with our consultant geriatrician. We have very experienced nursing teams, and we have integrated care assistants, which are health care assistants with extra training to support rehabilitation.

We have a therapy service, which includes physiotherapists, occupational therapists, occupational therapy assistants, and rehabilitation assistants, which again at present is fully staffed and we have an integrated discharge service on site which is provided by Basildon and Thurrock University Hospital.

But as I say they're based on site to help us facilitate discharge. We also get support from community teams including dieticians, speech and language therapists, tissue viability

nurses and podiatrists among others. Go to my next slide. Our outcome data. The outcome for the data for Thorndon Ward patients is very positive.

On admission to Thorndon Ward, patients have the modified Bartell index completed for that level of function. And then we complete it again on discharge. And patients on Thorndon Ward improve on average 5.66 on the modified Bartell index between admission and discharge. Many patients improve from a status of what's classified as total or severe dependency to a status of moderate dependency with further potential to improve in the community.

To tell you what that looks like, most patients arrive with 24 hour care needs, and I'll describe what some of those are in a little while, and are discharged with single handed packages of care. Patients have arrived using hoists and left going the stairs. Patients have arrived using patient turners and leave walking with Zimmer frames. We manage patients with significant complexity on Thorndon Ward, including those with advanced dementia, traumatic injuries, including spinal fractures, and those patients often require collars and braces, which we can manage on the ward.

Complex frailty syndromes, and new neurological symptoms. So recently we treated a patient who had actually been identified as having level two neuro rehab needs, but was declined due to previous cognitive impairment. And we rehabbed him on Thornton Ward. Next slide, please. Oh, sorry. There's one in between.

So our patient experience on Thornton Ward. So this data was taken from the NHS friends and family tests, and it was the answer to the question overall, how was your experience. 69 percent of patients rated us as very good, 26 percent of patients rated us as good, and only 4 percent rated us as neither good nor poor, with no patients rating us as poor or very poor.

We have written testimony from patients from our ward stating how positive they felt the impact we had on them was and I've got a whole spreadsheet of it, I can send it to you. Next slide, please.

In the pre consultation business case, they laid out targets for IMC beds. They created data on our performance, which suggested only 65, 66 percent of our patients improved with the input from IMC. However, I cannot find out from anyone when that data was collected, but we know it was collected in 2021, which was a year when we were facing a great deal of challenge following the COVID 19 pandemic.

Thorndon Ward specifically was operating on a temporary ward with extremely poor facilities and very low staffing. Now you can see our performance [table taken from the PowerPoint presentation], which has been measured by the data I've collected between the start of this year and the middle of March shows that 92 percent of our patients leave the ward with an improved level of independence or reduced level of dependency compared to the target of 85%.

Ambition	Indicator	Our current performance
Change in dependency	Improved – 85% Maintained – 8% Deteriorated – 7%	Improved – 92% Maintained – 5% Deteriorated – 3%*
Unplanned Returns back to the acute setting (%)	<15%	29% returned to acute
Discharge destination/usual place of residence	Year 2 – 75% Year 3 – 80% Year 4 – 85%	92% discharged to usual place of residence**
Average Exit Delays (days)	Of those delayed, no more than 2 days	No data at present
Patient recorded outcomes/satisfaction measure	At least equal to recovery at home	Patient experience: Very good – 69% Good – 26% Neither good nor poor – 4% Poor or very poor – 0%

These targets were set for after the consultation period has completed and all of the relevant changes have been made to the community beds. We do have an issue with unplanned returns back to the acute setting, and we would be very willing to complete a project on how we can reduce this. But what I will say is that many patients go back within the first 48 hours.

So in reality, they weren't well enough to be transferred to us. And we do understand our colleagues in the acute are under pressures. I was working in the Queen's frailty unit at Queen's Hospital until October last year. I do understand the pressure they're under. But often they're transferring patients to us who are not well enough to be with us as yet.

Discharge destination is very positive. We've discharged 92 percent of our patients to their usual place of residence against a target of 75%, which was set for two years after the changes from the consultation have been made. I haven't got data on exit delays, but they

will be significant. We have a significant issue with care waits, equipment waits, and family delays.

And then obviously the patient recorded outcomes or satisfaction ratings. I've already shared our data from that with you. Patients have very positive experience on our ward, so I feel we're already meeting that target. Next slide, please.

So there's a lot of talk in the consultation about how rehabilitation can be delivered in patients' homes, and a lot of the time that can be the case. However, for the majority of patients that are referred to us, that option has already been explored and deemed as not possible. So many of the reasons they can't be rehabilitated at home and therefore require 24 hour intermediate care is unstable medical statuses. So patients come to us still having oxygen requirements. We have fully piped oxygen at Brentwood Community Hospital and we will wean patients on the ward from their oxygen or arrange long term oxygen therapy in the rare cases where we can't. With patients who arrive with unstable BMs and patients who arrive with unstable blood pressure, including postural hypertension, which is often not even diagnosed until they get to us because of the extended bed rest that they've had in the acute. Patients who have high level of nursing needs, including those that require two hourly turning, we can manage on the ward.

That could not be managed with the QDS package of care, which is the maximum amount of care that someone can receive in the community. Patients with poor sitting tolerance, meaning that they couldn't sit out for long enough to wait between one care call and the next care call. Therefore, that patient would need to be cared for in bed at home, which is in conflict with the rehabilitation goals.

Reduce safety sitting in a chair so they're unable to sit in the chair safely, unsupervised. So if they lived alone, they again, they would need to be cared for in bed in their own environment. High night needs, including toileting. And I have to say, we often rehabilitate toileting and particularly night toileting.

So patients, as I say, the majority of our patients go home and we manage to successfully rehabilitate their nighttime toileting. And patients with resolving delirium who are not safe to live alone initially on discharge, but again, the majority of those we send home. After a spell of time at Thorndon Ward.

May I have the next slide, please? In conclusion, I would like to support option B because it involves the smaller reduction in intermediate care beds and also the maintenance of IMC on Thorndon Ward, which is an effective service with good outcomes and good patient satisfaction ratings. We're already meeting the future targets for IMC beds on Thorndon Ward and intermediate care in Mid and South Essex is a valuable service that can't be replaced by our current community services.

So I have a slide on the community services on Mid and South Essex. And the reason I've included this is because again, in the consultation paper, there was talk of patients being rehabilitated in their own home. At the moment in Mid and South Essex, most of the community rehab services are not fit for that purpose. So I don't know if we can find my

slide. Anyway, I can tell you from memory, in Brentwood and across all three areas in mid and south Essex. It's the second to last one. [Slide taken from the PowerPoint presentation.]

That's it. In Brentwood, the community services for our patients vary. South West Essex has quite good community services. This is Brentwood, Basildon, Thurrock and Wickford. They have the D2A service, so they can go out for one to two visits after discharge from either of the acute or us, and they can do safety checks, they can order equipment, they can troubleshoot but they cannot provide ongoing goal driven rehab.

We do have Brentwood Raft, which used to be called IRS. Now, they can provide up to four visits a week for three weeks, and they have a 48 hour response time. After that, patients will be referred to Brentwood and Basildon ICT, who have a waiting list and can go in about once a week. There's also a small amount of physio attached to the ECL service, which is reablement, if patients are accepted to reablement, which they will not necessarily be.

In Southeast Essex, I've actually rung them today to confirm this. So they have the D2A service, which is the service, which provides one to two visits after discharge for safety checks, as I mentioned before. And then they have a community physiotherapy service, which has a one to week, two, three week wait list, which is good.

But it can only, they can only go out once a week, so they're not providing intensive rehabilitation. In mid Essex, which is where we have our biggest problems, we have the D2A service and then the other service for community physiotherapy is available through Provide, who can provide once visits, but they have a 14 week waiting list. So we've had calls from a patient discharged from us recently stating that she's not getting any physiotherapy 14 weeks. They do have a physio attached to their reablement service, but I know that the moment they're currently carrying a vacancy. Apart from in southwest Essex, patients cannot receive intensive rehabilitation in their own homes as things stand and

therefore reducing IMC beds is going to drastically reduce the amount of intensive rehabilitation that's available for patients after they're discharged from hospital.

Thank you. Sorry it was in a funny order at the end.

Event Chair: That's okay very good information Donna. I'm going to let open it up now for people to ask questions if you're happy to take questions. Yep. Anybody want to open? Claire?

Discussion

Claire Hankey: Thank you. Thank you, Donna. Again, just really big thanks for taking the time and trouble to present to us and to put across the information and insights that you have.

And again, I'll say what I said to Kirsty, it's no reflection on the standard of care and compassion that staff in these teams deliver day in, day out to our population. So thank you to all for what you do in that regard. The area that I was interested in was you mentioned that Thorndon has a slightly different criteria and accepts higher risk patients, is that right? I just want you to understand that a little bit more.

Donna Murphy: So we're, it's a little bit anecdotal, but I've been there six months. My understanding is that Halstead near Colchester, which is one of our units is nurse led, so they will only take a limited range of patients. The other thing is that where we are set up with bays and not individual rooms, we can monitor our patients a lot more carefully.

And therefore we can take patients that require cohort bays or close monitoring while they're in bed. So there's that factor as well. We also have piped oxygen at our unit, so accepting patients who are on oxygen weans is a little bit easier. But yes, just anecdotally, often when the information comes through from our screeners, the other units will decline patients and we will accept them.

And as you can see from our outcomes, they do very well.

I think the reason that we are keen to prove our value is because of the entire consultation paper suggested that intermediate care was underperforming and the stroke rehabilitation was more valuable. And I don't in any way doubt that stroke rehabilitation is extremely valuable. It's an area that I've worked in the past. I'm a physiotherapist by trade, I should mention. But intermediate care is important as well. And we clear acute beds sometimes within 24 hours of referral and we reduce pressure on our acute Trusts. So reducing our beds will have an impact and we can't be replaced by community services.

Okay, and that's why we're keen to show that to you.

Claire Hankey: Yeah. And I can only apologise if that was the intimation that was taken from what was written. It wasn't a suggestion that intermediate care was any less valuable, particularly for those patients that are in need of it. It's absolutely valuable.

In terms of the community services piece, so I know, the development of virtual wards and all of that is still fairly in its infancy. Could you see in the longer term that becoming a bit more balanced across mid and south Essex so people have the same level of access across the patch? Because obviously we're probably basing what you've put there on old Commissioning patches probably when the clinical commissioning groups were in place. So obviously have been now one kind of commissioning footprint across mid and South Essex. Is there an opportunity there, maybe, to look at things differently, do you think, in terms of that provision of community services?

Donna Murphy: There is, because in Brentwood, Basildon, Wickford, Thurrock, we have much better services. We have the virtual frailty ward is much more up and running and the therapy provision is much, much better. But they still refer a lot of patients to us from Brentwood that they don't feel could have their needs met in the community.

What the Brentwood patients often can do is be discharged quicker from us. To the community, whereas in Mid Essex and South Essex, sometimes it takes a lot longer because if we haven't got as much therapy provision but we still take an awful lot of Brentwood patients who have very high levels of need and yes.

So it hasn't prevented those patients coming to IMC, but it does accelerate their discharges for sure.

Claire Hankey: Yeah, and just to your earlier point around people being placed in the first available bed rather than the bed nearest their place of residence. How, on average, what kind of, what's the balance in Thorndon around kind of those that are in the local area to that patch and those coming from outside?

Donna Murphy: I'd say it varies wildly. So I've gone through phases where I've had very few Brentwood patients in our ward and then phases where we've had a lot more. I think if there's two patients on the list and two beds, they'll put each patient in the bed that's closest to their address, but not necessarily.

We had a Colchester patient not long ago, and it's funny that Kirsty mentioned Shoeburyness because I did a home visit to Shoeburyness and I know what that drive is like. So yeah, we are receiving patients from all over Mid and South Essex at the moment. I know there was a large piece in the pre consultation business case about the right patient in the right bed, and we would be very supportive of that. Patients do better when they're closer to home for sure. It's as at the moment where how things are, we don't have a choice over who goes where and neither do the patients. They have to actually sign a contract to state that they will go to the first available bed.

Claire Hankey: Okay, that's really helpful insight. Thanks very much indeed Donna.

Event Chair: Okay, thanks, Claire. Caroline.

Caroline Dawson: Thanks Donna, and that was brilliant. It was really good. I haven't really got questions, more sort of comments as such. I just wanted to say, reiterate what Claire said, really sorry that you felt that IMC was the poor relation to stroke because that's

definitely not the point. Although I introduced myself as a stroke matron, the other two services that I manage are IMC services. So 100 percent IMC is just as important as stroke. So I just wanted to say that. And then the other point and again, I'm not expecting you to answer this, but I thought the data that you gave us regarding the outcomes that you got from Thorndon was really good.

And I think it would be really interesting to see how that compares with the other IMC units. I'm not expecting you to know the answer to that, but I'm just thinking as part of this, that would be really interesting to see how it compares and then potentially if there's any learning from that, that we can share across all of the units. I think that would be really good.

Donna Murphy: I think that the way we pull data at the moment for the units is a little bit unreflective. So I did that data collection by hand, as it were. And I, the one thing I did do was remove all the patients that were readmitted to the acute and didn't return to us because obviously I don't have discharge data for those patients. When you pull data from System One, it includes all of those patients and it puts their discharge score as the same as their admission score. Or if a Bartell index isn't entered for a patient on discharge, which is something we're working on they're in there for this group of patients. Then it does again score them as the same as admission. So there's a data collection issue there. I suspect you'll find the other units' data isn't far off of ours. But it's just how we pull it.

Event Chair: Okay Donna, would I be right in thinking that you think that a review of all the data might have an effect on decision making?

Donna Murphy: Potentially, but mainly I wanted to evidence that the good outcomes on Thorndon Ward and the impact of losing that service. As I say, we are the only fully staffed ward from our end of Essex. So Mayfield and Thurrock also the Matrons tell me, and we have a really resilient workforce of local residents who went through a lot during COVID and still stayed on our ward we have like daughters and mothers that work on our wards. It's a very family orientated unit, and I think if we became stroke, you would lose the staff from a very special workforce and that would be a loss to Mid and South Essex. I feel very strongly about that. Think that, yeah, I just want to just say what a good service we're providing and encourage you to consider keeping us as we are.

Close of session

Event Chair: Okay, brilliant. Any more questions before we do our close down? I think we've actually had today three excellent presentations with some very reasoned arguments and some very good informative data to go alongside it. So I'd like to thank Donna, Kirsty and Lynda. I think Lynda's left. She left didn't she? But thank Lynda as well because some really excellent information today. I've got to compliment all of you on the way in which you presented. You did a really good job. All right, so I know you were nervous, but it was really good, so be encouraged. Okay, and thank you also to our panel members today. Some very good inquiry, questions asking of the presenters, and it was

quite clear that you were really digging for some really useful information that will help you as well.

Gail Cobb: And just before the end, Nick I just want to apologise for any people that are waiting online for the live streaming. We've been trying to resolve the technical issue, so sorry to anybody who is waiting to get on for the live streaming.

Event Chair: This will be going out onto YouTube anyway.

It's being recorded. It'll go out, of course. So again, for those of you who are online watching this later after the event again, yeah, we apologise it didn't go out live for you. But you will be able to see all the information unadulterated, I believe. Okay. Just so everybody is aware, is that this is the, as things stand, this is the last of the hearings.

This one was put on as an additional hearing, because the hearing that we did in March, we had, we were oversubscribed, so felt that we needed to extend it. But if for those people who have placed submissions, there may be new information come to light today that might alter your submission.

Feel free to do but otherwise I believe that the consultation has a very short period left in it. And so if you need to make any responses now is the time. Sorry, Claire?

Claire Hankey: It was just to say, Nick, while people potentially may be watching this online later, to say that the date of submission has been extended, so people can now put their submissions in up to Thursday next week, the 11th, rather than, it was due to close today, but we felt we wanted to give people an opportunity to respond to any further information they may have heard.

Event Chair: Okay, so there's that Thursday 11th. You've got a bit more time if you want to put any extra in. Okay, or anybody new wants to put information in. Okay, so thank you very much, everybody. And hopefully this everybody's had a, a good experience today. I'm sure there'll be plenty more talk between you.

It looks like there's some interest there. It just takes me to say thank you to everybody and wish you all a good evening and a successful end to the consultation.

Thank you. Thanks, everybody. Thanks, everyone. Thank you. Bye.

Written submissions

Submission 15 - Judith and Roger Bond, Heybridge residents

Roger Bond's comments

1. Firstly, I would like to know why the ICB did not setup a consultation meeting in Maldon, the very place that the closure of St Peter's Hospital effects the most, the only face to face consultation carried out in Maldon to date was organised by our MP Sir John Wittingdale in conjunction with Maldon Council. This shows a complete lack of care and responsibility to the people of Maldon.

2. Why was there no consultation held prior to the, so called, temporary closure of the inpatient wards. Why were the sinks and other fixtures and fittings removed making the wards unusable and then shown to the BBC East News team to demonstrate how unusable the wards are, in my opinion this shows a high level of misdirection and deliberate sabotage to ensure the wards could not be used again.

3. Why didn't the ICB notify every resident in the Maldon district via a flyer in the post, this would have ensured that all residents were aware of the situation regarding your proposal to close our hospital. There are currently a huge number of residents that are still unaware of your closure plans.

4. Why did you made it so difficult for anyone to find information by using multiple web links, this includes the survey form. Why have you not printed enough Summary Documents & Survey Forms, which have only recently been made available in the places you advertised. I therefore believe that this is a deliberate attempt by yourselves to reduce the amount of feed back and lower the apparent level of interest and opinions about your proposed closure of St Peter's Hospital. There are also still a lot of people in the area that do not have internet access so the mail flyer would be the only way they of knowing about it. You also should have indicated where or how to return the survey forms.

5. Regarding the move of the Stroke Ward to Brentwood hospital, during the Brentwood consultation, I believe it was stated to the people of Brentwood that they would definitely get priority over anyone coming from the Maldon district, this does not sound like just a move of our stroke ward to another building but rather a transfer of staff and beds to enlarge the Brentwood Hospital's own facilities rather than still being under control from our area.

6. Regarding the Rochford Hospital option, it is ridiculous to expect people to get there, if you travel from Burnham-on-Crouch it looks great on a map, only 5.8 miles away as the crow flies, by road it is 22.2 miles (45mins drive) by train it would take 1hr if the connections all tie up. By comparison, if you travel from Burnam-on-

Crouch to Maldon Hospital it is a 23min journey 12.5miles still a long time but half the distance.

7. The fact that the NHS has neglected to fund and properly maintain the St Peter's Hospital buildings & site for well over 20 years is unacceptable. To then use the state of the site as a reason to close St Peter's Hospital is unforgivable. The mismanagement and/or incomitance of the NHS in this respect is not a problem or burden that the citizens of this community should bear. The NHS do not only have a duty of care for its patients but also to maintain and support the fabric and structure of its facilities. To just simply state that there is no money is not an appropriate argument or reason to close a hospital. The NHS should seek additional funding to ensure that this hospital remains open and own up to its incompetence and inability to continue providing the local care that it should.

8. On these grounds it is wholly unacceptable to close our hospital which, as stated in the Hospital Development Brief in Apr 2012, in sect 9.0 item 9.1 "Conclusions":

"9.1 The provision of a new community hospital for Maldon is critical. The existing St Peter's Hospital site lies within the built-up area of Maldon and is currently in hospital use. It is the responsibility of the NHS Mid Essex Trust to ensure that the people of Maldon and its environs receive 21st century healthcare from appropriate facilities and it is their desire to achieve this on the existing hospital site."

9. This is even more relevant today than ever before as Maldon & Heybridge are virtually doubling in size due to the extensive housing developments, along with other housing projects being carried out in the district which of course means a lot more patients requiring all the services that are and were provided by St Peter's Hospital.

10. Is there a breakdown of the St Peter's Hospital costs to repair the facilities, the figure of £18M+ must have come from somewhere, where is your evidence regarding this and where are your annual budget figures for maintenance and ongoing upkeep of the facilities. This evidence should be made public so we have a chance to comment on these figures.

11. What has happened to all the money saved from not maintaining St Peter's Hospital properly and what has happened to the Rent money received from Provide who have been using this hospital's facilities for so many years. This information should also be made public so we can determine if there is a problem here.

12. There is also a huge impact on the environment if this closure goes ahead due to hundreds of extra and longer journeys required, the carbon footprint of this closure would be enormous given that public transport is not adequate in this area.

13. To close, I think that this whole consultation has been put together in a very unprofessional and slipshod manner and is therefore a farse and should be deemed inadequate, misleading and worthless. It should be scrapped in favour of a properly organised and fair consultation process that is known about by all residents in advance within the affected areas, including meetings held in all parts of the area to truly understand people's views and opinions.

We are being rushed into making decisions that are not based on known facts, with no hard and fast alternatives as far as facilities, numbers of personnel being retained in the area or services being retained. Being asked if we prefer option A or option B is not good enough, when option A & B are not well defined, poorly supported with information and are basically not a replacement for a lost hospital.

Judith Bond's Comments

Maternity Services

Pg 32 Public Consultation Document

Quote:- The freestanding midwife-led birthing unit at St Peter's Hospital has been closed several times because there weren't enough staff available to run it safely. And the poor condition of the buildings has affected the quality of care we can provide there.

My comment:- The staff shortages were at Broomfield and St Peters was closed to take the midwives to cover there.

The care and safety at St Peters is excellent, the whole ward was not in poor condition and was not unsafe. Some of the ward has been redesigned to accommodate services from upstairs. If it is in such a poor condition, how can it be safe for the patients that are now seen in the clinic there.

Pg 32 Public Consultation Document

Quote:- Moving inpatient services out of St Peter's Hospital, as described on page 16, would have left the birthing unit isolated as the only 24-hour service on the site. Staff and service leaders told us they were concerned about safety out of hours.

My comment:- This problem was created by moving the stroke ward away, resulting in portering staff and cleaning staff being made redundant and leaving maternity as the only 24 hr service on site. The ICB stated that Midwives would be left without the support of cleaning services overnight but there never have been cleaning services overnight. The staff at the maternity unit deal with any cleaning that is needed after a birth. It would have been quite easy to employ security staff or a porter to cover Maternity and to keep the hospital secure overnight, it is not a good enough reason to close the Maternity unit.

Pg 32

Quote:- The WJC birthing unit is on a site with other 24-hour services. It is a modern purpose-built suite with better facilities that allow us to care for more families wanting to give birth in a freestanding midwife-led birthing unit.

My Comment:- WJC has 3 postnatal beds, St Peters has 6. How is that an improvement? Moving maternity patients from the Maldon 6 bed ward, to a 3-bed ward which has its own quota of patients from the Braintree area, theoretically reducing 9 beds to 3 is not an improvement by any stretch of the imagination. This is going to result in patients not having the choice to use the free-standing maternity unit and they will have to go to Broomfield increasing demand there.

Many maternity patients need a couple of days in hospital for postnatal care, St Peters can take postnatal patients from Broomfield for their postnatal recovery, freeing up beds that are needed for their local patients, reducing the need to discharge patients before they are ready.

Stroke Rehabilitation services

Pg 8 Public Consultation Document.

Quote:- 2000 + people in our area have a stroke each year of which 500 need a stay in a community hospital for specialist rehabilitation support.

That is 25%, are these figures from the whole of the Maldon district?

Pg 27 Public Consultation Document

Quote:- National guidance states that 4% of stroke patients are likely to need a short stay in a community hospital for recovery.

My comment:- These figures are quite different with the percentages.

With the increase in the population expected over the next few years, another 5000 houses in our area, numbers of people requiring these services is going to increase considerably. Brentwood and surrounding areas are also experiencing a huge increase in population and house building. Having just 50 beds for Stroke patients will very soon not be enough, so can the ICB guarantee that residents from Maldon and the surrounding areas be able to get a bed, or will they be moved even further afield, or be stuck at Broomfield bed blocking.

If St Peters was kept open it could take the overflow of local patients easing the pressure on Broomfield hospital. In the document it states that some parts of the hospital are no longer safe for patients to stay in or staff to work in. Some of the reasons given were the lift frequently breaking down. However parts were obtained to fix the lift but were never installed. The floors were said to be too weak for equipment and yet the floors had been strengthened recently and Staff managed perfectly well to look after their patients. The corridors were apparently not wide enough to safely move patients and equipment around.

For many years there has been enough room to move patients in beds and equipment right up to the closure of the ward. Patients could also be easily moved downstairs for x-rays or scans when needed.

Bayman ward has the capacity for 25 inpatients, an increase of 9 beds from the 16 at St Peters. This will not be enough as the communities grow and there will soon be no spaces for all that need it.

At the Chelmsford consultation meeting, the ICB stated that it would be a specialist stroke ward to concentrate all the experts in one place, which would be beneficial to the patient and there would be an increase in beds for our patients. At the Brentwood consultation the public were concerned that their residents may not get a bed, when required, because of the increase of patients that would be coming from the Maldon area. They were reassured that Brentwood residents would get priority over beds, this was not announced at the other meetings. When Brentwood is full to capacity where will our patients go?

The St Peters ward was moved temporarily in October 2023 for safety over the winter. In the pre consultation document Pg 10 under the heading of ‘temporary service changes’ it states (1.2.3) that the changes were temporary for winter and yet in the next section(1.2.4) it states that it should be made permanent with all other services being relocated. This has all been decided without consultation. Staff were made redundant and yet it is still being stated as a temporary move.

Public, patient and staff involvement

Pg 21

Quote:- Accessibility- minimising waiting times and geographically; focus on local based solutions where possible making it easier for carers, friends and family to visit.

My comment:- This has not been considered at all with the long distances that relatives now have to travel to visit their loved ones. They cannot go as often because it is no longer local, some have to rely on family to drive them there. Public transport to Brentwood can mean a 2 hour journey on the bus involving changes of buses and walking. The majority of people staying on the stroke ward are elderly and their partners are generally also elderly, some frail or have mobility issues and many do not drive.

It is easy to get to St Peters by bus (stops outside hospital gates) easy to drive to and park, the drive to Brentwood is horrendous at times.

Pg 22

Quote:- Things that staff said were important included: Delivering care as close to the patient’s home as possible. Clear communication with staff so they can support the continuity of patient care. Good transport links to health and care services for family, carers, friends and staff. The critical role that families and loved ones play in patient recovery, and the need to involve them in decision-making and care planning.

My comment:- On the ICB virtual views, a member of the public expressed their concerns about the difficulty for residents having to travel to the new sites on public transport. The answer given was shocking. Quote:- “The NHS is not responsible for public transport, however we are keen to understand associated concerns linked to these proposals.”

My comment:- It is the responsibility of the NHS to consider the inconvenience and hardship a change like these proposals can create. This proposal is severely disadvantaging those that do not drive or can’t afford the petrol.

Outpatients and Ambulatory care

Firstly, there are no options for these departments, the only information is to move to Maldon town and around. There are no definite sites secured, and at two consultation meetings, there were repeated requests to the residents to suggest where the services could go! They were asked to make suggestions if they knew of anywhere! How can there be a consultation about the options when there is only one and there are no details. How can there be an informed decision under these circumstances. At the very beginning of the consultation period, I asked if it could be assured that there would be no reduction in services and that it would be like for like. I also asked if it would be in Maldon. I was told yes, it would be like for like and there would be no reduction in services and it would be local. At a subsequent consultation meeting, when asking where it would be situated, I was told that nowhere was definite but discussions were on going, but if nowhere could be found then they may consider further afield, which is not acceptable as this was not in the consultation.

The ICB have tried to put a positive on these proposals stating that it might even be more beneficial to have a site in the town as residents could combine a visit to the town with their medical appointments. An example that was suggested was that the patient could combine their appointment with their trip to the town when they visit the bank etc. All but one of our banks have closed, therefore it is obvious that the ICB have not visited the town or done their homework.

St Peters hospital is 5 mins walk from the town centre for those that are able bodied, so the excuse that it would be beneficial to people to have medical facilities in the town is not of benefit, as the hospital **is** in the town.

Many people who come to St Peters for outpatient appointments are unwell, frail, disabled, have mental health issues, are in wheelchairs, mobility scooters use a frame or a stick. These patients have good access to the hospital as they can be dropped off at the front entrance and can easily get to the departments they need. There are sloped corridors and if someone is unable to use steps there is a ramp into the hospital and there is room to bring mobility scooters into the building through to the clinics if necessary. If a patient needs a carer to bring them, they can be safely brought into the front entrance and placed in a waiting room adjacent to the front door, in the warm, while they wait for the carer to park the car and meet back with them.

There is free parking and a bus stop right outside the hospital gates. There is the Dengie Dart that brings people from their front door to the hospital front door.

Everything is under one roof, and many patients book several appointments on the same day for different clinics, so that they only have to come out once instead of several different days. This is extremely important for the many patients who struggle with mobility, mental health, anxiety or breathing problems.

When a patient sees a consultant at St Peters outpatients department for diagnosis or new medication, the Dr. sometimes needs the patient to have a blood test and or an x-ray straight after that clinic, so that the new treatment can be started straight away. Blood tests and x-ray have an agreement with the other clinics that these patients are accepted as extra and are seen quickly, and do not have to wait for several weeks to get an appointment on another day, which would result in delaying their treatment.

If the outpatient and ambulatory services were to move into town as proposed, probably into two or three different buildings, not near to each other, it would make it very difficult for many of the patients because of lack of accessibility, and some who just could not do it at all.

Parking is limited in Maldon and quite often the main car parks are full. They will also incur a charge which could prove costly if the clinics are running late and there is a long wait. Pavements are not in the best condition and the difference to being able to park at the hospital and walk a short distance, to having to park in town and walk to wherever the ICB have decided to put the clinic, is not an improvement for the patient, and will cause difficulty and stress. If a patient has to go for a blood test or x-ray after a consultant appointment on the same day they will probably have to go to another building somewhere in the town, meaning further to walk or push a wheelchair and then have to get back to the car park which may not be nearby. I can give a good example of how difficult it will be for some patients with mobility issues, recently the front entrance of the hospital had to be cordoned off during the day while an urgent repair was carried out. Patients had to walk to the back entrance to get to the clinics, many patients struggled with that short detour and complained, imagine how difficult it will be when they have to walk from the public car park in town.

It will not be possible to stop in the high street to drop someone off by the clinic entrance. It will not be safe to leave the patient on the pavement or just inside the clinic, while the carer goes to park the car a distance away, hoping that they can find a parking space.

According to the consultation document there are 300 outpatients a day using St Peters hospital, most patients come by car. Where are 200 to 300 cars a day going to park in the town?

There are not enough disabled parking bays, people will be unable to get out of the car, because the normal spaces are tricky even for able bodied people to get out.

At one of the consultation meetings it was mentioned that the council offices could be considered for the relocation of St Peters. The ICB have not done their homework again as Princes Road that leads to the council offices and two different doctors' surgeries in itself is a reasonable width road ,but Warwick drive and Queen street are all narrow roads that lead from Fambridge road one end and Wantz road the other end. These roads have many parked cars which are difficult to pass because of oncoming cars, trying to navigate around the parked cars. Fambridge road is extremely busy twice a day when school starts and finishes and is frequently blocked with parked cars. How are the roads to cope with an extra 300 cars using these routes. (Photos to be included at the meeting.) Another suggestion for a site is the existing health facilities in Wantz Chase. The access road to this building is tiny, it is a no through road and it has absolutely no parking, resident permit only, and the clinic car park for staff only has room for 4 cars. There is little room to turn round at the bottom of the road as it tapers into a footpath. Wantz chase leads off Wantz road which is a one-way narrow road full of parked cars and a busy cut through for the middle of town. (photos to presented at the hearing)

The site suggestion of the Burnham Clinic is miles away from Maldon as is Braintree community hospital, that is not as promised, keeping it in the town.

The cost of updating St Peters is quoted as in excess of 18 million pounds where can the official breakdown of costs and quotes and the detailed surveys be found? St Peters does not have to be turned into some modern monstrosity like most modern hospitals, it just needs the maintenance and repairs that have been neglected over decades. The negative images the ICB have publicised have been completely misleading. They stated the rooves were leaking but they were repaired last year, the floors in the stroke ward were said to be too weak for the equipment, they have also been repaired and strengthened. I was told at the consultation meeting that the corridors were too narrow now for NHS standards and yet for all these years the wonderful staff on the stroke ward have managed to move patients completely safely. Another reason for St Peters not being fit for purpose is the lifts sometimes breaking down, I expect this happens at all hospitals from time to time and this is just a maintenance issue. There are two lifts at St Peters and it is unlikely that both would be out of action at the same time.

Whether running a home or an office or a hospital they all need maintaining and repairs, it is not unusual for things to break or need new parts. St Peters has been neglected and poorly maintained for years and now the NHS say it is unfit for purpose and they haven't got enough money to update it.

The government awarded 350 million pounds to be spent on the NHS for improvements, why has MSE not claimed money to maintain this hospital instead of condemning it. Where did the rent from Provide go? It would have gone a long way towards repairs. Why over the last 20-30 years has there been offers of a new health hub, plans made, promises made never to materialise and in the meantime, St Peters has been allowed to deteriorate. Why are we not being offered the promised health hub. The NHS stated they are still

looking for land for the Maldon health hub….. they own St Peters and the land problem solved!

How much will it cost to convert any building acquired for St Peters services, whether it be two or three different buildings or the council offices, to make them safe and fit for purpose. How much will the rent be over the next 5- 7 years, or longer, while we wait for the new health hub? Surely, although costly, a new health hub should be built on St Peters site and then, and only then the services currently provided at St Peters ,can move to the new hub and any remaining land after allowing for parking ,could be sold and money put back into the cost of the hub. This has been done on many NHS sites in our area and others. (evidence will be provided on the day)

At the beginning of the consultation the ICB stated that the move into town would be temporary. At My last consultation meeting It was stated that if the move to the town and services are working well, then it may be permanent, that is not what was originally said. Over the last 7 weeks information given has been contradictory, vague, misleading, uninformed and confusing. Some of the answers to residents' questions have been ridiculous or not answered at all. For example, when asked why has it not been considered to build a hub on St Peters site, of course cost was mentioned, and then it was explained that because of the Victorian sewer system, poor electrical supply and the fact that the site is on slope it would be too costly. I am not an architect or builder and have little knowledge of what it would involve to build a new hub, but on any new build drainage and electrics are put in before the build and if it is not easy to build on a slope how does Maldon even exist ! The whole town is on a slope and St Peters hospital has not fallen down the slope it has been standing on for last 150 years.

Finally, I would like to add that many people are still unaware of the consultation. I personally see 45 patients a day, and every day this week I have seen 20+ patients who are either unaware of the proposals or do not know about the consultation survey. In the first 5 weeks of the consultation, paper copies of the survey were unavailable in bulk, most of the consultations were online and nearly all the information needed was online. Some improvements have been made in the last week, 6 weeks in, but only after the public demanded these improvements. This consultation has been unfair and discriminatory to people who do not go online. Many volunteers have been copying and printing documents and surveys at their own expense and it has been very time consuming. These wonderful people have been doing the work the ICB should have done, it is a disgrace. Why has there not been much more advertised at the hospital site where all the people staff and patients will be affected.

I will also be bringing many quotes and comments from residents to the hearing.

Submission 16 - Lindsey Wright, Local Resident

Mid Essex Health Board. (All 71 of you!)

Dear People,

St Peter's Hospital Closure

Reasons to repair the hospital and continue its use:

Recent annual usage of the hospital:

Current uses at St Peter's Hospital	Miles to Broomfield Hospital (Other destinations even further)	
39,000 Outpatient appointments	1,170,000	
37,000 Blood tests	1,110,000	
8,500 x-ray appointments	255,000	
700 Ultrasound appointments	21,000	
70 births	2,100	
50% of journeys requiring assistance	42,635	
	2,600,735	Extra miles!

More than 2.5 million miles on narrow busy Essex roads
That's 10,000 extra miles on the road every day, Monday to Friday

Potentially 85,000 extra road trips to Broomfield, 15 miles each way, 30 miles return, (And that's from Maldon, what about from Burnham or Bradwell or SWF?) That is 2,550,000 additional miles! Estimated half of which will be through Hatfield Peverel and the narrow back roads, the other half facing an hour's plus bus trip each way. (Hoping that the bus is on time and they won't be late for the appointment.)

Having arrived at Broomfield there is literally miles to walk to the relevant department. If a patient needs a wheelchair it's impossible to park a car, then find a wheelchair, return to the car, deposit patient inside hospital, then return to park the car correctly. What are the facilities for this at Broomfield?

- Many of these patients will be over 70 years old. Yet there's a suggestion that over 70s should be deterred from driving.
- You are depriving patients of their independence; once someone is reliant on family support, it's a burden on the family who are still working.
- Don't forget the parking! I'm not just talking about the cost, but also the lack of spaces at Broomfield.
- Rehabilitation beds. These are such a great idea for elderly in-patients and stroke victims to finish recuperating if they are unable to return home. Potentially 26 beds. Bed-blockers. Don't send them to Brentwood or Rochford; how do you expect elderly relatives to visit them?

Yes, St Peter's is in a bad state of repair, but that's YOUR fault. YOU allowed it to deteriorate in order that you had an excuse to sell it. There is no RAAC in St Peter's. Look at all the 1960s school buildings that are falling down due to the concrete catastrophe. St Peter's doesn't have that problem.

It's cheaper to repair St Peter's than to build a new hub from scratch: there's no land to buy.

If you sell St Peter's a developer will repair the roof etc, why can't you?

You could demolish the 1960s buildings at the back of the site and create a wonderful building with GP facilities for the whole of the town. Now wouldn't that be a good idea? Both Blackwater & Longfield surgeries desperately need more space for the growing population.

According to your website: The Alliance is committed to:

- Understanding and working with communities
- Developing a deep understanding of local needs
- Connecting and listening to local communities

The local community needs a community hospital NOW. Repair it NOW. Not sometime, never, never in the future. So to those who are "listening": Claire Hankey and Tina Starling, LISTEN!

And finally, why is Southend getting a new hospital? That should be money spent in Maldon! That £25million should be for St Peter's. Southend already has an enormous hospital.

Regards Ms Lindsey Wright

Issues and learning opportunities

As with all processes, learning is available from the issues and challenges encountered.

Process learning

- Expectations communicated by some stakeholders was for the event to follow a more common public meeting format. Communications on the format were clear. There is an opportunity to be clearer and highlight in communications the format differences and features that set a public consultation hearing apart from other consultation events.
- Double the number of applications to present (18) were received than the planned capacity of the event (9). The ICB agreed to extend the event on 19 March to add an extra presentation slot, and to set up an extra online hearing session to accommodate NHS staff who wanted to present. This invitation was accepted by three of the four applicants it was extended to. Organisers are grateful to the applicants who either on request or by their own arrangements combined to present together, or provide a written submission instead, meaning that all applicants were offered the chance to participate. Two applicants didn't respond to the offer.
- Information asking presenting parties to limit their number to four people and nominate one as spokesperson wasn't included in early communications. Presenters' plans were advanced when that was communicated to them and after representations, these requirements were dropped by the organisers.
- Organisers were able at late notice to accommodate two presenters who applied after the deadline. One replaced a scheduled presenter who decided to submit evidence in writing rather than present to the panel in person. The other was invited to present by the chair, because the event was running ahead of schedule.
- Security issues raised by local police led to a last-minute requirement to have only named ticket holders to be admitted to the public gallery and the facility to confirm identities with photo ID. The booking system held contact details for ticket holders, so they could be contacted on 18 March. Four ticket holders had booked multiple tickets in their name. Each of these ticket holders was contacted to confirm the names of the people in their party.
- A glitch in the stream from Session 2 leaves 39 seconds at the beginning of Cllr Phill Barlow's presentation missing from the recording (Video timestamp 2:24:19 to 2:24:58).
- The fourth hearing session was conducted online. Presenters and panel members were able to access the hearing and take part as planned. Despite successful testing earlier in the day, there was a technical difficulty with the live streaming, which meant that people were not able to watch the proceedings live online as scheduled. Organisers issued apologies at the time. The recording of the

proceedings was posted to the ICB's YouTube channel and publicised on the consultation website and social media channels early on 5 April.

Feedback from presenters

- One presenter shared that they had felt both intimidated by the prospect of presenting and hounded by the organisers in the process of arranging their attendance at the hearing. This was noted and the chair apologised.
- One presenter, an employee of Mid and South Essex NHS Foundation Trust, shared that they had been spoken to by their line manager about their application to present at the hearing. Debbie Goldsmith on behalf of the Trust expressed apologies that the presenter had had that experience and offered to meet and look into what happened.
- One presenter expressed disappointment that Parish Councils hadn't been directly approached to attend.