Mid and South Essex Integrated Care System

NHS Mid and South Essex

Decision-Making Business Case on community services in mid and south Essex: The future location and configuration of community inpatient beds, the freestanding midwife-led birthing unit and ambulatory care services at St Peter's Hospital, Maldon

July 2025

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Glossary of Terms

Terms/Language

Intermediate care	Intermediate care is the term used for services that help people regain or maintain independence, with a focus on rehabilitation, reablement and recovery. Intermediate care is primarily for older people with complex care needs.
Ambulatory Care services	Ambulatory care services provide healthcare for individuals who do not require overnight hospital stays. These services offer same-day care for assessment, diagnosis, and treatment. Within this Decision-Making Business Case the term 'ambulatory care services' relates to outpatients and diagnostic services.
Midwife-led	Midwife-led means that care is primarily provided by midwives, rather than doctor/consultant led. Within this Decision-Making Business Case this relates to the birthing unit which is staffed by midwives.
Stroke Rehabilitation	Stroke rehabilitation relates to specialist support designed to help people recover after experiencing a stroke. The goal is to help individuals regain as much independence and function as possible, and to improve their quality of life. It is suitable for people who are medically stable but require intensive therapy. In this Decision-Making Business Case this relates to community stroke rehabilitation beds which provide this support to patients before they return home or to another community setting.

Organisational acronyms

CCTF	Community Capacity Task Force
CICC	Cumberlege Intermediate Care Centre
EEAST	East of England Ambulance Service
EPUT	Essex Partnership University Trust
ICB	Integrated Care Board
ICS	Integrated Care System
MNC	Mountnessing Court
MSE	Mid and South Essex
MSECC	Mid and South Essex Community Collaborative

MSEFT	Mid and South Essex Foundation Trust
MSEICB	Mid and South Essex Integrated Care Board
NELFT	North East London NHS Foundation Trust
NHSE	NHS England
NICE	National Institute for Health and Care Excellence
WJC	William Julien Courtauld

Further used acronyms / abbreviations

AIS	Accessible Information Standard
AMU	Alongside Midwifery Units
DMBC	Decision-making Business Case
D2A	Discharge to Access
CCORG	Clinical and Care Outcome Review Group
EDS	Early Discharge Service
EHIA	Equality and Health Inequality Impact Assessment
ESA	Environmental Sustainability Assessment
ESD	Early Supported Discharge
FAQ	Frequently Asked Questions
FMU	Freestanding Midwifery Units
HCAS	Higher Cost Area Supplements
HOSC	Health Oversight Scrutiny Committee
ICTH	Integrated Care Transfer Hub
ICSS	Integrated Community Stroke Service
IDT	Integrated Discharge Team
IIA	Integrated Impact Assessment
IMC	Intermediate Care
MLBU	Midwife-led Birthing Unit
MTP	Medium Term Plan
NICE	National Institute for Health and Care Excellence
OGSCR	Oversight Group for Service Change and Reconfiguration
PCBC	Pre-Consultation Business Case
PIFU	Patient Initiated Follow-up
PPG	Patient Participation Group
SRU	Stroke Rehabilitation Units
SSNAP	Sentinel Stroke National Audit Programme
TOCH	Transfer of Care Hubs
UCLP	University College London Partners

Note about this document

This Decision-Making Business Case has been written by the Mid and South Essex Integrated Care Board and the Mid and South Essex Integrated Care System Community Capacity Programme Board team for this workstream. Its purpose is to enable the Mid and South Essex Integrated Care Board to take an informed and evidence-based decision on:

1) The future location and configuration of community intermediate care and stroke rehabilitation beds across mid and south Essex.
2) The future location of the freestanding midwife-led birthing unit in mid and south Essex.
3) The future of ambulatory care services at St Peter's Hospital, Maldon.

It is a technical and analytical document, written at a point in time, and its contents reflect information (including sources and references accessed) as of the date of publication.

When this document uses the term 'we', this is referring to the Mid and South Essex Integrated Care Board and the Mid and South Essex Integrated Care System Community Capacity Programme Board team.

There is a glossary to assist with complex terminology.

Executive Summary

This Decision-Making Business Case (DMBC) sets out the rationale, evidence base, consultation outcomes, and final recommendations for the future configuration of community hospital services in mid and south Essex. Developed by the Mid and South Essex Integrated Care Board (MSEICB) and the Mid and South Essex Integrated Care System Community Capacity Programme Board team, the DMBC addresses three key service areas:

1) The future location and configuration of community intermediate care and stroke rehabilitation beds across mid and south Essex.
2) The future location of the freestanding midwife-led birthing unit in mid and south Essex.
3) The future of ambulatory care services at St Peter's Hospital, Maldon.

The DMBC builds upon the Pre-Consultation Business Case (PCBC), incorporates extensive public consultation feedback, and reflects the recommendations of the Community Consultation Working Group. It aims to ensure that service changes are clinically sound, financially sustainable, and aligned with the needs and expectations of local communities.

The case for change is underpinned by national policy, clinical evidence, and local service pressures relating to service capacity, clinical effectiveness and issues with estate.

The estate of St Peter's Hospital, Maldon, has significant safety concerns, including a failing lift, flooding risks, and outdated infrastructure. These issues prompted temporary service relocations in October 2023, including the transfer of stroke rehabilitation beds from St Peter's Hospital to Brentwood Community Hospital and the freestanding midwife led birthing unit from St Peter's Hospital to the William Julien Courtauld unit, Braintree. Ambulatory care services were also all relocated to the ground floor of St Peter's Hospital because of the identified risks with the lift and flooding on the first two floors of the site. Simultaneously, the configuration of community beds has been under review for several years and demand for community-based rehabilitation services has increased, particularly for stroke patients, necessitating a re-evaluation of bed capacity and distribution across the system.

National guidance and local audits support the shift toward more specialised, consolidated stroke rehabilitation units and a "home first" approach for intermediate care. Similarly, maternity care policy emphasises choice and safety, with freestanding midwife-led units offering a valuable option for low-risk births. The case for change also recognises the need to modernise outpatient and diagnostic

services, ensuring they remain accessible and sustainable for the growing and ageing population of mid and south Essex and, in particular, the Maldon district.

A comprehensive public consultation was conducted between January and April 2024, receiving over 5,500 survey responses and engaging more than 1,000 individuals through events, focus groups, and written submissions. The consultation revealed strong public sentiment, particularly from residents in the Maldon district, who expressed concern about the potential loss of local services and increased travel burdens. Feedback was grouped into five key themes:

- Strategy and case for change.
- Clinical models and patient pathways.
- Workforce and staffing.
- Estate.
- Travel and access.

In response to the strength of feeling around the proposals from the consultation, the Board of the Mid and South Essex Integrated Care Board made the decision to pause the decision-making process in September 2024 and established an independently chaired Community Consultation Working Group. This group met monthly from October 2024 to March 2025 and included representatives from the NHS, local authorities, and community organisations. The recommendations made by the Working Group have been instrumental in shaping the final recommendations within this DMBC.

The DMBC recommends the adoption of Option B for the future configuration of community inpatient beds. This option proposes a split model for stroke rehabilitation, with 25 beds at Brentwood Community Hospital and 22 beds at the Cumberlege Intermediate Care Centre (CICC) in Rochford. It also includes 91 intermediate care beds distributed across four sites (Brentwood Community Hospital, Halstead Community Hospital, Mountnessing Court in Billericay and the Mayfield Unit on the Thurrock Community Hospital site). This model balances clinical effectiveness, accessibility, and workforce sustainability, while addressing concerns raised during consultation about travel and equity of access.

For maternity services, the DMBC recommends the permanent relocation of the freestanding midwife led birthing unit from St Peter’s Hospital to the William Julien Courtauld Unit at St Michael’s Health Centre in Braintree. This site offers a safer, more modern environment and is co-located with other 24-hour services. Maternity outpatient services, including antenatal and postnatal care, will continue to be delivered from St Peter’s Hospital, preserving local access and continuity of care.

Regarding ambulatory care services, the DMBC recommends that services remain at St Peter’s Hospital for the short to medium term (0 to 5 years). This decision reflects

the lack of viable alternative sites, the strong public preference for retaining services locally at St Peter's Hospital, and the need for further planning and investment into a long-term replacement for St Peter's Hospital. During this period, essential maintenance will be undertaken to ensure the safety and functionality of the estate, while a long-term plan for a replacement for St Peter's Hospital is developed in collaboration with local stakeholders.

An Integrated Impact Assessment (IIA) and Sustainability Impact Assessment (SIA) were conducted to evaluate the effects of the proposed changes on patients, staff, and the environment. Positive impacts include improved clinical outcomes, better use of estate, and enhanced workforce stability. Adverse impacts, such as increased travel for some patients and visitors, have been acknowledged and mitigated through measures including planned clear communication about information on patient transport and travel options, the NHS travel cost reimbursement scheme, and community transport providers.

MSEICB has a statutory responsibility to consider the potential impact of service changes on climate change, the broader effects of service transformation on other services and neighbouring ICBs, and the implications for the Armed Forces Community. These factors have been assessed within this DMBC. The assessment concludes that the impact on our climate change obligations is minimal. Furthermore, no significant effects are anticipated on other services, neighbouring ICBs, or the Armed Forces Community compared to the current state.

The financial analysis confirms that the proposals are affordable. Option A and Option B for community beds are financially balanced and offer a small saving to the system, while the relocation of the MLBU incurs only a minimal cost. The continued use of St Peter's Hospital for ambulatory care services avoids immediate large amounts of capital expenditure on alternative service locations but does require capital expenditure to improve the site and ensure it remains safe for service delivery in the short to medium term (0 to 5 years). Future investment will be required for the development of a new Maldon Health Hub/replacement for St Peter's Hospital. There is further work to do on developing options for this and understanding the extent of capital investment needed.

The implementation of these recommendations will be overseen by the Community Capacity Programme Board, supported by dedicated subgroups for operations, workforce, finance, estates, and communications. A new 'Community Committee', with representation from the public and local community, will be established to provide ongoing scrutiny and advice, particularly in relation to ambulatory care services and the future of the St Peter's Hospital site. Indicative timelines suggest implementation of the community bed changes and MLBU relocation by the end of

2025, with continued planning for the replacement for St Peter's Hospital over the next five years.

This DMBC presents a robust, evidence-based approach to transforming community hospital services in mid and south Essex. It reflects the voices of patients, staff, and stakeholders, and balances clinical quality, financial sustainability, and public accountability. The recommended changes will ensure that services are safe, effective, and fit for the future, while maintaining a strong commitment to local access and community engagement.

Context and Clinical Model

1. Background and Case for Change

1.1. Purpose and Scope of Decision-Making Business Case

The purpose of this Decision-Making Business Case (DMBC) is to enable the Board of the Mid and South Essex Integrated Care Board (MSEICB) to take an informed and evidence-based decision on the following proposals:

1) The future location and configuration of community intermediate care and stroke rehabilitation beds across mid and south Essex.
2) The future location of the freestanding midwife-led birthing unit in mid and south Essex.
3) The future of ambulatory care services at St Peter's Hospital, Maldon.

The DMBC is based on the evidence compiled in the Pre-Consultation Business Case (PCBC) (published in January 2024[1]), feedback from the public consultation that was undertaken between 25th January 2024 and 11th April 2024 (see Appendix 1), recommendations made by the Community Consultation Working Group which met monthly between October 2024 and March 2025 (see Appendix 2), and other relevant information gathered since the publication of the PCBC. It considers the information and feedback which came forward during the public consultation, and which is covered in detail in the consultation feedback report as well as the recommendations put forward by the Community Consultation Working Group which are set out in detail in the 'Report from the Commission into St Peter's Hospital and associated options with care beds and birthing unit pathways across Mid and South Essex' (see Appendix 2).

This document will enable decision makers to ensure that decision making, and subsequent implementation, is informed by detailed consideration of all relevant information, including the consultation and Working Group feedback and suggestions for successful implementation of these changes.

This DMBC includes:

- An overview of the feedback MSEICB received from the public, patients, carers, NHS staff directly or potentially impacted by the proposals and other staff, public representative organisations, Health and Overview Scrutiny Committees, Local Authorities, and many other key stakeholders during our public consultation.
- Information about all the proposed options and service changes. This includes additional information gathered during the Community Consultation Working Group on the benefits and potential impacts on service users of the options presented, along with mitigations for the impacts.
- Recommendations for each proposal for consideration by the decision makers, and associated recommendations for implementation based on all the information gathered during this process.

The scope of this DMBC is outlined below:

[1] Pre-Consultation Business Case on Services in Mid and South Essex

- **The future location and configuration of community intermediate care and stroke rehabilitation beds across mid and south Essex.**

Intermediate care beds are beds which are primarily used to enable older people with complex care needs to be discharged from a main acute hospital for a short period of personalised, goal-based rehabilitation, where they are not yet well enough to return to their usual place of residence.

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

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

- **The future location of the freestanding midwife-led birthing unit in mid and south Essex.**

A freestanding midwife-led birthing unit, offering choice to women within mid and south Essex which otherwise has midwife-led birthing units attached to the obstetric units at each of the three acute hospital sites. Freestanding units are typically for women with low-risk pregnancies who are not anticipated to require medical interventions during labour.

- **The future of ambulatory care services at St Peter's Hospital, Maldon.**

Ambulatory care services provide healthcare for individuals who don't require overnight hospital stays. These services offer same-day care for assessment, diagnosis, and treatment. A range of ambulatory services are delivered from St Peter's Hospital, Maldon, including a mental health outpatient service in the Cherry Trees unit, as well as other outpatient services, plain film X-ray, ultrasound, phlebotomy, and office accommodation for community staff (see Table 2 in section '1.4.7 [Case for Change] Ambulatory Care Services' for a full list of the ambulatory services provided at St Peter's Hospital). Annually there are over 80,000 ambulatory care appointments, including around 39,000 outpatient attendances.

1.2. Intended audiences and their decision-making roles

This DMBC has been written by Mid and South Essex Integrated Care Board (MSEICB), with support from the Mid and South Essex Integrated Care System Community Capacity Programme Board. It is intended for:

- The MSEICB Board, who, based on the evidence provided, will decide on the future location and configuration of community intermediate care and stroke rehabilitation beds, the relocation of the freestanding MLBU and whether to

relocate ambulatory services currently provided at St Peter's Hospital to alternative locations in Maldon. The MSEICB is the statutory body responsible for making decisions on the recommendations made within this DMBC.

The following organisations have been involved in the decision-making process:

- The Board of Mid and South Essex NHS Foundation Trust (MSEFT) who will consider the recommendations prior to the DMBC going to the MSEICB Board so they have full sight of the evidence and rationale on which the MSEICB Board decision is based. MSEFT are the owners of the St Peter's Hospital site, are the provider of the freestanding midwife-led birthing unit and provide a range of ambulatory care services from St Peter's Hospital. The Board of MSEFT have been in support of the proposed changes throughout the PCBC and consultation process and are committed to supporting the delivery of high-quality services across the catchment area.
- The Board of Mid and South Essex Community Collaborative (MSECC) comprised of the organisations who provide NHS community services in Mid and South Essex (Essex Partnership University NHS Foundation Trust, North East London NHS Foundation Trust and Provide Community Interest Company), who will consider the recommendations prior to the DMBC going to the MSEICB Board so they have full sight of the evidence and rationale on which the MSEICB Board decision is based. MSECC are the provider of both intermediate care beds and stroke rehabilitation beds, and they are also the provider of a range of ambulatory care services from St Peter's Hospital. The Board of MSECC have been in support of the proposed changes throughout the PCBC and consultation process and are committed to supporting the delivery of high-quality services across the catchment area.
- NHS England who will consider the recommendations prior to the DMBC going to the MSEICB Board so they have full sight of the evidence and rationale on which the MSEICB Board decision is based. NHS England oversee Integrated Care Boards and their service changes, ensuring they operate within national standards and fulfil their commissioning responsibilities. Any proposal for service change must satisfy the government's five tests (refer to Section 4.6 for further detail), best practice checks, and must be affordable in capital and revenue terms. NHS England (regional team) followed an assurance process to confirm they were satisfied with the proposals prior to the Integrated Care Board formally consulting on them.

It will also be of interest to the following groups, who will need to be kept informed of the process throughout and the decisions made:

- The Integrated Care Partnership Board so they have full sight of the evidence and rationale on which the MSEICB Board decision is based.
- Essex County Council, Southend-on-Sea City Council and Thurrock Council's Health Overview and Scrutiny Committees (HOSCs), which have determined the proposed changes are substantial for their populations and have been formally consulted with, will scrutinise the final proposals in line with their responsibilities.

- Public and patient stakeholders, so they have full sight of the evidence and rationale on which the MSEICB Board decision is made. This will include the Community Consultation Working Group.
- Local councils and MPs, so they have full sight of the evidence and rationale on which the MSEICB Board decision is made.
- Staff and colleagues affected by the decisions, so they have full sight of the evidence and rationale on which the MSEICB Board decision is made.

1.3. The decision-making process we are undertaking

1.3.1. Our Responsibility

MSEICB are the accountable commissioner responsible for the commissioning of community inpatient beds, midwife led birthing units and ambulatory care services within the mid and south Essex footprint and under consideration within this DMBC.

Decision-making responsibility falls solely with the Board of MSEICB. As such this document, whilst set in the context of the Integrated Care System, is owned by MSEICB.

1.3.2. Background

For several years, the contribution and performance of community hospital beds in mid and south Essex has been under review. Covid-19 interrupted this work and caused an emergency redistribution of community beds, which was gradually reversed in 2022/23. Initial proposals for service changes to community intermediate care and stroke rehabilitation beds were looked at in 2022, and the East of England Clinical Senate was asked to consider these proposals. They reported that they thought the proposals had the potential to deliver good patient care and improve flow through the health and care system.

Work continued in developing the community bed clinical model and associated distribution of beds. In early summer 2023, Mid and South Essex Integrated Care System (MSEICS) established a multi-agency Community Capacity Task Force (CCTF) to explore the extent to which community hospital provision needed to change in the immediate and longer term, primarily due to ongoing quality, capacity, and estate issues. This led to the development of proposals to improve community hospital services and the production of the Pre-Consultation Business Case (PCBC).

The recommendations put forward within this DMBC stem from a lengthy process of discussion and engagement with patients, the public, partner organisations and health and care professionals. They take into account feedback from the formal public consultation, as well as the reviews of changes undertaken by clinical experts and an assessment of impact undertaken by system partners. They also take into consideration the recommendations put forwards by the Community Consultation Working Group (see Section 1.3.10 Community Consultation Working Group and Section 5.6 Post-Consultation working Group for further information and Appendix 2).

This DMBC is focussed on improving the safety and quality of services and enhancing outcomes for patients when they require community services. Thus, the decisions that will be taken are a sub-set of the wider range of actions that the MSEICB and MSEICS is taking to deliver safe and sustainable services for the population.

1.3.3. Temporary service changes

The CCTF initially focused upon the need to adjust the configuration of community beds to enable the system of health and care to respond to anticipated increased demand in the winter of 2023/24. It became evident that the distribution and number of stroke rehabilitation beds required was not going to be sufficient for winter 2023/24 and needed to change. It was also apparent that the estate at St Peter's Hospital was not fit to continue to provide inpatient services there as it was no longer felt to be safe in its current form, and not sustainable as a location for inpatient clinical care.

Specific issues with the estate identified were:

- The lift to the second floor, where community beds were situated, had for some time been an issue due to it frequently breaking down.
- The frequently broken lift increased the risk that people with limited mobility could not easily be evacuated from the first or second floor of the main building if needed, causing a safety issue for both patients and staff.
- The number of inpatient beds (stroke rehabilitation beds) was reduced to 16 as a result of issues with the estate, in particular the lift. 16 beds were identified as the maximum number of beds that could be accommodated safely to try and limit the number of patients and visitors using the lift on a daily basis.
- During heavy rain, the main building is prone to flooding with accompanying electrical and fire risks, creating an unsafe environment for both patients and staff.
- There had previously been issues with the floor loading and maximum weight it could take, but this had been repaired.

The CCTF therefore proposed temporarily transferring the 16 community stroke rehabilitation beds at St Peter's Hospital to Bayman Ward at Brentwood Community Hospital (which was void space) and increasing the number of beds to 25 stroke rehabilitation beds, as well as increasing the number of stroke rehabilitation beds at the Cumberlege Intermediate Care Centre (CICC) from 8 stroke beds to 14 stroke beds. The increase of stroke beds at CICC meant there was a reduction of intermediate care beds at CICC from 14 to 8 beds.

Moving the inpatient beds from St Peter's Hospital, even on a temporary basis, would leave the freestanding midwife led birthing unit, situated on the first floor of St Peter's Hospital, isolated as the only 24-hour service on the St Peter's Hospital site. Staff and service leaders raised concerns about safety of the service out of hours, and the service had the same issues with the poor condition of the building at St Peter's Hospital, such as the temperamental lift, impacting the quality of care provided there. It was therefore proposed that the freestanding midwife-led birthing unit at St Peter's Hospital was also temporarily relocated, and William Julien Courtauld (WJC) at St Michael's Health Centre, Braintree was identified as a suitable location as it is a more modern estate suite with other 24-hour services on site.

In August 2023, the Boards of the constituent organisations comprising the MSEICS approved proposals to temporarily transfer the 16 stroke rehabilitation beds from St

Peter's Hospital to Bayman Ward at Brentwood Community Hospital, and to increase stroke rehabilitation capacity in mid and south Essex from 24 beds across St Peter's Hospital and CICC to 39 beds across Brentwood Community Hospital and CICC in preparation for the expected increase in demand during the winter of 2023/4. The decision was also taken to relocate the freestanding midwife-led birthing unit from St Peter's Hospital to WJC at St Michael's Health Centre, Braintree. The inpatient transfers took place on 9 October 2023, leaving ambulatory services (outpatients, therapies and diagnostic services) still being provided at the St Peter's Hospital site.

Given the issues and risks mentioned above with the lift and leaking roof at St Peter's Hospital, in November 2023, all ambulatory care services being delivered from the first or second floor of the main building at St Peter's Hospital were temporarily relocated to the ground floor to mitigate the risks and issues identified. Administration teams and non-clinical activity was relocated to other sites where possible to allow clinical activity to take priority in the limited space available on the ground floor of St Peter's Hospital. All other ambulatory activity that was already being delivered from the ground floor continued.

1.3.4. Pre-Consultation Business Case

The CCTF's work to review community intermediate care and stroke rehabilitation bed provision led to the development of proposals to improve community hospital services in the long term, and the production of the Pre-Consultation Business Case (PCBC). The case detailed the recommendations made to the relevant Boards and Committees on the proposed options for service change. Its purpose was to:

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

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

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

- Describe the process that has been followed, using clinical advice, to generate the options for changes in community hospital bed services (intermediate care and stroke beds and the freestanding midwife-led birthing unit), then determining which options best meet the population needs through appraisal and evaluation of the options considered.

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

- Show how stakeholders and the public have been engaged in this preliminary process and their range of views captured.

The proposals contained within the consultation have successfully passed through rigorous regional assurance processes which were undertaken by NHS England (see section '4.2 and 4.6: Previous Assurance and Advice').

The decision to progress to consultation on the proposals was approved by the ICB Board on the 18th January 2024.

1.3.5. Public and Stakeholder Engagement

The CCTF oversaw the programme of work to develop the PCBC, including engagement that took place to develop the options and proposals presented within it. The programme was constructive in engaging with our internal and external stakeholders. Over this period, we worked closely with the public, patients, carers, community groups, staff, professionals, and other experts. MSEICB commissioned an external organisation- Kaleidoscope Health and Care- to support with our pre-consultation engagement. Together, we held several interviews and small focus groups. Both early and pre consultation engagement enabled us to:

- Establish what the public, patients, carers, staff and other stakeholders wanted from future services and what their concerns were.
- Develop decision making criteria that we used to help us with decision making, including moving from a long list of options to a short list. The five key domains we asked people to consider were: quality, workforce, accessibility, strategic alignment and cost.
- Understand key themes identified which we then used to both shape the programme and to develop potential options for the future configurations.
- Develop the PCBC, with clinical advice from the East of England Senate, HOSCs, acute trust, community trusts and other relevant bodies and experts within the Integrated Care System.
- Design, test and refine our approach to consultation, including what we did and how we did it.
- Undertake a comprehensive, wide reaching public consultation.

A separate report was developed that sets out in more detail the main things heard as part of pre-consultation engagement, and how the CCTF planned to incorporate this feedback into the consultation by building on previous themes (see Appendix 3). As part of the pre-consultation engagement, this outcome report received independent ratification from Healthwatch Essex, Healthwatch Thurrock and Healthwatch Southend.

The CCTF continued its programme of engagement through the formal consultation process with the aim to obtain a broad range of views from a wide variety of communities, services users, and their representatives on our proposals.

1.3.6. Consultation

The consultation on the future location and configuration of community intermediate care and stroke rehabilitation beds in mid and south Essex, the future location of the freestanding midwife-led birthing unit in mid and south Essex and the future of ambulatory care services at St Peter's Hospital, Maldon, ran from 25th January 2024 to 11th April 2024.

The consultation sought to:

- Ensure the population of mid and south Essex were aware of and understood the case for change and the proposals for change, by providing information in clear and simple language and in a variety of formats.
- Hear people's views on the proposed options for inpatient community beds, the freestanding midwife led birthing unit and proposals linked to ambulatory services at St Peter's Hospital.
- Ensure the ICB as decision-makers were made aware of any information and additional evidence which may help to inform the decision-making process.

Its purpose was to gather people's views on the proposals as well as their ideas for making any proposed changes transition smoothly. It also encouraged them to share their views, questions, ideas, and any additional information people thought the MSEICB should know when making a final decision about the proposed changes.

1.3.7. Consultation approach

Our approach to patient, public and staff engagement was multi-layered and targeted to different stakeholder groups and different people's needs to give the best chance of hearing from as many different perspectives as possible. We received 5544 responses to the consultation through questionnaire responses. Additionally, more than 1,000 people participated through face-to-face engagement sessions, online sessions, focus groups, official organisational responses and phone calls/emails and written submissions.

We held in total 30 face to face and online sessions and were invited to attend an additional nine community organised events. There were 216 media stories covering the consultation. Social media posts were seen by users 122,000 times and received more than 1,000 engagements. Pages on the consultation website, 'Virtual Views', were viewed more than 20,000 times as part of the communications campaign to prompt different organisations and individuals to share their views.

All the feedback also informed the refresh of the Integrated Impact Assessment (IIA) (see 'Section 8: Impact of proposed changes').

Details about the consultation and more information on the findings and feedback received are in 'Section 5: Consultation and engagement', 'Section 6: Feedback from public consultation' and 'Section 7: Addressing themes from the consultation' of this DMBC.

1.3.8. Output of consultation

We commissioned an external company- Stand- to receive and analyse the consultation data. This was to ensure that independent analysis of the feedback and suggestions received from the consultation took place, giving complete separation from the Mid and South Essex Integrated Care System (MSEICS) leads overseeing the work programme, and to give decision-makers, stakeholders and others assurance about the independence and impartiality of the process.

The independent consultation feedback report (see Appendix 1) explains that the consultation heard from a range of stakeholders and equality groups, with coverage of representation from across the geographical regions in the catchment area for the

services alongside targeted responses from those with protected characteristics. Perhaps unsurprisingly there was particularly strong response from those in the Maldon district, where St Peter's Hospital is located.

The outcome report was independently presented to the MSEICB Board on 11th July 2024. This enabled the MSEICB Board to consider the findings and consultation responses. The report and its findings emphasised the need for further engagement to more fully understand several themes raised during the consultation.

The report, and the insights within, have been used to inform the DMBC, on which the final proposals will be based. We are clear that the results of consultation are an important factor in health service decision-making and are one of a number of factors that need to be considered.

1.3.9. Conscientious consideration of the consultation findings

As part of the assurance process for developing the DMBC, we reviewed all information from the consultation process.

The feedback was grouped into themes that were reviewed by Subgroups of the Community Capacity Programme Board. These Subgroups were made up of subject matter experts from the MSEICS with expertise pertinent to the service areas, including management of clinical services, workforce, operations, data, travel, estates and finance. Information was shared with these groups for consideration, and they were asked to review all information and feedback and develop any necessary mitigations and solutions to issues raised.

The information and subsequent responses from the Subgroups were shared with the decision-making individuals and Community Capacity Programme Board to support them in a scoring and review process, a consistently applied methodology allowing robust evaluation of the proposal and options, which led to the development of the recommendations set out in this DMBC in 'Section 10.3: Recommendations'.

Further information about this work and process followed is in 'Section 10.1: Decision Making Process'.

1.3.10. Pertinent developments since the Pre-Consultation Business Case

1.3.10.1. Community Consultation Working Group

Following the public consultation and publishing of the consultation report, there was an evident strength of feeling that came through consultation feedback on the proposals, and ongoing dialogue with local stakeholders and community groups in the months following the end of the consultation process. Consequently, the MSEICB Board took the decision in September 2024 to enact a six-month delay in the final decision-making process regarding the reconfiguration of community hospital beds, the midwife-led birthing unit and ambulatory care services. The aim of the delay was to allow further engagement to take place to ensure the final decision making is fully informed and aligned with the needs of the local population and to enable the NHS in mid and south Essex to develop comprehensive solutions that address the needs of local communities to enable staff to deliver the best possible

care, deliver the best outcomes for patients and make the best use of taxpayer's money.

To ensure this happened, an independently chaired working group was established to support looking at the proposals in detail, including the long-term future of services provided at St Peter's Hospital in Maldon. The group included representatives from the NHS, local authorities, community organisations, Healthwatch and other stakeholders.

During the delay there were no changes to the provision of community hospital beds or ambulatory care services, and they remained in the current locations (for community inpatient beds and the midwife led birthing unit this meant services remained in the temporary locations, set out in 'Section 1.3.3 Temporary Service Changes'.

An independent Community Consultation Working Group Chair was appointed in September 2024, and the group was established in October 2024 where terms of reference were agreed (see Appendix 4). The Working Group met monthly between October 2024 and March 2025. The rationale behind the options set out in the PCBC and consultation, along with further evidence relating to the options for community inpatient beds, maternity services and future estates options were presented to and considered by the Working Group.

The Working Group developed a set of recommendations which were agreed by the group and published in March 2025 (see Appendix 2). The recommendations were presented to the MSEICB Board on the 15th May 2025.

The recommendations were shared with the Community Capacity Programme Board (previously the Community Capacity Taskforce, see 'Section 1.3.10.4 Community Capacity Programme Board' below) and the associated expert Subgroups. These groups were asked to give the recommendations from the Working Group conscientious consideration during their decision-making process (scoring and review, see 'Section 10: Decision Making' for more information) which was used to develop the final set of recommendation set out in this DMBC.

1.3.10.2. NHS developments

Since the production of the Pre-Consultation Business Case, and the undertaking of the consultation and engagement process, there have been a number of significant developments to the NHS nationally and locally. These include:

- Changes in national policy with the election of a new government who are focused on three 'shifts' required within the NHS – analogue to digital, treatment to prevention and hospital to community.
- The announcement of the abolition of NHS England and significant operating cost reductions and role changes for NHS Integrated Care Boards.
- Increased regulatory focus on certain areas of service provision within mid and south Essex.

These changes have been considered in this DMBC but, in summary, it is not believed that these affect the proposals made in the Pre-Consultation Business Case, although there may be some changes in the responsibilities around the implementation of these changes if approved, given the changing role of Integrated Care Boards.

1.3.10.3. Mid and South Essex Integrated Care System development

During the last quarter of 2024/25 the Mid and South Essex Integrated Care Board were required, by NHS England, to develop a system wide Medium-Term Plan (MTP). This is a system-wide recovery programme set out across the next five years. This work provides a structured approach to overseeing both organisational and system level recovery projects and programmes. There are a number of workstreams within Mid and South Essex MTP that have interdependencies with the community hospital beds service changes outlined in this decision-making business case and will help to make services fit for the future, along with the decision made during this business case process. The detail of these workstreams can be found in 'Section 2: Models of Care- Our vision for the future'.

1.3.10.4. Community Capacity Programme Board

Whilst not a pertinent change, it should be noted that the Community Capacity Task Force overseeing the work programme during the pre-consultation stage of this work programme transitioned into the Community Capacity Programme Board, following the MSEICB Board's decision to progress to consultation in January 2024. The Community Capacity Programme Board was established to lead the work programme during consultation and then the progression of the work to decision making. The membership of the group was refreshed to ensure it had all relevant and necessary representation to support the work programme through consultation, decision making and, in the future, implementation of the recommendations within this DMBC, if approved by the MSEICB Board (see 'Section 11: Implementation' for more information).

1.3.11. Decision-Making Business Case and Summary of Recommendations

This DMBC has been informed by both the feedback and evidence received throughout the consultation and by the work and recommendations made by the Community Consultation Working Group.

This DMBC is written based on the proposals that we consulted on and set out in Table 1 below. The recommendations and rationale behind the recommendations are set out in section '10.3: Recommendations' of DMBC. Table 1 below outlines the original proposals, and the recommendations made within this DMBC.

Proposal	Recommendation
The future configuration and location of intermediate care and stroke rehabilitation community hospital beds within Mid and South Essex. Two options were consulted on- Option A and Option B. In Option A all community stroke rehabilitation beds	The recommendation is that Option B is supported.

are in one unit at Brentwood Community Hospital. In Option B community stroke rehabilitation beds are split, with 25 beds at Brentwood Community Hospital and 22 beds at Cumberlege Intermediate Care Centre (CICC).	
The proposal to permanently relocate the freestanding midwife-led birthing unit to the William Julien Courtauld Unit at St Michael's Health Centre.	The recommendation is that this proposal is supported.
The proposal to relocate ambulatory care services currently provided at St Peter's Hospital, Maldon.	The recommendation is that ambulatory care services are not relocated at this point in time and that services continue to be delivered from St Peter's Hospital for the short to medium term (0 to 5 years). In this time a long-term solution for a new Maldon Health Hub/replacement for St Peter's Hospital should be developed and delivered which will then see ambulatory care services relocated to a 'new' facility.

Table 1: DMBC proposals and recommendations

1.4. Case for change

1.4.1. National Evidence for Case for Change

Our case for change is based on clinical guidance and evidence from national bodies and studies, set out below, as well as local evidence and need set out in section '1.4.2 Our case for change in mid and south Essex'.

1.4.1.1 Community Intermediate Care Beds

Much of the evidence in support of intermediate care has been long-standing with the 'National Service Framework for Older People, Ageing and Age-associated Disease and Disability (2001)' being published as long ago as 2001'[2]. This document outlined the need for older people to have access to a range of intermediate care services at home or in designated care settings, to promote faster recovery from illness, prevent unnecessary acute hospital admissions, support timely discharge from acute hospitals and maximise independent living. In support of the evidence in the National Service Framework there has been more recent work to evaluate intermediate care in its various settings, which shows that:

1) Rehabilitation in a community hospital delivers better outcomes for those who are suitable for community-based care, than rehabilitation in acute settings. This is evidenced in a number of recent studies including:

[2] National service framework: older people - GOV.UK

1.1) The British Medical Journal (2017) 'Improving Access to intermediate care', David Oliver'[3] which evidenced that a 2015 audit had shown that 90% of the 12,000 patients studied, who received intermediate care in the community, demonstrated improved functional independence, with four in five returning home.

1.2) In PubMed Central (2005) 'The effects of locally based community hospital care on independence in older people undergoing rehabilitation: Randomised controlled trial' John Green et al' [4]compared the Nottingham extended daily living scores of 220 patients in Bradford who had transferred to community hospitals with those who remained in an acute hospital setting and found a statistically significant improvement in those being rehabilitated in community hospitals.

1.3) The National Audit of Intermediate Care (2015) [5] reported that 71% of patients having undergone 6 weeks of reablement care had an improved dependency score, showing the positive impact of community rehabilitation.

2) Community rehabilitation is now advancing and can be provided from a wider set of locations. Deciding what the most appropriate setting of care for supporting an individual in their recovery is key. A recent NHS England publication 'A New Community Rehabilitation and Reablement Model: Good Practice Guidance for Integrated Care Boards (2023)'[6] emphasised that intermediate care can be provided in many care settings, not just community hospitals. These include care homes with visiting therapy staff and most commonly, peoples' own homes, the aim being that 95% of people discharged from an acute hospital should return to their usual place of residence enabling achievement of the best possible health, well-being, and independence outcomes. It suggested that the workforce should be multidisciplinary and can be multi-agency, with care being therapy-led, directed by qualified therapists, and often provided by rehabilitation assistants working under direction. Making the right decision as to which care setting is most appropriate for an individual is crucial. If this is done, services are aligned and skills deployed in the most effective manner whether provided in the community hospital, a care home or at a person's place of residence.

3) Advice and guidance on provision of intermediate care capacity is continuing to evolve - any future capacity within mid and south Essex will need to be able to continue developing as guidance does. There has been plenty of advice beyond the National Service Framework as to the most effective means of undertaking intermediate care. For example, the 'National Guideline 74 (2017) National Institute for Health and Care Excellence (NICE)'[7] describes in detail optimal

[3] David Oliver: Improving access to intermediate care | The BMJ

[4] Effects of locality-based community hospital care on independence in older people needing rehabilitation: randomised controlled trial - PMC

[5] NAIC (2015), National Audit of Intermediate Care Summary Report, Assessing progress in services for older people aimed at maximising independence and reducing use of hospitals, published November, NHS Benchmarking Network, England.

[6] NHS England » A community rehabilitation and reablement model

[7] Overview | Intermediate care including reablement | Guidance | NICE

arrangements for all aspects of intermediate care which the mid and south Essex system takes into account when planning and reviewing services and care pathways.

4) National guidance, such as the 'Hospital Discharge Service Guidance (March 2020)' [8]has indicated that of the inpatients discharged from an acute hospital 50% should be able to go home without further reablement or support (Pathway 0), 45% may go home with some further support (Pathway 1), 4% are likely to need a community bed, which could be NHS or social care depending upon need (Pathway 2), and 1% will need to be accommodated where their needs can be met such as in a care or nursing home (Pathway 3). This is illustrated in the figure below:

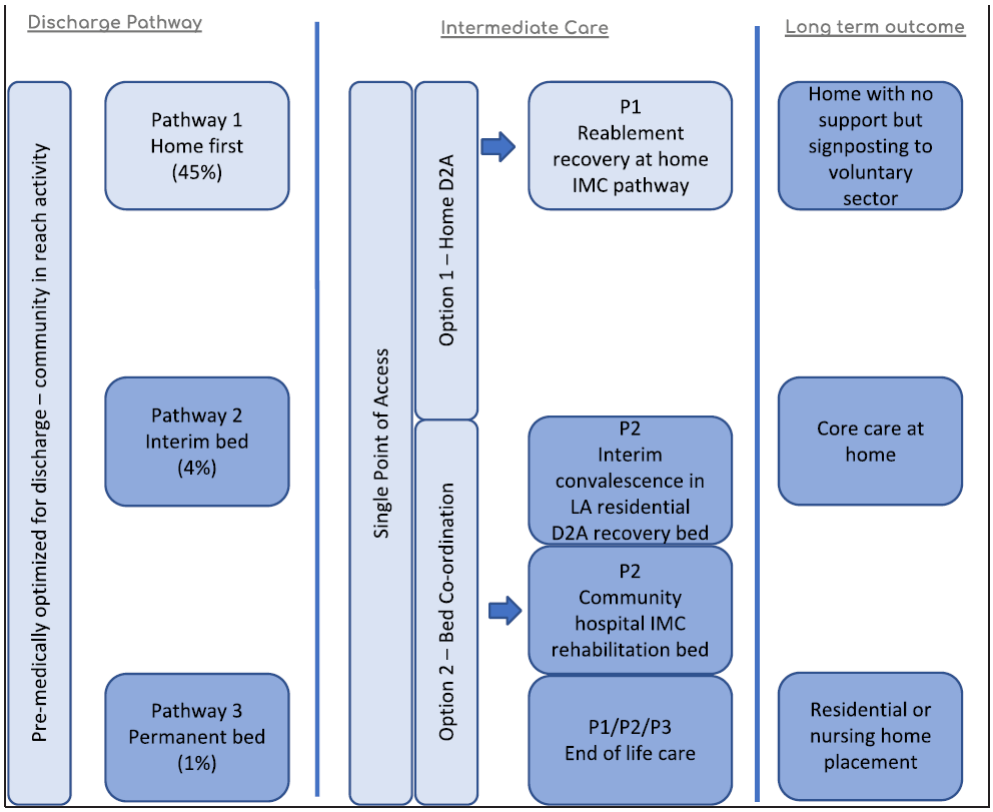

Figure 1: Intermediate Care Pathways for Patients

During the pause on the consultation and the discussions in the Community Consultation Working Group, further national evidence on the 'Home First Approach' and 'Discharge to Assess' was presented. The last few years have seen an emergence of guidance and national evidence suggesting that the home first approach is the model of care all health and care systems should be aspiring to. Mid and South Essex Integrated Care System are implementing these approaches and continue to work to review and improve pathways. Ensuring we have the right configuration of community inpatient beds in the right locations will support this work.

[8] COVID-19: Hospital discharge service requirements

NHS England's 'Hospital discharge and community support guidance', (January 2024)[9] sets out the 4 pathways under the discharge to assess model (see figure 2).

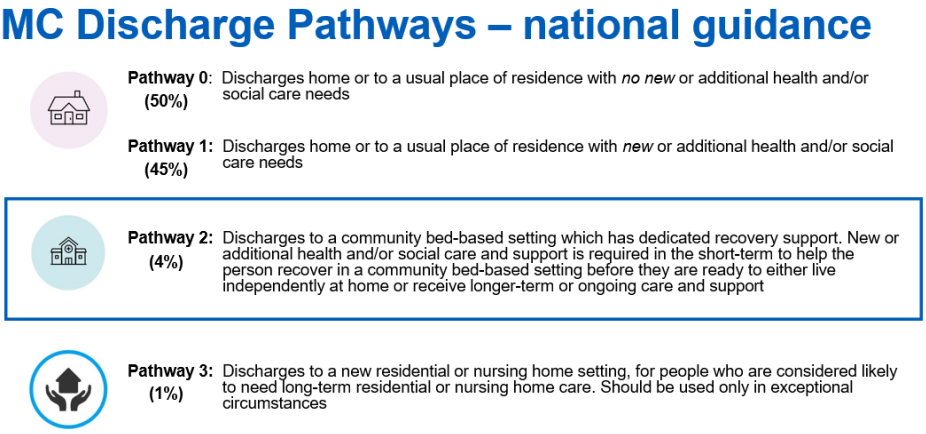

Figure 2: IMC Discharge Pathways - national guidance

The guidance states that 'introduced as best practice in 2016 by NHS England, the 'discharge to assess' (or D2A) model involves providing short-term care, rehabilitation and reablement, where needed, and then assessing people's longer-term needs for care and support once they've reached a point of optimal recovery. This may be in people's homes or using 'step-down' beds to support the transition from hospital to home. This means that people do not wait unnecessarily in hospital where there is a higher risk of acquiring infections or deconditioning. Assessing people out of hospital in the most appropriate setting, and at the right time for them, supports people's independence and long-term outcomes, reduces discharge delays and improves patient flow'.

5) In NHS England's improving hospital discharge guidance 'Reducing long stays: Where best next campaign (2019)'[10], under 'Principle 5: Encourage a supported 'Home First' approach' they state that 'implementing a discharge to assess model where going home is the default pathway (with alternative pathways for people who cannot go straight home) is more than good practice – it is the right thing to do'.

1.4.1.2. Community Stroke Rehabilitation Beds

The 'National Clinical Guideline for Stroke for the United Kingdom and Ireland (2023)'[11] sets out the evidence in support of effective rehabilitation, emphasising the need for clinical leadership and concentrating available skills in stroke rehabilitation units.

The guidance recommends that rehabilitation should be needs based and not time limited. A major change in the guidance was a shift in the intensity of rehabilitation

[9] Hospital discharge and community support guidance - GOV.UK
[10] NHS England » Principle 5: Encourage a supported 'Home First' approach
[11] National Clinical Guideline for Stroke

recommending an increase in therapy per patient from 45 minutes per day to 3 hours per day for at least 5 out of every 7 days. The National Guideline cited international evidence in support of the argument that the increase in intensity had significantly improved outcomes. While it is likely that it will take some time for health systems to adjust to these new demands it is something for systems to work towards. The National Guideline also proposes specific levels of staffing for stroke rehabilitation units (SRUs). The evidence is that concentrating expertise and resources to provide intensive rehabilitation is more likely to achieve a better result for the patient. Ensuring that service reconfiguration through this DMBC gives us the right capacity to support those needing stroke rehabilitation in a community bedded setting will support the future work that is needed to meet national guidance and give flexibility to keep evolving in line with guidance.

1.4.1.3 Freestanding Midwife Led Birthing Unit

Evidence shows that midwife-led services lead to better outcomes for women at low risk of developing intrapartum complications. The 'British Medical Journal - Birthplace in England study (2012)'[12] was a large cohort study that compared outcomes for births in different settings. The study found that for women at low risk of complications in birth, birth is as safe for babies in freestanding midwife-led units (FMUs) or alongside midwifery units (AMUs) as it is in obstetric units, but with a lower rate of intervention and a decreased use of pain relief. It has also been demonstrated that planning to give birth outside an obstetric unit is more cost-effective for the NHS than planning to give birth in an obstetric unit.

'Better Births: Improving Outcomes for Maternity Services in England – A Five Year Forward View for Maternity Care (2016)'[13] emphasised the need for personalised, safe, and family-friendly maternity care, including increased choice and access to midwife led birthing units. Continuing to offer the freestanding midwife led birthing unit in mid and south Essex supports this guidance and strengthens choice for women and birthing people across mid and south Essex.

1.4.1.4 Ambulatory Care Services

Increasing demand and the backlog caused by Covid-19 has focused national attention on ambulatory services such as outpatient services and diagnostic services. Long waits for appointments, together with the need to achieve cancer targets, has led to a series of national guidance documents on supporting service recovery. These include initiatives such as adopting patient-initiated follow-up, introducing digital solutions, and achieving the policy aim of reducing health inequalities.

The 'NHS Long Term Plan (2019)'[14] first set out the intent and this has been followed by a Delivery Plan for tackling the Covid-19 backlog of elective care and principles and approach to deliver a 'personalised outpatient model. Information can be found

[12] Perinatal and maternal outcomes by planned place of birth for healthy women with low risk pregnancies: the Birthplace in England national prospective cohort study | The BMJ

[13] NHS England » Better Births: Improving outcomes of maternity services in England – A Five Year Forward View for maternity care

[14] NHS Long Term Plan v1.2 August 2019

in the guidance on 'Delivering a personalised outpatient model (2022)'[15] together with toolkits and advice on transforming ambulatory services. This information is used to inform improvements in outpatient services across mid and south Essex.

Since the publication of the pre-consultation business case NHS England have published new guidance on elective care recovery which includes outpatients and diagnostics - 'Reforming Elective Care for Patients' (January 2025)[16]'. This builds on the work and guidance mentioned above and has four focus areas to support improvements in elective waiting times:

- Empowering patients by giving them more choice and control, and by establishing the standards they can expect to make their experience of planned NHS care as smooth, supportive and convenient as possible.
- Reforming delivery of services and care by working more productively, consistently, and in many cases differently, to deliver more elective care.
- Delivering care in the right place to make sure patients receive their care from skilled healthcare professionals in the right setting.
- Aligning funding, performance oversight and delivery standards, with clear responsibilities and incentives for reform, robust and regular oversight of performance, and clear expectations for how elective care will be delivered at a local level.

For ambulatory care services this means transforming the way services are delivered by reducing outpatient follow-up appointments of lower value to patients and clinicians, increasing remote consultations and remote monitoring to deliver more personalised and productive outpatient care, significantly increasing the uptake of patient-initiated follow-up (PIFU), supported by technology to help with things such as enhanced identification of suitable patients for PIFU by using AI and automation.

1.4.2. Our Case for Change in Mid and South Essex

This section sets out the case for change community hospital-based services in mid and south Essex (MSE). It takes account of the future needs of the local population of MSE, and national clinical guidance and studies as set out above. It also considers the Mid and South Essex Integrated Care System's (MSEICS) current financial position, the current estate where services are delivered from, our workforce and the views and feedback received from staff, patients and the public, all of which have a local bearing on how services can be delivered in the future.

The issues of the community bed clinical model and distribution have been under consideration since 2019, primarily due to quality, capacity and estate issues. In 2023, it became clear through the work of the Community Capacity Task Force (CCTF) that mid and south Essex needs more community beds for patients who need stroke rehabilitation support. It also became clear that parts of the building at St Peter's Hospital were deteriorating to a point that they were no longer safe in their current form, and not sustainable as a location for inpatient clinical care or staff to work in, and therefore changes needed to be made.

[15] B1388_i_principles-and-approach-to-deliver-a-personalised-outpatient-model_300322.pdf

[16] NHS England » Reforming elective care for patients

Collectively, through the proposals set out in the consultation, the aim is to ensure that the mid and south Essex health system can deliver the following for community hospital services across MSE:

- High quality services
- Services that are fit for now and for the future
- Services that are affordable and give value for money
- Services that meet the needs of the local population

1.4.3. Our Case for change for Community Intermediate Care and Stroke Rehabilitation Beds

1.4.3.1. Strategy

Demand and Capacity: Community Hospital Inpatient Beds

There is an identified need within mid and south Essex (MSE) to respond to the increasing demand for care. Demand for acute hospital treatment and care has been increasing principally because the total population of MSE has been growing. The most pronounced increase has occurred in the age groups of those 75 and over. This older population often have multiple ailments and need a longer time and more help to recover from an acute episode of illness. They are the principal users of community hospital beds where they benefit from a programme of rehabilitation in what is described as 'intermediate care'. The other significant users of community beds are patients undergoing rehabilitation after a period in an acute stroke unit. Some of these patients will be younger than patients in intermediate care beds. Annually around 2,080 people - 0.17% of the population in MSE- require access to a community intermediate care bed, and 500 people - 0.04% of the population in MSE- require access to a community stroke rehabilitation bed.

Demand and Capacity: Community Stroke Rehabilitation Beds

A key component of the case for change underpinning this work is the need to increase the number of community inpatient stroke beds within MSE. Modelling of community stroke beds in MSE showed that, based on national guidance, not only have there been too few stroke rehabilitation beds in community hospitals across MSE, but patients undergoing rehabilitation have continued to occupy beds in acute hospitals, because of the lack of community beds, which increases their risk of hospital acquired infection and is a less favourable therapeutic environment for recovery. Based on the following assumptions, MSE would ideally require 44-48 stroke rehabilitation beds (increasing to 47-51 if an additional three beds are included to support level 3a neurorehabilitation patients):

- 23% of acute stroke admissions requiring rehabilitation in a community stroke rehab bed (taken from MSE audit and modelling data), equalling 500+ admissions per year for community stroke rehabilitation.
- The target population is to increase by 8.59% in the next five years.
- An average length of stay of 27 days.
- Assumed community stroke rehabilitation bed occupancy of 95%.

The figure of 47-51 beds is also supported by the MSE Stroke Stewards (a group of experts in this field, from a range of organisations and in a range of roles across Mid and South Essex Integrated Care System). The assumption is that increasing the number of beds available will enable all suitable patients to be treated in community stroke rehabilitation beds, with the expertise available from dedicated staff, and decreasing the risk of infection from staying in an acute bed longer than necessary.

There are currently (as of October 2023 when temporary changes took place) 39 stroke rehabilitation beds provided across MSE, located at Brentwood Community Hospital (25 stroke rehabilitation beds) and the Cumberlege Intermediate Care Centre at Rochford Community Hospital (14 stroke rehabilitation beds). An audit of stroke rehabilitation patients in MSE undertaken in September of 2023 highlighted the limitations of the current structure of the service and the need for change. It showed that while most community hospital stroke rehabilitation beds were being appropriately used, stroke patients in acute hospitals needing rehabilitation were often awaiting referral and transfer. Others were also found to be 'outliers' on non-stroke wards in the acute hospitals across MSE. Details of the audit are available in Appendix 5.

Increasing the number of community stroke rehabilitation beds will allow for the right patients to be treated at the right time and in the right place, therefore improving patient outcomes and reducing the number of patients being cared for in an inappropriate setting which is not conducive to best meeting their needs and leaves them at risk of hospital acquired infections.

Demand and Capacity: Community Intermediate Care Beds

Reviewing the community stroke rehabilitation bed need led to a review of community intermediate care bed capacity, to enable the system to understand the need for community beds in totality rather than looking at community stroke beds in isolation.

The number of community intermediate care beds required now, and in the future, had not previously been systematically modelled on an MSE footprint until this work programme commenced. Modelling of intermediate care beds undertaken by the CCTF (see Appendix 6) showed that MSE requires between 87-99 community intermediate care beds based on the following assumptions:

- 4% of non-elective hospital discharges conform to national guidelines and are on 'Pathway 2'.
- The target population is to increase by 8.59% in the next five years.
- An average LOS (in line with national guidance) of 25.3 days.
- Assumed community intermediate care bed occupancy of 95%.
- Current Local Authority intermediate care capacity in each of Southend, Thurrock and Essex County Councils being appropriately used for Pathway 2 patients.

The modelled assumptions that 87-99 community intermediate care beds are required is a slight reduction on the current bed numbers (105 community intermediate care beds in the historic substantive model and 99 community

intermediate care beds in the temporary changes model (since October 2023). It is felt that the historic configuration of beds has not been optimally matched to the true community bedded inpatient rehabilitation needs of the population. It is anticipated that demand will reduce based on:

- Improving the variation in use of intermediate care beds (described below in section '1.4.3.2 [Quality] Clinical Case for change for Intermediate Care Beds')
- Reducing length of stay and better outcomes, based on the correct patients being in community intermediate care beds.
- Improving pathways of care outside the acute and community hospital setting and providing care closer to home.

During the six month pause in the decision-making process, the Community Consultation Working Group asked for intermediate care bed number requirements to be remodelled to look at the need for intermediate care beds in Maldon. The bed modelling was redone across the MSE footprint as part of this work and the following revised assumptions were used:

- 4% of non-elective hospital discharges conform to national guidelines and are on Pathway 2. Numbers were updated so they were based on 2024/25 actual demand and forecast outturn.
- The target population is to increase by 8.59% in the next five years.
- A target length of stay for intermediate care admissions of 21 days (based on Mid and South Essex Integrated Care System's target).
- Community intermediate care bed occupancy of 95%.
- Existing Local Authority commissioned IMC capacity in each of Southend, Thurrock and Essex County Councils being appropriately used for Pathway 2 patients.

The rationale for changing assumptions was to use the most up to date local data available in the system and to ensure assumptions were in line with local targets. The outcome of the refreshed modelling showed that the MSE health and care system require 86-93 intermediate care beds, so was in line with the original modelling and the intermediate care bed numbers in the options that we went out to consult on. See Appendix 7 for the detail of the information presented to the Community Consultation Working Group.

The Working Group also requested that information was presented on the demand for beds from Maldon district residents. Of the 86-93 requirement, Maldon residents were forecast to require 4 beds at any given point in time. The smallest possible functional unit would need to have 16 beds due to staffing ratios of 1:8 registered nurses.

Services that are Fit for the Future

It is key that when developing services and making any service changes we ensure that services meet patient needs now and are fit for the future to meet the future demands of the population of MSE.

The MSE health and care system must try and meet the evolving needs of the local population. The supply of community hospital beds is limited by the current premises, availability of a suitably skilled workforce and resources. It is neither possible nor desirable to keep building hospitals and putting people in institutionalised care if that can be avoided. Work to improve the overall pathway of care for intermediate care, stroke and discharge overall are all happening in MSE as part of ongoing transformation of services and will support the overall aims of the MSE system, as well as supporting the aims of this DMBC.

In line with national guidance MSE health and care system is working to develop their 'Home First' approach and ensure that wherever possible 'home' is the default pathway for patients, with alternative pathways, such as community beds, available for people who cannot go straight home. Recent development of virtual wards will help even more people receive support in their own place of residence. Transfer of Care Hubs are expected to promote optimal discharge to assess (D2A) performance, ensuring that patients enter the correct recovery pathway, enabling those admitted to community beds to have been accurately assessed as to their needs and referred without delay. This requires that clinical pathways are agreed and applied consistently.

It is recognised that delay in discharging patients adversely affects recovery, slows rehabilitation and can diminish people's ability to return home. In community intermediate care and stroke rehabilitation beds, active rehabilitation is required prior to the patient going to their place of residence. Housing large numbers of patients in community beds is not required and does not enable the best outcomes for this population. Effective use of the beds, provision of optimal home care services and community systems for early discharge, as well as close working with public and voluntary social care agencies, is necessarily the way forward. This promotes the improvement of population and system outcomes and is aligned to national best practice principles. In any event the underlying aim is to ensure that individuals, wherever possible, should be supported in their own home to support independence and wellbeing.

In dealing with the MSE focus on resolving health inequalities, the location of these facilities and their accessibility to populations in MSE is an important factor. Until now there has not been a clear picture as to how many community beds are needed in our health system, whether they are located in such a way as to meet the needs of the population served, whether they are suitable for the standard of care provided and whether the public purse is receiving the best possible value for every pound spent. This may need to be balanced against other equality factors such as the effectiveness of the services provided, and the patient outcomes achieved.

The work set out above is aligned with our clinical vision for the future and recognises that there are a number of interdependent workstreams that sit outside of this DMBC that will be pertinent to improving services and outcomes for patients in the future. These workstreams are aligned to the Mid and South Essex Medium Term Plan (MTP). More information can be found in section '1.4.4.4 Further work since the Pre-consultation Business Case' below. Ensuring we have the right beds, in the right place, and the right patients in them will support these wider workstreams

and will ensure the system is set up in such a way as to be able to make long term improvements in patient care.

Modelling for both stroke and intermediate care community beds has been undertaken and is set out in this DMBC. The modelling takes into account population growth, therefore ensuring we have the right number of beds for future demand.

Several of the current community bed settings have only been commissioned on a temporary basis, whilst work has been ongoing to review the future capacity, locations and configurations of community beds. This has reduced the ability to do effective service development and has also impacted staffing and recruitment as this has sometimes had to be done on a temporary or fixed term basis. By agreeing the locations and configuration of community beds for the foreseeable future, it is anticipated that the work highlighted throughout this section that needs to take place to optimise the use of community beds and outcomes for patients will be able to be realised due to more consistent staffing levels and the capacity for those staff to focus on these areas of work.

Relocating community beds to more appropriate, more modern estate will ensure services can function effectively in the future, and provide high quality, safe services for patients. It also gives consistency and clarity to staff about locations and configurations of community beds, which will improve the retention and recruitment of staff.

1.4.3.2. Quality

Clinical Case for change for Community Stroke Rehabilitation Beds

The 'National Stroke Service Model (2021)[17]' highlights that community inpatient stroke rehabilitation is an essential 'bridge' between acute and community rehabilitation for many people who have had a stroke. Community stroke rehabilitation beds are key for patients who are medically suitable to be discharged from an acute site, but who require intensive stroke specific rehabilitation which cannot be supported by Early Supported Discharge (ESD) services in the patient's own home.

Current arrangements in MSE are limited by a number of factors. Firstly, stroke rehabilitation bed capacity has historically been distributed across MSE, meaning there is no dedicated, ring-fenced inpatient stroke rehabilitation unit. The 'National Clinical Guideline for Stroke for the United Kingdom and Ireland (2023)' states that having a 'well-led, appropriately staffed and skilled multidisciplinary stroke unit is the cornerstone of holistic and comprehensive care for people who have had a stroke'. Developing a dedicated community stroke rehabilitation service on one, or at a maximum two sites, would align with best practice and national guidance. Having dedicated units will bring together specialist expertise, rather than these being spread across multiple units. The aim is that this will also allow for more sufficient intensity of rehabilitation for patients by these specialist staff being consolidated in one or two units, offering tangible benefits to patients in terms of outcomes.

[17] stroke-service-model-may-2021.pdf

There are currently an inadequate number of community stoke rehabilitation beds to meet demand now and projected future demand (set out in section '1.4.3.2 Demand and Capacity' above). Increasing the number of beds available will enable all suitable patients to be treated in community stroke rehabilitation beds, with the expertise available from dedicated staff, improving patient outcomes and decreasing the risk of infection from staying in an acute hospital bed longer than necessary.

There is variation in the provision of inpatient community stroke rehabilitation services across MSE, with an audit completed in September 2023 showing that some stroke patients who needed community rehabilitation were left in acute beds whilst waiting for referral and transfer to a community stroke bed. This is, in part, a legacy from available capacity and approaches across predecessor organisations. Alongside ensuring there are sufficient community stroke rehabilitation beds to serve the population of MSE, there is a need for the system to standardise clinical referral pathways from the acute hospitals and the provision of care in the community. This will ensure that there is consistency in support for patients who are best served by specialised stroke community rehabilitation units and for those who receive stroke rehabilitation or support in their own homes. This will both ensure care is delivered in the most appropriate setting for an individual and reduce inequity across the system.

It is recognised that intensive therapy for those receiving stroke rehabilitation in the community in MSE is not currently provided at the level recommended in NICE guidelines 'Stroke rehabilitation for adults (2023)[18]' and the 'National Clinical Guideline for Stroke for the United Kingdom and Ireland (2023)'. The guidance recommends that rehabilitation should be needs based and not time limited and proposes an increase in the amount of therapy patients would benefit from, citing international evidence supporting the approach. Increasing capacity for community stroke rehabilitation beds would provide additional capacity to do this and allow services in MSE to develop specialised skills and the necessary staffing levels to move towards a model that is closer to meeting the guidelines over time, improving outcomes for patients.

Finally, there is a requirement for a clear 'slow stream' rehabilitation pathway for patients who need longer term support (for example those with slower recovery or complex needs) and having an increased number of beds, in appropriate care settings, with dedicated staff, will allow for this model to start to be implemented across MSE.

Development of one or two dedicated stroke rehabilitation unit(s) together with agreed, standardised clinical pathways ensures we have the right bed capacity to best serve the population and creates the opportunity to cease the inappropriate use of beds in acute hospital sites for stroke rehabilitation, conforming more closely to the National Clinical Guidelines for Stroke.

System partners are working collaboratively to improve the discharge pathway across MSE, as outlined above and in section '2.2 Our vision for the future of community hospital services in mid and south Essex', so that patients are discharged

[18] stroke-service-model-may-2021.pdf

into the place that is most suitable to support their recovery and a return to their home as quickly and safely as possible. Whilst this work is not part of the scope of the DMBC, having agreed permanent locations and configurations of stroke beds will support in the development of these pathways, by giving staff and service leads more certainty and capacity to implement changes.

Clinical Case for change for Neuro-rehabilitation Beds

Currently there are no Level 3 neuro-rehabilitation beds permanently commissioned in MSE for people with neuro-rehabilitation needs that are not related to stroke, with beds being spot purchased as needed. This means patients requiring neuro-rehabilitation may end up with alternative care packages, including more expensive Level 2b beds, which are delivered by providers outside the boundaries of MSE, or support at home from local community teams.

Development of more extensive stroke rehabilitation facilities, especially where the beds are consolidated, creates the opportunity for those needing Level 3 neuro-rehabilitation to be cared for in dedicated community stroke rehabilitation units. Under this model, patients needing Level 3 neuro-rehabilitation may be treated by local specialist rehabilitation teams with the aims of restoring function and independence, benefiting from therapy and nursing teams with specialist expertise led by consultants in specialties such as stroke and neurology.

Clinical Case for change for Community Intermediate Care Beds

There are several drivers for change for community intermediate care beds in MSE, and these are informed by national guidance on intermediate care, and clinical studies or 'deep dives' that were carried out by the MSE health system in 2019 and 2020 to 2022.

A clinical audit in 2021 found that outcomes for intermediate care patients in MSE were below the National Audit of Intermediate Care benchmark for those improving or at least maintaining function. The table below illustrates the use of intermediate care beds in MSE and that patient selection for them needs to change.

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

Figure 3: Extract from 2021 Clinical Audit Reviewing NAIC Benchmarking agent MSE's IMC Bed Levels

Firstly, the number of NHS community intermediate care beds required now and, in the future, has not previously been systematically modelled on an MSE footprint until now. Section '1.4.3.1 [Strategy] Demand and Capacity- Community Intermediate Care Beds' above gives more detail on this. It sets out the modelling on future demand for intermediate care beds, which takes account of expected population changes and growth and improvements in the overall care pathway. Having the right

number of beds will ensure those needing an intermediate care bed are able to access one and will reduce spending longer than necessary in an acute hospital setting and will improve outcomes for patients.

Secondly, across MSE there is unwarranted variation in the demand for and use of intermediate care beds which cannot be explained by differences in patient population demographics, acute trust volume flows, or needs. There is variation in the way intermediate care beds are used (cohorts of patients), numbers of patients accessing beds, access criteria, and staffing levels. This is, in part, due to MSE being a relatively recent construct as a health economy which includes a wide range of providers.

This variation means that intermediate care pathways across MSE are not being fully optimised, and patients are not always ending up in the 'right' or 'best' place for them and beds may be used for patients who might be best served in a different setting. This may be contributing to outcomes for patients in intermediate care beds in MSE, demonstrating a poorer than national average performance (see table above).

A 2023 audit of intermediate care beds in MSE found that 76% of intermediate care patients in community hospitals were on the correct pathway for their needs, which is positive and is expected to improve outcomes. However, there is scope to further improve overall outcomes for patients across the intermediate care pathway.

System partners are working collaboratively to improve the discharge pathway across MSE so that patients are discharged into the place that is most suitable to support their recovery and a return to their home as quickly and safely as possible. Whilst this work, which includes use of discharge to assess (D2A) and Transfer of Care Hubs, is not part of the scope of the DMBC, having agreed permanent locations and configurations for intermediate care beds will support in the development of these pathways, by giving staff and service leads more certainty and capacity to implement changes.

Safe environment for care

The Section '1.4.6 [Case for Change] Estates' gives an overview of the St Peter's Hospital site and outlines the ongoing concerns with the site. This section relates to St Peter's Hospital as a whole, and therefore all services delivered from St Peter's Hospital, including community inpatient beds.

Specific issues with the St Peter's Hospital estate were one of the reasons why the decision was taken to transfer inpatient services from the site prior to winter 2023/24, and the reasons why the St Peter's Hospital site was not included in the shortlist of options for the future locations of community beds-

- The lift to the second floor, where community beds were situated, had for some time been an issue due to it frequently breaking down.
- The frequently broken lift increased the risk that people with limited mobility could not easily be evacuated from the second floor of the main building if needed, causing a safety issue for both patients and staff.

- The number of inpatient beds (stroke rehabilitation beds) was reduced to 16 as a result of issues with the estate, in particular the lift. 16 beds was identified as the maximum number of beds that could be accommodated safely to try and limit the number of patients and visitors using the lift on a daily basis.
- During heavy rain, the main building is prone to flooding with accompanying electrical and fire risks, creating an unsafe environment for both patients and staff.
- There had previously been issues with the floor loading and maximum weight it could take, but this had been repaired.

The issues outlined above mean the St Peter's Hospital site is no longer suitable, or safe, to be used for the provision of inpatient community beds.

Sustainable workforce: Community Hospital Inpatient Beds

The challenges faced within the community workforce in MSE are not unique. Across the NHS there are many vacant posts for skilled staff and competition for their services. There are not enough trained staff to fill all the jobs, so there is competition from hospitals in other areas for people with the right skills and qualifications.

In MSE these challenges have been aggravated by the adjustments made to the distribution of beds during and after the Covid-19 pandemic, and the temporary changes necessary for winter 2023/24, leading to uncertainty as to whether community hospital beds would be further reconfigured. In turn this meant that some posts were believed to be less attractive as job offers had to be made on a temporary or 'fixed term' basis until permanent solutions were agreed- one of the aims of this DMBC.

This uncertainty has led to the use of significant agency staff, who cannot sustain continuity of care, or the use of the staff bank. In both instances the cost of staffing units increases, putting pressure on NHS expenditure.

Retention and recruitment of staff is often hindered by the fact we are close to London. NHS staff employed on Agenda for Change receive an additional 'Higher Cost Area Supplements' (HCAS) payment (see NHS Employers Pay Scales for 2025/26[19]), accounting for the increasing costs of living in the capital. Whilst the outer HCAS is available in some areas of Essex, local residents can easily travel into London for work to earn higher wages for the same job. The jobs we have in our area must therefore be professionally and personally attractive, if we are to compete.

Greater certainty about the future location and configuration of community hospital beds is expected to support recruitment and retention of staff. A community bed configuration that is more permanent is expected to make available jobs more attractive to potential recruits and help to retain existing members of the workforce. This should also reduce the reliance on costly temporary staff.

[19] Pay scales for 2025/26 | NHS Employers

The consultation proposals suggest moving beds out of estate that is no longer fit for purpose and can cause significant issues for staff when trying to maintain high quality care for patients. The proposals mean that community inpatient beds will be in facilities that provide much better estate and conditions, which are able to support the delivery of high-quality care in good working environments. This is intended to influence recruitment and retention, which in turn will reduce rates of vacancies and the need to use agency and bank staff.

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

Sustainable Workforce: Community Stroke Rehabilitation Beds

It is expected that developing community Stroke Rehabilitation Units (SRUs) for community stroke beds (as the potential options in the consultation propose), that conform more closely to the National Guidelines, will be more attractive to potential recruits to the range of professionals required for the service. Consolidating the service to one or two sites should help to retain trained health professionals, especially where services are considered to be excellent, which we hope the SRUs in MSE will be over time.

Sustainable Workforce: Community Intermediate Care Beds

The principal gap in the current staffing model is the absence of 7-day therapy across all wards. Establishing a level of staffing that is safe and likely to lead to the best possible outcomes for patients, in addition to developing a consistent model for the system is a priority, which must be balanced by affordability. Agreeing the future location and configuration of intermediate care beds will support the system in delivering this ask and retaining and attracting staff.

1.4.3.3. Financial Impact and affordability

It is important to note that the Mid and South Essex Integrated Care System (MSEICS) is operating at a financial deficit, and significant efforts are underway to reduce, and ultimately eliminate the deficit. Part of that work includes improving patient flow from acute settings out into the community and home. Whilst finances were not a key driver for change within our case for change, consultation and associated business cases, the MSEISC has a duty to ensure that any service changes are affordable and offer value for money and cost effectiveness. Therefore, finances needed to be considered as part of the consultation and decision-making process.

Rationalising the community bed capacity, including intermediate care and stroke rehabilitation beds, is a key part of improving patient flow from acute settings out into the community and home. With the financial pressures faced, these changes are expected to be at least cost neutral, for both revenue and capital. All changes in Provider revenue expenditure patterns will be reflected as corresponding changes in income flow and will be transacted via the MSEICB.

1.4.3.4. Further work since the Pre-Consultation Business Case

During the last quarter of 2024/25 the MSEICB were required, by NHS England, to develop a system-wide Medium-Term Plan (MTP). This is a system-wide recovery programme set out across the next five years. This work provides a structured approach to overseeing both organisational and system level recovery projects and programmes. There are a number of workstreams within the MTP that have interdependencies with the community hospital beds service changes outlined in this DMBC and will help to make services fit for the future, along with the decision made during this business case process. The detail of these workstreams can be found in section '2.2 Our vision for the future of community hospital services in mid and south Essex'. The delivery of these workstreams is vital in resetting our health and care system and making a decision on the future location and configuration of beds will enable these work streams to be delivered by ensuring we have the right bedded community capacity and care available for patients, improving flow through our health system, and allowing permanency of staff who can support in the delivery of improved pathways.

1.4.4. Freestanding Midwife- Led Birthing Unit

1.4.4.1. Strategy

The community beds case for change has an unintended, but significant knock-on impact on the freestanding midwife-led birthing unit at St Peter's Hospital. The Community Capacity Task Force (CCTF) recognised that moving the inpatient beds from St Peter's Hospital would leave the midwife-led birthing unit isolated. There were concerns about safety out of hours once on-site services for inpatient community beds were removed from the site. For this reason, given that the options for community beds do not include an option for beds to remain at St Peter's Hospital, it is also proposed that the midlife-led birthing unit at St Peter's Hospital be permanently relocated to the William Julien Courtauld (WJC) Unit, St Michael's Health Centre, Braintree.

Demand and Capacity

The St Peter's Hospital freestanding midwife-led birthing unit (MLBU) in Maldon has afforded women and birthing people who have low risk pregnancies the choice to have a birth without the expectation of intervention.

Historically, there have been freestanding community birthing units at St Peter's Hospital, Maldon and WJC Unit, Braintree. WJC closed in August 2021 and had not been operational since, until recently, when temporary changes were made for winter 2023/24. Between August 2021 and October 2023 (when temporary changes were made) only the freestanding MLBU at St Peter's Hospital was operational due in part to limited demand (77 births in 2022/23), and in part because of lack of staffing due to shortages in midwives across MSE. The unit at St Peter's Hospital was subject to periodic closure due to lack of staff across the St Peter's Hospital site and the birthing units on the Broomfield Hospital site.

The capacity of birthing rooms at WJC is slightly reduced when compared to St Peter's Hospital. There are two less delivery rooms and five less postnatal beds. However, in recent years there has been a reduction in the number of people

choosing to give birth in mid Essex. Data taken from the most recent dashboard (calendar year of 2024) reports that births in mid Essex services over the 12-month period has decreased by 540 compared to the previous year. This is largely due to people from outside of the area now choosing to give birth in their local units. There has also been a change in the demographic of women and birthing people and there are now more complex births, including a higher rate of C-sections, and a higher rate of babies being born prematurely. This means that more births are required to take place in the main obstetric unit or for patients to remain in the main obstetric unit in their postnatal period, where obstetric and neonatal services are provided. Therefore, the historical delivery and postnatal bed capacity is not required.

There have historically been issues with the freestanding MLBU at St Peter's Hospital needing to close intermittently due to staffing issues. Through the process of the Community Consultation Working Group, further information was presented to the group on demand on maternity services. The information presented showed that there has now been an increase in midwifery staffing in MSE to the optimal level, however, due to a change in the demographic of maternity service users there is acknowledgement that the maternity population is becoming more complex and therefore require obstetric led care at Broomfield Hospital, where more midwives have also been required to support the increased and changing demand. Conversely this means that the number of midwives working in the MLBUs has needed to decrease.

By offering WJC and the Alongside Birthing Unit on the Broomfield site, women and birthing people are still afforded access to this type of service and choice in where they give birth. It also means there continues to be additional capacity in the system for births to happen outside of the acute units, relieving pressure at main obstetric units.

In addition, there is also further work being undertaken to improve the Home Birth services particularly in the Maldon area, an outcome of the Community Consultation Working Group.

To provide overnight staffing on the St Peter's Hospital site, in addition to WJC, would mean moving 2.6 whole time equivalent midwives and a further 2.6 wholetime equivalent maternity support workers from the main obstetric unit over to St Peter's Hospital site. This would not support the needs of the wider service and wider population. This reiterated the need for only one MLBU within the area, and as outlined below (see section 'Safe environment for care' below), the estate at WJC is more suitable and sustainable for the future.

Services that are Fit for the Future

Moving the freestanding MLBU into a modern estate, adjacent with other 24-hour services will enable the unit to operate from estate fit for the future. It will also allow for demand to be met as there is less likelihood of the unit having to close due to staffing issues. The modern estate is likely to be more attractive to staff, therefore improving staff retention and recruitment.

1.4.4.2. Quality

Clinical Case for change

Maternity Services in MLBUs offer women and birthing people with low-risk pregnancies the choice to give birth with minimum intervention. Each of the maternity units at Basildon, Broomfield and Southend Hospitals offer this facility co-located with obstetric units and no change to those arrangements is being considered. The scope of services being considered in this business case are therefore limited to freestanding midwife-led birthing units for the population of MSE.

MSE is committed to continuing to offer choice in accordance with the guidance provided in 'Better Births: Improving Outcomes for Maternity Services in England – A Five Year Forward View for Maternity Care (2017)'. The NHS England 'Three-Year Delivery Plan for Maternity and Neonatal Services (2023)[20]', places specific responsibilities on Integrated Care Systems and Integrated Care Boards to ensure that care is safe, personalised, more equitable, consistent and responsive. To provide additional maternity capacity and choice to women and birthing people in MSE, the decision was made to continue to have a freestanding MLBU, rather than move services to existing birthing units on the acute hospital sites at Basildon, Broomfield and Southend.

It is worth noting that in any MLBU, a number of patients are transferred from the unit to an acute hospital by dedicated ambulance during labour when there are complications. WJC is closer to Broomfield Hospital than St Peter's Hospital. This supports in the safer transfer and better outcomes, for parent and baby, when complications are experienced during labour. The reduced travel time for anyone needing to be transferred from the unit at WJC to Broomfield Hospital compared to the travel time from St Peter's Hospital to Broomfield Hospital, if complications arose, was felt to be beneficial to patients.

Over recent years, maternity services in MSE have seen a change in the demographic of maternity service users meaning that the maternity population is becoming more complex and therefore require more obstetric led care at the main hospital units. This includes a rising C Section rate and also a higher percentage of babies being born prematurely which often necessitates neonatal services. This is changing the clinical need of maternity services within MSE, with more staff and capacity needed in obstetric units as opposed to MLBUs, which are typically for lower risk, uncomplex births.

The proposal to move the freestanding MLBU from St Peter's Hospital to WJC will not change the current service model, but WJC offers more modern facilities and estate, and the expectation is the service will be able to be more consistently operational due to improved staffing, both of which should lead to better experience and outcomes for women and birthing people, babies and staff.

Safe environment for care

[20] NHS England » Three year delivery plan for maternity and neonatal services

The section '1.4.6 [Case for Change] Estates' gives an overview of the St Peter's Hospital site and outlines the ongoing concerns with the site. This section relates to St Peter's Hospital as a whole, and therefore all services delivered from St Peter's Hospital, including the freestanding MLBU.

Some of the issues highlighted in the section '1.4.4.2 Safe environment for care-Community Beds', such as the lift problems and risk, also impacted the freestanding MLBU at St Peter's hospital. This led to consideration of the safety of maintaining the MLBU at the hospital, as well as the service being left vulnerable in terms of security especially out of hours with no other 24-hour services on the site.

This is one of the reasons why the decision was made to temporarily move the freestanding MLBU from the St Peter's Hospital site to WJC for winter 2023/24 and one of the reasons why there was no option within the pre-consultation business case for services to remain at St Peter's Hospital in the future. It is felt it is no longer suitable, or safe, to be used for the provision of the freestanding MLBU.

Sustainable workforce

Having a freestanding MLBU in MSE offers staff the flexibility to work in a community environment. Staff engagement showed that midwives enjoy working within a community setting and in the context of a national shortage of midwives – removing options to work in low-risk community settings which are attractive to some could further compound vacancy rates and reliance on temporary staffing. Therefore, the option presented within the consultation to retain a freestanding MLBU is expected to support retention of staff and the recruitment of new staff who want to work in this type of setting.

Due to the difficulties in recruiting and retaining staff across the St Peter's Hospital site and the Broomfield Hospital site, the St Peter's Hospital MLBU has had to periodically close. One of the aims of relocating the service is to give greater workforce stability and elimination of the need to close the service because of staff shortages, which is expected to make roles more attractive and improve retention of staff.

Transferring the freestanding MLBU to the WJC Unit at St Michael's Health Centre, means there is a more modern estate available for services to be delivered from, with other 24-hour services on sight, ensuring a safe working environment for staff to deliver high quality services from.

Through the process of the Community Consultation Working Group, further information was presented to the group on demand on maternity services. A staffing review was undertaken in 2023 (Birth Rate Plus Tool). Best practice is to complete this review every three years as service needs are ever changing. A ratio of 1 midwife to every 24.6 births was calculated.This was calculated on a birth rate of 4410 (figures based on a three monthly average between September to November 2022). Following the identified decrease in births in the mid Essex area in the past 12 months and a change in the requirements of the service regarding clinical need, a local recalculation was undertaken of the staffing requirement in 2024. A reduction in

the overall midwifery staffing was therefore undertaken of six whole time equivalent posts (taken from the vacancy at the time).

As outlined above (section 1.4.4.1 [Strategy] Demand and Capacity) to provide overnight staffing on the St Peter's site, in addition to WJC, would mean moving 2.6 whole time equivalent midwives and a further 2.6 wholetime equivalent maternity support workers from the main obstetric unit over to St Peter's and this would not support the needs of the wider service. This reiterated the need for only one midwife led birthing unit within the area, to ensure safe staffing level can be maintained.

1.4.4.3 Financial Impact and affordability

As stated in section '1.4.3.3. Financial impact and affordability [Community inpatient beds)' above, it is important to note that the Mid and South Essex Integrated Care System is operating at a financial deficit, and significant efforts are underway to reduce, and ultimately eliminate, the deficit. Part of that work includes improving patient flow from acute settings out into the community and home. Whilst finances were not a key driver for change within our case for change, consultation and associated business cases, the Integrated Care System has a duty to ensure that any service changes are affordable and offer value for money and cost effectiveness, and therefore finances needed to be considered as part of the consultation and decision-making process.

Changes to the location of the freestanding midwife led birthing unit are expected to be cost neutral for both revenue and capital.

1.4.4.4 Further work since the Pre-Consultation Business Case

As outlined in the sections above, since the publication of the pre-consultation business case in January 2024, there has been a review of birth rates in mid Essex. A 'Birth Rate Plus' Review took place in 2023. This is a safer staffing tool that is nationally recognised for maternity services. Data taken from the most recent dashboard (calendar year of 2024) reported that births in Mid Essex services over the 12-month period decreased by 540. Much of this decrease is due to women and birthing people who live outside of the Mid Essex geographical location who previously attended Broomfield Hospital have returned to birthing at their local unit. Following the identified decrease in births in the Mid Essex area in the past 12 months and a change in the requirements of the service regarding clinical need, a local recalculation was undertaken of the staffing requirement. A reduction in the overall midwifery staffing was therefore undertaken of six whole time equivalent posts (taken from the vacancy at the time).

The review of births from January 2023 to December 2024 also showed that the C-section rate has significantly increased from just over 40% in January 2024 to 47% in December of the same year. There has also been a sustained increase in pre-term birth rates over the past two years (January 2023 to December 2024) moving from

below 6% to an average of 8% over the past two years. Reasons for this include more complex pregnancies now being supported through both maternal and foetal medicine services and changes in national guidance regarding timing of delivery.

With the increase in C-sections and pre-term births, the midwifery work force required in the obstetric unit needed to increase. Conversely this meant that the number of midwives working in MLBUs needed to decrease.

With the alongside Birthing Unit on the Broomfield site and the MLBU currently at WJC, women and birthing people in the mid Essex area are still afforded access to this type of service.

In addition, there is also further work being undertaken to improve the Home Birth services particularly in the Maldon area, an outcome of the Community Consultation Working Group.

1.4.5 Ambulatory Care Services

1.4.5.1 Strategy

Work undertaken by the Community Capacity Task force (CCTF) to understand the condition of the buildings at St Peter's Hospital in Maldon in regard to community beds and the freestanding midwife-led birthing unit led to further discussion on its suitability for any patient services. For this reason, the proposal to relocate ambulatory care services from St Peter's Hospital to other locations in Maldon was included within the pre-consultation business case, the public consultation and this DMBC.

Demand and Capacity

Over 80,000 ambulatory care appointments take place at St Peter's Hospital each year, including approximately 39,000 outpatient appointments. This includes around 8,000 outpatient appointments for the maternity service, with significant numbers for ophthalmology, therapy, and rheumatology attendances. Diagnostic services such as blood testing (approximately 37,000 appointments a year), X-ray (approximately 8,500 appointments year) and ultrasound (approximately 700 appointments a year), are also provided. Cherry Trees Therapy Centre on the St Peter's Hospital site also provides care for mental health patients.

The specialty distribution of outpatient attendances for services provided by Mid and South Essex Foundation Trust (MSEFT) and Mid and South Essex Community Collaborative (MSECC) is shown in Figure 4 and Figure 5 below. There were 19,000 outpatient appointments in St Peter's Hospital in 2022/23 for MSEFT and 20,000 for MSECC.

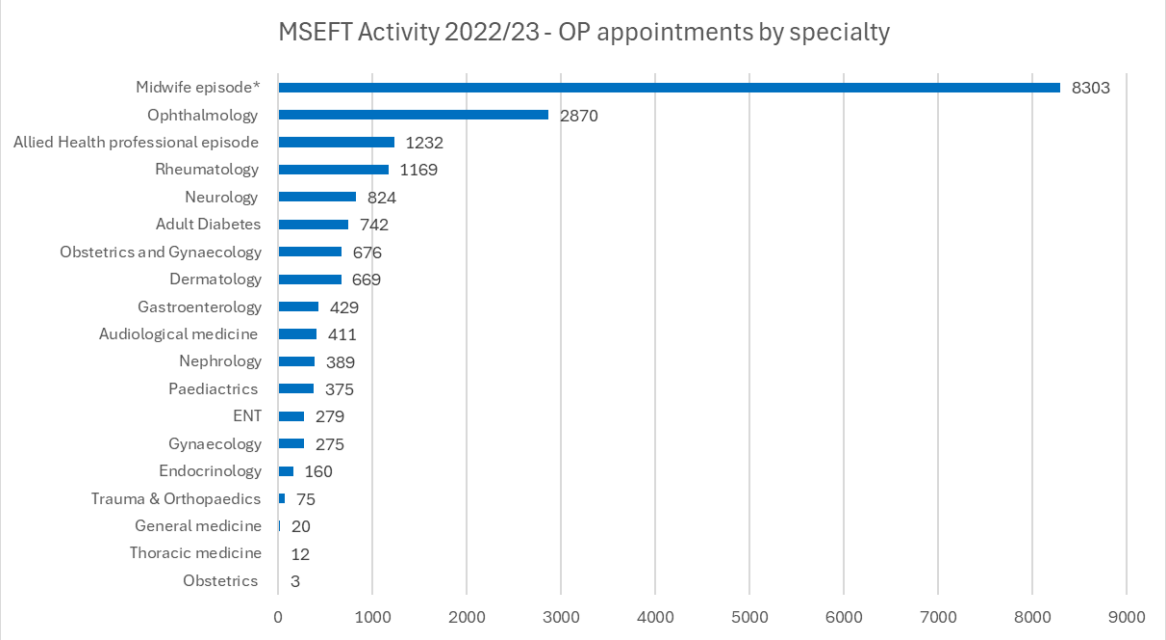

Figure 4: Outpatient Attendances (Mid and South Essex NHS Foundation Trust) by Specialty at St Peter's Hospital 2022/23

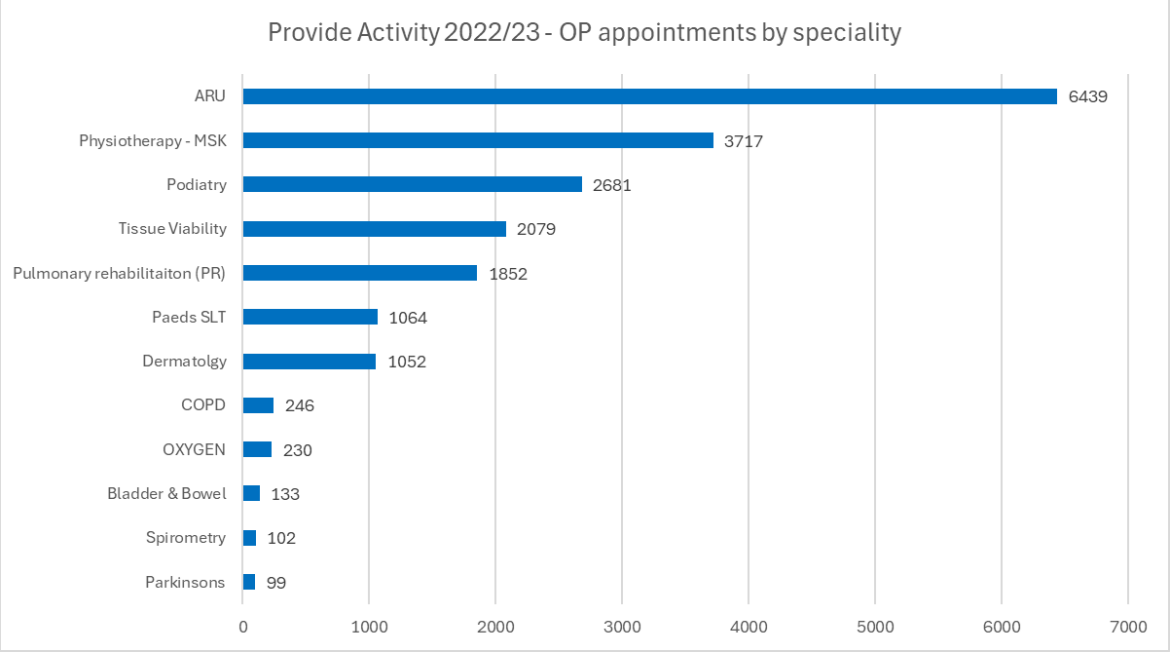

Figure 5: Outpatient Attendances (Mid and South Essex Community Collaborative) by Specialty at St Peter's Hospital 2022/23

The table below (Table 2) sets out all ambulatory care services currently being delivered from St Peter's Hospital.

Service currently provided on St Peter's Hospital site
Screen for abdominal aortic aneurysm (AAA)
Assessment and Rehab Unit (ARU)
Audiology
Bladder and Bowel
Mental health services provided in Cherry Trees
Cardiology
Catheter Clinic
Children's continence
Communication station initial assessments
Day Therapy
Dermatology
Diabetes
Dietetics
District Nursing
Endocrinology
Ear, nose and throat (ENT)
Gastroenterology
General Medicine
Long Covid
Maternity hub (antenatal and postnatal outpatients and classes)
Nephology
Neurology
Ophthalmology
Optometry
Orthopaedics
Orthoptics (surgical appliances)
Out-of-hours GP
Oxygen
Parkinson's
Phlebotomy
Physiotherapy
Podiatry
Pulmonary Rehabilitation
Radiology (X-ray)
Rheumatology
Speech and Language Therapy
Spirometry
Thoracic Medicine
Tissue Viability
Ultrasound
Unscheduled Therapy
Warfarin Clinics

Table 2: Table of Ambulatory Care Services currently provided on St Peter's Hospital site

The section '1.4.5.2 [Quality] Clinical case for change' below highlights some of the service changes planned in relation to outpatients and some specific outpatient specialties.

It is important to note that no recommendation within this DMBC will reduce the capacity of the existing ambulatory care services provided in Maldon.

All of the information above and below will need to be considered when deciding on the future of ambulatory care services in St Peter's Hospital, Maldon. This will be looked at as part of the process for developing options for the future location/s of services, dependent on the outcomes of the DMBC. The actual configuration of ambulatory care services will be undertaken working with the service users at St Peter's Hospital and the community in Maldon, as well as staff. This form of co-production is intended to reach the best possible solution, balancing clinical priorities with the need to ensure that ambulatory care services are accessible to the wider community.

Services Fit for the Future

For many years the NHS in mid and south Essex has recognised the need to move existing services from the current St Peter's Hospital site due to the age of the building and issues with the estate of the building. The need to develop sustainable, fit for purpose health care facilities in Maldon has resulted in numerous previous attempts to identify suitable options for a site to develop a Maldon Health Hub/replacement for St Peter's Hospital, which would provide the Maldon district with modern, and appropriate premises where health and wellbeing services are provided from.

Ensuring that services are fit for now and for the future and meet the future demands of the population of MSE will be part of the ongoing work to develop long term options for the delivery of ambulatory care services within the Maldon area and a replacement for St Peter's Hospital.

1.4.5.2. Quality

Clinical Case for Change

The CCTF and associated clinical Subgroup reviewed all ambulatory care services and suggested where services were best aligned to be delivered from in the future. The group agreed that the majority of ambulatory care services should remain local to Maldon, for example, the maternity pre and post-natal appointments (where co-location with other clinical services is not required), therapy services, nurse-led clinics, mental health services and blood testing to ensure that local residents have access to services which are best provided locally. However, they did note some services may be best co-located with other services and suggested this should be explored further when proposals for future locations were being reviewed. The table below (Table 3) sets out the CCTF's suggestions on where some current services could be best co-located in the future.

Service currently provided on St Peter's Hospital site	**Proposed future co-location**
Orthopaedics Rheumatology	Co-located with radiology services

Radiology and Ultrasound	Maldon or Braintree Community Hospital
Ophthalmology	Maldon or Diagnostic Hub

Table 3: CCTF's suggestions on where some current services could be best co-located in the future

The growing demand for outpatient services and the backlog caused by Covid- 19 has led NHS England to develop a new strategy for outpatient services, recognising that outpatient attendance represents the highest volume of NHS provision. Even before the pandemic the 'NHS Long Term Plan (2019)' had set out the need to transform the approach to ambulatory care services. The NHS is looking to rebalance outpatient capacity. There is an expectation that MSEICS reduces follow up appointments by 25%, to create capacity for more first outpatient appointments. This is significant for the services at St Peter's Hospital since the majority of visits are currently outpatient follow up appointments, as opposed to first appointments.

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

The NHS is seeking to provide elective services where possible in sites other than acute hospitals where the demand for diagnostics, treatments and beds is at its most extreme. In MSE, Braintree Community Hospital is designated to provide orthopaedic services suggesting that in future orthopaedic and possibly rheumatology outpatient services might be better co-located there.

MSEICS is also exploring options for an ophthalmic diagnostic 'hub' which would be able to offer extensive ophthalmic diagnostic services for the population of MSE. Community Diagnostic Centres, which provide a range of endoscopy and imaging modalities, are also being developed, such as the one at Braintree Community Hospital.

The new guidance published in January 2025- 'Reforming elective care for patients sets out a number of ways the NHS is expected to improve and transform outpatient appointments (see section '1.4.1.4 [National evidence for case for change] Ambulatory Care Services' above). This will impact on the way services are delivered and may in time impact on the ambulatory care services delivered in Maldon.

The use of technologies such as video consultation and remote monitoring are not part of this DMBC, but they and related technologies will reduce the need for face-to-face assessment and enable patients to determine whether they need a follow up appointment and will also change the ability of patients to communicate with clinicians. This will have a significant impact upon the provision of ambulatory and

other services in the future. The DMBC does not attempt to speculate upon the extent of the changes this will cause, but further work at a national level and at pilot sites is continuing to illustrate the way forward for the wider NHS.

However, no decisions have been made through this DMBC as to the clinical models for ambulatory care services and there is no suggestion that the delivery of services will change at this point in time. All of the information above will need to be considered when deciding on the long-term future of ambulatory care services in Maldon. This will be looked at as part of the process for developing options for the future location/s of services, dependent on the outcomes of the DMBC.

Safe environment for care

The section '1.4.6 [Case for Change] Estates' gives an overview of the St Peter's Hospital site and outlines the ongoing concerns with the site. This section relates to St Peter's Hospital as a whole, and therefore all services delivered from St Peter's Hospital, including ambulatory care services.

Outpatient and diagnostic community services continue to be provided at St Peter's Hospital. Due to issues with the estate, all ambulatory care services were relocated to the ground floor of the main building, which is least affected by the issues described, enabling services to continue in a safer environment for patients and staff.

The risks and challenges of the St Peter's Hospital estate, and the age of the building, make it prohibitively expensive to bring it up to date to meet technical health building notes standards and guidance (Health Building Notes standards). This led to the conclusion that alternative local facilities would be required in the medium term as the existing estate at St Peter's Hospital is not sustainable over the longer term for the delivery of ambulatory care services. It is for this reasons that the consultation asked for people's views on relocating services from St Peter's Hospital and asked for suggestions for alternative locations within Maldon.

Sustainable workforce

It is anticipated that creating a long-term solution for ambulatory services within Maldon will support the development of sustainable services in the area, which is turn is likely to support retention of current staff and attract new and local staff, particularly where new locations for services are modern and create a hub for the local community.

Supporting and developing the workforce needed for ambulatory care services will need to form part of the ongoing development work for any new locations and developing the long-term plan for ambulatory care services in Maldon.

1.4.5.3. Financial Impact and affordability

As stated in section '1.4.3.3. Financial impact and affordability [Community inpatient beds]' above, it is important to note that the MSEICS is operating at a financial deficit, and significant efforts are underway to reduce, and ultimately eliminate the deficit. Part of that work includes improving patient flow from acute settings out into

the community and home. Whilst finances were not a key driver for change within our case for change, consultation and associated business cases, MSEICS has a duty to ensure that any service changes are affordable and offer value for money and cost effectiveness, and therefore finances needed to be considered as part of the consultation and decision-making process.

St Peter's Hospital is an ageing site with significant backlog maintenance investment required. To keep St Peter's Hospital open would necessitate significant backlog maintenance and other capital investment required to bring the site back up to the required standard for the delivery of NHS services.

Any new location for ambulatory care services in Maldon would also likely require capital investment. Until a new site is identified it is not known what the capital investment requirements are likely to be, and the impact on revenue costs is also unknown. Therefore, further work will be needed to review financial affordability of any changes proposed to the delivery of ambulatory care services once any future site has been identified. This will be dependent on the outcomes of the consultation and subsequent decision-making.

If the decision was to be made not to relocate ambulatory care services from the St Peter's Hospital site, then a review of necessary capital investment needed to ensure the safe delivery of services from the site until there is a long-term solution for a future Maldon Health Hub/replacement for St Peter's Hospital would need to be undertaken.

1.4.6. Estates

The St Peter's Hospital site was originally built for use as a workhouse in 1873. It comprises several historic red brick buildings (used as the workhouse), many of which are locally listed, including the stand-alone Chapel, and a number of modern 20th century additions on the site which are not locally listed. The main hospital building is the largest on site and has a long symmetrical block of three stories. At the rear of the site is a range of structures that have been incrementally developed in the late 1800s and 1900s. These include three villa-type buildings built in the late 1960s and other single-story buildings originating from the 1940s. Cherry Trees House is a single-story, brick-built hospital building where the original section of the property dates to pre-1900s. The extended area was completed in the later part of the 20th century. St. Peter's Hospital became part of the NHS in 1948. The building has grown incrementally over the years, with a variety of extensions and additions, but the age of the building means modern health standards cannot be met.

The challenges with the St Peter's Hospital site and the age of the building has meant that for many years the overall condition of the estate has been a concern. The need to develop sustainable, fit for purpose healthcare facilities in Maldon has been recognised by the NHS for a long time. This has resulted in numerous previous attempts to identify suitable options for a site to develop a Maldon Health Hub, which would provide the Maldon district with modern, and appropriate premises where health and wellbeing services are provided on an integrated, multi-agency basis, delivering collaboration between GP services, the acute trust, Maldon District Council, health care provider organisations, social care and the voluntary sectors.

The last options appraisal took place in 2022, at which time the Wycke Hill development was identified as the most appropriate site for a Maldon Health Hub. A Programme Business Case was developed but work stalled because of issues associated with land ownership and a relief road needed to make the option viable, both outside of the NHS's control. Work has continued to identify alternative location/s for services in Maldon, working with local patients and the public, including seeking views from the public through the consultation process.

There are concerns about the safety and the suitability of the building as a location for providing clinical care as it does not meet the required standards of accommodation and services, including the most up to date technical health building notes standards and guidance (HBN standards).

Specific issues identified with the estate which led to the temporary service changes (see section '1.3.3 Temporary Service Changes') in October 2023 were:

- The lift to the second floor, where community beds were situated, had for some time been an issue due to it frequently breaking down.
- The frequently broken lift increased the risk that people with limited mobility could not easily be evacuated from the first or second floor of the main building if needed, causing a safety issue for both patients and staff.
- The number of inpatient beds (stroke rehabilitation beds) was reduced to 16 as a result of issues with the estate, in particular the lift. 16 beds was identified as the maximum number of beds that could be accommodated safely to try and limit the number of patients and visitors using the lift on a daily basis.
- During heavy rain, the main building is prone to flooding with accompanying electrical and fire risks, creating an unsafe environment for both patients and staff.
- There had previously been issues with the floor loading and maximum weight it could take, but this had been repaired.

Limitations on the availability of NHS capital funding restrict the ability to address the concerns with the current site and have historically restricted the ability to create a new Maldon Health Hub. This is an issue across many parts of the Essex estate. St Peter's Hospital is one of the oldest NHS properties owned by Mid and South Essex NHS Foundation Trust, with the costs of remedial works being particularly high due to the age of the building and its general lack of suitability for modern healthcare provision.

One of the key drivers that has guided this work, in line with the estates strategy of health and care services in MSE, and given the issues with availability of capital funding, is that it is necessary to make the best use of existing facilities across MSE, and to make the best use of facilities that do not require significant investment. It is for this reason that the options appraisal in the pre-consultation business case for the future location and configuration of community beds and the future location of the freestanding midwife led birthing unit ruled St Peter's Hospital out as a future site for these services, instead maximising more suitable estate elsewhere in MSE.

2. Models of Care - Our Vision for the Future

2.1. Alignment with wider strategic plans

The consultation and associated business cases focus principally on the future configuration of community beds across mid and south Essex (MSE), but these beds form part of a much wider and interconnected system of health and care. Therefore, it is necessary to consider how this work aligns with the longer-term plans that have been developed across MSE, including:

- The MSE Integrated Care Strategy 2023-33
- The Integrated Care Partnership Joint Forward Plan 2023-28
- The three Health and Wellbeing Board Strategic Plans across MSE, as well as the Essex county-wide Joint Strategic Needs Assessment
- Plans and capacity planning in adult social care
- The MSE Medium Term Plan 2025-2030

2.1.1. The Integrated Care Strategy and the Joint Forward Plan

The Integrated Care Strategy 2023-33 sets out the ambitions of the MSE Integrated Care Partnership (ICP), a broad alliance of organisations comprising the MSE Integrated Care Board and the three upper tier local authorities – Essex County Council, Southend-on-Sea City Council and Thurrock Council to improve the health and wellbeing of the population they serve. The partners have developed a Joint Forward Plan for 2023-28 (refreshed and published in March 2025 and now the Joint Forward Plan for 2024-2029[21]) that sets out their collective ambitions and shared commitments, how those ambitions will be achieved by working with communities through cross-system leadership and their plans to deliver on the NHS Long Term Plan commitments and on their legal duties. These strategies and plans aim to enable every resident to make informed choices to achieve a better quality of life supported by a strengthened health and care system. They focus on equitable partnerships and reducing inequalities, prevention and early support from high quality health and social care services working together and being delivered where people need them. Headline aims of the Joint Forward Plan include:

- Improving the health of the population and reducing health inequalities, including in healthy life expectancy, in access to health and care and in addressing unwarranted variation especially in groups most likely to experience poor health outcomes through a Core20PLUS5[22] initiative.
- Using data and insight to guide investment to achieve the best possible health and wellbeing outcomes. Continue to improve the quality of the care provided and learn from and build upon existing and future innovative practice.
- Working in partnership to reduce preventable deaths, develop a shared view of the capacity required, build clinical leadership, and provide local personalised coordinated services.

[21] Joint Forward Plan - Mid and South Essex Integrated Care System

[22] NHS England » Core20PLUS5 (adults) – an approach to reducing healthcare inequalities

- Ensuring that operational performance is improved across a wide range of services including maternity, outpatient services, stroke services, palliative and end of life services, cardiovascular and primary care services.
- The plan also identifies four levels or 'anchor points' at which the system will operate in achieving these ambitions:
    - The individual
    - Neighbourhood – supported through the development of Integrated Neighbourhood Teams
    - Place – reinforced by the four Local Alliances across MSE
    - System-wide- across the whole population of MSE

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

2.1.2. Health and Wellbeing Board Strategies

Each of the three Health and Wellbeing Boards to which MSE relates – Thurrock, Essex County and Southend – has produced wider ranging strategies for their areas which are 'owned' by their partners in producing and actioning their plans. Even though each of these plans focus on the different characteristics, priorities and challenges faced by their own local communities and areas, there are some common themes:

Essex:

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

Southend:

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

Thurrock:

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

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

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

2.1.3. Alignment with Adult Social Care Services

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

The commitment to partnership and joint working has resulted in consistency in planning and sharing of priorities and values. The work of this programme of change in community beds to offer services focused upon individuals, enabling participation in decisions, minimising inequalities, and improving outcomes reflects the broader intent of the MSEICS and its partners. The aims and ambitions set out in the strategy and work programmes above guide the development and assessment of the options for reconfiguration of community services, whilst also having to take into account the practical challenges confronting the system of health and care which also influence the choices and decisions which will be made. As a result, the growth in demand, recruitment and retention of the workforce, productivity and funding necessarily influences commissioning decisions, as does the system's financial situation.

2.1.4. MSE Medium Term Plan 2025-2030

The Mid and South Essex Integrated Care System (MSEICS) has developed a Medium-Term Plan (MTP). This builds on the commitments set out in the MSE Joint Forward Plan and the Mid and South Essex NHS Foundation Trust's 10-year strategy. The plan aims to deliver on national NHS commitments and meet the specific needs of the local population whilst also supporting the system to improve its financial position and support Mid and South Essex NHS Foundation Trust to exit the National Oversight Framework, segment 4 (NOF4). The plan was jointly developed and agreed by the system between January 2025-March 2025. The plan focuses on three key shifts that align with NHSE priorities:

- From Treatment to Prevention – Helping people stay healthier for longer.

- From Analogue to Digital – Using technology to enhance care and efficiency.
- From Hospital to Community – Providing more care closer to home.

There are seven improvement programmes to support this plan. These programmes draw on best practices from the NHS and international healthcare systems to improve patient care and system performance:

1. Preventative, Proactive Care – Helping people manage their health earlier.
2. Urgent & Emergency Care (UEC) & System Flow – Improving emergency care and hospital efficiency.
3. Community Mental Health – Expanding access to mental health services.
4. Learning Disability & Autism – Enhancing care for individuals with additional needs.
5. Acute Services Sustainability – Ensuring hospital services are effective and resilient.
6. Support Services Efficiency – Streamlining how we manage and deliver support services.
7. Primary care- Strengthening Primary Care services.

Whilst each of the work programmes will have an interdependency with the plans set out in this DMBC and will help strengthen the aims of transforming community hospital services, there are some areas within the Medium-Term Plan that will be particularly pertinent.

1) Intermediate care beds specification review
2) Optimisation of the virtual hospital model
3) Delivery of Integrated Neighbourhood teams
4) Optimising discharge to assess pathways
5) Development and delivery of stroke Integrated Community Stroke Service (ICSS) (in line with national guidance)

More information on each area is set out in the relevant sections below in section ‘2.2 Our vision for the future of community hospital services in mid and south Essex’.

2.2. Our vision for the future of Community Hospital services in mid and south Essex

Our overarching vision in the development of community hospital services across mid and south Essex is to create a system that delivers high-quality, integrated care closer to people’s homes, supporting individuals to live longer, healthier lives. Community hospitals play a pivotal role in shifting the focus from acute hospital-based care to prevention, early intervention, and rehabilitation, ensuring that patients receive the right care, at the right time, in the right place, whilst also making the best use of the resources we have available (estate and workforce) so that community hospital services remain responsive, resilient, and central to the health and wellbeing of our population.

2.3. Our vision for the future for Community Inpatient Beds

Our longstanding vision for the operation of intermediate care and stroke rehabilitation community bed-based services is that they should exhibit certain core principles:

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

Whilst this DMBC focusses on community hospital transformation, it is important to recognise that community hospitals do not stand alone. They are an element in the health and care landscape working with the acute hospitals, primary care, and social care as well as the wide range of community health services.

The landscape of health and care is constantly undergoing change. There are many workstreams and pathways of care that are interdependent with community hospitals and through the work happening across the MSEICS the aim is to continually improve these.

In line with national guidance, we want to optimise the potential of virtual hospitals and increase capacity in the current services where possible. Virtual hospitals have been developed in MSE over the last couple of years to support and treat patients in their usual place of residence. Currently these are services that support people exhibiting frailty, management of people with respiratory conditions, as well as people experiencing mental health conditions. The virtual hospital model seeks to provide better outcomes and enable patients to leave hospital earlier in their pathway. They are not a replacement for community hospital rehabilitation services. The virtual service model intention is to support people to remain in their usual place of residence to receive treatment rather than being admitted to hospital or a community bed. Optimising the model for virtual hospitals, reflecting the national requirements, is a key workstream in the MSEICS MTP. Virtual hospitals add capacity into the system which frees up acute hospital beds and ensures only those that need a community bed for further rehabilitation are admitted to one, whilst those that could return to their usual place of residence for ongoing care through the virtual hospital model do so. It is a pathway which is interdependent with the community hospital beds as patients can 'step up' and 'step down' into virtual hospitals depending on their needs.

Across MSE we are also looking to develop and drive delivery of Integrated Neighbourhood Teams (INTs), the aim of which is to deliver more joined up preventative care at a neighbourhood level. By sharing resources and information, teams can work together more collaboratively to simplify and streamline access to services and flow through services, supporting patients in receiving the right care in

the right place at the right time and allowing patients' health, care and wider social needs to be supported through multidisciplinary working across teams. Through the MSE MTP there is a dedicated workstream supporting the delivery of 24 INTs across MSE. In year one, INTs will focus on supporting those with frailty and end of life needs. The cohort of patients who use our community hospital beds tend to be older and therefore are often frail. Developing INTs will support in detection of frailty and care planning with the ultimate aim to keep people out of hospital (both acute and community) as long as possible and support them in returning from a stay in hospital (both acute and community) as quickly as possible.

Part of INT development has seen Transfer of Care Hubs (TOCHs) be developed in each locality across MSE, designed to streamline the processes which enable patients to move from one part of the health and care system to another. The MSE MTP also includes the development of an Integrated Care Transfer Hub (ICTH) to provide strategic oversight and coordination for discharge and flow across MSE hospital sites, community hospitals, virtual hospitals, system partner services (social care, hospice etc) and mental health services. The ICTH will provide a single, central point of coordination to inform actions and to provide a hub for collaborative planning and reporting of flow and any challenges for the health and care system. The aim is to ensure that patients are assessed and are placed, with their agreement, on the correct recovery pathway for their needs. For people assessed as having health or social needs who would benefit from further step-down care the right care can be supported by the hubs and made available, which will include community hospital beds.

Data published between April and August 2023 (at pre-consultation business case stage) showed the MSE system of health and care had the lowest percentage of delayed discharges in England at 5.8% compared to the national average of 13.7% and the worst performing system at 22.7%. The system improvement since the same period in 2022 has been attributed to the use of Urgent Community Response Teams (UCRTs), admission avoidance, Early Discharge Services (EDS), the development of Integrated Discharge Teams (IDTs) and 'bridging' where a person is medically optimised and ready to leave hospital, but their package of care is not available and so hours of support at home are provided to enable the discharge. This has demonstrated that the ability to have patients leave an acute care setting is not dependent upon there being a vast array of community beds to house appropriate patients. Instead, a variety of community health and care interventions are needed, and wherever possible, we would want these to be in a person's own home, avoiding admission to an acute or community bed setting. By focusing on this change, we can ensure that community hospitals beds are there for those that need them.

It is envisaged that improving the care pathways and services set out above for patients, and ensuring community beds are the right size, location, configuration and have the right patients in them in the future, will support the wider health and care system to improve outcomes for patients and reduce any delays in discharge from acute settings further, therefore supporting the system in achieving its aims.

2.3.1. Stroke Rehabilitation Beds

Our vision for stroke rehabilitation is that any patient admitted to a stroke unit in an acute hospital, if assessed as being able to benefit from rehabilitation that cannot be

provided in their own home, can be transferred to a bed in a community stroke rehabilitation unit (SRU). In this unit they will have access to physiotherapy, speech and occupational therapy, assessment and treatment by a psychologist and overall medical supervision from a stroke specialist to enable them to attain their optimum level of function. As soon as it is possible for rehabilitation to be continued in their own home this will be arranged.

The 'National Clinical Guideline for Stroke for the United Kingdom and Ireland (2023)' states 'well-led, appropriately staffed and skilled multidisciplinary stroke units are the cornerstone of holistic and comprehensive care for people who have had a stroke.' Whilst MSE has community stroke beds, there is not the type of specialised rehabilitation unit envisaged in the National Guideline. The aim must be, therefore, through this DMBC, to develop one or two specialised units for stroke rehabilitation beds to enable these units to be developed and specialised staffing and skills to be concentrated in one or maximum two units, rather than split across multiple sites.

Before autumn of 2023 there were only 24 community stroke rehabilitation beds which resulted in patients occupying beds in acute hospitals while requiring community stroke rehabilitation. Increasing the number of community stroke rehabilitation beds should minimise the number of stroke patients who are no longer acutely ill, being accommodated in acute hospital beds.

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

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

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

In summary, the approach to the future model of community stroke rehabilitation beds is to introduce consistent pathways underpinned by common access criteria; broadly standardised staffing levels; and improved patient selection so that only people who really need, and are most likely to benefit from, community stroke rehabilitation beds are admitted to them. In this manner, outcomes for patients can be improved. Whilst much of the work outlined above is already in progress and is not directly part of the DMBC, being able to confirm the future location and

configuration of community stroke beds will give clarity of future provision which will support the implementation of these new and revised pathways of care and will ensure we have the right number of beds across MSE to meet demand.

The aim for stroke rehabilitation in the future in MSE, and in line with national guidance, follows the principles of home first. In MSE there are already established Early Supported Discharge (ESD) teams for patients who have had a stroke and are appropriate to be discharged from hospital to their own home, coordinated by a team of therapists, nurses and a doctor, where specialist stroke rehabilitation is then provided in the patient's home. Through the MSE MTP, the aim over the next 3 years is to move local services closer to the model set out within the Integrated Community Stroke Service (ICSS), in line with recommended national guidance. This builds on the home first principles and the services already in place through community hospital beds and ESD services, by providing a broader, more flexible range of rehabilitation over a longer period. The ICSS aims to support stroke patients in returning home as quickly and safely as possible with appropriate support and rehabilitation. This means providing services and care at home rather than requiring a prolonged stay in a hospital or rehabilitation facility. The implementation of this model of care may mean that over time the demand for the current modelled stroke rehabilitation bed capacity may reduce.

2.3.2. Neuro- Rehabilitation Provision

In MSE in the future the aim is to provide local support to patients who require neuro-rehabilitation. More extensive community stroke rehabilitation facilities, concentrated in one or two specialist unit/s (as proposed in this business case), offers the opportunity to create a limited amount of capacity for patients who may be treated by a local specialist team and who require a Level 3 service. This would be led by consultants in specialties other than Rehabilitation Medicine (e.g., neurology/stroke medicine) and staffed by therapy and nursing teams with specialist expertise in the target condition.

2.3.3. Intermediate Care Beds

The aim of intermediate care beds both now and in the future is to rehabilitate patients and enable them to move to their place of residence within a defined period. The services therefore must integrate with primary care, social care, and community-based services. Maintaining a flow of patients through these beds serves to make them available for patients who otherwise might be admitted to an acute hospital or who have had an acute spell of illness and, while not ready to go home, may leave the acute hospital to be rehabilitated in a community bed. The aim of the service is:

- To reduce unnecessary acute hospital stays or inappropriate admission to acute hospital or long-term residential care.
- To maximise the individual’s capability to live independently and safely and reduce reliance on health and social care. It is essential that the focus of the service is on these individual outcomes.
- To enable individuals to continue to live or return to live independently in their chosen home and/or community.

The future model for intermediate care beds is primarily focused on addressing the shortcomings that have been identified and outlined in this DMBC in Section '1.4 Case for Change'. These include:

- Ensuring we have the right number of community intermediate care beds required for the MSE footprint.
- Ensuring that the 'right' cohort of patients to be admitted to intermediate care beds is consistently identified.
- Addressing unwarranted variation in the way in which intermediate care beds are used in the system. As MSE is a relatively recent construct as a health economy and includes a wide range of providers, there is considerable variation in the way in which intermediate care beds are used, including numbers, access criteria, and staffing levels.
- Improving outcomes for the patients in intermediate care beds.
- Ensuring services are delivered in a safe, fit for purpose environment, to support the points above.

Through the MSE MTP, work has already started on intermediate care beds specification review to support the developments set out above. The workstream is also looking at ensuring consistent staffing levels across all intermediate care community hospital beds. The workstream looking to optimise discharge to assess pathways has been piloted to support a wider cohort of discharge to assess patients, by expanding the scope of the criteria for intermediate care beds to support patients who historically would have gone to a care home whilst awaiting assessment of their long-term needs. They now receive rehabilitation in an intermediate care bed to maximise independence prior to them being assessed for their long-term care needs. The aim is to improve patient outcomes and experience and ensure people are discharged to the most suitable care setting for their long-term needs, at the right time, with the right support.

As outlined above in section '2.2.1 Community Inpatient Beds', intermediate care beds form one part of a wider system of interconnected provision for intermediate care. Taken together, these measures are intended to prevent acute hospital admissions where possible and, where someone is admitted to hospital, ensure that the system 'pulls' them out as soon as possible, with the support that is best matched to their preferences and level of need.

In summary, therefore, the approach to the future model of intermediate care beds is to introduce consistent pathways underpinned by common access criteria; broadly standardised staffing levels; and improved patient selection so that only people who really need and are most likely to benefit from a community intermediate care bed are admitted to them. In this manner, outcomes for patients can be improved. Whilst much of the work outlined above is already in progress and is not directly part of the DMBC, being able to confirm the future location and configuration of community intermediate care beds will give clarity of future provision which will support the implementation of these new and revised pathways of care and will ensure we have the right number of beds across MSE to meet demand. The implementation of these transformation workstreams and new ways of working may mean that over time the demand for the current modelled capacity needed for intermediate care beds may reduce.

2.4. Our vision for the future for Midwife-Led Birthing Units

The vision for maternity services across Mid and South Essex Integrated Care System (MSEICS) is for all maternity services across the system to work together to ensure that women and birthing people can access high-quality maternity care and are supported to make choices reflecting their needs. Work is focused on delivery of much of the vision set out in 'Better Births: Improving Outcomes for Maternity Services in England – A Five Year Forward View for Maternity Care (2016)' through the 'National Maternity Transformation Programme (2016)[23]'. This includes:

- Increasing choice and personalised care.
- Support from neonatal services when required.
- Addressing health inequalities, particularly for those from Black, Asian and minority ethnic groups and for those living in the most deprived areas of MSE.
- Support from 'smoke free pregnancy' pathways.
- Improved access to perinatal mental health services.

Retaining a freestanding midwife-led birthing unit within MSE offers choice to women and birthing people which otherwise has midwife-led birthing units attached to the obstetric units at each of the acute hospital sites. In addition to accommodating births, the freestanding midwife-led unit also cares for women and birthing people and babies after the birth has taken place at the main obstetric unit (or on rare occasions following a home birth), relieving pressure on the maternity unit at Broomfield Hospital in particular. Retaining maternity outpatient services locally in Maldon will also support the delivery of the aforementioned targets within the 'National Maternity Transformation Programme'.

2.5. Our vision for the future for Ambulatory Care Services

The delivery of the national guidance 'Reforming Elective Care for Patients (2025)' is a key part of the MSE MTP programme delivering acute service sustainability, with one of its objectives being to ensure elective care resilience by redesigning contracts to support delivery of cancer and elective care performance standards, waiting list reductions and improved service delivery. The future vision for this work is to make sure that across MSE we improve the patient experience, reduce waiting times, and ensure efficient delivery of care. The transformation programmes set out in the national guidance will impact the way outpatient and diagnostic services are delivered across MSE, not just at St Peter's Hospital. This work programme and its ambitions and outputs will be considered when developing future plans for services currently delivered on the St Peter's Hospital site.

2.6. Benefits of the future models of care

2.6.1. Benefits of the future models of care for Community Hospital Beds

The anticipated benefits of the future models of care for community hospital beds are:

[23] NHS England » Maternity Transformation Programme

- Improved access for patients as there will be the right capacity of beds available for intermediate care and stroke rehabilitation in the community and improved capacity in alternative pathways outlined above;
- Improved outcomes for patients through improved pathways of care, reduced length of stay in acute hospital beds, better access to rehabilitation and improved support for regaining independence;
- Safer care through reduced risk of hospital acquired infection and reduced risk of deconditioning in an acute hospital bed;
- Safer care by ensuring services are delivered in a safe, fit for purpose environment;
- Reduced variation in the way in which intermediate care beds are used in the system;
- Improved access to staff with specialist skills to support patient needs, therefore improving patient outcomes, particularly in stroke care where staff with the necessary expertise will be concentrated in one or two community stroke rehabilitation units;
- Improved morale and engagement from staff by having permanent solutions in place for the location and configuration of community hospital beds,
- Improved retention of existing staff;
- Improved recruitment of staff, particularly in stroke services, by having one or two specialist units for stroke rehabilitation in the community;
- Reduced reliance on bank and agency staff, improving patient outcomes and reducing costs;
- Improved patient flow through the system, freeing up acute hospital capacity,
- Improved bed utilisation across the system;
- Improved efficiency through use of ‘best fit’ estate available within the system.

In both community intermediate care and stroke rehabilitation beds a small number of indicators have been identified that will be tracked to ensure that there is a positive impact on outcomes. The baseline for most of these indicators is known and targets that were considered by both the East of England Clinical Senate and the local MSE Clinical and Care Outcomes and Review Group have been adopted.

The intermediate care indicators and improvement targets identified are:

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

Figure 6: Intermediate Care – key outcome indicators and target levels.

As a system, MSE collects and reviews a wide range of stroke data, and benchmarks using the Sentinel Stroke National Audit Programme (SSNAP) data. However, as most of the SSNAP data is at an aggregate stroke pathway level – and not specific to inpatient stroke rehabilitation – as well as including many processes rather than outcome measures, a small number of indicators for bed-based rehabilitation have been identified:

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

Figure 7: Stroke Rehab - key outcome indicators and target levels

2.6.2. Benefits of the future models of care for the Freestanding midwife led birthing unit

The anticipated benefits of the future models of care for the freestanding midwife led birthing unit are:

- Improved access to services as a reduced likelihood of service having to periodically shut due to staffing issues;
- Improved patient experience and satisfaction with care as midwife led birthing units are designed to promote a physiological and natural birth process;
- Reduced interventions for women and birthing people (studies suggest that women giving birth in midwife-led birthing units are less likely to need interventions like epidurals, forceps, or caesarean sections compared to those in hospital settings);
- Safer care by ensuring services are delivered in a safe, fit for purpose environment;
- Improved morale and engagement from staff by having a permanent solution in place for the location of the freestanding midwife led birthing unit;
- Improved retention of existing staff;
- Improved recruitment of staff, due to appropriate estate and opportunities of working in a freestanding midwife led unit;
- Improved capacity across the system as less likelihood of service having to periodically shut due to staffing issues;
- Improved efficiency through use of ‘best fit’ estate available within the system.

There is no direct impact upon the maternity outcomes from the transfer of the freestanding midwife-led birthing unit location. Here outcomes remain based upon case selection and the skills of the supporting midwife.

2.6.3. Benefits of the future models of care for Ambulatory Care Services

The anticipated benefits of the future models of care for ambulatory care services overall are:

- Improved patient experience through more patient centred care;
- Reduced waiting times for patients;
- More personalised patient care;
- Safer care by ensuring services are delivered in a safe, fit for purpose environment;
- Improved morale and engagement from staff by having better facilities for staff to work within;
- Improved retention of existing staff;
- Improved recruitment of staff;
- Increased capacity across the system;
- Improved efficiency, particularly through the use of technologies, and reduction in unnecessary appointments.

2.7. Potential negative impacts on patients of the proposed clinical models

As well as benefits for patients and staff outlined above, there will be some negative impacts of the future models of care:

- There will be increased travel, and therefore potentially cost to some patients and carers, as well as staff, in relocating community beds, relocating the freestanding midwife led birthing unit and if ambulatory care services are relocated. For some patients and carers there will in a decrease in travel time and access will be easier for them. Travel analysis is included within this business case and the integrated impact assessment in ‘Section 8: Impact of proposed changes’.

3. The Consultation Proposals

3.1. Key assumptions in developing our consultation proposals

Below sets out the key assumptions in developing our consultation proposals.

In developing the possible options for the future location and configuration of community hospital beds, the freestanding midwife-led birthing unit (MLBU) and potential relocation of ambulatory care services in mid and south Essex (MSE), it should be recognised that there are constraints that limit the range of options that are realistic.

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

These wider parameters are treated as 'givens' by Mid and South Essex Integrated Care Board (MSEICB) within the context of this decision-making business case (DMBC); the principal ones being:

- No major new capital expenditure where this can be avoided. It is recognised that for any new estate or reconfiguration of existing estate for ambulatory care services capital investment will be required, but in the short to medium term this should be limited.
- Making best use of the existing estate where we are able to do so, and it is appropriate to do so.
- Contributing to wider system recovery post-Covid.
- Ensuring proposals are future proofed, able to accommodate new service models and aligned with best practice.
- Admission avoidance and appropriate discharge from acute hospitals will depend upon a combination of agreed clinical pathways and services which include community hospital beds.
- Ensuring proposals contribute towards meeting the MSE ICS four aims:
    - Improving outcomes in population health and healthcare
    - Tackling inequalities in outcomes, experience and access
    - Enhancing productivity and value for money
    - Supporting broader social and economic development

3.2. Developing options for Community Hospital services in mid and south Essex

The Clinical Capacity Task Force (CCTF) was established in Summer 2023 to look at the provision of community hospital services in MSE, using a range of national guidance, local data, our senior doctors' and nurses' clinical experience, and advice from others to explore the extent to which community hospital provision needed to change.

The work of the CCTF started with stroke rehabilitation and intermediate care inpatient beds in community hospitals across MSE. Given proposed changes to these community inpatient beds and concerns raised about the MLBU remaining on

the St Peter's Hospital site without the other inpatient services, and given the problems with the estate of the St Peter's Hospital site, future provision of the freestanding MLBU in MSE was also considered as part of the CCTF's work.

With the potential move of community inpatients services off of the St Peter's Hospital site and the concerns around the quality of the estate on the site, options for the re-provision of all other services currently provided from St Peter's Hospital site were also therefore considered by the CCTF.

Options for each of the three services areas (community inpatient beds, MLBU and ambulatory care services) were developed through the CCTF and associated working groups made up of doctors, nurses, other health and care staff, and service leaders working together and considering the feedback given by patients, staff and residents through pre-consultation engagement.

After considering financial, strategic and quality criteria, the CCTF agreed upon the final proposals presented in the pre-consultation business case (PCBC) and consultation documents.

3.3. Developing options for community stroke rehabilitation and intermediate care inpatient beds

3.3.1. Confirming future demand for inpatient community hospital beds

To develop options for the future of inpatient community bed services, the CCTF considered both current performance across bed-based services and the potential future demand for services to identify how many of each type of bed is needed across mid and south Essex (MSE) in the future.

To do this they used the following assumptions:

Intermediate care beds	Stroke rehabilitation beds
4% of NEL hospital discharges conform to national guidelines and are on Pathway 2 and require an intermediate care community hospital bed	23% of acute stroke admissions required rehabilitation in a community stroke rehab bed (taken from MSE audit and modelling data)
The number of people needing a community inpatient bed is expected to increase by 8% in the next five years.	The number of people needing a community inpatient bed is expected to increase by 8% in the next five years,
95% of the community hospital beds we provide will be used at any one time	95% of the community hospital beds we provide will be used at any one time
An average length of stay in line with national guidance of 25.3 days	An average length of stay of 26.56 days (based on average length of stay for community stroke beds between April 2022-March 2023)

Table 4: Assumptions of potential future demand for community inpatient bed services across MSE

Taking account of these assumptions, the CCTF calculated that in the future MSE needs:

- Between 87 and 99 intermediate care beds, and
- Between 44 and 48 stroke rehabilitation beds, increasing to 47-51 beds if additional beds are added to support Level 3a neuro rehabilitation patients (see section '1.4.4.2 Clinical case for change for neuro-rehabilitation services' for more details).

In modelling the projected future demand, the CCTF did not consider future improvements that MSEICS may make in improving the overall pathway of care for people needing either intermediate care or stroke rehabilitation care. If improvements are made in supporting more people to return to their primary residence, including home, residential or nursing homes, after an inpatient stay in an acute hospital, the future demand for inpatient community beds across MSE may reduce.

The modelling data for intermediate care beds was updated at the request of the Community Consultation Working Group and the same bed requirement range was confirmed through that process. More information can be found in section '1.4.4.1 [Strategy] Demand and capacity- Intermediate Care Beds'.

3.3.2. Developing the options

In developing potential options for the future configuration of inpatient community beds across MSE, the CCTF considered several factors. They took the number of beds required by the MSE health system and looked at the buildings and facilities available across MSE and developed a list of 13 different ways community stroke rehabilitation beds and intermediate care beds could be organized- see Figure 8 below. None of the options considered continuing the use of St Peter's Hospital as its condition was considered to be unsuitable for continued use for inpatient bedded care.

It should be noted that the Clinical Subgroup of the CCTF was of the opinion that a dedicated stroke rehabilitation unit within a single community hospital, concentrating expertise, would create opportunities to have the best outcomes for patients, recognising that travel times for some relatives and carers would be increased. They did however recognise the limitations of this and therefore included options offering two stroke rehabilitation units (SRUs) in the long list of viable options.

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

Figure 8: Initial Longlist of Stroke Rehab / Intermediate Care bed Options. Note: Option 0 was the distribution of beds prior to the changes made in October 2023. Option 4 is the current distribution following those changes.

3.3.3. Evaluation of the options

The CCTF worked with clinical leaders across MSE in intermediate and stroke care to review all 13 options. Option 4 was selected as the most clinically appropriate arrangement to enable the system of health and care to respond to expected demand over the winter of 2023/24 through temporary changes. This provided 99 intermediate care beds and increased the number of stroke rehabilitation beds from 24 to 39 beds

In preparation for the PCBC a full review of the options was completed by clinicians. Recent audits informed the process and, using the decision tree in Figure 9 below, a shortlist of options for intermediate care beds and stroke rehabilitation beds was developed, shown in Table 5 below.

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

Table 5: Shortlist of options for Intermediate Care Beds and Stroke Rehabilitation Beds

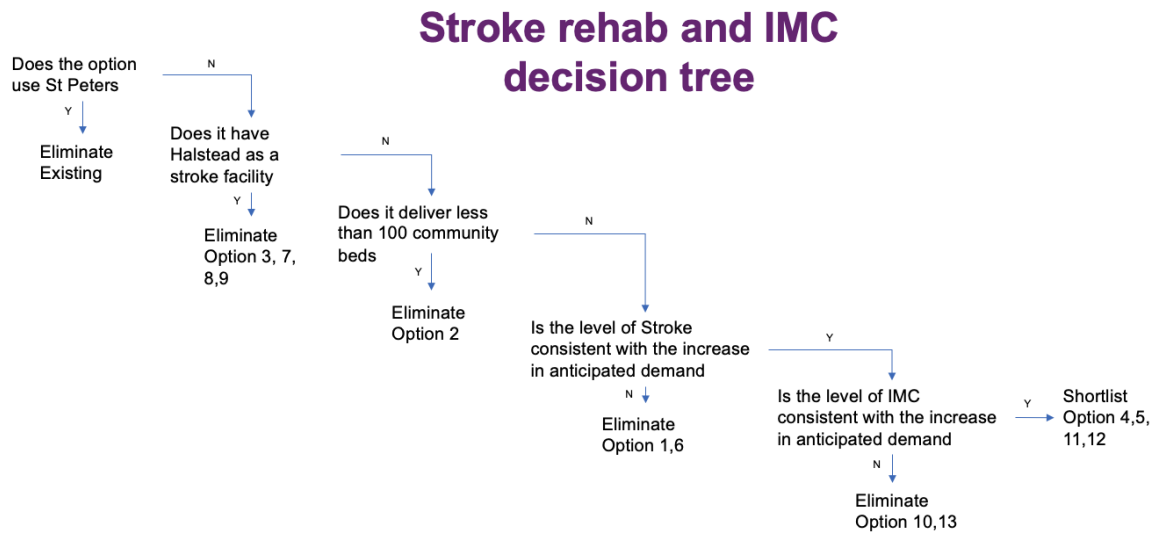

Figure 9: Stroke Rehab and Intermediate Care bed decision tree.

3.3.4. Scoring the options and preferred options

The four shortlisted options were reviewed and scored by the CCTF, using weighted criteria, set out in Figure 11 below.

Each option was reviewed against three criteria domains- quality, strategy and finance. These domains were agreed by the CCTF along with their sub-criteria, which were developed by the programme through work with clinicians and subject matter experts.

The 3 domains and associated sub-criteria were:

Quality domain

- Provision of a safe, secure, quality care environment
- Accessible from main centres of population in MSE
- Impact on capacity-supporting the health and care system to manage future demand.
- Impact on workforce-ability to recruit and retain skilled staff

Finance domain

- Financial Affordability

Strategy domain

- Moving towards the assessed bed requirement for stroke rehabilitation
- Clinically supported solution/fit with system clinical strategy
- Fit with system estate strategy

Before scoring took place, the different domains and sub-criteria were 'weighted', depending on their importance. This meant the more important the domains (and sub-criteria within the domains) were felt to be, the bigger percentage of the available score they could get. These weights were applied to the scores post panel evaluation. The domain weightings were determined by the CCTF. The agreed weightings are shown in the table below.

Criteria	Beds Weighting	MLBU Weighting
Quality	**50%**	**60%**
Provision of a safe, secure, quality care environment	10%	20%
Accessible from main centres of population in MSE	10%	10%

Impact on capacity-supporting the health and care system to manage future demand.	20%	10%
Impact on workforce-ability to recruit and retain skilled staff	10%	20%
Strategy	**25%**	**25%**
Moving towards the assessed bed requirement for stroke rehabilitation	5%	N/A
Clinically supported solution/fit with system clinical strategy	15%	20%
Fit with system estate strategy	5%	5%
Finance	**25%**	**15%**
Financial Affordability	25%	15%

Figure 10: Weightings for each of the scoring sub criteria.

Option 4 within the shortlist, which was the configuration that was agreed for the temporary transfer of beds after October 2023, meets the required bed demand for intermediate care beds and offers a spread of intermediate care beds which enables access for multiple areas of the population in MSE, particularly in the south, west and east of the South East catchment. However, it provides only 39 beds in two locations for stroke rehabilitation beds, which is significantly below the anticipated number of community stroke beds needed across MSE. In this option Cumberlege Intermediate Care Centre (CICC) at Rochford has a combination of intermediate and stroke beds. The view expressed by the CCTF was that all beds in combined units such as CICC should be staffed at stroke rehabilitation unit levels to enable flexible use and believed that this would be a costly solution for the NHS. Alongside this, the clinical view expressed at the time was that better outcomes are achieved where the stroke rehabilitation beds have the numbers and expertise to offer intensive rehabilitation therapy. As such, option 4 was not considered to be a preferred option and was ruled out from the final options presented in the PCBC.

Option 5 also only offered 39 stroke rehabilitation beds (significantly below the anticipated number of community stroke beds needed across MSE) and had CICC as a combined site for intermediate care and stroke rehabilitation beds. It also only offered 77 IMC beds, which is below the number required based on the bed modelling. As such, it was not considered to be a preferred option and was ruled out from the final options presented in the PCBC.

Option 11 concentrated all stroke rehabilitation beds in a single specialised unit at Brentwood Community Hospital and offers the necessary number of beds for stroke rehabilitation (50 bed across MSE). This option also means there are no combined

units. This option provides 88 beds for intermediate care, which is in line with the required number of intermediate care beds.

Option 11 offers the further potential benefit of the stroke rehabilitation unit accommodating up to three neuro-rehabilitation patients needing Level 3 rehabilitation supervised by staff whose skill set in stroke rehabilitation could support these patients. There are currently no Level 3 neuro-rehabilitation beds commissioned in MSE, and such a facility could be used for patients leaving an acute setting needing Level 3 services or patients receiving a higher service out of area who are ready for Level 3. Currently, these patients, their carers, and families are disadvantaged by having to be treated and travel some distance from their place of residence and out of the county.

Option 12 split the stroke rehabilitation beds across two wards- CICC in Rochford and Brentwood Community Hospital. Across the two sites there would be 47 community stroke beds, in line with predicted need. Clearly this is better for access from the east of the catchment for stroke rehabilitation but does not create a single stroke unit and leaves the southeast of MSE without intermediate care beds. This option provides 91 beds for intermediate care, which is in line with the required number of intermediate care beds.

Both option 11 and option 12 require the continued use of Mountnessing Court Billericay, which is not in line with the system estates strategy. However, at this point of time this additional site is required to ensure the best use of existing estate available, and to ensure there is capacity available across the system to meet predicted demand.

Following the scoring process and review, options 11 and option 12 were identified by the CCTF as the preferred options to consult on. Within the constraints of the current estate, clinical review and scoring process, it was agreed that they were most likely to improve care for patients and improve value compared with current services and were therefore set out as options within the PCBC. Within the constraints of available accommodation, both options respond to clinical advice by concentrating community stroke beds, and with them the clinical expertise needed to provide an excellent service with best outcomes for patients. The preferred options propose that the overall bed number increases (pre the temporary changes being put in place) from 129 beds to 138 community hospital beds (in the temporary arrangements there are 138 community inpatient beds) and options put forward for consultation on whether there should be a single stroke rehabilitation unit, or the stroke rehabilitation service should be in two units in separate locations.

3.4. Developing options for the freestanding midwife-led birthing unit

3.4.1. Developing the options

The Community Capacity Task Force (CCTF) recognised that moving the inpatient beds from St Peter's Hospital would leave the freestanding midwife-led birthing (MLBU) unit isolated as the only 24-hour service on the St Peter's Hospital site. Staff and service leaders raised concerns about the safety out of hours once on-site services for inpatient community beds had been removed from the site, and the

service had the same issues with the poor condition of the building at St Peter's Hospital impacting the quality of care provided there. It was therefore proposed that the MLBU at St Peter's Hospital be relocated to ensure the safe continuity of that service. MSE already has co-located midwife-led birthing facilities in the maternity units of each of Broomfield, Basildon and Southend Hospitals and no change to those arrangements is being considered. This restricts options to the future location of the freestanding MLBU.

The CCTF developed a list of options for the future of the freestanding MLBU. The group considered the option of not having a freestanding midwife-led birthing unit at all, but agreed that the system of health and care in MSE is committed to offering choice in accordance with the guidance provided in 'Better Births: Improving Outcomes for Maternity Services in England – A Five Year Forward View for Maternity Care (2017)' and therefore the decision was made to continue to have a freestanding MLBU in MSE.

This left seven potential options shown in Table 5 below:

- Three variations involving combining the service with the maternity service at Broomfield Hospital in Chelmsford,
- Three variations using the William Julian Courtauld birthing unit facility at Braintree Community Hospital, and
- One variation putting the service in a new primary care hub in Maldon.

Existing		Status Quo	St Peters maternity services continue as a MLBU
Option 1a	Broomfield Hospital (Chelmsford)	Absorb into Broomfield	Move St Peter's inpatient and outpatient Maternity services to Broomfield
Option 1b		Broomfield + Maldon Hub	Move St Peter's inpatient Maternity services to Broomfield and outpatient services to a Maldon hub
Option 1c		Broomfield + WJC	Move outpatient Maternity services to Broomfield and leave inpatient services at WJC
Option 2a	William Julien Courtauld (WJC) (Braintree)	WJC stand alone	Move St Peter's inpatient and outpatient Maternity services to WJC
Option 2b		WJC + Maldon facilities	Move St Peter's inpatient Maternity services to WJC and re-provide outpatient services Maldon residents locally
Option 2c		WJC + co-location with primary care	Move St Peter's inpatient Maternity services to WJC and re-provide outpatient services in co-location with a Maldon primary care development
Option 3	Maldon Health Hub	Maldon Health Hub	Inpatient and outpatient in a Maldon Health Hub

			(note: this option was eliminated as there was no immediate prospect of undertaking a development of the magnitude required)

Table 6: Initial Longlist of Maternity Options

3.4.2. Evaluation of the options

In preparation for the PCBC a full review of the options was completed by CCTF. The decision tree in Figure 11 below was used to develop a shortlist of options.

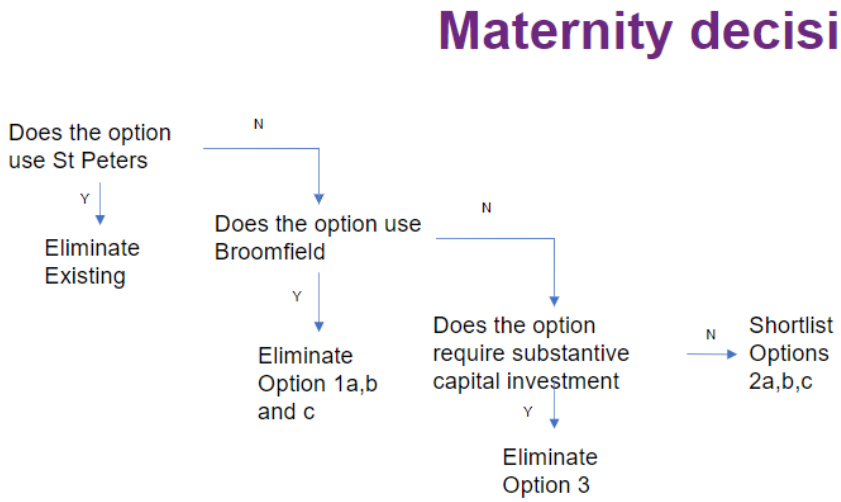

Figure 11: Freestanding midwife led birthing unit decision tree.

This led to there being three shortlisted options. The shortlisted options are shown in Table 7 below. The option of continuing to use St Peter's Hospital as a site for the MLBU was eliminated due to the issues highlighted above regarding safety and security of a 24-hour site and because its condition was considered to be unsuitable for continued use for inpatient community bedded care.

The variations at Broomfield Hospital (options 1a, 1b and 1c) were eliminated as the service there is already at capacity, and it would be expanding the current 'co-located' unit rather than offering a free-standing unit option.

Option 3 was eliminated owing to the potential capital cost, firm plans and timelines not being in place, and recognising any future facility in the pipeline was years away from being ready to accommodate this service.

Option 2a	Option 2b	Option 2c
William James Courtauld (WJC)		
WJC stand alone	WJC + Maldon facilities	WJC + co-location with primary care
Move St Peter's inpatient and outpatient Maternity services to WJC	Move St Peters inpatient Maternity services to WJC and re-provide outpatient services for Malden residents locally	Move St Peters inpatient Maternity services to WJC and re-provide outpatient services in co-location with a Maldon primary care development

Table 7: Shortlisted maternity options.

3.4.3. Scoring the options and preferred options

The three shortlisted options were reviewed and scored by the CCTF, using weighted criteria, set out in Table 11 above.

As with intermediate care and stroke rehabilitation beds, each option was reviewed against three criteria domains-quality, strategy and finance. These domains were agreed by the CCTF along with their sub-criteria, which were developed by the programme through work with clinicians and subject matter experts.

The 3 domains and associated sub-criteria were:

Quality domain

- Provision of a safe, secure, quality care environment
- Accessible from main centers of population in MSE
- Impact on capacity-supporting the health and care system to manage future demand.
- Impact on workforce-ability to recruit and retain skilled staff**.**

Finance domain

- Financial Affordability

Strategy domain

- Moving towards the assessed bed requirement for stroke rehabilitation
- Clinically supported solution/fit with system clinical strategy
- Fit with system estate strategy.

Before scoring took place, the different domains and sub-criteria were 'weighted,' depending on their importance. This meant the more important the domains (and sub-criteria within the domains) were felt to be, the bigger percentage of the available scored they could get. These weights were applied to the scores post panel evaluation. The domain weightings were determined by the CCTF.

Option 2a was eliminated as it was felt there would not be enough capacity for all the outpatient and pre-natal and ante-natal care at the William Julian Courtauld Unit, Braintree.

Option 2c was eliminated as is not realisable in the short term as there is not a viable short-term plan to develop a primary care facility in Maldon that outpatient maternity services could move to and plans that are in place for a replacement Primary Care branch surgery have progressed too far to add on additional services.

This left option 2b as the only viable option and was therefore the only option presented in the PCBC, and the only option consulted on.

3.5. Developing options for Ambulatory care services at St Peter's Hospital

3.5.1. Developing the options

Throughout the work the CCTF undertook in exploring the potential future options for community inpatient beds, the condition of the buildings at St Peter's Hospital was raised and became one of the reasons outlined in the case for change for moving inpatient beds and maternity services out of St Peter's Hospital. This led to further discussion on the suitability of the estate at St Peter's Hospital for any patient services. The age, condition, and suitability of St Peter's Hospital for future use has meant plans have previously been developed over many years to provide a new purpose-built replacement facility locally, but none have come to fruition. It was evident through the discussions the CCTF had across the MSEICB and MSEICS with partners that any new development is still some years away and that the current estate may not be suitable to be used across that time period, given the defects and issues identified with it. It was noted that significant work was needed to deal with the defects and issues at St Peter's Hospital and this would require a substantial injection of capital to do so, which was not available, and therefore continuing to provide health services from the current St Peter's Hospital site was felt to be unsustainable. The CCTF therefore agreed that alternative solutions were needed if residents of Maldon and surrounding Districts are to continue to have accessible ambulatory services. Therefore, the DMBC also seeks to confirm if these ambulatory services will be relocated from the St Peter's Hospital site to alternative local facilities.

CCTF started to think about where services could be relocated to, with the minimum requirements that:

- Any site must continue to provide as much capacity as possible to provide the current level of ambulatory services delivered from St Peter's (80,000 ambulatory care appointments, including 39,000 outpatient appointments and 37,000 phlebotomy appointments per annum).
- Any new site must be within the Maldon District area.
- Any site must have suitable parking and public transport links.

The three options identified by the CCTF were:

- Option 1: Locate services in alternative premises in and around the Maldon district and lease suitable premises where patients are best served by services remaining local. This will require some distribution of services, and it might require some services to be co-located elsewhere for clinical reasons, where patients will benefit.

- Option 2: Undertake essential repairs on the elements of the fabric of St Peter's in order to manage the safety and security risks and enable outpatient services to temporarily continue there. This assumes capital is available to effect essential repairs and that doing so represents value for money. The condition and costs of operating retained buildings at St Peter's suggest that this is an unattractive option, particularly when the cost of running a large site and ageing estate is considered.
- Option 3: Demolish the Villas and "C" Block to the rear of the St Peter's site and erect temporary accommodation for outpatient services there, bearing in mind that in the NHS temporary buildings tend to become unintentionally permanent. This option would require a significant capital outlay for which there is not an evident source.

It was recognised that further work was needed to explore and develop viable options. It was therefore decided that we would consult on the proposal to move all services out of St Peter's Hospital and a commitment was made to include patients and local people in future decision making.

3.5.2. Evaluation of the options

The CCTF reviewed and discussed the three options and at the time felt that of these options, the redistribution of ambulatory services to other locations was the most immediately realisable and would not require the expenditure of capital at St Peter's Hospital for what would only be a short-term extension of time for services on that site. Furthermore, the CCTF believed that patients who are not Maldon residents would have the opportunity to source services closer to where they live where that is possible. For those reasons, the relocation of services (option 1) was the preferred course of action and the decision was made to consult on whether or not ambulatory care services should be relocated to other sites in the Maldon district, and therefore this is what was presented in the PCBC and consultation documents.

3.5.3. Scoring the options and preferred options

There was no scoring process for the potential future options for the location of ambulatory care services. At the time of going to consultation options for where services could be relocated were not available and, whilst potential options had started to be explored, further work was required to review whether these locations were viable. It was also recognised that further work was required to develop and review any other potential viable options and locations for where services could be relocated to, and therefore as part of the consultation the public were asked to suggest options and locations that could be explored. There was a commitment made to involve patients, local people, and staff in the development of these options during and post consultation.

3.6. Summary of Consultation proposals

Following the process set out above and internal scrutiny of the options (see section '3.7 Internal scrutiny of proposals' below) the decision was made to consult on the following proposals:

1) **Intermediate Care Beds and Stroke Rehabilitation Beds**: Options 11 and Option 12 scored the highest and were therefore taken forward to consultation (renamed Option A and Option B).

	Option 11 (Option A)	Option 12 (Option B)
	IMC/Stroke	IMC/Stroke
St Peters	0	0
MNC	22/0	22/0
CICC	22/0	0/22
Halstead	20/0	20/0
Mayfield	24/0	24/0
Brentwood	0/50	25/25
Total IMC/Stroke	88/50	91/47
Total Beds	138	138

Table 8: Intermediate Care Beds and Stroke Rehabilitation Beds final options agreed to consult on

The consultation asked to seek views on these two options for the future location and configuration of community intermediate care and stroke rehabilitation beds across mid and south Essex.

2) **Freestanding Midwife-Led Birthing Unit:** Following the scoring process and review Option 2b was felt to be the only viable option and was therefore the only option presented in the PCBC, and the only option consulted on.

Option 2b
WJC + Maldon facilities
Move St Peters inpatient Maternity services to WJC and re-provide outpatient services for Maldon residents locally

Table 9: Midwife Led Birthing Unit Option 2b- final option agreed to consult on

The consultation asked to seek views on the future location of the freestanding midwife-led birthing unit in mid and south Essex.

3) **Ambulatory Care Services:** Option 1- 'locate services in alternative premises in and around the Maldon district'- was felt to be the most viable option and therefore the decision was made to seek views on the proposal to relocate ambulatory services currently provided at St Peter's Hospital, Maldon, through the consultation process.

3.7. Internal Scrutiny of Proposals

The development of the proposals set out above have been led by and involved a wide range of clinicians. At a programme level, there was a Clinical Subgroup in place, led by a clinical chair.

Our proposals have been internally scrutinised by:

- Clinical and Care Outcome Review Group (CCORG): This is a MSEICS multidisciplinary group, focused on the 'Ageing Well' population cohort, which brings together a wide range of clinical leaders from across the patch.
- Ageing Well and Stroke Stewardship groups: The MSE 'Stewardship' Programme' brings together a broad range of clinicians and professionals to look at a particular service area and consider how delivery can be transformed, within the available resources. There has been clinical and multi-professional input via the Ageing Well and Stroke Stewardship groups for both intermediate and stroke care.
- MSE Clinical and Multi-professional Congress: This is an advisory committee to the MSEICB Board, bringing together frontline perspectives and experience from primary, community, acute, social care, public health, mental health, medicines optimisation and resident engagement. It advises on complex or controversial issues affecting clinical services.

The CCORG and Ageing Well stewardship groups have considered evidence based best practice recommendations from sources of relevant national guidance and best practice policy, such as national discharge to assess policy guidance recommendations. Additionally, evidence was supported by findings from other local needs analysis and internal audit reviews that took place between 2021-2022. The potential configuration options were tested with CCORG and feedback from this group helped to iterate and improve the proposals set out in this PCBC, the public consultation and this DMBC.

The MSE Clinical and Multi-professionals Congress (Clinical Congress) has been involved in the development of the proposals for changes to community services set out in this decision-making business case. In September 2023, the temporary winter proposals were taken to Clinical Congress to ensure they were fully aware of the background to this PCBC. The PCBC was presented to the Clinical Congress in late November 2023. The Clinical Congress endorsed the proposals for community inpatient beds, relocating the Midwife led birthing unit to the William Julien Courtauld Unit at St Michael's Health Centre, and relocating ambulatory services in premises accessible to Maldon residents. The Clinical Congress advised that in making the changes to ambulatory care services consideration should be given to ensuring that waiting times were not adversely affected and that phasing any changes might be appropriate.

Further to the above the below assurance and advice was gained by expert groups.

3.7.1. Community Stroke Rehabilitation Beds

Improving the whole stroke pathway has been a priority for the system, as set out in the MSEICS Long-Term Plan. As a result, there is a well-established and energetic

Stroke Programme Board that includes a wide range of professionals to drive the improvement of each aspect of stroke care, from prevention right through to rehabilitation. The proposals for community bed-based stroke rehabilitation were developed and iterated by a 'stroke' Subgroup of the CCTF and the Stroke Programme Board.

3.7.2. Community Intermediate Care Beds

The proposals for community intermediate care beds have been developed and tested by the Ageing Well Stewardship Group, working with other Ageing Well related clinical stakeholder groups spanning primary, secondary, community and social care within MSE. It has provided advice on the development of the overall approach to care for adults living with frailty, the needs of the MSE population and, in recent months, has been specifically focusing on proposals for inpatient community beds for Pathway 2 rehabilitation.

3.7.3. Freestanding Midwife Led Birthing Unit

Clinical and Maternity Subgroups, as well as maternity service leaders and midwifery staff, have been engaged in developing the plans for the alternative location for the freestanding midwife led birthing unit, and with the implementation of the temporary change of service location in October 2023.

3.4.4. Ambulatory Care Services

The CCTF clinical Sub-group and the Clinical Congress considered the future of ambulatory care services and differentiated between services which would provide an improved clinical service if co-located with related clinical services, such as orthopaedics, rheumatology, ophthalmology and imaging diagnostics, and those other ambulatory services better provided in Maldon, offering local access.

4. Previous assurance and advice

Section '3.6. Internal scrutiny of proposals' sets out how the proposals and options were internally reviewed and scrutinised at the pre-consultation stage.

Our proposals were also externally scrutinised at the pre-consultation stage by:

- The East of England Clinical Senate: An expert group of senior clinicians who know the mid and south Essex regions well and offered an independent view. At our request they tested our proposals and gave us helpful advice.

- University College London Partners: An independent health innovation partnership working with the mid and south Essex health system at the time the proposals were first being developed. At our request they reviewed emerging proposals and offered advice on the available evidence base and on how the proposals might be further developed.

- NHS England: Any proposal for service change must satisfy the government's five tests, best practice checks, and must be affordable in capital and revenue terms. The NHS England assurance process was conducted by a team of reconfiguration experts who are not involved in the programme.

- The three upper tier local authorities' (Essex County Council, Southend-on-Sea City Council and Thurrock Council) Health Overview and Scrutiny Committees (HOSCs): HOSCs are local authority committee responsible for reviewing and scrutinising health and social care services within their area. They act as a critical friend, holding health bodies accountable and suggesting ways to improve services. This committee ensures that local health services meet the needs of the community, and that public money is spent effectively. The ICB have a statutory duty to engage with HOSCs on any significant service changes.

An interim Integrated Impact Assessment was also undertaken to support the pre-consultation business case.

4.1. East of England Clinical Senate

The role of Clinical Senates is to provide clinical advice and leadership to help statutory bodies make the best decisions about health for the populations they serve. The advice given by Clinical Senates is impartial and is informed by the best available evidence.

Initial proposals for the future configuration of community inpatient beds, which formed the basis of the Pre-Consultation Business Case (PCBC) and public consultation, were tested by the East of England Clinical Senate in 2022. The Senate considered that the then proposals had the potential to deliver good patient outcomes and support patient flow. The Clinical Senate supported the introduction of dedicated, ring-fenced stroke rehabilitation beds to deliver 'more consistent and resilient care' but did note that two community stroke rehabilitation units could still be challenging in terms of staffing.

The intermediate care clinical model and plans to enhance staff training were well supported, as was the aim to improve home first performance towards national recommended best practice.

Recommendations from the Clinical Senate review in 2022 included:

- Optimisation of the stroke pathway: Further co-produced work to be undertaken, with an aim to minimise the number of patient moves in the overall stroke pathways where possible and ensure that the appropriate criteria and assessments are in place to deliver the correct pathways for each patient. Further work to ensure clear criteria for all possible pathways.
- Digital pathway communications: Ensuring digital solutions in place to enable seamless communication throughout patient pathways and help facilitate transformation of pathways.
- Digital virtual wards: Further development of virtual wards and virtual ward monitoring to enable more rehabilitation at home.
- Development of a comprehensive workforce strategy: Development of a workforce strategy to support the proposals, with ongoing focus on new ways of working, new roles, competency sign off and recruitment and retention.
- Continued focus on access with co-production: Co-produced solutions to access issues should be developed by engaging with local transport services, councils, the voluntary sector and patients, families and carers.

The Clinical Senate Report from 2022, including the full list of recommendations can be found in Appendix 7.

The recommendations outlined above have been considered in work programmes that have been developing pathways of care over the last few years, but there is still more to do.

In December 2023, the East of England Clinical Senate reviewed the updated proposals set out in the PCBC for the future configuration of community intermediate care and stroke rehabilitation beds, the location of the freestanding midwife-led birthing unit and the transfer of ambulatory care services from the St Peter's Hospital site, and agreed that MSEICB's clinical governance and assurance processes were followed in developing the PCBC. The Senate supported the overall proposals and made a number of observations. These are set out, along with MSEICB's responses, in Table 9 below. The full response form the Clinical Senate is provided in Appendix 9.

East of England Clinical Senate observation	**MSEICS response**
1. There needs to be further work on the workforce plan for these proposals.	This will be done as part of implementation planning once the estates configuration has been confirmed via public consultation and the system decision-making route described

	elsewhere. The Clinical and workforce subgroups will lead on this area.
2. There should be further work on analysing travel times; especially the impact on areas of deprivation and the patient groups already identified as experiencing health inequalities.	This has been further explored following this feedback in an updated Integrated Impact Assessment, including travel analysis. There is a Healthcare Travel costs Scheme available for those that meet the eligibility criteria for the NHS Low Income Scheme to support with travel costs.
3. While there was consultation with the public in forming these proposals, more extensive public consultation and engagement may have been helpful.	At the time of meeting with the EoE Senate Council, the Pre-Consultation Engagement analysis report (containing the below information) was unfortunately not yet available. This was prepared by Kaleidoscope Health and Care and endorsed by the Healthwatch organisations for MSE (Healthwatch Essex, Southend and Thurrock). This gained over 170 responses via two different surveys on the MSE Virtual Views platform. A further 120 people were engaged via survey groups online or in person. This is available as part of the appendices.
4. When doing further patient and public consultation in the future, Mid and South Essex ICB should ensure that enhanced patient involvement and the voice of underserved groups is especially targeted and heard so that a more inclusive and diverse range of feedback is received.	Pre-engagement and public consultation plans have been based on the Integrated Inequalities impact assessment. They have included targeted engagement with the following groups who were identified as groups of interest who would be affected by the proposals: Maldon Stroke Club Thurrock Stroke and Carers Group Blackwater GP Surgery PPG (Patient Participation Group) Healthwatch Essex AIS (Accessible Information Standard) Working Group Slipper Exchange run by Age Concern Southend-on-Sea and hosted by Havens Hospices Carers First Canvey Community Supermarket Bus Brentwood Stroke Club Stroke Association SEE Alliance Winter Wellness event. Ad hoc engagement with women and birthing people at William Julien Courtauld

	at St Michaels, Braintree, and St Peter's Hospital
5. Mid and South Essex may wish to consider the recommendations of The British Psychological Society for integrated community stroke services.	Thank you, we will include this in our implementation work on the staffing model.
6. It was suggested that clearer diagrams that depict how different governance groups relate to each other within the context of this proposal would be helpful.	This was presented in the PCBC.

Table 10: East of England Clinical Senate observations and Mid and South Essex ICBs response

In addition to the East of England Clinical Senate, a meeting was also held with the Regional Chief Midwife to enable a further 'expert' review of the proposed plans to relocate the midwife led birthing unit and the proposed impact of relocating ambulatory services from St Peter's Hospital (which include maternity outpatients). The proposal was supported in principle with the following caveats:

1. Any new proposed facility for maternity outpatient appointments can be made fit for purpose as a clinical area including IPC measures.
2. Any new proposed facility is of sufficient capacity to undertake all the services that are required for maternity services e.g., antenatal clinics, parent session, scanning, phlebotomy.
3. There is adequate parking at any new facility for mothers.
4. There is a good working lift in any new facility.
5. That the head of Midwifery and Gynaecology and the Director of Midwifery at mid and south Essex Foundation Trust are happy with the facility.
6. That the William Julien Courtauld midwife led birthing unit is kept open at all times except in exceptional circumstances and closure can only be agreed by the Director of Midwifery or executive Team.

There was also an ask to ensure that the service user voice was considered during the decision-making process. The full response can be found in Appendix 10.

4.2. University College London Partners (UCLP)

- At an early stage in the development of the clinical models, expert external advice was obtained from UCLP. Colleagues from UCLP reviewed the emerging proposals and offered advice on the available evidence base and on how the proposals might be further developed. At our request they reviewed emerging proposals and offered advice on:
    - The case for change, including local and national baseline positions.
    - Data for the beds calculations, advising on optimising the available data at the time.
    - Including staff and patient voices as part of the pre consultation business case development process.

- Adding narrative around options development, feasibility consideration, and any decision-making criteria used.
- Ensuring that metrics include both demand and capacity metrics.
- Considering joining the community stroke and intermediate care bed consultation processes.

Their advice was considered when developing the PCBC.

4.3. NHS England

NHS England (NHSE) has a role in assuring proposals for significant service changes prior to commissioners formally consulting on them.

NHSE's 'Planning, assuring and delivering service change for patients (2018 and addendum 2022[24])', sets out the framework for assurance. Adhering to this has been acknowledged by the Courts as part of a successful defence in a Judicial Review. All proposals must be assured against the national five tests set out in the guidance- see Section 4.6 'Five tests for service reconfiguration' below.

NHSE assurance is a two-stage process:

- Stage One: The strategic sense check of proposals, which was undertaken on 18th September 2023. This included a review of the scope of the work, the case for change and the emerging proposals to address this. At this stage NHSE concluded that the process should progress.
- Stage Two: The assurance of the PCBC and associated documents, which was undertaken on 19th January 2024. The NHSE Regional Director was responsible for formally confirming assurance and, in line with regional governance, agreed the following approach:

    - Strategic change review- embedded in the local programme and in reviewing iterations of the PCBC.
    - Clinical assurance undertaken by MSE Clinical Congress, and its approach scrutinised by the East of England Clinical Senate Council. Separately the Regional Chief Midwife engaged on relevant elements and was supportive of this approach.
    - Legal advice sought from Browne Jacobson.
    - The PCBC being considered by the MSEICS System Oversight and Assurance Committee (SOAC), chaired by the MSEICB with the NHSE Strategy and Integration Director as a member. This was seen as a 'cross-system sign-off group' (including MSEICB and Mid and South Essex NHS Foundation Trust (MSEFT) Chief Executive Officers).
    - The PCBC being formally approved by MSEFT Board, the Mid and South Essex Community Provider Collaborative Board (MSECC), and the MSEICB Board in public.
    - The PCBC being formally assured in line with guidance and policy by NHSE Regional Strategic Development Committee (RSDC).

[24] NHS England » Planning, assuring and delivering service change for patients

- Formal assurance confirmed in writing by the NHSE Regional Director as per policy and guidance (subject to RSDC recommendations)- see Appendix 16.

The above approach was followed and NHSE's assurance process confirmed that it was its considered view that our proposals and consultation materials were suitable to be taken to public consultation.

4.4. Health Overview and Scrutiny Committees

4.4.1. Statutory context

Under the NHS Act 2006 (as amended)[25], NHS organisations have a duty to consult Health Overview and Scrutiny Committees (HOSCs) where substantial variations or developments to health services are proposed. These powers ensure that NHS bodies are accountable to local communities via their elected representatives and provide a mechanism for independent oversight of major service changes.

Throughout the development of proposals to reconfigure community beds and outpatient services, NHS Mid and South Essex Integrated Care Board (MSE ICB) has maintained open and continuous engagement with the three upper-tier local authority scrutiny committees covering mid and south Essex:

- Essex County Council Health Overview Policy and Scrutiny Committee (HOPSC)
- Southend-on-Sea City Council People Scrutiny Committee
- Thurrock Council Health and Wellbeing Overview and Scrutiny Committee

4.4.2. Engagement Approach

Engagement with HOSCs commenced in 2021 to inform the committees of temporary changes to community bed provision introduced as a result of the COVID Pandemic.

Committees were subsequently re-engaged in 2022 at the outset of the work to develop permanent proposals for community-based service transformation. This engagement has spanned:

- Initial briefings focused on case for change development and the proposed approach to engagement.
- Updates on pre-consultation engagement activity and emerging themes were presented at formal meetings in early 2023.
- Involvement in the review and development of the Pre-Consultation Business Case (PCBC) took place in Autumn 2023.
- Briefings and formal notifications of the intention to consult, in line with regulations, took place in December 2023 prior to the launch of consultation in January 2024.

[25] National Health Service Act 2006

- HOSC chairs were also invited to review and comment on the draft consultation document and communications plan in early January 2024.
- Ongoing liaison during the public consultation period with the presentation of the consultation outcome report in September 2024.
- Post-consultation feedback, the remit of the post-consultation Community Working Group and proposed next steps for consideration in the Decision-Making Business Case (DMBC) have been updated as required.

In recognition of the geographical and cross-boundary nature of the proposals, the MSEICB formally invited the three local scrutiny committees to establish a Joint HOSC in line with Regulation 30 of the 'Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations (2013)'[26]. However, all three HOSCs opted to remain as individual committees, preferring to undertake scrutiny of the programme within their own statutory remit.

Engagement therefore took place on an individual basis with each committee, including:

- Formal public committee meetings
- Regular informal meetings and briefings with committee chairs and scrutiny officers
- Written reports, verbal updates, and the opportunity for members to provide commentary on all stages of programme development

This tailored approach ensured that each local authority had sufficient opportunity to review and scrutinise the process in a way that reflected the needs and priorities of their respective populations.

4.4.3. Areas of Focus and Feedback

Throughout the programme, HOSC members raised constructive challenge and contributed important insights relating to:

- Accessibility and equity of provision, particularly for rural communities and areas affected by the proposed changes at St Peter's Hospital.
- Transport and travel considerations, and the need for clear mitigation plans.
- Continuity and quality of care, including concerns about digital exclusion in outpatient settings.
- Future use of local NHS estate, including ambitions for local investment and long-term planning.
- Engagement quality, with members welcoming the ICB's proactive and inclusive approach to consultation and co-development.

[26] The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013

The ICB responded to this feedback through amendments to its proposals, enhanced mitigation planning, and the formation of a post-consultation working group to continue community dialogue.

4.4.4. Next Steps and Ongoing Accountability

The ICB remains committed to maintaining strong relationships with all three HOSCs and will continue to report progress through implementation. Subject to approval of this DMBC, future updates will include:

- Formal notification of decisions made.
- Implementation briefings where relevant or requested.
- Invitations to participate in the oversight of the programme's delivery.
- Formal responses to any further scrutiny or recommendations issued by the committee.

4.5. Integrated Impact Assessment

The Integrated Impact Assessment (IIA) is a set of collated evidence that provides information about the potential positive and negative impacts of proposed changes to services. Its purpose is not to determine any decision but to provide support to decision-makers by giving them better information on potential impacts of services changes and how they can best promote and protect the wellbeing of patients, staff and communities and have regard to reducing health inequalities.

The IIA includes an Equality and Health Inequality Impact Assessment (EHIA) which assessed and considered the potential impact which the proposed service changes could have on people with characteristics that have been given protection under the Equality Act 2010[27], especially in relation to their health outcomes and the experiences of patients, communities, and the workforce. With reference to health and health inequalities, the responsibilities include assessing and considering the impact on the whole of the population served by the relevant statutory bodies and identifying and addressing potential solutions (mitigations) which would reduce health inequalities, specifically with regard to access and outcomes.

The EHIA can be used to demonstrate compliance with the Public Sector Equality Duty 2010 (established as part of the Equality Act 2010 (s.149[28]) as the legal obligation for public authorities in England, Scotland and Wales) and the duty to reduce inequalities of access and outcomes under the 'NHS Act 2006 (as amended) s.14Z35'[29].

Travel analysis undertaken as part of pre-consultation was reviewed and has been factored into the IIA.

The IIA has been updated following the feedback in the consultation. The IIA can be found in Appendix 11.

[27] Equality Act 2010
[28] Equality Act 2010
[29] National Health Service Act 2006

4.6. Five tests for service reconfiguration

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

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

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

- That there is sufficient alternative provision in place alongside or ahead of bed closures
- They can show that new treatments or therapies will reduce specific categories of admissions.
- That there is a credible plan to improve performance without affecting patient care.

The options under consideration for community inpatient beds will mean a slight reduction in NHS intermediate care bed numbers, but all shortlisted options increase the number of stroke rehabilitation beds. In addition, the system of health and care is well along its path to developing alternative care settings to bedded provision such as virtual wards and community reablement, with the ethos of Home First at the forefront of future clinical care models.

Test 1 – Strong Public and Patient involvement

The PCBC was developed in conjunction with engagement with stakeholders. Following its approval by the MSE ICB, the system of health and care entered a period of public consultation, enabling the Decision-Making Business Case to be developed in the light of the public responses. It is also intended that the solutions for replacing ambulatory services to be transferred from the St Peter's Hospital site should be developed through a process of co-production with service users, clinicians, and the local community.

We undertook a comprehensive approach to enabling patients, carers, the public, staff, and key stakeholders to be involved in the public consultation through a wide range of activities, events, and media which ran from the 25th of January 2024 to the 11th April 2024. Following the consultation, analysis of insights from public and local government consultation has been undertaken and used to inform the development of this Decision-Making Business Case (DMBC).

For detailed information on how we have achieved this see 'Section 5: Consultation and engagement'.

Test 2 – Patient Choice

Choice of location

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

Test 3 – Clinical Evidence

Clinical leadership and scrutiny

The proposed service changes set out in the PCBC were led by a Community Care Task Force (CCTF) with clinicians in its membership, supported by a Clinical Sub-Group which reviewed in detail the long list of options, refining them to a short list which led initially to the interim changes to configuration to help the system of health and care manage winter demand. The system's Stroke and Ageing Well Stewards have met regularly and have been fully engaged in the development of options and in September 2023 an audit of stroke services was undertaken which has informed this business case. The PCBC refers to several clinical audits of intermediate care services since 2019 which illustrated the need to improve outcomes.

Section '3.6 Internal scrutiny of proposals' and sections '4.1 East of England Clinical Senate' and '4.4 University College London Partners' of the DMBC set out the extent of clinical engagement, both locally and regionally, and section '1.4 Case for change' sets out the extensive selection of national and other guidelines which support the approach being taken in the DMBC.

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

Test 4 – Support from Clinical Commissioners

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

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

The PCBC was reviewed and approved by each of the Boards of the constituent organisations of the MSE Integrated Care System, to confirm support from all NHS bodies in MSE.

Test 5 – Bed Numbers

Total number of beds

At an aggregate level, the number of beds in the MSE system do not materially change because of the proposals set out in this document. It is the configuration and location of the community inpatient beds that will change. A summary of the main potential bed changes is set out below:

- Under either Option A or Option B, MSE would have a total of 138 community inpatient beds across intermediate care and stroke rehabilitation. This is an increase of 9 beds from the 129 that were available prior to the temporary moves that took place in October 2023, and the same as the number of community inpatient beds currently in the system since the temporary changes took place. The split of intermediate care and stroke rehabilitation beds varies across the two options, with Option A also including the potential to accommodate up to 3 beds for Level 3 neuro-rehabilitation. In Section 5 of the PCBC, 'Options for Change', and in 'Section 1.4.3.1. [Strategy] Demand and Capacity' in the DMBC calculations have been shown for the numbers of beds required.

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

- The MSE system has been shown to have the lowest percentage of delayed discharges from acute hospitals in England with a percentage delay of 5.8% compared with the all-England average of 13.7% (data from April to August 2023). This is believed to be a result of community Early Discharge Services, the development of Integrated Neighbourhood Teams, use of 'bridging' to provide practical support for individuals ready to leave hospital, but without their package of care not being in place as well as the recent development of 'virtual ward' beds enabling people to stay at home and receive treatment and care.

- The current proposals contain options to increase the number of community stroke rehabilitation beds further (since the temporary increase in stroke rehabilitation beds in October 2023) from 39 to 47/50 either in a single specialised unit or in two units in the east and the west of the system.

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

- Of the virtual hospital beds now in operation across MSE there is support for patients with frailty, respiratory conditions and mental health patients. These do not replace community intermediate care and stroke rehabilitation beds but do provide a means of continuing to manage the medical needs of patients in people's place of residence.

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

- The William Julien Courtauld Unit at St Michael's Health Centre, adjacent to the Braintree Community Hospital which could replace the St Peter's Hospital freestanding midwife-led birthing unit has sufficient beds for women giving birth there.

4.7. Financial Assurance

The key financial test, set out in NHS guidance 'Planning, assuring and delivering service change for patients (2018 and addendum 2022)' is that any proposal is affordable in capital and revenue terms ahead of public consultation.

The Mid and South Essex system is currently operating at a financial deficit, and significant efforts are underway to reduce, and ultimately eliminate the deficit.

At the outset of the project, a Community Capacity Finance Subgroup was established (a Subgroup of the Community Capacity Programme Board) with representatives from the MSEICB, MSEFT and MSECC, with the following remit, via the agreed Terms of Reference.

- To critically challenge, review and oversee all revenue implications of the current and proposed changes in service configuration
- To ensure ownership of the financial position across all Partner organisations
- To sign-off all values within the financial model

Furthermore, all movements in cost relating to Operational service delivery were modelled and signed-off by both Clinical and Workforce Subject Matter Experts prior to financial modelling being undertaken.

Finance System Partners have worked together throughout the project, to assess costs, and ensure a consistent approach to the financial modelling across the system.

Following the process outline in 'Section 3: The consultation proposals', the proposals and associated options (for intermediate care and stroke rehabilitation beds) were costed, reviewed and agreed by the Finance Subgroup.

4.7.1. Community Inpatient Beds

As part of the financial assurance for community inpatient beds, the following were agreed as being in scope of the financial analysis:

- Incremental changes in revenue costs relating to the Intermediate Care and Stroke Rehabilitation bed-base.
- Mothballing of, and the associated benefits, of relocating the residual operational services to the Ground Floor of St Peters Hospital.
- Financial impact on other Acute services and benefits from Acute bed closures made possible from improving flow.

Option A and Option B for the bed configurations and locations were both costed.

The revenue impact of the options is shown in the table below.

Incremental Financial Changes Per Annum (£m)					
	Community Collaborative £m	ICB £m	MSE FT £m	System-Wide £m	Bed Movements
	(Cost)/Saving	(Cost)/Saving	(Cost)/Saving	(Cost)/Saving	(IMC/Stroke/Total)
Option A	(2.7)	(1.3)	4.2	0.3	-17/+26/+9
Option B	(2.5)	(1.3)	3.7	0.0	-14/+23/+9

Figure 12: Incremental changes in cost by Partner organisation

Option A derives a saving of £0.3m (£252k) per annum based on the financial analysis undertaken and Option B breaks-even (small saving of £5k per annum) based on the financial analysis undertaken.

The key financial assumptions used to develop the information above are:

- Changes in costs relating to front-line service delivery have been reviewed and signed-off by both clinical and finance subject matter experts.
- Savings associated with bed closures in the Acute setting are modelled on a proxy bed-day rate, provided by MSEFT.
- Current modelling assumes that for every increase in stroke rehabilitation beds in the community there is a corresponding reduction in acute located beds.
- Utility and capital charge savings, generated as a result of mothballing the St Peter's site, are based upon pro-rating existing total costs. The savings modelled assume that these will accrue based on proportional floor areas for ongoing use versus those which will no longer be operational and have been modelled and validated by the MSEFT finance team.
- Upon a final solution being agreed, changes in Provider revenue expenditure patterns will need to be reflected as corresponding changes in income flow, transacted via the Integrated Care Board.

4.7.2. Freestanding Midwife Led Birthing Unit

The only financial implication of the relocation of the midwife led birthing unit is a small, time-limited cost of £9k per annum, relating to excess travel charges for those staff changing base.'

Given the change in bed capacity, due to the change in demand (see section '1.4.4.1. [Strategy] Demand and capacity') MSEFT have made some internal staff changes to bolster capacity within their Alongside Birthing Unit on the Broomfield site, via the freeing up of resource as a result of there being fewer beds in William Julien Courtauld than there previously were in St Peter's Hospital. The cost of the William Julien Courtauld estate is already included within the MSEFT run rate. It is worthy of note that the MSEICB has no change in commissioning expenditure, as 'Midwifery' is part of the block element of its contract with MSEFT.

4.7.3. Ambulatory Care Services

It is recognised by the MSEICS that there is further work to be done once a decision has been made on the future location of ambulatory care services in Maldon, through this decision-making business case, to understand the full capital costs and associated revenue costs of that decision.

The rationalisation of all ambulatory care services onto the ground floor of St Peter's Hospital has already delivered revenue savings, which are embedded within the overall financial modelling for the 'community beds' element of this business case outlined above.

4.8. Additional Considerations

Under the NHS Act 2006 (as amended), new duties were introduced which require the Integrated Care Board to have regard to the wider effects of decisions that we make (s.14Z43[30] NHS Act 2006 (as amended)), generally referred to as the triple aim duty, and to have regard to the need to contribute towards compliance with the UK net zero emissions target (s.14Z44[31] NHS Act 2006 (as amended)). These are in addition to our general and other duties (s.14Z44 NHS Act 2006 (as amended)) and the public sector equality duty (s.149 Equality Act 2010).

In addition, under the Armed Forces Act 2006 (as amended[32]) a legal duty has been introduced, known as the Armed Forces Covenant Duty (s.343AA[33] Armed Forces Act 2006 (as amended)). The MSEICB has a responsibility to consider the unique obligations and sacrifices of the Armed Forces community.

4.8.1. Climate Change Duty (s.14Z44 NHS Act 2006 (as amended)

Mid and South Essex Integrated Care Board (MSEICB) has a statutory duty to consider the wider impact of its decisions on health, quality of services, and the sustainable use of resources. Along with the Mid and South Essex Integrated Care System (MSEICS) we are committed to achieving net zero carbon emissions by 2040 for its direct emissions and 2045 for the emissions it influences through its supply chain and other activities in line with the Greener NHS Programme. This is

[30] National Health Service Act 2006
[31] National Health Service Act 2006
[32] Armed Forces Act 2006
[33] Armed Forces Act 2006 Section 343AA

detailed in the MSEICS Green Plan 'Our Strategy towards net zero (March 2022)[34]', which outlines strategies to reduce carbon emissions, decrease pollution, and centres on building sustainable health and social care systems that deliver high-quality services and improve population health and wellbeing.

The MSEICS's 'Greener NHS' Board provides oversight and assurance that the MSEICB and system providers are delivering against the MSEICS Green Plan.

The MSEICS Green Plan is focused on five core areas to drive our sustainability efforts:

- Decreasing energy and water consumption.
- Transitioning to 100% green electricity.
- Promoting sustainable travel options.
- Ensuring supplier alignment with net-zero targets through sustainable procurement.
- Implementing contract monitoring, sustainability impact assessments, electric/hybrid car leasing, and a cycle to work scheme.

We have considered the potential environmental impacts of the proposed service changes within this decision-making business case. The IIA (see Appendix 10) includes a section on the environmental impacts of service changes. A Sustainability Impact Assessment has also been undertaken in line with the MSEICS Green Plan (see Appendix 14). More information can be found in section '8.4 Environmental impact analysis'.

4.8.2. Wider Effects of Decision Duty (s.14Z43 NHS Act 2006 (as amended))

Under section 14Z43 of the NHS Act 2006 (as amended), we have a duty to ensure that the organisation has regard to all the likely effects of our decision-making, especially the effects on:

- The health and wellbeing of the people of England (including inequalities in that health and wellbeing).
- The quality of services provided or arranged by both us and relevant bodies (including inequalities in benefits from those services).
- The sustainable and efficient use of resources by both us and other relevant bodies.

We have done this through:

- Our Integrated Impact Assessment (see 'Section 8: Impact of proposals' and Appendix 10) which includes a Health Equality and Inequalities Impact Assessment, and which reviews the impact of the proposals on the environment.
- Patient and public engagement, including the public consultation, and wider stakeholder engagement which assesses the impact of the proposed service changes on people with protected characteristics.

[34] ICS-Green-Plan-2022-v0.3.pdf

- Our work with clinicians and other experts, including before, during and following consultation.
- Our due diligence regarding the financial, environmental and other aspects of the proposals set out in this decision-making business case.

We have also considered the wider impact any service changes may have on existing services and the impact on neighbouring Integrated Care Board's service provision. More information can be found in section '8.6 Impact on wider services'.

4.8.3. Armed Forces Covenant Duty (s.343AA Armed Forces Act (as amended))

Under the Armed Forces Covenant Duty (s.343AA[35] Armed Forces Act 2006 (as amended)), certain public bodies, including the NHS, must have due regard for the principles of the Armed Forces Covenant when exercising specific functions. In the case of the NHS this means when exercising our healthcare functions, including functions under the NHS Act 2006 (as amended). The MSEICB has a responsibility to consider the unique obligations and sacrifices of the Armed Forces community and to ensure they are not disadvantaged when accessing services like healthcare.

We have considered the impact of the proposals in exercising our duty on delivering the Armed forces Covenant Duty. More information can be found in section '8.7 Impact on Armed Forces'.

[35] Armed Forces Act 2006 Section 343AA

5. Consultation and Engagement

5.1. Adherence to our Statutory Duties

NHS Mid and South Essex Integrated Care Board (MSEICB) has met its statutory obligations under the NHS Act 2006 (as amended) (s.14Z45[36]), Health and Care Act 2022[37], Equality Act 2010[38], and related legal and regulatory frameworks.

5.1.1. Adherence to the Gunning Principles

The Gunning Principles are a set of legal standards that underpin fair and lawful public consultation. NHS Mid and South Essex ICB has taken a transparent, inclusive and robust approach to consultation throughout the development of proposals for changes to community intermediate care and stroke rehabilitation beds across mid and south Essex, the freestanding midwife-led birthing unit in mid and south Essex and ambulatory care services at St Peter's Hospital, Maldon. This section sets out how each of the four principles has been met, with clear evidence to support compliance.

While some members of the public raised concerns regarding adherence to these principles, these were formally acknowledged and responded to through appropriate governance processes, reinforcing the ICB's commitment to lawful and responsive engagement.

Principle 1: Proposals were at a formative stage

The consultation was conducted at a point where no final decisions had been made. The process was genuinely open to influence and designed to enable community input to shape the outcome.

A preferred option was included in consultation materials, based on a rigorous options appraisal process carried out during pre-consultation planning. The inclusion of a preferred option is consistent with best practice in NHS consultations and does not imply a pre-determined outcome. Rather, it enhances transparency and allows consultees to respond meaningfully.

Throughout the consultation, the ICB maintained an open mind and actively sought new information and perspectives. The consultation was designed to test and validate previous engagement findings and to uncover new insights from staff, residents, partners and communities. These findings have informed revisions to proposals and have been integrated into both implementation planning and the final business case.

The consultation questions were specifically developed to invite constructive input on key issues, including potential impacts, access and travel, and perceived strengths and weaknesses of the proposals.

Principle 2: Sufficient information was provided for intelligent consideration

[36] National Health Service Act 2006
[37] Health and Care Act 2022
[38] Equality Act 2010

To enable informed responses, the ICB ensured that information was clear, accessible and tailored to meet diverse needs. A wide range of materials was produced in different formats, including:

- Full and summary consultation documents
- Easy Read and audio versions
- FAQs, podcasts, and video explainers
- Materials available via the consultation website, social media, local media, posters and community venues

The approach to information provision was tested with stakeholders during the pre-consultation phase to ensure clarity and relevance. The widespread and consistent feedback received demonstrates that consultees were able to engage meaningfully with the materials. The independent consultation analysis report shows that respondents across diverse stakeholder groups were able to offer detailed and consistent insights, indicating a high level of understanding of the content.

Principle 3: Adequate time was given for consideration and response

The consultation ran for an extended period of 11 weeks, exceeding the recommended eight-week minimum and approaching the widely accepted 12-week standard.

Key milestones:

- Initial launch: 25 January – 21 March 2024 (8 weeks)
- Mid-point review extension: Extended to 4 April 2024 (10 weeks)
- Final extension: Further extended to 11 April 2024 (11 weeks), accounting for the Easter holiday period and sustained response levels

The duration of the consultation was informed by advice from independent experts, including Stand (consultation analysts) and local Health Overview and Scrutiny Committees. The extensions demonstrate a responsive and adaptive approach, ensuring maximum opportunity for participation.

Principle 4: Conscientious consideration was given to responses

All consultation responses were independently analysed by Stand and presented in full to the MSE ICB Board. The ICB has reviewed and considered this feedback carefully in reaching its final recommendations.

Key assurance points:

- The independent consultation feedback report was published on 10 July 2024.
- The findings were formally presented to the MSEICB Board on 11 July 2024.
- The full report is included in this DMBC (Appendix 1)
- Feedback from the consultation and the subsequent further community engagement has directly influenced final proposals and planning

The ICB is confident that it has given conscientious and lawful consideration to the views shared throughout the consultation process and that the principles of good public consultation have been upheld.

5.2. Summary of consultation design and delivery approach

A comprehensive communications and engagement strategy was delivered through a multi-agency group, with leadership from MSEICB. Activities included:

- 10 public events (310 attendees), plus a formal public hearing (120+ observed live; 1,000+ post-event views).
- 5,544 survey responses; 1,108 additional responses to a locally organised survey.
- Targeted focus groups and voluntary sector-led engagement (61 participants).
- 407 staff involved through internal briefings and workshops.
- Wide-reaching multimedia campaign including over 200 media stories and 20,000 website visits.
- Supplementary public polling (1,108 respondents) and engagement with local MPs, councillors and stakeholder bodies.
- Analysis of a separate public meeting (attended by more than 400) and survey undertaken by a local MP
- Informal and formal meetings with the three Health Overview and Scrutiny committees covering mid and south Essex – Essex County Council, Southend-on-Sea City Council and Thurrock Council

The strategy included targeted efforts to reach underrepresented communities, digitally excluded individuals, ethnic minority groups, and people most affected by the proposed changes—particularly in Maldon, Southend, and Brentwood.

All consultation activity was supported by professional independent analysis and facilitation, with involvement agency Stand, commissioned to provide independent reporting.

5.3. Summary of our approach to inclusive and responsive engagement

Accessibility and inclusion were central to the consultation. Actions included:

- Easy Read and audio formats of materials.
- Paper surveys with prepaid return options.
- Translated content and focus groups tailored to specific communities.
- Additional publicity and events added mid-consultation in response to demographic analysis.
- Enhanced outreach through faith groups, men’s groups, maternity groups, and local voluntary organisations.

All materials were aligned to accessibility standards, and technical language was avoided.

A dedicated ‘public hearing’ allowed stakeholders to present directly to MSE NHS leaders. All feedback was recorded and independently reviewed. Frequently asked questions were continually updated in response to queries received via the consultation email and engagement platform.

5.4. Summary of Consultation Themes

Feedback from the consultation was grouped into five overarching themes:

1. Strategy and strength of case for change
2. Clinical models and patient pathways
3. Workforce and staffing
4. Estate
5. Travel and Access

Key messages included:

- Strong community concern regarding service changes at St Peter's Hospital.
- Broad opposition to the proposed permanent closure of the midwife-led birthing unit in Maldon.
- Concerns over travel time, costs, and access to services.
- Mixed views on digital outpatient delivery, with issues raised around exclusion.
- Requests for continued investment in the local NHS estate and staff.

All responses are detailed in the independently compiled Consultation Feedback Report (see Appendix 1).

5.5. Influence of consultation feedback on final recommendations

The MSEICB has given conscientious consideration to all feedback received through the consultation and associated engagement activities. Taking conscientious consideration of the feedback led to the implementation of the Community Consultation Working Group. The feedback, along with the recommendations from the Community Consultation Working Group, has played a critical role in shaping the final proposals, with a number of important amendments and areas of further development introduced as a direct result of public, patient, staff, and stakeholder input. In particular:

- The ICB has reaffirmed its commitment to maintaining locally based ambulatory care services.
- Additional measures to support workforce stability and continuity have been included, informed by feedback from staff and trade union representatives regarding the importance of protecting existing expertise and relationships.
- Issues raised in relation to the future of maternity services, community inpatient beds, and ambulatory care services in Maldon have been subject to further detailed exploration through a Community Consultation Working Group. This Working Group, chaired independently, included community, clinical, and system representation.
- Feedback on the importance of local access, especially for rural and older populations, has informed implementation and future planning of service transitions.
- Concerns about communication and transparency have been addressed through clearer public information, strengthened oversight arrangements, and the establishment of a proposed community and clinical advisory body to support ongoing dialogue.

These actions demonstrate the MSEICB's commitment to meaningful engagement, lawful consultation, and the co-development of sustainable, patient-centred solutions.

5.6. Community Consultation Working Group

In response to strong feedback during the consultation period, MSEICB committed to a further phase of engagement to ensure proposals for community health services were fully co-developed with local communities and stakeholders. As part of this commitment, the ICB established an independent Community Consultation Working Group in autumn 2024.

5.6.1. Purpose and Role

The group was created to review feedback from the public consultation and co-develop revised proposals for the configuration of community hospital services, particularly around:

- Community bed-based care for intermediate care and stroke rehabilitation
- Midwife-led birthing units
- Outpatient and ambulatory care services in Maldon
- A sustainable long-term health estate plan for the Maldon district

Chaired by Independent Chair James Halden, the group brought together clinical leaders, local authorities, NHS providers, Healthwatch, community representatives, and voluntary sector partners. It operated with a clear remit, code of conduct, and transparent governance.

5.6.2. Key Outcomes

Following six months of detailed engagement and collaborative working, the Community Consultation Working Group published its final recommendation report in March 2025 (see Appendix 2). The report reflects:

- Extensive engagement with patients, clinicians, community groups, staff, and local residents.
- Recommendations based on clinical evidence, community priorities, and practical delivery constraints.

Headline recommendations include:

- Preference for Option B, a 'split-bed model' across two sites rather than one site for stroke rehabilitation, ensuring equitable access across the geography.
- The permanent relocation of the freestanding midwife-led birthing unit to William Julien Courtauld Unit, Braintree, with a guarantee that over 14,000 pre- and post-natal appointments will remain accessible in Maldon.
- Continued use of St Peter's Hospital for a further five years for ambulatory care services, while plans are developed for a new, purpose-built healthcare facility on the current site.
- Establishment of a permanent oversight committee to support future transformation and monitor service delivery and quality, with a particular focus on maternity and rehabilitation services.

5.6.3. Impact on the Decision-Making Business Case

The recommendations of the Community Consultation Working Group form a core part of this Decision-Making Business Case (DMBC). They directly respond to the Gunning Principles by ensuring:

- Community concerns have shaped viable service models.
- Information shared through consultation was acted upon meaningfully.
- Final proposals are grounded in both public voice and clinical viability.

The group has demonstrated a model of participatory decision-making that the MSEICB intends to sustain through future oversight arrangements and co-design of service implementation.

5.7. Ongoing Engagement and Governance

The MSEICB supports the recommendation to establish a permanent community and clinical advisory body to oversee the implementation of service changes. This will ensure:

- Continued focus on access, quality and safety.
- Ongoing dialogue with the communities most affected.
- Transparent monitoring and reporting of service development.

The group has set a new standard for integrated, community-led service planning and its outputs provide a credible, co-produced foundation for sustainable change.

Consultation analysis

6. Feedback from the public consultation

6.1. Key Findings

During the consultation, people were asked to give their feedback on:

- Potential changes to locations for community hospital intermediate care and stroke rehabilitation services.
- A proposal to make permanent the temporary relocation of the freestanding midwife-led birthing unit from St Peter's Hospital, Maldon, to the William Julien Courtauld Unit at Braintree Community Hospital.
- The possibility of moving all other patient services from St Peter's Hospital, Maldon, to alternative sites, primarily in and around Maldon

People were asked for their views on the strengths and challenges of all proposals, as well as any suggestion for future locations for ambulatory care services in Maldon.

The consultation findings presented in this Section summarise feedback from all qualitative and quantitative engagement methods, from different stakeholder groups across different geographies within mid and south Essex. The independent consultation feedback report produced by Stand (see Appendix 1) identified them as key findings because many people talked about them, there was strength of feeling evident across engagement types and they relate to the future proposals.

The key findings were:

- There is widespread objection to all consultation proposals, especially the idea of moving ambulatory care services out of St Peter's Hospital in Maldon.
- The main reasons cited for the objection to these proposals were
    - The burden of extra travel time and costs the proposals would place on patients, families and carers, and its impact on the environment
    - How the potential closure of St Peter's Hospital in Maldon without a replacement facility would leave the health needs of residents of Maldon and the wider mid and south Essex population unmet.
- Where support is expressed, it tends to be limited and qualified, and in some cases caveated.
- There was a strong feeling that decisions about the future of these services, the other services at St Peter's Hospital, and the closure of the facility have already been made, with concern that the views expressed during the consultation activity will not be considered.
- Participants submitted a range of alternative solutions, which are included in the main report.

The consultation process was generally well received, with many appreciating the range of engagement methods, including the Virtual Views platform, public events, and targeted outreach to seldom-heard groups. However, there were some comments made that the perception was that limited effort has been made to promote the consultation, which it was claimed, resulted in a lack of awareness amongst Maldon residents and those from surrounding areas of the proposed changes. There were also concerns about the consultation materials not being easily digestible and accessible, the time frame for responses, inconsistent messages and

information (all addressed in the consultation) and Mid and South Essex Foundation Trust (MSEFT) and MSEICB representatives coming across as condescending and patronising at public meetings. 'Section 5: Consultation and engagement' sets out the consultation process and the efforts made to reach as many people as possible before and during the consultation process.

6.2. Overview of feedback on the proposals

This section, and the sections that follow, detail the feedback received on the proposals presented within the pre-consultation business case (PCBC) and present a summary of key findings across all stakeholder groups, from all geographies. Importantly, these are findings from all forms of feedback when considered together, including the questionnaire and qualitative engagement activities. This gives us a robust understanding of what people think about the proposals, which has been validated across different engagement types with different groups.

6.2.1. Feedback on options for community intermediate care and stroke rehabilitation beds

Both options for the future location and configuration of community intermediate care and stroke beds were rated poorly by most respondents.

Overall, feedback on the support and strengths of the options for community beds presented in the consultation were:

- Modernisation of community services: Many respondents did recognise the need to modernise and improve community services, especially to address population growth and changing needs.
- Improved local access for Brentwood residents: Support was noted for proposals that would improve local access, reduce travel times for visitors, and provide better facilities for Brentwood residents by offering a mix of stroke rehabilitation and intermediate care beds

Feedback on the objections and challenges of the options for community beds presented in the consultation were:

1. Travel and accessibility: The most prominent concern was about increased travel distances, poor public transport, parking difficulties and associated costs. These factors were seen as potentially leading to increased stress, patient isolation, poorer mental health outcomes, and longer hospital stays. Concerns were especially acute for vulnerable groups, including older adults, people with disabilities, and those without access to private transport. These issues were raised in all consultation activities.
2. Loss of provision at St Peter's Hospital, Maldon: There was significant local opposition to the closure of the stroke rehabilitation ward at St Peter's Hospital, with concerns about the loss of local services and the impact on patient outcomes, due to reduced service quality and accessibility, and loss of community identity. Many respondents felt the proposals did not sufficiently address the future of the hospital or the impact on the local community.
3. Service demand and capacity: Doubts were expressed about whether community services could support the patient load without sufficient intermediate care beds at Cumberlege Intermediate Care Centre (CICC), and concerns about the availability of therapy staff, particularly occupational

therapists. This was particularly in light of increasing demand with a growing and ageing population, and housing developments in Maldon and surrounding areas.

4. Distrust in the NHS and local government: Across all consultation activities, individuals expressed frustration and distrust, with feelings that decisions were financially driven rather than patient centric. Reference was also made to unmet promises of new services in the past within the Maldon district.

Feedback on Option A

Feedback on the support and strengths of Option A were that people recognised the benefits of having a dedicated stroke rehabilitation facility, more beds, adequate staff, and facilities at Brentwood Community Hospital. St Peter's Hospital was acknowledged as not being fit for purpose.

Feedback on the objections and challenges of Option A were that there were significant concerns around access difficulties for family members, impact on patients due to lack of support networks, staff travel issues, loss of intermediate care beds for Brentwood residents, significant staff changes, and implications associated with having centralised stroke services.

Feedback on Option B

Feedback on the support and strengths of Option B were that it gives improved access for more local care, especially for Southend-on-Sea and Rochford residents, reduced travel time for visitors, and is better for Brentwood residents as it offers them a mix of stroke rehabilitation and intermediate care beds.

Feedback on the objections and challenges of Option B were that there were concerns about the capacity of community services to support patients without intermediate care beds at CICC, and the level of therapy input required given current vacancies in occupational therapy.

Overall, Option B was viewed as a better compromise, offering improved access, reduced travel times for visitors, and a more balanced distribution of beds, particularly benefiting residents in Brentwood, Southend-on-Sea, and Rochford.

6.2.2. Feedback on options: Freestanding midwife led birthing unit

The option to relocate the freestanding midwife led birthing unit (MLBU) from St Peter's Hospital, Maldon, to William Julian Courtauld (WJC) Unit, Braintree, was rated poorly by most respondents.

Overall, feedback on the support and strengths of the option presented in the consultation were:

- WJC is seen to be a more appropriate, modern facility.
- Closer proximity to Broomfield hospital for transfer of patients if complications arise during labour.
- Potential to improve outcomes for patients.

Feedback on the objections and challenges of relocating the freestanding MLBU were:

1. Travel and accessibility: The most prominent concern across all engagement methods was increased travel distances, lack of or inadequate public transport options, perceived increase stress and risk of travelling further distances whilst in labour, parking difficulties and associated costs. There were also fears raised that increased travel contradicts guidelines on travel with newborn babies.
2. Loss of provision at St Peter's Hospital, Maldon: There was significant concern relating to the potential closure of St Peter's Hospital and reduced local birthing options. Many participants highlighted that St Peter's Hospital serves a large geographical area and is highly valued for its exceptional care and home-like birthing environment. There was a strong sentiment that maintaining a local birthing unit is essential, preferably at St Peter's Hospital with further investment, or at an alternative location in Maldon. Respondents also expressed frustration over temporary service changes being implemented without consultation and the lack of options for reinstating maternity services in Maldon, reflecting broader concerns about access to care and the future of local healthcare provision.
3. Service demand and capacity: References were made to the rapidly growing population with strong feeling that more services are needed, not less. Concerns were raised over capacity at WJC and Broomfield Hospital and the impact the changes will have on quality of care including time spent in hospital (i.e. discharge) and post-natal and breastfeeding support.

6.2.3. Feedback on options: Ambulatory Care Services

The proposal to relocate ambulatory care services form St Peter's Hospital to alternative locations in and around the Maldon area was rated very poorly by the majority of respondents.

In terms of support, just a small number of survey respondents and those who participated in other consultation activities discussed how St Peter's Hospital is no longer fit for purpose and that there is no other alternative than for it to close.

Feedback on the objections and challenges of relocating ambulatory care services:

1. Travel and access difficulties: Reference was made to cost, parking, poor public transport and road infrastructure, inconvenience and pollution. There was concern this would result in reduced appointment attendance with an associated health impact, especially for elderly, vulnerable, rural residents, and those without car access.
2. St Peter's Hospital: Reference was made to the lack of local provision that would be available with the loss of a vital local resource. Comments were made about the importance of ensuring local outpatient services are put in place prior to closure. Views included that increased uncertainty would have an impact on the local population, particularly older residents. Reference was also made to St Peter's Hospital being convenient and easily accessible with all services under one roof.
   There was widespread frustration about perceived historical mismanagement and lack of investment in St Peter's Hospital. Many believe that financial decisions are being prioritised over patient needs. There is a strong sentiment that proper maintenance could have prevented the current situation.

3. Increasing and ageing population: Reference was made to the ageing and rapidly increasing population with strong feeling that more services are needed, not less.
4. Increasing demand: Concern was raised about the increasing demand on already overstretched services (i.e. other hospitals, GP services, and ambulance services).

6.3. Themes arising from the consultation

The key themes arising from the independent consultation feedback report are explored in 'Section 7: Addressing Themes from the consultation', including our consideration of the feedback and evidence of how these themes have influenced further thinking.

6.4. Continued public and stakeholder engagement

The consultation has been a part of an ongoing engagement process, with many stakeholders having worked with us over several years. As part of our commitment to listening to feedback, a decision was taken in September 2024 to pause the decision-making process and to set up a Community Consultation Working Group to further engage with stakeholders and the public and continue to develop thinking around the proposals. This Working Group concluded in March 2025, but a commitment has been made to continue to work with stakeholders and the public in the development of short-, medium- and long-term plans for ambulatory services and the St Peter's Hospital site.

In the time between the close of the consultation and the decision-making meeting, we also continued to work with provider colleagues in the community and MSEFT to keep staff up to date and to keep open an offer of further engagement and staff briefings to answer questions and listen to any concerns.

We are grateful for all of the participation to date, which has helped to shape the decision-making process and outcomes.

Making the decisions on the proposals outlined in the consultation will mark the start of a new phase of engagement work, to support implementation where required, and to support in the further development of proposals linked to ambulatory care services and the St Peter's Hospital site. It will also signal a shift in engagement from the MSEICB to MSEFT, as owners of the St Peter's Hospital site, to lead on the development of future plans and, in time, oversee the implementation of these.

7. Addressing themes from the consultation

7.1. Process for addressing themes

As part of the assurance process for developing the decision-making business case (DMBC), feedback from the consultation responses was reviewed by the Community Capacity Programme Board and expert Subgroups. The Subgroups were made up of staff from across the Mid and South Essex Integrated Care System (MSEICS) with expertise in areas pertinent to the consultation proposals.

To address the key consultation themes, we used a process, set out in our framework for review of information below in Figure 13. The process we followed was:

- Assess whether the feedback and/or information from the consultation is new or has been previously considered.
- If it is not new, review how it has already been considered and accounted for and consider its impact on implementation and any further steps or mitigations needed.
- If it is new, assess whether it impacts the proposals set out in the consultation.
- If it does impact the proposals, consider the nature of that impact, and whether further steps are required, and any mitigations needed.

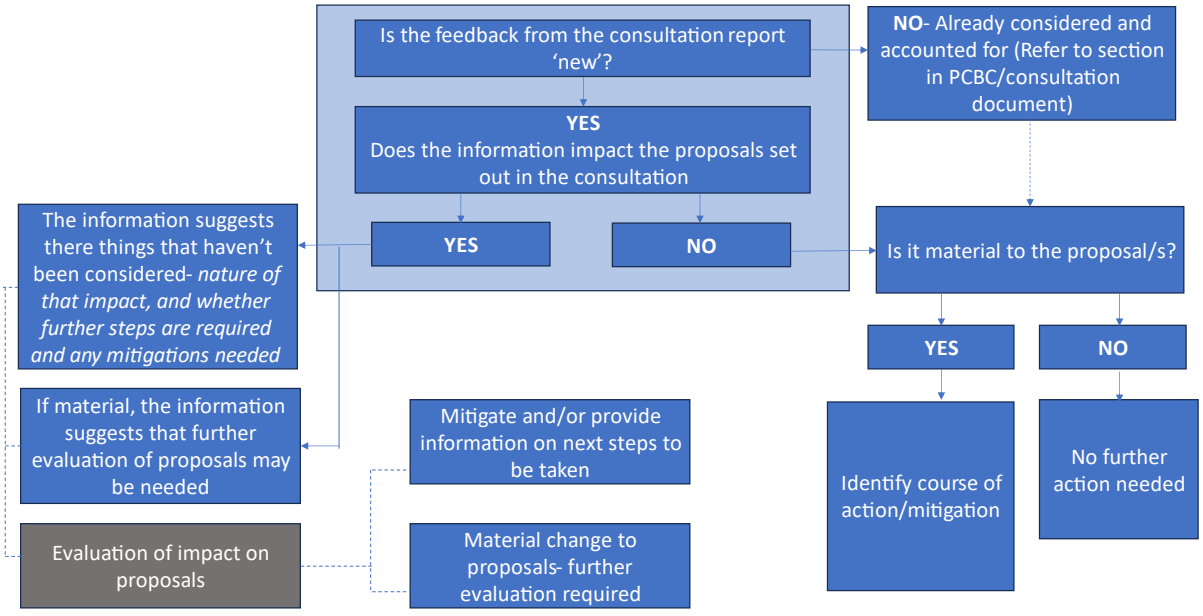

Figure 13: Framework for review of consultation feedback

We have categorised feedback from the consultation report and information and evidence into five overarching themes, which between them cover multiple sub themes. The five overarching themes identified are:

1. Strategy and strength of case for change
2. Clinical models and patient pathways
3. Workforce and staffing

4. Estate
5. Travel and Access

Some feedback received was not relevant to the current consultation but has been shared with relevant organisations and colleagues for them to consider in their work areas.

In the sections and tables below, we have summarised the considerations and responses to the feedback received form the public consultation, drawing from information provided pre-consultation and since the consultation and requesting additional information from expert groups and leads where needed.

The overarching feedback within the consultation was the strength of feeling towards the proposals in the consultation, particularly around the potential relocation of ambulatory care services and therefore potential future closure of St Peter's Hospital. It was this strength of feeling that resulted in the decision being taken to pause the decision-making process for six months and to establish the Community Consultation Working Group to further review the proposed changes to community hospital services. More information about the Working Group can be found in section '1.3.10.1 Community Consultation Working Group' and section '5.6 Community Consultation Working Group'. A very high-level overview of discussions and suggestions that came out of the Community Consultation Working Group are outlined in Section '7.7: Community Consultation working Group' below.

There was no new evidence received through the consultation feedback that had not already been considered in some way in the pre-consultation business case. However, there were requests to strengthen or further explain some information and we have, to our best endeavours, done that through our response to feedback set out in the sections and tables below, as well as through further information and discussions that took place with the Community Consultation Working Group.

7.2. Theme 1: Strategy and Strength of Case for Change

Sub theme- feedback from consultation	**Response**
Alternative locations: No identified alternative locations for ambulatory care services included in the consultation, but a commitment to any future location being 'in and around' Maldon. Clarity needed on what this means.	Within the consultation proposal, this meant that wherever it makes clinical sense to do so, services would continue to be delivered from a location within the Maldon district, or within a satisfactory distance from it. Exactly what is deemed as satisfactory would need to be agreed in collaboration with patients and the public. Alternative locations were suggested as part of the consultation feedback, and these have all been explored by the Estates Subgroup and the Community

	Capacity Programme Board overseeing the work. The suggestions were also shared with the Community Consultation Working Group and any suggestions outside of the Maldon district area were excluded. The strength of feeling around the potential relocation of ambulatory care services was evident from the consultation feedback report and the subsequent Community Consultation Working Group, the outcome of which is that the recommendation within this DMBC is to keep services at St Peter's Hospital in the short to medium term (0-5 years).
Bed modelling: Concern that there will not be enough community intermediate care beds or stroke rehabilitation beds in the system for future demand, given the ageing and increasing population.	Bed modelling included in the pre-consultation business case included future predicted growth at 8.59%, which is the anticipated growth in mid and south Essex up until 2030. Intermediate care bed modelling was revised at the request of the Community Consultation Working Group and showed that the demand expected for intermediate care beds is met by the capacity that will be provided in both Option A and Option B for community beds. The use of community beds, occupancy levels and any delays in access are routinely monitored through operational groups/leads as part of the day to day running of health services across mid and south Essex. There are several workstreams that are also being developed and delivered as part of ongoing pathway transformation in both intermediate care and stroke which will also support in creating additional capacity within pathways, with the focus on home first. More information can be found in 'Section 2: Models of Care- Our Vision for the Future'.

Community engagement: There was an ask for continued engagement with patients, the public and community groups for future development and delivery of plans, particularly in relation to ambulatory care services.	The pause in the decision-making process and the development of the Community Consultation Working Group evidences our ongoing commitment to engaging with stakeholders and the public. We heard the strength of feeling in the consultation feedback, particularly around the future of St Peter's Hospital and the proposed relocation of ambulatory care services in Maldon and that led to the decision to pause decision making. There is a commitment that there will continue to be stakeholder and public engagement with the further work there is to do in developing short-, medium- and long-term plans for ambulatory care services and the future of the St Peter's Hospital site. This is outlined in section '11.1.2 Post decision making governance arrangements'.
The Consultation process: Comments were made that not enough information was shared about the consultation and how to get involved, that materials weren't readily available and that it was not accessible to certain groups, such as those who do not have access to the internet.	See 'Section 5: Consultation and engagement'. This section covers all of the engagement and consultation opportunities that were made available and the process that was followed, as well as highlighting the significant number of responses to the consultation. Every effort was made to reach as many people as possible across mid and south Essex and this is evidenced within Section 5.
Distrust in the NHS and decision-making process: Comments were made that decisions had already been made and that temporary changes had already taken place prior to consultation.	No decisions about the proposals set out within the consultation have been made, and the process of pre-consultation engagement, the pre-consultation business case, the consultation, and now the decision-making business case evidence that the correct and necessary processes are taking place to ensure an evidence based, informed decision can be made by the MSEICB Board. The temporary service changes made in October 2023 were to improve capacity in response to clinical concerns raised

	around capacity and quality of services and estate and they remain as temporary changes only.
Environmental impact: There were multiple comments made relating to the need to undertake an environmental impact assessment as part of the implementation of any recommendations.	The environmental impact of the proposed service changes was referenced in the pre-consultation business case (PCBC) as part of the associated Integrated Impact Assessment (IIA) carried out at that point in time. The environmental impact of moving intermediate care and stroke rehabilitation beds and the freestanding midwife led birthing unit are minimal as the number of patients using the services are relatively small when looking at the mid and south Essex population as a whole and in some cases will mean shorter journeys for patients and families, depending on where they live. The strength of feeling around the potential relocation of ambulatory care services (including pre- and post-natal services) was evident from the consultation report and the subsequent Community Consultation Working Group that was established, the outcome of which is that the recommendation within this decision-making business case is to keep services at St Peter's Hospital in the short to medium term (0-5 years). Therefore, there will be no impact of increased travel on the environment. An updated IIA has been undertaken, and in line with the IIA in the PCBC includes a section on the environmental impact of proposed service changes. A review of the proposals against the Mid and South Essex Integrated Care Board's Sustainability Impact Assessment has been undertaken. The Sustainability Impact Assessment is aligned to the Mid and South Essex Integrated Care System's Green Plan

	'Our Strategy towards net zero (March 2022)' and the areas of focus contained within it. More information can be found in 'Section 8: Impact of proposals'.
Health inequalities: Concerns around the increase of health inequalities, particularly in the Maldon district, due to services moving out of the area.	An Integrated Impact Assessment (IIA) has been undertaken, which looks at the impact of proposed changes on certain groups, and more information can be found in 'Section 8: Impact of proposals'. Mid and South Essex Integrated Care System is committed to tackling health inequalities. This needs to be balanced against other equality factors such as the effectiveness of the services provided, and the patient outcomes achieved. Access for patients, relatives and carers is an important aspect when considering equality, but MSEICS is not in a position to enable equal geographical access for all since it is not proposing, nor has the finance to build and operate new community hospitals or freestanding birthing units, and therefore proposals are based on best use of existing premises which are themselves not distributed evenly throughout mid and south Essex. For community stroke rehabilitation beds, the clinical requirement is that the beds are concentrated, thereby concentrating expertise to ensure that the best outcomes for patients are achieved. If this were not done, another inequality would be created by offering sub-optimal stroke rehabilitation services. The number of people likely to be impacted by the proposed changes is relatively small. The largest impact would be to those using ambulatory care services but the commitment within the consultation was to keep these

	services within the Maldon district. The strength of feeling around the potential relocation of ambulatory care services was evident from the consultation report and the subsequent Community Consultation Working Group, the outcome of which is that the recommendation within this decision-making business case is to keep services at St Peter's Hospital in the short to medium term.
Housing developments and population growth: Concerns were raised about the increased housing across mid and south Essex and particularly in Maldon and questions were raised as to whether this had been considered when looking at future capacity and demand.	As part of the bed modelling work undertaken, population growth was factored into the figures at 8.59%, which is the anticipated growth to 2030 for mid and south Essex. The MSEICB works closely with local authorities in reviewing local development plans and the impact they will have on health and care services. Contributions are often made by developers, at the request of the NHS, through Section 106 funding to increase and improve healthcare services in areas where there are significant housing developments. We will continue to work with the local authorities as we further explore and develop plans for a new Maldon Health Hub/replacement for St Peter's Hospital and how these can be financed in the future, given the NHS constraints of capital funding. Ongoing work through a 'Maldon Summit' group, established and chaired by Essex County Council, which includes stakeholders from Essex County Council, Maldon District Council, and MSEICB, is taking place to review and plan for the increased housing developments planned for Maldon.
Lack of local provision: The loss of local provision of services was raised by Maldon residents in particular, but also by some residents in Southend and Brentwood who would lose either stroke rehabilitation beds or intermediate care	Community bed provision: Access and local provision for patients, relatives and carers is important in any service change, but MSEICS is not in a position to enable equal geographical access for all since it is not proposing, nor has the finance to build and operate new

beds depending on whether Option A or Option B is approved.	community hospitals or freestanding birthing units, therefore proposals are based on best use of existing premises which are themselves not distributed evenly throughout mid and south Essex. For community stroke rehabilitation beds, the clinical requirement is that the beds are concentrated, thereby concentrating expertise to ensure that the best outcomes for patients are achieved. Through the Community Capacity Working Group, it was evidenced that the need for beds for Maldon residents was not enough for community bed wards to stay in Maldon. Using the available estate for the whole of mid and south Essex and having larger units to ensure best use of the estate is key to the delivery of services, both in terms of value for money and from a staffing and workforce perspective. Whilst we recognise the impact of relocating intermediate care and stroke rehabilitation beds in areas of Maldon, Southend and Brentwood, this needs to be balanced against the benefits of better estate, more robust staffing and therefore better outcomes for patients through ensuring they receive the highest quality care, with access to specialist teams and facilities that can deliver better health outcomes. Ambulatory Care services: The strength of feeling around the potential relocation of ambulatory care services (including pre- and post-natal services) was evident from the consultation report and the subsequent Community Consultation Working Group that was established, the outcome of which is that the recommendation within this decision-making business case is to keep services at St Peter's Hospital in the short to medium term (0-5 years).

	Therefore, there will be no loss of provision to Maldon residents.
Mental health services: Concerns that mental health services would be lost from Cherry Trees, one of the units on the St Peter's Hospital site, particularly with rising dementia figures across the country.	The strength of feeling around the potential relocation of ambulatory care services (including pre- and post-natal services) was evident from the consultation report and the subsequent Community Consultation Working Group that was established, the outcome of which is that the recommendation within this decision-making business case is to keep services at St Peter's Hospital in the short to medium term (0-5 years). This includes the mental health services delivered from Cherry Trees.
Historical plans for replacing St Peter's Hospital: For many years there has been the promise of a new site/hospital to replace St Peter's Hospital, but plans have not come to fruition.	We recognise that for many years there have been plans to relocate services from St Peter's to a modern healthcare hub and the frustration from local residents that this has not happened. Numerous options have been previously considered, with the last options review taking place in 2022. This identified the potential for services to move to a new site (Wycke Hill). However, challenges with access to the site and its suitability have stopped these plans progressing. The Mid and South Essex Integrated Care System is committed to finding a long-term solution for replacing St Peter's Hospital, and will continue to work closely with stakeholders, staff and the public in developing plans for a long-term solution. More information on proposed next steps, plans and timeframes can be found in 'Section 11: Implementation'.
Midwife led birthing unit data: concerns that the data presented in the pre-consultation business case and the consultation documents was skewed. The number of births at St Peter's Hospital was very low, but this was because the unit had to intermittently	It is recognised that the freestanding midwife led birthing unit at St Peter's Hospital did have to intermittently close due to staffing issues across the St Peter's Hospital site and the Broomfield Hospital site. The rationale for moving the unit from St Peter's Hospital to William Julian Courtauld unit is

close to support birthing services at Broomfield Hospital.	multifaceted and not just due to low birth numbers. More information can be found in section '1.4.5 [Case for change] Freestanding Midwife Led Birthing Unit'. There has been an increase in midwifery staffing to the optimal level, however, due to a change in the demographic of maternity service users there is acknowledgement that the maternity population is becoming more complex and therefore require obstetric led care at the main unit. This includes a rising C Section rate and also a higher percentage of babies being born prematurely which often necessitate neonatal services. By offering WJC and also the Alongside Birthing Unit on the Broomfield site, service users have options for where they can give birth. Added to this there is a current piece of work being undertaken to improve the Home Birth services in the Maldon area, an outcome of the Community Capacity Working Group.
St Peter's sale: Respondents stated that any proceeds from the future sale of the St Peter's Hospital site, or part sale of the site must be put towards a Maldon Health Hub.	Comments have been noted and the intention from Mid and South Essex Foundation Trust (as the owners of the St Peter's Hospital site) is that any sale or part sale of the site would be reinvested into a Maldon Health Hub/replacement for St Peter's Hospital.
Suggestion of volunteer support to community inpatient beds: There was a suggestion made that a project could be set up to look at volunteer support to patients in community inpatient beds if they do not have support/visitors.	This suggestion will be explored as part of the implementation phase once a decision has been made on the location and configuration of community inpatient beds.

Table 11: Strategy and Strength of Case for Change- Consultation Feedback and ICB responses

7.3. Theme 2: Clinical models and patient pathways

Sub theme- feedback from consultation	**Response**
Admission criteria to community intermediate care and stroke rehabilitation beds: Suggestions were	Admission criteria for stroke rehabilitation and intermediate care beds are set out in the service

made that criteria for admission into the community inpatient beds should be reviewed.	specifications for the beds. These are reviewed as required by subject matter experts. As part of the wider workstreams on stroke care and intermediate care, as described in 'Section 2: Models of Care- Our Vision for the Future', service specifications, including admission criteria will once again be reviewed as part of the ongoing transformation of services.
Alternative locations: Suggestions were made to look at alternative locations in Maldon for inpatient care to be delivered from.	There is no suitable estate within the Maldon district for inpatient beds to be relocated to. Proposals are based on best use of existing premises within mid and south Essex which we recognise are not themselves distributed evenly throughout mid and south Essex. However, the Community Consultation Working Group did discuss wider transformation work around Discharge to Assess pathways (see Section 2: Our Vision for the Future for more information). Whilst not for the same cohort of patients who require a community NHS intermediate care bed, the suggestion from the working group was to look at opportunities for bedded care for other Pathway 2 patients, for example in care homes, where some patients currently go for an interim period whilst they await assessment for their longer-term care needs. The Working Group recommended that the MSEICB commission dedicated care home beds for these patients in Maldon. In response to this recommendation the medium-term plan (MTP) discharge to assess transformation programme now includes a workstream which will explore procurement options for dedicated discharge to assess bedded capacity within care homes in the Maldon district (and elsewhere in mid and south Essex).
Demand and Capacity: Capacity in community teams in Southend was questioned when beds are either all	Intermediate care and stroke community beds in all locations are open to residents from across mid and south

IMC provision or all stroke provision at CICC.	Essex so Southend patients will still have access to beds as required. As described in 'Section 2: Models of Care- Our Vision for the Future', transformation work is ongoing to look at delivering more care closer to or at home wherever possible. This ongoing transformation work will require looking at community teams, workforce and capacity.
Continuity of care: Concerns were raised around the lack of continuity of care for women and birthing people and for people accessing ambulatory care services.	The consultation proposal is to move the freestanding midwife led birthing unit from St Peter's Hospital, Maldon, to William Julian Courtauld Unit, Braintree. All maternity outpatient appointments will continue to be delivered from St Peter's Hospital, as per the recommendation in this decision-making business case (if approved) to keep ambulatory care services at St Peter's Hospital for the short to medium term (0-5 years), and therefore there will be no changes to the continuity of care for women and birthing people compared to how services run now. All other ambulatory care services will continue to be delivered from St Peter's Hospital as per the recommendation within this decision-making business case (if approved), and therefore there will be no change to the continuity of care compared to how services are run now.
Use of digital technology to improve patient care: Comments were made on the need to improve the use of technology and digital tools to improve care and access to care.	Whilst the consultation relates to the location and configuration of services, the use of technology wherever possible is a priority for the NHS both nationally and locally. Improving and transforming pathways of care, as outlined in 'Section 2: Models of Care- Our vision for the future', will need to include ongoing uptake and development of technology to support patient care. This will also include an increase in virtual appointments where possible to reduce travel and access issues.

Patient choice: Concerns were raised around women and birthing people being offered choice in where they give birth, in line with national guidance.	The proposals within the consultation and this decision-making business case mean that there will continue to be a freestanding midwife led birthing unit in mid and south Essex. This is in addition to midwife led birthing units which are co-located with obstetric units on the Basildon, Broomfield and Southend Hospital sites. Women and birthing people have the option to give birth in hospital (in doctor-led units), at a midwife led birthing center or at home, offering patient choice in line with national guidance.
Capacity (maternity services): Concerns were raised about the reduction in capacity at William Julian Courtauld Unit, Braintree, compared to St Peter's Hospital, Maldon, for both those in labour and those needing post-natal care. Concerns were raised about the capacity at Broomfield Hospital and within home birthing services to cope with increased demand.	Whilst there are two fewer birthing suites and five fewer post-natal beds at William Julien Courtauld (WJC) Unit compared to St Peter's Hospital, due to a change in the demographic of women and birthing people and the higher complexity of births, more people are required to give birth in and remain in the main obstetric unit in their postnatal period where obstetric/neonatal services are provided therefore the historical postnatal bed capacity is not required. There have been historical bed capacity issues at the Broomfield site, however, these issues have been significantly reduced due to the current process of reducing the numbers of women booking to give birth at Broomfield Hospital from out of the Mid Essex area. This has reduced the number of births within the service. There is also a new pathway in place where any neonatal readmissions go to the paediatric assessment unit rather than return to the postnatal ward (in line with pathways at Southend Hospital and Basildon Hospital sites) which again has reduced bed pressures. In addition to this there is currently design work being undertaken to create some more postnatal bed capacity in some of the expansion space within the Broomfield

	Hospital unit. This will help to future proof the service. As Broomfield currently have no vacancies for midwife posts we have been able to strengthen the community midwifery teams meaning that we are able to protect the availability of the homebirth service. This work is being led by the Consultant Midwife.
Emergency care/complications (maternity)- Respondents felt that there was risk to new parents and babies if emergency situations arose or there were complications and they were unable to get to William Julian Courtauld, Braintree, or Broomfield Hospital quickly enough because of the increased travel time for those in certain areas of Maldon.	In an emergency situation all service users would be advised to call an ambulance to be taken to Broomfield maternity unit. As St Peter's Hospital was a midwifery led unit no emergency cases would ever be directed there as there are no emergency facilities. This is the same at WJC. If emergencies occur the pathway is to transfer immediately to the main unit. If service users are concerned that their birth is imminent then again, they would be required to call an ambulance. A community midwife would also be sent to the home address if required.
Access to care (maternity): Concerns were raised about the reduced access to maternity care, both pre- and post-natal support, if ambulatory care services were to be relocated.	All maternity outpatient appointments will continue to be delivered from St Peter's Hospital, as per the recommendation in this decision-making business case (if approved) to keep ambulatory care services at St Peter's Hospital for the short to medium term (0-5 years), and therefore there will be no changes to access of care for women and birthing people compared to how services run now.
Staffing (maternity): Staffing issues at St Peter's were due to staffing issues at Broomfield Hospital that meant the unit had to close intermittently to enable staff to support the unit at Broomfield Hospital. Questions were raised about whether this were true and what has changed to ensure the same thing does not happen at the William Julian Courtauld Unit.	Historically there was a large number of vacant posts for midwives. This was recognised as a national problem. The reasons for this were varied including a change to the pension rules – which meant the profession saw an increase in midwives taking retirement and also the impact that the pandemic had on staff burnout which saw many midwives leave the profession and an even greater number reduce their contracted hours to become part time. These

	issues do however now appear to have resolved. Currently Broomfield hospital is fully established regarding midwifery posts. MSEFT also have midwifery student cohorts coming through every year to ensure sustainability.
Enhancement of community and home-based services: Concerns were raised that only residents in Southwest Essex can receive intensive rehabilitation in their own home and that reducing community bed capacity will reduce access to rehabilitation services for residents. Suggestions were made in relation to enhancing stroke and IMC care in a patient's own home.	There are Early Supported Discharge teams across mid and south Essex for stroke patients and these teams offer intensive rehabilitation and support to patients and their family in their own home. For patients requiring intermediate care support, national evidence and research shows that only 4% of the population leaving the acute hospital should require further stay in an alternative bedded pathway in the community. Bed modelling work undertaken for the PCBC, and then revised and rerun at the request of the Community Consultation Working Group, showed that the demand expected for intermediate care beds is met by the capacity that will be provided in both option A and option B for community beds. As set out in 'Section 2: Models of Care-Our Vision for the future', there are multiple pathways in place, and more being developed, to support the 'home first' ethos and ensure patients receive the care they need in the right place, at the right time, at home wherever possible, and that bedded care is only for those where other pathways or support in a patient's own home is not suitable.
Increased demand on the ambulance service: Questions were raised as to the impact of relocating the freestanding midwife led birthing unit on the ambulance service, as there may be increased demand from women and birthing people from the Maldon area.	It is not anticipated that there would be a significant increase in women and birthing people requiring an ambulance with the proposed move of the freestanding midwife led birthing unit. The temporary move of the unit to William Julian Courtauld Unit in October

	2023 has not resulted in an increased demand on ambulances.
Access to phlebotomy services: Concerns raised that phlebotomy services currently delivered at St Peter's Hospital could close for an interim period if they are moved to alternative locations and the impact this would have on other phlebotomy services across mid and south Essex, and patients and the public.	The strength of feeling around the potential relocation of ambulatory care services (including pre and post-natal services) was evident from the consultation report and the subsequent Community Consultation Working Group that was established, the outcome of which is that the recommendation within this decision-making business case is to keep services at St Peter's Hospital in the short to medium term (0-5 years), therefore there will be no impact on phlebotomy services.
Consultation proposals for community inpatient beds: None of the options presented in the consultation included keeping inpatient beds at St Peter's Hospital.	None of the options considered continuing to use St Peter's Hospital, Maldon, as its condition was considered to be unsuitable for continued use for inpatient bedded care. It was also recognised that there was more suitable estate elsewhere in mid and south Essex.
Suggestion of incorporating GP services into St Peter's Hospital replacement: Suggestions were made to incorporate GP services into a new Maldon health hub.	This suggestion is noted and was also a recommendation made by the Community Consultation Working Group. This will be factored into future planning for the long-term solution for a replacement for St Peter's Hospital.

Table 12: Clinical models and patient pathways- Consultation Feedback and ICB responses

7.4. Theme 3: Workforce and Staffing

Sub theme- feedback from consultation	**Response**
Midwifery staffing provision: What is being done to ensure sufficient midwifery staff are in place to staff William Julian Courtauld unit.	The Community Consultation Working Group also questioned staffing within maternity services and during the meetings maternity leads from Mid and South Essex Foundation Trust (MSEFT) presented information on staffing in maternity services. A staffing review was undertaken in 2023, using the Birth Rate Plus Tool, a safer staffing tool that is nationally recognised for maternity services. Best

	practice is to complete this review every three years as service needs are ever changing. A ratio of 1 midwife to every 24.6 births was calculated. This was calculated on a birth rate of 4410 across mid and south Essex (figures based on a three-monthly average September to November 2022). Data taken from the most recent dashboard (calendar year of 2024) reports that births in Mid Essex services over the 12-month period was 3860. This is a decrease of 540. Much of this decrease is due to women and birthing people who live outside of the mid Essex geographical location who previously attended Broomfield have returned to birthing at their local unit. Following the identified decrease in births in the mid Essex area in the past 12 months and a change in the requirements of the service regarding clinical need, a local recalculation was undertaken of the staffing requirement. A reduction in the overall midwifery staffing was therefore undertaken of six whole time equivalent posts (taken from the vacancy at the time). There are currently no vacant midwifery posts in the mid Essex geography.
Staff morale: Staff raised that there was upset and uncertainty for staff whose base is currently, or was previously (before the temporary changes), St Peter's Hospital. Staff are concerned about accessibility to services if locations permanently change and potential job losses.	Workforce engagement and consultation for any changes that arise from the decisions within this decision-making business case will need to be undertaken post decision making. Workforce leads across all areas within the consultation are part of the Workforce Subgroup supporting the Community Consultation programme Board and work programme and will continue to support staff through the planning for implementation and

	implementation process of any changes once they are agreed.
Stroke unit staffing: Concerns about having all stroke rehabilitation beds in one location. Some staff felt: - This may impact on recruitment and retention of staff - This may increase pressure on staff which could impact patient outcomes - That having two units would create resilience across community stroke rehabilitation beds	These comments were noted and considered when the Workforce Subgroup carried out the decision-making process on the impact of the options for community beds on workforce. The process undertaken is set out in 'Section 10: Decision Making'. The recommendation within this decision-making business case is for Option B, which means there will be two stroke units across mid and south Essex, meaning some of these concerns raised should be mitigated against.
Increased travel and costs for staff: Permanent changes to where staff's working bases are will impact of travel times and travel costs for some staff.	Workforce engagement and consultation for any changes that arise from the decisions within this decision-making business case will need to be undertaken post decision making. Workforce leads across all areas within the consultation are part of the Workforce Subgroup supporting the Community Consultation and will continue to support staff through the planning for implementation and implementation process of any changes once they are agreed.
Recruitment and retention of staff working in intermediate care and stroke community rehabilitation units: Some staff raised concerns regarding the challenges already faced in recruitment and retention of staff and that any permanent changes agreed through this decision-making business case may further exacerbate these challenges.	Challenges in having temporary locations and configurations of community beds has led to uncertainty in the future workforce requirements which in turn has meant that some posts were believed to be less attractive because of the uncertainty and job offers had to be made on a 'fixed term' basis until permanent solutions were agreed. This uncertainty has led to significant agency staff who cannot sustain continuity of care or the use of the staff bank. In both instances the cost of staffing units increases, putting pressure on NHS expenditure. Retention and recruitment of staff is often hindered by the fact we are close

	to London. NHS staff employed on Agenda for Change receive an additional 'Higher Cost Area Supplements' (HCAS) payment (see NHS Employers Pay Scales for 2023/24), accounting for the increasing costs of living in the capital. Whilst the outer HCAS is available in some areas of Essex, local residents can easily travel into London for work to earn higher wages for the same job. The jobs we have in our area must therefore be professionally and personally attractive, if we are to compete. Greater certainty about the future and location of community hospital beds is expected to support recruitment and retention of staff. A community bed configuration that is more permanent is expected to make available jobs more attractive to potential recruits and help to retain existing members of the workforce. This should also reduce reliance on costly temporary staff. The consultation proposals also suggest moving beds out of estate that is no longer fit for purpose meaning that inpatient beds will be in facilities that provide acceptable conditions, able to support the delivery of high-quality care. This is intended to influence recruitment and retention, which in turn will reduce rates of vacancy and the need to use agency and bank staff. These factors are moderated by considerations of the extent to which staff must travel to reach their workplace and the effect of geography on access for families and carers of patients.
Cross boundary working: Difficulties for staff working across boundaries i.e. local authority boundaries was raised, with some staff feeling this could cause delays in discharging patients.	Working across boundaries, both within mid and south Essex, and with neighbouring geographies already happens as part of normal operations across health and care. New models of care to support and improve discharge coordination have been introduced, and

	continue to be developed, for example Integrated Neighbourhood teams and associated Transfer of Care Hubs, as well as the development of the Integrated Care Transfer Hub. More information can be found in 'Section 2: Models of Care- Our Vision for the Future'.
Role attraction: Concerns about the proximity of services to London and the impact this has on being able to recruit and retain staff.	This is a problem continually faced by health and care services across mid and south Essex and is not a new problem resulting from the proposals outlined within the consultation proposals. Retention and recruitment of staff is often hindered by the fact we are close to London. NHS staff employed on Agenda for Change receive an additional 'Higher Cost Area Supplements' (HCAS) payment (see NHS Employers Pay Scales for 2023/24), accounting for the increasing costs of living in the capital. Whilst the outer HCAS is available in some areas of Essex, local residents can easily travel into London for work to earn higher wages for the same job. However, both Option A and Option B include positioning services at bases closer to London, which may attract more staff than previous services at St Peter's Hospital could. The jobs we have in our area must be professionally and personally attractive.
Improved staff engagement: There were some suggestions from staff that better engagement with existing staff was needed. There was also a request for further engagement to happen with staff once decisions have been made to support with implementation.	Dedicated engagement sessions were arranged for staff. More information can be found in 'Section 5: Consultation and engagement'. Through the Workforce subgroup and Operational subgroup which sit alongside the Community Capacity Programme Board ongoing communication has happened with staff to keep them updated on what is happening during the pause on decision making and the work of the Community

	Consultation Working Group on a regular basis. Following the consultation decisions engagement will take place with staff as part of the implementation phase of the process. A comprehensive workforce plan and associated engagement and consultation activities will be devised. The work that is needed to develop further plans for the future of ambulatory care services and the St Peter's Hospital site will require staff engagement through a newly formed working group which is planned (see section '11.1.2 Post decision governance arrangements'). Continuing to keep all staff working in these services updated will need to happen.
Staffing levels across all community inpatient bed sites: Staff commented that there was a need to ensure correct and consistent staffing across all community bed sites.	Work has already taken place to review staffing models across all sites. Following consultation and decision making concerning the future location and configuration of community inpatient beds a comprehensive workforce plan will need to be devised, and delivery monitored. Initially this will happen through implementation plans and will then move to 'business as usual', where workforce numbers and patient outcomes are routinely monitored by Providers and the MSEICB.
Staff training for intermediate care and stroke rehabilitation care in community beds: Staff requested ongoing training and development in their roles in inpatient units delivering intermediate and stroke care. Staff also raised that additional training and upskilling of staff would be required if all community bedded stroke care was within a single unit.	Proposals for workforce and associated training and development needs has been included in the financial modelling for both Option A and Option B. Ongoing professional development and training is a key part of any workforce development plan and will be included in the workforce plan that will be developed post the decision-making process. It is acknowledged that there would be significant training and upskilling of staff needed if all stroke rehabilitation moved to a single unit (Option A) as staff

	currently working on the intermediate care ward at Brentwood Community Hospital would need upskilling to deliver stroke care. Staff training had been factored into the high-level mobilisation planning that has already started for both Option A and Option B. However, the recommendation made within this decision-making business case is for Option B to be supported, therefore reducing the need for significant staff training and upskilling. Full mobilisation plans will be worked up following decision making (see 'Section 11: Implementation').

Table 13: Workforce and staffing- Consultation Feedback and ICB responses

7.5. Theme 4: Estate

Sub theme- feedback from consultation	**Response**
Future locations for ambulatory care services: Respondents raised significant concerns that there were no alternative locations for ambulatory care services proposed in the consultation and felt this showed a lack of planning by the Integrated Care System/Integrated Care Board.	At the time of going to consultation there were not detailed proposals for new locations for ambulatory care services. There are different types of consultation to inform different types of decision. This part of the consultation was the type sometimes called a 'gateway consultation' because it recognises it informs a pivotal point in the process. The first of the decisions that needed to be made was an 'in-principle' decision about whether ambulatory care services are continued to be delivered on the St Peter's Hospital site in the future, an important decision, that we needed public views on, as it could lead to the eventual closure St Peter's Hospital. The MSEICS had started to identify some potential new locations in Maldon prior to the consultation for ambulatory care services and these were shared during the consultation. We also asked people during the consultation to suggest any alternative

	locations for ambulatory care services, and we received numerous ideas. It was clear from the strength of feeling within the consultation that there was significant concern around moving services from St Peter's Hospital and the potential closure of the site in the future. This was one of several reasons why the decision was taken to pause the decision-making process and set up the Community Consultation Working Group. Suggested alternative locations identified by the Community Capacity Programme Board and from feedback in the consultation were shared with the Working Group and it was through this continued dialogue and engagement that the decision was made to relook at and re-review the option to continue to use St Peter's Hospital in the short to medium term (0-5 years) for ambulatory care services whilst a long term plan for the site and services provided from there is developed. See section '10.3 Recommendations' for more detail.
Fragmentation of ambulatory care services: Concerns were raised about fragmentation of services if they were moved to multiple locations in and around Maldon.	These comments were noted and considered when reviewing potential future locations for services. It is recognised that keeping services together where possible, and particularly where it makes clinical sense to do so is important for residents in Maldon, as well as staff. This was one of the reasons why continuing to use the St Peter's Hospital site for ambulatory care services in the short to medium term (0-5 years) is being taken forward as a recommendation within the decision-making business case (see section '10.3 Recommendations')
Unsuitable equipment at William Julian Courtauld (WJC): Concerns were raised by staff that one of the wards at WJC has two postnatal rooms that have double beds rather than postnatal beds and this is a problem for patients and staff.	This was a short term, temporary issue only and has now been resolved. The original double beds have now been replaced with profiling beds that are appropriate for postnatal care.

St Peter's backlog maintenance costs: Questions were asked as to how the identified backlog maintenance costs for St Peter's Hospital were derived.	A Six Facet survey is an independent assessment which identifies the extent of maintenance work required to a site. It focuses on backlog maintenance work and works that need to be carried out in the subsequent 5 years. The last survey of this type completed for St Peter's Hospital, on behalf of Mid and South Essex Foundation Trust (the owners of the St Peter's Hospital site) was undertaken in late 2021 (see Appendix 12). It showed that the total funds required to address all maintenance needs on the site equated to £20.07million, with 76% of the site being graded as being of poor condition and 24% as in bad condition. The survey grades the risk associated with the maintenance works. 'High' and 'Significant' are the main areas of concern. 52% of the work required for St Peters Hospital is 'High' with a cost of £6.9million and 37% is 'Significant' with a cost of £6.7million. The £20million quoted in the Six Facet Survey report reflects a point in time position. There are increasing costs across several capital programmes across the system, due to market forces and inflation, and therefore a note of caution should be applied to this figure regarding robustness as time progresses. A breakdown of costs was previously shared during the consultation on Mid and South Essex Integrated Care System's Virtual Views platform and can be found in Appendix 12.
St Peter's backlog maintenance costs: Respondents questioned why, if rent for use of space at St Peter's Hospital has been paid to Mid and South Essex Foundation Trust, facilities and maintenance has not been carried out and repairs have not been kept up to date.	Despite investment to keep St Peter's Hospital safe, a building of this age presents ongoing challenges. It was not originally built to be a medical facility. Long term it is not suitable for the delivery of modern, high-quality healthcare services. To keep facilities safe for patients and staff, reactive repair work has taken

	place across several years. Some key areas of repair work: • Some windows were replaced as there was an issue with gapping and draughts. • In 2023 the roof above the old kitchen area at the back was replaced. • Fire doors have been replaced via a phased approach over the past 2 years. • Small repair works to the lift when this breaks down, however the lift now needs replacing. • Partial improvements to the car park area surface. Mid and South Essex NHS Foundation Trust (MSEFT) are embarking on a five-year resilience plan to ensure the St Peter's Hospital site is maintained in a safe condition, and de-risked for its future use. This broadly includes sufficient maintenance to keep the building watertight (roofs, rainwater goods, brickwork and windows) and secure and safe (including fire containment, detection and alarms). MSEFT have notionally allocated funding this year under their risk-based backlog programme to repair and make safe roofs, windows, the lift and fire doors. Currently the allocated funding is £320k, but the funding needed is only estimated at this point in time and may evolve with the emerging reviews of the site and the ongoing short to medium term and long-term strategy for the site. MSEFT are currently drafting a specification to seek a contractor to support them with maintenance requirements for the St Peter's Hospital site, including an ongoing brief to 'de risk' future options for the site. More information can be found in section '10.3.3.5 [Recommendations] Identified risks and mitigations'.

Availability of capital investment: Respondents questioned the capital funding that is available to invest either in the St Peter's site or an alternative location. Concerns were raised that the Pre-Consultation Business Case contradicted itself as in some places it stated there was no capital funding available but also said that alternative locations would require an element of capital funding and suggested this was available.	During the consultation and following the review of alternative locations proposed for ambulatory care services it is clear that any estates solution, be this at St Peters' Hospital or alternative locations, would require capital investment. This was discussed at the Community Working Group and formed part of the recommendations and rationale for keeping services in the short to medium term at the St Peters site whilst a longer-term funding solution was identified for the future provision of a Maldon Health Hub/replacement for St Peter's Hospital.
Suggestions for alternative locations for ambulatory care services: Respondents offered several ideas for potential alternative locations, as well as suggestions for how the St Peter's Hospital site could be used differently or part used.	Mid and South Essex Integrated Care Board would like to thank respondents for their suggestions and innovative ideas made through the consultation. All suggestions made by respondents in the consultation were included in a long list of potential alternative sites. These were reviewed and analysed by the Estates Subgroup of the Community Capacity Programme Board. It was clear from the strength of feeling within the consultation that there was significant concern around moving services from St Peter's Hospital and the potential closure of the site in the future. This was one of several reasons why the decision was taken to pause the decision-making process and set up the Community Consultation Working Group. The long list of suggested alternative locations was shared with the Working Group, and it was through this continued dialogue and engagement that the decision was made to relook at and re-review the option to continue to use St Peter's hospital in the short to medium term (0-5 years) for ambulatory care services whilst a long term plan for the site and services provided from there is developed.

	The long list of options will continue to be reviewed and updated as the planning and development around the future Maldon health hub site takes place.
Suggestions on how capital funding can be raised: Respondents offered several ideas for how funding for capital investment into the current St Peter's site or an alternative location could be raised.	Mid and South Essex Integrated Care Board would like to thank respondents for their suggestions and innovative ideas made through the consultation. All suggestions made by respondents have been noted and are being explored as part of the ongoing work taking place to look at how capital investment can be raised to improve areas of the St Peter's site to allow ambulatory care services to stay there in the short to medium term (0-5 years), as well as for long term plans for a future health hub in the Maldon district to replace the current St Peter's Hospital site. More information on plans for short-, medium- and long-term plans for St Peter's Hospital can be found in section '10.3 Recommendations'.

Table 14: Estate - Consultation Feedback and ICB responses

7.6. Theme 5: Travel and access

Sub theme- feedback from consultation	**Response**
Accessibility of services: Concerns were raised that those using medical facilities tend to be older and therefore have more issues with mobility and travel. Concerns were also raised about increased travel time for the elderly.	Community intermediate care and stroke rehabilitation beds: The number of people likely to be impacted by the proposed changes is relatively small. Annually around 2080 people- 0.17% of the population in mid and south Essex, end up needing a stay in an IMC bed, and 500 people- 0.04% of the population in mid and south Essex, end up needing a stay in a stoke rehabilitation bed. For the majority of patients needing a community intermediate care or stroke rehabilitation bed, they would be transported from the acute hospital where they are receiving their care to the

	community hospital by patient transport services. Those who are eligible would also receive patient transport on discharge home. For those who are not eligible for patient transport there are community transport options available for patients. For some residents in mid and south Essex, proposed future locations for community beds will make travel easier and will reduce travel times. Access for patients, relatives and carers is an important aspect when considering equality, but mid and south Essex Integrated Care System is not in a position to enable equal geographical access for all since it is not proposing, nor has the finance to build and operate new community hospitals or freestanding birthing units, and therefore proposals are based on best use of existing premises which are themselves not distributed evenly throughout mid and south Essex. The challenges of potentially increased travel times for some residents need to be balanced against the benefits of better estate, more robust staffing and therefore better outcomes for patients through ensuring they receive the highest quality care, with access to specialist teams and facilities that can deliver better health outcomes. For community stroke rehabilitation beds, the clinical requirement is that the beds are concentrated, thereby concentrating expertise to ensure that the best outcomes for patients are achieved. If this were not done, another inequality would be created by offering sub-optimal stroke rehabilitation services. Travel analysis has been completed, and more information can be found in 'Section 8: Impact of proposals' and

	Appendix 13. An Integrated Impact Assessment (IIA), which includes looking at the impact of increased travel on certain groups, has also been completed and more information can be found in 'Section 8: Impact of proposed changes' and Appendix 11. The IIA found that while some patients may experience increased travel times, others may, in turn, benefit from being closer and more services may actually be delivered as home-based care where possible. For stroke patients and their relatives, travel analysis suggests 50-68.4% of people would see an increase in their journey times to travel to Brentwood rather than St. Peters and this is higher over the weekend. However, it also suggests that there is no significant variation in travel between Brentwood Community Hospital and Cumberlege Intermediate Care Centre (CICC) for intermediate care beds during the week and at the weekend, for either travel by car or by public transport. It is noted that travel challenges could significantly impact those living in deprived areas. Patients on low incomes may be able to claim back travel costs to hospital appointments through the NHS Healthcare Travel Costs Scheme. This scheme helps ensure that cost is not a barrier to accessing necessary care. During implementation we will ensure this information is widely available to the public. Information regarding travel advice, including public transport routes and community transport providers, will be clearly documented and made available to patients and their families as part of the implementation of any changes (see recommendation in section '8.5 Evidence based recommendations from

	the integrated impact analysis and mitigations' and 'Section 11: Implementation'. Ambulatory Care Services: The consultation committed to keeping ambulatory care services in and around the Maldon district. The strength of feeling around the potential relocation of ambulatory care services was evident from the consultation report and the subsequent Community Consultation Working Group that was established, the outcome of which is that the recommendation within this decision-making business case is to keep services at St Peter's Hospital in the short to medium term (0-5 years) which means there is no impact of increased travel to the elderly population.
Accessibility of services: Respondents asked that accessibility to any new location for ambulatory care services in Maldon be carefully considered.	Any new provision would be in the Maldon district and accessibility would be factored into any decision making as a key requirement. The strength of feeling around the potential relocation of ambulatory care services was evident from the consultation report and the subsequent Community Consultation Working Group that was established, the outcome of which is that the recommendation within this decision-making business case is to keep services at St Peter's Hospital in the short to medium term (0-5 years).
Increased costs: Respondents were concerned that there would be additional travel and parking costs for patients, their families and visitors across all proposal areas within the consultation. Concerns were raised that car ownership in Southend is lower than any other local authority area and so	The number of people likely to be impacted by the proposed changes is relatively small. The largest impact would be to those using ambulatory care services but the commitment within the consultation was to keep these services within the Maldon district. The strength of feeling around the potential relocation of ambulatory care services was evident from the consultation report and the subsequent Community Consultation Working Group that was established, the outcome of which is

there would be a particular impact for patients and visitors from Southend.	that the recommendation within this decision-making business case is to keep services at St Peter's Hospital in the short to medium term (0-5 years). For some residents in mid and south Essex, proposed future locations for community beds will reduce travel time, and therefore cost. Increased travel costs for some patients, relatives and carers is an important aspect when considering equality, but mid and south Essex Integrated Care System is not in a position to enable equal geographical access for all since it is not proposing, nor has the finance to build and operate new community hospitals or freestanding birthing units, and therefore proposals are based on best use of existing premises which are themselves not distributed evenly throughout mid and south Essex. The challenges of potentially increased travel costs for some residents and their families need to be balanced against the benefits of better estate, more robust staffing and therefore better outcomes for patients through ensuring they receive the highest quality care, with access to specialist teams and facilities that can deliver better health outcomes. For community stroke rehabilitation beds, the clinical requirement is that the beds are concentrated, thereby concentrating expertise to ensure that the best outcomes for patients are achieved. If this were not done, another inequality would be created by offering sub-optimal stroke rehabilitation services. For those patients who are eligible there are patient transport services available in mid and south Essex. For those who are not eligible for patient transport, and for

	families and carers there are community transport options available for patients. Additionally, patients on low incomes may be able to claim back travel costs to hospital appointments through the NHS Healthcare Travel Costs Scheme. This scheme helps ensure that cost is not a barrier to accessing necessary care. There is free parking available at all community hospital sites, including at the William Julien Courtauld Unit site. Similarly to at St Peter's Hospital, parking is limited and if no parking is available then there may be a charge to park in nearby carparks. Information on travel advice, routes and parking will be made available to the public, as per the recommendation made in section '8.5 Evidence based recommendations from the IIA and mitigations'. Travel analysis has been completed, and more information can be found in 'Section 8: Impact of proposals' and Appendix 13. An Integrated Impact Assessment (IIA), which includes looking at the impact of increased travel cost on certain groups, has also been completed. The IIA found that while some patients may experience increased travel costs, others may, in turn, benefit from being closer to services. The IIA can be found in Appendix 11. Information regarding travel advice, including public transport routes, parking and community transport providers, will be clearly documented and made available to patients and their families as part of the implementation of any changes (see recommendation in section '8.5 Evidence based recommendations from the integrated impact analysis and mitigation' and 'Section 11: Implementation'.

Public transport: Respondents commented that there is an absence of public transport, or inadequate public transport across certain geographies which would impact patients, visitors and carers. In particular this was heard from those residing in villages in and around the town of Maldon.	The number of people likely to be impacted by the proposed changes is relatively small. The largest impact would be to those using ambulatory care services but the commitment within the consultation was to keep these services within the Maldon district. The strength of feeling around the potential relocation of ambulatory care services was evident from the consultation report and the subsequent Community Consultation Working Group that was established, the outcome of which is that the recommendation within this decision-making business case is to keep services at St Peter's Hospital in the short to medium term (0-5 years). For some residents in mid and south Essex, proposed future locations for community beds will make public transport options better and easier. Issues with public transport for some patients, relatives and carers is an important aspect when considering equality, but mid and south Essex Integrated Care System is not in a position to enable equal geographical access for all since it is not proposing, nor has the finance to build and operate new community hospitals or freestanding birthing units, and therefore proposals are based on best use of existing premises which are themselves not distributed evenly throughout mid and south Essex. The challenges of poor public transport options for some residents and their families need to be balanced against the benefits of better estate, more robust staffing and therefore better outcomes for patients through ensuring they receive the highest quality care, with access to specialist teams and facilities that can deliver better health outcomes. For community stroke rehabilitation beds, the clinical requirement is that the

	beds are concentrated, thereby concentrating on expertise to ensure that the best outcomes for patients are achieved. If this were not done, another inequality would be created by offering sub-optimal stroke rehabilitation services. For those patients who are eligible there are patient transport services available in mid and south Essex. For those who are not eligible for patient transport, and for families and carers there are community transport options available for patients. Travel analysis has been completed, and more information can be found in 'Section 8: Impact of proposals' and Appendix 13. An Integrated Impact Assessment, which includes looking at the impact of public transport links on certain groups, has also been completed. The assessment found that those living in deprived areas, disabled people and older people may be impacted by using public transport. Information regarding travel advice, including public transport routes and community transport providers, will be clearly documented and made available to patients and their families as part of the implementation of any changes (see recommendation in section '8.5 Evidence based recommendations from the integrated impact analysis and mitigation' and 'Section 11: Implementation'. The MSEICB will continue to work with local authorities to raise concerns around public transport.
Increased travel time: Concerns were raised that there would be increased travel times for new parents and newborn babies.	The number of people likely to be impacted by the proposed changes is relatively small. The strength of feeling around the potential relocation of ambulatory care services (including pre- and post-natal maternity services) was evident from

It was also raised that guidance says newborn babies should not travel for more than 30 minutes.	the consultation report and the subsequent Community Consultation Working Group that was established, the outcome of which is that the recommendation within this decision-making business case is to keep services at St Peter's Hospital in the short to medium term (0-5 years). For some residents in mid and south Essex, proposed future locations for community beds will make travel easier and will reduce travel times for women and birthing people and newborn babies. Issues with public transport for some patients, relatives and carers is an important aspect when considering equality, but mid and south Essex Integrated Care System is not in a position to enable equal geographical access for all since it is not proposing, nor has the finance to build and operate new community hospitals or freestanding birthing units, and therefore proposals are based on best use of existing premises which are themselves not distributed evenly throughout mid and south Essex. The challenges of increased travel times for new parents and their newborn babies need to be balanced against the benefits of better estate, more robust staffing and therefore better outcomes for patients through ensuring they receive the highest quality care, with access to specialist teams and facilities that can deliver better health outcomes. Whilst guidance does generally recommended limiting car seat time to 30 minutes at a time for newborn babies it does also suggest that if longer journeys are unavoidable, then frequent breaks should be taken where the baby is taken out of the car seat and allowed to stretch and move around.

	Travel analysis has been completed, and more information can be found in 'Section 8: Impact of proposals' and Appendix 13. An Integrated Impact Assessment (IIA) (see Appendix 11), which includes looking at the impact of increased travel time on certain groups, has also been completed. It recognised that whilst there may be increased travel for some women and birthing people there will be a reduction in travel times for others. Maternity outpatient appointments remaining in Maldon will have a positive impact as it will mean women and birthing people would not have to travel further for their pre- and post-natal care.
Parking: Concerns around parking difficulties across all proposals within the consultation.	There is free parking available at all community hospital sites. Similarly to at St Peter's Hospital, parking is limited and if no parking is available then there may be a charge to park in nearby carparks. Information on travel advice, routes and parking will be made available to the public, as per the recommendation made in section '8.5 Evidence based recommendations from the IIA and mitigations'. The greatest concerns were raised around parking at any new locations ambulatory care services may have been moved to. The strength of feeling around the potential relocation of ambulatory care services (including pre- and post-natal services) was evident from the consultation report and the subsequent Community Consultation Working Group that was established, the outcome of which is that the recommendation within this decision-making business case is to keep services at St Peter's Hospital in the short to medium term (0-5 years). Information regarding travel advice, including parking options and public

	transport options, will be clearly documented and made available to patients and their families as part of the implementation of any changes (see recommendation in section '8.5 Evidence based recommendations from the integrated impact analysis and mitigation' and 'Section 11: Implementation'.
Impact on patient outcomes: Concerns were raised about the detrimental impact on patient outcomes if their support network (family, friends, carers) is unable to visit because of increased travel times, increased costs and poor public transport. Respondents felt this could lead to isolation, increased stress and poor recovery for patients.	The number of people likely to be impacted by the proposed changes is relatively small. The largest impact would be to those using ambulatory care services but the commitment within the consultation was to keep these services within the Maldon district. The strength of feeling around the potential relocation of ambulatory care services was evident from the consultation report and the subsequent Community Consultation Working Group that was established, the outcome of which is that the recommendation within this decision-making business case is to keep services at St Peter's Hospital in the short to medium term (0-5 years). For some residents in mid and south Essex, proposed future locations for community beds will reduce travel time, and therefore cost, and improve options for public transport services. Whilst we recognise and understand the concerns raised mid and south Essex Integrated Care System is not in a position to enable equal geographical access for all since it is not proposing, nor has the finance to build and operate new community hospitals or freestanding birthing units, and therefore proposals are based on best use of existing premises which are themselves not distributed evenly throughout mid and south Essex. The challenges identified for some residents and their families need to be balanced against the benefits of better estate, more robust staffing and

	therefore better outcomes for patients through ensuring they receive the highest quality care, with access to specialist teams and facilities that can deliver better health outcomes. For community stroke rehabilitation beds, the clinical requirement is that the beds are concentrated, thereby concentrating on expertise to ensure that the best outcomes for patients are achieved. If this were not done, another inequality would be created by offering sub-optimal stroke rehabilitation services. For those patients who are eligible there are patient transport services available in mid and south Essex. For those who are not eligible for patient transport, and for families and carers there are community transport options available for patients. For those patients whose families and carers cannot visit them in a community hospital, staff will always support in facilitating phone or video calls for patients to loved ones. Travel analysis has been completed, and more information can be found in 'Section 8: Impact of proposals' and Appendix 13. An Integrated Impact Assessment (IIA) (see Appendix 11), which includes looking at the impact of increased travel cost on certain groups, has also been completed. The impact assessment found that while some carers and relatives may experience increased travel times and costs, others may, in turn, benefit from being closer. The intention to develop more home-based care where possible may also support relatives and carers. Information regarding travel advice, including public transport routes and community transport providers, will be clearly documented and made available to patients and their families as part of

	the implementation of any changes (see recommendation in section '8.5 Evidence based recommendations from the integrated impact analysis and mitigation' and 'Section 11: Implementation'.
Impact on patient outcomes: Concerns were raised about the detrimental impact on patient outcomes due to increased travel and access issues for those with disabilities, learning difficulties, people with mental illness and people who are neurodiverse if ambulatory care services were relocated or fragmented across multiple sites.	The strength of feeling around the potential relocation of ambulatory care services was evident from the consultation report and the subsequent Community Consultation Working Group that was established, the outcome of which is that the recommendation within this decision-making business case is to keep services at St Peter's Hospital in the short to medium term (0-5 years). Therefore, there should be no impact on these groups.
Access to the freestanding midwife led birthing unit: Questions were asked as to whether East of England Ambulance Service will transport woman in labour as their website states this is not an emergency and suggests therefore, they would not.	For 'normal' labour, the East of England Ambulance Service (EEAST) advises against calling 999 for transport. However, an ambulance may be needed in emergency situations like imminent birth with a strong urge to push, heavy bleeding, or severe abdominal pain that persists. There are community transport options available for patients with a non-urgent requirement for transport.
Travel analysis: Some concerns were raised about the original travel analysis included in the pre consultation business case. Respondents felt it was incorrect, and the information hadn't been fully analysed. It was felt more consideration was needed for those living in the rural villages surrounding Maldon town.	The travel analysis was based on post codes and was not able to look into smaller conurbations. The challenges of rural travel are noted, and whilst we recognise and understand the concerns raised mid and south Essex Integrated Care System is not in a position to enable equal geographical access for all since it is not proposing, nor has the finance to build and operate new community hospitals or freestanding birthing units, and therefore proposals are based on best use of existing premises which are themselves not distributed evenly throughout mid and south Essex.

Suggestions to improve public transport offer: Suggestions were made that public transport routes should be improved to ensure adequate public transport is available.	While the NHS does not directly control public transport services, we do work closely with local authorities and transport providers and will continue to do so to flag concerns highlighted. Travel analysis has been completed, and more information can be found in 'Section 8: Impact of proposals' and Appendix 13. An Integrated Impact Assessment (IIA) (se Appendix 11), which includes looking at the impact of public transport links on certain groups. Information regarding travel advice, including public transport routes and community transport providers, will be clearly documented and made available to patients and their families as part of the implementation of any changes (see recommendation in section '8.5 Evidence based recommendations from the integrated impact analysis and mitigation' and 'Section 11: Implementation'.
Suggestions for patient transport services: Suggestions were made that free transport should be made available for patients and that community transport offers should be enhanced.	For those patients who are eligible there are patient transport services available in mid and south Essex. For those who are not eligible for patient transport, and for families and carers there are community transport options available for patients. While the NHS does not directly commission community transport, we do work closely with local authorities and transport providers and will continue to do so to flag concerns highlighted.

Table 15: Travel and access - Consultation Feedback and ICB responses

7.7. Community Consultation Working Group

The Community Consultation Working Group was established in autumn 2024, in response to the strong feedback received during the consultation period. More information about the group and its purpose and role can be found in 'Section 5: Consultation and Engagement'. During the process of further engagement with the Working Group there were many questions asked, and queries and concerns raised, many in line with the consultation feedback above. Discussions with the Working Group have helped to inform some of our responses outlined above. A very high-level overview of discussions and suggestions that came out of the Community Consultation Working Group are outlined in the bullet points below. The full report

detailing all the recommendations from the Community Consultation Working Group can be found in Appendix 2.

- Community intermediate care and stroke rehabilitation bed modelling: A detailed breakdown of bed modelling for community inpatient beds was shared with the Working group. Intermediate care bed modelling was redone at the request of the Working Group (to include more up to date figures and information) and shared with them.

- Home First and Discharge to Assess pathways: More information around home first and discharge to assess pathways/workstreams was shared with the Working Group to give greater understanding of the multifaceted work programmes that sit alongside the community consultation work programme.

- Maternity services: The group raised multiple concerns and questions about maternity services across mid and south Essex, not just relating to the freestanding midwife led birthing unit. They received two presentations from maternity leads from Mid and South Essex Foundation Trust to help clarify and better understand birthing rates, different birthing locations available, staffing numbers and changes in types of birthing activity.

- Ambulatory Care Services: The group reiterated the strength of feeling heard during the consultation that not having any alternative locations for ambulatory care services to move to be a significant concern for residents in Maldon. The long list of possible sites was shared with the Working Group and their request was that further work was done to explore use of the St Peter's site in the short to medium term given it is a large site, with many different buildings which are all in varying conditions and given that it already has acceptable parking, access and transport links.

- Capital funding in the NHS: The Working Group received a presentation from finance and estates leads in the MSEICB and Mid and South Essex NHS Foundation Trust to help them further understand the constraints of the availability of capital in the NHS and how it can be spent.

- Future plans for the St Peter's Hospital site: The Working Group were very clear that there needed to be a long-term plan for a Maldon health Hub to replace St Peter's Hospital and that development and implementation of these plans must include residents and community groups. The Group were clear that this work has been ongoing for many years, and a solution must be found this time round.

7.8. Mitigations and next steps based on the consultation feedback and the Community Consultation Working Group

Through the feedback from the consultation and the Community Consultation Working Group there are several mitigations in response to feedback that the Mid and South Essex Integrated Care System have or will put in place and several areas that will be taken into account during implementation of decisions and next steps in

this work programme. These are set out the tables below using a 'You said, We did' approach.

You said	We did
Theme 1: Strategy and Strength of Case for Change	
Community Consultation Working Group requested updated bed modelling for intermediate care beds to include more up to date figures and information.	Intermediate Care bed modelling was revised at the request of the Community Consultation Working Group and shared with the Group. This showed that the demand expected for IMC beds is met by the capacity that will be provided in both option A and option B for community beds (see Appendix 7).
Ask for continued engagement with patients, the public and community groups for future development and delivery of plans, particularly in relation to ambulatory care services.	The pause in the decision-making process and the development of the Community Consultation Working Group evidences our ongoing commitment to engaging with stakeholders and the public. We heard the strength of feeling in the consultation feedback, particularly around the future of St Peter's Hospital and the proposed relocation of ambulatory care services in Maldon and that led to the decision to pause decision making. There is a commitment that there will continue to be stakeholder and public engagement with the further work there is to do in developing short-, medium- and long-term plans for ambulatory care services and the future of the St Peter's Hospital site. This is outlined in 'Section 11: Implementation'.
Suggestion made that a project could be set up to look at volunteer support to patients in community inpatient beds if they do not have support/visitors.	This suggestion will be explored as part of the implementation phase once a decision has been made on the location and configuration of community inpatient beds.
Theme 2: Clinical models and patient pathways	
Suggestions were made to look at alternative locations in Maldon for inpatient care to be delivered from.	The Community Consultation Working Group discussed wider transformation work around discharge to assess pathways (see Section 2: Models of Care- Our Vision for the Future for more

	information). Whilst not for the same cohort of patients who require a community NHS intermediate care bed, the suggestion from the working group was to look at opportunities for bedded care for other Pathway 2 patients, for example in care homes, where some patients currently go for an interim period whilst they await assessment for their longer-term care needs. The Working Group recommended that the MSEICB commission dedicated care home beds for these patients in Maldon. In response to this recommendation the medium-term plan (MTP) discharge to assess transformation programme now includes a workstream which will explore procurement options for dedicated discharge to assess bedded capacity within care homes in the Maldon district (and elsewhere in mid and south Essex).
Theme 3: Workforce and staffing:	
Continued staff engagement throughout the decision-making process and during implementation of recommendations.	Workforce leads across all areas within the consultation are part of the Workforce Subgroup supporting the Community Consultation and will continue to support staff through the planning for implementation and implementation process of any changes once they are agreed.
Staff raised concerns about changes to their work base and increased travel times and costs.	Workforce engagement and consultation for any changes that arise from the decisions within this decision-making business case will need to be undertaken post decision making.
Staff commented that there was a need to ensure correct and consistent staffing across all community bed sites.	Following consultation and decision making concerning the future location and configuration of community inpatient beds a comprehensive workforce plan will need to be devised, and delivery monitored. Initially this will happen through implementation plans and will then move to 'business as usual', where workforce numbers and patient outcomes are routinely

	monitored by Providers and the MSEICB.
Theme 4: Estate	
Through the consultation feedback there were lots of ideas suggested for potential alternative locations for ambulatory care services, as well as suggestions for how the St Peter's site could be used differently or part used.	All suggested locations have been included in a long list of options which has been reviewed by the Community Capacity Programme Board. The long list of suggested alternative locations was also shared with the Community Consultation Working Group and it was through this continued dialogue and engagement that the decision was made to relook at and re-review the option to continue to use St Peter's hospital in the short to medium term (0-5 years) for ambulatory care services whilst a long term plan for the site and services provided from there is developed. The long list of options will continue to be reviewed and updated as the planning and development around the future Maldon Health Hub/replacement for St Peter's Hospital takes place.
Suggestions on how capital investment for the future use of the St Peter's site or alternative locations could be funded: Respondents offered several ideas for how funding for capital investment could be raised.	All suggestions made by respondents have been noted and are being explored as part of the ongoing work taking place to look at how capital investment can be raised to improve areas of the St Peter's Hospital site to allow ambulatory care services to stay there in the short to medium term (0-5 years), as well as for long term plans for a future Maldon Health Hub/replacement for St Peter's Hospital. More information on plans for short-, medium- and long-term plans for St Peter's Hospital can be found in section '10.3 Recommendations' and 'Section 11: Implementation'.
Theme 5: Travel and access	
Concerns were raised about access to services and the impact on some	As part of implementation planning information will be developed and made

residents of increased travel and associated costs.	widely available for patients and the public on: • Travel advice, routes (by car and public transport) and parking availability for the locations of community inpatient beds and the freestanding midwife led birthing unit. • The NHS Healthcare Travel Costs Scheme (a scheme for patients on low incomes that allows them to claim back travel costs to hospital appointments through the, helping to ensure that cost is not a barrier to accessing necessary care). • Patient transport services and eligibility. • Community transport providers across mid and south Essex.

Table 16: You Said, We Did approach to consultation feedback and ICB responses

Impact of the proposals

8. Impact of proposed changes

8.1. Integrated Impact Assessment

An Integrated Impact Assessment (IIA) has been conducted to assess and evaluate the potential impact of proposals on our population; to support in decision making and ensure decision makers meet their Public Equality Sector Duty 2010 (established as part of the Equality Act 2010 (S.149) as the legal obligation for public authorities in England, Scotland and Wales.

In relation to equality, these responsibilities include assessing and considering the potential impact which the proposed service changes could have on people with characteristics that have been given protection under the Equality Act 2010, especially in relation to their health outcomes and the experiences of patients, communities and the workforce.

With reference to health and health inequalities, the responsibilities include assessing and considering the impact on the whole of the population served by the relevant statutory bodies and identifying and addressing factors which would reduce health inequalities, specifically with regard to access and outcomes.

The report also considers the impact to the environment that the proposed changes may have.

The development of the IIA has occurred in two phases:

1) The interim IIA which was developed prior to consultation.
2) The refreshed IIA which took place after the consultation, allowing for refreshed analysis and reflection of the consultation feedback on additional impacts or mitigating actions.

The interim IIA was shared in the pre-consultation business case. The updated 'second phase' IIA can be found in Appendix 11 of this decision-making business case. Below is a summary of findings from the refreshed IIA.

8.2. Summary of Impacts assessed in the Integrated Impact Assessment (IIA)

8.2.1. Positive Impacts

A number of positive impacts were identified for each of the proposals in the IIA. These are summarised below:

Community Inpatient Beds

- The proposed changes to community hospital beds would allow for stroke patients to receive care in better equipped facilities and provide appropriate room for expansion to meet the population's needs as required.
- For stroke patients who meet the criteria to be treated outside of the acute hospital, receiving care in a community-bedded setting both reduces risks

associated with acute care (e.g., hospital-acquired infection etc), and provides access to dedicated rehabilitation care, optimising patient outcomes.

- By improving the intermediate care offer and increasing stroke capacity in the community, the population of mid and south Essex (MSE) will have access to optimised community care which will keep care closer to home for patients and improve facilities, training for staff and rehabilitation opportunity following a stroke.
- By ensuring the MSE population has access to the number of community inpatient beds that will best serve its needs, it can support patients that require the services to recover as close to home as possible.
- Both Option A and Option B ensure intermediate care bed numbers remain consistent with existing demand and keep an intermediate presence across the MSE footprint, whilst accommodating the stroke expansion which is important to meet the future demands of the population.
- Both options propose dedicated intermediate care facilities across 4 community hospital sites in MSE. Dedicated intermediate care will enable development of specialist staff skill sets, care processes, easier audit and monitoring, and greater potential for research and innovation.
- Both options offer dedicated stroke rehabilitation care options- at Brentwood Community Hospital only for Option A or Brentwood Community Hospital and Cumberlege Intermediate Care Centre (CICC), in Rochford, for Option B. This will enable development of specialist staff skill sets, care processes, easier audit and monitoring, and greater potential for research and innovation.
- Whilst both options may increase travel for some patients and visitors, for others they will reduce travel times.

Freestanding Midwife-Led Birthing Unit

- The freestanding midwife led maternity unit proposal proposes permanently relocating inpatient activity to William Julien Courtauld (WJC) in Braintree. This will mean maintaining choice in maternity services for patients across MSE by continuing to deliver a freestanding midwife-led birthing unit.
- At WJC, patients will have access to better, more modern facilities which are consistently open and available, and therefore more reliable.
- The proposal would keep prenatal and postnatal outpatient services local in Maldon. therefore ‘closer to home’, reducing the need for patients to travel for their outpatient care.

Ambulatory Care Services

The MSEICB consulted on the proposal to relocate ambulatory care services from St Peter’s Hospital and asked for people’s views on this. There was a commitment made in the consultation to keep outpatients and diagnostics in Maldon locally wherever possible to do so.

- If outpatient and diagnostics were located locally in built up areas of Maldon, transport links may be improved which could make travel cheaper and easier for patients.
- If services were available in areas of Maldon that were possible to reach via public transport, some carers may find this easier as patients may be able to

get to appointments alone and patients may have a greater independence due to this.
- Those with Mental Health conditions may have mixed responses to the proposed changes. Some patients may prefer a more familiar and less clinical environment that could be provided by local Maldon locations.
- District nurses and early supported discharge working in an integrated way in Maldon could impact all patient's pathways positively, allowing for an integrated approach to discharge and support at home.
- Having improved facilities for musculoskeletal conditions could support optimised rehabilitation.

8.2.2. Adverse Impacts

Several adverse impacts were identified for each of the proposals in the IIA. These are summarised below:

Community Inpatient Beds

- Reducing intermediate care community inpatient bed capacity from the capacity previously available (prior to temporary changes in October 2023) could have positive impacts long term as more patients will move to appropriate pathways, including home based care. Only those who need to be in inpatient intermediate care beds will be. This, however, could have short term implications whilst the infrastructure is being put in place to ensure patients are on the right pathway.
- For patients who could receive care at home rather than in community intermediate care beds, this could put more responsibility on carers which could result in anxiety or fatigue. The Virtual Hospital model offers support to carers and relatives including training when needed and regular visits or support in line with patient need.
- Increased opportunity for patients to be treated at home improves patient outcomes but relies on appropriate infrastructure being in place.
- Patients and carers from Maldon could experience increased travel times as no proposals include St. Peters Hospital.

Freestanding Midwife-Led Birthing Unit

- Some patients may live closer to St Peter's Hospital than WJC, Braintree, and travelling further for birthing services could result in additional travel time and associated costs. This could impact patients with disabilities, living in deprived areas, or those who are reliant on carers for transport for example. On average, however, the average journey time for patients overall is similar and maternity outpatient appointments will remain in Maldon.
- 61.3% of maternity patients travelling by car and 61.8% of maternity patients travelling by public transport would experience increased car journeys to WJC, Braintree, on a weekday, compared to travelling to St. Peters Hospital. This increases to 77.9% of people by car and 77.5% of people by public transport at the weekend. For those who experience an increase in journey times, this is a this is a 14-minute increase by car and a 26-minute increase by public transport on weekdays and a 12-minute increase by car and a 29-minute increase by public transport on the weekends.

Ambulatory Care Services

- If outpatient services are moved across multiple locations within the Maldon district, then patients could find travel to these different locations difficult. Cohorts who may find this challenging are those who have difficulty with mobility or a disability, those who rely on public transport, those with mental health conditions and carers or unpaid carers.
- Ophthalmology and audiology patients may experience some sensory impairment which could mean they may find attending an appointment in a new setting more challenging or less comfortable.
- Those with a disability or any other conditions which could impact mobility, for example, musculoskeletal conditions or obesity, may find travel in local areas more difficult as parking may be more difficult, and this may require more walking from local car parks.
- Some patients, particularly those with multi-morbidities, may find it difficult to keep track of where their appointment is if they attend multiple locations.
- Some carers may find travel easier, and others may find travel more difficult based on these proposed changes. It is important to note that, as not all patients who currently attend appointments at St Peter's Hospital live in Maldon, travelling to new locations in Maldon may be more difficult, for example, parking or because more walking is required.
- Those with Mental Health conditions may have mixed responses to the proposed changes. Some patients may feel anxious about new locations.

8.2.3. Assessment of impact on protected characteristics

As part of the IIA an assessment was undertaken to review whether different groups of the patient population and workforce population, namely those that fall under protected characteristics, are disproportionately impacted by the proposed changes. This is done within the context of equality and diversity, health inequalities and population health impact. For each category of assessment, themes are used to assess impact and whether it was positive, negative or neutral.

The assessment is summarised in Figure 14, Figure 15 and Figure 16 below. More detail can be found in the IIA in Appendix 11.

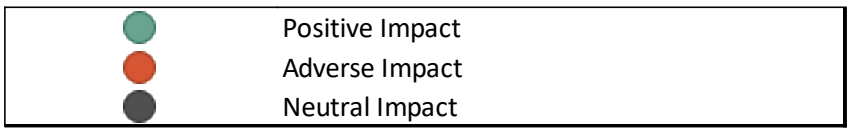

Figure 14: Integrated Impact Assessment rating of impact

Community Inpatient Beds

		Option A	Option B
Equality Impact Analysis	Age		
	Disability		
	Sex		
	Pregnancy & Maternity	Separate Deep Dive	
	Martial Status		
	Race		
	Sexual orientation		
	Religion or Belief		
	Gender reassignment		
Health Inequalities Analysis	Deprivation		
	Carers and Unpaid Carers		
	Homelessness		
	Mental Health		
	Substance Misuse		
	Gypsy, Roma and Traveller communities		
Health Impact Assessment	Dementia		
	Falls		
	Stroke		
	Frailty		

Figure 15: Community Inpatient Beds IIA ratings of protected characteristics

Freestanding Midwife Led Birthing Unit

		Inpatient WJC Outpatient Maldon Hub
Equality Impact Analysis	Age	
	Disability	
	Sex	
	Pregnancy & Maternity	
	Martial Status	
	Race	
	Sexual orientation	
	Religion or Belief	
	Gender reassignment	
Health Inequalities Analysis	Deprivation	
	Carers and Unpaid Carers	
	Homelessness	
	Mental Health	
	Substance Misuse	
	Obesity	
	Gypsy, Roma and Traveller communities	
Health Impact Assessment	Diabetes	

Figure 16: Freestanding midwife led birthing unit IIA ratings of protected characteristics

Ambulatory Care Services

		1. Midwife episodes & Obstetrics, gynaecology, Glucose testing, paediatrics and SLT within Maldon, with midwife and neonatal in WJC	2. Phlebotomy, District Nurses, ESD and Cherry tree at Maldon	3. MSK, Physiotherapy & AHP at Maldon	4. All other outpatient services potentially located in Maldon or where clinically appropiate
Equality Impact Analysis	Age				
	Disability				
	Sex				
	Pregnancy & Maternity				
	Marital Status				
	Race				
	Sexual orientation				
	Religion or Belief				
	Gender reassignment				
Health Inequalities Analysis	Deprivation				
	Carers and Unpaid Carers				
	Homelessness				
	Mental Health				
	Substance Misuse				
	Obesity				
	Gypsy, Roma and Traveller communities				
Health Impact Assessment (only for options which impact conditions directly)	Ophthalmology				
	Musculoskeletal conditions				
	Neurology				
	Dermatology				

Figure 17: Ambulatory Care Services IIA ratings of protected characteristics

The section ‘8.5 Evidence based recommendations and Mitigations’ below sets out how we plan to try and mitigate against adverse impacts.

8.3. Travel Analysis

As part of the pre-consultation business case and IIA process a comprehensive travel analysis was undertaken. A summary of the travel analysis is outlined below. The Travel Analysis can be found in Appendix 13.

Community Inpatient Beds

- 50% of patients and/or visitors travelling by car to Brentwood Community Hospital for stroke rehabilitation facilities and 68.4% travelling by public transport would experience increased car journeys on a weekday compared to travelling to St Peter's Hospital. 50% of people by car and 75.4% of people by public transport would see increases at the weekend. For those who experience an increase in journey times, this would be an 18-minute increase by car and a 31-minute increase by public transport on weekdays and a 17-minute increase by car and a 51-minute increase by public transport on the weekends.
- On average, it takes 45 minutes to travel from CICC to Brentwood Community Hospital on a weekday and 40 minutes on a weekend by car and 55 minutes by public transport on a weekday and 57 minutes by public transport on a weekend. There is no patient data set for CICC as patients may be placed in any of the intermediate care bed facilities across mid and south Essex dependent on bed availability (although proximity to patient's usual place of residence is always considered, as well as patient choice where a choice of available beds exists). There is no significant variation in travel between the two sites during the week and at the weekend, for either travel by car or by public transport.

Freestanding Midwife Led Birthing Unit

- 61.3% of maternity patients travelling by car and 61.8% of maternity patients travelling by public transport would experience increased car journeys to Braintree on a weekday compared to travelling to St Peter's Hospital. This increases to 77.9% of people by car and 77.5% of people by public transport at the weekend. For those who experience an increase in journey times, this is a 14-minute increase by car and a 26-minute increase by public transport on weekdays and a 12-minute increase by car and a 29-minute increase by public transport on the weekends.

Ambulatory Care Services

- Across MSE, 10.1% of residents live in the 20% most deprived neighbourhoods. This is approximately just over 120,000 people. When looking at those who attend outpatient and diagnostic clinics at St Peter's Hospital, approximately 0.5% live in the 20% most deprived, followed by 14% in the second quintile. This equates to 2,823 patients living in deprivation in some way, either in the first or second quintile. Therefore, it is important to consider the impacts of travel to patients in deprivation and ensure considerations around cost of travel and parking are made.

Whilst it is recognised that there will be an impact on travel for some residents across MSE if the proposals within the decision-making business case are supported the number of people likely to be impacted by the proposed changes is relatively small. For community intermediate care and stroke rehabilitation beds, annually around 2080 people- 0.17% of the population in mid and south Essex, end up needing a stay in a community intermediate care bed, and 500 people- 0.04% of the population in mid and south Essex, end up needing a stay in a community stoke rehabilitation bed.

For the majority of patients needing a community intermediate care or stroke rehabilitation bed, they would be transported from the acute hospital where they are receiving their care to the community hospital by patient transport services. Those who are eligible would also receive patient transport on discharge home. For those who are not eligible for patient transport there are community transport options available for patients.

For some residents in mid and south Essex, proposed future locations for community beds will make travel easier and will reduce travel times.

Access for patients, relatives and carers is an important aspect when considering equality, but Mid and South Essex Integrated Care System (MSEICS) is not in a position to enable equal geographical access for all since it is not proposing, nor has the finance to build and operate new community hospitals or freestanding birthing units, and therefore proposals are based on best use of existing premises which are themselves not distributed evenly throughout mid and south Essex.

The challenges of potentially increased travel times for some residents need to be balanced against the benefits of better estate, more robust staffing and therefore better outcomes for patients through ensuring they receive the highest quality care, with access to specialist teams and facilities that can deliver better health outcomes.

For community stroke rehabilitation beds, the clinical requirement is that the beds are concentrated, thereby concentrating expertise to ensure that the best outcomes for patients are achieved. If this were not done, another inequality would be created by offering sub-optimal stroke rehabilitation services.

It is noted that travel challenges could significantly impact those living in deprived areas. Patients on low incomes may be able to claim back travel costs to hospital appointments through the NHS Healthcare Travel Costs Scheme. This scheme helps ensure that cost is not a barrier to accessing necessary care.

Information regarding travel advice, including public transport routes, the NHS Healthcare Travel Costs Scheme and community transport providers, will be clearly documented and made available to patients and their families as part of the implementation of any changes (see recommendation in section ‘8.5 Evidence based recommendations from the integrated impact analysis and mitigation’ and ‘Section 11: Implementation’).

For ambulatory care services the recommendation within this decision-making business case is to keep services at St Peter's Hospital in the short to medium term (0-5 years) which means there is no impact of increased travel for patients or carers.

8.4. Environmental Impact Analysis

Mid and South Essex Integrated Care Board (MSEICB) has a statutory duty to consider the wider impact of its decisions on health, quality of services, and the sustainable use of resources. This means analysing how we have met our duties on climate change in accordance with the NHS Act 2006 (as amended) section 14Z44.

We have considered the potential environmental impacts of the proposed service changes within this decision-making business case. The IIA (see Appendix 11) includes a section on the potential environmental impacts of service changes.

We have also reviewed the proposed service changes against the Integrated Care System's Green Plan 'Our Strategy towards net zero (March 2022)' and have carried out the associated Sustainability Impact Assessment (see Appendix 14).

8.4.1. Integrated Impact Assessment- Environmental Impacts

As part of the IIA process the impact to the local environment of any proposed changes was reviewed. The analysis is summarised below.

- By providing outpatient services in Maldon, local shops may see the benefit of an increased population of customers which could help to sustain local businesses.
- If outpatient services are provided in built up areas of Maldon, these are likely to be more accessible to people without cars and offer a chance to promote other sustainable forms of travel. Low traffic neighbourhoods have shown to increase life expectancy.
- By increasing outpatient and diagnostics locally in Maldon, with the potential for increased public transport use, these benefits may be realised.
- The proposed changes to St. Peter's Hospital could reduce Mid and South Essex's carbon footprint as the building was originally built in 1872 and, despite improvement works being carried out since, does not efficiently use energy due to its vast size.
- The proposed model for outpatients and diagnostics could use local amenities to boost pride in the local community. The difficulty will be to sustain this if patients are not from the area, however, the majority do live near Maldon so this impact still could be seen.
- By providing outpatient services in local areas, this could create a pressure on local car parks that are not equipped to deal with an increase in demand that may be generated.
- Increase in travel times and mileage, as suggested in the travel analysis, could result in increased air pollution from traffic across MSE. However, for stroke and intermediate care beds and for the maternity midwife led birthing unit, the number of patients is relatively low in comparison to the mid and south Essex population as a whole. The services are also inpatient services

and require a length of time in an inpatient bed which means there is not travel back and forth for patients, but there may be for visitors, especially for community inpatient beds where patients can spend a number of weeks in the units being rehabilitated.

- The proposals for the future locations of community inpatient beds and the freestanding midwife led birthing unit are in more modern estate than St Peter's Hospital, which are more energy efficient.
- The use of existing estate available in mid and south Essex for community inpatient bed services and the freestanding midwife led birthing unit means we are making best use of available estate and not building new units which is better for carbon emissions. While new buildings can be designed for energy efficiency, the initial carbon footprint from materials and construction is substantial. Using existing buildings minimises this impact by repurposing existing structures and infrastructure.

Much of the above related to the potential relocation of outpatient services. It should be noted that as the recommendation within this decision-making business case is not to relocate ambulatory care services, the impacts would not apply. Instead, the impact of the recommendation to keep services at St Peter's Hospital for the short to medium term (0-5 years) will have the following impact on the environment:

- The continued use of the St. Peter's Hospital site for ambulatory care services means that we continue to deliver services from a site that is not energy efficient due to its age and vast size.

8.4.2. Sustainability Impact Assessment (SIA)

A review of the proposals against the Mid and South Essex Integrated Care Board's Sustainability Impact Assessment was undertaken. The Sustainability Impact Assessment is aligned to the Mid and South Essex Integrated Care System's Green Plan 'Our Strategy towards net zero (March 2022)' and the areas of focus contained within it. The anticipated impacts identified were:

8.4.2.1. Positive Impacts

SIA area	Overview of impact
Sustainable models of care	• Optimising the location of care through the use of existing buildings to reduce carbon emissions associated with new builds. For community inpatient beds and maternity services this means using the most 'fit for purpose' estate available across mid and south Essex for these services. For ambulatory care services, the recommendation within this decision-making business case is for services to remain at St Peter's Hospital in the short to medium term. There were no viable alternative locations that would not have needed a significant about of refurbishment which would have meant increased carbon emissions.

	• Earlier and quicker detection, diagnosis and treatment through right sizing the capacity in community inpatient beds to meet demand, both now and in the future. Keeping ambulatory care services at St Peter's Hospital, Maldon means residents continue to have access to outpatient and diagnostic services locally. • Changes will provide evidence-based, personalised care that achieves the best possible health and well-being outcomes with the resources available across the system. Best clinical practice will be embedded through changes to the location and configuration of services and the wider interdependent workstreams happening across the system (see Section 2: Models of Care- Our vision for the future'). Consolidating community stroke rehabilitation beds into two stroke units means clinical expertise and staff are concentrated across two units which will better support in embedding the best clinical care in community stroke rehabilitation beds. • Rehabilitating people in intermediate care and stroke rehabilitation beds in the community supports in treating people 'for the long-term' by helping people to become more independent again after a stroke or an episode of illness or an acute hospital stay. Community hospital inpatient beds reduce the need for unnecessary hospital stays or prolonged care in an acute hospital. This supports in 'carbon savings' from reduced bed days in the acute hospital. It also reduces the number of people going on to need a permanent admission into a residential or nursing home or needing ongoing care in their own home, which also creates a 'carbon saving'.
Travel and transport	• For some patients and visitors, the change in the location of inpatient community beds and the freestanding midwife led birthing unit, will mean a reduction in travel, therefore minimising care miles. • Keeping ambulatory care services where they are at St Peter's Hospital, rather than relocating them to other sites in and around Maldon, also means travel will not be impacted for those using the services. • As part of the implementation of community inpatient bed changes and the freestanding midwife led birthing unit changes, if approved, information on travel advice, including public transport, will be developed and shared with patients and visitors.

	• Keeping ambulatory care services at St Peter's Hospital for the short to medium term (0-5 years) means that there are good public transport links already in place for patients. This was one of the reasons the Community Consultation Working Group recommended keeping services on the site.

Social value	• Social value refers to the positive impact an organisation or activity has on the well-being of people and communities, beyond just financial gains. It encompasses the social, economic, and environmental benefits that contribute to the overall wellbeing of a society.
	
	• It is anticipated that the proposed service changes will increase social value by:
	  • Reducing health inequalities and improving population health outcomes through reducing travel for some residents across mid and south Essex and using more modern estate that may be more accessible for older adults or those with complex needs (community inpatient beds and the freestanding midwife led birthing unit proposals).
	  • Increasing patient satisfaction through more modern, welcoming environments for community inpatient beds and the freestanding midwife led birthing unit.
	  • Supporting workforce wellbeing and long-term sustainability by confirming the permanent location of services and using more modern, fit for purpose estate.
	  • Boosting local economy by ensuring services continue to be delivered within the mid and south Essex footprint and have the right capacity to meet demand, therefore ensuring that jobs remain within the mid and south Essex footprint.
	  • Contributing to environmental sustainability through the best use of more modern estate available across mid and south Essex, therefore reducing the need for new buildings (for community inpatient beds and the freestanding midwife led birthing unit).

Estates and Facilities Management	• Using existing estate across mid and south Essex for community inpatient beds and the freestanding midwife led birthing unit supports in the reduction of carbon emissions because it means new buildings are not needed to deliver these services. Instead, the most 'fit for purpose' estate available will be used. These sites are more modern than the St Peter's Hospital site and therefore more energy efficient. • As St Peter's Hospital is an old site which is not energy efficient, not using the site for inpatient services will hopefully reduce some of its carbon emissions.

	• For ambulatory care services, the recommendation within this decision-making business case is for services to remain at St Peter's Hospital in the short to medium term. There were no viable alternative locations that would not have needed a significant about of refurbishment work, which would have increased carbon emissions. • The facilities management of all the community hospitals across mid and south Essex is the responsibility of the owners of the sites. Through contracts Mid and South Essex Integrated Care Board hold with these providers they are expected to work in line with the Mid and South Essex Integrated Care System's Green Plan. This is managed and monitored through contract meeting governance.
Workforce & System Leadership	• All services will be delivered within the mid and south Essex Integrated Care Board footprint, therefore ensuring there are job opportunities available for local people. • The uncertainty around the future permanent location and configuration of community inpatient beds has led to the use of significant agency staff or the use of the staff bank. Being able to confirm the future location and configuration of inpatient community beds is expected to support staff recruitment and retention. • An aim of permanently moving the freestanding midwife led birthing unit is also to give greater stability to the workforce. • It is anticipated that creating a long-term solution for ambulatory services within Maldon will support the development of sustainable services in the area, which in turn is likely to support retention of current staff and attract new and local staff.
Digital Transformation	• As part of the ongoing work across the NHS to 'move from analogue to digital', the Mid and South Essex Integrated Care System's plan is to increase the use of technology to support patient initiated follow ups in outpatients. This is part of the interdependent workstreams happening alongside this decision-making business case. More information can be found in section '1.4 Case for change'.
Community Engagement	• As set out in the Integrated Impact Assessment (IIA) (see Section 8: Impact of proposed changes'), an assessment of the impact of proposed changes on inequalities in health and access to services has been undertaken. For some the proposed changes will support in better access to services and reduce health inequalities. For some there will be an adverse impact as patients and visitors may have to travel further.

	• Access for patients, relatives and carers is an important aspect when considering equality, but Mid and South Essex Integrated Care System is not in a position to enable equal geographical access for all since it is not proposing, nor has the finance to build and operate new community hospitals or freestanding birthing units, and therefore proposals are based on best use of existing premises which are themselves not distributed evenly throughout mid and south Essex. • The challenges of potentially increased travel times for some residents need to be balanced against the benefits of better estate, more robust staffing and therefore better outcomes for patients through ensuring they receive the highest quality care, with access to specialist teams and facilities that can deliver better health outcomes. • For community stroke rehabilitation beds, the clinical requirement is that the beds are concentrated, thereby concentrating expertise to ensure that the best outcomes for patients are achieved. If this were not done, another inequality would be created by offering sub-optimal stroke rehabilitation services.
Food and nutrition	• In line with Mid and South Esses Integrated Care System's Green Plan, all community hospital service providers across mid and south Essex endeavour to procure food from sustainable and local sources. The Mid and South Essex Integrated Care Board monitors compliance against this through contract monitoring governance.
Medicines management	• All community hospital service providers across mid and south Essex work in accordance with national and local policies around medicines management. • Through contracts Mid and South Essex Integrated Care Board hold with these service providers they are expected to work in line with the system's Green Plan around medicines management. This is managed and monitored through contract meeting governance.

Table 17: Sustainability Impact Assessment- Positive impacts identified

8.4.2.2. Adverse impacts

SIA area	Overview of impact
Sustainable models of care	• This decision-making business case recommends ambulatory care services continuing to be delivered from the St Peter's Hospital site for the short to medium term (0-5 years). The continued use of the St. Peter's Hospital site for ambulatory care services means that we continue to

	deliver services from a site that is not energy efficient due to its age and vast size.
Travel and transport	• Increase in travel times and mileage as suggested in the travel analysis could result in increased air pollution from traffic across mid and south Essex and increased care miles for patients and visitors.

Social value	• Social value refers to the positive impact an organisation or activity has on the well-being of people and communities, beyond just financial gains. It encompasses the social, economic, and environmental benefits that contribute to the overall wellbeing of a society.
	
	• There may be some adverse impacts from the proposed service changes on social value from:
	  • Reducing accessibility to services for some residents with transport barriers (i.e. no access to private transport) and the increase in travel time and costs (community inpatient beds and the freestanding midwife led birthing unit proposals).
	  • Loss of local services (community inpatient beds and the freestanding midwife led birthing unit) may see a reduction in community cohesion as local services can often act as community 'anchors'. However, this impact is reduced by the proposal to keep ambulatory services on the St Peter's Hospital site in the short to medium term (0-5 years) whilst a long-term solution for a future Maldon Health Hub/replacement for St Peter's Hospital is developed.
	  • Potential widening of health inequalities as deprived communities may be disproportionately affected by service changes due to having to travel further and increased travel costs to reach services (community inpatient beds and the freestanding midwife led birthing unit).
	  • Reduced trust and engagement with the NHS in mid and south Essex as communities may feel deprioritised.

Estates and Facilities Management	• This decision-making business case recommends ambulatory care services continuing to be delivered from the St Peter's Hospital site for the short to medium term (0-5 years). The continued use of the St. Peter's Hospital site for ambulatory care services means that we continue to deliver services from a site that is not energy efficient due to its age and vast size. • There will need to be maintenance work carried out on the St Peter's Hospital site over the short to medium term which

	will result in carbon emissions, although this is expected to be limited.
Workforce & System Leadership	• The proposed permanent change in location for community intermediate care and stroke rehabilitation beds and the freestanding midwife led birthing unit may have an adverse impact on the workforce that previously delivered these services at St Peter's Hospital, particularly if they live locally and may now have to travel further to the other proposed sites. This may impact on retention of these staff.
Community Engagement	• As set out in the Integrated Impact Assessment (IIA) (see Section 8: Impact of proposed changes', an assessment of the impact of proposed changes on inequalities in health and access to services has been undertaken. For some the proposed changes will have an adverse impact on access to services and therefore may increase health inequalities as patients and visitors have to travel further for community intermediate care and stroke rehabilitation beds and the freestanding midwife led birthing unit. • Access for patients, relatives and carers is an important aspect when considering equality, but Mid and South Essex Integrated Care System is not in a position to enable equal geographical access for all since it is not proposing, nor has the finance to build and operate new community hospitals or freestanding birthing units, and therefore proposals are based on best use of existing premises which are themselves not distributed evenly throughout mid and south Essex. • The challenges of potentially increased travel times for some residents need to be balanced against the benefits of better estate, more robust staffing and therefore better outcomes for patients through ensuring they receive the highest quality care, with access to specialist teams and facilities that can deliver better health outcomes. • For community stroke rehabilitation beds, the clinical requirement is that the beds are concentrated, thereby concentrating expertise to ensure that the best outcomes for patients are achieved. If this were not done, another inequality would be created by offering sub-optimal stroke rehabilitation services.

Table 18: Sustainability Impact Assessment- Adverse impacts identified

8.5. Evidence Based Recommendations from the Integrated Impact Assessment and Sustainability Impact Assessment and Mitigations

A summary of evidence-based recommendations from the Integrated Impact Assessment (IIA) and Sustainability Impact Assessment (SIA) are set out in the table

below, along with our response to these and any mitigations or proposed mitigations that will be put in place as part of the implementation process. The recommendations have been formed following a review of all the information and evidence gathered and analysed for the IIA and SIA. It also takes into consideration feedback on the proposals from the public consultation.

Recommendations	**Mitigation/Proposed Mitigation**
Patients	
Ensure there is clear documentation regarding travel advice, routes and parking availability for patients and staff including working with local partner organisations, such as local authorities, to explore how patients can be supported if they have travel difficulties.	This will be developed as part of implementation of approved recommendations. See 'Section 11: Implementation' for more detail on implementation plans. Information on the following will also be included to support patients and visitors: • The NHS Healthcare Travel Costs Scheme (a scheme for patients on low incomes that allows them to claim back travel costs to hospital appointments through the, helping to ensure that cost is not a barrier to accessing necessary care). • Patient transport services and eligibility. • Community transport providers across mid and south Essex. • Public transport routes to support in the reduction of any increase in care miles.
Provide clear information around the provision that will be available for: • Stroke rehabilitation beds • Intermediate care beds • Birthing unit types/locations • Ambulatory care services in Maldon As well as information on how this provision meets the needs of the growing population locally in areas	This decision-making business case provides this information.

where services are proposed to be removed, for example Maldon.	
Provide clear guidance around the intermediate care offer for patients, including the rehabilitation offer.	This will be developed as part of implementation of approved recommendations. See 'Section 11: Implementation' for more detail on implementation plans.
Consider moving outpatient appointments to virtual appointments where appropriate. Consider the increased use of the virtual hospital model where possible to save on unnecessary travel for patients. It is important to consider areas of digital exclusion as part of this.	Whilst these two areas are not directly part of the consultations or the proposals there are workstreams in place to explore the increased use of virtual appointments for outpatients, in particular follow up appointments, and also a work programme looking at optimising the use of the virtual hospital model. More information can be found in 'Section 2: Models of Care- Our Vision for the Future'. During implementation we will ensure that this recommendation is fed back to the relevant workstream leads.
Provide clear plans around waiting lists for ambulatory care services, and if any of the proposed changes will impact on waiting list length and any mitigations to this.	As there is no proposed change to ambulatory care service provision and delivery in Maldon, there will not be an impact on waiting lists.
Assess the environmental impacts of the proposed changes to understand if this will impact pollution in the area and if there are any ways this can be mitigated.	Patient cohort numbers for stroke and intermediate care beds and the freestanding midwife led birthing unit are relatively low in comparison to the MSE population as a whole, so the impact of the changes is expected to be minimal in terms of air pollution. Information on available public transport routes will be made available for

	patients and visitors to try and minimise any impact. The recommendation for ambulatory care services to remain at St Peter's Hospital for the short to medium term (0-5 years) means there will be no adverse impact on pollution compared to how things currently stand.
Consider patients and the public with mobility and sensory conditions, such as, musculoskeletal conditions, ophthalmology and audiology patients to understand their needs with regards to travel and the impact of navigating a new setting for ambulatory care services.	The recommendation within this decision-making business case is to keep services at St Peter's Hospital in the short to medium term (0-5 years). Therefore, there should be no impact on these groups.
It is recommended to consider where services will be best co-located to reduce patient travel and ensure that facilities, such as X-ray are accessible and comfortable for patients.	The recommendation for ambulatory care services to remain at St Peter's Hospital for the short to medium term (0-5 years) means there will be no adverse impact on travel to facilities for ambulatory care services.
Staff	
Provide documentation to staff around travel routes and alternative transport options, including any programmes that support staff to travel to work and park in the local area.	This will be developed as part of implementation of approved recommendations. See 'Section 11: Implementation' for more detail on implementation plans.
Services	
It is recommended to work with organisations such as dementia services and falls services to ensure services are designed appropriately for people with dementia and those at risk of falls.	This will be considered as part of implementation of approved recommendations. See 'Section 11: Implementation' for more detail on implementation plans.
It is recommended to work with mental health services and carers/ unpaid	This work will be undertaken as part of implementation of approved

carers and/or services who support carers to understand the impact of travelling to a different location for intermediate care or stroke community inpatient beds which may be further from their home. It is also important to understand the impact of increased home-based care on mental health. For patients who could receive care at home rather than in intermediate care bed, this could put more responsibility on carers which could result in anxiety or fatigue.	recommendations. See 'Section 11: Implementation' for more detail on implementation plans.
It is recommended to work with local authorities to understand transport links offered to locations which may be used for ambulatory services previously at St. Peter's Hospital if they are relocated. This can be provided to patients who may be reliant on public transport to reach appointments.	The recommendation for ambulatory care services to remain at St Peter's Hospital for the short to medium term (0-5 years) means this will not be necessary.
It is recommended to consider those who live alone or those who have home based services, such as virtual wards, to understand the impact of the proposed models on patients who do not have additional support at home when designing new services.	In our current care models, before patients are discharged from a community inpatient hospital bed or a birthing unit their ongoing care and support needs will be reviewed and identified and any additional support put in place. There is a work programme looking at optimising the use of the virtual hospital model. More information can be found in section '2.3 Our vision for the future for Community Inpatient Beds'. During implementation we will ensure that this recommendation is fed back to the relevant workstream leads.
It is recommended to work with the pregnancy diabetes services and other complex conditions during pregnancy to	The changes proposed within this decision-making business case are for inpatient maternity beds within the

understand how patients will be impacted by the proposed changes and ensure services are designed appropriately.	freestanding midwife led birthing unit only. Maternity outpatient appointments will remain in Maldon. The recommendation for ambulatory care services to remain at St Peter's Hospital for the short to medium term (0-5 years) includes maternity outpatients. The freestanding midwife led birthing unit is typically for women and birthing people with low-risk pregnancies who are not anticipated to require medical interventions during labour and therefore it is unlikely that those with diabetes or complex conditions would birth at this unit. This will be reviewed during the implementation phase.
It is recommended to explore if parking will be more limited and the cost, if any, to park needs to be considered.	This was particularly in relation to the ambulatory services if they were to be relocated. The recommendation for ambulatory care services to remain at St Peter's Hospital for the short to medium term (0-5 years) means there will be no adverse impact on travel to facilities for ambulatory care services. There are no parking charges at Brentwood Community Hospital, Cumberlege Intermediate Care Centre or William Julien Courtauld Unit. Similarly to at St Peter's Hospital, parking is limited and if no parking is available then there may be a charge to park in nearby carparks. Information on travel advice, routes and parking will be made available to the public, as per the recommendation made above.
Continue to work with local communities in the future development of short to medium term, and long-term plans for	A 'Community Committee' will be established post decision making. The role of the group will be to scrutinise

St Peter's Hospital to increase 'social value' and community engagement.	and advise on the implementation of the recommendations approved during this decision-making process in regard to ambulatory care services and the future of St Peter's Hospital. Membership will include community and public representation from the 'Save Maldon Medical Services' group. More information can be found in section '11.1.2 Post decision making governance'.
It is recommended the ICB continues to work closely with all providers across community hospital sites to ensure they are delivering against the Mid and South Essex Integrated Care System's Green Plan.	This work is already happening and will be ongoing. Oversight, monitoring and assurance happens through formal contract meetings with providers.

Table 19: Evidence Based Recommendations from the IIA and SIA (to be added) and ICB Mitigations

8.6. Impact on wider services

Under section 14Z43 of the NHS Act 2006 (as amended), we have a duty to ensure that we have taken due regard to any wider impact service changes may have on existing services through our decision-making process, as well as consideration as to whether the proposed service changes will impact on neighbouring Integrated Care Board's service provision.

Community Inpatient Beds

For community intermediate care and stroke rehabilitation inpatient beds the proposals and associated options relate to the location and configuration of the beds only. Therefore, the impact on wider services is likely to be minimal and any impact there may be is likely to be positive. Ensuring community beds have the right capacity, are in the right location and the right patients are admitted to them in the future (with the work set out in section '2.3 Our vision for the future for community inpatient beds'), will support the wider health care system to improve outcomes for patients and reduce any delays in discharges from acute settings.

Being able to confirm the future location and configuration of community beds will give clarity of future provision which will support the implementation of new and revised interdependent pathways of care, improve staffing and will ensure we have the right number of beds across mid and south Essex to meet demand, ensuring best use of all associated services available for intermediate care and stroke care.

It is very unlikely that there will be any differential impact on neighbouring Integrated Care Boards (ICBs) with the proposed location and configuration changes compared to current service delivery. The proposed locations for the community inpatient beds

are within the MSEICB's footprint. Residents living on the border of neighbouring ICBs already have access to the community beds in mid and south Essex if it is appropriate for them to be admitted to them and similarly our residents have access to community inpatient beds in neighbouring systems. Operational teams already work collaboratively to ensure patient admissions and discharges from these beds are as smooth as possible across bordering health and care systems and this would continue with any new locations and configurations of beds.

Freestanding Midwife Led Birthing Unit

For the freestanding midwife led birthing unit, the proposals relate to the location of the service only. There is no anticipated impact on wider services. Since the temporary changes took place in October 2023 (see section '1.3.3 Temporary Service Changes') the service has been operating from William Julien Courtauld and there have been no adverse impacts reported on wider services.

There is also no anticipated impact on neighbouring ICBs if the midwife led birthing unit is permanently moved to William Julien Courtauld. Similarly to when the service was at St Peter's Hospital, if women and birthing people from neighbouring ICBs choose to give birth at the freestanding midwife led birthing unit, they are able to under the right to choose for patients (although this may be dependent on individual circumstances and availability of resources, but that is no different to the service delivery at St Peter's Hospital).

Ambulatory Care Services

The proposals for ambulatory care services within this decision-making business case state that services would remain in the Maldon district and that there would be no change to the services being delivered. Therefore, there would be no impact on wider services within mid and south Essex or on neighbouring ICBs.

The recommendation within this decision-making business case is to keep services at St Peter's Hospital in the short to medium term (0-5 years) and therefore there will be no impact on wider services within mid and south Essex or on neighbouring ICBs.

The long-term plan for a future Maldon health Hub/replacement for St Peter's Hospital will need to include its own review of the impact of any changes on wider services within mid and south Essex and neighbouring ICBs.

8.7. Impact on the Armed Forces Community

Under the Armed Forces Covenant Duty (s.343AA[32] Armed Forces Act 2006 (as amended)), the MSEICB must give due regard to the principles of the Armed Forces Covenant when exercising our healthcare functions and must consider the unique obligations and sacrifices of the Armed Forces community and ensure they are not disadvantaged when accessing healthcare services.

In March 2023 the MSEICB successfully achieved 'Veterans Aware' accredited status and signed an Armed Forces Community Commitment on behalf of the MSEICS, signifying our dedication to ensuring this community has fair and easy access to health and care services. All our Provider organisations delivering the services within this decision-making business case are also signed up to the Armed Forces Covenant Duty. This means that in the day-to-day operational running of

services healthcare staff and managers take Armed Forces personnel and veterans needs into account. For example:

- The ability of IT systems to identify Armed Forces community status for patients to ensure they receive appropriate care.
- Staff being trained and educated in the needs of the Armed Forces community.
- Establishing links to appropriate nearby Armed Forces community services such as Op COURAGE: The Veterans Mental Health and Wellbeing Service and Op RESTORE: The Veterans Physical Health and Wellbeing Service.
- Referring the Armed Forces community to other services as appropriate.
- Raising awareness of the Armed Forces community through internal websites and communications and commemorating key events for the Armed Forces community.
- Supporting the Armed Forces community as employers with schemes such as 'Guaranteed Interview Schemes' for members of the Armed Forces community.

The impact of relocating and reconfiguring community intermediate care and stroke rehabilitation inpatient beds in mid and south Essex and permanently relocating the freestanding midwife led birthing unit from St Peter's Hospital to William Julien Courtauld is very unlikely to have any impact on the Armed Forces community. Those needing access to the services will continue to receive access as they previously have and do now.

Those that receive the War Pension Scheme or Armed Forces Compensation Scheme payments, with a valid war pension exemption certificate, may be entitled to support with travel costs for NHS services and this would support this cohort of residents with any increased costs of travel due to changes in location of community intermediate care and stroke rehabilitation beds and the freestanding midwife-led birthing unit.

The proposals for ambulatory care services state that services would remain in the Maldon district and that there would be no change to the services being delivered. Therefore, there would also likely be no impact on the Armed Forces community.

The recommendation within this decision-making business case is to keep services at St Peter's Hospital in the short to medium term (0-5 years) and therefore there will be no impact on the Armed Forces community within mid and south Essex.

Ensuring the Armed Forces community is identified and therefore can be supported and prioritised as appropriate to use and access health services is key and the MSEICB will continue to work with system partners to ensure this is happening and to promote this to our communities.

8.8. Financial impact assessment

NHS England has laid out the process to follow for service changes in guidance 'Planning, assuring and delivering service change for patients (2018 and addendum 2022)'. The key financial test is that any proposal is affordable in capital and revenue terms ahead of publication. The test was met before the public consultation was launched.

Section ‘4.7: Financial Assurance’ sets out the process that was undertaken for the proposals and options and sets out the associated scope and assumptions.

Community Inpatient Beds

Both options within the proposal on the location and configuration of community intermediate care and stroke rehabilitation beds demonstrate that they are affordable and deliver a small and positive value for money outcome. Option A derives a saving of £0.3m (£252k) per annum based on the financial analysis undertaken and Option B breaks-even (with a very small saving of £5k per annum) based on the financial analysis undertaken.

Freestanding Midwife Led Birthing Unit

The only financial implication of the relocation of the midwife led birthing unit is a small, time-limited cost of £9k per annum, relating to excess travel charges for those staff changing base.

Given the change in bed capacity, Mid and South Essex NHS Foundation Trust (MSEFT) have made some internal staff changes to bolster capacity within their Alongside Birthing Unit on the Broomfield site, via the freeing up of resource as a result of there being fewer beds in William Julien Courtauld than there previously were in St Peter’s Hospital. The cost of the William Julien Courtauld estate is already included within the MSEFT run rate. It is worthy of note that the MSEICB has no change in commissioning expenditure, as ‘Midwifery’ is part of the block element of its contract with MSEFT.

Ambulatory Care Services

It is recognised by the Mid and South Essex Integrated Care System that there is further work to be done once a decision has been made on the future location of ambulatory care services in Maldon to understand the full capital costs and associated revenue costs of that decision. The consultation asked for views on whether or not we should relocate services, which was the first step in the process.

If the recommendation not to relocate ambulatory care services from the St Peter’s Hospital site in the short to medium term (0-5 years) is supported through this decision-making process, then a review of necessary capital investment needed to ensure the safe delivery of services from the site until there is a long-term solution for a future Maldon Health Hub/replacement for St Peter’s Hospital will need to be undertaken.

9. Further scrutiny and advice

Since the publication of the pre-consultation business case we have continued to engage, work closely with, and have due regard for comments and recommendations from:

- Health Overview and Scrutiny Committees (HOSCs): The three upper tier local authorities' (Essex County Council, Southend-on-Sea City Council and Thurrock Council) HOSCs are responsible for reviewing and scrutinising health and social care services within their area. They act as a critical friend, holding health bodies accountable and suggesting ways to improve services. This committee ensures that local health services meet the needs of the community, and that public money is spent effectively. The MSEICB have a statutory duty to engage with HOSCs on any significant service changes.

- Mid and South Essex Clinical and Multi-Professional Congress: An advisory committee to the MSEICB Board, bringing together frontline perspectives and experience from primary, community, acute, social care, public health, mental health, medicines optimisation and resident engagement. It advises on complex or controversial issues affecting clinical services.

- NHS England: Any proposal for service change must satisfy the government's five tests, best practice checks, and must be affordable in capital and revenue terms. NHS England (NHSE) carried out an assurance process at the pre-consultation business case phase (see section '4.3 NHS England') and have undertaken a review of the decision-making business case.

- Stakeholders and the community through the Community Consultation Working Group.

- Maldon District Council: The lower-tier local authority whose residents are most impacted by the proposals within the consultation and this decision-making business case.

We welcome the ongoing input of all stakeholders and groups. An overview of engagement and any feedback and advice is set out below.

9.1. Health Overview and Scrutiny Committees

Essex County Council's HOSC and Southend-on- Seas City Councils HOSC both received a presentation on the consultation process and outcomes of the Public Consultation Report in September 2024. Thurrock City Council's HOSC declined the offer to receive a presentation on the consultation process but did provide written feedback from their Committee. An overview of the HOSCs' responses are outlined in Table 20 below and the full documents can be found in Appendix 15.

HOSC	Key points raised
Essex County Council	• Overall, the committee were satisfied with the consultation process, and felt that it included

	the relevant people, organisations and groups that would be most affected by any changes. • Concerns were raised specifically around the St Peter's Hospital site in Maldon, where it was felt that the consultation could have reached further. • Since the transfer of the birthing unit from St Peter's Hospital to the WJC birthing unit at St Michael's Hospital in Braintree, concern was raised that a significant number of births that had taken place at WJC had been transferred by ambulance to the birthing unit at Broomfield Hospital in Chelmsford and therefore queried whether WJC was a suitable alternative to St Peter's Hospital. • Whilst St Peter's Hospital in Maldon is in a state of disrepair now, members raised questions over the condition of the other sites within MSE that the services are being moved to, and whether long-term, they are suitable or will they need to be moved again in years to come. • The committee raised concerns around what the future looks like for residents of Maldon, given they are most severely impacted by this consultation and the decision to move services away from St Peter's Hospital. • The committee recognise that 71% of survey responses were from people living in the Maldon district and would like it recognised that the good response rate to the consultation is down to the tenacious and hard work of Maldon residents who completed the survey. • As the decision-making process moves forward, the committee would like Maldon residents to be kept informed, more so than other districts, as they are most affected by this process.
Southend-on-Sea City Council	• The committee noted that the number of consultation responses were significantly smaller for the City of Southend-on-Sea in comparison to other districts (3% of those who responded were from Southend-on-Sea). • Members of the Committee felt that neither of the presented consultation options (option A or option B) for community inpatient beds were in the best interests of Southend residents and

	welcomed the decision by Mid and South Essex ICB to delay the final decision-making process by a period of 6 months, so that further engagement and co-development can take place. • Whilst the committee understood the desire to locate specialist services on one site, to provide improved outcomes, it was felt that locating all stroke rehabilitation beds to Brentwood may be too far for residents and relations to travel. • The committee were concerned that losing a number of intermediate care beds may prove challenging for an ageing population locally. • Maintaining connections to family and receiving care, rehabilitation and support in the home or local community cannot be underestimated as an aid to recovery. The Committee observed that a more holistic approach is required, to support an early supported discharge pathway for patients. • The committee questioned whether there was an opportunity to consider other public sector estates to deliver some of these services, such as rehabilitation and physiotherapy and outreach models of care.
Thurrock	• The Committee was provided with a briefing note on the consultation process and was given the opportunity to comment on the community beds consultation at the formal committee meeting held in March 2024. Members were advised both Option A and Option B for community inpatient beds within the consultation include the retention of 24 intermediate care beds at the Mayfield Unit in Thurrock Community Hospital. • The committee noted the briefing note at their meeting and had no further comments to make regarding the consultation as they did not feel the proposals impacted their local residents.

Table 2020: HOSC responses to the community consultation process and feedback

We have kept the HOSCs updated on the progress of the consultation and decision-making process, including the pause on decision making and the establishment of the Community Consultation Working Group through updates at formal meetings and through stakeholder engagement newsletters sent out from the MSEICB.

In June 2025 members of the Essex HOSC visited the St Peter's Hospital site to walk around the site and discuss the progress of the decision-making process with leaders from the MSEICB, Mid and South Essex NHS Foundation Trust and the Independent Chair of the Community Consultation Working Group.

9.2. Mid and South Essex Clinical and Multi-Professional Congress

In May 2025, an update on the decision-making process was presented to the Mid and South Essex Clinical and Professional Senate (MSE Congress). This included an overview of the Community Consultation Working Group and their recommendations. MSE Congress were also given an overview of the decision-making process followed to develop the recommendations within this decision-making business case and the scoring and feedback from the Clinical Subgroup was shared with them.

Feedback from MSE Congress was:

- Community Inpatient Beds: They agreed with the Clinical Subgroup's review of both Option A and Option B. The group scored both options equally. Congress agreed from a clinical perspective there was little variation in being able to deliver high quality, safe services for residents in both options.
- Freestanding Midwife Led Birthing Unit: In line with the feedback and review by the Clinical Subgroup, MSE Congress broadly supported the proposal to permanently move the freestanding midwife-led birthing unit to William Julien Courtauld Unit.
- Ambulatory Care Services: In line with the feedback and review by the Clinical Subgroup, MSE Congress were not supportive of continuing to deliver ambulatory care services at St Peter's Hospital because of the impact the poor estate has on the delivery of high quality of care. They felt wherever possible services should be moved as soon as possible to alternative locations. They did however recognise that, at this point in time, there are no other viable options available. Planned mitigations to improve the estate at St Peter's Hospital in the short to medium term for the delivery of ambulatory care services can be found in section '10.3 Recommendations' and 'Section 11: Implementation'.

9.3. NHS England

We have kept NHS England (NHSE) abreast of the progress of the consultation throughout the process. The Public Consultation Report and the report on the recommendations from the Community Consultation Working Group were both shared with NHSE regional colleagues.

The NHSE Strategy and Integration Director visited the St Peter's Hospital site in May 2025 and made recommendations and gave advice around work that needs to take place during implementation if ambulatory services are to remain at St Peter's Hospital for the short to medium term (0-5 years), as the recommendations within this decision-making business case suggest. The recommendations and advice from NHSE has been factored into the recommendations, mitigations and implementation plans set out in 'Section 10: Recommendations' and 'Section 11: Implementation'.

NHSE regional colleagues have reviewed the decision-making business case prior to the decision making MSEICB Board and offered feedback and advice which has been considered and the document updated in accordance.

9.4. Stakeholders and the community through the Community Consultation Working Group

In response to strong feedback from the public consultation, a further phase of engagement was put in place with the establishment of an independent Community Consultation Working Group in autumn 2024.

The group was created to review feedback from the public consultation and co-develop revised proposals for the configuration of community hospital services and was independently chaired. The group brought together clinical leaders, local authorities, NHS providers, Healthwatch, community representatives, and voluntary sector partners, who further scrutinised and reviewed the proposals within the pre-consultation business case and consultation.

Following six months of detailed engagement and collaborative working, the Community Consultation Working Group published its final recommendation report in March 2025. The report reflects:

- Extensive engagement with patients, clinicians, community groups, staff, and local residents.
- Revised options based on clinical evidence, community priorities, and practical delivery constraints.

The recommendations of the Community Consultation Working Group form a core part of this Decision-Making Business Case and have been given conscientious consideration throughout the decision-making process (more information can be found in section ’10.3 Recommendations’). They directly respond to the Gunning Principles by ensuring:

- Community concerns have shaped viable service models.
- Information shared through consultation was acted upon meaningfully.
- Final proposals are grounded in both public voice and clinical viability.

9.5. Maldon District Council

Following on from the initial consultation on proposed service changes, we have worked closely with Maldon District Council, as the area where the impact of the proposed changes will impact most, and the local MPs for the area, to ensure that any service changes are inclusive and responsive to local needs. We have kept local councillors abreast of the progress of the consultation, and the District Council were a key stakeholder in the Community Consultation Working Group. We have had regular sessions with council representatives- both councillors and officers.

A quarterly ‘Maldon Summit’ has been put in place, which is a strategic meeting with representatives from Maldon District Council, local MPs, Essex County Council and the MSEICB and has included representatives from areas of highways, transport and housing. The aim of the ‘Summit’ has been to look at the wider impacts of housing

developments in the area and to keep everyone updated on the progress of the Community Capacity Work Programme. The group has also been supportive in looking at viable options for alternative sites for the long-term development of a Maldon Health Hub/replacement for St Peter's Hospital.

Decision making

10. Decision Making

This decision-making business case (DMBC) has been written with the purpose of providing an evidence base to inform decision making by the Mid and South Essex ICB Board on the following proposals:

1) The future location and configuration of community intermediate care and stroke rehabilitation beds across mid and south Essex.
2) The future location of the freestanding midwife-led birthing unit in mid and south Essex.
3) The future of ambulatory care services at St Peter's Hospital, Maldon.

In their decision making, the MSEICB Board are to consider the recommendations made within this DMBC and are asked to look at all the evidence and information presented within the DMBC to enable them to do so. This includes, but is not limited to:

- The evidence and information set out in the 'Case for Change'.
- The evidence and information set out in our 'Vision for the Future'.
- Feedback from the public consultation.
- Feedback and recommendations made by the Community Consultation Working Group.
- The findings of the East of England Clinical Senate.
- The integrated impact assessment.
- The financial impacts of the proposed changes.

10.1. Decision Making Process

In the pre-consultation phase, options for the proposals for community hospital service reconfigurations, as set out in the consultation, were assessed against three domains (quality, strategy and finance) and associated sub-criteria. This DMBC uses the same domains and sub-criteria against which to review and score the proposals and options and make recommendations.

There was one addition made to the sub criteria for community intermediate care and stroke rehabilitation beds during the decision-making process, which was the need to consider the impact of mobilising the options. The addition was recommended by the Operational and Workforce Subgroups and supported by the Community Capacity Programme Board.

In line with the pre-consultation assessment process, the different domains and sub-criteria were 'weighted', depending on their importance. This meant the more important the domains (and sub-criteria within the domains) were felt to be, the bigger percentage of the available score they could get. These weights were applied to the scores post subgroup evaluation. The domain weightings were originally determined by the Clinical Capacity Task Force and reconsidered and agreed by the Community Capacity Programme Board. The only change in weightings was as a result of the additional sub criteria added in for intermediate care and stroke rehabilitation community beds, around the impact of mobilisation- see Figure 18 below.

The three domains and associated sub-criteria used to assess the proposals and options within the consultation are:

Quality domain

- Provision of a safe, secure, quality care environment
- Accessible from main centres of population in MSE
- Impact on capacity-supporting the health and care system to manage future demand.
- Impact on workforce-ability to recruit and retain skilled staff

Strategy domain

- Moving towards the assessed bed requirement for stroke rehabilitation and intermediate care beds (for intermediate care and stroke rehabilitation beds only)
- Clinically supported solution/fit with system clinical strategy
- Fit with system estate strategy.
- Mobilisation of bed configurations (for intermediate care and stroke rehabilitation beds only)

Finance domain

- Financial affordability

Criteria	Beds Weighting	MLBU Weighting
Quality	**50%**	**60%**
Provision of a safe, secure, quality care environment	10%	20%
Accessible from main centres of population in MSE	10%	10%
Impact on capacity-supporting the health and care system to manage future demand	20%	10%
Impact on workforce-ability to recruit and retain skilled staff	10%	20%
Strategy	**25%**	**25%**
Moving towards the assessed bed requirement for stroke rehabilitation	5%	N/A
Clinically supported solution/fit with system clinical strategy	15%	20%
Fit with system estate strategy	3%	5%

Mobilisation of bed configuration	2%	N/A
Finance	**25%**	**15%**
Financial Affordability	25%	15%

Figure 18: Weightings for each of the scoring sub criteria.

For ambulatory care services, whilst the above domains were considered they were not scored against. Instead, the group were asked to review written evidence about the developments in the work on future locations for ambulatory care services, which outlined:

- There was strong public feeling and concerns raised regarding the suggestion to relocate ambulatory care services that came back through the public responses to the consultation.
- One of the key reasons for pausing the DMBC was to enable further discussions to take place with partners and community representatives on the future of ambulatory care services within Maldon.
- Further work has taken place since the consultation, through both the Working Group and the Community Capacity Programme Board (in response to the Working Group discussions).

The outcomes of this work and discussions was shared with the Subgroups and Community Capacity Programme Board. In summary:

- Despite a number of suggested locations being explored for ambulatory services to be relocated to, there was no preferred solution that offered the capacity and access needed, or that were affordable to the MSEICS.
- The cost of configuring any estate in the suggested new locations to make it fit for purpose for healthcare service was likely to be very expensive and would only offer a medium-term solution, whilst a long-term solution is still being developed for a new Maldon Health Hub/replacement for St Peter's Hospital.
- There was a very strong public feeling through the consultation responses and the Community Consultation Working Group that services should remain at St Peter's Hospital until there is a long-term plan in place.
- Recognition that St Peter's Hospital does need some remedial works to allow ambulatory services to remain there in the short to medium term (0-5 years) and the cost of this is currently unknown. Therefore, a piece of work is underway to look at how the current estate could be best utilised (see section '10.3.3. Recommendation for ambulatory care services' for more information.

Taking the above information into consideration, as well as the domains and sub criteria, Subgroups and the Community Capacity Programme Board were asked two questions:

1. Are you supportive of the outcomes of the Community Consultation Working Group and suggested way forward, that services remain at St Peter's wherever possible for the short to medium term (0-5 years)?

2. Should ambulatory services be relocated from the St Peter's site to alternative site/s in and around Maldon (in line with the question that was consulted on)?

The Community Capacity Programme Board and its associated expert Subgroups carried out a full review and scoring process for all proposals and options set out in this DMBC. The Subgroups of the Community Capacity Programme Board were made up of experts from across the Mid and South Essex Integrated Care System (MSEICS). Each Subgroup was asked to review and score (scoring for community beds location and configuration options and the freestanding midwife led birthing unit only)/respond to questions (ambulatory care services only) for each of the proposals and options, using their knowledge in each of the areas and evidence provided as part of the process. The evidence and information shared with them for consideration in their review and scoring/question responses was:

- The evidence and information set out in the pre-consultation business case.
- In particular they were asked to take into account the evidence set out in the 'Case for Change' and the 'Future Models of Care' sections.
- Feedback from the public consultation- both the Public Consultation Report and the thematic review of the feedback, outlined in 'Section 6: Feedback form the public consultation' and 'Section 7: Addressing themes from the consultation' of this DMBC.
- Feedback and recommendations made by the Community Consultation Working Group.
- The findings and recommendations from previous assurance and advisory bodies, outlined in the pre-consultation business case and in 'Section 4: Previous assurance and advice' of this DMBC, particularly the recommendations of the East of England Clinical Senate.
- The Integrated Impact Assessment.
- The financial impact of the proposed changes, as set out in the pre-consultation business case (this was reviewed by the financial Subgroup and the Community Capacity Programme Board in their final decision-making role)

The expert Subgroups looked at all three proposals that were consultation on. The areas they were asked to review, and score were:

Quality and Strategy Criteria

- Clinical Subgroup
- Operational Subgroup
- Estates Subgroup (relating to estate only)
- Workforce Subgroup (relating to workforce)
- Community Capacity Programme Board

Finance Criteria

- Finance Subgroup

For each of the Subgroups the following process was followed:

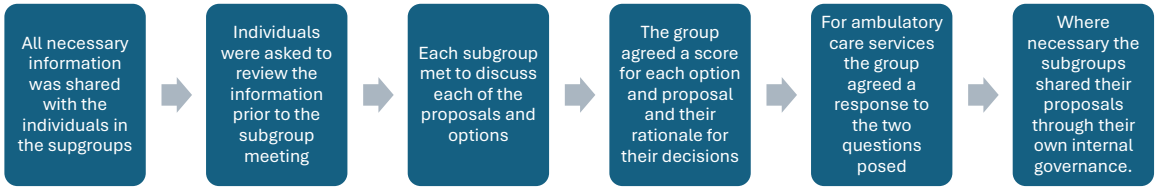

Figure 19: Subgroup scoring process

Once each subgroup had agreed their scores and responses they were submitted to the Community Capacity work programme lead. All the scores were then collated, weighting was applied, and this gave an overarching score and the associated responses for each proposal and option. The Community Capacity Programme Board then met to review the scores, responses and rationale behind them.

10.2. Decision Making

The Community Capacity Programme Board considered all the scores from the Subgroups, the associated rationale, and the information and evidence shared in the pre-consultation business case, the Consultation Feedback Report, the recommendations of the Community Capacity Working Group, the Integrated Impact Assessment and any other relevant information, and agreed the final recommendations that are put forwards in this DMBC. The recommendations and rationale are outlined in the section below.

10.3. Recommendations

10.3.1. Recommendation for community intermediate care and stroke rehabilitation inpatient beds

'The future location and configuration of community intermediate care and stroke rehabilitation beds across mid and south Essex.'

The MSEICB Board is asked to **approve** that **Option B** for the location and configuration of community intermediate care and stroke rehabilitation beds is implemented. This will mean:

- Stroke rehabilitation beds will be split across Brentwood Community Hospital (25 beds) and Cumberlege Intermediate Care Centre (CICC), Rochford (22 beds).
- There will be 25 intermediate care beds at Brentwood Community hospital.
- There will be no intermediate care beds located at CICC.
- Permanently closing the stroke rehabilitation ward at St Peter's Hospital, Maldon.

Location	Facility	Stroke rehabilitation beds	Intermediate care beds
Billericay	Mountnessing Court	-	22
Brentwood	Brentwood Community Hospital	25	25
Grays	Thurrock Community Hospital	-	24
Halstead	Halstead Hospital	-	20
Maldon	St Peter's Hospital	-	-
Rochford	Cumberlege Intermediate Care Centre	22	-
	Total	**47**	**91**
		138	

Figure 20: Option B - Location and configuration of intermediate care and stroke rehabilitation beds in mid and south Essex

10.3.1.1. Rationale for recommendation

Domain 1: Quality

Sub criteria	Rationale/evidence
Provision of a safe, secure, quality care environment	Both options were felt to provide a safe, secure, quality care environment. Option B scored slightly higher as it was felt operationally continuing to use CICC as a site for stroke care provides less challenges than having all stroke beds at Brentwood Community Hospital given estate limitations at Brentwood Community Hospital in respect to a number of areas such as storage of additional equipment and sufficient gym and rehabilitation facilities needed for an expanded unit. Option A would mean all stroke services were delivered in one place, which it has previously been suggested could become a 'Centre of Excellence', however, having just two sites still allows for the concentration of staff and their relevant skills in dedicated units. In the review of the proposals by the East of England Clinical Senate in December 2023 (see section '4.1 East of England Clinical Senate) they supported concentrating stroke rehabilitation beds across two sites stating this could 'provide more resilience than the previous model' but did also recognise that two sites compared to one site could 'be challenging in terms of staffing' and recommended that 'two rehabilitation units should work together as much as possible to share staffing resource and build resilience'. This recommendation will be factored into implementation planning.

Accessible from main centres of population in MSE	Option B offers more choice and more equity in access across mid and south Essex than Option A, with stroke beds being provided across two sites, rather than all at one site. It was recognised that there will be increased travel for some patients and their relatives across mid and south Essex, but for some travel times will reduce. In the review of the proposals by the East of England Clinical Senate in December 2023 (see section '4.1 East of England Clinical Senate) they supported concentrating stroke rehabilitation beds across two sites stating this would 'deliver a better solution in terms of access than one site', however they did also recognise the potential issues with staffing- see comment in column above.
Impact on capacity- supporting the health and care system to manage future demand.	Both options provide the capacity needed based on bed modelling. It was felt that Option B offers more flexibility for future models of care as services are split across two sites rather than all being on one site. Option A offers an additional three stroke beds which in the pre-consultation business case suggested could be used for Level 3 neurorehabilitation care. Whilst this was not proposed if Option B was chosen, the Integrated Care System will consider whether it is possible to deliver this additional support to neuro rehabilitation patients if and when there is capacity within community stroke rehabilitation beds.
Impact on workforce- ability to recruit and retain skilled staff	Both options were felt to have a relatively equal impact on workforce and staffing, but Option B scored slightly higher than Option A as it provides more flexibility and options for staff on where they work as there will be two sites delivering stroke care, one in Brentwood Community Hospital and one in CICC. During engagement with staff working in the units the majority stated their preference would be Option B. This option also requires less mobilisation and disruption as it most closely replicates the existing temporary arrangements in place. Option A required significant upskilling of staff at Brentwood Community Hospital who are currently delivering intermediate care on the intermediate care ward rather than stroke care. Whilst some staff may welcome this, some would not want to go through this training and upskilling process which may cause problems with staff retention and ultimately impact patient care.

	In the review of the proposals by the East of England Clinical Senate in December 2023 (see section '4.1 East of England Clinical Senate) they recommended that a comprehensive workforce strategy be developed with 'an ongoing focus on new ways of working, new roles and competency sign-off, as well as recruitment and retention. This will be part of implementation planning- see 'Section 11: Implementation'.

Table 21 21: Community Inpatient Beds - Rationale for recommendation - Quality

Whilst scoring of both options was very close, Option B scored slightly higher than Option A in the quality domain review. This was primarily due to Option B offering more options in the location of bedded stroke rehabilitation care in the community, and therefore better access for residents across mid and south Essex, and the impact on workforce with Option B offering staff more choice in their work base and less impact in terms of upskilling and training needs.

Domain 2: Strategy

Sub criteria	**Rationale/evidence**
Moving towards the assessed bed requirement for stroke rehabilitation and intermediate care beds	Both options deliver the capacity needed based on bed modelling and therefore scored equally.
Clinically supported solution/fit with system clinical strategy	Both options were felt to support the future clinical models of care for intermediate care and stroke rehabilitation care. It was felt that stabilising capacity and staffing by agreeing and implementing an option through this decision-making business case will enable the system to look at further opportunities for transforming these areas of care. For stroke care it was felt that Option A creates greater opportunity for developing a single 'Centre of Excellence', but there was recognition that Option B still offers opportunity for better alignment of single standards, policies and clinical practice across two sites. This will be part of mobilisation and implementation plans. In the review of the proposals by the East of England Clinical Senate in December 2023 (see section '4.1 East of England Clinical Senate) they supported concentrating stroke rehabilitation beds across two sites stating this could 'provide more resilience than the previous model' and 'delivers a better solution in terms of access than one site'

	but did also recognise that two sites compared to one site could 'be challenging in terms of staffing' and recommended that 'two rehabilitation units should work together as much as possible to share staffing resource and build resilience'. This recommendation will be factored into implementation planning.
Fit with system estate strategy	Both options fit with the system estates strategy and mean the system are best using available estate across mid and south Essex. Option B scored slightly higher based on there being less challenges in equipment needs and space constraints if all stroke beds were on one site.
Mobilisation of bed configurations	Whilst it was recognised that long term decisions should not be based on the difference in mobilisation timeframes, Option B scored slightly higher than Option A in this sub criteria, not only because it can be implemented faster but because it has less impact on the workforce and staffing because of the reduced need for additional training and upskilling of staff. It was felt operationally having two stroke units is less challenging than having all stroke beds at Brentwood Community Hospital given estate limitations at Brentwood in respect to a number of areas such as storage of additional equipment and sufficient gym and rehabilitation facilities needed for an expanded unit. Given the timing of decision making, Option B can be implemented prior to winter 2025 which was felt to be a benefit to the whole health and care system. Many staff have been waiting a long time for decisions to be made, once the locations and configurations of beds are made permanent the workforce would welcome implementation as rapidly as possible.

Table 22 22: Community Inpatient Beds - Rationale for recommendation - Strategy

Whilst scoring of both options was very close, Option B scored slightly higher than Option A in the strategy domain review. This was due to Option B being less of a challenge in terms of mobilisation and it being easier to manage estate challenges with stroke being split across two sites.

Domain 3: Finance

Sub criteria	Rationale/evidence

Financial affordability	Both Option A and Option B deliver savings to the system in terms of revenue costs. Option A scored higher than Option B. This was due to Option A delivering three additional community stroke rehabilitation beds compared to Option B. The assumption behind the financial modelling is that for every additional community stroke bed there will be a corresponding reduction in acute stroke beds. However, it was recognised that there is a risk in the system's ability to reduce the number of acute beds, particularly given current operational and financial pressures within the acute trust and therefore would be at high risk of non-delivery of the savings. This will not prevent implementation but would mean the Integrated Care Board would need to fund the community beds from an alternative funding source. The way that the scoring for financial affordability was derived was that there was a sliding scale from the most cost-effective solution. Both options offered a revenue saving to the system. Option A scored full points as it offered the best value for money, with the greatest saving to the system, whilst Option B was scored on a sliding scale reduction, given it offers a less cost-effective solution (less savings to the system).

Table 23 23: Community Inpatient Beds - Rationale for recommendation - Finance

Option A scored higher than Option B on financial affordability.

For transparency in decision making, it is important to note that when all scores from the Subgroups and the Community Capacity Programme Board were amalgamated for all domains and sub criteria, and the weighting applied, Option A came out as scoring higher than Option B by two points. The Community Capacity Programme Board considered the scores, but also the supporting information and evidence, including the feedback from the consultation and the Community Consultation Working Group.

The Community Capacity Programme Board also considered that whilst Option A did score slightly higher, this was due to the financial affordability domain scoring. For the quality and strategy domains Option B scored slightly higher than Option A in both areas. The operational and workforce Subgroup's scoring, and the Community Capacity Programme Board's scoring, all favoured Option B over Option A. The clinical subgroup scored both options equally. The Community Capacity Programme Board were conscious of the risks in the delivery of savings in both options given they rely on a reduction in acute hospital beds.

The Programme Board did recognise that we are a system in significant financial deficit, but the potential savings in both options are relatively small when the total cost of services and our total budget are taken into account alongside the risk associated

with the delivery of these savings and balancing this with the quality, safety and strategic fit of the options.

The Community Capacity Programme Board made the decision to recommend Option B in this decision-making business case given it scored higher in the quality and strategy domains, was the preferred option from the consultation feedback, and was the recommendation given by the Community Capacity Programme Board. Whilst both options were seen to have their benefits and challenges, overall, the Programme Board felt Option B was the better option for the residents of mid and south Essex, the wider health system and our workforce.

10.3.1.2. Consultation and Community Consultation Working Group feedback

The independent analysis of the public consultation found that, whilst most people were not supportive of Option A or Option B, Option B was the preferred option out of the two and 16% of respondents considered it a 'good' solution compared to just 5% for Option A.

The Community Consultation Working Group recommended that Option B was approved by the ICB Board. In their report they said that they felt offering stroke rehabilitation beds across two sites better reflects the nature of strokes being more volatile and that Option B also ensures that Southend and the surrounding area will not need to travel as far if they need community inpatient stroke rehabilitation care.

Community Consultation Working Group – recommendation C4

"With regards to 'options A or B' in the original consultation in terms of the reprovision of stroke beds, it is noted that 'splitting' the stroke beds means we reflect the nature of strokes being more volatile. Therefore, it is recommended that 'option B' be approved. This also ensures that the further flung area, Southend, has a health mix of provision and Southend City citizens will not need to travel as far...."

10.3.1.3. Integrated Impact Assessment

Through the Integrated Impact Assessment (IIA), both options were identified as providing benefits to the population. By 'right sizing' the community intermediate care bed offer and increasing the community bed-based stroke rehabilitation capacity, the population of mid and south Essex will have access to optimised community care which will keep care closer to home for patients and improve facilities, training for staff and rehabilitation opportunity.

There were also adverse impacts identified for both options. Option A would result in stroke rehabilitation beds being centralised in Brentwood Community Hospital which would mean fewer location options across mid and south Essex for patients. Option B results in community stroke beds based in two locations, which would mean splitting community bedded stroke rehabilitation resources across mid and south Essex which could reduce the opportunity for increased training, development and research opportunities that can be achieved with one centralised location. It also results in three fewer stroke beds across mid and south Essex compared to Option A.

Both Option A and Option B were assessed as having either positive or neutral impacts on the protected characteristics assessed within the IIA, other than those for those living in deprivation and carers/unpaid carers where both options were assessed as having a negative impact. This will be mitigated wherever possible during implementation. It was also recognised that both options may increase travel for some patients and visitors, for others they will reduce travel times. More information can be found in 'Section 8: Impact of proposed changes'.

In summary the IIA does not favour one option or another.

10.3.1.4. Implementation considerations

If the recommendation is supported by the MSEICB Board, the estimated timeframe for implementation is early December 2025.

Implementation will require engagement and consultation with the affected workforce. It will also require the development of a comprehensive workforce strategy.

The recommendation from the East of England Clinical Senate to ensure that the two stroke rehabilitation units 'work together as much as possible to share staffing resource and build resilience' will need to be factored into implementation and ongoing ways of working between the sites.

Option A offered an additional three stroke beds which in the pre-consultation business case suggested could be used for Level 3 neurorehabilitation care. Whilst this was not proposed if Option B was chosen, the Integrated Care System will consider during implementation whether it is possible to deliver this additional support to neuro rehabilitation patients if and when there is capacity within stroke rehabilitation beds.

More information can be found in 'Section 11: Implementation'.

10.3.2. Recommendation for the freestanding midwife led birthing unit

'The future location of the freestanding midwife-led birthing unit in mid and south Essex.'

The MSEICB Board is asked to **approve** the permanent relocation of the freestanding midwife-led birthing unit from St Peter's Hospital, Maldon to the William Julien Courtauld (WJC) Unit, St Michael's Health Centre, Braintree. This will mean:

- The freestanding midwife led-birthing unit will permanently relocate to William Julien Courtauld Unit, Braintree.
- Permanently closing the freestanding midwife-led birthing unit at St Peter's Hospital, Maldon.
- Maternity outpatient appointments (pre- and post-natal care) will remain in Maldon.

10.3.2.1. Rationale for recommendation

Domain 1: Quality

Sub criteria	Rationale/evidence
Provision of a safe, secure, quality care environment	The unit at WJC is felt to provide a safe, secure, quality care environment. Services have been delivered from the unit since October 2023 when they were temporarily relocated from St Peter's Hospital, Maldon. The unit at WJC is felt to offer a better clinical environment than the unit at St Peter's Hospital and better continuity of service as the unit has not had to intermittently close.
Accessible from main centres of population in MSE	The site has sufficient parking and is accessible by public transport. It was recognised that there is an impact for the Maldon population, in particular, where travel times will increase when travelling to WJC compared to St Peter's Hospital, but that for the wider mid and south Essex population WJC is more easily accessible.
Impact on capacity- supporting the health and care system to manage future demand.	Based on current birthing rates the unit has sufficient capacity. In the time the unit has been operating at WJC it has remained open, when St Peter's regularly had to shut due to issues with staffing across other sites, which means the option for women and birthing people to give birth in the freestanding midwife-led unit has improved and increased, offering more capacity across the system. Continuing to offer a freestanding midwife-led unit is felt to offer more choice to the population of mid and south Essex and using WJC is felt to be the most appropriate and best use of available estate and staffing to do so.
Impact on workforce- ability to recruit and retain skilled staff	WJC is a more attractive location for staff to work as it offers a more modern estate, and the initiatives carried out as part of the temporary arrangement have proved positive with improved retention. Therefore, WJC was felt to have a more positive impact of the system's ability to recruit and retain staff.

Table 2424: Freestanding Midwife Led Birthing Unit - Rationale for recommendation - Quality

Scoring of all sub criteria for the Quality domain was above the 50% threshold meaning that from a quality perspective the recommendation to permanently move the freestanding midwife led birthing unit to WJC was supported for this domain. This was particularly due to the 'provision of a safe, secure, quality care environment' sub criteria as it was felt WJC offers a better environment for patients and staff.

Domain 2: Strategy

Sub criteria	Rationale/evidence

Clinically supported solution/fit with system clinical strategy	The recommendation to move the freestanding midwife-led birthing unit from St Peter's Hospital to WJC will not change the current service model, but WJC offers more modern facilities and estate, and the expectation is the service will be able to be more consistently operational which should lead to better experience and outcomes for women and birthing people. There was recognition that the maternity population is becoming more complex and therefore require obstetric led care at the main unit. This includes a rising C Section rate and a higher percentage of babies being born prematurely which often necessitate neonatal services. By offering WJC and the Alongside Birthing Unit on the Broomfield site service users have options for where they can give birth, and the freestanding unit offers additional capacity in the system. In addition, it was noted there is a current piece of work being undertaken to improve the Home Birth services in the Maldon area, an outcome of the Community Capacity Working Group. The reduced travel time for anyone needing to be transferred from the unit at WJC to Broomfield Hospital compared to the travel time from St Peter's Hospital to Broomfield Hospital, if complications arose, was felt to be beneficial to patients.
Fit with system estate strategy	WJC offers more modern facilities and estate. Similarly to community beds, MSEICS needs to make the best use of existing facilities available, and to make the best use of facilities that do not require significant investment, and it is felt that permanently relocating the unit to WJC from St Peter's Hospital does this.

Table 2525: Freestanding Midwife Led Birthing Unit - Rationale for recommendation - Strategy

Scoring of all sub criteria for the Strategy domain was above the 50% threshold meaning that from a quality perspective the recommendation to permanently move the freestanding midwife led birthing unit to WJC was supported for this domain. It was felt that moving the unit to WJC gives a better clinical environment and provides better service continuity and uses the best available estate within mid and south Essex to deliver the service from.

Domain 3: Finance

Sub criteria	**Rationale/evidence**
Financial affordability	The only financial implication of the relocation of the MLBU is a small, time-limited cost of £9k per annum relating to excess travel charges for staff changing base, which has no impact on the affordability scoring.

Table 2626: Freestanding Midwife Led Birthing Unit - Rationale for recommendation - Finance

10.3.2.2. Consultation and Community Consultation Working Group feedback

The independent analysis of the public consultation found that the majority of respondents thought the proposal to relocate the freestanding midwife led birthing unity from St Peter's Hospital to the WJC was a poor proposal, with only 2% of respondents rating the proposal as good or very good. 75% of respondents this proposal in the consultation were from the Maldon area. The Community Capacity Programme Board did give the feedback from the consultation conscientious consideration in their discussions, but they felt the benefits of relocating the service were such that it should be put forwards as the recommendation in this DMBC.

The Community Consultation Working Group, having had a significant amount of information and data shared with them by the Mid and South Essex NHS Foundation Trust (MSEFT) maternity teams during the Working Groups, and following a light-touch peer review they requested from an independent NHS Trust, recommended the permanent closer of the freestanding midwife-led birthing unit at St Peter's Hospital and supported the recommendation that the unit be permanently moved to WJC.

Community Consultation Working Group – recommendation D2

"The midwife-led birthing unit conversation caused the greatest consternation. Elements of the thinking and rationale seemed rushed by the ICB. Due to this, the decision was taken to having the data and conclusions undergo a lite-touch peer reviewed by an independent NHS Trust. The review helped conclude the following – the Maldon and surrounding birth rate remained low, with increases in birthing events being negligible (the rate is in fact in decline – in 2015 59.8 births per month in Maldon (Essex County Council, Birth Rates by District) whereas it had fallen by 2024 est. 53.1). The argument that staffing an ad hoc unit for so few cases was inefficient for the taxpayer and unsafe in terms of not always being able to fully staff such a small unit was a sound argument. Therefore, it is recommended to close the midwife-led birthing unit. "

10.3.2.3. Integrated Impact Assessment

The Integrated Impact Assessment (IIA) identified that the proposal within the decision-making business case for the freestanding midwife led birthing unit means there will continue to be choice in birthing locations for women and birthing people across mid and south Essex. Keeping maternity outpatient services in Maldon means women and birthing people won't have any increased travel for their pre- and post-natal appointments.

The proposal was assessed as having either a positive or neutral impact on the protected characteristics assessed within the IIA, other than for those living in deprivation and carers/unpaid carers where both options were assessed as having a negative impact. This will be mitigated wherever possible during implementation. There was recognition that there may be increased travel for some patients and visitors, for others they will reduce travel times. More information can be found in 'Section 8: Impact of proposed changes'.

10.3.2.4. Implementation considerations

The freestanding midwife led birthing unit is already operating from WJC and therefore the mobilisation needed will be minimal.

Implementation will require engagement and consultation with the affected workforce.

10.3.3. Recommendation for Ambulatory Care Services

'The future of ambulatory services at St Peter's Hospital, Maldon.'

The MSEICB Board is asked to **approve** the recommendation that ambulatory care services are **not relocated** from St Peter's Hospital, Maldon, to alternative locations in the short to medium term (0-5 years). This will mean:

- Wherever possible, ambulatory care services will continue to be delivered from the St Peter's Hospital site for the next 0-5 years whilst a long-term solution for a Maldon health hub/replacement for St Peters Hospital is developed and delivered.

The caveats to this recommendation are:

- It is recognised that the St Peter's Hospital site remains unsuitable for the delivery of clinical care in the long term and remains a high-risk site. Therefore, action must be taken to make best use of and to optimise the quality of the site as far as is practicable in the short to medium term.

- There must be a review of the areas on the ground floor of St Peters Hospital that are currently being used for the delivery of ambulatory care services and agreement across the Integrated Care System on essential work that needs to be carried out to improve the estate to allow services to continue to be delivered safely.

- This will require capital expenditure and the sharing of a full report on the anticipated costs and plan for how capital will be found to support the work (this is the responsibility of Mid and South Essex Foundation Trust).

- Essential maintenance must be carried out routinely over the 0-5 years to ensure services can continue to be delivered as safely as possible.

- There must be regular assessment of the estate over the 0-5 years to ensure it is safe and services can continue to operate safely from the environment they are being delivered from.

- A plan for a future Maldon health hub/replacement for St Peter's Hospital must be developed and delivered in the next 0-5 years.

- This work, alongside any developments of any service in Maldon which require a change in estate provision should be reviewed collectively and in partnership with the communities of Maldon to ensure that these do not result in a gradual

reduction of services on the St Peters site over time that make the site unviable, or services being lost from the Maldon District.

- Emergency Preparedness and Business Continuity Plans for ambulatory care services delivered from the St Peter's Hospital site must be regularly reviewed and kept up to date to ensure services could continue and patient care could be maintained should there be a significant deterioration in any part of the estate.

10.3.3.1. Rationale for recommendation

Domain 1: Quality

Sub criteria	Rationale/evidence
Provision of a safe, secure, quality care environment	It is recognised that there are significant issues with the care environment in some areas of St Peter's Hospital and that long term it is not a sustainable or suitable environment for care. However, to mitigate risks and concerns raised in the pre consultation business case regarding the estate at St Peter's Hospital, all ambulatory care services were moved onto the ground floor of the site in October/November 2023 to mitigate against the risks highlighted regarding the top two floors of the main site where there were issues with the roof leaking and the lift breaking down, and historical issues with the load bearing capacity of the floor. Services have been consolidated to the most suitable estate available and ambulatory care services have continued to be delivered from the site. All patients attending the site are 'ambulatory' and are therefore mobile and not in inpatient beds, therefore reducing the risk for patients and staff if an evacuation was needed, for example if there was a fire. Work to maintain the site is underway and work is in development to review all the areas that are being used to see what work and capital investment is required to improve the estate and therefore service delivery in the short to medium term (0-5 years). Emergency preparedness plans and business continuity plans are being reviewed and updated for all areas and services. Processes must be put in place to ensure there are regular and routine reviews of the site to check it continues to be a safe environment for delivering care.

	The processes and mitigations that will need to be put in place to enable services to continue to be delivered from the site for the short to medium term (0-5 years) are outlined in the section in 'Implementation Considerations' below.
Accessible from main centres of population in MSE	Ambulatory care services delivered from St Peter's Hospital are predominantly used by residents living in 'mid Essex', and the largest number of residents who use services are from the Maldon district. The site has good parking and reasonable public transport links for those coming from the mid Essex area.
Impact on capacity- supporting the health and care system to manage future demand.	Ambulatory care services delivered from St Peter's Hospital could not be consumed within other sites, for example Broomfield Hospital. Therefore, services must continue to be delivered, or this would have a significant detrimental impact on other service areas and access and outcomes for patients.
Impact on workforce- ability to recruit and retain skilled staff	For staff working at St Peter's Hospital, keeping services on site is beneficial and may help in the retention of staff compared to if services were moved elsewhere. Consultation responses showed the majority of staff (81%) felt relocating services was a bad idea. However, it is recognised that the poor estate has impact on existing staff morale and may not help in attracting new staff.

Table 2727: Ambulatory Care Services- Rationale for recommendation - Quality

Domain 2: Strategy

Sub criteria	**Rationale/evidence**
Clinically supported solution/fit with system clinical strategy	Clinically and operationally continuing to deliver services from St Peter's Hospital raises challenges, due to the poor estate. Having said that, continuing to deliver services and making the best use of the available estate or these services in mid and south Essex, as well as investing where possible and necessary to improve estate does mean that we can continue to deliver services for the short to medium term (0-5 years) whilst a long term replacement for St Peter's/Maldon Health Hub is in development, ensuring we do not lose capacity in the system. There will also need to be a review of all ambulatory care services being delivered from the St Peter's Hospital site with clinical and operational leads to see if there are any service changes that need to take place, or any shift of

	services from the St Peter's Hospital site that are necessary because it is clinically best to do so to support in delivering better patient outcomes. At this point in time, continuing to deliver ambulatory care services from St Peter's Hospital is felt to be the only viable option to enable clinical services to continue.

Table 28 28: Ambulatory Care Services- Rationale for recommendation - Strategy

Domain 3: Finance

Sub criteria	Rationale/evidence
Financial affordability	Keeping services at St Peter's Hospital for the short to medium term has no immediate impact on revenue costs as costs will remain the same. Indeed, revenue costs have already reduced, as a result of rationalising operational services onto the ground floor. There is more work to do to understand the capital investment required in the short to medium term to maintain services at St Peter's Hospital. A review of the backlog maintenance requirements within the area which continues to be used to deliver services will need to be undertaken. This will enable quantification of any essential capital works that need to be carried out to improve the estate and thus allow services to continue to be delivered from the site safely. This work has already started, and funding identified for 2025/26 (see further information in section 10.3.3.5. Identified risks and mitigations' below). Subsequent identification of a capital funding source is essential to maintain service delivery. Continuing to use St Peter's Hospital to deliver ambulatory care services does mean that we are using available estate within our system and not investing in new alternative location/s which would require more significant capital investment in the short to medium term.

Table 2929: Ambulatory Care Services- Rationale for recommendation - Finance

The Community Capacity Programme Board discussed this proposal at great length. The Programme Board recognise the problems and challenges with continuing to deliver services from St Peter's Hospital. However, without a viable alternative location, and recognising that services do continue to be delivered on the site, albeit with a number of actions and mitigations that will need to be put in place, as well as the requirement for an element of capital investment on the site, it was felt at this time keeping ambulatory care services on the St Peter's Hospital site is the best option for residents, patients and staff. However, this will need to be regularly reviewed to ensure this is still the case. Whilst it is the best solution at this point in time, it is by no means felt to be an ideal solution given the challenges with the site. It is the best use of current

estate and public money whilst a long-term solution is found for a Maldon Health Hub/replacement for St Peter's Hospital.

10.3.3.2. Consultation and Community Consultation Working Group feedback

The independent analysis of the public consultation found that the majority of respondents thought the proposal to relocate ambulatory care services from St Peter's Hospital to an alternative location/s within the Maldon area was a bad or very bad idea, with 93% on the 4,196 respondents expressing that opinion. The Community Capacity Programme Board gave this feedback from the consultation conscientious consideration in their discussions.

The Community Consultation Working Group recommended that ambulatory care services should not be relocated to alternative sites. The working Group felt there should be no closure of the current building or moving of services from the St Peters estate until a long-term solution for the provision of services into a new Maldon Health Hub/replacement for St Peter's is in place. The Working Group stated that Mid and South Essex Foundation Trust must make provision to keep the current St Peters site open and fit for purpose.

Community Consultation Working Group – recommendation A4

"…It is recommended that there must be no closure of the current building or moving of services from the St Peters estate until the full funding stream and associated planning consents have been granted. The ICB must commit to the continuation of all outpatient services from St Peters while the new hub is built. MSEFT must make provision to keep the current St Peters site open and fit for purpose."

The Community Consultation Working Group also recommended that a new modern build to replace St Peter's Hospital must become a priority project for the ICB.

Community Consultation Working Group – recommendation A1

"The outpatient provision (all the current services from physiotherapy to blood work) at St Peters is vital for the people of Maldon and surrounding areas. Maldon already suffers from a lack of health infrastructure. It is recommended that a new modern build and protection of current services must become a priority project for the ICB. "

The Working Group did not support the idea that some services could move in the interim where it made clinical sense to do so as they felt this could lead to a gradual reduction in services being delivered from the site over time and being lost for the catchment area covered by St Peter's Hospital. Reviewing all the services delivered on the site will need to happen, but this will need to be done in collaboration with stakeholders and the public so any changes can be discussed and understood.

10.3.3.3. Integrated Impact Assessment

As there is no proposed change to service delivery there is no impact from an Integrated Impact Assessment (IIA) perspective.

However, the IIA does recognise that the continued use of St Peter's Hospital does mean relatively high carbon emissions which, whilst not a change to the current position, should be noted. The building was originally built in 1872 and, despite improvement works being carried out since, does not efficiently use energy due to its vast size and difficulty in isolating areas effectively, for example, when heating the building. More information can be found in the IIA in Appendix 11.

10.3.3.4. Implementation considerations

If the recommendation is supported by the MSEICB Board, ambulatory care services are already being delivered on the St Peter's Hospital site so there would be no mobilisation plan required as such, however, there are several considerations and actions that will need to happen to ensure services can continue to be delivered from the St Peter's Hospital site and to give assurance that the site is a safe as possible and services are able to deliver high quality care. These relate to the caveats outlined at the start of this section regarding the recommendation for ambulatory care services. Some of this work has already begun to take place as this DMBC has been developed and is outlined in section '10.3.3.5 Identified risks and mitigations' below.

- There must be a review of the areas on the ground floor of St Peters Hospital that are currently being used for the delivery of ambulatory care services and agreement across the Integrated Care System on essential work that needs to be carried out to improve the estate to allow services to continue to be delivered safely.
- This will require capital expenditure and a full report on the anticipated costs and plan for how capital will be found to support the work shared.
- Essential maintenance must be carried out routinely over the short to medium term proposed (0-5 years) to ensure services can continue to be delivered as safely as possible.
- There must be regular assessment of the estate over the short to medium term (0-5 years) to ensure it is safe and services can continue to operate safely from the environment they are being delivered from.
- A plan for a future Maldon health hub/replacement for St Peter's Hospital must be developed and delivered in the next five years.
- A review will take place of all ambulatory care services being delivered from the St Peter's Hospital site with clinical and operational leads. Any developments of any service in Maldon which require a change in estate provision should be reviewed collectively and in partnership with the communities of Maldon to ensure that these do not result in a gradual reduction of services on the St Peters site over time that make the site unviable, or services being lost from the Maldon district.
- Emergency Preparedness and Business Continuity Plans for services delivered from the St Peter's Hospital site must be regularly reviewed and kept up to date to ensure services could continue and patient care could be maintained should there be a significant deterioration in any part of the estate.

'Section 11: Implementation' sets out the governance arrangements for these areas of work. A letter from Mid and South Essex Foundation Trust's (MSEFT) Chief

Executive confirming MSEFTs continued commitment to the delivery of ambulatory care services in the Maldon district can be found in Appendix 17.

10.3.3.5. Identified risks and mitigations

The risks identified with the St Peter's Hospital site and further work that is needed to ensure the ongoing safety of the site, set out in section 10.3.3.4 'implementation considerations' above, have been reviewed and the table below sets out the work that has taken place and work that is due to take place to mitigate against these risks and further ensure the safety of the site and services that are delivered from it. Further work will need to happen as part of implementation, and this is set out in 'Section 11: Implementation'. A letter from Mid and South Essex Foundation Trust's (MSEFT) Chief Executive confirming MSEFTs continued committed to the delivery of ambulatory care services in the Maldon district can be found in Appendix 17.

Risk	Mitigation
The lift to the second floor, where community beds were situated, had for some time been an issue due to it frequently breaking down.	The recommendations made within this decision-making business case mean that community inpatient beds will be permanently removed from the St Peter's Hospital site, therefore mitigating the risk of people with limited mobility and babies being on the site in inpatient beds. Ambulatory care services have all been moved to the ground floor of the St Peter's Hospital site to reduce the risks identified with the lift and flooding. Ambulatory services by their nature mean patients attending are ambulant and therefore more mobile, meaning there is less risk to patients and staff in the case of an evacuation of the site being needed in an emergency. A review of Serious Incidents on the St Peter's Hospital site over the last 18 months was undertaken by the Community Capacity Programme Board. This has been used to inform the initial maintenance works needed on the site this year (2025/26). The areas identified as needing work are aligned with the plans Mid and South Essex NHS Foundation Trust (MSEFT) have started to develop- see below. MSEFT are embarking on a five-year resilience plan to ensure the St Peter's Hospital site is maintained in a safe condition, and de-risked for its future use. This broadly includes sufficient maintenance to keep the building watertight (roofs, rainwater goods, brickwork and
The frequently broken lift increased the risk that people with limited mobility could not easily be evacuated from the first or second floor of the main building if needed, causing a safety issue for both patients and staff.	
During heavy rain, the main building is prone to flooding with accompanying electrical and fire risks, creating an unsafe environment for both patients and staff.	

	windows) and secure and safe (including fire containment, detection and alarms). MSEFT have notionally allocated funding this year under their risk-based backlog programme to repair and make safe roofs, windows, the lift and fire doors. The notional allocated funding is £320k, but the funding needed is only estimated at this point in time and may evolve with the emerging reviews of the site and the ongoing short to medium term and long-term strategy for the site. MSEFT plan to bring the lift into use to support access to the first and second floor of the main St Peter's Hospital building for potential use for non-clinical/non patient facing services- see rows below for more information.
There had previously been issues with the floor loading and maximum weight it could take, but this had been repaired.	Previous issues that were identified with the load bearing ability of the floors have been repaired prior to the pre-consultation business case.
There must be a review of the areas on the ground floor of St Peters Hospital that are currently being used for the delivery of ambulatory care services and agreement across the Integrated Care System on essential work that needs to be carried out to improve the estate to allow services to continue to be delivered safely. The work outlined in the row above will require capital expenditure and a full report on the anticipated costs and plan for how capital will be found to support the work shared.	As per the information above, a review of Serious Incidents on the St Peter's Hospital site was undertaken by the Community capacity programme Board. This has been used by MSEFT to allocate funding this year to areas of the site that need to be updated/maintained immediately. Spend this year (2025/26) has notionally been allocated (£320k) to repair and make safe roofs, windows, the lift and fire doors (see rows above for more information). This work is ongoing and will be overseen by the governance structures and groups set out below under 'Section 11: implementation'.
Essential maintenance must be carried out routinely over the short to medium term proposed (0-5 years) to ensure services can continue to be delivered as safely as possible.	As set out in the rows above, MSEFT are embarking on a 5-year resilience plan to ensure the site is maintained in a safe condition, and de-risked for its future use. MSEFT are currently drafting a specification to seek a contractor to support them with maintenance requirements for the St Peter's

	Hospital site, including an ongoing brief to 'de risk' future options for the site. This includes: • Surveys of underground services- electrical, gas and drainage (mechanical, electrical and plumbing). • Surveys of above ground infrastructure – electrical, gas and oil- to identify redundant and obsolete installations and those with value/those that are operational (engines, boilers and tanks). • Audit of equipment, furniture and refuse in storage. This will allow for the potential removal of redundant infrastructure and dangerous structures (subject to reserved planning rights) and contamination (including asbestos) as these items add value to future use/development of the site by providing due diligence, or even removal to improve future planning.
There must be regular assessment of the estate over the short to medium term (0-5 years) to ensure it is safe and services can continue to operate safely from the environment they are being delivered from.	As set out in the rows above, this work has already started but will be ongoing and will be overseen by the governance structures and groups set out below under 'Section 11: implementation'.
A plan for a future Maldon health hub/replacement for St Peter's Hospital must be developed and delivered in the next five years.	Outside of the space occupied by clinical services, the site curtilage contains a mix of buildings in differing conditions, useability and value. Subject to funding, a number of outbuildings may be removed as they are beyond useable condition, are unsafe, contain asbestos and refuse. This will offer a tidy remediated site for future use. Typically, remediation costs are used to discount acquisition value and will add cost to any redevelopment of the site. Whilst scoping out the five-year de-risking strategy for the St Peter's hospital site, MSEFT have identified that whilst some buildings are inappropriate for clinical use they could offer

	some opportunity for limited occupation. Some of the first-floor space in the main St Peter's Hospital building has working heating, lighting and fire equipment and are spacious and light. Some of the floors have been re-enforced for bariatric patients so have good loading capacity. Considerations for short term use may include medical equipment management and storage, records storage, education centre, offices, meetings and light industry. It could be prepared for third party paid occupation for these uses and therefore generate income to support the 5 year 'de risking' workplan. MSEFT plan to bring the lift into use to support the five-year strategy by proving much better access throughout the building. The staircases are very narrow for moving equipment, materials or furniture. The top floor of the main St Peter's Hospital building does suffer from more water ingress and general disrepair that will benefit from the planned maintenance on windows and roofs. The works will involve significant investment in scaffolding, so any works to prepare for temporary occupancy as outlined above can make use of that period of better access for contractors. Work has started to look at possible long-term solutions for the site/a future site and this work will be ongoing and will be overseen by the governance structures and groups set out below under 'Section 11: Implementation'. It will involve the community, patients, public and staff.

Table 3030: Identified risks and mitigations of St Peter's estate

11. Implementation

11.1. Governance arrangements

11.1.1. Overview

Once decisions have been made on the proposals and subsequent recommendations outlined in this DMBC, the Mid and South Essex Integrated Care System (MSEISC) will need to ensure there is robust governance in place for the implementation of the agreed recommendations and then the ongoing oversight of monitoring and benefits realisation of the changes.

The key considerations to ensure successful implementation of the recommendations include:

- Addressing the recommendations agreed at decision making, putting everything in place for a safe and smooth transfer of services.
- Addressing the implementation considerations set out in 'Section10.3: Recommendations'.
- Reviewing and addressing the recommendations from the Integrated Impact Assessment and Sustainability Impact Assessment (see 'Section 8.5 Evidence Based Recommendations from the Integrated Impact Assessment and Sustainability Impact Assessment and Mitigations).
- Ongoing engagement with stakeholders, staff and the public in relation to plans for ambulatory care services.
- Development of a comprehensive workforce strategy to address gaps, and to ensure the availability of workforce to staff current and future services with appropriate skill mix, training and education as required.
- A focus on supporting staff, to ensure staff retention and help with staff recruitment to help ensure service sustainability.
- A focus on capital plans, for the short-medium term (0-5 years) to ensure the continued delivery of ambulatory care services from St Peter's Hospital, and long term to ensure there is a solution for a replacement for St Peter's Hospital.

11.1.2. Post decision governance arrangements

Robust governance arrangements will be key in the implementation of agreed proposals, enabling risks and dependencies across the system to be managed. The governance arrangements will build on the governance structures that were put in place for the development of the pre-consultation business case and the decision-making business case.

The Community Capacity Programme Board will continue to provide direction and oversight for the implementation of the agreed proposals, overseeing the delivery of recommendations, priorities, realisation of benefits, supporting collaboration between stakeholders and ensuring risks are managed and mitigated. It will be important that implementation is undertaken in a timely fashion, so the Community Capacity Programme Board will be responsible for ensuring this happens.

The Community Capacity Programme Board will continue to be supported by the Subgroups put in place during the pre-consultation and decision-making process.

For the time being the Community Capacity Programme Board will continue to oversee the immediate work programmes identified for implementation. However, once the implementation of the new configuration of community intermediate care and stroke rehabilitation beds and the freestanding midwife led birthing unit are complete, the Community Capacity Programme Board will stand down and there will need to be a new Programme Board established across the MSEICS to oversee the ongoing medium term workstreams and development on long term plans for St Peter's Hospital- see section '11.1.3 Post implementation/future governance arrangements' below.

For the ongoing work on the future of ambulatory care services at St Peter's Hospital, the oversight and responsibility will transition from the MSEICB to Mid and South Essex NHS Foundation Trust (MSEFT) as the owners of the St Peter's Hospital site.

The governance arrangements also include the implementation of a 'Community Committee', based on the recommendations of the Community Capacity Working Group. This will likely be set up in late summer 2025. The role of the group will be to scrutinise and advise on the implementation of the recommendations approved during this decision-making process in regard to ambulatory care services and the future of St Peter's Hospital. Membership will include community and public representation from the 'Save Maldon Medical Services' group, Maldon District Council, Essex County Council and MSICB, as well as MSEFT as the responsible lead organisation for the Committee. A Terms of Reference for the Committee will be developed once a decision has been made on the recommendations set out within this DMBC.

The proposed implementation governance is outlined in Figure 21.

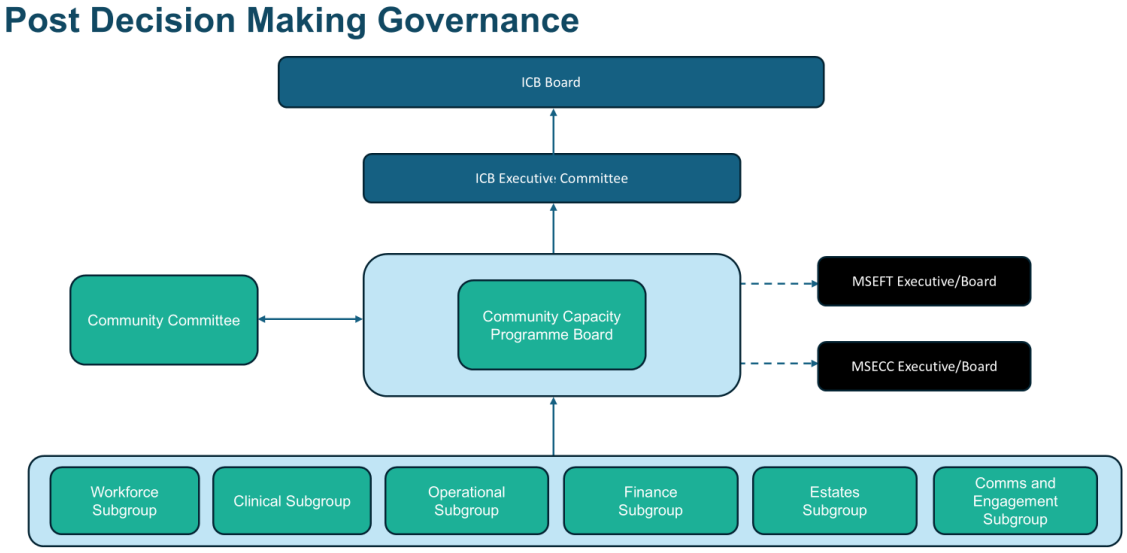

Figure 21: Post decision making governance structure diagram

The role of the Community Capacity Programme Board will be to:

- Oversee the implementation of the recommendations approved through this decision-making business case.
- Monitor service quality and delivery during the implementation phase.
- Ensure the programmes of work deliver within their agreed parameters (for example, within reasonable time periods and management of costs)
- Ensure any impact on other services are identified and mitigated against.
- Resolve any strategic issues that arise during implementation which need input and agreement of senior stakeholders
- Support the resolution of escalated risks and issues.

Membership of the group includes leads in the relevant areas linked to the proposals from MSEICB, MSEFT and Mid and South Essex Community Collaborative (MSECC).

The proposed focus and responsibilities for each of the Community Capacity Subgroups is listed below. This is indicative and will be developed further once decisions have been confirmed.

Subgroup	**Responsibilities**
Operational Subgroup	• Oversight of the operational elements of the transition of services. • Oversight of patient transition planning. • Monitor and review any operational risks and issues that arise during implementation and work with other Subgroups and the Programme Board to mitigate against these. • Work closely with the Workforce Subgroup on the transition planning for staff. • Work closely with the Estates subgroup to ensure the continued safe delivery of ambulatory care services, raising any operational issues arising from the estate and supporting in the mitigation of any risks and issues identified. • Explore the suggestion of a project to look at volunteer support to patients in community hospital inpatient beds for those that don't have visitors/support. • Oversee the development and delivery of relevant recommendations from the Integrated Impact Assessment. • Oversight of operational risks and benefits realisation. • Ensure Emergency Preparedness and Business Continuity Plans for services delivered from the St Peter's Hospital site are reviewed and kept up to date. • Oversee a review of the possibility of using stroke beds to support Level 3 neurorehabilitation care.

	• Oversee plans on how the two stroke units work together as much as possible to share staffing resource and build resilience (as per the recommendation from the East of England Clinical Senate).
Workforce Subgroup	• Continue to support and engage staff through the planning for implementation and implementation process. • Support and oversee engagement and consultation that each employing organisation will need to undertake with those staff affected by the decisions made. • Develop a comprehensive workforce plan and monitor delivery against. • Oversee the retention and recruitment of staff where required. • Oversee any training or upskilling of staff. • Oversight of operational risks and benefits realisation.
Finance Subgroup	• Assess the value of any implementation costs or stranded costs associated with the agreed changes. • Ensure the anticipated funding, costs and associated assumptions linked to them are realised. • Work closely with the estates subgroup in the development of plans for the capital costs associated with ambulatory care services, both in the short to medium term and the long term (recognising this will transition into a future governance structure- see 'Future governance' below). • Oversight of operational risks and benefits realisation. • Oversee the enactment of contract variations between the ICB and Providers for all associated changes in financial flows associated with decisions made.
Estates Subgroup	• Oversee the review of the estate at St Peter's Hospital currently being used to deliver ambulatory care services. • Develop a plan for essential work that needs to be carried out to improve the estate to allow services to continue to be delivered safely, work closely with the other Subgroups for their input.

	• Develop a plan to quantify the anticipated capital costs for any essential work and how capital will be found to enable this to happen. • Develop a plan to provide assurance around how essential maintenance must be carried out routinely over the short to medium term proposed (0-5 years) to ensure services can continue to be delivered as safely as possible. • Develop a plan to provide assurance around how regular assessment of the estate over the short to medium term (0-5 years) will take place to ensure it is safe and services can continue to operate safely from the environment they are being delivered from. • Continue to review potential options for raising capital funding for a future Maldon health hub/replacement for St Peter's Hospital to be developed and delivered in the next five years. • Monitor and review any risks and issues linked to estate and work with other Subgroups and the Programme Board to mitigate against these. • Oversight of operational risks and benefits realisation.
Communications Subgroup	• Develop strategic and operational communications and engagement activity to ensure staff, stakeholders and the public are kept fully informed of decisions and implementation progress. • Define key messages, selecting appropriate communications channels, to ensure staff, stakeholders and the public are clearly communicated with through the decision making and implementation process. • Ensure regular and effective updates on key milestones. • Oversight of operational risks and benefits realisation.
Clinical Subgroup	• Oversee the delivery of the agreed models of care for service areas set out in the proposals and recommendations during the implementation stage. • Monitor and review any clinical risks and issues that arise during implementation and work with other Subgroups and the Programme Board to mitigate against these. • Oversight of operational risks and benefits realisation.

Table 3131: Proposed focus and responsibilities for each of the Community Capacity Subgroups

The role of the 'Community Committee' will be to:

- Scrutinise and advise on the plans for the continued delivery of ambulatory care services at St Peter's Hospital.
- Co-design any changes or amendments to ambulatory care service delivery.
- Co-design and advise on plans for the long-term Maldon Health Hub/ replacement for St Peter's Hospital.
- Represent the community voice in the above work.

11.1.3. Post implementation/future governance arrangements

At a point in time, likely late autumn/early winter 2025, once implementation of changes to community inpatient beds and the freestanding midwife led birthing service is complete, and the initial review of improvements needed to St Peter's Hospital to continue to deliver ambulatory care services in the short to medium term has been agreed, the Community Capacity Programme Board will be responsible for making the decision to stand down the programme governance. At this point, ongoing monitoring of the changes implemented, the continued work needed for ambulatory care services at St Peter's Hospital and the ongoing work looking at the future solution for a new Maldon Health Hub/replacement for St Peter's Hospital will move to a new governance structure.

For community inpatient beds there are workstreams in place through the Medium-Term Plan (see section '2.2 Our vision for the future of Community Hospital services in mid and south Essex' for more information) for both intermediate care and stroke services. Therefore, the routine monitoring of metrics relating to the community beds and the role they play in the wider pathways of care for intermediate care and stroke services will be overseen through the existing 'Medium Term Plan' work programmes and associated governance routes. The proposed future governance structure for community beds is set out below in Figure 22. The governance structure is already in place as part if the MSEICS's Medium-Term Plan governance structure so the work programmes will slot into these existing governance structures.

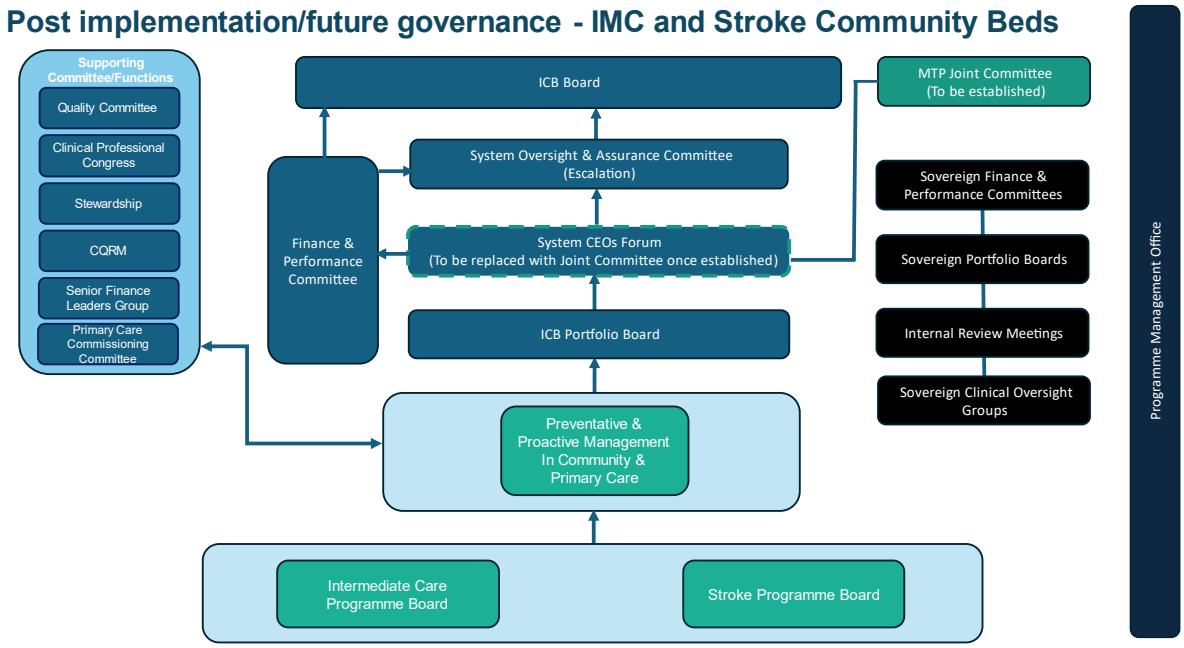

Figure 22: Post implementation/future governance making governance structure diagram- Community intermediate care and stroke rehabilitation inpatient beds

For the freestanding midwife led birthing unit there is already a governance structure in place for maternity services across the MSEICS so the routine monitoring of metrics and the role the unit plays in the wider pathways of care will be managed through the existing governance routes. The governance structure is set out below in Figure 23.

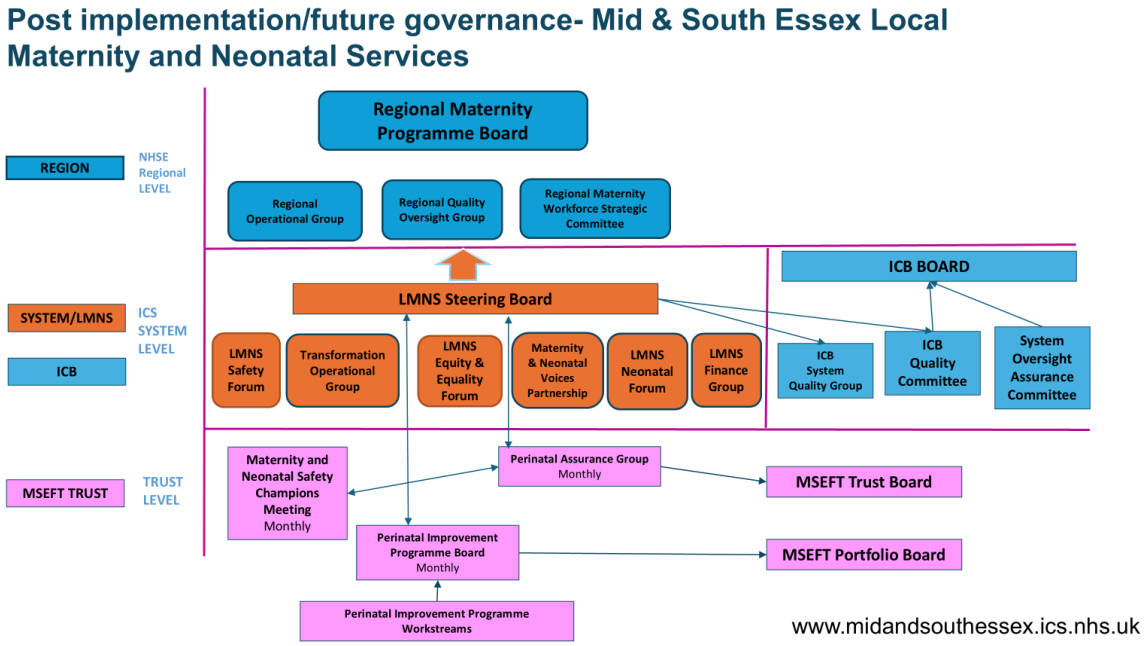

Figure 23: Post implementation/future governance making governance structure diagram - Maternity

For ambulatory care services and the future plans for a Maldon Health Hub/replacement for St Peter's Hospital there will be a new 'Maldon Health Hub' Programme Board set up, likely in late summer 2025. The Programme Board will be led by MSEFT, as the owner of the St Peter's Hospital site, with representation from MSEICB and MSECC, as well as other stakeholders. The 'Maldon health Hub' Programme Board will work with the 'Community Committee' to gain views and advise on plans as they develop. The new Programme Board will report into the governance of MSEFT but will also have a reporting line into MSEICB. The proposed future governance structure is set out below in Figure 24.

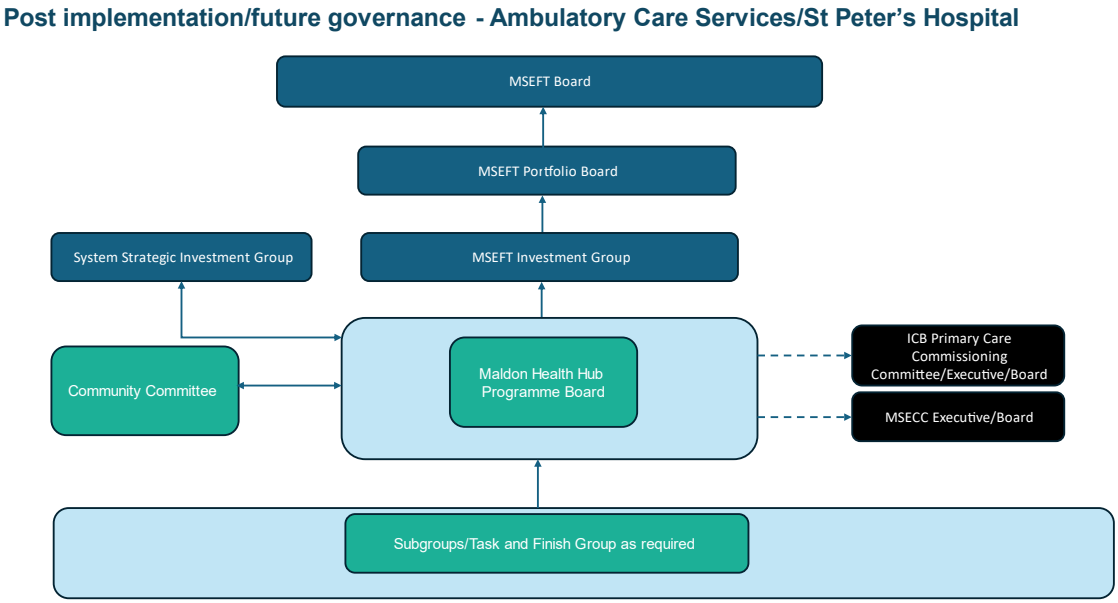

Figure 24: Post implementation/future governance making governance structure diagram- Ambulatory Care Services/future of St Peter's Hospital

These governance structures will be reviewed and refined during the implementation stage to ensure they are fit for purpose, and to develop the detail.

11.2. Monitoring and Management

11.2.1. Risk management

The reconfiguration of services can bring about risks which need to be carefully managed throughout implementation and beyond if necessary. Operational level risks will be identified, managed and mitigated against wherever possible by the relevant Subgroups and shared with the Community Capacity Programme Board. At any time, risks can be escalated from the Subgroups to the Programme Board. Any strategic risks will be identified, managed and mitigated wherever possible through the Community Capacity Programme Board. Risks are rated based on their probability and impact. These are combined into an overall risk rating.

Any risks outstanding post implementation or any risks identified during implementation that may impact the 'business as usual' running of services will be handed over to the new groups identified in the post implementation governance structure.

A full register of risks will be identified and managed through the governance arrangements following decision making.

Once the ongoing ambulatory care services/future of St Peter's Hospital work programme transitions to MSEFT to lead, it will be imperative that the MSEICB receives the necessary assurances it needs, in its commissioning role, that services are being delivered in a safe care environment and any risks are being managed and mitigated against wherever possible.

11.2.2. Benefits realisation and monitoring

Providers of care have overall accountability for the delivery of the benefits associated with service changes. The Community Capacity Programme Board, and then the future responsible Programme Boards/workstream groups (identified in the proposed future governance structures), will be responsible for monitoring of the benefits management process. This process will include the following key steps:

- Identification and agreement of all anticipated benefits, building on those identified in section '2.6. Benefits of the future models of care'.
- Development of agreed quantification measures.
- Management of benefits through implementation.
- Communication of benefits progress to programme leadership, during and post implementation.
- Post project evaluation and any lessons learnt activities.

We will also be asking the East of England Clinical Senate to review the outcomes of the service changes made in one year's time post decision making.

11.2.3. Recommendation monitoring

Recommendations agreed as part of decision-making will be managed and monitored through the Community Capacity Programme Board and progress reported to the MSEICB's Executive Committee with escalations to other MSEICB Board Committees and the MSEICB Board as required during implementation.

11.2.4. Capital Investment Planning for the future Maldon Health Hub/replacement for St Peter's Hospital

Ensuring there is sufficient capital funding available to develop a Maldon Health Hub/replacement for St Peter's Hospital in the future is vital in the delivery of the long-term plans for health services in Maldon. There were several public suggestions for raising the required capital investment needed in the consultation feedback and these have all been noted.

It is imperative that the Integrated Care System work together to develop a capital investment plan for the future provision of a Maldon Health Hub/replacement for St Peter's.

There are a number for potential funding sources that will need to be explored, and some initial discussions have already begun. These are, but are not limited to:

- The sale of the St Peter's Hospital site or part sale of the site

- NHS capital allocations, through ICB or national programmes like the Health Innovation Programme and Community Diagnostics Centres.
- Local authority contributions from available Section 106 funding.
- Third-party development, for example Community Health Partnerships, NHS Property Services, or the private sector.
- Charitable or philanthropic funding.
- Blended finance models/joint ventures.

This work will be led by the 'Maldon Health Hub' Programme Board proposed in the section above '11.1.3 Post implementation/future governance arrangements' but will also need to be supported by the System Strategic Investment Group. The role of this group is to provide oversight, direction, support, advice and guidance for the MSEICS's programme of Strategic Investments, working collaboratively across partner organisations within the MSEICS. The group is included in the proposed future governance structure above (section 11.1.3).

11.2.5. Indicative Implementation timetable

The anticipated implementation timetable for the recommendations set out in this decision-making business case are set out in the table below:

Recommendation	Commencement of implementation	Completion of implementation
Community Inpatient Beds		
Changes to the location and configuration of community inpatient intermediate care and stroke rehabilitation beds	August 2025	Start of December 2025
Freestanding Midwife Led Birthing Unit		
Permanent change to the location of the freestanding midwife led birthing unit	July 2025	August 2025
Ambulatory Care Services		
Continuation of the delivery of ambulatory care services from St Peter's Hospital	July 2025	July 2025
Review of the areas of St Peters currently being used to deliver services from an agreement across the Integrated Care System on essential work that needs to be carried out to improve the estate to	In progress	September 2025 (25/26). Rolling review for future years.

allow services to continue to be delivered safely.		
Development of a capital expenditure plan linked to the above review.	July 2025 Backlog maintenance funding agreed for 25/26	September 2025 Rolling review for future years.
Plan for essential maintenance work that will be carried out routinely over the next 0-5 years to ensure services can continue to be delivered as safely as possible.	In progress for 25/26.	September 2025. Rolling review for future years.
Plan for regular assessment of the estate over the 0-5 years to ensure it is safe and services can continue to operate safely from the environment they are being delivered from.	In progress for 25/26.	September 2025. Rolling review for future years.
A plan for a future Maldon health hub/replacement for St Peter's Hospital must be developed and delivered in the next 0-5 years.	July 2025 (work already underway)	April 2027

Table 3232: Indicative implementation timetable

12. Conclusion and next steps

For several years there has been a recognised need to address capacity challenges within intermediate care and stroke rehabilitation community hospital inpatient beds across mid and south Essex. Proposed changes to community inpatient beds at St Peter's Hospital, combined with ongoing estate issues at the site, prompted the development of a proposal to relocate the freestanding midwife led birthing unit from the site to William Julien Courtauld unit in Braintree. The impact of the proposed removal of all inpatient services from St Peter's Hospital site and continued concerns with the estate led to the proposal to consider relocating all remaining ambulatory care services from St Peter's Hospital to alternative sites within Maldon.

As commissioners, we have run a robust process, including public consultation and further engagement through the Community Capacity Working Group, to evaluate the proposals and options with the aim of making a decision that improves services for our residents.

The Integrated Care Board will continue to have a role in overseeing the implementation of decisions. Programme governance will provide a mechanism to oversee this, which will also be underpinned by collaborative working between all stakeholders involved.

In making a decision on the proposals and options set out within this decision-making business case, our ambition is to make the best decisions that give us the greatest confidence that we can deliver the best quality of care for our residents, within the parameters and challenges that have been identified throughout the decision-making business case.

Appendices List

No.	Title
1.	Consultation Feedback Report
2.	Report from the Commission into St Peter's Hospital and associated options with care beds and birthing unit pathways across mid and south Essex
3.	Pre-consultation engagement report
4.	Community Consultation Working Group Terms of Reference
5.	Audit of stroke rehabilitation patients in MSE (undertaken in September of 2023)
6.	Intermediate Care and Stroke Rehabilitation community inpatient bed modelling (undertaken by the CCTF)
7.	Refreshed Intermediate Care community inpatient bed modelling (presented to the Community Consultation Working Group)
8.	East of England Clinical Senate Report 2022
9.	East of England Clinical Senate Report December 2023
10.	Review of proposed plans to relocate the midwife led birthing unit and the proposed impact of relocating ambulatory services from St Peter's Hospital (which include maternity outpatients) from the Regional Chief Midwife
11.	Integrated Impact assessment
12.	Six Facet Survey summary- St Peter's Hospital
13.	Travel Analysis
14.	Sustainability Impact Assessment
15.	Health Overview and Scrutiny Committee's consultation feedback responses
16.	Letter from NHS England Regional Director confirming the formal assurance of the Pre-Consultation Business Case and associated documents
17.	Letter from MSEFT Chief Executive confirming MSEFT's commitment to continued work on the future of ambulatory care services within the Maldon district