Questions from Southend Public Discussion Event
Cliffs Pavilion
7th March 2018

These questions have been transcribed from the original questions submitted from the event on 7th March. All personal information has been removed from this document however, where individuals provided a contact email address, we will email a personal response.

1. What is to be done to "beef up" patient transport; to make it accessible; reliable and suitable for people with various disabilities	The changes to some hospital services that are being proposed would ensure that the vast majority of care continued to be available at all three hospital sites. This includes the A&E department, all outpatient appointments, tests, scans and day case surgery. As a result of the proposed changes to some specialist inpatient care, we expect that an average of 14 patients per day would receive elective care at a different site to their local hospital. We also estimate that further 15 patients per day (on average) would be transferred to receive care from a specialist team at a different hospital. We recognise the impact that such changes may have on patients and their family and have therefore proposed a free transport service for those patients, family and friends who may need to travel slightly further to receive specialist care. During the course of the consultation, we have heard lots of views from patients and the public about what they think would be the key elements of a family transport service; we will also be holding a number of focus group sessions with patients and carers to obtain their views, as well as liaising closely with local authority colleagues so that we can build a service that meets needs. We would look to make all reasonable adjustments so that future transport provision is accessible to people living with a disability and are be planning for this.

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2. The responses to the numerous questions asked at the last discussion event say that you can't accurately specify patient transfer arrangements until the CCG deliver the final commissioning decisions on the reconfiguration of hospital services. • So how as we, the public, meant to give a response to the public consultation in order for the CCG to take into account our views if we STILL have no idea about how you will provide, staff, operate the internal transfer system and HOW will the CCG make a safe and effective decision when the transport plans are central to the service relocations? It really is a clear and appalling 'chicken and egg' scenario • Furthermore the EEAS Chief Exec has stated in letter dated 14.02.18 to MP Rebecca Harris that – and I quote the response **EEAST has maintained a position in recent years that we are not funded to deliver the level of service expected.** • From this it is extremely clear that East of England will NOT be in a position to conduct the increased figure you have given of a further 15 patients per day between hospitals. You have also stated in your responses that 'transfer time between hospitals is less critical than the time to initial treatment and stabilisation at the nearest A&E". Do you stand by that statement?? If this is the case, then why in 2017 did you plans include the blanket re-direction of 999 ambulances	We already transfer patients across the county for urgent treatment (e.g. patients suffering a heart attacks are already transferred to the Essex Cardiothoracic Centre at Basildon Hospital, patients with severe burns are already transferred to Broomfield hospital, patients with complex trauma injuries are transferred into London for treatment). There are clear standards in place for such transfers and we would expect the clinical transfer service to mirror these. We have published a discussion paper (see our website at Patient Transport Process Green Paper) on our clinical transfer model to provide information on the type of issues we are exploring as we develop this transport plan. The CCG Joint Committee will consider, as part of its decision making process, a detailed transport plan with costings and staff models. The final specification will, of course, be subject to their decision-making process. Please be assured, if we do not have a clear and safe clinical transfer model, we will not proceed with the transfer of patients as described in the consultation. EEAST are one potential provider of the service, there are others, and the hospitals could decide to provide the service themselves. We have built in additional revenue funding for transport services as part of the finances supporting the public consultation. We stand by the statement that the time to initial treatment is a critical

from Southend to Basildon Hospital which would have increased the risk to life for many local residents. How can the public ever trust you following this?	factor in many conditions, and this is the model that we are pursuing – we will maintain three fully functioning A&E departments that will continue to receive walk-in and ambulance attendances 24/7. Patients will be assessed, treated and stabilised and only then will a decision be made, from a clinical discussion with the patient/carers, as to whether the patient would benefit from specialist care at a different location. The exception to this is, as described above, patients experiencing a heart attack, those with severe burns and major injuries, where ambulances already bypass the nearest hospital in favour of taking the patient to a specialist centre where evidence shows outcomes are more favourable. As you will be aware, the original proposals to redirect some ambulances from Southend were changed after discussion with clinicians and the public. This is not the model we are consulting upon.
3. How can you say it takes 13 minutes (google maps according to your document) to get from Southend to Basildon. It "assumes" that you can travel on the A13 at a constant 70mpt in an ambulance. Assume = An Ass of U and Me! Given only today (7/03/18) the A13 was closed due to an accident – how is this the best for the patient?	The travel times described in the PCBC were an average, using Google Maps API using four different travel times (08.30, 13.00, 17.00, 21.00). Any road can be subject to closure and disruption and we recognise how difficult this can be for ambulances already travelling on our roads. The proposed clinical transport model would enable travel by "blue light" if required and, of course, patients will be accompanied by appropriately trained clinicians on the journey to ensure their safety. As described above, we already move patients to the Essex Cardiothoracic Centre, burns unit and major trauma centres using road-based transport.

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4. The responses to the numerous questions asked at the last event say that you can't accurately specify patient transfer arrangements until the CCG deliver the final commissioning decisions on the reconfiguration of hospital services. So how are we the public, meant to give a response to the public consultation in order for the CCG to take into account our views if we STILL have no idea how you will provide, staff, operate the internal transfer system and how will the CCG make a safe and effective decision when the TRANSPORT PLANS are CENTRAL to the service relocations?	Please see response to question 2, above.
5. Why is it proposed that emergency surgery will no longer be available at Southend Hospital. For patients having to travel long distances to have their operation at another hospital creates greater stress for them and separates them from their family and friends, who will be forced with having to make long journeys to visit them.	Separating planned from emergency care, particularly in specialties where lots of treatments occur, can help in reducing the number of operations that are cancelled due to emergency pressures. Having a dedicated team, theatres and resources for planned care should help to improve our waiting times for elective treatment and enable patients to receive faster care. We recognise that there may be impact upon family members and carers if patients need to spend time in a more distant hospital. This is why we are proposing a free family transport service. We will develop the service with input from patients and carers so that we can take full account of their concerns and design a service that meets their needs as far as possible.

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6. I believe this consultation was fully booked – how many booked people turned up? How many unbooked people were allowed in? Were any turned away?	For this public event, 126 tickets were booked, our estimate of attendees on the evening were approximately 90. No person was turned away.
7. After last months consultation question and your answers re: Q6 Your answer: you state that the traffic data is available in your clinical evidence. I cannot see any traffic data.	The transport modelling done during the development of proposals forms part of the pre-consultation business case for these changes and can be found here: http://www.nhsmidandsouthessex.co.uk/background/further-information/
8. Q73. Your answer to patients friends and family transport to Broomfield or Basildon free. You say a detailed plan will be presented. When? Have you added to your cash?	During the consultation we have engaged with the public to seek their views on how a transport plan could support them if these proposals were to be implemented. Using this insight to support a detailed transport plan is being developed and will be considered by the CCG Joint Committee when it takes decisions on service change. Within the planning for the pre-consultation business case, funding for the service was factored in.
9. Your Appendix 8 – Overview. You state within 30 mins for emergency patients transferred across sites – proof and evidence please. You also state these journeys of 45 minutes by car. Where did you get this data? At what time of day or year – I see on p6 you use google maps. Is that your traffic data?	The travel times described in the pre-consultation business case were an average, using Google Maps API using four different travel times (08.30, 13.00, 17.00, 21.00).
10. P11 Appendix 8. You state locations finalised after consultations	This is correct, we cannot finalise the exact locations and service changes until after the consultation. The CCG Joint Committee will ultimately make decisions on this based on a range of evidence, including feedback from the public consultation.

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11. Of the patients that are transferred to Basildon (?14) how many do you predict will need to be transferred again back to their original hospital i.e. back to Southend?	It is important to note that not all patients would transfer to Basildon, they may transfer to Broomfield or Southend depending on the care they require. The need for patients to transfer back to their nearest hospital would depend on the patient's condition, some may go home or to a community facility straight from the specialist centre whereas some may require on-going care at their local hospital based on their clinical need.
12. Times for people without access to cars (see attached google sheets:) Thursday 9.00am morning Thundersley to (one way) • Southend Hospital – 34 minutes to 57 minutes • Basildon Hospital – 49 minutes to 1 hour 03 minutes • Broomfield Hospital – 1 hour 11 minutes to 1 hour 33 minutes i.e. 3 hours plus round trip Rayleigh station has a footbridge between platforms need to use bus.	We recognise that travel times will vary throughout the day. The travel analysis that was completed looked at four different departure, using Google Maps API using four different travel times (08.30, 13.00, 17.00, 21.00).
13. We have been promised a transport service for family members. For how long will the NHS be able to afford to move relatives? (e.g. an elderly spouse from Shoeburyness to Broomfield). Will it only be a matter of time before we are told that the service is too expensive. Is this what you mean by "review and adapt"	During the consultation we have engaged with the public to seek their views on how a transport plan could support them if these proposals were to be implemented By "review and adapt" we mean that we would, as with any other service, review its use over time and adapt to the needs of the population. We are not proposing to run the service only for a specific period of time, we will run the service to support patients and family members as required.
14. You gave the example of the benefits of short hospital stays. I had keyhole Gall Bladder removed. My discharge was in less than 12 hours. I was sent home in a great deal of pain.	Firstly, we are sorry to hear of your poor experience. Over recent years, the NHS has, through use of new technologies and different care models, managed to decrease the length of time patients need to stay

There was no follow up or pain relief offered. I would rather have been cared for in hospital until my pain was under control. How would my care change if these changes go ahead where speedy discharge is favoured?	in hospital after procedures or operations. Patients often fare best in their own environment, but clearly the right support is required to ensure this. Discharge planning starts as soon as a patient is admitted, and we look to identify a patient's needs on discharge so that we can have the right support in place. Over time, we are seeking to join up care between the hospital, community, mental health, social care and primary care services. This will help ensure patient needs are met in a more coordinated way. Access to urgent care, in your example, perhaps for assessment and stronger pain relief, will be accessed via NHS 111, where a clinician will be able to speak to you over the phone and assess your needs.
15. Since I became aware of the proposed changes I have made it my mission to ask every NHS professional I have encountered and tell every friend, relative and acquaintance. • Most have not heard anything about it. • I spent a morning in Hockley handing out "Save Southend NHS" campaign leaflets (inc Pharmacies, community halls, cafes, shops). Not a single person that I told knew anything about it. Can you honestly say that the consultation has been wide enough or reached the wider public	Throughout the consultation we have distributed thousands of consultation documents, summary documents and leaflets - materials have been available from GP surgeries, pharmacies, council buildings, libraries and all health facilities. Where we have been alerted that materials have run out, we have replenished stock. At the same time, we have had significant media coverage of the consultation and have also paid for advertising in local newspapers with a readership of over 300,000 across the STP. Our social media reach has been significant with over 200,000 people reached via Facebook alone; this includes sponsored advertising on timelines as well as "organic" reach, where our content has been shared or commented upon. We've also had an active Twitter feed.

	To date almost 700 people have attended public events and we have held more than 20 smaller focus groups .We have received over 800 responses to the on-line survey. We also commissioned a telephone survey of a further 750 people. All of our consultation activities, and the feedback received will be independently analysed and the analysis report will form an important part of the information for the CCG Joint Committee as it takes decisions on the proposed service changes.
16. The "service design" phase on your slide has not been completed if you still don't have a proper, funded transport plan. Has it?	During the consultation we have engaged with the public to seek their views on how a transport plan could support them if these proposals were to be implemented We have published a discussion paper (see our website at Patient Transport Process Green Paper) on our clinical transfer model to provide information on the type of issues we are exploring as we develop this transport plan. The CCG Joint Committee will consider, as part of its decision making process, a detailed transport plan with costings and staff models. The final specification will, of course, be subject to their decision-making process. Please be assured, if we do not have a clear and safe clinical transfer model, we will not proceed with the movement of patients as described in the consultation.

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17. We understood the merger of Southend/Basildon/Broomfield had already happened	No, this is not the case. The three hospitals have been working closely together for over 18 months. The three Trusts boards have agreed to progress with a formal merger plan. This plan will need the approval of our regulators and the Competition and Markets Authority and this process is likely to take at least 12 months to complete. To note, the merger plan is entirely separate to the public consultation process.
18. Benefit – those on benefits should get fares back if they have relevant documentation. Has this been factored in where cost?	During the consultation we have engaged with the public to seek their views on how a transport plan could support them if these proposals were to be implemented. There are already processes in place to support those on low incomes and receiving benefits to be reimbursed for reasonable travel costs. This process will not change as a result of the proposals.
19. I have a 'written reply' to a previous question about access to public transport increases to support patients families to get to alternative hospitals. It stated there is an 'assumption' that the local authority will be subsidising the service: • What level of funding has been identified that will be necessary? • What discussions have there been with our elected officials regards this matter? • What commitment has been given? • Why was this cost not included in the recent SBS budget?	We will be working with patients, carers, local authority colleagues and others to develop plans for the proposed family transport service. Funding has been identified in the financial plans for a transport service.

20. Logistics are unrealistic when can a more sensible assessment be presented. Most in this room are too old for fairy tales	We recognise that there is frustration regarding the detailed plans for transport. However, we cannot finalise these until the CCG Joint Committee has made decisions about service change. We are, however, working up plans and have published a discussion paper (see our website at Patient Transport Process Green Paper) on our clinical transfer model to provide information on the type of issues we are exploring as we develop this transport plan. The CCG Joint Committee will consider, as part of its decision making process, a detailed transport plan with costings and staff models. The final specification will, of course, be subject to their decision-making process. During the consultation we have engaged with the public to seek their views on how a transport plan could support them if these proposals were to be implemented and this insight will help to form the more detailed plans. Please be assured, if we do not have a clear and safe clinical transfer model, we will not proceed with the movement of patients as described in the consultation. It is important to note that transferring patients between hospitals is not new - we already have significant experience of doing this (e.g. patients suffering a heart attacks are already transferred to the Essex Cardiothoracic Centre at Basildon Hospital, patients with severe burns are already transferred to Broomfield hospital, patients with complex

	trauma injuries are transferred into London for treatment). There are clear standards in place for such transfers and we would expect the clinical transfer service to mirror these.
21. Travel between – look at the National Royal Orthopaedic Hospital, Stanmore, London with the hopper bus between the different sites	Thank you for this suggestion. During the course of the consultation, we have heard lots of views from patients and the public about what they think would be the key elements of a family transport service; we will also be holding a number of focus group sessions with patients and carers to obtain their views, as well as liaising closely with local authority colleagues so that we can build a service that meets needs. We will ensure this suggestion is fed in to those discussions.
22. Free transport for patients has been proposed. How can you guarantee that this will take place and that the patients will be accompanied by correctly or well trained staff?	During the consultation we have engaged with the public to seek their views on how a transport plan could support them if these proposals were to be implemented. We are working on detailed plans for family transport and we are committed to ensuring this service is in place and that the model is staffed by appropriately trained staff.
23. Can the CCG guarantee that sufficient staff will be put in place in centres of excellence so that medical staff are not dealing with excessively larger number of cases, and having to work longer hours?	The main objective of the proposed changes is to improve specialist care and patient outcomes as a result of our teams working together across the three hospitals. Working in a larger team improves experience and skill in some specialist services and has the potential to offer a greater work/life balance for our staff by reducing the need for them to be on-call as frequently, as is happening now in a number of specialities. This might include flexible working options, but also sub-specialisation, training,

	education and career development opportunities.
24. Not enough detail has been provided on the transport model. What work/scoping has been done around this as part of the development of the business plan to consider its feasibility? You have said this will be looked at when the consultation is completed – while I recognise you will not have all of the information at this stage – the public cannot be expected to respond to the consultation without some sense of what this looks like and consideration of safety, cost, staffing etc. Has there been any engagement/discussion with partners around the transport proposal – public or private? What would this 'new' service look like?	We are working on our plans for transport and have published a discussion paper to provide further detail (please see our website Patient Transport Process Green Paper). During the consultation we have engaged with the public to seek their views on how a transport plan could support them if these proposals were to be implemented and this insight will help to form more detailed plans. We are also planning focus group sessions with patients and carers to help us shape the proposals further. The CCG Joint Committee will consider a detailed transport plan should they make a decision on service change.
25. Question 7 page 6 – of responses. Your response is staff get local T&Cs. They do not get London fringe pay (only Basildon) so:- • How can a nurse live on the pay given Southend prices are now reflecting Basildon London prices. Its not the same as across the country. A nurse in Norwich will get same pay as Southend. But Southend won't get the fringe pay – a portion of fish and chips in Norwich is £5 yet it's £6.50 in Southend. Southend's cost of living is high. • How will Southend retain staff? Why won't they go to Basildon for more pay or move away to a cheaper area? How does this improve services in Southend?	As stated in our earlier responses, Agenda for Change terms and conditions are set nationally and those in Southend mirror this. You may be interested in reading our green paper on the acute workforce to get more information about how service proposals may impact on our workforce (Acute Workforce Green Paper)

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26. Why have you lost 4 consultants? • Do Southend not pay enough? • Are specialists not trained? • Why won't they come to Southend?	Trusts in Essex can struggle to attract senior medical staff for a number of reasons, including the intensity of workload in maintaining smaller rotas, the inability to specialise, and the competing opportunities presented by other larger centres. We aim to address these challenges through these proposals. You may be interested in reading our green paper on the acute workforce to get more information about how service proposals may impact on our workforce (Acute Workforce Green Paper)
27. If you need renal care – you want people to travel distance for treatment?	Please be assured that all outpatient appointments, tests, scans and day case treatments such as kidney dialysis will remain at each local hospital. For patients with complex renal problems, who require an inpatient stay, we believe that concentrating their care on one site will lead to better outcomes.
28. Training – where is here? Where will training happen? Southend or Basildon? What incentives to get people here?	Training for clinical staff happens on all sites, and will continue to do so. Working in larger teams across our hospital sites creates greater opportunities for rotational training programmes and career development. In terms of medical training, Anglia Ruskin University is planning to open a School of Medicine in 2018 at its Chelmsford Campus. Having such a facility locally will assist with our workforce challenges over coming years as many students who study at the school will take up local placements and, once qualified, many may wish to stay in the

	area.
29. Trauma – if you break something will now go to Basildon. How does that help e.g. mum – how will her family visit? Or an elderly person? I spent time in hospital with a broken ankle. I had to get childcare plus toiletries etc – no good if people can't get to me. Leads on to how will travel for families work? Bus – free? How much will that cost NHS?	Please be assured that most fractures will continue to be treated at the local hospital. For complex trauma injuries requiring an overnight stay, patients in our proposals could be treated at Basildon hospital, and for very serious trauma, patients will continue to be transferred directly to a major trauma centre, either in London or Addenbrooke's, as happens now. During the consultation we have engaged with the public to seek their views on how a transport plan could support them if these proposals were to be implemented and this insight will help to form more detailed plans We are proposing a free transport service for families and carers and we are working on plans to develop this.
30. The importance of IT, including systems which allow pt sharing information is paramount. Has monies been identified to focus on this early on and through the transformation process.	We completely agree. Significant funding has been identified within the bid for capital funding to help us to upgrade our technology systems. We can only access these funds should a decision be made regarding service change following this consultation.
31. Southend provides NIV services. Patients will end up treated with acute NIV at SOS then go to Basildon for further NIV then most of these patients are likely to need a long period of rehab – where will this happen? Back at Southend for prolonged rehab – 3 different hospitals for 1 admission	We are proposing that patients with complex respiratory problems who need a period of inpatient care could be treated in a specialist centre at Basildon Hospital. Patients will only be transferred if they are stable, and will be transported via our proposed clinical transport service and with appropriately trained personnel to ensure their safety on the journey.

	The transfer of patients with non-invasive ventilation is under discussion by clinicians and no decision has yet been reached.
32. In response to questions raised by Rebecca Harris MP, CP Robert Morton Chief Exec EEAST stated 'funding for ambulance services come from CCG. EEAST has maintained a position in recent years we are not funded to deliver the level of service expected'. • How many ambulances and fully trained staff are required by the proposed changes and patient transfers? • How much will this cost? • Is the CCG prepared to finance this resource and for how long?	The EEAST service is commissioned by the CCGs. We all recognise the pressures that the ambulance service experience. EEAST are one potential provider of the clinical transport service we are proposing; there are others, and the hospitals could decide to provide the service themselves. Detailed plans on the clinical transport service are being drawn up and will be considered by the CCG Joint Committee. We have published a discussion paper on clinical transport, which can be found at Patient Transport Process Green Paper
33. What percentage of public interaction does the CCG consider is adequate to meet the consultation guidelines? • Why even now that it has been highlighted there is a lack of publicly available information in GP surgeries? Has there been no additional information sent out? • The Hollies Hadleigh, Queensway (1 x black and white photocopy). No staff awareness in GP surgeries	Throughout the consultation we have distributed thousands of consultation documents, summary documents and leaflets - materials have been available from GP surgeries, pharmacies, council buildings, libraries and all health facilities. Where we have been alerted that materials have run out, we have replenished stock. At the same time, we have had significant media coverage of the consultation and have also paid for advertising in local newspapers with a readership of over 300,000 across the STP. Our social media reach has been significant with over 200,000 people reached via Facebook alone (this includes sponsored advertising on

	timelines as well as "organic" reach, where our content has been shared or commented upon. We've also had an active Twitter feed. To date almost 700 people have attended public events and focus groups and we have received over 800 responses to the on-line survey. We also commissioned a telephone survey for 750 people. All of our consultation activities, and the feedback received will be independently analysed and the analysis report will form an important part of the information for the CCG Joint Committee as it takes decisions on the proposed service changes.
34. Dr Gowrie stated the hospital can no longer provide the level of support it wants to. Surely this is due to lack of funding and improving the infrastructure locally not be relocating services away from Southend. Why is there a difference of opinion between senior clinicians? I am not convinced there is total agreement as stated by Celia Skinner	Dr Balasubramaniam mentioned that renal services had struggled to attract and retain senior medical staff which had impacted on the level of service. We have challenges including the intensity of workload in maintaining smaller rotas, the inability to specialise and the competing opportunities presented by other larger centres. We aim to address these challenges through these proposals. You may be interested in reading our green paper on the acute workforce to get more information about how service proposals may impact on our workforce (Acute Workforce Green Paper) Dr. Skinner mentioned that current proposals had been developed by local terms of clinicians. She and Dr. Fenton stated that although medical staff may sometimes have differing opinions, the view was that these proposals were the best option for local services at this time.

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35. There has been opportunities for the public to ask questions of the STP but in the spirit of consultation it should be about the STP asking questions of the public and service users. How will the STP gather feedback on proposals rather than just answering questions about them?	Throughout the consultation process, we have listened to the views of our patients and the public. At all of our public events, we have gained valuable feedback, heard questions and concerns. We have also held more than 20 smaller focus groups to gain insight into how these proposals may impact particular patient groups including the nine identified protected characteristics as set out in the Equalities Act. We have also received feedback in the form of the on-line survey, telephone survey and the many letters, emails and social media comments. All of this feedback will be independently analysed and be considered by the CCG Joint Committee, alongside other evidence, when it makes decisions about service change.
36. With the government plan to a while ago to cut pharmacies. The public are asked to go down this route with your views. Only are the NHS dragging their feet on walk in centres where this is important. Only today at Civic Centre moves afoot to carry out road works. Where is the tie up?	The whole health and care system in mid and south Essex is working to one plan to improve the health and care services across the STP footprint. All health and care leaders come together in the STP Board to ensure delivery of this plan.
37. Stroke units – but are they local? • 50 beds really not? As thinks will be shifted/cut • Reasons for problems i.e. staff retention • How long will the transport be funded for – will this be cut?	All three hospitals will be able to diagnose and start initial treatment for a stroke. Under the proposals stroke patients may, once stable, be transferred to Basildon Hospital for up to 72 hours of intensive treatment and care. After this period, if their condition has improved the patient may be able to go home. Otherwise they will be transferred back to their local hospital for on-going care. In relation to bed expansion, we are proposing that part of the capital

	funding is used to increase the number of beds by 50. We recognise that workforce is our biggest challenge and that successful recruitment and, importantly retention of dedicated and skilled staff is paramount. We have published a discussion paper on workforce which can be found at Acute Workforce Green Paper In relation to transport, we committed to funding the family transport on an on-going basis. During the consultation we have engaged with the public to seek their views on how a transport plan could support them if these proposals were to be implemented and this insight will help to form more detailed plans
38. Broomfield Hospital is quite a distance from Basildon and, especially Southend Hospitals made worse by extremely busy roads and the location of Broomfield at the other side of the very busy City of Chelmsford. Has any thought been given to simply linking Basildon and Southend Hospitals as these are, geographically a 'natural fit'. Broomfield is not. Should Broomfield be better linked with Colchester and Ipswich Hospitals – a far better link via the A12?	The three hospitals (Basildon, Southend and Broomfield) are part of the sustainability and transformation partnership footprint and have been working closely together for the past 18 months. The hospitals already share services and teams and are looking to increase their collaboration through a formal merger process (separate to the consultation and subject to approvals from regulators). For some patients in north Chelmsford it may be that hospitals in Colchester and Ipswich are easier for access. If patients are referred for planned treatment, they can choose which hospital they wish to attend. This can be discussed with the GP at the point of referral.
39. How much will it cost to transfer patients between hospitals? Will the transfers be done by a private company?	During the consultation we have engaged with the public to seek their views on how a transport plan could support them if these proposals were to be implemented and this insight will help to form more detailed

	plans, including costings, for both the clinical and family transport services. This detailed plan will be considered by the CCG Joint Committee should it make a decision on service change. Until we have specified the services required, we cannot identify who might provide the service – the NHS is bound by procurement rules and will abide by these in any procurement process.
40. I had BIPAP (NIV) in 2016. I went to Southend A&E really ill. I was admitted to respiratory ward for BIPAP. I went home from Southend with a BIPAP machine. In future are you saying I would have to go to Southend then Basildon next time if I go to A&E with my complex breathing problem?	Firstly, we are sorry that you were unwell and hope that you received good treatment at Southend. We are proposing that patients with complex respiratory problems who need a period of inpatient care could be treated at a specialist centre at Basildon Hospital. Patients will only be transferred if they are stable, and will be transported via our proposed clinical transport service and with appropriately trained personnel to ensure their safety on the journey. The transfer of patients with non-invasive ventilation is under discussion by clinicians and no decision has yet been reached.
41. It was mentioned that there is evidence for the benefit of stroke units – were the units involved in the studies local stroke units? In which case I doubt this can be transferable to the proposed changes.	The data to support the proposed model for stroke care is included in a summary of the clinical evidence we have reviewed in developing proposals for hospital services. This document is downloadable from http://www.nhsmidandsouthessex.co.uk/background/clinical-evidence/ You may also find it helpful to read the policies supported by The Stroke Association, which explain the benefits of a specialist stroke unit, based

	on national clinical evidence. This can be found on The Stroke Association website at https://www.stroke.org.uk/what-we-do/about-us/our-policy-positions It is important to note, however, that the proposals we are putting forward for mid and south Essex are not the same as the nationally recognised good practice that was implemented in London and Manchester, which is quoted within the national clinical evidence. In London and Manchester, people who have experienced a stroke are taken directly to a specialist stroke unit, or hyper acute stroke unit as it is known. Our proposal is that patients should be taken to their nearest A&E for assessment, diagnosis and initial treatment. Then the patient may be transferred to a specialist stroke unit in Basildon, if it was assessed that the patient would benefit from such a transfer. The reason this option is preferred by our local stroke consultants is that it preserves the vital time to assessment and initial treatment, but also means that we can improve the patient's outcomes by getting the right level of doctors, nurses and therapists to provide the really intensive support in the specialist stroke unit, in the subsequent critical 72 hours. This is what the clinical evidence suggests gives patients a better chance of a good recovery. The transfer time between hospitals is less critical than the time to initial treatment and stabilisation in the nearest A&E. It is only after the patient was stabilised that they would be transferred to Basildon

	Hospital for a period of intensive support and treatment (approx. 72 hours) in the proposed specialist stroke unit. Once this period was over, the patient may be able to go home (if their condition has improved significantly), or come back to their local hospital for on-going care and rehabilitation. Patients who are transferred to Basildon would travel via a dedicated clinical transport vehicle that meets national specification for clinical transport, and only when safe to do so and in discussion with the patient and their family. They would be accompanied by an appropriate clinical team to support them on the journey. Evidence from the UK and internationally – reviewed for us by UCLPartners and by the East of England Clinical Senate – has shown this transfer can be done safely. A summary of this evidence is on our website at http://www.nhsmidandsouthessex.co.uk/background/clinical-evidence/
42. How long will the transport service be funded for? I imagine even if this gets agreed this will end up being cut.	During the consultation we have engaged with the public to seek their views on how a transport plan could support them if these proposals were to be implemented and this insight will help to form more detailed plans We are committed to providing both the clinical and family transport services on an on- going basis.
43. There is no political mandate for the cuts that are triggering the need for these proposals. Funding the NHS properly and maintaining and improving local public services is what we	We are not proposing to cut services but improve the way we use the resources available. We spend around £1.95 billion for health services in mid and south Essex, and a total of around £2.5 billion on health and

should be focusing on achieving.	social care combined. By working together as a system we can be more effective, meet increasing needs, and keep people well for longer.
44. I think reasons for problems with staff retention are massively misunderstood (burn out, pay restraint and London weighting being a few). These will not be solved by these proposals and I am concerned with how the units and transfer service will be staffed. I am concerned with how this will work when patients with multiple needs will need staff from another specialism if there are not enough staff.	We agree that workforce is a challenge. Our current proposals for hospital services would see concentration of expert skills in many cases, helping to reduce the strain on key specialist roles. We have already seen in mid and south Essex that working together as one team across the three hospitals has helped recruit staff, as it offers less intensive working patterns and a broader range of work and opportunity that we can offer to skilled clinicians.. NHS Employers and national regulators have noted that organisations able to do this are better at retaining their staff. We often treat patients with multiple conditions and in such a case, the multi-disciplinary team treating the patient, and in discussion with the patient and carer, will take decisions on where and how the patient should receive care to enable best clinical outcome and chances of recovery. Our clinical teams will be working as one across the three sites. This means that, where, for example, a patient's condition means that they cannot be transferred to the hospital with the specialist team for a particular condition, the specialist team will provide advice and support to the local team to support excellent clinical care; in addition, the specialist may travel to the patient where this was required.
45. You mention the 5 principles of future hospital services. Where is the 6th principle – cuts - £407m OR £530m	We are not proposing to cut services. The NHS in mid and south Essex will receive an increase in annual

	funding of around £280 million over the next five years. This is an increase in recurring funds, which means an increase in the income we receive every year. We are also informed by NHS England that we can expect an additional £78 million in funding for transformation. These additional sums would be added to the £1.95 billion that we currently spend on health services. While these are significant funding increases, they alone would not cover the estimated increase in demands on the local NHS over the next five years, which could arise from the growing population and increasing complexity of health and care needs. We therefore need to plan different ways of meeting these needs and avoiding the potential overspend estimated at £532 million, if we took no action at all.
46. As funding follows patients, do you have the office staff and systems in place to track them through the STP hospitals; and give up to date information to relatives?	Hospitals will no longer work in isolation, and will therefore be able to manage the flow of patients around our system more effectively…This will be supported through the implementation of a single, cross site, operational and clinical management model for cross site services and a single command centre which will support greater visibility across all three sites, supported through the TeleTracking programme that the trusts have secured in partnership with NHS Improvement.
47. Moving patients with clinical care requires staffing (medical staff from initial A&E base). Do you have enough staff to do this and not leave gaps at the base? They will need (salaried) time and transport to return do you have enough funds for this, and extra funds for the ambulance service?	If we are transferring patients between hospital sites to receive the best care for their condition, we will ensure they are accompanied by members of staff with the appropriate clinical skills to ensure the patient's safety. We are working up detailed plans for this service, which will include costings and workforce. We will not implement the

	clinical transfer process unless we have sufficient, trained staff to manage the service.
48. Does the ambulance service have enough ambulances and staff, plus logistics operatives to run the new system? TOTAL CARE + POPULATION • Will the proposed bus service between the South Essex Hospitals:- i. Run only at visiting times ii. Run 9 to 5 for clinics as well as visiting iii. Run 24 hrs? • Obviously patients recover faster if they can have family/friend support. Bed blocking is always a problem	We recognise that the ambulance service is under significant pressure at times. EEAST are one potential provider of the proposed clinical transfer model, but there may be other providers, or we may provide the service from the hospital. We will ensure that, before implementation, the service is appropriately staffed and resourced. During the consultation we have engaged with the public to seek their views on how a transport plan could support them if these proposals were to be implemented and this insight will help to form more detailed plans. We absolutely recognise that patient's fare better when surrounded by loved ones and are committed to providing a service that enables visiting where patients are receiving care at a more distant hospital.
49. For patients not treated in their local area is there a new liaison team available for Social Care Assessments and transfer to their home patch? Bed blocking again!	We work closely with social services teams from across the three local authorities on a daily basis and they are aware of the proposals. Once CCG decision making has taken place we will be in a position to draw up detailed plans with our local authority colleagues to ensure smooth discharge processes.
50. Resources seem rather stretched for 808,000 population and if Mid Essex is included this will go over 1 million people. I presume these figures do not include tourists and non-permanent residents (do you have a figure from the Local Councils for these?) Do you think your allowances e.g. £26m	The total population of the mid and south Essex area is 1.2m people, with this population (based on people registered with local GPs) being the basis on which the NHS is funded in England. In undertaking the detailed planning leading to this public consultation

Care in Community will even touch the sides of demand?	we have looked both at current usage of NHS services by local residents, non-permanent residents and tourists and the forecast changes in our population across mid and south Essex as a result of demographic change and new housing developments.
51. How much money has this project cost in terms of additional managers, executives, meeting etc has this exercise cost so far? Many adverts have gone out asking for managers but no money for additional staffing?	Supporting our clinical teams to implement a large scale change process requires administrative and managerial support so that clinicians can be free to focus on patient care. Please be assured, however, that alongside the clinical changes we are proposing, we are also working hard to reduce inefficiencies in the system. The three hospitals currently operate separate support services and non-patient facing functions, and there are opportunities from working together to reduce duplication and the associated costs of bureaucracy in these areas.
52. As six out of nine specialist units are concentrating at Basildon and staff like to work in specialist units. • Does this indicate a future rundown of the other hospitals? • Poor staffing levels at the other hospitals?	Our proposals for hospital services would see concentration of expert skills in many cases, helping to reduce the strain on key specialist roles. We have already seen in mid and south Essex that working together as one team across the three hospitals has helped recruit staff, as it offers less intensive working patterns and a broader range of work and opportunity that we can offer to skilled clinicians. It is our aim to bolster teams to have increased resilience and better opportunities to develop their skills.
53. Previous amalgamations in other NHS areas have led to 70 mile round trips for elderly patients to clinics, plus local hospitals having no A&E but 8am to 8pm Minor injury and fracture clinics. So seriously ill patients are ferried long distances or in grid locked traffic. Will this happen here?	Please be assured that the vast majority of care will remain local – this includes A&E and urgent care, outpatient appointments, tests, scans and day case surgery. In addition, we want to move some of these services out to the community, closer to people's homes, where this is safe and possible. For example, our proposals for services in Orsett are

Are treatment time parameters worked out for the new package?	based on providing the range of outpatient clinics, tests, scans and minor injuries services in new integrated medical centres in Thurrock and in new and existing facilities in Basildon and Brentwood.
54. There has been underfunding of training for nurses, doctors in all specialism. With continuous cuts and ageing population leading the ever increasing demand. When will the next round of mergers/concentration of services take place, due to lack of safe-level consultants/ nurses etc.	We agree that workforce is a challenge. Our local NHS is struggling to offer round-the-clock, responsive services patients need; now and in future, we will need to recruit and retain the right workforce. There is no simple solution to the workforce supply gap, which is manifest across most of England, but working together in mid and south Essex across our hospitals and our wider community gives us the opportunity to review the skills and roles we need, and adopt innovative approaches, will help address this. Our current proposals for hospital services would see concentration of expert skills in many cases, helping to reduce the strain on key specialist roles. We have already seen in mid and south Essex that working together as one team across the three hospitals has helped recruit staff, as it offers less intensive working patterns and a broader range of work and opportunity that we can offer to skilled clinicians. NHS Employers and national regulators have noted that organisations able to do this are better at retaining their staff. There is substantial funding to recruit and train staff. The money to train clinicians is separate from the funding we receive for healthcare, and managed by Health Education England, which monitors needs and trends to determine the number of training places required each year. Within the hospitals, we already spend significant sums on locums and bank staff to cover rota gaps; therefore, the ability to employ

	substantive (permanent) staff would be more affordable in the long term.
55. Why can't the three hospitals order supplies as one order getting better value for money?	This is absolutely our intention. There is significant scope for efficiency in the way we operate our hospitals and we will seek to exploit such opportunities so that we can further invest in patient care.
56. Isn't part of the reason we cannot attract or retain staff because Basildon pay more and because of the uncertainty surrounding this merger?	Although Southend has local terms and conditions, they do mirror the national NHS terms and conditions under the Agenda for Change framework. Basildon has the fringe allowance which may result in higher overall compensation at present due to zoning of payments for the London fringe allowance – these zones are set nationally. Pay frameworks are linked to particular aspects of each role, and there are clear processes we need to follow on pay and conditions. The proposed merger of the three hospitals should create greater certainty for our staff on our future organisational form and cement opportunities to work in a larger team, with all the benefits this brings. We have been clear with clinical staff that given current vacancy levels across our hospitals we do not envisage any redundancies or reduction in the number of clinicians we employ across the three hospitals.
57. If Basildon will have the expertise and developed staff, who will be providing outpatient consultations locally? ~? Staff who does not have the expertise?	Our intention is to maintain the vast majority of services at the local hospital – this includes A&E, outpatient appointments, tests, scans and day case procedures. All care will be delivered by trained, experienced staff at each site. This will mean, as now, our consultants and other specialist staff will have dedicated time during the week to undertake outpatient consultants locally, alongside time on specialist units.

58. Underfunding and lack of staff is a national problem. What makes you think we're able to resolve this by working differently? Patients live longer which is the main reason for a lot of admissions – social care and community support needs to be put in place first and foremost which would resolve a lot of issues in any case. How will you recruit increased community care?	There is substantial funding to recruit and train staff. The money to train clinicians is separate from the funding we receive for healthcare, and managed by Health Education England, which monitors needs and trends to determine the number of training places required each year. Within the hospitals, we already spend significant sums on locums and bank staff to cover rota gaps; therefore, the ability to employ substantive (permanent) staff would be more affordable in the long term. We agree that services are under pressure – by working differently, supporting people to stay well, we will be able to decrease the number of people requiring expensive hospital care, and reinvest this money in developing and enhancing our community services.
59. What level, other than clinicians have staff been consulted? What makes you think you can fill staff vacancies when they can earn more through agency and the flexibility of working hours. What saving do you expect through purchasing power on economies of scale and how?	We have engaged with staff at all three hospitals through meetings, briefings and newsletters. Staff have been encouraged to give their views on the consultation proposals. We hope that the proposed services changes will provide exciting opportunities for our staff and, through working in larger teams, staff will be able to enjoy opportunities for flexible working, training, education and obtaining experience in different environments.
60. How will it be possible to fund the changes whilst employing so many locum and bank staff?	Within the hospitals, we already spend significant sums on locums and bank staff to cover rota gaps; therefore, the ability to employ substantive (permanent) staff would be more affordable in the long term.

Questions from Southend Public Discussion Event
Cliffs Pavilion
7th March 2018

61. I would like to specifically ask Gowrie whether he would agree that the genuine problem here apart from the clear goal of the government to privatise is that there is simply a total mismatch between the staff requirement of the NHS and the FACT that we are 140,000 (12%) short nationally of the required human resource? Also why the NHS, in 20 years has gone from being the chosen career of so many to being an orphan child?	We agree that workforce is a challenge. There is no simple solution to the workforce supply gap, but working together in mid and south Essex across our hospitals and wider community to develop the skills and roles we need, and adopting innovative approaches will help address this. You may be interested in reading our green paper on the acute workforce to get more information about how service proposals may impact on our workforce (Acute Workforce Green Paper)
62. Stroke – why bother moving patient once stabilised? Surely better to move consultants to strokes. Have a recruitment drive. Why can't you get staff? You pay locums – put money into decent packages to attract staff!!	The reason for our proposal to move stroke patients after they have been stabilised is national evidence shows that outcomes improve significantly for patients who receive intensive nursing care and support in the first 72 hours after a stroke. A dedicated team of nurses, physiotherapists, speech and language therapists and other clinicians provide an intensive period of investigation and treatment with the patient. Although our stroke services are excellent, we do not currently have sufficient staff to provide this dedicated and intensive support across all three-hospital sites. We believe that by having this service on one site we can ensure patients receive the care they need to increase their chances of survival and recovery and provide a better working solution for our staff.
63. Free bus service: • How will it be funded? • How long will it be funded for? • How will you make sure it's for patients/their families etc and not someone "cadging a lift"?	The changes to some hospital services that are being proposed would ensure that the vast majority of care continued to be available at all three hospital sites. This includes the A&E department, all outpatient appointments, tests, scans and day case surgery. As a result of the proposed changes to some specialist inpatient care, we expect that an

• How long will the journey take? • Why should US (the public) tell you how to do your job – you say you want our ideas – point of consultation give us the costs/ propositions so we can then have proper facts	average of 14 patients per day would receive elective care at a different site to their local hospital. We also estimate that further 15 patients per day (on average) would be transferred to receive care from a specialist team at a different hospital. We recognise the impact that such changes may have on patients and their family and have therefore proposed a free transport service for those patients, family and friends who may need to travel slightly further to receive specialist care. We consider it important to plan this service with patients, rather than to impose a particular model. During the course of the consultation, we have heard lots of views from patients and the public about what they think would be the key elements of a family transport service; we will also be holding a number of focus group sessions with patients and carers to obtain their views, as well as liaising closely with local authority colleagues so that we can build a service that meets needs. Part of the planning we will be doing is to look at journey times, the best pick up/drop off points, how to regulate the service and so on.
64. You say children's services will be unchanged!! With emergency surgery taking place at Broomfield Hospital what happens to children who require surgery at Southend Hospital? There doesn't seem to be any information regarding this. What about orthopaedic surgery for children?	We are not proposing to change children's services, except to improve the current provision of paediatric assessment units at each of our three A&E departments. Children will continue to be treated, as now, across our three hospitals by consultants with paediatric training. Very complex and specialist surgery for children will continue to be transferred to specialist centres such as Great Ormond Street.

65. Why are NHS resources being moved from this area of greatest intensity i.e. Southend Stroke unit	Our proposals seek to improve the quality of care our patients receive. The vast majority of care will remain available in each of our three hospitals, including A&E departments, outpatient appointments, tests, scans and day case surgery. For some specialties, there is clear evidence that concentrating care in one place can improve outcomes. The stroke unit at Southend Hospital will remain, we are proposing to move patients to Basildon for the first 72 hours after a stroke, so that we can concentrate teams of nurses, physiotherapists, speech and language therapists and other clinicians in one place to provide intensive care and support over this period. After this critical period patients may go home, if their condition has improved significantly, or may be returned to their local hospital for on-going care and support.
66. So who is responsible on the STP/CCG team for getting the final agreement from specialist commissioners for the gold standard stroke model to take place? (24/7 MRI at each site, specialist stroke DR and Nurse 24/7)? • When can we have confirmation of an Essex Thrombectomy unit – today??? Or if not – when??? • When will the business case be signed off so Dr Guyler can actually get on with developing the stroke service and saving more lives?	Mechanical thrombectomy is a treatment for stroke that removes blood clots that block large blood vessels. Some patients may benefit from this procedure using radiological support and a device that grabs hold of the clots and removes them, to re-establish blood flow to the brain. Only Interventional Neuroradiologists are currently able to provide this service in neuroscience centres (24 in England, our nearest is Queens Hospital, Romford), although we do have a doctor trained locally here, providing a "best endeavours" system in Southend (i.e. it depends on the individual doctor happening to be available, so is only available on certain days and if certain individuals are available). Interventional Neuroradiologist staffing levels vary between centres and currently only one centre in England is staffed to provide 24/7 cover for mechanical thrombectomy. In April 2017 NHS England announced that the NHS intends rolling out

	emergency mechanical thrombectomy to hospitals across the country, so there is support to invest in more of these doctors. In Essex we will support training and expansion of these skills, as stated at recent public events. However it is acknowledged by NHS England and the Royal College of Radiologists that generally there are not enough Neuroradiologists who are trained in the procedure to offer it universally, and indeed the numbers of Neuroradiologists available are below what we would need for the NHS in general - this is a key shortage profession. Training programmes for thrombectomy are in place, but it will take time to release clinical staff and allow them exposure to sufficient cases in a learning environment to develop and accredit their skills.
67. It was unclear at the last Cliffs meeting what will happen with a patient who needs more than 1 speciality. It was said that the specialist doctor would visit the different hospital. But it was also said that technology would be used and no visit. Can we get clarification on which.	We often treat patients with multiple conditions in our hospitals, bringing together input from a range of different professionals. With increasingly complex numbers of conditions this is becoming more common. In such cases there is a discussion across the multidisciplinary team involving all the specialties which require input into the patient's care. This team will then make a decision on where and how the patient should best receive care. These decisions will always be in partnership with patients and carers to enable access to the right advice and treatment at the right time, to achieve the best clinical outcome and chances of recovery. Our clinical teams will be working as one across the three sites. This means that, where, for example, a patient's condition means that they cannot be transferred to the hospital which hosts the specialist team for a particular condition, the specialist team will provide advice and

	support to the local team to support excellent clinical care either remotely, if possible, or by the specialist travelling to the patient if needed.
68. Where will the eye clinic be?	Our proposals aim to move some services traditionally provided from a hospital site to be provided closer to where people live; for example, in Thurrock, we are proposing to provide services from the Orsett site in new integrated medical centres. We are seeking views on where a range of services historically provided in hospital would be best provided. This includes ophthalmology services, as well as renal dialysis.
69. Where will routine dialysis take place? Still at Southend. Access by bus will be a serious problem if moved	Routine dialysis will continue to take place at all three local hospitals. For our proposed changes to the Orsett site, we are seeking the views of local people who currently receive kidney dialysis at Orsett to find out where the best location for dialysis would be.
70. Which conditions/cases to you see that are currently dealt with at hospital that will be dealt with locally? • Who will deliver these services? • How will they be funded? • Who oversees their care? • If person's condition changes who will decide it should be treated at hospital	A range of outpatient clinics, tests and scans could be provided closer to where people live, for example in GP surgeries, existing community facilities and within the locality hubs that the CCGs are working to develop. Hospital staff already provide some care in the community. Under the proposals, services will continue to be provided by trained and experienced staff, either from the hospital or, where appropriate, by staff from community and primary care. Exact details will be worked through once the CCG Joint Committee has taken decisions on service

	change.
71. My experience is that usually claims made during new projects are a show business and reality is different. Should your speech be trusted	Prior to being given approval to consult, our plans have been through a rigorous assurance process by NHS England and NHS Improvement regional and national teams. Our clinical proposals have been scrutinised by twice by the East of England Clinical Senate, and will undergo further assessment as our plans develop. Once decisions about service change are made by the CCG Joint Committee, our implementation plans will be under similar scrutiny by local, regional and national teams.
72. They choose questions they want to answer rather than open floor	We are sorry that you feel this way. At the event, we asked for written questions and our staff attempted to sort the questions into themes. The chairman selected questions at random to ask on the evening. There was not the time to be able to ask all questions. By encouraging people to write their questions down we have been able to respond to many more than just at that event.
73. Speakers have referred to the loss of consultants and the extreme difficulty of recruiting clinical staff. What are the reasons for this, and how does this compare to the rest of the country?	We have faced significant workforce challenges. Our local NHS is struggling to offer round-the-clock, responsive services patients need; now and in future, we will need to recruit and retain the right workforce. There is no simple solution to the workforce supply gap, which is manifest across most of England, but working together in mid and south Essex across our hospitals and wider community to think about the skills and roles we need, and adopting innovative approaches, will help address this.

	Our current proposals for hospital services would see concentration of expert skills in many cases, helping to reduce the strain on key specialist roles. We have already seen in mid and south Essex that working together as one team across the three hospitals has helped recruit staff, as it offers less intensive working patterns and a broader range of work and opportunity that we can offer to skilled clinicians.. NHS Employers and national regulators have noted that organisations able to do this are better at retaining their staff. In terms of the medical workforce, we have a number of schemes in place. Anglia Ruskin University is planning to open a School of Medicine in 2018 at its Chelmsford Campus. Having such a facility locally will assist with our workforce challenges over coming years as many students who study at the school will take up local placements and, once qualified, many may wish to stay in the area.
74. Basildon Hospital equally has hard winter pressures and has had their clinics and operations cancelled. Having a specialised unit will only deal with the immediate problem. Recovery will need to take place at local hospital. How will this resolve the bed state at all sites?	The winter pressures have been particularly challenging this year for hospitals across the country. We believe that working together as a system with our health and social care partners, will give us the best chance of dealing with times of pressure. We also believe that by getting patients specialist treatment quicker through the creation of the specialist centres as described within the consultation we will be able to reduce the overall length of time patients need to spend in hospital and therefore free up beds to better deal with times of pressure as we have seen this winter.

75. Define "complex lung conditions" – who will make the decision to divert to Basildon and at what stage. Should a "complex lung condition" not be diagnosed by a consultant rather than ambulance driver. What expertise can be referred at Basildon that is not available at Southend?	In our proposals, we do not expect ambulance staff to diagnose complex lung problems – patients will still be brought to their local hospital by ambulance and will be assessed by senior clinicians, as happens now. For a small number of patients with complex conditions, who would benefit from a period of inpatient care, our consultants may, in discussion with the patient and their family, decide that they would benefit from a period of care in a specialist unit. Only once the patient was stable to be transferred would they be transported, with appropriately trained clinical staff, to another hospital site. The purpose of proposing to develop a complex respiratory inpatient care at Basildon is that we can concentrate specialist doctors, nurses and therapists in one place to provide the best care to patients requiring enhanced care and support to recover.
76. Community services developed by hospital previously were cancelled as they were deemed too expensive and not being able to staff them. How is it different this time?	We know that we can make improvements to patient care by working together with our community, social care and primary care colleagues. Our plans are aimed at providing the best care in the most efficient way.
77. What evidence is there that the proposed community plans will be able to be implemented? Where are you with recruitment of specialist staff? The main issue of <u>not</u> being able to discharge patients is because of lack of community care, adding to the pressures. How confident are you that your <u>plans</u> will be put into <u>practise</u>?	We recognise that we face significant challenges in primary care – individual CCGs and NHS England have plans in place to enhance the current workforce through continued recruitment and retention schemes and through enhancing the education and training of other health and care practitioners to support primary care. Clinical Commissioning Groups have already begun the development of primary care services in defined localities, which will support the resilience of general practice and enable patients to access a wider range of health

	and care services closer to home. Individual CCGs have plans for locality development, and these will be available from the relevant CCG.
78. Winter cancellations were nationwide as well documented in the press. In fact cancellations were instructed for all hospitals by NHS E. How will amalgamating services avoid cancellations during these winter pressures, where other hospitals who have previously amalgamated still struggled and were affected by the winter pressures?	As healthcare providers we regret having to cancel patient's planned operations. Our plans propose the separation of planned from emergency care, particularly in specialties where lots of treatments occur. We know that this can help in reducing the number of operations that are cancelled due to emergency pressures. Having a dedicated team, theatres and resources for planned care should help to improve our waiting times for elective treatment and enable patients to receive faster care.
79. If they are planning on closing Orsett Hospital are there going to be extra beds at Basildon – can't possibly increase the beds across 3 hospitals to make up for closing one hospital and where are the extra staff coming from as already a huge problem recruiting staff	We are proposing to close the Orsett site as it is extremely expensive to run given its age and poor facilities. We will only do this once the services provided there can be re-provided in the community in Thurrock and Basildon and Brentwood. We are working closely with the CCGs on these proposed changes. It is important to note that there are no beds on the Orsett site and therefore closure will not reduce the bed base for the three acute hospitals. Our plans in fact aim to increase the bed base by 50.
80. Who is your team has a responsibility for social media and what were their proposals for engagement? Did they have experience of marketing a consultation via social media? Social media engagement is not about paying to have a video autoplay in peoples timelines, it is about actually responding to people on your timeline. Not leaving it ten days plus to	The use of social media has been employed as both a promotion and engagement tool with Facebook and Twitter as the main platforms. In terms of promotion, sponsored advertisements on Facebook has allowed targeted adverts to be placed on news feeds highlighting opportunities to get involved.

respond. From looking at your Facebook and Twitter page it is clear there is very little positive engagement by the public. If you have a communications manager, at least 2 people working on social media (lady at the council meeting reporting and a man responding on Facebook – who was off ill for a week so messages weren't answered) then why do little engagement.	It has also enabled relevant posts to appear targeting key demographics based on for example age, health workers, religious affiliations and gender. As of March 9 2018 information about the consultation has appeared on the newsfeeds of more than 200,000 people through the combination of paid advertising and via the STP Facebook page.
81. You state in your documents you want to hear from the public, but it seemed very much to be a one way thing. Getting a response via social media was impossible. The basics of customer service are working with the public, giving replies, even difficult ones. Surely that is what your team is for, to alleviate the fears and reassure of this being a positive change. By ignoring and just saying "this is right" that isn't consultation? You have had a very poor response so far to the consultation and have extended the deadline. What you have done in the last few weeks to improve the response? Why haven't you tried things like a stall in the high streets on a Saturday. Actually getting out and meeting the public and informing them?	The consultation has been widely publicised through the local media including television, radio and local newspapers in editorial coverage. The use of social media has been employed as both a promotion and engagement tool with Facebook and Twitter than main platforms. In terms of promotion sponsored advertisements on Facebook has allowed targeted adverts to be placed on news feeds highlighting opportunities to get involved. It has also enabled relevant posts to appear targeting key demographics based on for example age, health workers, religious affiliations and gender. As of March 9 2018 information about the consultation has appeared on the newsfeeds of more than 200,000 people through the combination of paid advertising and via the STP Facebook page Aside from both traditional and social media a cascade approach has been adopted through established channels using key communicators

	across a range of local networks to reach a variety of groups and communities. Examples of this approach include a focus group session with local Diversity Networks supporting people with physical and/or learning disabilities, formal letters to traveller liaison groups, articles run in weekly CVS updates to their membership and postal mail-louts to patients on CCG engagement databases without email addresses. Healthwatch Essex, Healthwatch Southend and Health Thurrock have also supported this community cascade approach. The variety of activities has included: • Essex: social media cascade, out and about in the Chatterbox Cab • Southend: Mailshots and shopping centre promotional stands • Thurrock: Face to face events, visits to sheltered housing
82. On the 18th February you were informed on Twitter of the lack of consultation posters and information at GP surgeries across the area. What have you done since then to make sure that more people are aware that the consultation is happening? Have visits to surgeries been done to check they have posters advertising the consultations are up? You list on your response to the last cliffs event and engaging minority groups all the ways you have tried to reach people. But have you checked they have worked? Have you had a wide response to the consultation from different minority groups?	In line with our cascade approach the CVS organisations have written to their members to raise awareness of the consultation and encourage participation. These networks include a wide range of advocates and representatives of minority groups and has resulting in direct invitation to attend groups such as Southend Ethnic Minority Forum and Transpire (LGBT). Letters have also been sent to groups aligned with the nine protected characteristics requesting they consider the proposals from the perspective of those they support.

	This includes groups such as Age UK Essex, Royal Association for Deaf People, Blind Welfare, Stonewall, Traveller Liaison, Roma Support Group, Peaceful Place, YMCA, and Family Action. A number of focussed group discussions have also been undertaken and includes sessions with young mums, representatives of the Jewish community and diversity coalitions. Throughout the consultation the team has responded to a number of requests and based on feedback received undertaken additional activities. Examples of this include: • Additional events put on in Southend and South Woodham Ferrers • Produced a video on the Orsett proposals • Produced summary sheets on stroke, finance and transport • Extended the deadline for responding to the consultation to March 23 2018 • Revisited GP practices to ensure materials are on display • Undertaken paid advertising in the local media to promote the extended time frame
83. Are you looking into infra-red scanners to identify serious hematomas in the ambulance?	We are not aware that East of England ambulance service is currently considering the use of IR scanners as part of the diagnostic equipment available in ambulances locally. However we are very keen to support innovation and the adoption of new methods and approaches once these are proven.

Questions from Southend Public Discussion Event
Cliffs Pavilion
7th March 2018

84. Elderly patients do not have access to the internet – must allow access to the "system" by post etc. New technology is not the answer for the elderly!	We recognise that not all our patients will have access to the internet. It is not our intention to completely eradicate notification of appointments, e.g. by post.
85. How much is change costing?	The principle cost of the proposed changes that we have identified is the need for us to invest in our buildings and technology in order to enable model of care as outlined within the consultation. To this end we were successful in bidding for £118m of additional capital funding from the Treasury to support the new model of care. Once the outcome of the consultation is known and a decision has been made by the CCG Joint Committee we will submit a series of more detailed business cases to the Treasury in order to release this money and to allow us to undertake this work.
86. Better system needed for those with dementia who live on their own. Only letters are picked up by carers who "pop in"	Thank you for this suggestion, we will pass this to our community providers.
87. Understand why Southend and Basildon but why the outlier Broomfield? South Essex splits from Essex County council could make very difficult?	The three hospitals (Basildon, Southend and Broomfield) are part of the sustainability and transformation partnership footprint and have been working closely together for the past 18 months. The hospitals already share services and teams and are looking to increase their collaboration through a formal merger process (subject to approvals from regulators). Our three hospitals work across three top tier local authorities (Southend Borough Council, Essex County Council and Thurrock Council) and so we are well versed in working across local authority boundaries.

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88. What convalescence facilities are to be available to those who live on their own (with other complex needs) e.g. dementia?	CCGs are responsible for planning and arranging care outside of hospital and they are already working on plans to develop localities and further improve community services.
89. As yet I have not seen or heard 1 single thing on mental health. I feel very strongly that there's lack of services when it comes to mental health. Millions are spent on medication, people are committing suicide (the rates are increasing) there's 18 week plus for any help. There's only 6 safe rooms at Southend Hospital. I feel strongly that there's too many chiefs earning high salaries/get rid of half and put that on frontline where MH people need it and stop sweeping MH under the carpet and start listening to your patients.	Mental health services are vitally important and CCGs are working with mental health providers to improve services across the STP. We will pass your concerns to the CCGs. Mental health services are not subject to the consultation proposals, however we have contact support groups and our partners who provide mental health services to ask them to respond to the consultation highlighting any potential impact these proposals could have for.
90. When you present to a doctor at your practice you are told you need 2 types of identification. Not everyone can afford to pay for a passport or a driving licence so by that you are disenfranchising thousands from health care? Homeless, those who have suffered fines etc. Anywhere for self referral. A GP told me that I could. • How much has this presentation cost?	We will pass this concern on to the NHS England who set national policy in relation to access to GP services. The cost of the presentation was within the budget set for the public discussion events.
91. What is the total budget figure for this change? • How many senior managers (paid over £65,000) are in place at present in the 3 hospitals and what will be the number if this consultation is agreeable to the public? • How many orthopaedic beds has Southend to cope	We do not have information on the total number of senior managers employed across the NHS in mid and south Essex as this is not information we routine compile across the NHS, you would be able to find this out by writing Freedom of Information requests to each of the local hospitals.

with patients from Basildon, Southend for hip and knee replacements? • On ophthalmic – where do young children receive orthoptic care in Southend?	The number of orthopaedic beds at all of our hospitals changes on a day to day basis dependent on patient need; in the case of south Essex the proposal within the consultation is that the current elective beds at Basildon would be converted to emergency beds and vice versa at Southend to accommodate the new service model and the patients affected. We are not proposing any changes to children's orthoptic care in Southend under these changes.
92. Following last meeting at the Cliffs and the absence of the Ambulance service at that meeting, I am concerned that this will be another consultation which is based on a blinkered approach based up on the views of senior NHS staff and limited data plus the need to save money without looking at the wider picture of health and social care in south and mid Essex. The proposed changes will involve many health and social care services. These include both public and private services. Residents are particularly concerned about future services, namely; GPs, ambulance services, mental health services, residential and nursing homes and social services provided by councils and privately and not forgetting different policed services. I feel that you need a separate committee to ensure there are no gaps in service provision from all sources.	We are consulting on changes to hospital care and as such staff from the hospital, clinical and managerial, have presented the proposed changes at each of the public events. Colleagues from the ambulance service have joined some meetings but have not been able to attend all events. We agree that the health and social care service needs to do more to provide joined up services, this is why all providers and commissioners across mid and south Essex are working together to one plan – the sustainability and transformation plan – of which the proposed changes to hospital services are on part. Please be assured that we involve patients in the development of all of our plans. We also have a Service User Advisory Group that works closely with the STP Board and have worked closely with the existing patient participation groups across the five CCGs.

May I suggest that you involve representation from a limited number of selected patients which has the merit of fulfilling the requirements of the Department of Health to involve the public?	
93. We know in Southend that around 2,500 homes will be built over the next few years. It is unlikely that this will not place additional load on medical and other services which is likely to undermine rigid plans. The public expressed concern when Rochford Hospital closed that there would not be sufficient car parking at Southend Hospital to cope with the increased number of patients being directed to Southend Hospital. It appears this was not looked at seriously until it became a serious problem for staff, visitors and residents. Are similar problems associated with the current proposal likely to occur again? If so are there plans to avoid similar problems with implementing the current proposals?	Our plans have taken account of growth forecasts in the population surrounding mid and south Essex. We realise that parking at our hospitals can be a challenge at times and we are working hard to try to alleviate these problems.
94. It would be helpful for the public to know your views about the location of future and existing services, how you propose to work with medical and support staff at the three hospitals to understand their concerns about possible relocation and the action you will take to implement a smooth transition from the present arrangements to the proposed arrangements. Last but not least your views on how to ensure your customers, the patients, understand what changes in access to services that they see.	We have set out in the consultation document our proposed service changes and locations. We cannot identify the final location for services until the CCG Joint Committee has taken decisions about service change. We have involved clinical and administrative teams to co-design our plans and will continue to do this once the CCG Joint Committee has made its decisions on future service configuration. The views of our staff are important and we will continue to take on board their concerns and questions, supporting them through the change process.

	It is course, vital that our patients understand our services and we will continue to work with our patients to do this.
95. Merger – so will it become 1 hospital? Most Southend going away from Southend so are you eventually closing Southend?	The three hospitals have been working together for some time. The three Trusts boards have agreed to progress a merger application that will be overseen by our regulators. The three hospitals will remain; there is no plan to close Southend Hospital.