Questions from Southend Public Discussion Event

Cliffs Pavilion

8th February 2018

These questions have been transcribed from the original question submitted from the event on 8th February, as such there are a number of questions that appear more than once (as the same question was submitted by more than one person). All personal information has been removed from this document however, where individuals provided a contact email address, we will email a personal response.

Question Submitted	Response
1. Workforce is clearly a significant challenge. What is the solution to the workforce problem if we don't change to the future model? Are we better to try something rather than just be sitting ducks?	All health and care organisations across mid and south Essex are working together with Health Education England (HEE) and unions to develop our workforce across the health and care spectrum. Action is coordinated by a Local Workforce Action Board chaired jointly by Dr Caroline Dollery (Chair, Mid Essex CCG) and Sally Morris (Chief Executive of Essex Partnership University Trust). 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 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, subject to final approvals, 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. The primary care workforce strategy and delivery is overseen by the Primary Care Transformation and Development Group, a sub-group of the Local Workforce Action Board, and is supported by close working links with Health Education England.
2. Without funding for the recruitment/training of staff, these proposals will not work. What guarantees are there to ensure that you will be able to	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.

implement this?	Locally we use various ways to recruit and retain talent (see response to Question 1, above). 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.
3. Patients awaiting transfer between hospitals will be delayed by waiting for their medication. How will you be able to speed up the process from the pharmacy to give these people lesser waiting times?	We recognise that there are sometimes delays in providing medicines to patients upon discharge, and we already have a range of processes in place to help reduce delays, such as having medicines ordered in advance, and delivering medicines to patients after discharge. However, patients requiring transfer between hospitals would not be required to wait for medicines as their medication needs would be met at the receiving hospital. All the patients' needs would be documented and communicated through any transfer process, and a coordinated pharmacy process for the hospitals.
4. The road networks are abysmal. With proposed "improvements" to A127/A130 Fairglen Interchange with years of roadworks, you would be better off building a train network between the 3!	We have noted your view and will ensure it is taken into account in decision-making.
5. Much of the money in our hospitals is spent on agency	Pay frameworks in the NHS are set nationally, and linked to particular aspects of each role. There are clear national processes we need to follow on pay and conditions.

nurses. Money could be saved by rewarding current staff and improving their morale. Why can't they be paid more in order to retain them?	It is true that across our providers we currently spend significant sums on agency and bank staff to fill rota gaps and cover vacancies. With three hospitals working together there are opportunities to develop permanent staff and promote a "home grown" workforce for the future. We know that valuing our staff, engaging them in improving services, offering them chances to develop their skills and to have a range of working patterns is really important. We think that the proposals for hospital services give us a better chance to do that for specialist teams, and we will of course look to make sure that all staff have the opportunity to contribute to plans. Our ultimate aim is to employ a well-motivated and rewarded substantive workforce across the area, in organisations that engage all our staff and offer an exciting range of career options in health and care.
6. I would like to see the data on which your evidence has based that transporting vulnerable stroke patients will have an improved service? Where is the traffic data? Are you wanting to tender the transport used here to a private company? – In which case how will this be an improved service regarding cost and having specialist staff on board for the	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

transit?	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/ In relation to the provider of this clinical transport, no decisions have been reached as yet as we need to await the CCG commissioning decisions on hospital services before we can accurately specify the service required.
7. Will the staff at Southend have their salaries raised to match Basildon?	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.
8. Will patient/carer shuttle bus be operating 24/7?	We will be working over the coming months to identify the requirement for the family transport service including how it will be provided, hours of operation, where it

	should run from/to, etc. and will be involving existing patients and carers in our work.
9. What about transport for staff? No one been to talk to me	We do not expect that many staff will need to work across sites, but where this is the case, we would work with them to make the most appropriate arrangements. Under the current proposals for changes in some specialist services, only consultants in those specialist areas would potentially work across hospital sites, and no-one would be expected to work at more than two hospitals. There would also be opportunities for any member of staff interested in working at more than one site in order to develop their expertise and career, such as gaining experience with a particular specialist team.
10. Some time ago I read about a scheme called Patient Transfer Safety Intervention (I think). This scheme was to allow ambulance crews to hand over their patients and get back on the road quickly. This scheme obviously did not happen because the queues of ambulances outside A&E's meaning 999 call outs took many hours. Why was this plan not implemented	The PSIT was in operation over the winter months with, as you have pointed out, the aim of handing over patients to clinical teams within the hospital to enable the ambulance service to get crews back on the road. At times, the demand for our services was such that this plan was not always effective. We continue to work in close partnership with the ambulance service to ensure we support our patients to receive the best possible care and we are able to respond during peaks in demand.

11. Transport – no information on this seems to be agreed or worked out yet. When will this be sorted? Who will staff it? Where will those staff come from? It doesn't seem very decided	A detailed clinical specification for inter-hospital transfers depends on what is agreed (by the clinical commissioning groups) for future hospital services, following the consultation. This will lead to further clinical work to develop the protocols for safe patient transfers. In anticipation of commissioning decisions for hospital services, we are working with East of England Ambulance Service. The London Ambulance Service and with colleagues from the major trauma networks. This builds on past and current experience in practice - where we already safely transfer patients across the county and into London to access the best available specialist care, when needed. In relation to family transport, we will be working with patient groups and colleagues from local authorities to develop our plans over the coming months.
12. How do staff feel about moving? Have they been asked? Are they happy to travel? Are you concerned if they will stay?	The only staff we will expect to travel between sites would be consultant staff in the areas we are consulting on; they may be expected to work across more than one site in order to undertake their work (e.g. orthopaedic surgeons undertaking emergency operations at one site and planned operations at another). We would not expect staff to have to work across more than two hospitals. In the case of non-consultant staff there may not be an expectation for them to work across sites, but if we expected a staff to travel to work across sites, this would be subject to a consultation process. Where a member of staff expresses an interest in working across more than one site to develop their expertise and

	career in a particular service area, for instance in a specific specialism which we will be able to newly provide as a result of creating these specialist centres, then we will obviously aim to make this happen.
13. Consultation – how have you reached out to different ethnic communities to make them aware of the consultation? The room doesn't see to be filled with the vibrant mixture of communities that Southend is.	We have promoted the consultation through the networks of the five clinical commissioning groups, the patient representative network associated with all health and care organisations and partners in the voluntary sector. These networks include a wide range of advocates and representatives of minority groups. Activities include email notifications, information in newsletters and on websites, as well as social media communications by all health and care organisations and partners. Southend Association of Voluntary Services (SAVS), for example, has highlighted the consultation several times in its weekly email to members, including groups such as the Hindu Elderly Day Centre, Essex Asian Women's Association, Hungarian Community of Southend, Polish Saturday School, Masowe eChisanu and Faith Realities (which works with homeless people), Southend CCG, for example, has sent information to various groups representing vulnerable people, such as local members of Age UK, Alzheimer's Society, MENCAP, Essex Dementia Care, Havens Hospices, Headway Essex, Take Heart, Southend Blind Welfare Organisation and Action for Family Carers. We have also held a number of focus groups for people with protected characteristics. For example, we have held sessions with new and "hard to reach" mothers, with members of the LGBT community, with learning disability

	groups and with young people. Full details on all consultation activities will be published in the outcome report in May.
14. What will you do if you have an older patient who has multiple issues? Like a stroke, fractured hip or gastrointestinal issues. These will be specialised at different sites?	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.

15.23 Jan @lisacarol of Guardian reported:Senior doctors from overseas (outside EU) who have been appointed to fill key roles in hospitals around the UK are being blocked from taking up their jobs by the Home Office because NHS salaries are <u>too low</u> under immigration rules (£55000). 18 staff turned down in last 2 months including 16 doctors in senior medical posts in trauma from Caribbean and India as recruitment from Greece and Spain have "dried up". Should we lobby the Government to require the Home Office to abolish these absurd rules and allow qualified specialists to work in the NHS (who have passed GMC tests and language tests already)? We cannot be reliant on EU pool which is unsustainable. Are these another example of UK civil servants absurd bureaucracy blaming Brexit for the staff shortage – when it clearly isn't.	There are complexities with recruiting clinical staff from overseas, however we have significant experience of this in the hospitals where we have run successful nurse recruitment campaigns over recent years from Spain, the Philippines, etc. We also have a defined EU recruitment scheme in place, which will enable us to recruit 50 GPs over the coming 2 years. Through this scheme we work closely with the GMC and Health Education England to overcome some of the challenges associated with recruiting from overseas. Anglia Ruskin University is planning, subject to final approvals, 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

16. Please can you explain how transport is costed between hospitals? How does a patient travel back when discharged and will their family carers have transport too? How will staff manage the additional hours of care that would have been provided by unpaid carers (family & friends) who will not be able to make the journey for health or reasons of other commitments such as childcare?	Under the proposals, the vast majority of services remain at each hospital – this includes outpatient appointments, tests and scans and day case surgery. Therefore, the average number of patients per day that may be required to travel to a different hospital site for *inpatient* (planned) care is 14. Clearly, we want to minimise the impact on these patients and their carers. There is already in operation a patient transport service for patients who qualify, and financial support for patients required to travel, if they are on low income or receiving certain benefits. This will continue. In relation to the proposed family transport service, we are working with patient groups and colleagues from local authorities to develop our plans over the coming months. We must await CCG decision making before finalising our transport plans, but we are working on details and will present information to the CCG Joint Committee to support their decision making process. This will include costings.
17. How many people have asked questions? Why are you not prepared to answer individual questions? Why are you so undemocratic to ignore the will of the people who did not (require/want) a break?	We received over 100 questions at the Southend event. By asking for questions in writing, we are able to respond to many more questions than there was time available at the event itself. On the evening, a break in proceedings was taken to enable those in the audience the opportunity to formulate their comments and questions following the presentation on the proposals.

18. Could not see the slide for the stroke presentation. It was not included in any handouts. Please email a copy	This is now available on the consultation website on the Events page at http://www.nhsmidandsouthessex.co.uk/have-your-say/events/ (can you check link)
19. We are being told care will be in the community, there is a shortage of district nurses, in Rochford, Rayleigh and Castle Point the 0-19 years is under the care of Virgin Care, there is a dire shortage of Health Visitors, they are leaving and not being replaced as Virgin Care do not train health visitors.	The five clinical commissioning groups (CCGs) are working with GP practices, community, mental health providers and social care to bring together and develop care in each of their localities. This will enable a greater range of services to be provided closer to home, and will support local GP practices with their workload. The 0-19 pathway is not the subject of this consultation. We will pass your comments on regarding this service.

20. Can the committee provide details and evidence of which local clinicians are backing the plans for reconfiguration relating to the renal medicine respiratory and transfer of patients

A list of local clinicians who have led the development of our current proposals (along with clinical teams across the three sites) is as follows. In addition there has been close involvement of the Medical Director (Dr Ronan Fenton), and Chief Medical Officer (Dr Celia Skinner) for the three hospitals, as well as the three site medical directors (Mr Neil Rothnie, Southend, Dr Tayeb Haider, Basildon and Dr Ellie Meakins, Mid-Essex, Dr Donald McGeachy, medical director for the CCG Joint Committee, local GPs and community colleagues.

Pathway	Clinical Lead
Orthopaedics	Greg Packer
	Sean Symons
Renal Medicine	Gowrie Balasubramaniam
Stroke Care	Paul Guyler
	Ramanathan Kirthivasan
Cardiology	Stuart Harris
Gynaecology	Mandeep Singh
General Surgery	Emma Gray
	Bryony Lovett
Urology	Peter Acher
	Martin Nuttall
Emergency Pathway	Edward Lamuren
	Hagen Gerofke (AMU)
Vascular	Vijay Gadhvi
Respiratory **Gastroenterology**	Steve Jenkins, Marcus Pittman Duncan Powrie Ronan Fenton

21. You keep saying many proposed changes will affect only small numbers of patients – how are the changes cost effective?	The main objective of the proposed changes is to improve specialist care and patient outcomes. This is not a cost-saving exercise. By our teams working together across the three sites, we believe we will improve the quality of care we can provide for our patients. This is because working in larger teams improves experience and skill in some specialist services. A larger team offers more flexible working options, training, education, career development and improved uptake of new ideas to improve patient care.
22. Why can't more stroke specialist doctors who can remove clots be trained? Pay them! How does the UK compare with the rest of the civilised world in numbers of such specialists?? MORE FUNDING NEEDED.	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.
23. Consolidation of specialist teams will result in duplication of job roles and subsequent job losses if experiences in pathology are indicative – please confirm this won't happen	Please be assured that we are not anticipating any redundancies in clinical posts associated with the proposed changes. We do need to look at running costs for our services and we continue to do so. 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 associated costs in these areas. We are still in the early stages of redesigning corporate services so we are not in the position to comment on whether there will be any job losses.

24. Mentioned at the start that there is a GP shortage (all know) and that specialised nurses would be trained to support/cover shortfall in GPs but nurses are: a. Leaving service because of stress or going P.T or retiring b. Leaving country re: Brexit c. Not training re: no student bursarys Where will nurses come from?	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. Individual CCGs and NHS England have plans in place to enhance the current primary care workforce through continued recruitment and retention schemes and through enhancing the education and training of health and care practitioners to support GPs. Clinical commissioning groups have already started the development of primary care services, which will increase the resilience of general practice and enable patients to access a wider range of health and care services closer to home. You can find out more about the specific plans by contacting your local clinical commissioning group (CCG). Some examples may be found in the "Further Information" section of our website at http://www.nhsmidandsouthessex.co.uk/background/further-information/
25. Investing in our hospitals. £118 million. Yes but where and how are we getting them we are already running short?	The funds are identified for the STP and once any decisions are made we will submit business cases for the individual investment schemes to make use of the capital and redesign services. It is important to note that this capital will enable service changes and address some of the infrastructure and challenges faced by the hospitals, but it will not address all staffing and infrastructure requirements within the trusts, and our usual cycles and processes of prioritising investment will continue. Across the STP we are working together to identify how we

	can achieve efficiencies, reduce waste and improve the value of our services.
26. I am concerned that the senate council have no local knowledge only one is based on any of the 3 sites. Why are the decision makers not local and have no local knowledge?	The Clinical Senate is an independent function and there are purposefully no local clinicians involved as it is designed to be independent and free from any potential conflict of interest. The Senate is made up of experienced clinicians from across a range of specialties. The decision-makers are the five clinical commissioning groups (CCGs) of mid and south Essex, which have in-depth knowledge of the local area and health and care needs of the population.
27. What complex medical cases where there are several specialists care teams required?	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 patients 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.
28. How much investment is required overall for the changes proposed, but also to upgrade the degraded infrastructure and make good staffing deficits?	We have made a bid for £118m of capital funding part of which will be used to upgrade our infrastructure. It is important to note that this capital will enable service changes and address some of the infrastructure and challenges faced by the hospitals, but it will not address all staffing and infrastructure requirements within the trusts, and our usual cycles and processes of prioritising investment will continue. Across the STP we are working together to identify how we can achieve efficiencies, reduce waste and improve the value of our services. We must await the outcome of CCG decision making so that we can finalise infrastructure plans to implement proposals that are supported A summary of the financial plan for the next five years is available in the consultation documents, and explained in a summary sheet on finance, which is downloadable from our website at http://www.nhsmidandsouthessex.co.uk/resources/
29. Where is that deficit funding to come from?	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. All NHS organisations are able to make efficiencies every year, by taking advantage of new technology and different ways of running services. Making these annual efficiencies is "business as usual" for the NHS, rather than as a result of major service changes. Over the next five years, this would avoid around £372 million of potential, which is most of the potential overspend. Further ways in which we could avoid an overspend over the next five years would come, not from cuts in services, but from organisations working together to save on bureaucracy and management costs; and from developments in care and support for people at home and in the community that avoid serious illness and people having to go into hospital. Our plan for the next five years aims to avoid around £126 million of increased costs.

30. The presentation and consultation documents give the impression that most A&E is the main point of admission to inpatient care. Is that so? How does those admission compare with planned admissions?	Across our three hospitals, around 960 patients on average attend our A&E departments per day. Of these, around 300 patients per day on average are admitted to a hospital bed as an emergency. We perform thousands of treatments and procedures per day across our hospitals, many of these as day cases (which will, under the proposals, continue to occur on each hospital site). Around 380 patients per day are admitted to our hospitals for planned care.
31. You have made no reference to mental health provision. Can you please explain what is happening and money earmarked.	Mental health care is not the subject of the public consultation. The CCGs, and the CCG Joint Committee, are committed to improving the mental health care of our population, and will focus on the delivery of the Essex mental health strategy. A copy of the Mental Health and Wellbeing Strategy 2017 – 2021 is available at https://www.livingwellessex.org/news/lets-talk-about-mental-health/
32. I have been informed that these changes are based on research can we please have a full copy of this research including methods and methodology	The clinical evidence used to support the proposed changes can be found on our website at http://www.nhsmidandsouthessex.co.uk/background/clinical-evidence/ or you can request a printed copy from us by calling 01245 398 118.
33. Can I be assured that these proposals will not mean further privatisation of the NHS.	It is government policy that the NHS remains free at the point of delivery for all. Some services are already delivered by private providers, but under

	standard NHS contracts and specifications. This adds to the capacity and range of NHS services (e.g. using the private sector to deliver some operations when the NHS does not have the capacity). The NHS abides by current procurement law in relation to the tendering of NHS services.
34. What is the evidence for separating planned and emergency care?	Further detail on evidence considered in the preparation of proposals can be found here: http://www.nhsmidandsouthessex.co.uk/background/clinical-evidence/. The Keogh report from NHS England identifies that best practice is to segregate elective surgery from emergency care entirely through the use of dedicated beds, theatres and staff. This greatly reduces cancellations and improves outcomes and patients' journey through their treatment. The Royal College of Surgeons has reported that separating elective and non-elective work can reduce patient disruption and cancellations, and reduce rates of hospital-acquired infection. 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.

35. What continuity of care problems might arise as a result of patients being partially cared for in one place then moved to another?	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.
36. Dr Guylers' presentation was good – indicated all based on increased funding, 5 year plan. What is the likelihood of this model being funded and when?	Thank you for your supportive comments regarding the proposals on stroke care. Commissioners will make commissioning decisions on future arrangements when they have had the opportunity to review the consultation feedback and other key documents to support decision making.
37. Throughout the consultation there is a huge reliance on pre hospital care and prevention of attendances. As Southend has the second highest vacancy rate for GPs in the UK at present and the second highest number of GPs due to retire within the	Over the next five years, the whole system in mid and south Essex is working to a plan that transforms the way patients receive health and care services. Our focus is very much on supporting population health. This starts from before birth, supporting people (children and adults) to live healthy lives, and arming people with the tools to look after their health. We are also working to enhance the care patients receive locally, supporting GPs, community, mental health and social care services

next 5 years – why is there such reliance on primary care to prevent hospital admission? What will happen when these results are not delivered?	to work more closely together. Over time we expect this to reduce demand on hospital services so that we can continue to meet demand within expected population growth. 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.

38. Re: Your Care in the Best Place – developments over next 5 years. In light of the current nursing crisis (40000 unfilled vacancies). How do you propose to recruit and train 'advanced practitioners' in primary care. One in three nurses currently on the register are set to retire within the next 5 years AND the number of nurses entering training has declined drastically since the removal of the student nurse bursary. In real terms their pay has DECREASED by 14% since 2010. I don't believe that this proposal is sustainable due to the above. Also nurses with children and other family commitments will NOT want to travel away from their current site.	We absolutely recognise that workforce is a challenge. There is no simple solution, but we are 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 hospital proposals 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. Flexible working is important to many staff - working together across sites and in larger teams also offers more opportunity to support flexible working patterns, as well as innovative working arrangements such as rotational posts. Staff will not be required to move if they do not wish to.
39. You have done an excellent presentation but you will be aware of the sceptism in the audience. What we would like to know is it possible to make £400 million worth of cuts and still maintain, let alone improve services?	The predicted deficit figure relates to the financial state we would experience if we were to continue with commissioning and providing services in the way that we do currently. We recognise that we can make significant efficiencies in the way we deliver services now, and in future. We are not proposing to make cuts to services, we are proposing working in different ways to prevent ill health from developing, support patients to manage their conditions in a more structured way and improve the

	services we provide. Our summary sheet on finances provides further details (http://www.nhsmidandsouthessex.co.uk/wp-content/uploads/2018/01/Finance-summary.pdf) add in phone number too
40. Will Southend Hospital staff receive pay in line with Basildon Hospital	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 which 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.
41. Are outsourcing companies e.g. Capita Carillion involved – any plans to use such companies.	The hospital trusts do not have any outsourced contracts with Carillion. We currently use a variety of third party suppliers for corporate and other services in facilities, for example for catering and cleaning on our sites. The trusts will review insourcing/outsourcing options as part of our normal value for money processes, this is not related to the current proposals. There are no specific plans to outsource other services although this remains an option where this provides a good quality/value for money solution. The NHS abides by current procurement law in relation to the tendering of NHS services.
42. How can you guarantee that all the	Some £28m of the £118m capital investment we have been earmarked to

services will be able to work together? Not like when it was tried before but the wrong computers were purchased that were not compatible therefore a loss of money	receive will be used to ensure technology is upgraded – this will ensure differing systems across the three hospitals are able to communicate with each other and medical records can be accessed at all sites.
43. Your plans for managing hospital attendances are key to achieving your targets. Southend has the second highest vacancy rate for GPs in the UKand many GPs are due to retire. How can we be sure that you will address the number of GPs and where is your concrete plan for delivery of GP services by other staff? Is it not 'pie in the sky' to talk about nurses and pharmacists taking on other roles?	Over the next five years, the whole system in mid and south Essex is working to a plan that transforms the way patients receive health and care services. Our focus is very much on supporting population health. This starts from before birth, supporting people (children and adults) to live healthy lives, and arming people with the tools to look after their health. We are also working to enhance the care patients receive locally, supporting GPs, community, mental health and social care services to work more closely together. Over time we expect this to reduce demand on hospital services so that we can continue to meet demand within expected population growth. 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

44. I have recently been to a private medically health service for treatment under NHS. How do these costs fit/go/change in the new planned structures. I worry about cost/benefit re light of constraints	Where NHS treatment is provided by alternative providers, commissioners will pay private sector providers the same tariff (rate) as that paid to the NHS.
45. There is a strong emphasis on cost cutting strategies with terms such as "reduction and restriction of low value services " (9:5.2 full STP) a. What services procedures will this include? b. Who decides what is of low value? c. Will this mean older people will be prevented from some treatments?	All CCGs currently have service restriction policies in place. These policies set out the clinical criteria for a large range of medical treatments and procedures and are designed to help ensure they are only carried out where there is clinical evidence that they are effective, beneficial to patients, and also affordable within available funding. CCGs will, in the usual course of their work, review these policies on a regular basis and where appropriate consult on any changes. Please be assured that treatments are not restricted on the basis of a patient's age.
46. There is reference to treatment at integrated neighbourhood hubs – a. Where will these be located? b. How will these be funded? c. How will these be staffed? d. What will they be treating?	CCGs are working with GPs, community and mental health providers and local authorities on developing their local plans for service delivery. Plans are available from the relevant CCG.

47. Chapter 10 focuses on clinical assurance behind the decisions being taken. Given that EAHSN independent report cites the limited availability of research and published literature relating to the exact proposed model how can reliance be put on decisions taken based upon it.	We will make use of the available published literature and national guidance, combined with local clinicians' knowledge of their services and information from our own processes and systems, to bring together our best plans. There is not always a large volume of definitive evidence from other areas, but detailed reviews by the external independent clinical experts of the East of England Clinical Senate will assist in examining and challenging the evidence. Where we have felt it necessary to seek out further evidence, we have commissioned specific research, such as for the proposed model for stroke (the independent report from UCL Partners on national and international clinical evidence on stroke care can be found on our website here: http://www.nhsmidandsouthessex.co.uk/background/clinical-evidence/) Our local commissioners, in supporting this consultation have taken advice from the East of England Clinical Senate. The Senate has reviewed clinical proposals and their supporting evidence base on three occasions in 2016 and 2017, and has provided assurance to CCGs. During April 2018, proposals will again have a detailed review by the senate, and all feedback will be included when any decisions are taken in the Summer. The role of Clinical Senate is to be a source of independent, strategic clinical advice and guidance to health commissioners and other stakeholders to help them make the best decisions about healthcare for the populations they represent. We can also make sure that plans are

	robust by putting measures and monitoring processes in place to check that they are implemented properly, and, as we work within them, that they are working well and if there are further improvements as plans progress. Previous reports from the Clinical Senate may be found on our website at http://www.nhsmidandsouthessex.co.uk/background/further-information/
48. Given that the published literature review has been given a 60% weighting is based on articles that are almost 30 years old and a higher proportion from countries outside the UK with different health care systems, how can the public have confidence that decisions based upon this clinical evidence are in the best interests of patients?	See response to question 47, above
49. The finance section refers to 'redundancies in the acute sector' a. Will these be voluntary or compulsory? b. How many jobs are at risk?	Please be assured that we are not anticipating any redundancies in clinical posts associated with the proposed changes. We do need to look at running costs for our services and we continue to do so. 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 associated costs in these areas. We are still in the early stages of redesigning corporate services so we are not in the position to comment on whether there will be any job losses.
50. I am concerned that there is a lack of specific knowledge within the clinical senate with none of the members being based as the 3 main sites. The only link to the local area is a member of one of the CCGs with over 20 members coming from the wider geographical area. A high proportion come from more rural less densely populated areas, meaning that they are unlikely to experience the high volumes of traffic and congestion that is common between the 3 sites. Why are the decision makers not locally based?	The Clinical Senate is an independent function and there are purposefully no local clinicians involved as it is designed to be independent and free from any potential conflict of interest. The Senate is made up of experienced clinicians from across a range of specialties. Once the Clinical Senate has completed its second stage review (after the consultation process has ended), the proposals will go through a further review by our Clinical Cabinet (a panel of local senior doctors, nurses and health care professionals from across all organisations in mid and south Essex, who will collectively look at the proposals and provide feedback). The decision-makers are the five clinical commissioning groups (CCGs) of mid and south Essex, which have in-depth knowledge of the local area and health and care needs of the population.
51. What local clinicians are backing these plans?	A list of local clinicians who have led the development of our current proposals (along with clinical teams across the three sites) is as follows. In addition there has been close involvement of the Medical Director (Dr Ronan Fenton), and Chief Medical Officer (Dr Celia Skinner) for the three hospitals, as well as the three site medical directors (Mr Neil Rothnie,

<table>
<tr><td></td><td>Southend, Dr Tayeb Haider, Basildon and Dr Ellie Meakins, Mid-Essex,Dr Donald McGeachy, medical director for the CCG Joint Committee, local GPs and community colleagues.

<table><tr><th>Pathway</th><th>Clinical Lead</th></tr><tr><td>Orthopaedics</td><td>Greg Packer</td></tr><tr><td></td><td>Sean Symons</td></tr><tr><td>Renal Medicine</td><td>Gowrie Balasubramaniam</td></tr><tr><td>Stroke Care</td><td>Paul Guyler</td></tr><tr><td></td><td>Ramanathan Kirthivasan</td></tr><tr><td>Cardiology</td><td>Stuart Harris</td></tr><tr><td>Gynaecology</td><td>Mandeep Singh</td></tr><tr><td>General Surgery</td><td>Emma Gray</td></tr><tr><td></td><td>Bryony Lovett</td></tr><tr><td>Urology</td><td>Peter Acher</td></tr><tr><td></td><td>Martin Nuttall</td></tr><tr><td>Emergency</td><td>Edward Lamuren</td></tr><tr><td>Pathway</td><td>Hagen Gerofke (AMU)</td></tr><tr><td>Vascular</td><td>Vijay Gadhvi</td></tr><tr><td>Respiratory</td><td>Steve Jenkins, Marcus Pittman Duncan Powrie</td></tr><tr><td>Gastroenterology</td><td>Ronan Fenton</td></tr></table></td></tr>
<tr><td>52.Why don’t Government increase the</td><td>We will include your view in our report on feedback.</td></tr>
</table>

NHS insurance to cover the additional cost?	
53. Does the free bus service apply to staff?	Staff could make full use of the proposed family transport service. Our plans will be fully worked through for this service and presented to the CCG Joint Committee to aid decision-making.
54. How many jobs will be lost with the merger plan?	The proposed trust merger is an entirely separate process to the public consultation and is not related to any of the proposed service changes. We do need to look at running costs for our services and we continue to do so. 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 associated costs in these areas. We are still in the early stages of redesigning corporate services so we are not in the position to comment on whether there will be any job losses.
55. For cardiology cases, if an operation is diagnosed at the local hospital, how quickly will the patient be transported to Basildon and be operated on?	It is already the case that patients requiring urgent cardiothoracic procedures are transferred between hospitals to be treated at the specialist centre at Basildon Hospital. The speed of transfer would be dependent on the patient's clinical need.

56. How are you going to recruit more nurses and doctors and how will you afford to pay for them? Does the current bursary scheme for nurses training, work in helping to recruit or does it deter would be nurses from training because of the debt.	We will continue to proactively recruit locally, national and overseas, we intend to refresh our marketing approach, offer schemes to retain our nurses and doctors and enhancing our recruitment processes. We currently spend significant sums of money on hiring locums and agency staff to cover rota gaps- therefore an increased substantive workforce will be affordable within current levels of funding. It is too early to say whether the removal of nurse bursaries will impact on the future nursing workforce. The Trusts are working closely with local university providers and in the last intake (September 2017) all three Trusts doubled their numbers of newly qualified nurses compared to previous years. We will be developing a range of strategies across group to increase our recruitment within this area. The opportunity of the group means that we can create a wealth of job opportunities, skills development, training and education and the ability to learn from clinical experts. We will build on these opportunities to create an attractive offer to our staff.
57. Have you done an environmental impact assessment on the significant increase in transportation across Essex?	An environmental impact assessment will be included in the detailed transport plan which will be submitted to the CCG Joint Committee to support its decision-making.

58. Talking of £118m CAPITAL what is the projected cost cut (revenue) as a part of this STP? And how are cuts contributing to the required £2.2bn NHS savings?	There is not specifically a cost reduction as a result of the capital spend as the rationale for the investment is to ensure that facilities are of the highest quality needed to support patient services. There are however anticipated revenue savings as a result of the wider acute reconfiguration which could generate up to £20.8m savings per annum once fully implemented (likely to be from 2021/22). These are as a result of efficiencies in four areas – • Productivity gains through reduced patient length of stays and pre-procedure stays, • economies of scale in the delivery of services, • reductions in the utilisation of agency staffing • through increased capacity which means some of the activity currently undertaken outside of our area (notably in London) can now be delivered within the three local hospitals. A summary of the financial plan for the next five years is available in the consultation documents, and explained in a summary sheet on finance, which is downloadable from our website at http://www.nhsmidandsouthessex.co.uk/resources/
59. Care in the community should be in place before services are cut in acute care. Will they be and what is the funding for this?	Firstly, we do not have plans to cut services in acute care. The proposals we are consulting on relate to: - Maintaining and enhancing A&E services at each site - Consolidating some specialist services which need a hospital stay

	on one site - Developing a specialist stroke unit on the Basildon Hospital site - Separating some planned operations from emergency care - Moving some hospital services closer to home (Eg. in Orsett where we are proposing to more services from Orsett Hospital to centres in the community) 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. The CCG Joint Committee will reach a decision on the proposals, considering the feedback to the consultation and further detail on proposed implementation plans.
60. If your proposals depend on preventing people coming to A&E and in getting people out of hospital and into the community, how will this ever work given that councils face a funding crisis and that residential and domestic care companies face tighter contracts? There is not enough social care provision now! What will you do if the right social care provision continues to be unavailable?	Over the next five years, the whole system in mid and south Essex is working to a plan that transforms the way patients receive health and care services. Our focus is very much on supporting population health. This starts from before birth, supporting people (children and adults) to live healthy lives, and arming people with the tools to look after their health. We are also working to enhance the care patients receive locally, supporting GPs, community, mental health and social care services to work more closely together. Over time we expect this to reduce demand on hospital services so that we can continue to meet demand within expected population growth. This joint working approach will also have the benefit of supporting discharge from hospital.

61. As the £118 million is only 'ear marked' at present and not in the bank for our 3 hospitals; 1. Has the criteria for accessing the £118 million been set? 2. What is it? 3. Does the 1st slide on page 6 of our handout meet it? 4. If any of our list doesn't meet the criteria where's the funding coming from?	We had to go through a bidding process and the additional facilities we need are all costed. The plans went to the Treasury. Following the consultation process, and decision-making, we have to submit business cases in stages to release the capital money. The criteria for that are based on an assessment of whether the changes will deliver the benefits to patients that we have described within the pre-consultation business case that supports all of these changes. We need to articulate we are spending the money on the things that deliver the best outcomes for patients. In the next stage of the process for accessing funds we would need to go into more detail on potential patient benefits. We are not bidding against anyone, the funding has been identified and we were named in the Autumn Budget as £118m identified for mid and south Essex.
62. Does the amount for each hospital including funding the transport transfers for patients and free transport for visitors? Which would take priority equipment (e.g. MRI machines) or transport?	Funding for clinical and family transport is identified within the pre-consultation business case developed as the basis of proposals. Associated infrastructure requirements within the £118m includes necessary equipment, e.g. for theatres, critical care beds and where needed to increase diagnostics capacity.

63. Where will the funding for specialist staff be coming from?	We currently spend significant sums of money on hiring locums and agency staff to cover rota gaps- therefore an increased substantive (permanent) workforce will be affordable within current levels of funding.
64. Will the transport have blue flashing lights to indicate emergency vehicles? As at present most/some thoughtful move out of the way for the emergency services on already congested roads.	The precise design of the inter-hospital transfer service is still being developed and the type of vehicles, etc. will depend on patient need. Of course it is important to transport patients quickly and when necessary, emergency priority access will of course be used. All vehicles will be equipped to national ambulance standard and so capable of travelling under blue light should the need arise. A detailed clinical specification for inter-hospital transfers depends on what is agreed (by the clinical commissioning groups) for future hospital services, following the consultation. This will lead to further clinical work to develop the protocols for safe patient transfers. In anticipation of commissioning decisions for hospital services, we are working with East of England Ambulance Service. The London Ambulance Service and with colleagues from the major trauma networks. This builds on past and current experience in practice - where we already safely transfer patients across the county and into London to access the best available specialist care, when needed.

65. Will staff be <u>expected</u> to travel across the three sites	The only staff we will expect to travel between sites would be consultant staff in the areas we are consulting on; they may be expected to work across more than one site in order to undertake their work (e.g. orthopaedic surgeons undertaking emergency operations at one site and planned operations at another). We would not expect consultant staff to have to work across more than two hospitals. In the case of non-consultant staff there may not be an expectation for them to work across sites, but if we expected a staff to travel to work across sites, this would be subject to a consultation process. Where a member of staff expresses an interest in working across more than one site to develop their expertise and career in a particular service area, for instance in a specific specialism which we will be able to newly provide as a result of creating these specialist centres, then we will obviously aim to make this happen.
66. If creating centre of excellence for stroke at all hospitals – why not other areas of health?	There are clear clinical standards and expectations placed upon acute trusts to provide specialist stroke care to maximise benefits for patients, specifically for the first 72 hours post-stroke. We are proposing to develop a specialist stroke unit at Basildon Hospital for this purpose. Evidence and published guidance is that this unit is best placed at Basildon, co-located with specialist vascular and interventional radiology services. The current proposals lay out plans to create several centres of excellence across our system for patient benefit – in addition to, and in some cases, enhancing those we already have at Basildon for Cardiothoracic Care, Southend for Cancer and Broomfield Hospital for Plastic Surgery, Ear, Nose

	and Throat and upper gastrointestinal surgery and Burns. Proposals describe consolidation of specialist vascular and medical conditions (such as renal medicine) to Basildon, Gynaecological surgery to Southend and General Surgery and Benign Urology to Broomfield, for example.
67. Free transport is not going to meeting the needs of carers – carers/family increase patient improvement time take "hours" to get there with road traffic.	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.
68. How can savings mean more specialist teams?	We currently spend significant sums of money on hiring locums and agency staff to cover rota gaps attempting to maintain specialist services on several sites - therefore an increased substantive workforce will be affordable within current levels of funding.
69. What will be the cost of losing staff that are trained and integrated cost of redundancy as suitable alternatives not available?	Please be assured that we are not anticipating any redundancies in clinical posts associated with the proposed changes. We do need to look at running costs for our services and we continue to do so. 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 associated costs in these areas. We are still in the early stages of redesigning corporate services so we are not in the position to comment on

	whether there will be any job losses.
70. How many jobs/trained NHS workers will leave due to these changes i.e. move to a different hospital, lack of opportunities in their own hospital as services removed	We expect that from working in larger teams across sites, staff will experience greater opportunities for career development, training and education, innovative working patterns, flexible working, etc. We are working hard to continually discuss the proposed changes with our staff and many have already starting to work in different ways. While we cannot categorically say how individual staff members will react, we do think our plans offer the best chance of recruiting and, most importantly, retaining the dedicated and well-trained staff that we have.
71. When will you know how many jobs for workers will change?	A small number of jobs may change as a result of the proposals, primarily in specialist service areas. Such changes are being discussed with staff as part of service design and preparing these proposals. If the decision is taken by commissioners to proceed, implementation of changes will be carried out in consultation with any staff members affected and with the appropriate union representatives.
72. Pathology services for Southend were outsourced to a private company. And I hear many staff resigned due to unacceptable working conditions recently they've been in media following a cervical smear, catastrophe endangering the lives of many people. Money has been taken out of the NHS and now profiting a private company.	The pathology service has been set up as a joint venture between Basildon and Southend NHS Trusts and a private company to deliver an essential service across the locality pooling expertise from the public and private sector. You may have read in the media that a re-examination is currently taking place of a number of cervical screening tests. This is because an issue was identified in the cervical screening lab service provided by Pathology First following a routine Public Health England Screening Quality Assurance visit

How can you assure us that what has happened in pathology won't happen to the rest of the services?	in June 2017. An investigation was immediately launched and it was agreed that 2,500 samples should be reviewed from the period April 2016 to September 2017, from women that were aged between 24 and 29, for whom it was their first smear test, and a small number of women in their 60s for whom it was their last smear test. It is government policy that the NHS remains free at the point of delivery for all. Some services are already delivered by private providers, but under standard NHS contracts and specifications. This adds to the capacity and range of NHS services (e.g. using the private sector to deliver some operations when the NHS does not have the capacity). The NHS abides by current procurement law in relation to the tendering of NHS services.
73. How are family's going to get from Shoeburyness to Chelmsford or Basildon at 3am without transport. If the patient is the only one who can drive. How much will this cost 365 days a year?	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. A detailed plan on transport arrangements, with costings, will be presented

	to the CCG Joint Committee to aid their decision-making.
74. You are proposing transferring the sickest patients – as stated by Dr Fenton in The Echo, totalling 25 patients per day. These will need a specialist tam including a highly skilled doctor or nurse escort. As staff shortages are documented as part of the reason you say service relocation and centralisation are required, how can you even consider this as part of the solution? Where are you getting these staff from to man a 24/7 internal transfer service? And who will train them?	It is not the intention to transfer the sickest patients, rather to treat and stabilise immediate issues at the presenting hospital and then to transfer for ongoing complex care. The average number of patients who may need to transfer to a different hospital for urgent care is 15 per day– this is an average and as such will differ on a daily basis. We are currently running a number of real-time audits of patients presenting to our three A&E departments who may be transferred should the proposals be accepted and implemented in order to help validate these modelling assumptions. Currently this audit is confirming that the average number of patients requiring transfer per day is in line with our original calculations (i.e. an average of 15 per day). Our plans for a clinical transfer service include a dedicated fleet of vehicles, and trained clinical staff to escort patients on their journey. The number and skillset of the staff accompanying the patient will depend on the patient's need. We are working closely with the ambulance service and with colleagues from major trauma centres across the region on clinical protocols and transfer standards and working to define appropriate training programmes for staff.
75. If a patient is transferred to Broomfield – for major surgery – how are they going to get home? From your figures 1200 people will be using	As with any patient requiring inpatient care, their discharge will be carefully planned with the patient and their family. This will enable us to assess the patient's needs on discharge, including transport. Many patients are taken home from hospital by family or friends, some are taken by our dedicated

transport a week – what if they live in Great Wakering – where will they get transport from?	patient transport service.
76. Have you formally surveyed the staff at the three sites to gauge how willing they would be to travel? There are multiple opportunities for many staff to leave the trusts and work in the community or travel to London. How has this been quantified and risk assessed?	The only staff we will expect to travel between sites would be consultant staff in the areas we are consulting on; they may be expected to work across more than one site in order to undertake their work (e.g. orthopaedic surgeons undertaking emergency operations at one site and planned operations at another). We would not expect consultant staff to have to work across more than two hospitals. In the case of non-consultant staff there may not be an expectation for them to work across sites, but if we expected a staff to travel to work across sites, this would be subject to a consultation process. Where a member of staff expresses an interest in working across more than one site to develop their expertise and career in a particular service area, for instance in a specific specialism which we will be able to newly provide as a result of creating these specialist centres, then we will obviously aim to make this happen
77. Where funding for transfers 29 per day across 3 centres = 10,324 journeys a year!! Where money how number of vehicles	Funding for the clinical transport and family transport service has been allowed for in the pre-consultation business case. We are working on detailed transport plans, including costings, that will be presented to the CCG Joint Committee to aide their decision-making.
78. How does the proposals allow recruit and retention of staff where are they	Our plans for teams to work together across the three hospitals offer improved opportunities for staff in terms of care development, training and

now? Budget?	education, flexible working, etc. We know from other areas that offer such opportunities it does help with recruitment and retention. We currently spend significant sums of money on hiring locums and agency staff to cover rota gaps- therefore an increased substantive (permanent) workforce will be affordable within current levels of funding.
79. Dr Guyler ignored the content of 'stroke slide' i.e. Basildon as Centre?	Proposals are for Basildon Hospital to be the site of the Specialist Stroke Centre where patients from across the three hospitals would receive hyper-acute care which has been shown to improve outcomes, as detailed in the consultation document.
80. £118m is it in the budget of the merged Trust's or each individual Trust?	The £118m relates to the bid for capital funding to support the proposed changes across the three hospitals. It is not the revenue budget for the three hospitals. The proposed merger of the three trusts is separate to the public consultation.
81. Why has the choose and book system been changed. Doctors referral letters now go to triage where non clinical people decide	The NHS e-Referral Service (e-RS) is a service that offers electronic and telephone booking. Patients can choose their initial hospital or clinic appointment, book it in the GP surgery at the point of referral, or later at home on the phone or online Triage processes are in place in some areas. This is to ensure that the referral contains adequate information, is directed to the appropriate place, and is for a treatment that is currently supported by the CCGs service restriction policy. All referrals are triaged by clinical staff.

82. Question for Dr Skinner – Is there going to be a stroke ambulance equipped with a CT scanner operating in Southend? Does Dr Guyler think this is a good thing?	A stroke ambulance is not included in these proposals. In other countries, cities such as Berlin have ambulances with a CT scanner in them to diagnose stroke earlier. In Southend for a while, local clinicians have been looking at this model and have good links with Germany. There is consideration of a trial of this ambulance for the region, and we are hopeful we may be able to do so. What we do not know is whether this would work in a more distributed geographical region than in a city. We would like to try it out. If this does seem feasible, it could be in addition to the hospital service changes proposed at the moment, but until we know the model would be better, we would not be able to invest in the development.
83. What will you do if a patient refuses to be transferred? What will you do if a doctor refuses to transfer a patient as it is not in their best interests? What happens when a patient is so unwell it is unsafe to transfer them yet specialist required to treat them are no longer at the Southend Hospital site?	If a patient with capacity refuses to transfer to a location which is thought to be best for their care their wishes will be adhered to and every effort will be made to optimise care where they wish to remain, including specialists travelling to the patient if required or directing optimal care from the specialist centre. If a clinician or the clinical team consider patient transfer not to be in the patient's best interest then the patient will not transfer and every effort will be made to optimise patient care including specialists travelling to the patient or directing care from the specialist unit.
84. What data is your analysis based upon regarding travel times and traffic studies. Where is the evidence for your assertions?	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/

85. Where will they treat an elderly patient who has had a stroke, fractured their hip and has gastrointestinal issues – as these will be at three different sites	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.
86. What is planned for patients not ticking the box for ambulance transport yet cannot get on a bus?	In these proposals if a patient was being transferred between hospital sites for urgent treatment, this would be via clinical transport.
87. Regarding respiratory transfers will the Royal Brompton or Addenbrookes not now be appropriate	Pathways to tertiary referral services such as those at Brompton and Addenbrookes remain unchanged in these proposals.
88. We are aware that at your STP meetings, staffing modelling showed that EVEN MORE staff would be required to run a hub and spoke model for all services which were analysed, yet you are still claiming that this is a solution to staffing issues.	The intention is not to reduce staffing numbers across the acute hospitals. Currently there are issues with attracting staff to funded posts and these either remain unfilled or occupied by locum health care workers. The proposed models of care allow improved professional opportunities for staff and will improve our ability to attract and retain staff to this area. The models proposed provide both better job satisfaction and more sustainable on call rotas for staff who currently are working to challenging out of hours shift patterns.

89. How can running a whole new transport service for relatives and patients save money? Where are the projected costs for running this service and how will this money be saved from elsewhere? Are the already under-resourced East of England Ambulance Service going to be expected to assist with the transfers?	The proposed family transport service does not save money, it is proposed to relieve the concerns that patients have raised regarding how they and their relatives and friends might be able to visit a more distant hospital. There are various ways that this service could be delivered and we are exploring these. A detailed plan, with costings, will be provided to the CCG Joint Committee to aide their decision-making. With regard to clinical transport, we recognise the pressures that the East of England Ambulance Service Trust are under at present. We are drawing up detailed plans for the clinical transport model. We may run this service "in house", or may procure a service. East of England may wish to bid for this work. As per usual procurement rules, we would need to ensure the provider was able to deliver the service to the required standards.
90. Your modelling emphasises the separation of emergency and planned care for these changes to be successful. You state only a 'minimal' number of people will be transferred between sites yet this actually totals 775 patients per month – not very minimal in our opinion – so how are these two statements not mutually exclusive?	In the context of the c 3300 patients per day that attend an outpatient appointment and the c380 people a day that visit our hospitals for a planned operation, the average of 14 patients per day who may be referred to a more distant hospital for treatment is small. We absolutely recognise however, that the impact on families could be significant. 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. A detailed plan on transport arrangements, with costings, will be presented to the CCG Joint Committee to aide their decision-making.

	Patients will continue to be able to exercise choice at the point of referral and if they do not wish to be treated within mid and south Essex, they can choose to be treated at any other hospital that provides the service they need. This should be discussed with the GP at the point of referral.
91. A few months ago the trusts said there would be no merger now there is a proposal to do that. Why should we believe our A&E and stroke units will not eventually go?	The three rust boards have supported progressing with a merger of the three hospitals. This is entirely separate to the proposed service changes which are the subject of the current consultation and decided upon by the five CCGs. Regardless of whether the trusts merge, any further service change would be subject to a full public consultation. All NHS organisations have a duty to consult on significant service change.
92. If someone who would now have a clot removed in Southend but has to in future go to Basildon, what danger would that present to the patient?	The ability to provide a thrombectomy (clot removal) service seven days a week would be a vast improvement on the current provision - which is on a "best endeavours" system in Southend (i.e. it depends on individual doctors happening to be available, so is only available on certain days and if certain individuals are available). The difference in travel time from Southend to Basildon following initial stabilisation at Southend would not outweigh the advantage of having increased access to this service. Currently when the service is not available patients have to travel to Queens Romford or Addenbrookes Hospital.

93. How will they take the publics' opinion on board? If people don't want this, can and how can it affect the plans?	We are running this consultation to gather the views of the public living in mid and south Essex. The consultation includes a range of public events, focus groups, patient group meetings and the use of social media. We encourage people to complete our on-line survey to give us their views, or write to us; all feedback will be independently analysed at the close of consultation and this report will be considered by the CCG Joint Committee when it takes decisions on the proposed changes. In making the decision the Joint Committee will take into account a range of information and evidence when looking at the future of services in mid and south Essex. It is not a referendum, but it is important to express views and ideas as feedback from patients and the public, along with equality impact assessments, will form an important part of that process. Our aim is to provide the best service to our whole population, using the resources we have available.
94. Why is there no-one from the ambulance service here? Surely we should have some data and detail from them?	The services provided by the ambulance service are not subject to this public consultation. However, we have, and continue to, work closely with colleagues in the ambulance service as we develop our proposals and they have been involved in our discussions. Senior colleagues from the ambulance trust form a part of our local Clinical Cabinet and are central to all our discussions. We will relay views from earlier events and will endeavour to have representatives from the ambulance service at future public events if possible.

95. All of these improvements need to be planned, funded and embedded before any services are withdrawn. I'm completely opposed to <u>any</u> privatisation viz. The scandal about 55,000 smear tests that need to be re-done due to the failure of a private provider (announced this week)	The CCG Joint Committee will take decisions on whether the proposals will be implemented. An important part of our assurance processes if we move to implementation will be to ensure the right conditions for service change. The pathology service has been set up as a joint venture between Basildon and Southend NHS Trusts and a private company to deliver an essential service across the locality pooling expertise from the public and private sector. You may have read in the media that a re-examination is currently taking place of a number of cervical screening tests. This is because an issue was identified in the cervical screening lab service provided by Pathology First following a routine Public Health England Screening Quality Assurance visit in June 2017. An investigation was immediately launched and it was agreed that 2,500 samples should be reviewed from the period April 2016 to September 2017, from women that were aged between 24 and 29, for whom it was their first smear test, and a small number of women in their 60s for whom it was their last smear test. It is government policy that the NHS remains free at the point of delivery for all. Some services are already delivered by private providers, but under standard NHS contracts and specifications. This adds to the capacity and

	range of NHS services (e.g. using the private sector to deliver some operations when the NHS does not have the capacity). The NHS abides by current procurement law in relation to the tendering of NHS services.
96. Care agencies are stepping out of Local Authority (LA) contracts as they cannot deliver the services at the price. This means vulnerable people are becoming more frail and desperate – how is the plan going to deal with this issue when (LA) funding has been cut??	We recognise that the care market is stretched at present and our local authority colleagues are working hard to reduce the impact of this. Over the next five years, the whole system in mid and south Essex is working to a plan that transforms the way patients receive health and care services. Our focus is very much on supporting population health. This starts from before birth, supporting people (children and adults) to live healthy lives, and arming people with the tools to look after their health. We are also working to enhance the care patients receive locally, supporting GPs, community, mental health and social care services to work more closely together. This will include proactive identification of patients requiring care planning and additional support. Over time we expect this to reduce demand on hospital services so that we can continue to meet demand within expected population growth. This joint working approach will also have the benefit of supporting discharge from hospital.
97. Shortage of GPs, midwives, psychiatric nurses, health visitors, social workers –	We recognise that we face significant challenges in primary care – individual CCGs and NHS England have plans in place to enhance the

how can primary services be improved when staff not available?	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
98. Isn't prevention services an area that has already been cut? Of little use to over 60s. Social care needs major input of funds	We are clear that we need to work harder on disease prevention and on helping people to self-care. We are working with local authority partners, GP practices, community and mental health services and the voluntary sector to achieve this. That said, we absolutely recognise that we have a cohort of patients who have already developed ill health that need our support. Our plans for local health and care and developing localities are aimed at ensuring GPs and primary care teams can focus their attention on the patients that need the most care and support.
99. It is not clear from this form that the questions are focussed on primary care	The improvements we are making in primary care are not the subject of this consultation but provide helpful context to the system wide changes we need to make.
100. For Tom Abell – Please can you advise us if you think that Hyper Acute Stroke Units are a good thing?	Yes.

So if they provide such good outcomes for stroke patients, then why did you block the formation of a Hyper Acute Stroke Unit several years ago when you were part of the Basildon and Brentwood CCG? Are you actually telling us that patients have been dying or suffering disability for all those years but now suddenly it is a good thing. PLEASE EXPLAIN	What we did not have previously, but we now have in mid and south Essex, is our clinicians working together. There was not, previously a consensus between our consultants that this was the right thing to do. Since then there have been many more conversations between the clinical bodies of the three hospitals to establish this as the consensus way forward. Dr. Guyler also expressed a desire to move forward, as we are now at a new level for stroke and if we work together we can have better stroke services, he felt this should have been done in 2011, but now we will move on and gain senior support to take forward discussion with commissioners about thrombectomy.
101. For Paul Guyler: The stroke service is very important to the people of Southend therefore can we hear a detailed summary of the exact plans for stroke patients in Southend from Dr Guyler please? Follow up question… So Dr Guyler, these plans sound very positive and would appear to be in the clinical best interests of Southend patients. Can you tell us if these plans are guaranteed to happen and if so,	We want the best standard for stroke for the best outcomes, absolutely. That is why clinicians have worked together and we want the right patients to get to the specialist stroke unit at Basildon, to fund the right scans, and that funding is identified. For thrombectomy, to develop this service past that currently being delivered through the best endeavours of the specialist doctors, to more patients in Southend, Basildon, wherever, that has to be funded through the commissioners. This is not STP funding, it is the commissioning model. We will fight for that and we are in active conversations about that now with commissioners. There are lots of benefits to working together and Dr. Guyler stated a desire to get on with the new service improvements, and that it will take time to train, etc. for new treatments. As stated by Dr. Guyler, clinicians will not operate a model that is wrong for patients, and if there is anything that it turns out we cannot do and need to change the model in a

when will they start?	significant way, he will not go ahead as we will not be providing the best care.
Follow up question… So Dr Skinner, can YOU guarantee here and now that the STP are willing to invest the necessary money needed for the stroke interventional service and further guarantee that there will be 24/7 MRI scanning at each hospital, a fully staffed acute assessment team 24/7 at each hospital and a thrombectomy service covering the region??	We have been allocated capital by the Treasury which includes funding for stroke e.g. scanning capacity for MRI early in the pathway, changes needed to the building at Basildon for the intensive acute stroke care. After that, in terms of a thrombectomy service, the trusts are behind developing that and want it to happen, but this activity needs to be funded by NHS England Specialised Commissioners. This funding is not provided from the Trusts, it is income we would get for delivering that care.
When is this going to happen and is there a formal agreement for the investment for this to take place confirmed? Also, is it true there will be a stroke ambulance equipped with a CT scanner operating in Southend? Dr Guyler, do you have anything to say about the stroke ambulance and also can we ask, if your vision for stroke services detailed here tonight does not	A stroke ambulance is not included in these proposals. In other countries, cities such as Berlin have ambulances with a CT scanner in them to diagnose stroke earlier. In Southend for a while, local clinicians have been looking at this model and have good links with Germany. There is consideration of a trial of this ambulance for the region, and we are hopeful we may be able to do so. What we don't know is whether this would work in a more distributed geographical region than in a city, so what we would like to do is try it out. If this does seem feasible, it could be in addition to the hospital service changes proposed at the moment, but until we know the model would be better, we would not be able to invest in the development.

materialise, where are we then with the stroke service?	
102. The consultation includes plans which we know DO NOT have clinician approval – for example the transfer of people on NIV (non-invasive ventilation), pneumonia and pleural disease. Clinicians have specifically told us these patient will not be transferred. Why are you even consulting on this and why are you stating they will have a better outcome when there is no clinical evidence to support this.	There are acknowledged difficulties in transferring patients requiring NIV (Non Invasive Ventilation). This has been highlighted by a number of clinicians. In medicine there are frequently differences of opinion expressed between colleagues. Discussion continues with clinicians regarding whether there is an advantage to concentrating this patient group's treatment on one site. Should it be concluded that there is an advantage then the issues around transport of this patient cohort will be addressed. This is a patient cohort which is successfully managed in this way in other parts of the country and we have been in discussion with these areas regarding the optimal transport management. Critically ill patients are transported daily between hospitals right now by highly experienced inter-hospital patient transfer teams. It is understandable and correct for clinicians who are not used to actually transporting critically ill patients to raise concern which is why we are including these colleagues together with experts in actual patient transport in the development of protocols.
103. There has been no cross-site consultation or agreement for some of the changes which you are consulting on – for example – gastroenterology, orthopaedics and trauma therefore	A list of local clinicians who have led the development of our current proposals (along with clinical teams across the three sites) is as follows. In addition there has been close involvement of the Medical Director (Dr Ronan Fenton), and Chief Medical Officer (Dr Celia Skinner) for the three hospitals, as well as the three site medical directors (Mr Neil Rothnie,

why are you going ahead with this when it has not been clinically led or agreed?	Southend, Dr Tayeb Haider, Basildon and Dr Ellie Meakins, Mid-Essex, Dr Donald McGeachy, medical director for the CCG Joint Committee, local GPs and community colleagues.

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Renal Medicine	Gowrie Balasubramaniam
Stroke Care	Paul Guyler
	Ramanathan Kirthivasan
Cardiology	Stuart Harris
Gynaecology	Mandeep Singh
General Surgery	Emma Gray
	Bryony Lovett
Urology	Peter Acher
	Martin Nuttall
Emergency	Edward Lamuren
Pathway	Hagen Gerofke (AMU)
Vascular	Vijay Gadhvi
Respiratory	Steve Jenkins, Marcus Pittman Duncan Powrie
Gastroenterology	Ronan Fenton

104. Is it true that Pat Oakley (independent advisor to the NHS) has suggested that the only way to manage orthopaedic demand is to build a new, independent orthopaedic unit outside of the 3 hospitals at the junction of the A13 and A130? How do you foresee service provision at Southend if this is pursued?	Dr. Pat Oakley has spoken to staff in the NHS locally as part of some workshops to help develop thinking about future strategies, technological advancement and workforce change; she aims to arouse ideas. As part of her approach she often presents challenging, unfamiliar or unusual proposals to stimulate debate – for these purposes, such points on occasion may be hypothetical rather than directly informed by specific local circumstances. Any suggestions made by Dr Oakley in this context should not be considered as planning assumptions or proposals which will be pursued at this time. The specific example mentioned here is not something that is part of current proposals or this consultation.
105. You are proposing transferring the sickest patients – as detailed by you in the Echo totalling 25 patients per day – these will need a specialist team including a highly skilled doctors or nurse escort to do so. As staff shortages are documented as part of the reason you say service re-location and centralisation are required, how can you even consider this as part of the solution? Where are you getting these staff from to man a 24/7 internal transfer service? Who will train them?	It is not the intention to transfer the sickest patients, rather to treat and stabilise immediate issues at the presenting hospital, and then to transfer for ongoing complex care. The average number of patients who may need to transfer to a different hospital for urgent care is 15 per day– this is an average and as such will differ on a daily basis. We are currently running a number of real-time audits of patients presenting to our three A&E departments who may be transferred should the proposals be accepted and implemented in order to help validate these modelling assumptions. Currently this audit is confirming that the average number of patients requiring transfer per day is in line with our original calculations (i.e. an average of 15 per day). Our plans for a clinical transfer service include a dedicated fleet of vehicles, and trained clinical staff to escort patients on their journey. The number and skillset of the staff accompanying the patient will depend on the

How can running a whole new transport service for relatives and patients save money? Where are the projected costs for running this service and how will this money be saved from elsewhere? Are the already under-resourced East of England Ambulance Service going to be expected to assist with the transfers? (Same as Q93)	patient's need. We are working closely with the ambulance service and with colleagues from major trauma centres across the region on clinical protocols and transfer standards and working to define appropriate training programmes for staff. Who will accompany a patient when transferred will depend on their clinical condition, it is not always the most highly trained members of staff in the team that will be required. At the moment we transfer patients between our sites with a commissioned transfer service. We have an inter-hospital transfer group which is looking to consider patient needs and the skills required to support these additional transfers, should proposals go ahead. The proposed family transport service does not save money, it is proposed to relieve the concerns that patients have raised regarding how they and their relatives and friends might be able to visit a more distant hospital. There are various ways that this service could be delivered and we are exploring these. A detailed plan, with costings, will be provided to the CCG Joint Committee to aide their decision-making. With regard to clinical transport, we recognise the pressures that the East of England Ambulance Service Trust are under at present. We are drawing up detailed plans for the clinical transport model. We may run this service "in house", or may procure a service. East of England may wish to bid for this work. As per usual procurement rules, we would need to ensure the provider was able to deliver the service to the required standards.

106. What will you do it a patient refuses to be transferred? What will happen if a doctor refuses to transfer a patient as it is not in their best interest? What happens when a patient is so unwell it is unsafe to transfer them yet the specialists required to treat them are no longer at the Southend hospital site? (Same as Q87)	If a patient with capacity refuses to transfer to a location which is thought to be best for their care their wishes will be adhered to and every effort will be made to optimise care where they wish to remain, including specialists travelling to the patient if required or directing optimal care from the specialist centre. If a clinician or the clinical team consider patient transfer not to be in the patients best interest then the patient will not transfer and every effort will be made to optimise patient care including specialists travelling to the patient or directing care from the specialist unit.
107. Where will they treat an elderly patient who has had a stroke, fractured their hip and has gastrointestinal issues – bearing in mind these specialties will be at three different sites if plans go ahead?	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
108. Have you formally surveyed the staff at the three sites to gauge how willing they would be to travel? There are	The only staff we will expect to travel between sites would be consultant staff in the areas we are consulting on; they may be expected to work across more than one site in order to undertake their work (e.g.

multiple opportunities for many staff to leave the trusts and work in the community or travel to London. How has this been quantified and risk assessed? (Another question is the same)	orthopaedic surgeons undertaking emergency operations at one site and planned operations at another). We would not expect staff to have to work across more than two hospitals. In the case of non-consultant staff there may not be an expectation for them to work across sites, but if we expected a staff to travel to work across sites, this would be subject to a consultation process. Where a member of staff expresses an interest in working across more than one site to develop their expertise and career in a particular service area, for instance in a specific specialism which we will be able to newly provide as a result of creating these specialist centres, then we will obviously aim to make this happen. We expect that from working in larger teams across sites, staff will experience greater opportunities for career development, training and education, innovative working patterns, flexible working, etc. We are working hard to continually discuss the proposed changes with our staff and many have already starting to work in different ways. While we cannot categorically say how individual staff members will react, we do think our plans offer the best chance of recruiting and, most importantly, retaining the dedicated and well-trained staff that we have.
109. Throughout the consultation there is a huge reliance on pre hospital care and prevention of attendances. As	Over the next five years, the whole system in mid and south Essex is working to a plan that transforms the way patients receive health and care services. Our focus is very much on supporting population health. This

Southend has the second highest vacancy rate for GPs in the UK at present and the second highest number of GPs due to retire in the next 5 years – why is there such reliance on primary care to prevent hospital admission? What will happen when these results are not delivered? (same as another question)	starts from before birth, supporting people (children and adults) to live healthy lives, and arming people with the tools to look after their health. We are also working to enhance the care patients receive locally, supporting GPs, community, mental health and social care services to work more closely together. Over time we expect this to reduce demand on hospital services so that we can continue to meet demand within expected population growth. 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.
110. Your modelling emphasises the separation of emergency and planned care for these changes to be successful. You state only a 'minimal' number of people will be transferred between sites yet this actually totals 775 patients per month – not very	In the context of the c 3300 patients per day that attend an outpatient appointment and the c380 people a day that visit our hospitals for a planned operation, the average of 14 patients per day who may be referred to a more distant hospital for treatment is small. We absolutely recognise and want to mitigate the impact. 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

minimal in our opinion – so how are these two statements not mutually exclusive? (Same as Q94)	design a service that meets their needs as far as possible. A detailed plan on transport arrangements, with costings, will be presented to the CCG Joint Committee to aid their decision-making. Patients will continue to be able to exercise choice at the point of referral and if they do not wish to be treated within mid and south Essex, they can choose to be treated at any other hospital that provides the service they need. This should be discussed with the GP at the point of referral.
111. We are aware that at your STP meeting, staffing modelling showed that EVEN More staff would be required to run a hub and spoke model for all services which were analysed, yet you are still claiming that this is a solution to staffing issues. (Same as Q92)	The intention is not to reduce staffing numbers across the Acute Hospitals. Currently there are issues with attracting staff to funded posts and these either remain unfilled or occupied by locum health care workers. The proposed models of care allow improved professional opportunities for staff and will improve our ability to attract and retain staff to this area. The models proposed provide both better job satisfaction and more sustainable on call rotas for staff who currently are operating in extremely onerous conditions.
112. As most services are based around the numbers of patients being seen either in a clinic or procedure list how will moving these to different places save money? The demand will still be the same and hence resources required the same?	The proposals are not about saving money, they are about improving our offer to patients, improving the quality and safety of the care we provide. The way services are organised has a big impact on how much the cost to run and how well they can be reliably sustained – such as having a larger team covering a single rota rather than smaller teams covering several rotas. We can make changes to help reduce costs of staffing gaps, etc. in

	this way, and also help to make sure services run as planned and we do not waste resources or need to re-provide care because it has been disrupted – for example by aiming to separate out elective operating from emergency cases. We are aiming to avoid costs where possible in the future and will still be increasing the number of beds in the hospital by around 50 beds.
113. Pathology services for Southend Hospital were outsourced to a private company. This has led to a mass resignation of 10 of the pathology staff employed by the company due to unacceptable working conditions and poor service provision. Most recently they've been in the national media following a cervical smear catastrophe endangering the lives of many women. Money is now being taken out of the NHS and is profiting a private company when it should have been invested in the hospital, benefitting the local community. This is typical of the stealth privatisation of NHS services. We need this to be reversed, investment improved, work conditions in the hospital to improve so that staffing isn't such a desperate issue.	The pathology service has been set-up as a joint venture between Basildon and Southend NHS trusts and a private company to deliver an essential service across the locality, pooling expertise form the public and private sector. You may have read in the media that a re-examination is currently taking place of a number of cervical screening tests. This is because an issue was identified in the cervical screening lab service provided by Pathology First following a routine Public Health England Screening Quality Assurance visit in June 2017. An investigation was immediately launched and it was agreed that 2,500 samples should be reviewed from the period April 2016 to September 2017, from women that were aged between 24 and 29, for whom it was their first smear test and a small number of women in their 60s for whom it was their last smear test. It is government policy that the NHS remains free at the point of delivery for all.

How can you assure us that what has happened to pathology won't happen to the rest of services?	Some services are already delivered by private providers, but under standard NHS contracts and specifications. This adds to the capacity and range of NHS services (e.g. using the private sector to deliver some operations when the NHS does not have the capacity). The NHS abides by current procurement law in relation to the tendering of NHS services.
114. Given that the published literature review that has been given a 60% weighting in this instance is based on some articles that are almost 30 years old and that not all the published literature related to the UK, with a higher proportion of published literature used from countries abroad who do not have the same health care system as in the UK. How as a member of the public reading this information can I have confidence that the decisions based on the clinical assurance will be to the benefit of and not to the detriment of the patients of Mid and South Essex?	We will make use of the available published literature and national guidance, combined with local clinicians' knowledge of their services and information from our own processes and systems, to bring together our best plans. There is not always a large volume of definitive evidence from other areas, but detailed reviews by the external independent clinical experts of the East of England Clinical Senate will assist in examining and challenging the evidence. Where we have felt it necessary to seek out further evidence, we have commissioned specific research, such as for the proposed model for stroke (the independent report from UCL Partners on national and international clinical evidence on stroke care can be found on our website here: http://www.nhsmidandsouthessex.co.uk/background/clinical-evidence/) Our local commissioners, in supporting this consultation have taken advice from the East of England Clinical Senate. The Senate has reviewed clinical proposals and their supporting evidence base on three occasions in 2016 and 2017, and has provided assurance to CCGs. During April 2018,

	proposals will again have a detailed review by the senate, and all feedback will be included when any decisions are taken in the Summer. The role of Clinical Senate is to be a source of independent, strategic clinical advice and guidance to health commissioners and other stakeholders to help them make the best decisions about healthcare for the populations they represent. We can also make sure that plans are robust by putting measures and monitoring processes in place to check that they are implemented properly, and, as we work within them, that they are working well and if there are further improvements as plans progress. Previous reports from the Clinical Senate may be found on our website at http://www.nhsmidandsouthessex.co.uk/background/further-information/
115. I am concerned that there is a specific local knowledge within the Senate Council with none of the members being based at the 3 main sites under consideration. The only link to the local area is a member of one of the local CCGs with over 20 other members coming from a wider geographical area. A high proportion of the membership come from more rural less densely populated areas,	The Clinical Senate is an independent function and there are purposefully no local clinicians involved as it is designed to be independent and free from any potential conflict of interest. The Senate is made up of experienced clinicians from across a range of specialties. Once the Clinical Senate has completed its second stage review (after the consultation process has ended), the proposals will go through a further review by our Clinical Cabinet (a panel of local senior doctors, nurses and health care professionals from across all organisations in mid and south Essex, who will collectively look at the proposals and provide feedback).

meaning that are unlikely to experience the high volumes of traffic and congestion that is common in the areas between the 3 sites. Why are the decision makers not those with local experience and knowledge of the area?	

116. Senate membership encompasses a broad range of specialism for different fields – but is lacking clinicians from the sites in question and with direct links to the service under reconfiguration. The public learnt that the previous plans were not backed by local clinicians, can the committee provide details and evidence of the which local clinicians are backing these plans for reconfiguration?

A list of local clinicians who have led the development of our current proposals (along with clinical teams across the three sites) is as follows. In addition there has been close involvement of the Medical Director (Dr Ronan Fenton), and Chief Medical Officer (Dr Celia Skinner) for the three hospitals, as well as the three site medical directors (Mr Neil Rothnie, Southend, Dr Tayeb Haider, Basildon and Dr Ellie Meakins, Mid-Essex, Dr Donald McGeachy, medical director for the CCG Joint Committee, local GPs and community colleagues.

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General Surgery	Emma Gray
	Bryony Lovett
Urology	Peter Acher
	Martin Nuttall
Emergency Pathway	Edward Lamuren
	Hagen Gerofke (AMU)
Vascular	Vijay Gadhvi
Respiratory **Gastroenterology**	Steve Jenkins, Marcus Pittman Duncan Powrie Ronan Fenton