The Future of Local Health Services in Northern Staffordshire

Reference Group

Options appraisal event

25 May 2018

Agenda

10.00	Welcome and context setting
10.10	Community Beds – re-cap and actions from the last Reference Group
10.20	Community Beds – feedback on application of Hurdle Criteria on 16th May
10.35	Short Break
10.45	Community Beds – Desirable Criteria and scoring exercise
11.30	Short Break
11.40	Wider Community Services – feedback on application of Hurdle Criteria on 16th May
11.55	Wider Community Services – Desirable Criteria and scoring exercise
12.40	Final Q&A session / other considerations not captured during the event
12.55	Next steps and close

1. Overview

The purpose of today is to present the process undertaken to develop a short list of options, and then to score them against the desirable criteria

The purpose of today

- Feedback to you on how we have incorporated your suggestions to date ('You said, we did')
- Confirm with you where the bed modelling numbers come from
- Presenting how the Expert Group* developed a short list of options, including presentation of the emerging evidence discussed
- Presentation of emerging evidence to score the desirable criteria
- Assessment of short list of options against the desirable criteria

What we won't be doing today

- Outlining or agreeing a preferred option

This is part of a process to reach NHSE Assurance

- Reference Group #3 30th May
  - Presenting back the outputs from scorings of the short list of options
- Testing with Governing Bodies, Councils, legal advisors

Reference Group roles today

- Objective view on evidence
- Working together to reach a consensus
- The approach to scoring is outlined in more detail on the following slides

**The Expert Group is comprised of clinical leads and service leads, including representatives from the CCG, Trusts, City Council, County Council and Health Watch.*

The minutes of the Expert Group session will be published by the 1st June.

Options Development: Process

Step 1

- **October – December 2017**
- Listening Events
- Online Survey
- Bespoke Events
- Clinical Engagement

Step 2

- **January – April 2018**
- Options Development Event
- Options Appraisal Event
- Commissioner & Execs Consideration
- Partner involvement
- Data Modelling

Step 3

- **May 2018**
- 10th May Reference group: Check we have captured all your previous feedback and understood it this, presented indicative beds long list
- 16th May Expert application of hurdle criteria – must haves
- Today (25th May) Options Evaluation – desirables
- 30th May: Reference group to present short list
- 12th June: Second Expert Group session

Step 4

- **June 2018**
- Ranked Shortlist
- Due consideration by Governing Body

2. Context

The draft case for change is founded on a number of challenges that the health economy is facing

There are three key challenges to be included within the case for change

Clinical

- Health and wellbeing (growing demand, aging population, increased prevalence particularly with LTCs, entrenched health inequalities)
- Patients in the wrong place, meaning higher risk and worse outcomes
- Findings of point prevalence studies (9% appropriate for beds)
- Workforce recruitment and retention challenges

Estates

- Estates are not evenly distributed for effective and efficient community service provision
- Some of the community hospital buildings were built before 1948
- Urgent repairs are required across the community hospitals (£7.5m backlog maintenance)

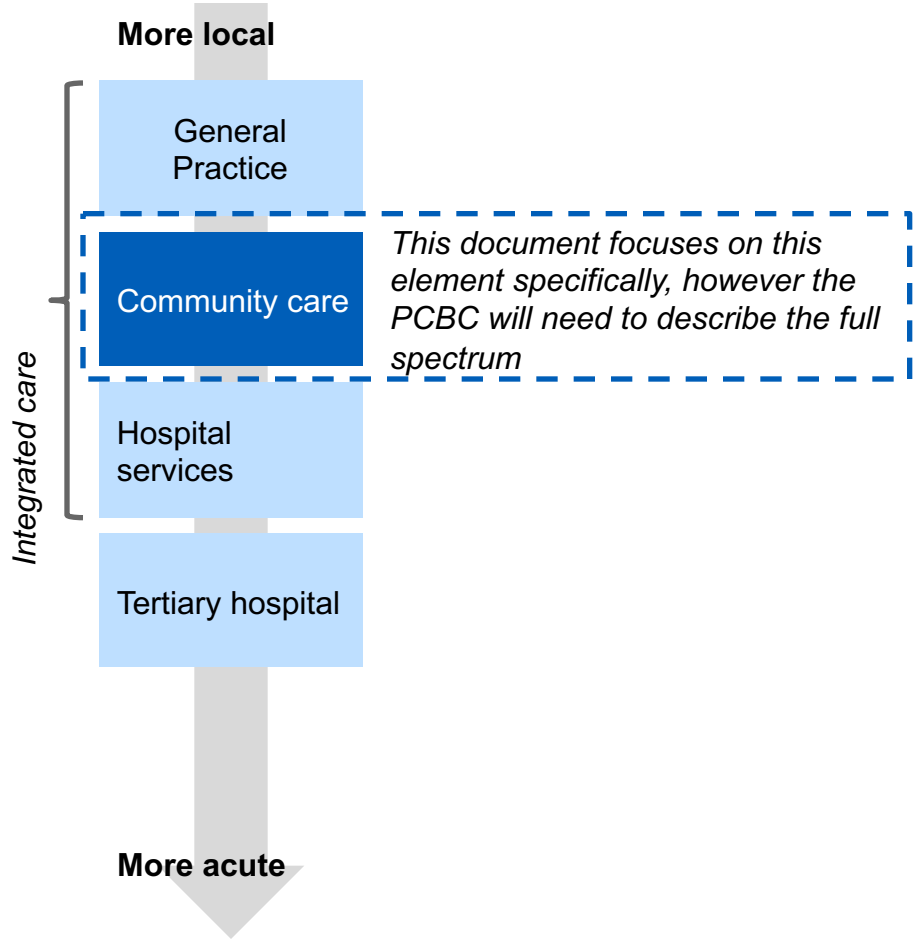
Financial

- There is a **significant deficit** of c.£10m for the community Trust who own the community hospitals
- This is contributing to the significant financial deficit of the whole health economy; Staffordshire STP estimates that there will be a funding gap of over £500m by 2020/21 including cost pressures in Social Care.

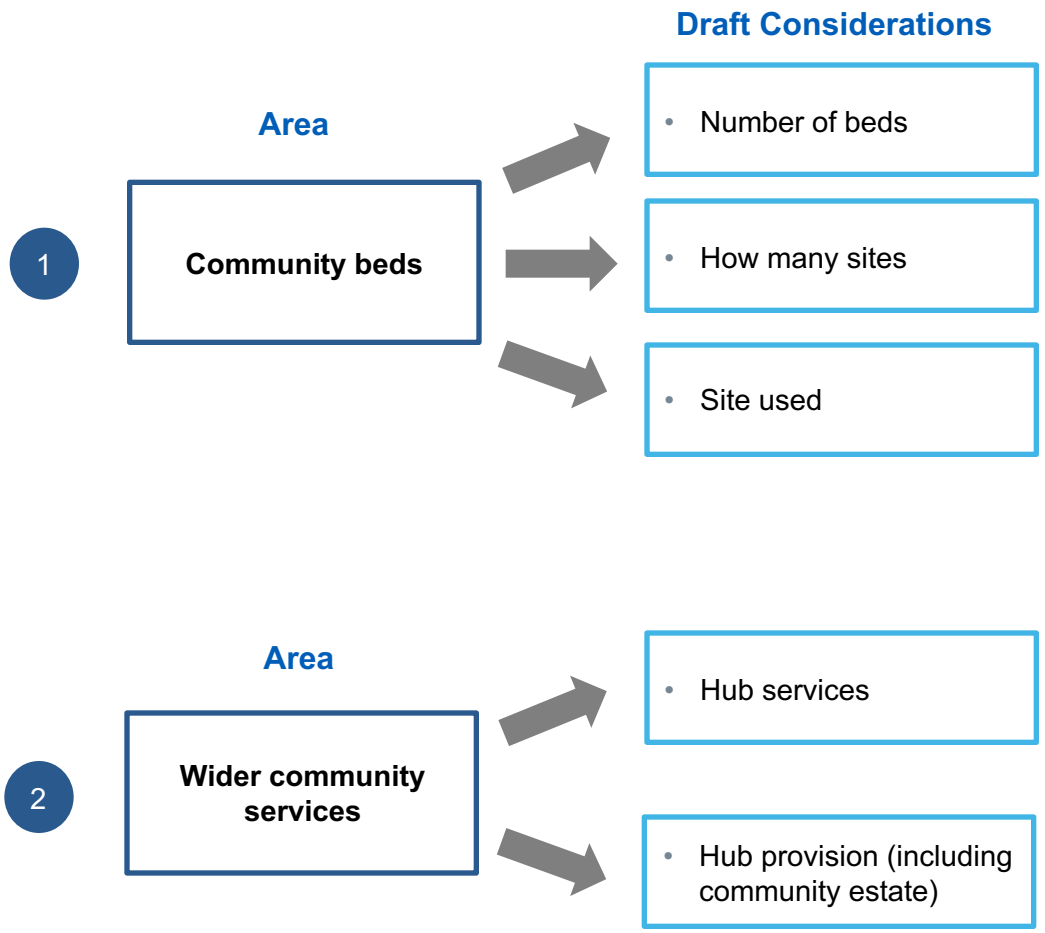
Whilst we are considering the future of the Community Hospitals, we need to consider other local health services

- The model of care across Staffordshire will be changing
- We are looking to develop more community centred service where the teams which look after you are based within hubs in your communities
- This transformative approach is being developed as part of the STP
- This **process focuses on the community services** – specifically, the clinical model and subsequent options for their delivery

Spectrum of care and scope of this work



We are proposing to consider draft impacts across two key areas



We have listened to what you said and incorporated the feedback

- Please see the ‘You said, we did’ hand outs on your table

3. Community beds

Analysis suggests 132 beds are potentially required to meet the population need, however additional escalation capacity will also be available

The new care model

- With the 264 bed base there were **2,758 community care hours** at any one time where **183 patients could be supported** for Intermediate Care, Reablement and Palliative Care, to manage the number of discharges 264 beds were required.

- The care model has evolved to provide care closer to home, and in the appropriate setting.

- As such, the number of **community care hours has increased by 125% to 6,200** at any one time which allows **413 patients to be supported**. Consequently, the requirement for community beds has decreased by 50% to 132.

Modelling

- Complex discharge data from University Hospital North Midlands was considered which identified where patients were being discharged to, this should that there was a 50/50 apportionment between patients going home or into a community bed or a nursing / residential bed

- Modelling was undertaken over a six month period, including the Winter period

- Based on patient need (evidenced by point prevalence studies, as well as evaluations of Home First pilots in localities) and changes to the care model (above), the apportionment of patients discharge shifted to 70% at home, 30% to beds – note national best practice is 90% Home and 10% to beds

- Undertaking the analysis on this basis leads to estimates of 132 beds meeting need

- Recognising that increased bed capacity will be needed at various points for un-predicted surges in demand, e.g. a bad flu season, additional escalation capacity be made available to ensure flexible reaction to this. There are several potential options currently available for this e.g. through Care Homes.

To enable this, a number of key services are being delivered

Community services

- Home first
  - Intermediate care – c2,000 clinical and therapy hours (with night sits)
  - Reablement – c4,200 reablement hours
- Discharge
  - Discharge any patients that go home, into home first
  - If social care assessment is required, this is done in an individuals own home rather than in a community bed
- Provision of palliative care, nursing and general care hours
- Total investment of c.£6.2m over the baseline (total budget for Home first is c.£12.5m)
- Further detail on the hub principles, services and clinical model is presented in following slides

Community beds

- Realigned bed provision in line with patient need:
  - Intermediate care beds for rehab and assessment
  - EMI assessment beds
  - Shared mental and physical health beds

Modelling assumptions (1/2)

- 30% of complex discharges patients require a bed following discharge from Royal Stoke University Hospital.
- Based upon the modelling, this equates to 31 patients per week.
- Rehabilitation and assessment beds are commissioned with a 28 day length of stay and EMI assessment beds with a 34 day length of stay.
- It is also assumed that bed occupancy will be 95% to allow for flexibility and surge.
- This equates to a requirement for 132 beds.

Points of entry into IP/D2A services	No. referrals needing a service (per week)	Home based IP/D2A total	Commissioned interim bed placement (D2A)	Non-commissioned bed (e.g. CHC funded fast track)
Home: Bed target ratio		70%	30%	
GP referrals	46	46	0	0
Acute hospital referrals	146	102	31	13
Community Hospital Referrals	43	23	0	20
Total	**192**	**148**	**31**	**13**

Referral location	Proportion of home based entering each service							
	Intermediate care	Reablement				Palliative care	Voluntary Sector	TOTAL
		General SCC	EMI SCC	General SoTCC	EMI SoTCC			
GP	100%							100%
Acute hospital	19%	29%	3%	29%	3%	15%	3%	100%
Community Hospital	13%	34%	2%	34%	2%	16%	0%	100%

Modelling assumptions (2/2)

Home First

Home First is commissioned in totality by the NHS and includes reablement care.

The premise is that patients return home with an intensive package of care and therapy for 3 days initially with a full review at day 3.

All service users will then be reviewed at day 7, 14 and 21 with the aim of reducing the required hours of care as patients become more independent. All packages are based upon an individuals assessed need.

Patients who require an assessment for ongoing domiciliary care will remain in the service at home whilst a statutory assessment is carried out and a care package sourced.

Further detail regarding the model is presented below

Days in Service	Intermediate Care and Reablement	EMI Stay at Home	Palliative care
Day 1-4	13.8 hours across 4 days	72 hours across 4 days	36 hours across 4 days
Day 5-14	12 hours across 10 days	56 hours across 10 days	36 hours across 10 days
Week 3	10.2 hours across 7 days	15.2 hours across 7 days	36 hours across 7 days
Week 4	8.3 hours across 7 days	12.5hours across 7 days	36 hours across 7 days
Week 5	6.5 hours across 7 days	9.8 hours across 7 days	36 hours across 7 days
Week 6	4.7 hours across 7 days	7.1 hours across 7 days	36 hours across 7 days

Recap: Long list

We shared with you last time the long list of solutions around the community beds

How many sites	How many sites could we deliver these beds from?	• 1 • 2 • 3 • 4 • 5 • >5
Site(s) used	Which sites could be used to deliver community hospitals?	• 1 to 5 existing sites • Other e.g. care homes

We also shared with you last time the 'must have' hurdle criteria based on a number of key principles

The principles these have been developed around are outlined below:

'Must haves'

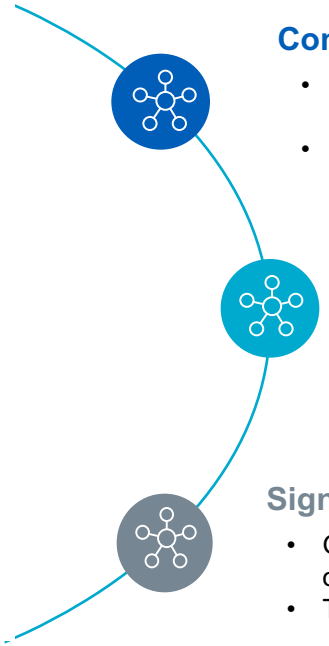
- Hurdle criteria for which there is a binary answer and can be evaluated on a pass/fail approach.
- Determined by a finite parameters e.g. financial envelope, nationally mandated or clinically safe
- To be determined by technical experts who work in the field

#	Grouping	Evaluation criteria	Question
1	Must have	Clinically sustainable	• *Does the option support clinical sustainability?*
2	Must have	Fit with national and local strategy	• *Is the option consistent to national and local strategy?*
3	Must have	Affordable	• *Does the option improve the financial position of the system?*

#1 Must have - clinically sustainable, quality outcomes and workforce

Hurdle: Does the option support clinical sustainability?

Evidence



Consultant recruitment challenges

- Attempted to recruit speciality doctors and consultants five times in the past 18 months with not interest shown into the post
- Longton site closed on clinical safety grounds due to staffing challenges

Financially unsustainable solutions

- The cost of a locum is significantly more than full time cost

Significant nursing gaps

- GP are used to mitigate the lack of consultant/specialty doctors, though they are only at hospital twice a week
- The care model is dependent on ANPs, though it is difficult to recruit

Number of beds – what is clinically sustainable per site?

Evidence from the provider

In order to safely staff community hospital beds, a minimum of two wards per site are required to ensure that a good staffing ratio can be maintained and to allow for appropriate cover for absences.

This also allows for cross cover and support between wards on a site.

An ideal ward size is around the region of 20 patients per ward, with a good mix of side rooms and bays. The average staffing model per 20 bedded ward is outlined below:

Nursing and HCSW	7 staff in a morning - 3 qualified and 4 HCSW/ night shift - 2 qualified 6 staff in the afternoon - 3 qualified and 3 HCSW 3 staff overnight - 2 qualified and 1 HCSW
Physiotherapy	Based on 1.00 wte B6/ B5
Occupational Therpay	Based on 1.00 wte B5
Ward clerk	Based on 1.00 wte B2
Discharge facilitator	Based on 1.00 wte B3
Diversional therapist	Based on 0.64 wte B2
Housekeeper	Based on 0.64 wte B2

#2 Must have - fit with national and local strategy

Hurdle: Is the option consistent to national and local strategy?

Evidence	*Implication*
Five year plans – Five Year Forward View, Mental Health 5 year Strategy	• No implication, overall care model and plans focused around strategy outlined in five year plans, particularly around right care, right place and care closer to home
CCG Operational Plans	• No implication, options outlined aligned to CCG operational plans
Commissioning intentions	• No implication, options aligned to commissioners vision, objectives and strategy
Staffordshire Transformation Partnership	• No implication, STP requires a care model which is clinically sustainable and affordable – these are picked up in the other criteria
Joined up social and health care commissioning	• No implication, options reliant on closer care and health working for delivery
National strategy for care closer to home	• No implication, increase in community care hours supports national strategy

#3 Must have – affordable (1)

Hurdle: Does the option improve the financial position of the system?

Evidence (1)

1. The organisations within the system have the following financial positon:
   - Trust: c. - £9.5m 17/18
   - CCGs: c. -£0.5m 17/18
2. The Haywood site:
   - PFI cost of c.£6m per annum
   - There are 25 years left on the contract
   - This cost is significant, for example at a cost of £100k per bed – this relates to 60 beds per year
   - Most suitable environment to deliver care
3. Relative cost of care across settings
   - Comparison of average community cost per bed (£2,100 per week) to average care home nursing bed (£750 per week)

#3 Must have – affordable (2)

Does the option improve the financial position of the system?

Evidence (2)

1) The current bed capacity is limited in a number of sites,

- Bradwell – 63 beds
- Cheadle – 48 beds (only 2 wards useable)
- Haywood – 77 beds
- Leek – 36 beds
- Longton – 37 beds

2) Looking at data that has been made available to us by the Community Trust, each Community Hospital site requires investment to eradicate 'moderate and low risk' backlog maintenance in a range between £0.2m - £1.4m (with the Haywood site having the lowest requirement and the Bradwell site having the highest). W are working collaboratively with the provider on more detailed data analysis which will inform the final shortlist of options which goes forward into the Pre-Consultation Business Case.

A summary of the findings from the expert group applying the three hurdle criteria is presented below

Clinical sustainability

- Recruitment of staff and maintaining the workforce required in the Stoke / Staffordshire area is difficult due to national challenges and worker preference (bigger cities in close proximity e.g. Birmingham, Manchester)
- From a clinical sustainability perspective (workforce gaps, challenges), the current set up of provision of care across five sites needs to be changed
- Given, from a sustainability and safety perspective, a minimum of 40 beds per site is required, options with delivery of beds across more than two sites will be ruled out from the long list

National and local strategy

- The expert group outlined that the STP had a clear requirement for health systems to ensure they are sustainable and affordable, however practically speaking in this exercise, these considerations are captured in the other two hurdle criteria
- As such, the expert group found that there were no implications or changes to the long list from applying the national and local strategy hurdle

Affordability

- The expert group explained that whilst the 264 beds is important to retain in the process as a 'do nothing' option, it is not a viable option due to both its lack of affordability (reinvestment into community based care capacity of £6.5m and the additional workforce costs associated with it) and it being clinically unsustainable (clinical case for change and lack of staff to provide care safely), as such it should be ruled out from the short list in that way
- The expert group noted that there would be a significant financial cost of vacating the Haywood Hospital, which would not be viable – as such the group agreed to include the Haywood and utilise available beds (77) as much as possible in all shortlisted options
- The expert group stated that following the provision further information regarding the Longton site's condition, options which contain this site could also drop out of the long list from an affordability perspective

Short list

The short list of options for community beds is presented below

Note the options for the provision of care in localities and hub services is presented in the following sub-section.

	Option 1 (Haywood)	Option 2 (Haywood and Leek)	Option 3 (Haywood and Longton)	Option 4 (Haywood and Cheadle)	Option 5 (Haywood and Bradwell)	Option 6 (Haywood and Care Homes)
Total number of beds	**132***	**132***	**132***	**132***	**132***	**132***
Haywood	✓	✓	✓	✓	✓	✓
Leek		✓				
Longton			✓			
Cheadle				✓		
Bradwell					✓	
Care Homes						✓

*132 beds based on current modelling outlined in previous slides, though as noted flexing of capacity to account for surges will be built in

Desirables scoring

Process for scoring – your role (1/2)

- We want you to consider each bed option against 3 desirable criteria:
  - Quality Care
  - Meets Need
  - Accessibility

- To do this we want you to consider example evidence (presented within this slide pack and additional material on your tables) and your own local knowledge and experiences

- After we have taken you through each criteria on the next few slides, your task will be as follows:

A: Weighting the desirable criteria

1. Use the form provided to you (handout titled **Weighting matrix**) to individually assign a score out of 100 to the three criteria (the sum of the scores should equal 100)
2. We will collect these from you and independent leads will develop an average score for the room

B: Scoring the beds options against the desirable criteria

1. In pairs score each option for each criteria out of 10 (10 being the highest score) using the handout titled **Community Beds scoring sheet** – this will show the relative preference for each option
2. Feedback to your table and reach a consensus on your table
3. Feedback to the room via a nominated spokesperson

We are keen to capture qualitative comments as well. Facilitators will make notes of table discussions and write down any key points from pairs discussions that you request to be captured.

Process for scoring – how scores are estimated (2/2)

Once you have weighted the criteria and independent leads have developed the averages, we will take your scores of each option and the following estimation process will be undertaken:

1. Score x weight = weighted score

2. Sum of weighted scores = option total

The table below outlines an example of this process. The total scores for each option can subsequently be compared and a preferred option will be evident from this exercise.

Criteria	Weight		Option 1 Score		Option A total
Criterion 1 (e.g. Quality Care))	60	x	10	=	600
Criterion 2	20	x	1	=	20
Criterion 3	20	x	2	=	40
TOTAL					660

→

	Option A	Option B	Option C
Score	660	280	320

Evaluation criteria and considerations

Grouping	Evaluation criteria	You told us this means:
Desirable criteria	Quality care	• Holistic – patient centred, personalised approach • Parity between physical and mental health • Safe, timely and effective • Correct diagnosis • Delivery of waiting times • GP standards for recalls and use of technology • Available, accurate and up-to-date patient information • MDT and Integrated Care Teams – skills mix to meet the needs of patients • Seamless services, patient experience • Good / Outstanding CQC scores • Environment – premises/ languages / clear communication
Desirable criteria	Meets need	• Based on demand in the local area • Needs not want - be realistic and honest • Based on clinical evidence • Self-management support • Mange long term conditions within the community – i.e. sufficient depth and quality of services to keep people out of hospital • Timeliness • Equity of service • Objective modelling
Desirable criteria	Accessibility	• Travel time & transport routes with subsidised transport • Digital Technology - skype, telephone conversations, apps • Equity of service based on local need • Electronic patient records to be available to all Health and Social Care • Waiting times • GP opening hours – extended hours • Out of Hours • Car parking • Outpatient clinic availability • IT – linking care records across organisations • Communication: Speak plainly, Health literacy, Patient centred language

#1 Desirable – Quality care

- What you have described as being important for the quality care sub-criteria is difficult to present quantitative evidence for, as many are subjective criteria. However, there are minimum expectations for quality of care delivered in our area. Care homes and community providers are measured against over 30 quality metrics (aligned to national guidelines) which the providers have to ensure their service delivery model meets.

- These metrics span across domains such as **Clinical Effectiveness**, **Patient Experience**, **Patient Safety** and **Workforce** – a full list is presented in your handout

- In procuring care home beds, the following elements will be considered for each Provider to ensure a minimum quality threshold is met:
  - Nursing and Care staffing model
  - Therapy model
  - CQC rating
  - Quality measurements and metrics
  - Medicines admin records
  - Financial model
  - Model of delivery

- To appraise providers, we:
  - Review dashboards of performance against the metrics
  - Meet them on a monthly basis through a Contract Review Board including the Clinical Quality Review element
  - Undertake announced and unannounced visits on a regular basis
  - CCG managers sit as part of the Multi-disciplinary Teams on a weekly basis

- We recognise that there are differences in quality across sites, for example the Longton site was closed due to the inability to safely staff, as well as clinical leads noting that the Haywood is able to deliver better quality care due to it being fit for purpose.

- You may wish to consider these aspects alongside your own personal and local experience and knowledge of care across the various sites.

#2 Desirable – Meets need

Draft evidence

- CCG and Community Hospitals discharge destination data has been assessed to understand the type of beds aligned to meeting need (community beds or care home)
- Based on discharge data, 70% of those in CCG beds (from April to March 2018) were discharged to require 24 hour care – 112 patients into discharge care in the table below compared to 49 discharged into home
- Clinically, this cohort who require assessments for longer term care are better placed in a care home

Organisation	Service Type	Feb-2018	Mar-2018	Apr-2018	Grand Total
CCG Beds	24 Hour Care	34	43	35	112
	Home	20	16	13	49

#3 Desirable – Accessibility (1/2)

Travel time

- Analysis has been undertaken to consider the **average change in patient travel time and distance** from the current configuration of beds (with temporary closures in effect) and previous configuration (prior to temporary closures) across each of the six options
- That is, we look at how long it would take on average a patient to travel to their closest site in the current and previous configurations (post and pre temporary closure) and compare this against what the time would be under each of the six options
- Our analysis shows that on average, the additional average travel time across each options is less than 10 minutes – though this doesn't into account traffic conditions
- This is not expected to have an impact on quality of care received
- Though noting that we have to go through a process to procure care homes, the estimation shows that if care homes were procured locally, there will be a more beneficial (smaller) change in travel time

Bus routes

- Analysis of bus routes across the various sites suggests there is a range of between 65 – 92 minutes to travel between the hospital sites on average at peak times (8am), with the Haywood being the most accessible
- In terms of drive times, the average range across the hospitals is much smaller, between 21 – 29 minutes at peak times (8am)
- Further detail regarding this is presented in handouts

#3 Desirable – Accessibility (2/2)

Site	Information
Haywood Hospital	• Car park available on site – charges apply (up to 4hrs £2, up to 8hrs £4, up to 24hrs £8)
Longton Cottage Hospital	• Free car park available on site
Bradwell Hospital	• Free car park available on site
Leek Moorlands Hospital	• Free car park available on site
Cheadle Hospital	• Free car park available on site

Scoring

Please see the hand out titled **Community Beds scoring sheet** on your tables

4. Wider community services

Recap: Services to be delivered (new care model)

The proposed model has had engagement and sign up with a number of organisations

Groups that have been engaged during the service development process include:

- Health watch
- Acute Trust UHNM
- SSOTP
- Combined healthcare
- Voluntary sector
- Stoke on Trent City C
- Staffordshire County C
- Patient members
- Lay members
- Alliance boards
- GP federation
- Overview and scrutiny committees
- MPs meeting
- NHSE
- NHSI
- Localities
- General Practice
- Pharmacy
- Optometry

The service development forms part of the Enhanced Primary Care work stream of the wider STP being developed

The new care model is developed on the basis of provision of at least one hub in each locality

Hubs by locality

- Given the population sizes across localities, we would expect the provision of a hub in each locality
- As such, any 'no hub' options could be ruled out from the long listing exercise
- This approach was agreed by the Expert Panel

Locality	Weighted Population as at 01.02.2018
Stoke North	170,675.53
Stoke South	137,168.44
Newcastle	134,528.94
Moorlands	95,172.13

Recap: Long list

We shared with you last time a number of solutions, driven by the number of hubs and sites

Long list

Based on these services, we have optionality around the number of hubs and sites

Number of hubs	How many hubs could be developed?	• 4 • 5
Site(s) used	Where could the hubs be provisioned?	• Existing sites • Alternative site (new 1, new 2)

Based on the above, the long list of draft options were:

Locality	Refined
Stoke South (Longton)	One hub, As is from existing community site
	One hub, New site (ETTF) + site repurpose of existing community estate
	One hub, Use of Meir LIFT + site repurpose of existing community estate
Moorlands (Leek, Cheadle)	Two hubs, As is from existing community site
	Two hubs, Leek new (Knivedon), Cheadle existing community site
	Two hubs, Leek existing community site, Cheadle new
	One hub, Leek existing community site, Cheadle site repurpose
	One hub, Leek new (Knivedon), Cheadle site repurpose
	One hub, Cheadle existing community site, Leek site repurpose
Newcastle Bradwell	One hub, as is from existing community site
	One hub, Use of Milehouse LIFT + site repurpose of existing community estate
Stoke North Haywood	One hub, as is from existing community site
	One hub, Use of Middleport LIFT + site repurpose of existing community estate

Recap: Hurdle criteria

As we have shown you earlier for the beds discussion, we have applied 'must have criteria for the hubs as well

The principles these have been developed around are outlined below:

'Must haves'

- Hurdle criteria for which there is a binary answer and can be evaluated on a pass/fail approach.
- Determined by a finite parameters e.g. financial envelope, nationally mandated or clinically safe
- To be determined by technical experts who work in the field

#	Grouping	Evaluation criteria	Sub criteria
1	Must have	Clinically sustainable	• *Does the option support clinical sustainability?*
2	Must have	Fit with national and local strategy	• *Is the option consistent to national and local strategy?*
3	Must have	Affordable	• *Does the option make best use of system financial resource?*

#1 Must have - Clinically sustainable, quality outcomes and workforce

Hurdle: Does the option support clinical sustainability?

Evidence

1. GPs preference is to organise themselves around four localities, based on their view of where clinical outcomes and efficiency improvements can be driven

2. There are challenges for the GP workforce, which could be mitigated through provision of care from a consolidated number of localities:

    - ***Aging Workforce:***
        - North Staffordshire identified that 16% of the GP workforce is over 60, compared with 3% for East Staffordshire.

    - ***Recruitment:***
        - 33 GP vacancies across Staffordshire (10 of which had been vacant for more than 18 months).
        - 55% of the vacancies are in Stoke on Trent and North Staffordshire compared with 9% across East Staffordshire.

#2 Must have - fit with national and local strategy

Hurdle: Is the option consistent to national and local strategy?

Evidence

Population by locality is estimated to be :

- Stoke North – 170k
- Stoke South – 137k
- Moorlands – 95k
- Newcastle – 134k

The size of the population served best by the hub is dependent largely its service delivery model.

Other systems have developed ‘super-hubs’ , providing services for populations over 100,000, for example:

- Plan by West Hertfordshire has a hub for Watford & Three Rivers locality which has a population of c.164,000 and is future-proofed to c.230,000. For Dacorum locality the population is c.165,000 and future proofed to c.179,000.
- Ealing system developing a hub to service a locality of c.200,000.

#3 Must have – affordable

Hurdle: Does the option make best use of system financial resource?

Evidence

1. The organisations within the system have the following financial positon:
   - Trust: - £9.47m 17/18
   - CCGs: -£0.5m 17/18
2. In providing services (e.g. community nursing, long term conditions nursing) from multiple hubs, the following considerations apply:
   - Minimum staffing requirements, especially in the context of 7 day services
   - Clinical escalation network for each hub is significant
3. The greater the number of sites, the less opportunities to achieve economies of scale
4. Provision of diagnostics and additional capital requirements across options (e.g. Stoke South ETTF and LIFT building optionality)

A summary of the findings from the expert group applying the hurdle criteria is presented below

Clinical sustainability

- The expert group highlighted that it would be difficult to deliver care across two hubs in the Moorlands with particular concerns raised around:
    - Inability to sustainability staff and operate two hubs within the Moorlands site
    - There are a small number of specialist LTC management nurses for which it would not be viable to work across two sites
    - Mis-alignment with the future model of care based around MDTs
- As such there was a consensus that a single hub at the Moorlands would be more appropriate.

National and local strategy

- The expert group highlighted that the population size in the Moorlands would make it challenging to deliver a two hub option (due to the workforce required at each hub and lack of critical mass to make viable), as such there was a consensus that a single hub at the Moorlands would be more appropriate.

Affordability

- The expert group stated that the financial suitability across the two hubs in the Moorlands would be challenging from an affordability perspective (minimum staffing requirements for each hub).
- The expert group did not take the Middleport option forward, given the affordability implications of having the Haywood PFI on the alternative site; moreover the Haywood PFI site option was thought to strengthen co-location with other services

Short list

The short list of options for the wider community services is presented below

Locality	Option	
Stoke South (Longton)	1a	One hub, New site (ETTF) + site repurpose of existing community estate
	1b	One hub, Use of Meir LIFT + site repurpose of existing community estate
Moorlands (Leek, Cheadle)	2a	One hub, Leek existing community site, Cheadle site repurpose
	2b	One hub, Leek new (Knivedon), Cheadle site repurpose
	2c	One hub, Cheadle existing community site, Leek site repurpose
Newcastle Bradwell	3a	One hub, as is from existing community site
	3b	One hub, use of Milehouse LIFT + site repurpose of existing community estate
Stoke North Haywood	4a	One hub, as is from existing community site

Desirables scoring

Process for scoring – your role

- We want you to consider each bed option against 3 desirable criteria:
  - Quality Care
  - Meets Need
  - Accessibility

- To do this we want you to consider the available evidence (presented within this slide pack and additional material on your tables) and your own local knowledge and experiences

- After we have taken you through each criteria on the next few slides, your task will be as follows:

A: Weighting the desirable criteria

1. Use the form provided to you (handout titled **Weighting matrix**) to individually assign a score out of 100 to the three criteria (the sum of the three scores should equal 100)
2. We will collect these from you and independent leads will develop an average score for the room

B: Scoring the beds options against the desirable criteria

1. In pairs score each option for each criteria out of 10 (10 being the highest score) using the handout titled **Wider Community Services scoring sheet** – this will show the relative preference for each option
2. Feedback to your table and reach a consensus on your table
3. Feedback to the room via a nominated spokesperson

We are keen to capture qualitative comments as well. Facilitators will make notes of table discussions and write down any key points from pairs discussions that you request to be captured.

Evaluation criteria and considerations

Grouping	Evaluation criteria	You told us this means:
Desirable criteria	Quality care	• Holistic – patient centred, personalised approach • Parity between physical and mental health • Safe, timely and effective • Correct diagnosis • Delivery of waiting times • GP standards for recalls and use of technology • Available, accurate and up-to-date patient information • MDT and Integrated Care Teams – skills mix to meet the needs of patients • Seamless services, patient experience • Good / Outstanding CQC scores • Environment – premises/ languages / clear communication
Desirable criteria	Meets need	• Based on demand in the local area • Needs not want - be realistic and honest • Based on clinical evidence • Self-management support • Mange long term conditions within the community – i.e. sufficient depth and quality of services to keep people out of hospital • Timeliness • Equity of service • Objective modelling
Desirable criteria	Accessibility	• Travel time & transport routes with subsidised transport • Digital Technology - skype, telephone conversations, apps • Equity of service based on local need • Electronic patient records to be available to all Health and Social Care • Waiting times • GP opening hours – extended hours • Out of Hours • Car parking • Outpatient clinic availability • IT – linking care records across organisations • Communication: Speak plainly, Health literacy, Patient centred language

#1 Desirable – Quality care

- What you have described as being important for the quality care sub-criteria is difficult to present quantitative evidence for, as many are subjective criteria.
- However, we have minimum expectations for quality care delivered in our area. For care delivered from the hubs, within the contract there are quality metrics (aligned to national guidelines) which the providers have to ensure their service delivery model meets
- You may wish to consider these aspects alongside your own personal and local experience and knowledge of care across the various sites.

#2 Desirable – Meets need

Draft evidence

- In hand outs, we have provided information regarding the health and wellbeing and needs of the local population across each locality.
- This information was considered in the development of the hub services outlined in your handouts.

#3 Desirable – Accessibility (1/2)

Travel time

- Given the hubs are going to be new and there isn't a clear 'as-is' comparator to assess accessibility against, we have narrowed our analysis to look at the average travel time and distance to the possible hub locations within each locality
- Our analysis shows that additional average travel time to each hub is on average c10 mins – though this doesn't into account traffic conditions

Bus routes

- Analysis of bus routes across the various sites suggests that:
  - In Stoke South the range in bus times from the existing community sites to the two possible hub locations is 6 – 8 minutes, for car travel it is 3 – 8 minutes
  - In the Moorlands, the range in bus times to travel between the existing community sites and other hub locations is between 65 – 75 minutes , drive time ranges between 22 – 24 minutes (excluding times between the existing Leek side and the Knivedon site)
  - In Newcastle, there bus travel between the existing community hospital site and the Milehouse Lift is c.25 minutes, where as by car it is c6 minutes
- Further detail regarding this is presented in handouts

#3 Desirable – Accessibility (1/2)

	Site 1 Building	Site 1 Information	Site 2 Building	Site 2 Information	Site 3 Building	Site 3 Information
Stoke South	**ETTF development**	• [Greenfield site – car parking TBC]	**Meir Primary Care Centre**	• Free car parking on site		
Moorlands	**Leek Moorlands Hospital**	• Free car parking on site	**Cheadle Hospital**	• Free car parking on site	**Knivedon**	• [Greenfield site – car parking TBC]
Newcastle	**Bradwell Hospital**	• Free car parking on site	**Milehouse Primary Care Centre**	• Free car parking on site		
Stoke North	**Haywood Hospital**	• Car park available on site – charges apply (up to 4hrs £2, up to 8hrs £4, up to 24hrs £8)				

Scoring

Please see the hand out titled **Wider Community Services scoring sheet** on your tables

5. Next steps

Next steps

1. Reference Group 3 to recap the outputs of the scoring, and present further evidence where available – 30th May

2. Expert group technical session 2 to go into further analysis of each of the options against the 'Must have' criteria – 12th June

3. CCG Governing bodies and other stakeholder meetings

**The Expert Group is comprised of clinical leads and service leads, including representatives from the CCG, Trusts, City Council, County Council and Health Watch.*

5. Annex

This could still leave over 60 potential solutions

Provisional long list – subject to significant testing

On the preliminary basis of 132 beds, there could be 60+ potential solutions in the long list; based on 'How many sites' and 'Sites used' categories – this could be greater if new sites were also considered. Further, this doesn't account for different profiles of beds across sites.

All possible solutions within the defined dimensions

n=60+

No consolidation (5 site): the number of community beds across the 5 sites reverts to before the temporary closures

n = 1

#	# Sites	Beds	Site combination
1	5	264	Longton, Leek, Cheadle, Bradwell, Haywood

Full consolidation (1 site): 132 beds consolidated across 1 single site

n = 6

#	# Sites	Beds	Site combination
2	1	132	Longton
3	1	132	Leek
4	1	132	Cheadle
5	1	132	Bradwell
6	1	132	Haywood
7	1	132	Care Home

Partial consolidation (2 site) – 132 beds consolidated across 2 sites

n = 15

#	# Sites	Beds	Site combination
8	2	132	Longton, Haywood
9	2	132	Longton, Cheadle
10	2	132	Longton, Leek
11	2	132	Longton, Bradwell
12	2	132	Longton, Care Home
13	2	132	Haywood, Cheadle
14	2	132	Haywood, Leek
15	2	132	Haywood, Bradwell
16	2	132	Haywood, Care Home
17	2	132	Cheadle, Leek
18	2	132	Cheadle, Bradwell
19	2	132	Cheadle, Care Home
20	2	132	Leek, Bradwell
21	2	132	Leek, Care Home
22	2	132	Bradwell, Care Home

This could still leave over 60 potential solutions

Provisional long list for discussion

All possible solutions within the defined dimensions

n=60+

Partial consolidation (3 site) – 132 beds consolidated across 3 sites

n = 20

#	# Sites	Beds	Site combination
23	3	132	Longton, Haywood, Cheadle
24	3	132	Longton, Haywood, Leek
25	3	132	Longton, Haywood, Bradwell
26	3	132	Longton, Haywood, Care Home
27	3	132	Longton, Cheadle, Leek
28	3	132	Longton, Cheadle, Bradwell
29	3	132	Longton, Cheadle, Care Home
30	3	132	Longton, Leek, Bradwell
31	3	132	Longton, Leek, Care Home
32	3	132	Longton, Bradwell, Care Home
33	3	132	Haywood, Cheadle, Leek
34	3	132	Haywood, Cheadle, Bradwell
35	3	132	Haywood, Cheadle, Care Home
36	3	132	Haywood, Leek, Bradwell
37	3	132	Haywood, Leek, Care Home
38	3	132	Haywood, Bradwell, Care Home
39	3	132	Cheadle, Leek, Bradwell
40	3	132	Cheadle, Leek, Care Home
41	3	132	Cheadle, Bradwell, Care Home
42	3	132	Leek, Bradwell, Care Home

Partial consolidation (4 site) – 132 beds consolidated across 4 sites

n = 15

#	# Sites	Beds	Site combination
43	4	132	Longton, Haywood, Cheadle, Leek
44	4	132	Longton, Haywood, Cheadle, Bradwell
45	4	132	Longton, Haywood, Cheadle, Care Home
46	4	132	Longton, Haywood, Leek, Bradwell
47	4	132	Longton, Haywood, Leek, Care Home
48	4	132	Longton, Haywood, Bradwell, Care Home
49	4	132	Longton, Cheadle, Leek, Bradwell
50	4	132	Longton, Cheadle, Leek, Care Home
51	4	132	Longton, Cheadle, Bradwell, Care Home
52	4	132	Longton, Leek, Bradwell, Care Home
53	4	132	Haywood, Cheadle, Leek, Bradwell
54	4	132	Haywood, Cheadle, Leek, Care Home
55	4	132	Haywood, Cheadle, Bradwell , Care Home
56	4	132	Haywood, Leek, Bradwell, Care Home
57	4	132	Cheadle, Leek, Bradwell, Care Home

This could still leave over 60 potential solutions

Provisional long list for discussion

All possible solutions within the defined dimensions

n=60+

Partial consolidation (5 site) – 132 beds consolidated across 5 sites

n = 6

#	# Sites	Beds	Site combination
58	5	132	Longton, Haywood, Cheadle, Leek, Bradwell
59	5	132	Longton, Haywood, Cheadle, Leek, Care Home
60	5	132	Longton, Haywood, Cheadle, Care Home, Bradwell
61	5	132	Longton, Haywood, Care Home, Leek, Bradwell
62	5	132	Longton, Care Home, Cheadle, Leek, Bradwell
63	5	132	Care Home, Haywood, Cheadle, Leek, Bradwell

No consolidation (6 site) – 132 beds consolidated across 6 sites

n = 1

#	# Sites	Beds	Site combination
64	5	132	Longton, Haywood, Cheadle, Leek, Bradwell, Care Home

Based on the above, the long list of draft options could be…

Locality	Refined
Stoke South (Longton)	One hub, As is from existing community site
	One hub, New site (ETTF) + site repurpose of existing community estate
	One hub, Use of Meir LIFT + site repurpose of existing community estate
Moorlands (Leek, Cheadle)	Two hubs, As is from existing community site
	Two hubs, Leek new (Knivedon), Cheadle existing community site
	Two hubs, Leek existing community site, Cheadle new
	One hub, Leek existing community site, Cheadle site repurpose
	One hub, Leek new (Knivedon), Cheadle site repurpose
	One hub, Cheadle existing community site, Leek site repurpose
Newcastle Bradwell	One hub, as is from existing community site
	One hub, Use of Milehouse LIFT + site repurpose of existing community estate
Stoke North Haywood	One hub, as is from existing community site
	One hub, Use of Middleport LIFT + site repurpose of existing community estate