Cannock Chase Clinical Commissioning Group
East Staffordshire Clinical Commissioning Group
North Staffordshire Clinical Commissioning Group
South East Staffordshire and Seisdon Peninsula Clinical Commissioning Group
Stafford and Surrounds Clinical Commissioning Group
Stoke-on-Trent Clinical Commissioning Group

The Future of Local Health Services in Northern Staffordshire
Expert Session

Wednesday 16th May 2018

8.30am – 2.00pm

Minton Room, Smithfield 1, Hanley, Staffs.

Attendees:

Zara Jones	ZJ	Director of Strategy, Planning & Performance, CCGs
Steve Fawcett	SF	Medical Director, CCGs
Gemma Smith	GS	Head of Strategic Commissioning, CCGs
Cheryl Hardisty	CH	Director of Strategic Commissioning & Operations, CCGs
Lorna Clarson	LC	Clinical Director for Partnerships & Engagement, CCGs
Lorraine Cook	LCO	Head of Quality, CCGs
Nicola Day	ND	Senior Commissioning Manager: Market Management and Quality Assurance Health and Care Staffordshire
Bridget Cameron	BC	Assistant Director – Commissioning, Health and Social Care, Public Health and Adult Social Care, City of Stoke-on-Trent
Robert Graves	RG	Director of Estates SSOTP & SSSFT
Jayne Deaville	JD	Director of Finance & Performance SSOTP & SSSFT
Alistair Mulvey	AM	Chief Finance Officer, CCGs
Dave Rushton	DR	Healthwatch Engagement Officer, Stoke-on-Trent
Paul Astley	PA	Healthwatch Engagement Officer, Stoke-on-Trent
Marcus Warnes	MW	Accountable Officer, CCGs
Christian Norris	CN	PA Consulting
Sohrab Khan	SK	PA Consulting
Anna Collins	AC	Head of Communications & Engagement, CCGs
Matt Oakes	MO	Senior Intelligence Analyst , CCGs
Jayne Brookfield	JB	Executive Assistant to Zara Jones (Minutes)

Introductions & Overview

ZJ explained that the purpose of the 'Expert Session' would be to take the emerging evidence into account regarding the future of the local health services in Northern Staffordshire, taking an objective rather than subjective view, with representatives from Health Watch attending to observe the process and provide feedback and challenge where appropriate. PA Consulting also attended in their role to help support the production of the business case. The Consultation Institute are providing quality assurance support and oversight of the legalities of the process being followed. ZJ referred to the pre-consultation activity and options development process undertaken by the CCGs and provided the following overview:

'Options Development Process'

October - December 2017

- Listening Events, Online Survey, Bespoke Events, Clinical Engagement

January - April 2018

- Options Development Event, Options Appraisal Event, Commissioner & Execs Consideration, Partner Involvement, Data Modelling.

May 2018

- 10th May Options consolidation event - to check we have captured previous feedback and understood this, presented beds long list.
- 16th May - Expert application of the hurdle criteria – must haves
- 25th May - Options Evaluation – public evaluation of the desirable criteria
- 30th May – Check Back – to present shortlist

June 2018

- Ranked shortlist & Due consideration by Governing Body

Pre-Consultation Engagement and the Modelling

LC gave an overview of the case for change, and highlighted the three main areas to be considered which are currently challenging the health economy, these being:

- Clinical
- Estates

- Financial

LC further explained the potential harm to patients caused by long term community bed based care, resulting in the deconditioning of patients. LC advised that the proposal is to 'left shift' and provide more care for patients closer to home, therefore there are difficult decisions to make in order to utilise staff and resources effectively and to also provide the right support for the workforce. With regards to the matter of estates, some buildings are not fit for purpose and would also have a negative impact on the quality of care provided. Therefore using the hospital sites effectively from both a quality of care and financial perspective is the challenge.

Understanding the potential options around the community beds

ZJ gave an overview, and highlighted the three main questions to be considered:

- How many beds may be required?
- How many sites could we deliver these beds from?
- Which sites could be used to deliver community hospitals?

ZJ further explained that the analysis suggests **132 beds are potentially required to meet the population need:**

The New Care Model

- With the previous 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.

Supporting Analysis

- Recognising the significance in change, significant supporting analysis has been undertaken by the system.
- Modelling indicating 132 beds are appropriate for needs was based on using six months discharge data from Acute Trust from September 16 to March 17.
- Of the main assumptions underpinning this position: 70% of complex discharges are cared within the patient's home and the remaining 30% either in a community bed or a nursing / residential bed, aligns with national best practice.
- In addition, there was national benchmarking, reviewing historical data and point prevalence

studies which supported the above assumption and outputs.

ZJ explained that to enable this to happen 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 individual's 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)

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

DR asked for clarification on the sites and exactly what the 132 beds includes, CH also questioned if the type / cohort of beds would be specified, GS advised that there would need to be flexibility on these points. LCO referred to the winter safety net as another example, with regards to having a robust and flexible system in place to cope with the demands of the system, and the possibility of utilising spot purchase beds when required. GS acknowledged that there would be a period of transition, but added that now the capacity is up and running and there is a reduced requirement for beds. GS also confirmed that there had not been any significant changes over the past 5 years regarding patient surges / demand for the number of beds required. SF asked if the current situation is a steady situation. GS confirmed that capacity is steady, but that the process requires attention, as the focus is to drive down the length of patient hospital stays and to prioritise the processes around the 'Home First' model, in order to deliver what the service requires. AM questioned if the proposal addresses the assumptions of the process, further explaining that there should be a different emphasis, as the figure of 132 beds could change. ND questioned how far ahead this current plan would cover. GS confirmed that the forecast is for the next 5 years.

There was a discussion about the detailed workings behind the modelling. MW stressed that the public perception is that the system is still in crisis, therefore the detailed level of information is important to understand to support the proposal. GS reassured that there are monthly CRB meetings, quality visits, KPIs, GP input and patient outcomes which have all contributed to ensure a robust process is in place. PA referred to public concerns about comparing like with like as far as commissioned beds in nursing homes and community beds are concerned as the public believe that the CQC assessments of care homes indicate that care is of poorer quality than is a hospital setting. MW agreed it was a fair comment as

people only tend to read about lower quality ratings and the CCGs would not commission beds in the badly performing care homes. GS also added that here had been issues regarding some care homes, but again reassured that positive work is being done to improve this matter moving forward.

JD also added that having enough beds to ensure the system is not being run on the minimum requirements is a major concern. GS / CH advised that this would be addressed, with a similar system possibly to be implemented as used for the winter pressures.

BC suggested that looking at the evidence again with members would be a positive step, advising that this should happen prior to the next 'Cabinet Meeting', AC agreed to look at arranging this.

MW stressed that wrap around care is needed to address these important concerns. ND referred to concerns around care home beds, MW again reassured on this matter, SF also added that there are 'step up beds' in place accordingly. LCO highlighted again that the public require reassurance on the quality of care being provided, referring to the evidence based around falls and the need to keep patients safe.

Over 60 potential solutions - provisional long list – subject to significant testing

ZJ advised that 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.

ZJ questioned if attendees thought there were any other options to consider, as all possibilities would need to be explored. It was agreed by all attendees to progress to the next stage of the process with these options.

Draft criteria - Based on a number of key principles

ZJ advised that this technical expert session looks at the application of the 'Must haves' criteria – if an options fails a 'must have' criteria, it will be removed. 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

'Desirables'

- Based on stakeholder feedback about what is important
- Public acceptability is a qualitative factor used to indicate preference
- Determinants may be based on local knowledge and patient experience
- Sentiment can be given a mathematical indicator using weighting s and scores
- Not a vote

Discussion continued around other issues relating to this process, ZJ addressed concerns around matters that are less fixed such as bus routes, advising that moving forward a reference group could be involved. ZJ further reassured, advising that the CCGs would be considering the views of the public in this process through scoring of desirable criteria, with the CCGs Governing Bodies making final decisions following this broad stakeholder input.

Draft criteria based on a number of key principles

ZJ presented the 3 areas of evaluation as below:

Clinically sustainable:

- Safety
- Clinical quality / outcomes
- Meeting clinical standards
- Clinical Governance of services
- Long term Workforce
- High quality training
- Needs to be efficient to maximise capacity at the most local level possible
- Services that will be available and secure into future
- Integrated teams
- Focus on Prevention and Education

Fit with National and Local Strategy:

- Strategic alignment
- Five year plans – Five Year Forward View, Mental Health 5 yr Strategy
- CCG Operational Plans
- Commissioning intentions
- Staffordshire Transformation Partnership
- Joined up social and health care commissioning
- National strategy for care closer to home

Affordable:

- Income & Expenditure impacts
- Net present value of options
- Capital receipts and expenditure

ZJ asked if there were any further criteria to be considered, and if the attendees were in agreement that a subset of criteria should be focused on. It was agreed to move to the next stage of the process with these

criteria

Potential Hurdle Criteria

ZJ further presented the potential hurdle criteria as follows:

- **Clinically sustainable** - Potential hurdle: Does the draft option support clinical sustainability?
- **Fit with National and Local Strategy** - Potential hurdle: Is the draft option consistent to national and local strategy?
- **Affordable** - Potential hurdle: Does the option improve the financial position of the system?

The attendees were asked to consider these key questions as an important part of the process, in order to move forward.

LC presented the following 3 'Must have criteria':

#1 Must have - Clinically Sustainable, Quality Outcomes and Workforce

#2 Must have - fit with National and Local Strategy

#3 Must have – affordable (1) #3 Must have – affordable (2)

LC explained that clinical sustainability can be difficult to measure. RC questioned why recruitment of staff and maintaining the workforce required is so difficult in the Stoke / Staffordshire area. LC advised that it is a combination of national challenges, as staff may prefer to work in bigger cities such as Birmingham or Manchester, and also the nature of the Stoke / Staffordshire area which is generally more deprived. LC added that the morale of staff can be lower in this area, therefore trying to apply the appropriate skill mix is important, incorporating development opportunities for all staff. AM agreed that addressing these staffing issues is vitally important, with a need to test out the risks involved and to look at the clinical sustainability, skill mix being a measure. RG raised the point that there could be more community hubs than community beds. AM reassured that all of the options would be evaluated accordingly. LCO questioned what the aspiration is to attract new staff, LC advised that the Haywood Hospital is a good example of excellent care and is well recognised for this. LC added that there could be a hub and spoke model to address this.

ZJ acknowledged the points raised and advised that the more detailed analysis would be addressed at a later stage in the process, but stressed that the priority of this session was to ensure all attendees are in agreement that the conversations around clinical sustainability are adequate. JD added that it is obvious that the current set up of 5 sites needs to be changed. ND referred to the matter of continuity plans. CH gave the example of Longton Hospital closing following safety concerns, which had been dealt with successfully. CN asked whether people wanted to move to the financial discussion of the process

alongside the clinical sustainability criteria. All attendees agreed to move the discussions forward accordingly.

RG referred to the matter of care being provided closer to home for patients, questioning what this actually means. BC referred to local geographic hotspots regarding residential planning and school numbers, advising that there are papers to discuss on these matters to ensure alignment of hospital services. BC further added that it is important to understand the significant impact of new housing and schools on NHS services. GS explained that from a beds perspective that 'step-down' beds are the focus, with the challenge from the public being the removal of local beds, adding it can be difficult to factor in as families are often spread across different areas. BC acknowledged the good work that has been done in researching this area. GS further added that from a patient perspective there should not be a negative impact. BC also referred to the capacity and access issues which could be faced.

CN asked whether people had any views around the total number of sites. JD explained that the option of 5 sites could be ruled out as this is not at all viable, either from a clinical or financial perspective. This was supported in the room. It was also explained that whilst 264 beds is important to retain in the process as a 'do nothing option,' the group needed to consider the viability of taking forward this option whilst considering the current state of a significant number of empty beds which could not be staffed and capacity not there to fill them. The group agreed to continue to review the options around the 132 beds on this basis. MW referred to the STP and having clear criteria to fit with the STP strategy. AC advised that there are certain points which are mandatory in the STP consultation process.

The list of options continued to be reviewed, and the discussion regarding Haywood Hospital continued. JD referred to the significant financial cost of vacating Haywood Hospital, which would not be viable. ZJ questioned if the decision would therefore be to include Haywood Hospital, the attendees agreed. LCO added that from a clinical / quality of care perspective the Haywood Hospital is a very positive example. GS questioned if it would be possible to have more than 77 beds at Haywood Hospital. RG advised that this would need to be looked put increasing the number of beds could be a possibility. GS clarified that there are currently 132 beds in total at Haywood Hospital when specialist care beds are also included. ZJ questioned if the option of Haywood Hospital providing all of the beds would be viable. LC questioned if there would be the finances to implement this. MW also added that looking at the type of beds to be used would be very important. RG referred to the capital money from the PFI contract. CH stressed concerns around having Haywood Hospital as one main site only. AM reiterated that this emphasised the need for the hurdle criteria proposed. CN asked if all beds could be fitted into this location. MW referred to the Haywood Hospital PFI as a fixed point to feature in the options. BC/CH raised instinctive concerns again about having Haywood Hospital as the one main site. ZJ reiterated that the process needs to be objective, and reassured that a quality impact assessment would always be implemented. CH referred to the financial cost of £2,100 per bed at Haywood Hospital, questioning if this would rule it out. AM again stressed that decisions should not be based on instinct and the importance of following the hurdle criteria, to ensure the correct level of scrutiny and an objective process.

There was a discussion around the minimum number of beds which a hospital site could run in order to be clinically viable. It was acknowledged that there was no set national evidence aside from safe nursing to patient ratios. JD indicated that SSOTP would be able to provide an indication of the appropriate sizing based on current and previous experience across the sites. It was suggested that a level at around 2

wards worth of beds would be in the right region to provide safe and sustainable care. It was agreed that SSOTP would be engaged with to gain a clinical view.

SK provided further clarification of the details on the presentation being referred to. ND referred to the possible ranking care for each site, SK / CN advised that they would check if it is possible to get this information. AM referred to the financial cost of updating the different sites. RG stressed caution regarding the financial details and stressed that clinical sustainability is a priority. AM added that using the tools at our disposal and how we use them to improve the current situation is the question. ND referred to the quoted cost of an average care home bed, which is £750 per week, GS confirmed this figure which also includes therapy costs. GS advised that it would be a formal process of choosing care homes accordingly.

CN asked about the role of other hospital sites, in the context of the Haywood discussion, SF referred to Longton Hospital, advising that it is not a good site, but the financial information would need to be reviewed, as this is not in the current details provided. RG stressed that it would be dubious to rule out any sites at this stage, advising that business cases would need to be done on each site moving forward.

BC added that business cases would evidence for each site, giving an overview of information and demonstrate why sites can be ruled out, both clinically and financially, stressing that this would be an articulated narrative moving forward. AC acknowledged these points and advised that it would be important which direction is taken in this process. It was agreed that the key financials relating to each site would be used in the latter stages of the process to support shortlisted options and a preferred option.

CN noted that typically further information is considered and developed around the shortlisted options. JD advised that staffing costs equate to 70% of hospital care, therefore if there is not a large enough cohort of beds in a location then the costs are dramatically increased.

ZJ advised that the key points of the presentation had been put forward, therefore having attendees views regarding the desirable criteria would be next.

The discussion moved onto a summary, setting out that the 3 hurdle criteria had been discussed. Firstly the clinical / quality hurdle, including any concerns around fewer than a set number of beds at any location, implying a minimum number requirement could be stipulated. Secondly the strategic hurdle, with no immediate changes to the set of options proposed. Thirdly the financial hurdle, with agreement on using the 77 beds at Haywood Hospital, with further discussion required as to whether there should be an increase / expansion at Haywood Hospital, or if other sites should also be used. This summary was considered and agreed to be a reasonable reflection of the discussion.

Across the four localities, options around the potential sites:

GS gave a detailed overview of the four localities, Site 1 buildings: Haywood Hospital, Longton Cottage Hospital, Bradwell Hospital and Leek Moorlands Hospital, Site 2 buildings; Middleport Medical Centre, Meir Primary Care Centre, Milehouse Primary Care Centre and Cheadle Hospital.

Hubs need to align to practices:

GS further explained that the proposed four of five Hubs to serve the population accordingly:

- 77 practices in Stoke and North Staffordshire
- From the 77 practices, there are 8 localities who geographically aligned to work together to support local service provision
- From the 8 localities, in order to deliver services at scale to benefit local populations, it is proposed that there will be four or five Hubs serving population sizes of between 100,000 and 190,000

Developing a new model for delivering wider community services:

GS advised that the proposed services have been developed in a number of areas. Advising regarding the groups that have been engaged during the service development process which include: Health Watch, Acute Trust UHNM, SSOTP, Combined Healthcare, Voluntary sector, Stoke on Trent City Council, Staffordshire County Council, Patient members, Lay members, Alliance boards, GP federation, Overview and Scrutiny Committees, MPs meeting, NHSE, NHSI, Localities, General Practice, Pharmacy, and Optometry.

GS also added that service development forms part of the Enhanced Primary Care work stream of the wider STP being developed.

Proposed draft hub services have been developed against a number of principles:

- Provision of services at scale
- Community centred care
- MDT approach
- Extended access to GP practices
- Coordination of cross sector services
- Holistic and based on patient needs

GS further explained that the service will be delivered through localities and primary care hubs, moving forwards under a multi-disciplinary approach, utilising risk stratification to identify those patients requiring proactive management and support across a team of specialist nurses. These teams would also include: therapists, mental health professionals, pharmacists, and social care professionals, supported by the overarching governance of specialist consultants where required. With the certain constraints also highlighted, as below.

It is important that the services are considered in the context of a number of constraints:

Not Commissioned by CCGs:

- Drug & Alcohol services
- Smoking cessation
- Sexual health

- Hydrotherapy
- Fitness Support
- Respite care
- LA led areas e.g. health care village services

Cannot be provided everywhere:

- Diagnostics
- Urgent Treatment Centre
- Maternity / ultrasound

The discussion referred back to the potential sites which had been looked at by attendees, ZJ again asked for clarification as to whether any other locations are to be considered in the process. RG referred to LIFT, long term contracts which are a fixed cost to the health economy for 25 – 40 years. SF referred to Biddulph, GS advised that Leek Hospital would be looked at as the only viable option for that area. CH advised that site 2 costs would also be needed. RG agreed stressed that all details are important to be considered. AC also added that if the Federation have ruled out any options then an explanation about why this decision was taken would be required.

Draft Hub options from a clinically sustainability perspective:

GS gave an overview of these options, questioning if these were deliverable. Further discussion followed around these options. DR raised concerns around issues encountered with bus routes, stressing that this could have an impact on patients getting to sites. BC also added that patient parking would need to be considered, as complaints from residents can cause significant issues, therefore accessibility is key.

LC highlighted that the Membership have been engaged with and gave an overview of the draft 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

ND questioned why there is such a dramatic difference in the GP vacancies across the different areas, LC explained that unfortunately Stoke on Trent and North Staffordshire are not as such desired destination for GPs, and there are also many older GPs who have also retired.

#2 Must have - Fit with National and Local Strategy:

Draft evidence: The size of the population served best by the hub is dependent largely by its service

delivery model. Other systems have developed 'super-hubs', providing services for populations over 100,000. Population by locality is estimated to be :

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

ZJ questioned if this is the right hurdle criteria and requested views from all attendees. All attendees agreed with the hurdle criteria accordingly. ND specifically asked if demand is based on demographics. AC clarified that local need is a specific desirable.CH added that plans for housing and the subsequent populations as a result of this will have a massive impact. AC advised that the local need is a desirable criteria, which will take into account the JSNA, local health data, differences in rurality, and specific conditions in some locations such as respiratory and health inequalities. AC also added that projects such as HS2 mean that demographics will change in some areas. JD added that there is also the army base in the Stafford area which will significantly increase in size in the coming years.GS acknowledged all of these important points and stressed the need to ensure the right model is delivered in the right locations.

#3 Must have – affordable:

Draft 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)

ZJ gave an overview of these points and requested any comments from attendees. SF advised that regarding the broader estate information would be required to make an informed decision. SF specifically referred to SSOTP and the physiotherapy service which they provide. RG added that aligning the community hubs is a priority.

The group worked through how the discussed criteria might impact the possible 60+ options for sites which could be considered. Based on a minimum number of beds at a site and including all beds at the Haywood PFI from a financial perspective, then only 2 site options would meet these criteria.

This therefore would leave 6 possible site options available as follows:

1. **Haywood Hospital**

2. **Haywood Hospital & Longton Hospital**
3. **Haywood Hospital & Bradwell Hospital**
4. **Haywood Hospital & Leek/ Moorlands Hospital**
5. **Haywood Hospital & Cheadle Hospital**
6. **Haywood Hospital & Care Homes**

SK agreed to check the estimate of work required to update Longton Hospital, as SF / JD thought the estimates quoted seemed very low in comparison to the amount of updating the building requires.

CN asked if 6 possible options was a reasonable short list. CH asked if it would be possible to compare affordability, CN suggested this could be achieved in the next stage. DR raised concerns regarding geographic locations of the 6 sites. CN suggested the equalities impact assessment could consider travel times.

LC advised that the public are to have their say on 25th May, therefore there is a need to ensure a safe and viable service is put forward. AC agreed with this point, but also added that it is important to articulate clearly the proposed service. ND referred to care homes, CH advised that all of the details would be considered. GS highlighted that a balance regarding the number of beds is important, as a small number are not the best solution, and neither are too many. GS also reassured JD that wrap around services will be addressed. ND also stressed that moving patients on from care homes is of concern. GS explained that the outcomes are similar for both 24 hour care and care homes, that the evidence suggests no significant difference. GS referred to EMI beds which are of interest to the public and therefore clarity would be required. GS also referred to ward 4 and that the contracts are time limited, therefore the outcome of procurement would determine the number of beds.

ZJ / GS asked attendees for feedback regarding the 'Hub' options. SF advised that 2 hubs in the Moorlands area would not be viable. MW agreed that splitting the smallest area into 2 hubs is not really viable. AC therefore questioned if there should be 2 hubs in the Moorlands. MW advised that it would be necessary to look at the diagnostics available at the different hubs to have the evidence required. GS explained that historical data shows patients prefer not to go to Cheadle Hospital. ZJ sought clarification from the group that the 2 hubs in the Moorlands area would not be sustainable, therefore the 1 hub options would only be considered, the attendees agreed accordingly.

ZJ asked attendees for feedback regarding the 'Hub' options for the Stoke South area, discussion followed regarding Haywood Hospital as the key hub. There was then a conversation about Middleport GS expressed concerns around this suggestion. BC again reiterated concerns around parking matters and the ability to develop the facility was articulated. MW suggested that Haywood Hospital would be the best option, when comparing the two sites.
ZJ further summarized that looking at the further hurdle criteria, the 2 'Hubs' in the Moorlands area are not viable, this was agreed by all attendees.

ZJ questioned if further criteria would possibly affect the options again, therefore the **8 possible 'Hubs'** were reviewed again to clarity from a clinical sustainability perspective.

Following the review the 8 possible 'Hubs' below were agreed:

Stoke South (Longton)

1.One hub, New site (ETTF) + site repurpose of existing community estate
2.One hub, Use of existing site (Meir LIFT) + site repurpose of existing community estate

Moorlands (Leek, Cheadle)

3.One hub, Leek existing community site, Cheadle site repurpose
4.One hub, Leek new (Knivedon), Cheadle site repurpose
5.One hub, Cheadle existing community site, Leek site repurpose

Newcastle / Bradwell

6.One hub, as is from existing community site
7.One hub, Use of existing site (Milehouse LIFT) + site repurpose of existing community estate

Stoke North / Haywood

8.One hub, as is from existing community site

Actions:

1. Longton backlog maintenance information to be checked - CN / SK

2. Number of beds sustainable to be clarified, whether 32 beds min / 40 beds min – LC / SF
(Cumbria example given as 1 nurse to 8 patients ratio)
Need to consider what is clinically viable, therefore input from clinicians and nursing staff required.

3. Contingency and flex in system should there be a crisis – CH / GS

It was agreed that the 'Expert Session 'had achieved the objectives set out. ZJ thanked all attendees for their positive contribution to this important process.