PCBC Reference Group Event
Thursday 10th May 2018
Bridge Centre

Below are the flipchart comments and questions from both sessions working in groups on tables, and from the final question and answer session with questions from individuals to the panel.

Long list development and hurdles

1. Haven't stipulated how have reached 132 from 264? Need to know where beds were initially, there were:

- 64 Bradwell
- 48 Cheadle
- 36 Leek
- 77 Haywood
- 44 Longton
- + 5 per week
- 264

2. These slides need to be bigger so can read
3. New sites- what are these?
4. As patient- would like this simplified. This seems to be designed to confuse, the presentation doesn't help anyone
5. Is it possible to set an independent person to check how these numbers have been reached, not CCG/NHSE
6. Most areas will want integrated care hubs and beds
7. We need step up and step down beds- if had been these beds at UHN wouldn't have been in state it was. At present many medically fit for discharge patients in Royal Stoke who could have gone to these beds. Correlation with no ot temp closed beds

1. Aligning UTC decisions which depend on the STP with decisions within this consultation
2. 184 beds closed- are they going to re-open
3. No indication of where the beds will be distributed- i.e how many in each location
4. What is the 'new site'
5. Don't accept/understand the 132 beds
6. In sufficient detail- should be further on regarding options
7. What can the CCG afford?
8. Can quality care be produced across (how many sites?)
9. Don't have defined options yet

1. +132, seasonality/ winter planning if AVG doesn't work
2. Needs to have flex
3. Is it an av of year?
4. Is it an av of country?

5. Need to see the data
6. Unmet demand
7. Where is the phasing of alternative services
8. Comm/pc services needed
9. If 260 over capacity, would have seen
10. STP demand/ capacity model, alignment e.g winter planning alignment, winter modelling, S.C
11. 2nd highest in county for avoidable death
12. S.C no rep but key to model, no invites
13. Evidence of joined up?
14. Long list- aligned to need pod, demo, need, accessibility
15. Framing, justify what done, publicity stunt
16. Work for 132 # has not been done, health system wide modelling
17. Bradwell, very busy upward utilisation - # to argument in report # reality
18. Don't see capacity in com
19. Bradwell beds not acute meeting unmet need
20. UHNM strategy, up beds while?
21. Home first, need infrastructure in the comm
22. Impact of STP on key areas e.g UTC
23. Backlog maintenance 7.5m, e.g.west building, other money for beds required in system
24. Hurdle, affordability, deliver ability, quality of care, missing accessibility
25. To consider, transition/ comms, workforce training, morale low, staff/patients,
26. Higher rate of avoidable death in Stoke
27. Data used, 15/16 16/17, UHNM discharge patients
28. Can't at one not consult on terms, not consider
29. CCG and care organisations need to work together, EQIA, impacts

1. Wish list, not considered resources available in community, i.e district nurses, default back to GPs
2. Social services, community and voluntary sector
3. Not adequate now so reduced beds could put pressure on resources
4. Some care services, concerns over quality, young- 2 days training
5. Decisions being made by other organisations having impact on ability to offer services
6. Use of care homes, concerns over quality
7. Hurdle criteria- big items need breaking down.
8. Geography/rural areas
9. Support network/family
10. Accessibility
11. Clarify- want to understand the modelling/data to get the 132

1. Kings fund re intermediate care beds in the area- neighbouring table.
2. OECD bed base-
3. Logic of argument doesn't hold sway- focus on closure.
4. People will fall through gaps and will die- to applause.

5. define what we need by bed based care- never have they had 24 hours bed based care.- people do not stay in bed.
6. Leek losing intermediate
7. care beds - patients ending jump in congleton.
8. Outsourcing making it difficult to repatriate to community.

9. Accessibility caused a lot of discussion- can't have quality if not accessible.

10. Medical cover for intermediate care- needs adequate and safe workforce.
11. Where is the needs analysis for the community service and workforce offer?

12. Quality impact assessment needs to be made public in a way that people understand and should be part of discussion.

13. Affordability- equals systemically sustainable Patient needs data is missing- point prevalence study is insufficient- we need patient needs data by locality to inform the discussion- what we have had is inadequate or not provided.

14. Sequencing- community beds need to work alongside left-shift etc..

<u>Question from many tables: </u>How did we arrive at 132?

Hubs / Services and Estates long list

- Another option for 'hub' – (similar to option 4 at Leek)
  - 'Well Street' site – even temporarily while re-developing Cheadle Hospital
- Not clear if Consultant link to secondary care is included
  - More than just geriatrician
- Pharmacy needs to be part of Hub – to go along with extended access
- Should there be a 'Stoke central' locality Hub?
- Evidence that 'health villages' work?
- Joining up IT services across the health services – use of different systems
- Question around Voluntary Sector Commissioning – if health services are going to work with the Voluntary Sector need to improve the commissioning process to be considerate of how those organisations work – to ensure their survival and viability

- Perinatal / services
- Options: residential element at Longton – not needed large sheltered housing next door
- Day care facilities / social facilities
- 3 GP surgeries – Leek – clarity on incorporating GP services verses practices
- Family services – clinics
- Links to community services
  - Care in the community
  - SSOTP
  - Oversight of community services

- Quality monitoring / contracts
- Commissioned – sustainability
- Minor ailments / MIUs – urgent care offer
- Kniveden – where's it up to? Been talked about for a while
- Hubs need to be tailored to geography i.e. rural areas

- Options – reflection
- Explain Hub and spoke model – services clarity – 2A CARIER / young adolescent services
- Ethos – implementation
- Options do not reflect end to date – Bradwell
- Bradwell – need what we have and Mental Health unit and expand ETTF Primary Care unit
  - Longton OP2 + Bradwell OP3 – what they ask for
  - Need an active mental health unit
  - Int hospital + Hub – alleviate pressures throughout
- Leek, Cheadle
  - Disparate and sparse
  - Hubs – not accessible – mitigated by the spoke
- Explain Hubs and spoke model – needs better explanation
- Bradwell Hospital – Newcastle – impressing mental health / elderly – services for younger need; Newcastle needs teenager / adolescent – the village needs to be more than elderly care
- Ethos – how you integrate
- Care village – subset of delivery including LD needs
  - Hub w/spoke
  - Happy w/principle
- Locality – facility of a 'super community hospital'
  - Location of community hospital and Hubs
- North of Stoke ok location
- South – more difficult accessibility
- Activity flows in and out of the system

1) Please supply glossary of all terms used in slides e.g. HCAs etc.
2) How many doctors would be in each Hub?
   - Workforce
   - Planning for all skills essential
3) How are the demographics worked out – some areas needs are different from others
4) Concerned all older GPs are going to retire. Lot of new GPs only want to work 9am – 5pm on locum basis
5) If this Hub model works – it would be good as long as works
6) Are these services 9am – 5pm or 24/7? Need fast response – move towards STP requirements
7) Workforce concerns
8) Services like sexual health – even if commissioned by other organisations – need to be at Hubs
9) Accurate signposting for public needed
10) Need GP triage system – so GP there 24/7 to refer to right place / Walk in Centre and Hub
11) Need realistic timescale for the transition – this is a major change in service provision and public need to buy into this so that services are used
12) Mental health – Hub needs to be able to help people in crisis

13) Dementia centre of excellence (good one in Dudley) (some elderly people MFFD but can't afford to keep homes and carers won't go in – need grants advice)
14) Benefits / advice needs to be in Hubs
    - Grants – need to give CAB etc. grants to fund this
15) Is there any guarantee that Voluntary Sector funding will be there?
16) Want an ambulance service back, rather than based at Festival Park – not even got a first response service

1. Gaps in services-
2. We need to understand the urgent care offer and how this dovetails with extended access.
3. Community Mental health services need to be embedded within the hubs.

4. What do we mean by core services.
5. Concerns for existing GP practice options and level of distribution .
6. Concerns re northfield village model- overselling the positives but not recognising negatives, where we got to was that it may make sense for multi purpose facilities to support financial viability- but may not all be integrated.

Questions and comments captured in final part of the session

- What is 'new' site referenced in the slide?
- What is long term vision?
- Emotive comments not helpful
- Disconnect with wider system
- Back to front
- Need to know resources verses options / priorities
- Internal experts - need independence
    - Internal experts = Healthwatch / Lay Members to observe process
    - Consultation Institute = advisors

- UHNM moving services to Stafford – travel times from Moorlands
- Not working with you
- Part of STP consultation
- People not being offered services in community: figures maybe incorrect
- Travel is an issue – other side of coin is waiting times for elective
- Important to give people options
- Referral to outpatient services is clinical decision
- Physio etc.
- Choice of location needs to be given as options
- Consultant needs to offer community options
- On 25th will we get granular information on finance / workforce?
- Outpatient appointments in community – part of future fit?
- Different schools of thought around outpatients i.e. technology
- But now services more specialist: general clinics more difficult for some conditions
- Thank you for building in training and forward planning

- Planning for issues upfront i.e. workforce
- Praise for hip replacement at County