The Future of Local Health Services in Northern Staffordshire

OWNERSHIP & CONTROL
Organisation: North Staffordshire & Stoke on Trent Clinical Commissioning Groups
Assessment Lead: Associate Director, Anna Collins
Directorate/Team responsible for the assessment: Communication & Engagement
Board Member responsible for the assessment: Accountable Officer, Marcus Warnes
Date of commencing the assessment: 8th June 2018
Date for completing the assessment: Ongoing to completion of formal consultation
Version: Draft v.3
Peer Reviews: "The Public Consultation should include seeking feedback which considers what reasonable adjustments would help people with disabilities and enabling fair access and take-up of local hospital and community services. This Equality Impact & Risk Assessment (EIRA) provides an overview of our current understanding of how CCGs can build on the existing targeted engagement with the various diverse populations and their associated health challenges of both Stoke-on-Trent and North Staffordshire. It recognises our 'due regard' legal responsibilities under the Public Sector Equality Duty (PSED) to provide an audit trail of our deliberate consideration of people from groups protected by the Equality Act 2010, in all our planning and decision making. The EIRA captures how CCGs are taking 'due regard' in the Future of Local Health Services and the Pre Consultation Business Case in their planning and decision making. We evidence what we are doing to meet the PSED and how our approach to commissioning of healthcare services is inclusive of people from local protected characteristic groups. The Public Consultation will seeking feedback from diverse communities to consider the reasonable adjustments would help people with disabilities and enable fair access and inclusion to local hospital and community services". **Equality & Inclusion Business Partner – Midlands and Lancashire Commissioning Support Unit** "Firstly it's great that this piece of work has been undertaken, that it's using a process which has been designed to be compliant with the legislation and by a person who knows what they are doing. However, the real issue ensuring that this desk research under goes sensitivity testing with local PC groups and even more importantly that there is a meaningful discussion of its findings by decision makers during the option development phase. I see there is time scheduled for the latter and I recall that you have a plan for the former whereby the EA is to be reviewed by your local Equalities Advisory Group. This is good stuff". **The Consultation Institute**

Sign Off: CCGs Joint Governing Body 18th June 2018

BACKGROUND

The health and social care needs of the North Staffordshire and Stoke-on-Trent population are changing. People are living longer with increasing long-term conditions, requiring ongoing support and management. This is putting a significant strain on our services and the sustainability of the health system.

Given these pressures, we need to think differently about how we provide services closer to home, and in particular for adults with high clinical needs (such as multiple long term conditions and/or significant frailty) who are at risk of unnecessary or inappropriate admission to acute hospitals. Our community hospitals provide both bed-based services and wider non-bed based services including outpatient care, minor injuries, day case and, x-ray.

Our focus is on ensuring the greatest health benefit from these resources which will allow patients to manage their own conditions and access care from home. We are engaging with the public and local stakeholders to develop proposals to meet these aims, including what the future role of our community hospitals and associated services should be.

The draft model of care we have developed for our community services aims to meet the needs of the local population and deliver the right care in the right setting. This is consistent with the NHS Five Year Forward View, the GP Five Year Forward View and the Five Year Forward View for Mental Health. We believe the range of services within our communities, including community hospitals, can make a significant contribution to the development of new local care models. This should lead to better outcomes for patients and provide more sustainable services.

The clinical case for change along with the viable solutions to the problems described are clearly articulated in the Pre-Consultation Business case which has been developed with clinicians, providers, patients and other key stakeholders.

By designing a model of care closer to home, this PCBC focusses on community-based services across North Staffordshire and Stoke-on-Trent. Specifically, we consider the proposed way forward for community-based care covering:

- The bed configuration for community services Adult Intermediate Rehabilitation Service Beds (AIRS beds); and
- Our proposals to integrate and expand existing wider community services into Integrated Care Hubs.

STAKEHOLDERS WHO MAY BE AFFECTED BY THE PROPOSALS

In developing our approach and considerations the approach has been to ensure that no-one receives less favourable treatment due to their personal circumstances, i.e. the protected characteristics of their age, disability, sex (gender), gender reassignment status, sexual orientation, marriage and civil partnership status, race, religion or belief, pregnancy and maternity status. Appropriate consideration will also be given to gender identity, socio-economic status, immigration status and the FREDA principles of the Human Rights and health inclusion groups – where there are local concerns.
An overarching consideration in the proposals has been to reduce health inequalities and improve patient outcomes.

It is considered that the following groups of people all have the potential to be positively or negatively affected by the proposals:-

- Patients, service users
- Carers or family
- General Public
- Staff
- Partner organisations

PROTECTED GROUPS INVOLVED IN THE EQUALITY IMPACT ASSESSMENT

The North Staffordshire and Stoke on Trent CCGs have undertaken substantial engagement with a wide range of stakeholders and the public since it commenced pre consultation in 2014. This on-going dialogue has informed the development of this Case for Change.

A stakeholder mapping exercise was undertaken with the Local Equality Advisory Forum (LEAF) on 23rd May 2018 to inform the Consultation Plan. This is provided at Appendix 1. It was cross referenced against the CCGs database of organisations representing protected groups. This will ensure that the appropriate organisations and individuals are consulted in an accessible and appropriate way that meets their needs. A comprehensive stakeholder list is provided as Appendix 3 of the Consultation Plan.

Representatives of people with the protected groups will be asked to provide feedback on a regular basis on the Equality Impact assessment through the CCGs Local Equality Advisory Forum (LEAF). The group meets bi-monthly and acts as a group of critical friends to give feedback from the perspective of groups including older people, race & ethnicity, LGB&T+, Disability (learning disability, deafness and disability support are represented), faith, pregnancy & maternity, homelessness, asylum seekers & refugees & gypsy/traveler.

LEAF representatives were involved in the Options Development and Appraisal Reference Groups.

EVIDENCE USED FOR ASSESSMENT

The following evidence has been considered as part of the Equality Impact Assessment

Local Service Usage data equality monitoring data

- Joint Strategic Needs Assessment
- Local Health Inequalities data
- Demographic data and Office of National Statistics projections

A summary of local health needs and equality data is provided as Appendix 2 and more detail can be found by following the links below.

Staffordshire Moorlands Data Pack

Newcastle & District Data Pack

Stoke North Data Pack

Stoke South Data Pack

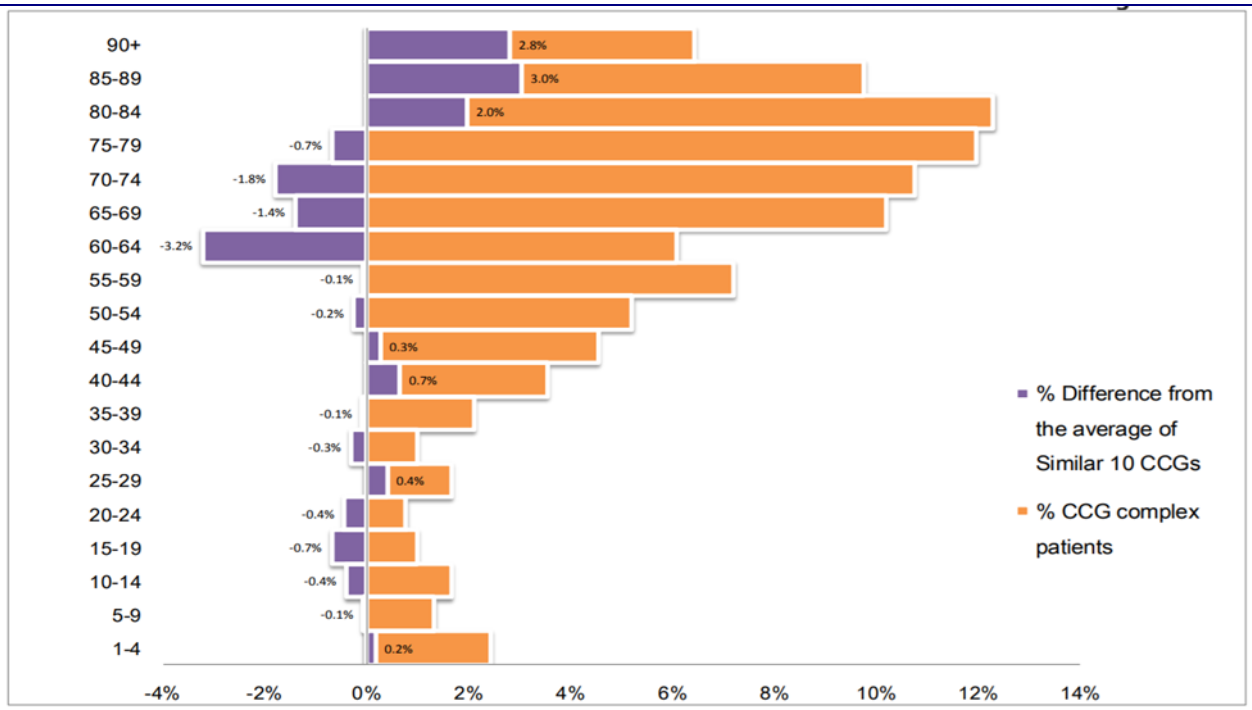
- The shortlist of options was developed against accessibility assessment criteria which was co-produced with stakeholders and considered:-
    - Travel time & transport routes with subsidised transport
    - Digital Technology - skype, telephone conversations, apps
    - Equity of service based on local 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 centered language

HEALTH INEQUALITIES

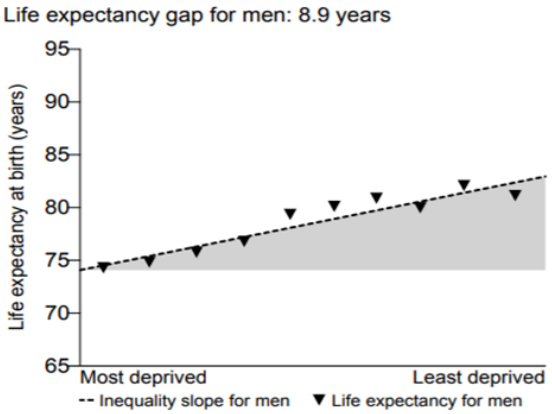
Complex patients profile and Life Expectancy for Stoke-on-Trent CCG

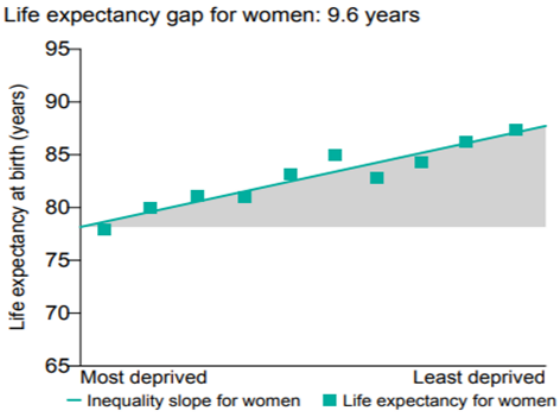
- The profile of complex patients within Stoke-on-Trent is also older than within comparator CCGs, with the 80+ age bracket making up an increased proportion of complex patients in Stoke-on-Trent relative to statistical comparators. The below chart demonstrates the number of complex cases managed within the CCG area by age bracket. This chart shows that complexity significantly increases with age, with over 65% of complex cases within the CCG being associated with the 65+ age brackets.

Chart A1.4 - The number of complex cases managed within the CCG area by age bracket



Source: Stoke-on-Trent CCG NHS Right Care pack January 2017 https://www.england.nhs.uk/rightcare/wp-content/uploads/sites/40/2017/01/cfv-stoke-on-trent-jan17.pdf





The charts below compare the death rates in people under 75 (early deaths) between Stoke-on-Trent and the England average. The life expectancy in the most deprived areas is significantly lower than the England average for both men and women.

The positive impact on health outcomes and reducing health inequalities are that the better access patients have to the right care for their acute needs and long term health conditions, the lesser the need will be for admissions to hospital and the greater the level of management of conditions, thus improving quality of life. Greater accessibility also leads to reduced anxiety and an improved patient experience.

COMMUNITY REHABILITATION BEDS

Currently, 175 Adult Intermediate Rehabilitation beds are provided from the 5 community hospitals plus additional capacity in the care home setting. 184 of the rehabilitation beds are temporarily closed.

In addition, a broad range of community based services are spread across a variety of settings including community hospitals and GP Practices. The Services are currently commissioned from the Midlands Partnership Foundation Trust (MPFT) and from individual nursing and residential homes.

The short list of options for community beds is presented below:-

	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

Older people, who require rehabilitation and reablement support, following an illness or injury, are often admitted to a community hospital bed, particularly following an acute hospital episode.

The current model of care can cause 'decompensation' for elderly patients as well as being clinically and financially unsustainable:

Improving quality of care: Caring for older people in a hospital bed can be detrimental to such an extent that it can outweigh the benefit of care received due to the extent of physical, psychological, cognitive and social 'deconditioning'.

Improving the sustainability of the workforce: The majority of community beds are provided from single stand-alone wards across 5 community hospitals which face continual workforce resilience challenges.

Improving service effectiveness and efficiency: The mind set of health and social care is still too often hospital bed first, although people want to remain in their own home whenever possible. They are often cared for 'at levels of care' which are higher than required to meet their needs. Not only is this not what most people want it is also resource inefficient and increases the risk of iatrogenic (health and care induced) harm.

Proposed future models:
The default care setting for all patients should be the place they call home as this can significantly improve the quality of care received (due to a reduced likelihood of decompensation). The proposed service change would see those people who are medically fit for discharge (MFFD) receiving reablement and rehabilitation support in a community hospital bed NHS care home bed or at home.

Travel times and accessibility for patients, whilst analysed, are of lesser consequence in this scenario as patients would be ambulated by Community Transport Services from an acute setting to Community Hospital or Care Home.

THE IMPACT ON WIDER COMMUNITY SERVICES

The options developed are considered against a Do-Nothing scenario where wider community services are largely provided from existing community hospital sites within a locality.

To identify the potential solutions that could address our case for change and ability to deliver our clinical model, we have considered three ways that the provision of community services could be organised in our localities. We have considered the options in terms of:

- The **set of services** required to deliver our model of care;
- **How many hubs** could be developed; and
- **Where** the hubs could be located.

The services to be delivered from the hubs, as defined in the clinical model, have been developed based on key principles which align to national and local strategies; including:

- Provision of services at scale;
- Community centered care;
- Undertaking a Multi-Disciplinary Team approach;
- Extended Access to GP practices;
- Coordination of cross-sector services; and
- Delivering a holistic service based on patient needs.

To develop the appropriate set of hub services, significant engagement across a large number of organisations took place.

There are two possible permutations for the number of community services hubs across the localities. The first is having the same number of hubs as there are existing community hospitals within the localities (i.e. five, with two in the Moorlands) or alternatively considering a hub per locality (four).

Existing or alternative sites could deliver the wider community services across localities. As such, the options consider the provision of services across the existing community hospital sites as well as an alternative provision (new sites).

Details of current services provided from the Community Hospitals have been published on the CCGs websites and were presented and considered as part of the Options Development process.

The Impact of Travel on Disadvantaged Groups

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 looked 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 option 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. In order to mitigate the impact of this on disadvantaged groups we will:-

- Continue to work with local authority partners to discuss additional transport provision
- Commission additional community transport services as part of implementation plan
- Discuss these mitigation's and other suggestions as part of formal consultation with disadvantaged groups

Though noting that we have to go through a process to procure care homes, the estimates show 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)

We undertook analysis to estimate the travel times (via car) from geographical locations within the area to each potential site, and compared these with the estimates travel times to the current locations of community hospital beds (i.e. with temporary closures in effect), and the previous locations (i.e. community hospital sites prior to temporary closures).

This shows the **average change in patient travel time and distance** across each of the 6 options.
For example, for option 1 (Haywood only), patients will have to travel on average between 8 and 10 minutes longer than with the current or previous configurations.

	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
Change in travel time (mins) – from current sites	8.02	6.04	2.59	5.3	5.08	0.07
Change in travel time - from previous sites	9.37	7.39	3.95	6.65	6.43	1.42
Average travel time (by car)	**18.66**	**16.67**	**13.23**	**15.94**	**15.72**	**10.70**
80th Percentile travel time	**26.31**	**23.74**	**18.25**	**22.14**	**22.95**	**14.37**

Average travel times range from 10 to 19 minutes depending on the option, and 80% of the population (80th percentile) could be able to access their closest site by car within 14 - 26 minutes depending on the option.

Across the options, Option 6 (Haywood and Care Homes) results in the shortest travel times, followed by Option 3 (Haywood and Longton). Option 1 results in the longest travel times.

*A procurement process will have to be undertaken if option 6 is deemed the preferred option, the result of which may affect the travel times. For the purposes of this analysis, we have used the locations of care homes which have been commissioned in the past.

Community beds – Accessibility – Bus and drive time between sites at peak time

The below shows bus routes between community hospital sites, as well as the estimated travel time (at peak times – 8am) an estimated travel time for car users is also shown.

	Longton Hospital	Leek Hospital	Cheadle Hospital	Bradwell Hospital	Haywood Hospital	Average duration
Longton Hospital		Bus 16 - change at Hanley onto Bus 6 Bus: 85 mins Car : 28 mins	Bus 32 - change at Hanley onto Bus 6 Bus: 90 mins Car: 16 mins	Bus 94 - change at N-U-L onto Bus Orange 1A Bus: 90 mins Car: 17 mins	Bus 7 - change at Hanley onto Bus 6A Bus: 75 mins Car: 22 mins	**Bus: 85 mins** **Car: 21 mins**
Leek Hospital	Bus 6 - Change at Hanley onto Bus 18 Bus: 90 mins Car: 30 mins		Bus 32 - change at Southlow Road onto Bus 16 Bus: 55 mins Car: 21 mins	Bus 4 - change at Hanley onto Bus 101 and change at N-U-L onto Bus 18 Bus: 110 mins Car: 37 mins	Bus 7A - change at Old Town Road, Hanley onto Bus 18 Bus: 63 mins Car: 25 mins	**Bus: 80 mins** **Car: 29 mins**
Cheadle Hospital	Bus 6 - Change at Hanley onto Bus 32 Bus: 80 mins Car: 16 mins	Bus 16 - change at Southlow Road onto Bus 32 Bus:65 mins Car: 22 mins		Bus 4A - change at Hanley onto Bus 32 towards Cheadle Bus: 95 mins Car: 30 mins	Bus 7A - change at Hanley onto Bus 32 Bus: 70 mins Car: 33 mins	**Bus: 78 mins** **Car: 26 mins**
Bradwell Hospital	Bus 6 - Change at Longton onto Bus Orange 1 and change at N-L-U onto Bus 4A Bus 85 mins Car: 19 mins	Bus 18 - change at Hanley onto Bus 4E Bus: 110 mins Car: 39 mins	Bus 32 - change at Hanley onto Bus 101 change at N-U-L onto Bus 94 Bus: 100 mins Car: 35 mins		Bus 7a - change at N-U-L onto Bus 94 Bus: 70 mins Car: 15 mins	**Bus: 92 mins** **Car: 27 mins**
Haywood Hospital	Bus 6 - Change at Hanley onto Bus 7a towards Biddolph Bus: 57 mins Car: 28 mins	Bus 18 - Change at Kidsgrove onto Bus 7 Bus: 65 mins Car: 27 mins	Bus 32 - change at Hanley onto Bus 7 Bus: 75 mins Car: 35 mins	Bus 94 - change at Hanley onto Bus 7A Bus: 60 mins Car: 13 mins		**Bus: 65 mins** **Car: 23 mins**

Off peak bus travel times for community beds

	Option 1 Haywood	Option 2 Haywood & Leek	Option 3 Haywood & Longton	Option 4 Haywood & Cheadle	Option 5 Haywood & Bradwell	Option 6* Haywood & Care Homes	Closest Option	Closest Option
Cheadle (ST10 1AQ)	00:59	00:59	00:59	00:05	00:59	00:55	00:05	Option 4
Newcastle Town Centre (ST5 1AG)	00:33	00:33	00:33	00:33	00:23	00:07	00:07	Option 6
Chesterton (St5 7JB)	00:51	00:51	00:51	00:51	00:10	00:08	00:08	Option 6
Keele village (ST5 5AF)	00:57	00:57	00:57	00:57	00:44	00:34	00:34	Option 6
Leek town centre (ST13 6BD)	00:58	00:16	00:58	00:58	00:58	00:58	00:16	Option 2
Biddulph town centre ST8 6HR	00:34	00:34	00:34	00:34	00:34	00:34	00:34	All
Burslem town centre (ST6 3EW)	00:30	00:30	00:30	00:30	00:30	00:30	00:30	All
Hanley town centre (ST1 3AL)	00:16	00:16	00:16	00:16	00:16	00:16	00:16	All
Longton town centre (ST3 1DB)	00:44	00:44	00:12	00:44	00:44	00:13	00:12	Option 3

NHS Care Homes – Travel Impact Analysis

The table below shows the total average travel times and distances between the scenarios of:

a) Haywood Hospital plus Bradwell Hall, Hilton House, Adderley Green and Farmhouse care homes

b) Haywood Hospital plus Bradwell Hall and Adderley Green care homes

For each scenario, the average, median and 80th percentile travel times and distances are shown, as well as the difference in each of these metrics from the current configuration of community hospital and care home beds.

On average, using two care home settings rather than four, would increase average drive times across the population by 0.6 miles (2 minutes) from what the system currently has in place. For 80% of the population, the change in travel time would be 0.1 miles (0.5 minutes)
There would be no change in the median travel time.

Above the 80th percentile, the travel times would increase by 1.5 miles (5.6 minutes) which suggests that the 20% of the population living furthest away from these sites would be affected the most, however given the magnitude of the change in times and distances, the changes are unlikely to be significant.

Total Travel		Difference from current	
Distance	Time (mins)	Distance	Time (mins)

		(Miles)		(Miles)	
4 Care Homes + Haywood	80th %ile	4.4	14.4	0.0	0.0
	Median	2.4	8.9	0.00	0.00
	Average	3.3	10.7	0.02	0.07
2 Care Homes + Haywood	80th %ile	4.9	17.2	1.5	5.6
	Median	3.2	11.7	0.0	0.0
	Average	3.8	12.8	0.6	2.1
Difference	80th %ile	0.6	2.9	1.5	5.6
	Median	0.8	2.8	0.0	0.0
	Average	0.5	2.1	0.6	2.0

Parking

The Haywood Hospital is the only site that charges for car parking.

Community hospitals car parking information

Site	Car parking 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

The table below shows that Haywood has the most parking spaces available per community bed, suggesting it is the most accessible of the five hospitals.

Crucially, the table highlights the non-clinical space available and the relative challenges across the sites (excluding the Haywood). This is an important consideration in relation to understanding 'best fits' to support future demand for community services.

Size and capacity of estates

Site	No. of parking spaces available	Clinical space (m^2)	Non-clinical space (m^2)	Parking spaces per bed available
Haywood	322	10,172	6,512	4.2
Leek	98	2,915	1,814	2.7
Cheadle	99	2,871	1,710	2.1
Bradwell	179	2,758	1,399	2.8
Longton	38	1,667	1,349	1.0

Integrated Care Hubs

The proposed hub services have been developed against a number of principles

- Provision of services at scale
- Community centered care
- Multi-Disciplinary Team approach
- Extended access to GP practices
- Coordination of cross sector services
- Holistic and based on patient needs

Travel time

Given that 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.

Wider community services – Accessibility – Travel times across options

- The table below shows estimated travel times and distances (by car) from geographical locations within the area to their closest proposed hub site.
- Given that hub services are not currently delivered at the same locations, we cannot compare the travel times against the current configuration of services (as we have done for the options on beds) – so we can only state the estimated travel times and distances.
- Our analysis shows that average travel time to each hub is on average approximately 10 mins, with 80% of the population (the 80th percentile) being able to arrive at a hub location within approximately 15 minutes.

	Option	Average Travel Time (mins)	Average Distance (miles)	80th Percentile Travel Time	80th Percentile Distance
Stoke South	(Option 1a) New site (ETTF)	9.91	2.67	13.28	3.52
	(Option 1b) Use of Meir LIFT	10.67	2.74	15.09	3.89
Moorlands	(Option 2a) Leek existing community hospital site	9.44	3.08	14.32	5.14
	(Option 2b) Kniveden	9.44	3.08	14.32	5.14
	(Option 2c) Cheadle existing community hospital site	11.51	3.67	15.13	5.19
Newcastle	(Option 3a) Bradwell existing community hospital site	9.95	3.14	13.77	3.95
	(Option 3b) Milehouse LIFT	9.05	2.84	12.13	3.59
Stoke North	(Option 4a) Haywood existing community hospital site	11.05	3.42	14.59	4.50

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 site and the Knivedon site)

In Newcastle, there bus travel between the existing community hospital site and the Milehouse Lift is c.25 minutes, whereas by car it is c6 minutes

Public travel (Bus) at peak times from localities to hub locations

	Stoke South			Moorlands				Newcastle			Stoke North
	1a ETTF	1b Meir	Shortest	2a Leek	2b Kniveden	2c Cheadle	Shortest	3a Bradwell	3b Milehouse	Shortest	4 Haywood
Cheadle	01:13	01:18	EFFT	00:30	00:33	00:05	Cheadle	01:47	01:40	Milehouse	01:01
Newcastle Town Centre	00:33	00:38	EFFT	01:12	01:16	01:12	Cheadle	00:18	00:14	Milehouse	00:47
Chesterton	00:58	01:02	EFFT	01:35	01:39	01:36	Leek	00:10	00:19	Bradwell	00:55
Keele village	01:07	01:18	EFFT	01:43	01:47	01:40	Cheadle	00:56	00:47	Milehouse	00:59
Leek town centre	01:24	01:25	EFFT	00:13	00:17	00:59	Leek	01:43	01:39	Milehouse	00:46
Biddulph town centre	01:27	01:26	Meir	01:19	01:23	01:31	Leek	00:46	00:55	Milehouse	00:44
Burslem town centre	01:01	01:00	Meir	01:13	01:17	01:05	Cheadle	00:37	00:52	Milehouse	00:18
Hanley town centre	00:30	00:29	Meir	00:46	00:50	00:43	Cheadle	00:51	00:42	Milehouse	00:19
longton town centre	00:08	00:17	EFFT	01:13	01:17	01:10	Cheadle	00:55	00:47	Bradwell	00:49

Source: Google Maps

Car Parking

	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)				

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

Table 50: Average change in patient travel time by car across each of the six options compared with the Do Nothing Baselines

	Option Number	Option Name	Average Travel Time (mins)	Average Distance (miles)	80th Percentile Travel Time	80th Percentile Distance
Stoke South	Option 1a	New site (ETTF)	9.91	2.67	13.28	3.52
	Option 1b	Use of Meir LIFT	10.67	2.74	15.09	3.89
Moorlands	Option 2a	Leek existing community hospital site	9.44	3.08	14.32	5.14
	Option 2b	Kniveden	9.44	3.08	14.32	5.14
	Option 2c	Cheadle existing community hospital site	11.51	3.67	15.13	5.19
Newcastle	Option 3a	Bradwell existing community hospital site	9.95	3.14	13.77	3.95
	Option 3b	Milehouse LIFT	9.05	2.84	12.13	3.59
Stoke North	Option 4a	Haywood existing community hospital site	11.05	3.42	14.59	4.50

Source: ONS, Ordnance Survey

EQUALITY IMPACT AND RISK ASSESSMENT

	Negative Impact	Positive Impact
Age	**Rehabilitation Beds** Potential Impact identified from data and feedback to date. Concerns arose over available social care capacity and the impact upon older people in Staffordshire and Stoke-on -Trent. There is a possibility that some carers and family members may have to travel further due to the removal of community hospital beds but the overall impact on travel is that on average more would have to travel less as the majority of patients will be treated in their own home. The potential impact on some carers and family members in accessing public transport may be negatively affected by the reduction in community transport There is a greater risk of isolation for patients and carers would need to include more voluntary sector organisations to support socialisation.	**Rehabilitation Beds** The majority of older people will be cared for at home rather than having to travel to an inpatient hospital setting. This would have a positive impact on carers too who would also not have to travel to visit their loved ones. Care for the elderly patient in the place they call home can greatly improve the quality of care received and the outcomes achieved. Continuity, and therefore remaining at home, is key for all patients particularly dementia patients, in order to limit confusion and associated distress. Improved dignity would be helped if the patient remained in their own home. Reduced exposure to communal acquired infections would be helped if the patient remained in their own home. Again being in a familiar place - treated at home, would minimise the feeling of disorientation or loneliness

		Hubs The views of the community should be taken into consideration for the most appropriate location of the hubs. Any transferral of services will be required to be the same or better than currently provided; otherwise there will be a negative impact.
Disability	Potential impact on people with mobility impairment from reduced access to services.	Access needs to be considered whether this is in relation to existing sites or new sites. The sites are required to be DDA compliant, including Fire, Health and Safety compliant, parking facilities and easily available by public transport. Communicating the changes including the re-location of current services may be difficult for some people.
Gender Reassignment / Transgender	There needs to be an assured level of staff competency in caring for this protected characteristic in a person centred way.	The delivery of care at home or in a place called home helps people to retain their independence, confidence and therefore wellbeing as opposed to being treated in an unfamiliar hospital setting. Retention of independence helps patients to remain in their place of usual residence for longer. Continuity is key for all patients particularly patients who are transgender or who have chosen gender reassignment.
Pregnancy and Maternity	An acknowledgement needs to be made with regard to family members, who are informal carers, particularly a female who may be pregnant, that 'The welfare and wellbeing of the family which is supporting the relative will always be considered.	Not specifically identified
Religion or Belief	There needs to be an assured level of staff competency in caring for this protected characteristic in a person centred way.	Care for patients will be personalised to ensure it meets all their medical, nursing and personal care needs. Care provided at home will be closer to the place of worship. Assurance that patients personal beliefs will be taken into consideration i.e.(jabs/injections and care planning) Particular consideration required to the End of Life Care Plans. Care Planning will also take into account any personal preferences of patients such as beliefs. Dignity and respect are a core component of care planning for patients within these services and decisions about care are taken in partnership

		with the patient, their family and, or carers to ensure an appropriate approach
Race	Health Information leaflets in community beds and hubs need to be readily available to people in a range of common languages. Cultural awareness and sensitivity to the diverse needs of people within the community, e.g. at end of life care where many of the BAME community cultures and traditions require open access for visiting family members. Care Plans to have specific references on how to respond to the patient and their cultural traditions.	Currently patients from BAME Communities may need to make advanced appointments (not just GPs) to ensure that if required, interpreting services can be arranged which could more easily be achieved through the hub CAB or Vol Sector services Assurance is required that staff have cultural awareness and sensitivity to the diverse needs of people within the travelling community, e.g. at end of life care where many community cultures and traditions require open access for visiting family members. The model of providing support closer to home will have a more positive take up from the Traveller Community.
Sex (Gender)	Different gender bed provision bust be adhered to in community beds.	Census 2011 figures highlight that men and women are equally represented
Sexual Orientation	Recognition and understanding of same sex couples and Next of Kin arrangements. Ensure partners are not excluded. Include in the Care Plan process. Ensure people are treated with dignity and respect.	Not specifically identified
Marriage and Civil Partnership	Marriage & Civil Partnership is a protected characteristic in terms of work-related activities and NOT service provision	Many married older couples rely heavily on each other as the main carer, friend and companion. Intermediate Care Service teams will include the spouse in decisions about care planning for relatives. The delivery of care at home or in a place called home helps people to retain their independence, confidence and therefore wellbeing as opposed to being treated in an unfamiliar hospital setting. Retention of independence, patients will be able to remain in their place of usual residence for longer.
Vulnerable & Deprived Communities	**Rurality** Consideration must be given to accessibility of services for patients in areas of the Staffordshire Moorlands and Newcastle-under-Lyme	With the new proposals, because more people will be cared for at home or in intermediate care beds within their own communities, travel will be significantly reduced. The use of cross border facilities will assist in reducing negative impacts of rurality and poverty in terms of ability to visit.

	Homeless The concept of providing care at home could mean that the care needs to be provided in a hostel. But without a home this proposal may have a negative impact on those without a home. There needs to be awareness and training given to staff to enable them to have the skills needed to respond to issues that are not every day occurrences. **Carers** With the new proposals, because more people will be cared for at home or in intermediate care beds within their own communities, travel will be significantly reduced for carers. Equally as a result of more people being cared for at home there will be less disruption to the carer's routine and their loved ones will retain their independence, confidence and therefore wellbeing for longer. Integrated care planning will respond to personal preferences of patients as well as family and carers views to ensure that an appropriate approach to care is taken.	Services based on a hub and spoke model may be easier to access. An engagement exercise with homeless people was undertaken in summer 2017 and separate services are currently being commissioned to meet their health needs. **Informal Carers -** Informal carers must be recognised and their needs responded to, to ensure there is continuity of care for their cared for. They need more respite particularly young carers **Choice -** People need to remain in control with choice. For example, family carers don't want paid carers coming in at 7am or 11pm at night. Don't want different carers on different days. **Carers Information -** When people register as a carer they should be provided with relevant carers information at the hub rather than having to seek it out for themselves e.g. carer's allowance, attendance allowance, NHS transport reimbursement costs.

ENSURING LEGAL COMPLIANCE		
Current service delivery	Proposal	Mitigation
All larger providers are required to submit annual equality compliance reports reflecting requirements (e.g. EDS; NHS England mandated standards) in the NHS National Standard Contract 2018-19. Contract Managers send this information to the Equality & Inclusion Business Partner for content check This should evidence that providers are meeting the PSED and most importantly, how they are using this monitoring data such as	The Consultation Plan aims to engage with local representatives from all 9 protected groups to ensure they have a voice in informing the decisions about future service delivery. The service will be accessible to all and available regardless of age, race, gender, gender reassignment, sexual orientation, disability, religion or belief, pregnancy maternity and breastfeeding mums. Equity of Access, Equality and Non-Discrimination is included in the NHS standard contract for providers	The CCGs will engage with representatives from local protected groups to request their feedback on any adverse impacts arising from Options contained in the PCBC. The identified providers will be expected to submit monthly data on performance against agreed (KPIs). Performance data will be provided to the contract monitoring meetings, which will be responsible for monitoring performance against the service specification. The provider will provide through disaggregated

complaints and workforce profiles, to improve fair access to information, services and premises (and any employment opportunities) for local people from groups protected by the Equality Act 2010. Provider workforce data should annually evidence how it reflects the communities they serve and the support available to staff. This data should be available to be viewed by the public and lead commissioner on provider website – 'How we are meeting the PSED' and evidencing 'due regard' of people from groups protected by the Equality Act 2010 and health inclusion groups under the H&SC Act 2012.	under service condition 13. The re-designed service will offer opportunity for patients and carers to give any feedback on barriers encountered by protected group patients / carers to ensure fair access to information, services, premises, and any employment opportunities.	equality monitoring data on patient satisfaction experience. As included with in the standard NHS contract (FFT). The service specifications will include a local service user survey which will request demographic information as a default requirement (provides the option for patients / primary carers to declare) to enable feedback to be analysed to ascertain who is taking up the services and differential satisfaction levels.
PROMOTE EQUALITY OF OPPORTUNITY		
Community services to be delivered from the hubs have been commissioned separately. Fair access to information and services was a key element.	By bringing together services under a single specification for integrated care teams (hubs) it is envisaged that it will support further reductions in duplication improving multi professional communication and a more streamlined pathway.	Periodic requirement to offer the option to patients and carers to complete a satisfaction with services survey with equality monitoring included (within service spec).
Foster Good Relations Between People	**Foster Good Relations Between People**	**Foster Good Relations Between People**
The Joint Strategic Needs Assessment highlights local issues based on the analysis of the information available. It identifies where needs are not being met describing these as themes for action. It is a particularly useful tool for local commissioners as it provides a wealth of quantitative and qualitative data that clearly describes the key issues for the local population.	Consideration will be given to the local issues identified within the report and patient / carer feedback received, when designing integrated care services.	The CCGs work strategically to influence the Health & Wellbeing Board and inclusion within the JSNA for North Staffs and for Stoke-on-Trent localities, Health Needs Assessments which focus specifically on the healthcare needs and health inequalities of local people from groups protected by the Equality Act 2010.

EXPECTED OUTCOMES

Benefits to patients

There is consensus across North Staffordshire and Stoke-on-Trent that if we do not redesign and transform services to improve quality, using the available resource as efficiently as possible, our population will experience poorer health outcomes as a direct result. There are a set of key principles that sit behind the implementation of providing care closer to home as outlined below:

- The model will be based upon a pull by community not push by acute;
- Clinical governance will sit with the community provider
- No assessments for on-going care needs will carried out in an acute bed (unless by clinical exception);
- The full implementation will ensure that more people go home with a reduction in the number of patients going into a bed based rehabilitation service;
- Pathways and principles across Northern Staffordshire will be aligned to ensure equity of provision.

Improving the quality of care

Caring for elderly patients in the place they call home can greatly improve the quality of care received and the outcomes achieved. Evidence suggests that caring for older people in a hospital bed can often outweigh the benefits of care received due to decompensation. Emergency Care Improvement Programme reported that the negative impact of bed rest in older people is as follows:

In the first 24 hours:

- Reduction in muscle strength of 2-5%;
- Reduction in circulating volume by up to 5%;

In the first 7 days:

- Reduction in circulating volume by up to 20%;
- Loss of muscle strength 5-10%;
- Reduction in functional residual capacity (FRC) of 15-30%;
- Negative impact upon skin integrity

Two separate studies have shown that 10 days in a hospital bed (acute of community) leads to the equivalent of 10 years ageing in the muscles of people over 80.

Improving the delivery of services

- The default care setting for all elderly patients should be the place they call home. Our local engagement has told us that this is not only what people want but it can also improve outcomes and be a more effective use of available resources.

- Historically, the number of beds within Northern Staffordshire has led us to a position where patients have been cared for at a level higher than required to meet their needs. This is not an efficient use of resources and also leads in many cases to a longer length of stay and a higher likelihood of entering long term care.

- It is however acknowledged that some patients upon discharge will have needs that place them beyond the thresholds to be cared for safely at home. The CCGs will continue to commission a significant number of beds to support patients requiring a higher level of care and/or requiring an assessment for longer term 24 hour care needs. These beds will be commissioned in line with the clinical need of this cohort of patients.

- The integration of services and a flexible workforce will support the maximisation of capacity within the community and will reduce the numbers of handoffs between services therefore positively impacting upon individual patients experience

- Through the new model of care patients will receive the right level of support, by an appropriately skilled workforce, in a timely way and for a time limited period. The model will also maximise independent living and actively support people to return to optimal levels of functioning.

- The clinical model was iterated with stakeholders, generating support amongst staff, the public and key stakeholders. To release capital to fund this new care model, 132 community beds were temporarily closed. These temporary closures were aligned with modelling the CCG had conducted around demand in North Staffordshire and Stoke-on-Trent and the emerging care model.

Elements of the new care model include:

- Developing the Home First model; and
- Significantly increasing the hours of community care by 25%.
- Providing wrap-around services based on patient need in the Integrated Care Hubs

HOW OUTCOMES WILL BE MONITORED, REVIEWED, EVALUATED AND PROMOTED

The revised service specifications for Home First and Integrated Care Services will be outcome focused. A number of quality requirements and key performance indicators will be developed to ensure that quality and safety of services are not compromised and are included in the specification

The Providers will be expected to submit monthly data on performance against agreed KPIs. Performance data will be provided to the contract monitoring meetings, which will be responsible for monitoring performance against the service specification.

The providers will provide through the quality accounts information on patient satisfaction experience.

HUMAN RIGHTS

The Stage 1 Equality Impact and Risk Assessment identified that there was no requirement to carry out a stage 2 Human Rights Assessment

RISK ASSESSMENT					
	Risk level				
Consequence level	**RARE 1**	**UNLIKELY 2**	**POSSIBLE 3**	**LIKELY 4**	**VERY LIKELY 5**
1. Negligible	**1**	**2**	**3**	**4**	**5**
2. Minor	**2**	**4**	**6**	**8**	**10**
3. Moderate	**3**	**6**	**9**	**12**	**15**
4. Major	**4**	**8**	**12**	**16**	**20**
5. Catastrophic	**5**	**10**	**15**	**20**	**25**
Consequence Score: Likelihood Score: Risk score = consequence = 4 x likelihood = 3					**12**
Any comments / records of different risk scores over time (e.g. reason for any change in scores over time):					**N/A**

EQUALITY IMPACT AND RISK ASSESSMENT AND ACTION PLAN

Risk identified	Actions required to reduce / eliminate negative impact	Resources required	Action Owner	Target date
Proposal to change service provision has not undergone due process with evidence of following due regard 'Brown' principles and risk of legal challenge through Judicial Review.	Consult with people with protected characteristics who may be directly or indirectly affected by the proposal. To show understanding of the issues that may affect protected groups in relation to the proposal.	Consultation and engagement plan.	Comms and Engagement	Oct 2018
Not considering re-shaping services following feedback from stakeholders	Governing Body to consider how the proposals will be implemented following feedback received	Consultation analysis	Comms & Engagement	Jan 2019

ONGOING MONITORING AND REVIEW OF EQUALITY IMPACT RISK ASSESSMENT

The equality impact assessment action plans will be monitored through Governing Body meetings held in public

Equality Delivery System:

The Goals and Outcomes of the Equality Delivery System			Tick box(s) below
Objective	**Narrative**	**Outcome**	
1. Better health outcomes	The NHS should achieve improvements in patient health, public health and patient safety for all, based on comprehensive evidence of needs and results	**1.1** Services are commissioned, procured, designed and delivered to meet the health needs of local communities	✓
		1.2 Individual people's health needs are assessed and met in appropriate and effective ways	✓
		1.3 Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed	✓
		1.4 When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse	✓
		1.5 Screening, vaccination and other health promotion services reach and benefit all local communities	
2. Improved patient access and experience	The NHS should improve accessibility and information, and deliver the right services that are targeted, useful, useable and used in order to improve patient experience	**2.1** People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds	✓
		2.2 People are informed and supported to be as involved as they wish to be in decisions about their care	✓
		2.3 People report positive experiences of the NHS	✓
		2.4 People's complaints about services are handled respectfully and efficiently	✓
3. A representative and supported workforce	The NHS should increase the diversity and quality of the working lives of the paid and non-paid workforce, supporting all staff to better	**3.1** Fair NHS recruitment and selection processes lead to a more representative workforce at all levels	
		3.2 The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations	
		3.3 Training and development opportunities are taken up and positively evaluated by all staff	
		3.4 When at work, staff are free from abuse,	

	respond to patients' and	harassment, bullying and violence from any source	

Equality Impact and Risk Assessment Checklist	

		3.5 Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives	
		3.6 Staff report positive experiences of their membership of the workforce	
4. Inclusive leadership	NHS organisations should ensure that equality is everyone's business, and everyone is expected to take an active part, supported by the work of specialist equality leaders and champions	**4.1** Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations	✓
		4.2 Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are managed	✓
		4.3 Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination	✓

Scope	Yes/No
Have I made the reader aware of the full scope of the proposal and do I understand the current situation and what changes may occur?	Yes
Legal	
Have I made the reader aware of our organisation's legal duties with regard to Equality & Diversity and are they documented? ACTION: raise discussion at Governing Body	Yes
Has the relevance of these duties pertaining to this item been outlined explicitly and documented?	Yes
Have I explained how in this area we currently meet our Public Sector Equality Duties and how any change may affect this?	Yes
Information	
Have I seen sufficient research and consultation to consider the issues for equality groups? (this may be national and local; demographic, numbers of users, numbers affected, community needs, comparative costs etc)	Yes
Have I carried out specific consultation with affected groups prior to a final decision being made?	In Plan
Has consultation been carried out over a reasonable period of time i.e. no less than six weeks leading up to this item?	In Plan
Have I provided evidence that a range of options or alternatives have been explored?	In Plan
Impact	
Do I understand the positive and negative impact this decision may have on all equality groups?	Yes
Am I confident that we have done all we can to mitigate or at least minimise negative impact for all equality groups?	Yes
Am I confident that where applicable we considered treating disabled people more favourably in order to avoid negative impact? Any negative feedback would be considered to avoid any potential negative impact where appropriate	Yes
Am I confident that where applicable we allowed an exception to permit different	N/A

treatment (i.e. a criteria or condition) to support positive action	
Have I considered the balance between; proposals that have a moderate impact on a large number of people against any severe impact on a smaller group. Highlighted within feedback received	Yes
***Wider Budgetary Impact (where applicable)**	
Within the wider context of budgetary decisions did I consider whether an alternative would have less direct impact on equality groups?	Yes
Within the wider context of budgetary decisions did I consider whether particular groups would be unduly affected by cumulative effects/impact?	Yes
Transparency of decisions	
Will there be an accurate dated record of the considerations and decisions made and what arrangements have been made to publish them? Governing Body will be held in public and minutes published.	Yes
Due regard	
Did I consider all of the above before I made a recommendation/decision?	Yes