Cornwall and the Isles of Scilly
Health and Care Partnership

Penwith and Edward Hain Community Hospital review workshop 4

19 August 2020

Workshop 4: About today

Cornwall and the Isles of Scilly Health and Care Partnership

10am to 10.10am
Introductions and explaining how the meeting will work

10.10am to 10.25am
Opportunity to hear about local developments since we last met

10.25am to 11.30am
A recap from workshop three.
A review of the outcomes of the evaluation process.

11.30am to 11.45am
Comfort break.

11.45pm to 12.30pm
Further discussion and next steps

12.30pm: meeting closes.

Aims for the day:

1. Share and understand the outcomes of the evaluation of the short listed option

2. Provide information on service changes since covid

3. Share the next steps

Where are we in the process?

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30 April 2019 - workshop 1:
The broad context: Themes, questions and ideas

- Needs
- Challenges
- What's important
- Self nomination for options or evaluation development

17 July 2019 - workshop 2:
Exploration of working ideas/long list of options based on themes raised

- Agreed principles of approach
- Agreed long list of options
- Review/ endorsement of evaluation process and criteria.

11 November 2020
Postponed due to purdah

13 January 2020 - workshop 3:
Review of long list of options
Agreement of short list of options

- Review/ appraisal of long listed options
- Agree short listed option

16 March 2020
Postponed due to COVID

Today

- Review evaluation outcome
- Has COVID changed anything?
- Agree next steps including decision process

What has happened / is happening since Covid-19?

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The COVID-19 crisis has required unprecedented levels of flexibility and initiative: co-operation across the system has enabled quick decision making. Here are some examples of the positive things that have happened.

New ways to provide care

- **Remote access to care:** All GP practices in Cornwall and Isles of Scilly initiated triage functions to reduce face-to-face contact and provide care remotely, using digital solutions such as e-consult, video consultations plus telephone support.
- **'Hot' clinics for people with suspected COVID-19 symptoms:** Clinics were set up in every PCN almost overnight, either in separate designated sites or isolated zones within an existing health site.
- **Drive-through blood testing clinic:** The first ever clinic opened at Costa in Penzance – patients requiring regular blood tests for medication control did so from the safety of their car, while clinical staff in the drive-through took blood and gave vitamin B12 injections to those who needed them.
- **Clinical assessment and treatment units (CATUs):**–Set up in West Cornwall Hospital and Camborne/Redruth Community Hospital – whose purpose is to rapidly diagnose, assess and treat people to help keep them safe at home rather than needing an acute hospital bed..

What has happened/is happening since COVID-19?

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Working as a whole system

- **Community co-ordination centres (CCC)**: Integrated health and social care place-based teams were mobilised and linked to primary care. Open 8am to 8pm 7 days a week.
- **Hotels providing additional capacity**: Penventon Hotel, Redruth was one of several hotels across the county that provided step-down ‘discharge lounges’, working with the Bed Bureau to co-ordinate care.
- **Support to care homes**: Examples all over the county of primary care, community teams and acute staff coming together to support care homes through COVID-19 outbreaks. A local incentive scheme was quickly agreed to support practices in this work.

Processes to support new ways of working

- **Single electronic referral**: A process was developed for all referrals to go via the CCC. Practices were quick to take on this new way of working to change the way that we plan community activity.
- **Honorary contracts**: For practice nurses and health care assistants to work within community teams.
- **Returning GPs**: Supported to get new contracts and a host practice/organisation to be able to provide additional capacity during the crisis.eriatrician support: Allocated to every PCN, following the success of the Penwith community geriatrician trial.

A re-cap from workshop 3

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Longlisted options	Short listed options
1. Model of care development (in progress)	Re-instate 12 inpatient beds and continue existing community clinics
2. Do nothing	
3. Alternative care provision on existing site- extra care housing	
4. Alternative care provision on existing site- care home	
5. Staff and administration base	
6. Family hub for children and young families	
7. Expand the building size with a new build to accommodate increased numbers of inpatient beds.	
8. Day services reablement centre	
9. Re-instate 12 inpatient beds and continue existing community clinics	
No other options identified	

Reminder of the evaluation process: 13 evaluators

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Local representative: Cornwall councillor, West Penwith Community Network Panel, Cornwall Council	Deputy director of human resources and organisation development, CFT	Head of patient flow manager, Cornwall Partnership NHS Foundation Trust	Human resources and equality manager, Royal Cornwall Hospital Trust
Local representative: West Cornwall HealthWatch member	Associate director business development, CFT	Commissioning officer, Cornwall Council.	Deputy director finance, NHS Kernow
Director of integrated care (community services) NHS Kernow	GP lead community hospital, East, CFT	Head of clinical quality, NHS Kernow	Integrated community services programme manager, CFT
Property Strategy lead, Cornwall Council			

Scoring system

0	1	2	3	4
No evidence	Limited evidence	Adequate evidence	Good evidence	Exceptional evidence

Reminder: final evaluation criteria

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Headline criteria	Sub-criteria
1. Quality	1a. Effectiveness 1b. Experience 1c. Responsiveness (based on need) 1d. Safety (there will be a minimum score required)
2. Access	2a. Impact on individual choice 2b. Distance, cost and time to access services 2c. Equity of access 2d. Extended access 2e. Equity of provision
3. Workforce	3a. Workforce supply 3b. Workforce upskilling 3c. New ways of working
4. Deliverability	4a. Timescales and ease to deliver 4b. Sustainability
5. Environmental	5a. Climate management 5b. Environment of service delivery
6. Financial	6a. Value for money 6b. Affordability (there will be a minimum score required) 6c. Financial sustainability (there will be a minimum score required)
7. Wider impact	7a. System impact 7b. Community impact

Reminder of the evaluation process

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Local community (x2) and countywide ‘subject matter experts’ (x11) evaluators

Individual evaluation of 21 evaluation criteria

Group moderation of individual scores (17 of 21 scores agreed). Minimum scores for safety, financial affordability and sustainability not met.

Super moderation of four questions (NHS Kernow execs) to make final decision on the four scores not agreed on at group moderation.

Final agreed scores

Reopening 12 inpatient reablement beds and maintaining current community clinics

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	Evaluation criteria: Quality	Score 0-4	Evaluator's score rationale
1a	Effectiveness	1	• Contrary to strategy to increase community based provision • Bed capacity is under Clinical Senate guidelines for effectiveness. • Bed based care available in nearby hospice/hospitals. • Service/building not flexible. • Environment not safe/effective. • Limited evidence that hospital stay will improve outcomes. • Building space below standards for inpatient care. • Provision of care closer to home for some.
1b	Experience	1	• Provision of care closer to home, but not to the standard expected. • Limited diagnostic facilities. • Care at home is the better option (if people are supported). • Provision of hospital reablement and people are closer to home networks and voluntary sector support. • Physical constraints of building-need to use existing bed stock better.

Reopening 12 inpatient reablement beds and maintaining current community clinics

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	Evaluation criteria: Quality	Score 0-4	Evaluator's score rationale
1c	Responsiveness	0	• No specific identified need for local inpatient-bed based care. • Higher acuity medical and care needs could not be met. • A person in their own home is likely to maintain more flexibility, choice and control over their care. • Home based option will be preferable and more suitable for most people than a traditional in patient setting. • Investing in a static bed based model limits ability to develop flexible services that deliver on prevention and reablement. • Reflects the needs of some people-personalised, close to home for St Ives, promotes community connectedness, local ownership of resources, additional reablement.
1d	Safety (minimum score of 2 required)	0	• Bed based stay poses a high risk of avoidable harm. • It could not be reliably safely staffed putting inpatients at risk of harm. • The restricted and inadequate space described potentially breeches rights to dignity and respect by reducing independence and privacy.

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	Evaluation criteria: Access	Score 0-4	Evaluator's score rationale
2a	Impact on individual choice	1	• Choice is maintained for outpatient clinics, but the lack of diagnostic services means this is a limited choice. • Operational flow and needs may mean local people wont be able to access the beds. • Better facilities with more specific care pathways are available in locations not too far away. • Choice enabled if the social benefits of reablement and end of life care being available within the patient's own local community are embedded in clinical decision making. • It may be a 'false choice' as local people may still need to have inpatient care elsewhere based on clinical need.
2b	Distance, cost and time to access services	1	• Convenient in principle for some, specific transport/location issues for St Ives, but there is limited scope of provision of care. • It will reduce travel time and/or cost for some people but not for others.

Reopening 12 inpatient reablement beds and maintaining current community clinics

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	Evaluation criteria: Access	Score 0-4	Evaluator's score rationale
2c	Equity of access	0	• No changes to equity of access as the provision of community clinics remains the same. • Community rehabilitation teams providing in reach support may reduce community access to rehab. • There is no equity of access to the clinics due to the access to the building. • The in-patient wards are too small to allow for adequate privacy and dignity-difficult for people in wheelchairs to move around.
2d	Extended access	1	• Nurse-led care would be provided 24 hours a day, therapy would remain within working hours. • It is unlikely that GP and other medical services could be provided 24 hours to such a small site.
2e	Equity of provision	0	• Refurbishment may not address access issues for all client groups, and therefore lead to sub optimal solutions which in turn put an extra strain on staff. • In-patient wards are too small to allow for adequate privacy and dignity.

Reopening 12 inpatient reablement beds and maintaining current community clinics

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	Evaluation criteria: Workforce	Score 0-4	Evaluator's score rationale
3a	Workforce supply	1	• Difficulty in staff recruitment and retention predicted as small/standalone site. • Some possibilities of innovative recruitment using integrated networks but nothing guaranteed. • Travel and parking will prove difficult for staff.
3b	Workforce upskilling	1	• Possibilities of linking to local education in the longer term, immediate upskilling needs will require months to fulfil. • Concerns about ability of the system to provide people with the right skill.
3c	New ways of working	1	• New roles like social prescribing link workers, community makers and care coordinators could provide in reach support, but they are busy in the community. • We will be deploying resource into a traditional model of care, rather than providing added impetus for the new models of care which have a greater chance of delivering integration. • Inefficient inpatient bed number and the facilities will not enable modern ward layouts for efficient working.

Reopening 12 inpatient reablement beds and maintaining current community clinics

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	Evaluation criteria: Deliverability	Score 0-4	Evaluator's score rationale
4a	Timescales and ease to deliver	1	• Competition for workforce from elsewhere, which could lead to care services failing. • If funding is provided for building work on a sub-optimal site there will still be significant limitations for future sustainability. • Inefficiency inherent with a 12 bed facility when 16 bed is considered to be the minimum ward size for efficient staffing.
4b	Sustainability	1	• Opportunity to improve health outcomes for the local population-mental health and rehabilitation services. • Responds to needs in short, but not in the long term. • Use of technology could be developed. • Limited ability to work with primary care and community services. • Does not contribute to any strategic direction whether nationally or for Penwith. The significant limitations of the site make it unsuitable for future development

Reopening 12 inpatient reablement beds and maintaining current community clinics

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	Evaluation criteria: Environment	Score 0-4	Evaluator's score rationale
5a	Climate management	1	• Significant travel required by staff and clients to support and utilise the site, particularly if any sustainable workforce model relies on rotational posts. • Based on age and how this building is currently configured, it is very unlikely that it will ever produce a carbon neutral footprint. It would require a substantial amount of money being spent to ensure it was a more energy efficient building in order to reduce carbon emissions.
5b	Environment of service delivery	0	• Existing internal and external environment is poor. • Safe useable outdoor space minimal, but it is essential for happy, healthy staff and service users. • Medical facilities are not sufficient to deliver high acuity medical care. • The building and facilities are not suitable for those with frailty, disability or dementia. • Upkeep of the site and using the site flexibly for the future is challenging.

Reopening 12 inpatient reablement beds and maintaining current community clinics

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	Evaluation criteria: Financial	Score 0-4	Evaluator's score rationale
6a	Value for money	1	• Inpatient provision costs in excess of community alternatives. • Inefficiencies of a limited number of beds in an isolated location- poorer value for money than expanding other facilities. • Unsure if improvement costs would create viable care space for the 21st century, noting the room sizing and irregular layout of the building, as well the further potential maintenance costs on an old building.
6b	Affordability (minimum score of 2 required)	0	• Competing demands for any capital that is made available. • Would increase cost against an overspending background. • Less 'affordable' (in a relative sense) than alternative bed based models that could be developed on other sites. • No certain plan to fund the capital required to make the hospital safe, nor is there a source of funding identified to meet the ongoing revenue costs. • There is no plan that describes the realisation of benefits to neutralise the investment required.

Reopening 12 inpatient reablement beds and maintaining current community clinics

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	Evaluation criteria: Financial	Score 0-4	Evaluator's score rationale
6c	Financial sustainability (minimum score of 2 required)	0	• Not a viable future for the unit even if beds were restored in the short term. • Whilst the support of the League of Friends (if still available) would be a significant boost to refurbishment/upgrade costs (if other funding could also be located to complete the project), it does not offer a secure future income stream to support the relatively expensive delivery model (small, remote unit, in an old, constrained building). • The provision of such a small unit would be difficult to prioritise (in terms of ensuring investment to keep it sustained) compared to larger units where a critical mass of services and staffing can offer a broader, more 'future-proof' model of care. • The background context of the financial situation of the local NHS system necessitates that all funding is carefully and efficiently deployed, so there is no 'leeway' to support less efficient models of care into the future.

Reopening 12 inpatient reablement beds and maintaining current community clinics

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	Evaluation criteria: Wider impact	Score 0-4	Evaluator's score rationale
7a	System impact	0	• Difficulties in recruitment-could impact on other services. • Provide further choice and improved health outcomes to patients and the local community. • Likely that this option will support discharges if the service is used appropriately-and not used as an 'overflow'. • Benefit to the wider health and care system, but day to day challenges in delivering the basic service provision. • Not fair and proportionate allocation of funds against need given the small number of people who would be treated.
7b	Community impact	1	• Additional employment for the area, but competition from care and hospitality may de-stabilise care market • Benefit St Ives and the surrounding area and should help to improve/promote independence with limited hospital stays. • Not responsive to more acuity of need (not 'future-proofed'). • Importance of building as community asset-an essential aspect of the historical roots of community identity. • Locally provided clinics are a vital resource which support community interactions as well as access to services

Headline criteria	Criteria	Final score
1. Quality	1a. Effectiveness	1
	1b. Experience	1
	1c. Responsiveness (based on need)	0
	1d. Safety (there will be a minimum score of 2 required)	0
2. Access	2a. Impact on individual choice	1
	2b. Distance, cost and time to access services	1
	2c. Equity of access	0
	2d. Extended access	1
	2e. Equity of provision	0
3. Workforce	3a. Workforce supply	1
	3b. Workforce upskilling	1
	3c. New ways of working	1
4. Deliverability	4a. Timescales and ease to deliver	1
	4b. Sustainability	1
5. Environmental	5a. Climate management	1
	5b. Environment of service delivery	0
6. Financial	6a. Value for money	1
	6b. Affordability (there will be a minimum score of 2 required)	0
	6c. Financial sustainability (there will be a minimum score of 2 required)	0
7. Wider impact	7a. System impact	0
	7b. Community impact	1

A total score of 13 out of 84.
The minimum score is not met for safety, financial affordability or sustainability

Reopening 12 inpatient reablement beds and maintaining current community clinics

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Full evaluation of short listed option to confirm or deny viability

The short listed option is not viable due to:

1. Minimum scores for safety, financial affordability and financial sustainability not met

2. Rest of scores are low (either ‘0=no evidence’ or ‘1=limited evidence.’ No scores for 2 or above. (‘2=adequate evidence’).

3.The option did not met any of the criteria for quality, access, workforce, deliverability, environmental, financial or wider impact.

The option scored a total of 13 out of 84.

Are these results still valid post COVID-19?

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Comments, views, observation, questions, concerns?

A stocktake of where we are

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We have worked together to:

1. Co-develop the process to determine how we create options for Edward Hain hospital and evaluate those.
2. Co-develop a long list of options and appraisal of those to agree which to short list to evaluate.
3. Provide local representation to the development of the evaluation process, criteria and scoring.
4. Provide local representation to the evaluation of the short listed option.

What have we achieved together? Listening to views, opinions and ideas to co-develop options

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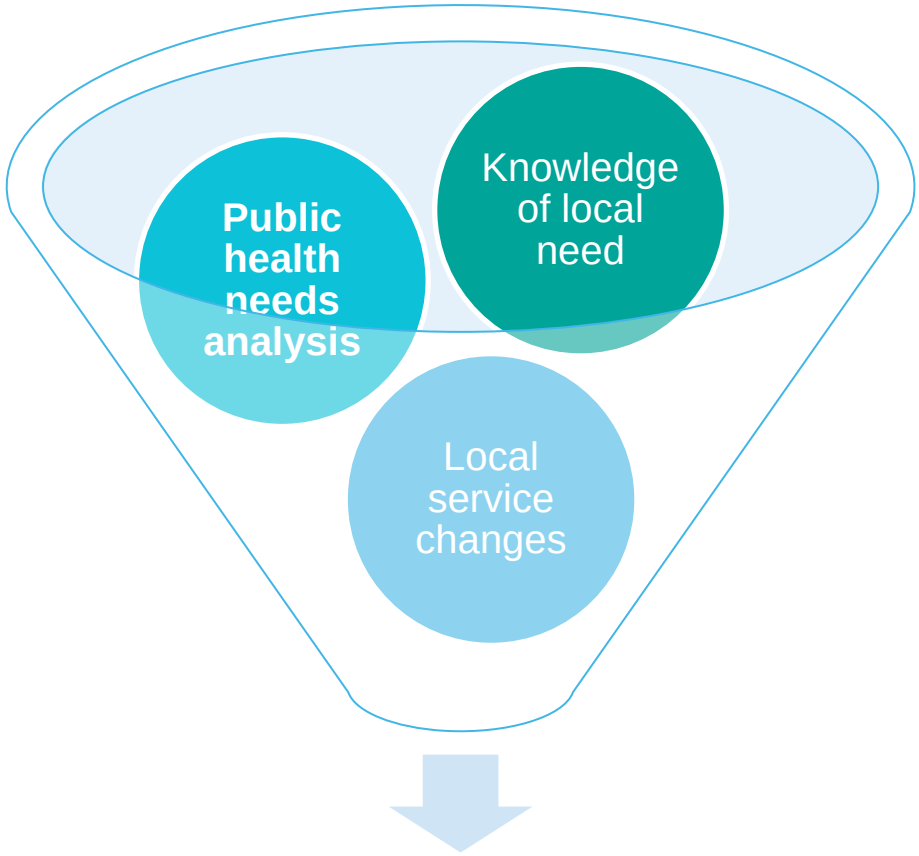
4 local model of care development workshops 2018/19 (120 attendees)

3 local Shaping Our Future workshops 2017/18 (126 attendees)

Information from clinicians, services, pilots, Embrace, building reports



3 public drop in sessions, 2019 (11 attendees)

3 community stakeholder Edward Hain workshops 2019/20 (109 attendees)

Co-produced options

Implications of evaluation outcomes: recommendations

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We have no viable or deliverable options for Edward Hain community hospital.

The process has been inclusive and robust.

We will capture all the learning from this process-continuing to build on this work via Penwith Integrated Care Forum, Primary Care Networks and West Integrated Care Area.

We will keep you informed of future work.

What happens next?

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- We will share the minutes of this meeting.
- Informal and formal briefing with health and adult social care and Overview and Scrutiny Committee
- Assurance reports for NHS England and South West Clinical Senate
- Assurance meeting with NHS England and South West Clinical Senate
- Inform Citizen's Advisory Panel
- NHS Kernow Governing Body to receive recommendations as they are the decision making body

Thank you!

Cornwall and the Isles of Scilly Health and Care Partnership

Thank you for all your time and input to this process.

- Do you have any feedback for us?
- Do you want to:
- Raise a question or concern?
- Make a comment or observation?
- Receive further information?
- Make arrangements to have a further discussion with members of the project team?

Please feel free to contact us by 28 August.

Email kccg.engagement@nhs.net