IMProVE – Integrated Management and Proactive Care for the Vulnerable and Elderly

Better Care for the vulnerable and elderly in South Tees

Recommendations on proposed changes to community services

October, 2014
1. Purpose of the report

This report provides the Governing Body with recommendations around the progression of our vision to improve services for the vulnerable and elderly. These recommendations have been based upon a review of:

- the key drivers for change;
- our proposed model of care based on best practice;
- how we reached an option for delivering our model of care;
- how we have engaged and consulted with members of the public, clinicians and other key stakeholders; and
- feedback received from our formal consultation and recommendations made by South Tees Joint Overview and Scrutiny Committee.

The report also aims to provide assurance to the Governing Body that we have fulfilled our duty to secure services to meet the needs of people in our area; that we have followed national best practice guidance, ensuring our consultation was conducted fairly and legally; and that we have fulfilled our responsibilities to consult in line with the Health and Social Care Act 2012.

2. Case for change

2.1 The Health of our population

While the health of people in Tees is generally improving, it is still worse than the England average. Historically, our local area has been highly dependent on heavy industry for employment which has left a legacy of industrial illness and long term conditions. This, coupled with a more recent history of high unemployment as the traditional industries have declined, has led to significant levels of deprivation and health inequalities that rank amongst the highest in the country. South Tees also ranks higher than the England average for almost all disease prevalence, eg, respiratory disease, stroke, heart disease and diabetes.

2.2 Increasing elderly population

The total population of South Tees is 273,742 of which 48,689 are over the age of 65. By 2021 it is predicted that this number will increase by 20% and for those living beyond the age of 85 by 3%. Whilst it is good news that people are living longer, this represents a challenge for health and social care with older people more likely to access services. We also have high numbers of people living in residential homes rather than remaining in their own home compared to other parts of the country. Therefore it is imperative for the NHS and local authorities to work more closely together; commissioning integrated services.

2.3 Clinical considerations

Frail Elderly People

Nationally, South Tees has the fourth highest number of emergency admissions to hospital and at present, elderly and vulnerable people in our area go into hospital more often than in other parts of the country. An independent analysis (Medworxx
Study) of community beds showed that 49% of patients did not need to be in hospital and could have been cared for at home with the right community support. We also know that the average length of stay for patients who are transferred to a community hospital after a period in James Cook Hospital is 28 days.

National and local evidence also tells us that unnecessary time in hospital can be detrimental to frail older patients, exposing them to risks, such as hospital acquired infections as well as increasing the likelihood of depression and loss of confidence and independence.

**Stroke Services**

Stroke is the leading cause of adult disability and costs the NHS over £3 billion a year. Around one in four people who have a stroke die as a result and around half of stroke survivors are left dependent on others for everyday activities. Stroke services provided by South Tees Hospitals NHS Foundation Trust are highly rated nationally, but the stroke rehabilitation element of the service needs to be improved in line with best practice. According to NICE (National Institute for Health and Care Excellence) guidance, stroke patients recover much better if they have rehabilitation in their own homes delivered by community based stroke teams. Currently there are no community stroke teams in South Tees. The National Clinical Guidelines for Stroke (Royal College of Physicians, 2012) recommend that hospital rehabilitation services are carried out in a single dedicated stroke unit. Stroke rehabilitation in South Tees is delivered across three separate hospital sites.

**General Rehabilitation**

GPs and hospital consultants say that patients currently do not receive the same level of rehabilitation support at home or in a community hospital as they do in James Cook University Hospital. We need to improve this as effective rehabilitation can lead to better outcomes for people, enabling them to live more independent lives.

### 2.4 Local & national plans

The CCG’s plans are based on the health needs of our local population and have been developed in partnership with patients, health professionals and key organisations across the South Tees community. The introduction of Health and Wellbeing Boards has been the key to building strong and effective partnerships ensuring that all local organisational plans are aligned to an overarching health and wellbeing strategy in order to achieve improved health and wellbeing for local people.

Our plans also reflect national guidance and good practice. For example, NHS England’s National Medical Director, Sir Bruce Keogh, calls for system wide changes so care can be delivered in or as close to peoples’ homes as possible; the NHS England’s planning guidance, calls for CCGs and key partners to lead the development and implementation of a ‘modern’ integrated model of care. This planning guidance also advocates:
- Improving the health related quality of life of the 15 million+ people with one or more long-term condition, including mental health conditions
- Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital
- Increasing the proportion of older people living independently at home following discharge from hospital
- Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community.

The announcement of Integrated Care Funding in July 2013, now known as the ‘Better Care Fund’ aims to assist this integrated transformation, with a single pooled budget to support health and social care services to work more closely together in local areas.

IMProVE is therefore one of a number of planned areas of work which will lead to improvements in local services for the whole population and should not be progressed in isolation.

CCG Urgent Care Strategy

In 2013, there was a national review of emergency and urgent care in England. Sir Bruce Keogh managed this review with NHS England. The review suggested that current service provision is fragmented and confusing. Following this guidance and recommendations, South Tees CCG reviewed its urgent care provision in December 2013. In line with Sir Bruce Keogh’s report, the CCG has found that services in South Tees are complex and difficult to navigate, with multiple points of access for patients. Our emerging urgent care strategy, again developed with key partners, recommends the development of a 7 day a week urgent care community service providing more comprehensive care for a broader range of conditions.

2.5 Community facilities

South Tees CCG is in an unusual position compared with neighbouring CCGs in that community based estate includes four community hospitals that between them have 132 beds. These beds are currently under-utilised or as stated previously, are occupied by patients who could be better supported in the community. Not all of our community hospitals were designed to provide the modern, flexible, health services local people need. They are not fully occupied, resulting in empty space with recurrent costs of £1.95 million per annum.

2.6 What our public say

Throughout the development of our vison and proposals, we have engaged with the public and we learned that co-ordination of services between health and social care was really important to patients and carers. People want access to more information about services and care options and they value care at home or in local community settings. The quality of community provision was identified as extremely important with a number of people commenting that if there were to be a reduction in the
number of community beds, they would want first to see improvements in community health and social care services.

2.7 A summary of the challenges faced across South Tees are as follows:

- People are living longer and therefore the number of people living with long term conditions is increasing.
- Nationally South Tees has the fourth highest number of emergency admissions with too many elderly and vulnerable residents admitted to hospital or residential care when they could be better supported in their own homes.
- Older patients spend more time in hospital than they need to, which can often be detrimental to their recovery.
- Stroke rehabilitation services are not delivered to best practice; local people should have access to the same high quality care as those in other parts of the UK.
- We do not deliver the same level of rehabilitation in community hospitals as we do in the acute hospital (James Cook University Hospital).
- Any proposals to change our community services need to reflect existing and future strategies particularly in relation to the way we deliver urgent care.
- We have a community bed surplus across South Tees.
- We need to gain most value from the money we spend; the CCG is currently spending £1.95 million per year on empty space.
- Some of our buildings are not designed to deliver the modern, flexible services people need and incur high maintenance costs.
- Our public tell us that we need to improve the quality of our community services and that the NHS and local authorities need to work closely together so that services are more joined-up.

3. Developing our proposed model of care

3.1 Working in partnership

Over the last two years, we have been working closely with key partners across South Tees in order to agree a joint vision and develop plans to improve services for the vulnerable and elderly. We recognise that this is the only way to achieve true transformation. This vision and planning has been progressed through the IMProVE Advisory Group which comprises representatives from:

- NHS South Tees Clinical Commissioning Group
- South Tees Hospitals NHS Foundation Trust
- Tees Esk and Wear Valleys NHS Foundation Trust
- Middlesbrough Borough Council
- Redcar and Cleveland Borough Council
- Durham, Darlington and Tees Area Team (NHS England)
- Healthwatch (Middlesbrough and Redcar)
- Redcar and Cleveland Housing providers
As well as developing the vision above, this partnership group also set a number of key objectives:

- To offer targeted and proactive individualised case management in a community setting with a range of additional support services for patients aimed at maintaining and improving their current health.
- To improve routine care for all patients with long term conditions to prevent deterioration of their overall condition.
- To identify the need for and improve access to a range of integrated support services on a 24 hour, 7 day a week basis to allow patients to better manage their own condition and remain as independent as possible.
- To improve outcomes for elderly and frail patients and those with long term conditions.
- To identify early, via the use of a predictive risk tool, those patients at risk of a future admission.
- To effectively deliver care and support for patients through making the best use of our available resource.

The work of the IMProVE Advisory Group to date has culminated in the development of a proposed new model of care for South Tees based on the following patient centred principles:

- **Stroke rehabilitation** delivered in line to national best practice – Implementing a community stroke team delivering rehabilitation at home for up to 40% of patients
- Centralising in-patient stroke rehabilitation onto a single site to ensure patients
receive faster, more streamlined and regular access to consultants and other specialist staff.

- **Step up** in-patient care - Beds for elderly patients requiring stabilisation or treatment in order to avoid deterioration and potential acute hospital admission such as: remobilisation following falls; exacerbation of long-term conditions; end of life support and treatment of minor illnesses, e.g. urinary tract infections and chest infections.

- **Step down** in-patient care - High quality packages of planned care supporting vulnerable adults in effective recovery and reablement, in particular those patients recovering from stroke, fractured neck of femur or requiring stabilisation for heart failure.

- **An assessment hub** - where elderly patients could be quickly assessed and diagnosed.

- **Community based medical day treatments** - where treatments such as intravenous therapies and cancer therapies can be delivered closer to patients’ homes.

- **A greater range of outpatient clinics** - with supporting diagnostics to help clinicians make quicker diagnoses and reduce travelling for patients.

- **Improved palliative/end of life care** - where the individual’s preferred place of death would be in hospital, buildings will be conducive to providing privacy and dignity for individuals and their carers, e.g. provision of single rooms and facilities for relatives to stay.

4. **Option appraisal process**

4.1 **Reviews and studies**

In order to gain a wider view on the future vision and to assess the ability to implement the proposed new model of care over the next two to five years, the IMProVE Advisory Group commissioned a number of reviews and studies. These included:

1. A clinical review of community hospital provision
2. A bed modelling study
3. An estates review
4. A workforce review
5. A series of clinical and public engagement initiatives
6. An accessibility travel plan

1. **Clinical review of community hospital provision**

A set of quality criteria, based on a clinical view of what would need to be in place to deliver the best model of care was developed and agreed. The criteria were informed and influenced by broad clinical engagement including GPs, Consultants and Clinicians working within the hospital and the community, the general public, council members and members of voluntary organisations. The criteria were based around key aspects of our proposed model which requires delivery within community buildings and it was divided into what was considered essential or desirable. The quality requirements are summarised in the table below:
<table>
<thead>
<tr>
<th>Generic to all services</th>
<th>Essential</th>
<th>Desirable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meets NHS essential standards for environment</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Meets environment standards for dementia.</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Adequate numbers of staff who can deal with elderly patients, co-morbidities, and dementia.</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Impact upon other services delivered from that Estate</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Accessibility</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>The percentage population living within 30 minutes’ drive of that Estate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The percentage population able to access the Estate via public transport within 1 hr.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The percentage population able to access the Estate via public transport during the day</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The percentage population able to access the Estate via public transport in the evenings/weekends</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Affordability of required development</td>
<td>Yes</td>
<td></td>
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<table>
<thead>
<tr>
<th>Stroke Rehab</th>
<th>Essential</th>
<th>Desirable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialist stroke rehabilitation delivered on one site according to NICE guidance</td>
<td>Yes</td>
<td></td>
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<tr>
<td>Access to X-ray facility</td>
<td>Yes</td>
<td></td>
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<thead>
<tr>
<th>Step Up/Step Down</th>
<th>Essential</th>
<th>Desirable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fit for purpose rehabilitation facilities</td>
<td>Yes</td>
<td></td>
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<tr>
<td>X-ray facility</td>
<td></td>
<td>Yes</td>
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<tr>
<td>Ultrasound facility</td>
<td></td>
<td>Yes</td>
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<tr>
<td>Near Patient Testing or urgent access to labs</td>
<td>Yes</td>
<td></td>
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</tbody>
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<table>
<thead>
<tr>
<th>Assessment Hub/Day Treatments</th>
<th>Essential</th>
<th>Desirable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estate capacity to accommodate patients for up to 4hrs for assessment and 24hrs for treatment.</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Access to X-ray</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Access to Pharmacy</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Critical mass of patients requiring assessments and medical day case therapies</td>
<td>Yes</td>
<td></td>
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</tbody>
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<table>
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<tr>
<th>Outpatients</th>
<th>Essential</th>
<th>Desirable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical mass of outpatient activity</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Access to x-ray</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Access to ultrasound</td>
<td>Yes</td>
<td></td>
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<table>
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<tr>
<th>Palliative Care – Inpatient Care</th>
<th>Essential</th>
<th>Desirable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Room for relatives to stay</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Private room to maintain privacy and dignity</td>
<td>Yes</td>
<td></td>
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</table>
On considering further development of the criteria it was necessary to make a number of assumptions that would support delivery of the proposed model of care and to ensure efficient, quality services. Again these assumptions were made and agreed through a process of continued engagement between GPs and hospital/community clinical staff.

- The sites being considered in this process are: Redcar, Guisborough, East Cleveland and Carter Bequest Primary Care Hospitals.
- The services that need to be delivered are: Step up / Step down Rehab, Stroke, Outpatients, Assessment Hub / Medical day unit and Palliative/End of Life Care.
- The Assessment Hub is dependent on being in close proximity to a bed base.
- Outpatients can be provided at any site and other current community locations.
- Bed utilisation is to be maintained at 85% with an occupancy tolerance of 75 – 95%.
- In line with best practice, stroke rehabilitation should be provided on one site.
- X-ray facility and near patient testing/access to urgent laboratory reporting is essential for Assessment Hub.
- Redcar Primary Care Hospital is to be retained as it is a Private Finance Initiative (PFI) with a 35 year lease contract (30 years still to run).

2. **Bed Modelling Study**

We know that we have variable use and occupancy of the beds across our four community hospitals. In order to better understand both the current and potential future requirements of our community bed base, we commissioned a number of studies. One of these studies undertaken by Medworxx focused specifically on bed occupancy within both the Acute and Community Hospitals. The report concluded that 49% of patients in community beds and 33% of patients in acute hospital beds did not have an acute medical need and could have been appropriately supported by other services such as nursing and social reablement support at home.

We also commissioned a further independent report to model the impact of introducing new models of care across South Tees including its potential impact upon bed requirements. This study highlighted that, based on current utilisation levels, and without further development of existing community infrastructure, we require 102 community beds; currently we have 132 beds (i.e. 30 more than we require). Through implementing the proposed model of care, the study indicates that by 2016/17 we will require around 68 community based beds. The bed modelling analysis demonstrates that this is a conservative estimate and also takes into account the anticipated growth in demand from our increasing frail and elderly population. These studies have been shared previously with the Governing Body and made available to the public on our website.

3. **Estate review**

The CCG received a final estate report from NHS Property Services (NHSPS) in February 2014. The report related to the utilisation and condition of NHS owned and leased community buildings. The report refers to all community estate but concentrated specifically on the condition and functionality of the four community hospitals in the South Tees area.

The review:
- Identified issues with the long term viability of Carter Bequest Hospital and Guisborough Primary Care Hospital due to the condition and the assessment of
current functionality;
- Illustrated some significant issues that need to be addressed primarily: ‘void’ space in these hospitals equating to £1.95 million per annum in value;
- Assessed the condition and functionality of Carter Bequest Hospital to be poor with a high maintenance backlog; and
- Noted that Guisborough Primary Care Hospital requires an investment of £1.2 million in its engineering infrastructure.

The NHSPS report does not recommend a course of action. It outlines a series of options and opportunities relating to the potential disposal or part disposal of community hospitals and facilities. It recommends that Redcar Primary Care Hospital is retained on the basis that:
- void space at Redcar could accommodate new service models for stroke, an assessment hub, outpatients and rehabilitation; and
- Redcar Primary Care Hospital was built in 2010 and is subject to a further 30 year PFI lease agreement.

4. Workforce review

In response to developing a new model of care for the future, we recognised that the workforce required to provide quality care is key for successful delivery. Acknowledging the significance of this, we commissioned an external workforce analysis and plan in order to assess the capacity and skills of the current workforce and the capacity and skills required for the future.

The preliminary findings of this work identified:
- a potential shortfall in funded therapy staffing to meet patient need;
- no major cause for concern over the supply of suitably competent staff to meet increased demand for community service staff; and
- challenges around changing culture to deliver care closer to home requiring staff to work differently.

We will work with providers to establish a specific work stream to support workforce changes and developments as part of the overall programme.

5. A series of clinical and public engagement initiatives

We have sought to extensively engage with the public around IMProVE. A ‘Call to Action’ event held in December 2013 had a specific focus on the vulnerable and elderly and a pre-engagement consultation from 23 September to the 22 November 2013 was also undertaken with the specific aim of engaging a range of stakeholders, services users, carers and providers and the general public in a discussion around the IMProVE vision. This was carried out with our partner organisations including representatives of Middlesbrough and Redcar and Cleveland Council and South Tees Hospitals NHS Foundation Trust who were all involved in developing the consultation document and associated questionnaire.

Questionnaires were further supported by an in-depth survey of patients and their carers carried out by the independent voluntary organisation Carers Together, particularly targeting the elderly and vulnerable. Five public drop-in events across South Tees were also held as part of the consultation designed to offer interested individuals, stakeholders, service users
and carers the opportunity to contribute their views and opinions. We received around 100 replies to questionnaires with limited attendance at the drop in events. The in-depth survey gave us a wealth of information with 348 respondents. There was positivity around current services but a number of key themes emerged with suggestions for improvement:

- Co-ordination of services – The need for better collaboration and co-ordination between health and social care and different services;
- GP access – Sometimes poor access to appointments, continuity of care and more home visits required;
- Access to information – Consistency and the importance of carers and families understanding information;
- Care closer to home -There was considerable support for the suggestion that more care should be provided in the home or in a community setting. Respondents felt that this could aid recovery, prolong independence and keep hospital beds free for the seriously ill. Many commented that for this vision to become a reality, community-based care would need to improve significantly;
- Quality of community provision -The quality and extent of community-based services was a recurring theme. Respondents identified a number of areas for improvement including more frequent and longer home visits from both health professionals and home care providers, more rapid assessment of need and access to services and equipment, more practical support in the home, and on-call support available on weekends and in the evenings. There were a number of comments about hospital discharges being delayed because of lack of community provision;
- Hospital beds - There was some confusion about the difference between community and acute beds with a number commenting that beds were needed in case of a flu epidemic or major incident. Opinions differed on the impact of closing community beds with some reflecting that it would take pressure off the hospital system and others claiming it would increase demand for acute beds. Around half supported the idea of closing beds and providing greater care in the community. Amongst other things, respondents felt that this would aid recuperation and promote independence. Many qualified their support for the closure of beds with the need to improve community health and social care services first. Some questioned whether there was sufficient budget/staff to develop and improve community services in line with the CCG’s vision;
- Physiotherapy and Occupational Therapy services - There were a number of comments about the length of time taken for assessments/access to services. Some commented that this was impacting upon recovery and hospital discharge; and
- Dementia services - The need for improvement in services was mentioned by a number of people. This ranged from the need for better information for patients and their carers through to the extent of the services available locally.

6. An accessibility Travel Plan

The CCG area includes a number of urban centres and a significant rural area in East Cleveland. In recognition of the feedback received via the public engagement exercises and by listening to patients’ views regarding accessibility to services as being an important factor in the patient experience, the CCG commissioned Tees Valley Unlimited to undertake an accessibility study for the hospitals within the CCG area. This study demonstrated that:

- In terms of private car travel to any of the sites, given the data available at this stage, analysis indicates that all sites are accessible within a 30 minute timescale.
• Both James Cook University Hospital and Guisborough Primary Care Hospital provide access during regular hours to 75% of the population of Middlesbrough and Redcar & Cleveland within one hour’s travel by public transport. Both sites benefit from a wide variety of public transport services relatively close to the hospital. James Cook University Hospital will see an increase in options with the opening of the rail station at the hospital. However accessibility to Guisborough Primary Care Hospital reduces significantly later in the evening with only two buses serving the hospital hourly.

• Carter Bequest Hospital can be accessed by around 45% of the population within the hour; this would be increased with the opportunity to change buses at the undercover Middlesbrough Bus Station. Accessibility to the site via public transport is lower than that of all the other locations in this report.

• East Cleveland Hospital provides access to a wide area of East Cleveland which would have significant travel times to access care in Middlesbrough, Redcar or Whitby. Even with the lower population density in this rural area, greater than 50% of the population can access the hospital within the one hour target.

• Redcar Primary Care Hospital’s location has relatively good accessibility; the bus service serving the hospital is high frequency and serves a significant proportion of the population, with 74% being able to access within the hour, and 61% able to access the facility later in the evening. The bus interchange possibility in Redcar would further increase accessibility. Improvement works to the existing waiting facilities would be favourable; providing a better option for bus users, and is something to consider in the longer term.

4.2 Option appraisal

The next stage of developing our options involved applying our agreed criteria individually to each of our four community hospitals to assess their quality and ability to deliver our proposed model of care now and into the future. It was agreed that our criteria could be divided into three key areas:

• **Quality** – ability to deliver services now and provide a quality service;

• **Sustainability** – ability to deliver future developments and accommodate expansion of community services; and

• **Efficiency** – cost effectiveness and ability to deliver the model currently and into the future.

The following tables illustrate the results of that exercise:
## Quality

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Redcar</th>
<th>Guisborough</th>
<th>East Cleveland</th>
<th>Carter Bequest</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ability to deliver improved stroke rehabilitation model</td>
<td>Fully met – Modern rehabilitation facilities, benefits from hydrotherapy pool and transition flat</td>
<td>Partially met short term only – would need significant remedial work to incorporate all associated stroke services/therapies</td>
<td>Partially met – would require reconfiguration of ward areas at cost</td>
<td>Not met – does not have x-ray facility</td>
</tr>
<tr>
<td>Ability to deliver improved step/up and step down in-patient rehabilitation</td>
<td>Fully met – Modern rehabilitation facilities</td>
<td>Partially met – would need some remedial work to improve environment and co-location of associated services</td>
<td>Partially met – would require reconfiguration of ward areas at cost</td>
<td>Not met – does not have x-ray facility</td>
</tr>
<tr>
<td>Ability to deliver improved in-patient palliative/end of life care</td>
<td>Fully met – All single rooms</td>
<td>Partially met – Only 4 single rooms. Would require significant remedial work to expand and reconfigure</td>
<td>Partially met – 6 single rooms – would require remedial work to expand and reconfigure</td>
<td>Partially met – 8 single rooms. Would need remedial work to expand at significant cost</td>
</tr>
<tr>
<td>Meets NHS essential standards for environment</td>
<td>Fully met – A standard for quality</td>
<td>Partially met – B standard, would require significant investment to achieve A grading</td>
<td>Partially met – B standard but with no significant issues</td>
<td>Partially met – C standard and will never be able to achieve A standard due to the age and nature of the building</td>
</tr>
<tr>
<td>Accessibility</td>
<td>Good accessibility for whole population</td>
<td>Good accessibility for whole population</td>
<td>Least accessible for Middlesbrough patients but offers good accessibility for rural East Cleveland</td>
<td>Fairly good accessibility for Middlesbrough but limited access for East Cleveland’s rural population</td>
</tr>
</tbody>
</table>
## Sustainability

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Redcar</th>
<th>Guisborough</th>
<th>East Cleveland</th>
<th>Carter Bequest</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ability to deliver future Out Patients developments</td>
<td>Fully met</td>
<td>Partially met – would need some remedial work and investment</td>
<td>Fully met</td>
<td>Not met – no room for OPD expansion</td>
</tr>
<tr>
<td>Ability to deliver future assessment hub/day treatments development</td>
<td>Fully met – has capacity now and benefits from attached pharmacy</td>
<td>Partially met – would need remedial work and investment</td>
<td>Partially met – would need remedial work with minimal investment</td>
<td>Not met – no room for expansion, no x-ray facility</td>
</tr>
<tr>
<td>Maintenance of building over next five years</td>
<td>New building – no significant issues (PFI)</td>
<td>Older building – high maintenance costs £1.6 million</td>
<td>Partially met – fairly modern building 25 years old – will require maintenance programme over next 5 years – £900K</td>
<td>Older building – high maintenance cost for the smallest hospital – £420K</td>
</tr>
</tbody>
</table>

**Workforce**
- Met

**Efficiency**

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Redcar</th>
<th>Guisborough</th>
<th>East Cleveland</th>
<th>Carter Bequest</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flexibility to utilise void space</td>
<td>Current cost of void space = £942K Modern property, layout of building is really designed for specialist health care use</td>
<td>Current cost of void space = £364K Opportunities for clinical, office and other services</td>
<td>Current cost of void space = £592K Building could be split easily and offers a variety of potential uses</td>
<td>Current cost of void space = £82K Limited. Would offer some office space</td>
</tr>
<tr>
<td>Cost for any required development to deliver model</td>
<td>None</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Impact upon other services delivered from that Estate</td>
<td>None</td>
<td>Minor Injuries Unit Out-patient services Limited Community Estate in Guisborough to transfer OPD services</td>
<td>Minor Injuries Unit GP Surgery</td>
<td>GP Surgery Limited number of other services</td>
</tr>
</tbody>
</table>
4.3 Preferred option

Community hospitals

The modelling work demonstrates that the need for beds will diminish over time as a result of improving and investing in alternative community provision, despite the predicted increasing elderly population. In fact it demonstrates that there is already a significant bed surplus. As a result of feedback from the pre-engagement work with the public, we have acknowledged the need to ensure the new model of care is working effectively before further reducing our community bed base in line with the modelling analysis.

The clinically agreed criteria used to assess whether South Tees community hospitals are capable of delivering the proposed new model of care clearly demonstrates that:

• Only Redcar Primary Care Hospital is capable of delivering the proposed full model of care;
• Guisborough Primary Care Hospital and East Cleveland Primary Care Hospital deliver elements of the proposed model but would require investment to realise full delivery; and
• Carter Bequest Hospital is not capable of delivering the model of care to the standards required and would not be capable of doing so in the future without significant investment. Carter Bequest Hospital could never reach an A standard for quality environment due to the age and nature of the building, and therefore it is unsustainable and not fit for the future.

It is important that the rurality of East Cleveland is taken into account and as such there is a need to provide accessible services in this locality. East Cleveland Primary Care Hospital is a fairly new building and has a large amount of empty space which lends itself to redevelopment.

Guisborough Primary Care Hospital is split into two buildings; the building which houses beds is an old building (main building) and not sustainable in the long term, a second, newer building (the Chaloner Building - primarily used for administration), houses a number of outpatient and community services. Guisborough lacks alternative community health estate. Retaining and developing outpatient services are central to the planned model and it was therefore proposed to retain and develop the newer building to support the delivery of the model for increased outpatient services.

It is important to ensure any new service model is working before any reduction in the bed base. Redcar Primary Care Hospital is the estate of choice for stroke rehabilitation and the assessment hub, offering excellent modern rehabilitation facilities without the need for additional investment. In centralising stroke beds at the Redcar Primary Care Hospital site, the need for beds at Carter Bequest Hospital and Guisborough Primary Care Hospital is significantly reduced.

Carter Bequest Hospital, as previously stated, scores low for quality, sustainability and efficiency, does not support the delivery of the proposed model of care and is
therefore not sustainable for the future. There are very few community services delivered from this site and these could be easily accommodated elsewhere. Middlesbrough already has alternative community estate from which outpatient and community services are delivered, e.g. One Life and North Ormesby Health Village which have available capacity. In view of this, the age and unsustainability of the building, it is proposed that Carter Bequest Hospital should be the first facility to reduce bed numbers with transfer of all other services/office accommodation. A General Practice is located at the building and we recognise that this is an important service for our local population. Our preferred choice is to maintain a general practice facility on the site. NHS England, responsible for GP services, is working closely with the practice to agree a preferred option.

As the model develops and becomes embedded, the need for community beds will further reduce. As previously stated, Guisborough Primary Care Hospital is unable to deliver the best practice model of care for stroke and therefore its bed base will reduce when stroke rehabilitation is centralised. The quality and age of the building are such that this building is unsustainable without significant financial investment. Thus the proposal is that Guisborough Primary Care Hospital should be the second bed base to close, whilst retaining and expanding out-patient and community services.

East Cleveland Primary Care Hospital, a newer more sustainable building capable of increasing capacity and suitable for re-development is therefore the best choice for retention. This site provides accessible services to the more rural population and will be retained together with Redcar Primary Care Hospital.

**Minor Injury Units**

Minor Injury Units exist at Guisborough and East Cleveland Primary Care Hospitals and were therefore considered as part of this option appraisal process. As previously stated in section 2.4, it was important to consider the impact of the IMProVE proposals upon our other plans and strategies. Minor injury units form part of the future strategy for urgent care.

A review of minor injury services in East Cleveland and Guisborough has shown that demand for this service is low and that the services have struggled to attract the skilled staff they need to operate 24 hours a day, seven days a week. As a result they are open 9 a.m. to 5 p.m. Monday to Friday and 8 a.m. to 8 p.m. on weekends and bank holidays. The service is currently nurse-led. Each service treats between six and eight people a day compared to around sixty a day at other similar services in the area. Our emerging urgent care strategy proposes to develop a centralised, 7 day a week urgent care service in Redcar. This will enable a broader range of urgent care conditions to be diagnosed and treated and will deliver a better and more clinically robust service for patients. By delivering this more comprehensive support, there will be less need for patients to be directed to James Cook Hospital.
4.4 **Summary of our proposed option**

Discussion was based on the model of care and how our estate could support its delivery. The option is summarised as below and supplemented by an implementation plan (Appendix 4):

<table>
<thead>
<tr>
<th>PHASE</th>
<th>DESCRIPTION</th>
<th>DATE/S</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Development of community services which focus on improving pathways of care and discharge processes. Implement a community stroke team, increase reablement, rapid response and therapy services. Implement a single point of access and implement an assessment hub.</td>
<td>April 2014 – March 2016</td>
</tr>
<tr>
<td>2</td>
<td>Centralise stroke rehabilitation services to one specialist unit (Redcar Primary Care Hospital). Closure of Carter Bequest Hospital and transfer of services within the community. Closure of the two minor injury services in East Cleveland and Guisborough Primary Care Hospitals. Consolidation and enhancement of minor injury services onto one single site (Redcar Primary Care Hospital).</td>
<td>By April 2015</td>
</tr>
<tr>
<td>3</td>
<td>Closure of Guisborough Primary Care Hospital (main building) and removal of community bed base. Redevelopment of Chaloner Building <strong>only</strong> in order to retain existing services and also increase the range of community based services.</td>
<td>April 2015 – March 2016</td>
</tr>
</tbody>
</table>

5. **Overview and scrutiny engagement**

As part of statutory public sector duties, we have worked and engaged with a number of Overview and Scrutiny Committees (OSC), Tees Valley OSC, Redcar OSC, North Yorkshire OSC and primarily South Tees Joint Health Overview and Scrutiny Committee, as we have progressed our IMPROVE programme. OSC have been invaluable with their advice and support around the process, particularly in suggesting ways in which we could better engage with the public. Their suggestions were built in to our communication and engagement plans, particularly with regard to engaging Black Minority Ethnic (BME) communities.
North Yorkshire OSC was satisfied that the consultation process would receive appropriate consideration and simply asked to be kept informed.

In addition we have worked closely with both Health and Wellbeing Boards in developing and progressing these proposals.

6. **Formal public consultation**

The NHS Act 2006 (as amended by the Health and Social Care Act 2012) places legal duties on CCGs to make arrangements to involve service users in the development and consideration of proposals for change in commissioning arrangements where this will impact on how services are delivered, or the range of services that will be available.

Following development and agreement of the IMProVE proposals, we developed robust plans to deliver engagement and formal consultation, and to communicate the scope of the consultation and case for change effectively to patients, the public, political and wider stakeholders and the media. A range of communications and consultation mechanisms were utilised to ensure sufficient information and involvement opportunities were available to identified stakeholders. These plans were informed by learning from IMProVE pre-engagement, guidance from the Joint Overview and Scrutiny Committee, local Healthwatch and feedback from the stakeholder meeting held on 29 January 2014.

The formal public consultation on the proposals ran from 30th April, 2014 to 31st July 2014.

The timing of the consultation period took account of the period leading up to local and European elections taking place during May 2014. A key consideration was to ensure that key messages and options were not confused with wider debates about the NHS. We aimed to ensure that informed views were received from patients, the public and all other stakeholders on the consultation proposals. We responded to ongoing requests for information throughout the consultation period.

6.1 **Equality Impact Assessment**

Throughout the IMProVE consultation, persons offered protection under the equality act 2010 that are referred to as ‘protected groups’ have been considered through an Equality Analysis to eliminate any discrimination and to advance equality. The details of the Equality Analysis are enclosed with this paper. The impact assessment also covered the consultation process, resulting in a significant targeting of some of the more vulnerable and ‘hard to reach’ groups, such as older people’s groups, stroke condition groups and BME community both before and during the formal consultation. We have worked closely with South Tees Hospitals NHS Foundation Trust to engage their staff in the process, allowing opportunities for them to talk to CCG executive GP members.

Responses to the formal consultation survey were received from different groups and individuals. The support of partner community and voluntary sector
organisations working with protected groups, as defined by the Equality Act 2010, is evidenced through the survey response rates, including BME groups (Everyday Language Solutions) and the elderly and carers (Carers Together).

6.2 Consultation Process

The consultation process included:

- 24 public, community and councillor meetings;
- Opportunity to provide questionnaire feedback by post or electronically;
- Presentation at formal Scrutiny Forums/Committees, Health and Wellbeing Boards and a range of clinical meetings;
- Individual letters and e-mails etc;
- Independent analysis of questions; and
- Triangulation of public and clinical meeting responses.

As part of the consultation process people were asked for their views on the vision for improving services and ensuring that more elderly and vulnerable patients with long-term conditions are able to remain independent for longer. The consultation questions posed were developed with clinical input and following stakeholder feedback and are outlined within the consultation report (Appendix 1).

6.3 Consultation document and supporting information

The formal consultation document presented the case for change and outlined the background to the proposals. This document included a questionnaire distributed within a consultation booklet and was also hosted on the NHS South Tees CCG website. An accessible summary document was also produced. Consultation documents and questionnaires were delivered to all GP practices, community based health facilities and libraries in South Tees. The questionnaire was also available as an online survey.

Supporting information made available on the NHS South Tees CCG website included the IMProVE Case for Change and the Outline Business Case. This supporting data was provided in order to enable as much informed engagement in the consultation process as possible.

6.4 Consultation events and mechanisms

A number of formal public meetings, drop-in sessions and engagement with individual groups were held at a variety of locations and times which were selected to ensure equitable opportunities across South Tees. Venues were selected based on accessibility. A total of 24 events were held across the South Tees area; five of these were formal public meetings.

The format of the formal public consultation events was an open forum ‘market place’ style session with dedicated discussion tables for those attending who wished to participate. The aim was to enable understanding of the proposals and issues so that responses would be more informed. Each of the events held took place outside of normal working hours (5.30-7.00pm) to support the general public’s attendance.
A core team of clinicians, managers from the acute Trust and local authorities and CCG GPs and commissioners were present to facilitate each event and to address and manage concerns, particularly from people attending with specific concerns about their own experiences.

This format was chosen as an alternative to a presentation and question and answer session with representatives on a top table as it provided an opportunity for discussion and dialogue which supported more informed responses to the questionnaire. The drop-in style format was also chosen to provide more flexibility in when people could attend. Those who attended were keen to speak to clinicians. A number of supporting staff from North of England Commissioning Support (NECS) were also present to capture themes from the discussions.

To ensure opportunities for face to face discussion were as wide-ranging as possible, further local public events and group discussions were organised throughout the consultation period.

A full list of events is contained within the consultation report (Appendix 1).

6.5 Meeting the four key tests as outlined in the NHS Operating Framework

The Secretary of State for Health introduced four key tests which CCGs are required to meet when introducing major changes in service. These are:
1) Support from GP commissioners;
2) Strengthened public and patient engagement;
3) Clarity on the clinical evidence base, and;
4) Consistency with current and prospective patient choice.

A detailed report (Appendix 2) gives a full account of how the CCG has met these four tests but they are summarised below:

1. GP commissioner support

There is recognition that it is not always possible to gain unanimous support from all member practices. Overall, the consultation option has received substantial support from clinical members of the CCG whose patients are affected by the changes, both in their capacity as commissioners and as providers of GP services.

2. Patient and public engagement

We have actively sought the views of patients, public and other key partner organisations on the IMProVE programme. Our formal public engagement was preceded by a 13 week formal pre-engagement consultation.

3. Clinical evidence base

We have clearly set out our clinical case for change, aligned to the best available evidence and ensuring it has considered improvements that could deliver further benefits for patients. This is outlined in the Case for Change Document and the
Outline Business Case previously shared with Governing Body members and published on our website.

4. Patient choice

The NHS Constitution states: “If your GP refers you to see a consultant you may have a choice of a number of hospitals. You might want to choose a hospital that has better results for your treatment, or one near your place of work.” This will not change with our new proposals. In fact, it is expected that with plans to deliver more outpatient clinics and diagnostic services out in the community, the choice of localities available to patients will increase.

Currently, patients discharged to community hospitals are not guaranteed a choice of hospital site as beds are allocated on a clinical needs basis. This is in line with legal requirements. This arrangement will continue under new proposals with a focus on clinical need but with choice of site where capacity allows.

Changes to minor injury units will mean that patients will have less choice of where they might attend across the South Tees community but they will have access to improved minor injury services. The proposed enhancement of services in Redcar, increasing diagnostic capacity and increasing the skills of staff working in those units is intended to improve the patient experience and potential outcome, enabling a broader range of conditions to be treated in minor injury units without the need for transfer to the A & E department at James Cook University Hospital.

It is important to state that our IMProVE proposals do not include any change to existing providers.

7. Feedback from the formal consultation

The majority of respondents agreed with the key proposals for better care for the vulnerable and elderly in South Tees. Feedback from the formal consultation is contained within appendix 1. Of note is the above average response rate to our consultation, 2.2% as opposed to the national average of around 1.7%.

The CCG has shared and presented the results of the formal consultation with a number of key partners at various meetings:

- IMProVE Advisory Group – 10/09/14
- Middlesbrough, Eston and Langbaurgh CCG Locality Meetings – 10/09/14
- South Tees Integration Programme Board – 18/09/14
- South Tees Clinical Professional Forum – 25/09/14

No concerns on the consultation process were expressed and members of groups who attended the IMProVE drop-in events felt that the report reflected their observations.

The report was presented to the Joint OSC on 17 September. The full report is contained as appendix 3. With regard to the consultation process, the Committee were generally ‘supportive of the process that had been undertaken by the CCG.
Members had the opportunity to contribute to the questionnaire and suggest people/organisations that the CCG should include in their consultation.

With regard to whether this was the right thing to do for the people in Redcar and Cleveland and Middlesbrough, the Committee were ‘broadly supportive of the proposals on the basis of the clinical improvements that will take place and the improvements to community services’ however, they did make a number of recommendations which are summarised below:

- **Transport** - Although they recognise that transport is not an issue for the CCG to solve alone, they recommend that the CCG should take every opportunity to influence public transport design. They also ask whether the eligibility process for patient transport could be made easier.
- **Stroke** - That the CCG works with both Councils to ensure that the community stroke provision will provide a sufficient level of support and care and ensure services are in place before closing community beds currently provided for stroke rehabilitation.
- **Evidence of investment** – Members would like to see evidence and examples of reinvestment into community services.
- **Involvement in future stages** – OSC were keen to engage with the CCG to receive updates on the implementation of a phased approach.

### 7.1 Themes arising from the consultation

**Transport**

Whilst any patient who is admitted to a community hospital will arrive by planned ambulance transport, it is recognised that there will be implications for some families and carers who might need to travel further to visit a relative. Indeed the CCG and other partners did include access as part of the option appraisal criteria. Although not seen as an essential criterion by our stakeholders (including members of the public), they did feel it was desirable to have good access to venues during the day and in the evenings. In addition to commissioning an independent transport plan, we also undertook a ‘snapshot’ questionnaire over a ten day period in order to gain a greater understanding of how our patients access our Community Hospitals. This revealed that the majority of people arrived at community hospitals by car (69%) with only 13% arriving by public transport.

Although access by car to Redcar has been shown to be within a 30 minute journey for all of our South Tees population, it is recognised that it is more difficult for those travelling by public transport. This does cause inconvenience and this is not underestimated. However, particularly around stroke, the main aim is to ensure delivery of high quality rehabilitation which will achieve better outcomes for our local population. We believe that the clinical gains made by having a centralised high quality stroke service balance the short-term inconvenience of increased travel time for some visitors. It is important to note that with the introduction of a community stroke team and other home based services, fewer people will require an inpatient stay and there will therefore be fewer visits by relatives.
As travel has been raised as such an important issue throughout our consultation, we have re-visited our travel plan and our local GPs have also travelled by public transport to and from all venues to coincide with visiting times, including weekends to gain more of an understanding of issues. We recognise that we are not able to solve issues around public transport alone and therefore we will set up meetings with local authority partners and public transport providers to raise concerns and try to influence the future design of routes which take into account patient flows. We will also involve the voluntary sector, such as Tees Valley Community Council, the Red Cross and the Royal Voluntary Service who currently offer some support with transport for the vulnerable and elderly.

In respect of outpatient visits and day treatments, we plan to deliver more appointments in the community, therefore transport issues for this group of patients should lessen.

Concern was also raised that our changes to community venues would ‘overstretch’ the ambulance service. It is important to state that community hospital transfers are planned and therefore emergency ambulances will not be required as Patient Transport Services will be dealing with the majority of planned cases as they do now. The reduction in community beds is also expected to decrease the demand on transport services.

The Joint Overview and Scrutiny Committee also highlighted the need to make accessing Patient Transport Services easier. In line with national guidance for eligibility we will explore how improvements could be made to the process. We also plan to raise awareness of the Patient Transport Service further as part of the IMProVE programme.

**Minor Injury Units**

We recognise that the area of our proposal with the lowest level of agreement was around the provision of a minor injury service at a single location, and although this proposal also achieved majority support (68%), nearly a third of respondents disagreed. The key concern of those who disagreed was around ease of access. It is the view of our clinical leads that the clinical gains made by having a centralised high quality, urgent care centre balances the short-term inconvenience of increased travel time for the small number of people accessing the service.

From discussion at the consultation events, (and supported by the data) it is clear that patients are not getting to the right place first time. 12% of patients in our area who attend minor injury units need to be referred somewhere else. It was also recognised that some conditions for which patients were attending could have been seen more appropriately by their own GP. In line with the national direction of travel and guidance, our strategy identifies the need to streamline access points and to provide better information to support the public getting to the right service, first time. It is the clinically held view that when people do require support for an urgent issue, this should be available with the support of appropriate diagnostics and clinical staff.

It was also apparent from the consultation that within the Brotton community, where there have been recent changes to GP provision, there is concern that without a
minor injuries service, people will have to travel for ‘simple’ treatments such as wound dressing, injections etc which could probably be carried out within general practice if access was available at weekends. In light of the strength of feedback from this locality, we propose to pilot and evaluate weekend district nurse clinics within East Cleveland Hospital. This would be planned to be in place by April, 2015.

In addition it is also proposed that we lead a local publicity campaign to raise awareness of what services are available and what they are able to provide.

**Credibility in delivering the proposals**

It is clear that concerns have been expressed around the ability to deliver our proposed changes and improvements, particularly in relation to improving community and home based services. We will continue to work with partners and use robust project planning to ensure that changes are delivered (Appendix 4) and we remain committed to a phased approach to implementation which we agreed in response to public feedback from our pre-engagement phase. We will ensure that improvements and new pathways have been achieved and scrutinised with partners before progressing to the next stage. For example, our community stroke team will be in place before stroke beds are centralised.

We have already committed to a period of financial ‘double-running’ in order to initiate new services, such as rapid response and integrated community care teams and further investment will follow as we progress through our plans.

Critical to the success of the programme will be the continued support of our partners in health and social care. The commitment and involvement demonstrated to date by all partners has been extremely positive and the development of a South Tees Integration Board comprising Chief Officers across key South Tees organisations and the appointment of an Integrated Programme Manager, jointly funded by all organisations, further demonstrate commitment to working together. The IMProVE Advisory group comprising all key partners will have an ongoing role in managing delivery.

**Workforce issues**

We recognise that the workforce is essential to delivering a new model of care and, as such, commissioned an independent workforce review. This review showed that there was no major concern over the supply of additional suitably competent staff to provide more care in the community. The report highlights the need for additional training and development to support new ways of working.

Members of the CCG have worked closely with the provider as it has consulted and engaged with staff during the IMProVE consultation process and will continue to do so as we move into the implementation phase. We have attended South Tees Hospitals NHS Foundation Trust Board meetings and a number of meetings with clinical staff groups.
Attachment to buildings

Throughout the consultation, we acknowledged and recognised that some of the existing community estate was viewed as a community asset. We understand that there is often an emotional attachment to buildings, however, as a Clinical Commissioning Group, we need to be clinically focussed on the services we commission and how the estate enables that delivery.

Access to GP practices

We acknowledge the concern expressed around the importance of good access to primary care if more patients are to be treated in the community. We continue to work closely with NHS England as they review GP practice contracts. To date there has been no reported negative impact on access to primary care with analysis indicating that patients have been able to register with another GP practice in their area. This observation was supported by Healthwatch at the Joint Overview and Scrutiny meeting in September 2014.

Although the CCG is not responsible for managing GP contracts, we have a well-established work stream which focusses on improving quality in primary care. In addition we have also commissioned general practice to develop and implement initiatives which could improve their access, reducing reliance on urgent care services.

Why deliver stroke services in Redcar?

A number of people asked our GPs at the drop-in events, why we chose Redcar to deliver stroke services rather than Guisborough Hospital or Carter Bequest Hospital, both of which already deliver this service. Section 4.2 describes in greater detail how we developed and applied criteria to develop our option. It was agreed that to deliver the best outcomes for patients, stroke services need to:

- be centralised on one site to ensure daily support from one dedicated, specialist stroke team as recommended by national guidance;
- have purpose built, modern, fit-for-purpose rehabilitation facilities – NICE guidance recommends a dedicated stroke environment with access to a dining area, gym and assessment kitchens;
- have an x-ray facility on site for those patients fitted with naso-gastric tubes;
- be accessible to a high majority of the population within 30 minutes by car and 1 hour by bus;
- be sustainable into the future; and
- ensure the service was cost effective to deliver.

After applying these criteria to all four hospitals, only Redcar Primary Care Hospital is able to deliver the full model without incurring significant additional costs. It also offers the best rehabilitation facilities with a purpose built gym and hydrotherapy pool with space to accommodate all associated stroke and therapy services. Redcar offers reasonably good accessibility for the whole population. It scores the highest for quality of estate in general and as this is a PFI with a 30 year lease, it is both cost-effective and sustainable.
8. Factors used in decision making

The Department of Health outlined in its *Real Involvement Guidance, 2008* that three key factors should be taken into consideration when reaching a decision:

![Diagram showing three factors: Affordable, Clinically safe and effective, Acceptable to patients, staff and the public]

These themes have been used to inform our decision making process and we have ensured that our recommended decision is balanced between all three.

In terms of **affordability**, the key drivers for change associated with the development of our new model of care do not include a cost saving element. Our proposal represents a shift of resource from funding empty space and maintenance of buildings to investment in staff to deliver improved services. It is also important to state that monies raised by the sale of land following disposal of any of the community buildings will be paid to the Department of Health via NHS Property Services.

**Clinically** our case for change has outlined the need to improve quality standards for our South Tees population which are equal to the rest of the country. The key driver for change is to ensure people receive the best possible rehabilitation and support at home in order to remain independent for longer. With regard to minor injuries, we want to ensure that patients receive the right treatment, at the right time, at the right place. This too will improve the outcomes for people requiring urgent care. We also need to ensure that services are sustainable in the long term.

In terms of **acceptability** to patients, staff and the public the consultation has highlighted that our proposals are acceptable, by a majority of the respondents. We acknowledge the concerns and issues raised; notably transport and the minor injury service in East Cleveland and in response, these issues have been explored and analysed with recommendations to address the concerns set out in this paper.

9. Summary

This paper has summarised our ‘IMProVE’ journey so far, culminating in a series of recommendations. These recommendations support our initial aims of developing a model of care which is based on the principles of ’right care, right place, at the right
time’ with the overall aim of providing care as close to home as possible, wherever this can be done safely and cost effectively.

The public consultation on the IMProVE proposals has been a carefully planned exercise in moving towards significant improvements for our vulnerable and elderly population. Prior to and during the formal consultation the CCG has sought expert independent legal advice and an external Department of Health Gateway Review on our decision making procedure (Appendix 5) to ensure we have followed due process.

Through this paper and the associated documentary evidence we can provide assurance to the Governing Body that we have undertaken a robust process, taking into account relevant legislative frameworks and national guidance in arriving at our proposed recommendations. For example:

- The four key tests have been met as set out in appendix 2;
- The consultation was undertaken in accordance with the relevant legislative framework
- The Equality Act 2010 has been followed accordingly

10. Recommendations

After seeking a balance between what is clinically safe and effective, what is acceptable to patients, staff and the public and what is affordable, it is recommended that we should progress all of our proposals for the IMProVE programme including the consolidation of minor injury units onto a single site in Redcar. The clinically led view is that it is in the best interests of our South Tees population to do so. It is important to address the issues highlighted by our public and as such; we are proposing a number of recommendations to the Governing Body for consideration and agreement.

We have welcomed the opportunity to discuss these proposals with local people and with organisations across South Tees and the surrounding area in order to gather as wide a range of views as possible.

We have followed best practice to ensure that the consultation process has been transparent and open in presenting the clinical evidence and views which supported our IMProVE proposals.

Therefore the Governing Body is asked to:

1. Note and support the work undertaken to develop proposals for a new model of care for the vulnerable and elderly;
2. Consider the independently analysed outcome of the full public consultation proposals on IMProVE - Better Care for the vulnerable and elderly in South Tees;
3. Consider the feedback from South Tees Joint Health and Social Care Scrutiny Committee;
4. Consider whether the Governing Body are assured that we have undertaken a robust process, taking into account relevant legislative frameworks and national guidance in arriving at our proposed recommendations.

5. Agree that the proposals from the consultation are taken forward in a phased approach as referenced within the enclosed implementation plan, specifically:
   a. Centralisation of stroke services to Redcar Primary Care Hospital by April 2015
   b. Closure of the two minor injury services in East Cleveland and Guisborough Primary Care Hospitals. Consolidation and enhancement of minor injury services onto one single site (Redcar Primary Care Hospital) by April 2015
   c. Closure of Carter Bequest Hospital and transfer of services within the community by April 2015 alongside the progression of improved community infrastructure
   d. Part closure of Guisborough Primary Care Hospital (main building), removal of the bed base subject to implementation of improved community infrastructure by April 2016
   e. Redevelopment of the Chaloner building in order to house transferred services as well as additional community based services by April 2016

6. Work with key partners to monitor and assure phased implementation, providing and receiving regular update reports

7. Agree that a system-wide group is established in order to explore the potential to influence travel plans and routes to take into account future patient flows

8. Agree a public campaign to raise awareness around eligibility for the Patient Transport Service

9. Develop a public communication plan to support understanding of what is urgent care and where to access services

10. Agree to pilot a weekend district nursing clinic within East Cleveland Hospital to commence by April 2015 in line with consolidation of minor injury services

Appendices

1. Report on the outcome of IMProVE public consultation
2. Four Test Paper
4. High Level Implementation Plan
5. Gateway Healthcheck - Department of Health, August, 2014

Julie Stevens
Commissioning & Delivery Manager
8 October, 2014