Your Care, Your Future

18 July Acute Engagement Event

On 18 July 2016 *Your Care, Your Future* held a meeting in Hemel Hempstead with more than 80 stakeholders to:

- Provide stakeholders with an update on the progress achieved so far in delivering the vision of *Your Care, Your Future*
- Share an outline of plans to evaluate the acute hospital services options and gather views from people in order to review and refine this process
- Discuss what the appropriate clinical model could be for the acute services – the clinical model that underpins all options
- Consider the options that will be taken forward for further evaluation over the summer and seek feedback on our working drafts

This report summarises the key themes, discussions, questions and feedback that were captured during three workshop sessions at this event.

The first workshop explained the proposed method of evaluating the acute options and sought feedback during table workshops to refine this process by listening to the views of participants.

The discussions covered each of the evaluation criteria:

- Deliverability
- Access
- Quality and patient experience
- Affordability

The second workshop focused on two different clinical models where participants were asked to draw out advantages and disadvantages of each model, including how they can be developed and applied to the options, regardless of location.

One of the clinical models was a 'centralised' model, which sets out the extent to which an emergency acute service is delivered in a consolidated way on one emergency specialist site. The alternative was outlined as a 'distributed' clinical model, where inpatient acute care services are delivered via a smaller central specialist site, with patients moving to other locations – which may be called 'district general hospitals' – when they have reached a certain level of stabilisation. The latter model is sometimes known as 'the Northumbrian model'.

The third workshop saw participants consider the range of options and understand how each clinical model might apply to them. The purpose of this session was be to make sure everyone understands the process – and its logic – and to see if there are other options that need to be included.

Workshop 1: Key themes summary

Quality and patient experience

Patient safety

The majority of groups made that point that the first sub-criteria should be Patient Safety and Experience, not just Patient Safety. In fact Patient Experience, and more importantly, Patient Outcomes were seen by most groups as one of the priority criteria for assessing the options

(alongside financial viability). There was discussion in some groups about how you measure outcomes, but it was pointed out there are many existing measures in place for this - CQC, mortality rates, discharge rates etc. Similarly, the issue of quality was raised on the basis it means different things to different people. Effectiveness and timeliness around patient safety were raised by one group. Another group commented that this was about more than access to clinical services but access generally was an issue (see below). The term 'access' was also picked up by another group which felt it to be a confusing term here and that access was better considered as a separate, second criteria. Participants in this group added that it wasn't just about access per se but more about access to what you need, when you need it. One group commented that patients need to be firmly at the centre of this assessment process. Another said that carers should be mentioned in this section. It was suggested that consideration should be given to the balance of expertise between sites with any given option. One group made the point that the wording needed to be changed, and that 'intensive care' was not generally regarded as a clinical support service. The term 'patient safety' was felt by one group to be too broad and required more detail. It was suggested by this same group that this should be broken down and judged in context of the clinical strategy to see how each option delivers against this.

Workforce requirement

The second sub criteria, Workforce Requirement, was viewed by all groups as critical as it would be key to delivering quality of care and patient experience and, in fact, represented a risk if it wasn't addressed. One group questioned the wording around 'ease of staffing rotas across sites' saying the focus should be on staff development, opportunities (for example better links to UCL, working with HEE) and training and making sure the focus was on attracting and retaining the best staff (both acute and in community settings). Similarly, this theme was picked up by another group who questioned the use of the term 'maintained' and said 'attract and retain' was better. One group stated that it was essential to have the right skills and expertise if we are to deliver the optimum patient outcomes and experience, and that this should include sub-specialties. Sustainability of staffing was seen as critical to the evaluation process as was flexibility of staffing (for example a shift to more services delivered in the home). One group noted that this criteria has a financial implication too. This same group noted that there was already a staff/skills shortage and West Herts and that the dispersed model could exacerbate this, as could the need for 7-day working. Two groups asked if this process opened up the opportunity to work differently, and that this was a fundamental principle of YCYF.

Joined up Care

More than one group suggested the third sub-criteria, Joined up Care, should be expanded to specify health and social care and that consideration should be given when assessing options to improving pathways for patients as they make their way through the various parts of the system (within hospital and beyond). Carers were also mentioned by several groups as being a group to consider formally as part of this process. One group suggested that this sub-criteria should be classified as financial/non financial as well as clinical. Several groups did not like the term 'unnecessary handoffs' questioning what is 'unnecessary' to one person may be 'necessary' to another, although it was pointed out that this point was more about reducing inefficiency. The word 'handovers' was suggested by one group. Two groups suggested that this was not in fact a Criteria for assessing options. One group suggested Self Care should be an additional Sub- Criteria and that education plays a big role in achieving more joined up care.

Modern facilities

The fourth criteria, Modern Facilities, was felt to be a clinical as well as a financial consideration by one group. People felt strongly that the current outdated condition of Watford did not lend itself to providing adequate clinical care, and that refurbishing Watford would impact on patient experience. The attractiveness and cleanliness of facilities was felt by one group to be important.

Additional criteria

In addition to the sub-criteria listed groups recommended the following additional sub-criteria: Diagnostic Equipment, IT infrastructure (and how crucial this is to delivering high quality patient care, as well as having modern equipment to support), administration teams (how easy it is for the patient/user) and links to other systems (eg UCL, Royal Free etc).

In general, several groups mentioned that the quality and patient experience category seemed to be tailored to suppliers rather than patients.

Access

Accessibility

All groups felt that accessibility should cover a range of detailed travel and access issues not just average travel times but also public transport, parking (for staff and patients), hospital/inter site transport for staff and patients. It was also felt that access for staff and visitors (including carers) should be considered, not just access for patients.

Car parking in general stimulated significant discussion in all groups. Some participants felt that parking is never given enough attention, and that car parking should be a Sub Criteria of its own; however others said the Sub Criteria should encompass car parking and public transport. Financial considerations were felt to play a part when it came to spending money on land – and if that was best spent on a new hospital or a big car park.

Several groups felt 'average travel times' was inadequate and questioned if this was a good enough measure for decision making. Some groups suggested peak travel times need to be taken into account. Rather than take out 'average' it was felt that there needed to be a thorough analysis of travel times (of which average was one element). Another group said there are spikes – eg match days, peak hour and other issues eg Sunday bus service which meant calculating average travel times was inadequate. This group suggested median and mode measurements should be used. The point was made in this same group that accessibility is financial too.

A couple of groups questioned how 'protected groups' would be defined and that actually the needs of all patients need to be taken into account, rather than specific groups or categories. One group suggested a Sub Criteria 'Alternative Initiatives' should be added to include access to other interventions, or where there might be barriers to this.

There was discussion in one group about the weighting that access should be given, on the basis that access to services is important, but not as important as waiting times. This same group felt that this Criteria should be expanded to include access to services.

Deliverability

Political support

One group commented that the Sub-Criteria Political Support should be more active, and less passive, and should involve active lobbying, enlisting support from STPs and a wide range of stakeholders. One group felt this Sub Criteria should actually be less about political support and more about how the options align with national, regional and local initiatives but said this was a difficult factor to weight. One group asked if there was a leading figure who could be approached to support the process. This links to the point made by another group who said the process needed stakeholder support, which should translate into public support. One group pointed out that this Criteria should also reflect national professional guidance (Royal Colleges, NICE etc) especially regarding standards.

Timescale

One group felt the second criteria Timescale (of new models) should consider a range of factors such as the impact on clinical outcomes and the interest on borrowing costs. Another group felt the timescale also had a financial implication.

Capacity and capability to deliver

In terms of the third criteria, Capacity and Capability to Deliver, one group felt that the complexity of the project and resources required should not be a strong consideration. Another agreed that it was important for the project to have commissioners with the right knowledge in order to deliver. Participants from another group said it was less about capacity to deliver now but feasibility of maintaining costs in the future. One group also noted it was about deliverability across the wider system and the ability to support changes.

Implementation approach

With the fourth criteria, the Implementation Approach, one group felt there was a potential conflict in the ability to implement the preferred option incrementally and spread the investment required over a number of years. The point was made that business continuity should be considered, as it should be a goal that there were no or few interruptions to services while for example building work took place.

One group felt that the impact on IT systems and the wider system should be included as a Sub-Criteria in this section.

Affordability

Several groups mentioned the 'Affordability' criteria must be rooted in reality and options must be considered in the context of delivering value for money and delivering best 'bang for buck' across the whole system. One group mentioned that affordability needed to be considered in the round, in other words if we spend X on this, we can only spend X on that, and therefore what are the priorities. One group said Affordability couldn't be weighted but should be measured on Pass or Fail.

Capital costs

In terms of the Sub Criteria 'Capital Costs' one group felt that the release of net receipts was very important and required more detail. It was noted that equipment had a bearing on cost and that 'servicing of capital costs' should be added to the criteria. It was suggested that 'some models may produce more efficiencies' should be added, and it was noted that we do not know what Treasury's rules will be regarding capital costs.

Impact of activity flows

In relation to the fourth Sub Criteria 'Impact of Activity Flows' one group said flexibility was required when looking at the net impact on the Trust's cash flow due to activity flowing in or out of its catchment area. This group also noted that affordability should be viewed in light of all structural changes and given co-dependencies. The need to look at co-dependencies was echoed by another group, which also questioned the wording 'Impact of Activity Flows' should be amended to focus on the impact on the patient pathway.

Sustainability

This is not a criteria currently included, however it was a topic raised by a number of groups. Many felt that when considering options consideration should be given to 'future proofing' and the longer term impacts, in other words ensuring that all options are considered in light of the need to adapt and grow as the population and care change. Taking into account developments in technology was also mentioned by some groups as being a consideration in the planning process.

Scoring and weighting

One person made the point that the scoring process was critical and that data needed to play a huge part in the review of options. The point was also made that any assumptions made about system capacity and demand must be very carefully worked through, for example is increased demand inevitable? Is the number of predicted beds correct? What about waiting lists? One group noted that assumptions made in the past (for example about community provision) didn't hold true leading to a shortage of beds. They also made the point that we need to consider the quality of service you are trying to provide and how much of it is needed.

Some attendees felt that weightings should be allocated to the criteria. One group did assign weightings to the criteria, ranking the following as most important: Workforce requirement, joined up care, access/travel times, timescales to deliver the project, capital and operating costs. Operating costs were mentioned by other groups as being an important consideration. Another group also put workforce high on the list in terms of weighting criteria and one group said Affordability and Deliverability were the most important two criteria and the two things are very much linked. This same group also put Patient Safety at the top of their list of key criteria.

In general groups agreed with the implications for each Criteria (whether they be Clinical, Non-Financial and Financial), although in some instances they felt the Criteria had additional implication than those identified. For example, Modern Facilities, had a financial implication as well as a non-financial implication, and Patient Safety and Experience had non financial and financial implications as well as clinical.

Workshop 2 – key themes summary

This workshop session saw groups discuss the benefits and disadvantages of two clinical models – one centralised model and one distributed model. The key themes that arose from these discussions are outlined below.

Bed numbers and modelling assumptions

Distributed model

- One group noted that the concept around bed numbers in the distributed model is plausible for that as 'step-down' beds, but emphasised that these must be for clinically stable and non-specialty patients. It was noted that 55 per cent of bed days are occupied by patients who are clinically stable but in acute settings with nowhere else to go eg. frail elderly, and that this is who should be transferred in the distributed model.
- During discussions about 'step-down' beds, one participant mentioned that 'step-down' beds should be in place before any reduction in the number of beds.
- One participant questioned whether the bed numbers in the distributed model would have the critical mass required. This was echoed in another discussion group, where it was highlighted that you need enough patient numbers and that really local services don't work with big fixed point things – it works for services like dermatology.
- One participant – who runs a small hospice – stated that small units give you no staff flexibility, noting that staffing something with 30 beds is very difficult
- One group questioned the applying the 'Northumbria' to West Hertfordshire, noting that the model in theory looks good but questioned whether it would work in practice by asking: "how many times will Hertsmere patients have to go to Watford as there are no beds?", noting that Hertsmere patients tend to go to other hospitals.

Centralised model

- There was a discussion in one group that hospitals with 600 beds tend to struggle, noting that data exists to support this. This led to discussions about increasing the number of beds to 700 if required and questions around the optimal number of beds. It was noted that the Royal Free site has 600 beds and performs well, so depending on the service model, case mix and staffing it isn't all about the size of the facility
- One participant mentioned ambulances queuing at Watford and 95% bed occupancy, raising concerns about capacity in the assumptions, which others in that group agreed with.

Data and evidence

- Comments and questions around the assumptions on bed numbers were raised by most groups at the event, with many asking for more information on the statistical evidence behind the assumption for 600 beds. Some participants highlighted that the number of beds had been declining steadily over the past 20 years, whilst others felt the number of

beds assumed would not be sufficient. It was discussed in different groups that bed numbers in the UK were the smallest in Europe. One participant highlighted that medical advancements should be factored into the bed numbers, citing the improvements in treatments for cataracts as a good example of progress historically (where patients used to get admitted for 2-3 days).

- There were questions raised as to why the data regarding bed numbers ran out after 10 years when this was a 20 year project – others wondered whether this was because 20-year projections on bed numbers might be unreliable
- There was general consensus that if there was going to be smaller number of beds, provision must be factored in elsewhere. It was noted on one table that "extending beds does not add up to the extent of pressure on acute – greater provision of care in the community is essential for this." This was also highlighted by another group, who noted the impact that 'stranded patients' have on bed numbers and that these numbers must be reduced in future.
- One group discussed delays in transfers of care, noting that if these fell then the required number of beds would reduce.
- One participant questioned the reliability of the assessments given incorrect calculations on the patch in the past, noting previous miscalculations with regard to the Acute Admissions Unit at Hemel Hempstead. A participant in another group cited a hospital in Glasgow as an example of building hospitals too small.
- One group asked for more detail on the bed numbers, including breakdowns (eg. male and female and mental health) and how these had been considered in the total number of 600 beds. Similar questions were raised by another group, who asked whether step-down beds in the current system were working well and noted that the right criteria need to be applied to these beds.

Geography and demographic change

- Related to conversations about bed numbers were discussions around the future population of West Hertfordshire – some participants questioned the twenty year timescale and whether adding 25% capacity would be sufficient.
- When discussing the distributed 'Northumbrian' model, one group discussed the different geographical conditions between the two sites, noting that Northumbria is around six times bigger than West Hertfordshire with 60% of the population.

Patient experience

There were a number of questions and comments about patient experience under the distributed 'Northumbria' model, whilst there were fewer comments in general about the centralised model with regard to patient experience.

Distributed model – advantages

- Some participants highlighted the Northumbria Healthcare NHS Foundation Trust's Outstanding CQC rating, noting that it is local hospital model much like London/ Herts.
- It was also noted that Northumbria is one of the NHS England 'Vanguard' sites and that the Trust's CEO has gone to work for NHS England, which indicates that the model must be working.

- The same group also highlighted benefits of the model with regard to length of stay, noting that some people are being transferred straight to home after 48 hours because they are well enough.
- When discussing how the model in Northumbria (a much larger geographical area) has effected patient experiences, it was noted that the model has seen an increase in the number of people moving sites and a decrease in the number of stays.
- One participant noted that when patients have longer stays carers visit them every day before suggesting that the distributed model is better as it's closer to home.
- One group agreed that some advantages of the distributed model included the availability of different services and different cultures, noting that it would be easier to build a culture through this model.
- The same group also noted that the distributed model could make transition easier.

Distributed model – disadvantages

- A prevailing theme across all discussion groups was the experience of (and impact on) patients when being transferred from the specialised and emergency care site to the locally delivered medical beds. Some noted that patients do not like to be moved, whilst another group noted that stroke services struggle when having to transfer services from Watford to Hemel Hempstead, and that this could be improved by centralising on one site.
- There were a significant number of questions about <u>how</u> patients would be transferred and the assumption that patients will be stable within 48 hours. A number of groups raised safety concerns about this, warning that some patients would be discharged too early and vital signs would be missed. Others asked who would be responsible for a patient's condition if it transpires that a patient is not well or stable enough to be transferred. One group called for more information on how regularly the 48 hour mark is exceeded, as this would have a big impact on the model.
- One group called for further detail around how the distributed model would be joined up with other systems, including integrating the system with community and social care.
- One group discussed the dispersed model and diagnostics, noting that it would not be ideal if you have to move patients daily for diagnostics.
- Out of hours care was mentioned in by participants in different groups, with one seeing it as a disadvantage of the distributed model. This led to questions and calls for more information about how the Northumbria model cares for patients after hours.

Centralised model – advantages

- One participant commented that the centralised model assumes that all surgery takes place there, which was seen as being an advantage from a safety perspective. Similarly, another group highlighted the existence of a Centre of Excellence as an advantage of the centralised model.
- Another group noted that the centralised model would ensure that all the clinicians would be where they are needed.
- It was also noted that coordination is an advantage of the centralised model.

Additional comments

- There was consensus across all groups that more information and detail on the Northumbria model is required, particularly with regard to risk management with transfers.
- There were comments stating that the question should be less about sites and more about whether if the patient is in the right place at the right time.
- One group agreed that, whatever the model of care, it must not be 'disempowering' or 'deskilling' and should account for the 'basics' (e.g. patients to be able to go to the toilet on their own). The group added that culture and quality of management were more important than size.

Access

- A number of different discussion groups noted that an advantage of the distributed model would be that patients would be closer to their own homes. Distance from patients' homes was also seen as a disadvantage of the centralised model.
- A number of participants stated that a Greenfield site for acute care would suit the entire patch due to the ability to choose the location.
- It was agreed in one group that there was consensus that planned and acute care should be provided separately and that the big question is over location.
- Differences between the size of Northumbria and West Hertfordshire were raised in one group, where it was noted that the problem of being treated miles from relatives is not a real problem for West Hertfordshire, although it was noted that it could be an issue for older people.

Workforce

- A prevalent theme across the majority of discussion groups was the workforce challenges associated with the distributed model. A number of comments noted that staffing a number of facilities would be a disadvantage given the requirement for specialist staff in more than one place.
- It was noted on several tables that a large increase in the number of consultants would be required for the distributed model – one table noted that West Herts has neither the resource nor the physical space to meet the requirements of the distributed model.
- A handful of discussion groups also highlighted the requirement of staff to move between sites under the distributed model, noting challenges around multi-site working and travel times moving between the sites.
- One group also noted that staff in one locality may not want to work in another locality.
- The importance of culture – and the ability to build and develop the culture – was mentioned by one group of participants; these comments can be seen in the 'Patient Experience' section of this report.

Deliverability and affordability

- Increased financial costs of the distributed model were mentioned in various discussion groups, which focused on increased staff and building costs.
- On the other hand, another group mentioned costs around Watford, with one participant noting that £20m per year would be required just to make existing services acceptable.

- Improvements in IT, technology and medical equipment were highlighted across a number of tables as enablers for the future clinical model and reducing bed numbers and length of stay.
- One group discussed the financial costs of the Northumbria model, noting that additional funding for the North East has made it difficult to decipher what the improvements have resulted from. It was also mentioned that healthcare in Hertfordshire is generally good, so the area may miss out on funding opportunities available in Northumbria.
- Inflexibility around the centralised model was mentioned in one discussion group, where it was agreed that a disadvantage of the centralised model was that the area would be tied into a model that would be difficult to change in the long-term – it was agreed that it would need to be made flexible enough to expand/change.
- One group discussed Sustainability & Transformation Plans (STP), with one participant noting that the longer the wait for service change, the greater the chance of missing out on changing services for years.
- The cost of providing care at home was mentioned in one group, where one participant noted that providing care for people in their own homes is not necessarily cheaper as it depends on who provides it.

Key themes from workshop 3

During this session, participants considered the range of options and discussed how clinical models might apply to them. The purpose of this was to talk through different options and highlight advantages and disadvantages of the location options for a potential Greenfield site.

Access

- Parking facilities were a key consideration for many attendees. It was noted that parking would need to be considered for each site, and specifically mentioned that parking at St Albans and Watford needed to be increased. Other parking options such as Park and Ride and Valet Parking were also raised for consideration.
- Public transport and infrastructure was discussed in detail. It was noted that public transport for a new Greenfield site would need to be considered, and that someone would need to be responsible for ensuring that transport services were provided.
- Existing infrastructure was discussed, particularly in relation to Watford. It was noted that the new road in Watford gives access to the motorway and new tube station and that there is lots of development taking place in Watford. However, congestion in Watford on football match days was also raised as a key consideration in relation to emergency care.
- Many people supported the idea of a Greenfield site, stating that this would be more accessible and could be located equidistant to population centres so travel times would be good.
- Accessibility was also raised from a staffing perspective, which included the suggestion that staff would appreciate being near the M25 and that a Greenfield site would enable access for staff.
- Cross border services were raised as a consideration in relation to patients living in West Herts who access services outside of West Herts or population growth in certain areas and impact on West Herts or cross-boundary services.

- There were differing opinions in the room around the location of site four, the chosen site option. One table commented positively on this location, stating that it was "dead centre" of the A41, M1, M25 and Kings Langley railway station. However, attendees on another table commented stated that this might be accessible from Hemel, but that it is too far from Watford, Harpenden and Hertsmere. It was also raised by another member of the group that the distance to Three Rivers must be considered. Another attendee commented that this site was "isolated".
- The Radlett Aerodrome was also discussed, with one table stating that this site would be good for the M25, M40, M1, A40. Attendees from this group stated that this option might also be attractive to the local planners – it is on the green belt but alternative use would be popular.

Viability of the site

- There was considerable level of disagreement over the viability of Watford as a site for acute care. A number of people felt that the location was entirely unsuitable for a hospital site. However, other members of the group stated that work could be done on Watford, for example infrastructure changes would be extremely helpful, whereas the site at Hemel is very constricted. It was noted that there is lots of land on the Watford site and the Watford Health campus that could be redeveloped.
- There was a number of discussions over the mechanics of rebuilding Watford. A number of attendees questioned whether it would be possible to keep services running without any disruption. A number of attendees stated that service continuity was critical. However, one participant discussed refurbishment at Chase Farm and other attendees mentioned the successful redevelopment in East and North Herts. However, it was noted that this site is less physically constrained than Watford.
- Travel times were raised as a key consideration, with regard to choosing the preferred option. This was particularly around the viability of Watford as an acute site. A number of attendees commented that there was a need to thoroughly analyse travel times and the potential improvements that new infrastructure could make and see whether that makes Watford more viable.
- A number of attendees noted the benefits of a new acute site, particularly regarding planning for the future. Comments were raised regarding the site's ability to retain the option of expansion if necessary. Other attendees commented that the new site would give the option of purpose building to a spec, more efficiently, which would enable more effective planning. Another attendee stated that with a redevelopment, you're retrofitting, commenting that this involves compromising and ending up with something not as beneficial to the patient. Another attendee commented that it is easier to downgrade the site than upgrade it. Some attendees raised questions around how much Watford would deteriorate in the projected 10-15 year timescale.
- There was more discussion around the STP plan timings and the viability of the plan. Some people pressed the urgency around answering what the plan would do for the local area over the next few years. However, other members of the group stated that whilst they appreciated this, a longer term plan was also important – we don't need any more short term fixes. Some people noted the political implications and considerations of the STP plan.
- The demographic growth of the local area was raised as a key issue by many attendees. Questions were raised as to what extend the demographic growth in each area has been explored and considered.

- Questions were raised as to the capacity of smaller hospital sites. One attendee commented that in 1 day there are 110 ambulance visits at Watford and questioned how smaller hospitals could cope. Other comments on this topic considered the impact of locating the acute site near the motorway – some noted that the risk of footfall attendees is reduced, however, others commented that this may result in more calls for ambulances and that trauma patients would increase.
- Impact on other services was also discussed, with questions being raised as to what impact the options would have on other services located on hospital sites, for example hospices, community services. Other attendees stated that a key consideration in building the new site would be the impact this would have on the other sites – which sites would be closing.

Clinical considerations

- There was a great deal of disagreement over the location of planned and acute care, however the importance of this decision was stressed by many attendees. It was also commented that the back-up for planned care was an important consideration. Some comments suggested that this decision was more important than the location, however another member of the group stated that the location for acute services is key because people don't have any choice, whereas patients may well decide to not go to most inconvenient site for planned care.
- Participants in two discussion groups mentioned that the distributed model did not reflect the Northumbria model as Hemel Hempstead and St Albans were not included – they felt that as the Northumbria model has three sites the West Herts version of this model would include planned surgery at Hemel.
- A number of attendees noted the positives of co-locating acute and planned care sites, this was often presented from a clinical perspective. It was noted that co-locating services allows access to equipment and clinicians, more staff cover, ambulance flows into one place. It was also noted that a single site would be efficient. It was noted that for a clinician, co-locating services means all bases are covered. It was commented separating care results in a risk to patients as emergency care is not available. Another attendee stated that some planned care should be provided at the specialist hospital – a site for complex patients.
- A number of attendees noted the positives of separating acute and planned care sites. For example, there were comments suggesting that separating the planned site would mean that elective beds aren't sacrificed for emergency pressures. Additionally, separating planned care would mean that clinicians were not used for emergency care, which could result in their planned care load getting behind. Another attendee stated that in the event of a major disaster, it would be better to have split care as less of a knock on impact on elective surgery. Separating planned care could also result in reliable planned care from a patient experience. Patient experience could be improved as treatment would not be delayed due to emergency pressures.
- A question was raised as to how delivering care out of a building site would satisfy the CQC. This would be a risk and would require engagement with the CQC.

Finance

- There was disagreement over the cost of building a new site. A number of attendees expressed that a new build would cost more than refurbishing existing sites. However,

other attendees stated that a new build would not be much more than refurbishing existing sites, and another attendee commenting that the final cost of refurbishing Watford would be 20% more than building a new site. It was also noted that if a hospital was built on a new site, investment would be required to keep other services standing for use.

- Affordability was a key consideration, with many attendees requesting information on the cost of the options. Many people stated that the decision would need to be based on this and that affordability would limit options available. Attendees stated that there was a need to be realistic about how much money will be available.
- Timescale was raised by a number of attendees, this was raised in relation to STP plans with some attendees stressing the need to put forward a plan to obtain information on the finance available. One attendee commented that the cost of a Greenfield site would have increased since the last figure of £720 million was announced.