Insight | Change | Management

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Penley Community Hospital Balanced Room No. 1

Outcomes Report

October 2025

Contents

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1 INTRODUCTION

Background, context, and participants

1.1 Introduction

This report sets out the summary record of the deliberations and outcomes of a scenario development and appraisal session held on the 26th of September 2025. 15:30.

The session was designed to develop a longlist of scenarios for potential services at Penley Community Hospital following a temporary bed closure in late 2024

1.2 Essential Criteria

The agreed essential criteria, against which any scenarios developed in the session were to be appraised are shown in the table below.

Criteria	Test
Quality and Safety Services meet standards, minimise risk to patients and patients have a good experience.	Can the option provide safe, evidence-based care with sufficient registered staff, maintaining or improving outcomes and patient experience?
Efficiency and Effectiveness • Efficiency - Ability to do things well and without waste. • Effectiveness – the extent to which desired outcomes or results are achieved.	Can the option deliver services efficiently, following effective clinical pathways and achieve intended outcomes?
Deliverability That we can actually deliver what we say we will.	Is the option realistically achievable with available resources (e.g. finance, people) and within a reasonable timeframe?
Sustainability Ability to manage risk and adapt over time.	Can the option be maintained over time, adapting to workforce, demographic and technological changes, while supporting recruitment and retention?
Accessibility and Inclusion Services are equally available and accessible to all. **Note:** The Integrated Equality Assessment highlights the needs of older and disabled people (who are frequent users of community hospitals), as well as carers and those who are economically disadvantaged	Does this option avoid creating extra obstacles for these groups in accessing healthcare?

1.3 Participants

Participation in the event was recruited based on creating a 'balanced room.' The balanced room approach ensures that a diverse mix of perspectives is represented when developing and appraising Scenarios. Rather than allowing one group or viewpoint to dominate, participants are selected to reflect different stakeholder interests, levels of influence, and lived experience. This creates a fairer, more transparent process where evidence, values, and practical considerations are weighed collectively. The aim is not consensus at all costs, but a balanced discussion that tests assumptions, highlights trade-offs, and strengthens the legitimacy of the final outcomes.

The participants were in three broad categories:

- **Voting participants:** a mix of stakeholders and representatives of BCUHB, all of whom have equal voice and vote in deliberations.
- **Expert participants:** representatives of BCUHB on hand to provide expert opinion and input to deliberations.
- **Facilitation team:** the team who enabled discussions without taking part in decision making.

1.3.1 Voting Participants

Stakeholder group	Name
Staff - community matron	Lucy Reid
Staff - director of AHPs	Representative on behalf of Nesta McCluskey
Staff - facilities	Julie Sinclair
Staff - matron, Chirk	Victoria Sheffield
Helping Hands CIC	Paulina Dymnicka
GP - Hanmer Surgery	Kieran Redman
GP - Overton	Gareth Bowdler
NEWCIS - North East Wales Carers Information Service	Michael Langford
AVOW	Jane Edwards
The Rainbow Foundation	Caroline Tudor James
Wrexham Council	Victoria Bishop
Maelor South Community Council	Awyn Reay
Wrexham Council	John Pritchard
Hanmer Surgery Patient Group	Phil Jones
Hanmer Community Council	Lady Hanmer

1.3.2 Technical experts

Dr Sara Gerrie, Consultant Geriatrician, BCUHB

Erin Humphreys, Interim Associate Director of Nursing – East, BCUHB

Ryan Welch, Lead Manager, Community Services – East, BCUHB

Stephen Doore, Equality and Inclusion Manager, BCUHB

1.3.3 Event Facilitation Team (non-voting)

The facilitation team supporting the event's running consisted of:

- Independent Facilitator — Nick Duffin, ASV
- Joint SRO and facilitator — Paolo Tardivel, BCUHB
- Facilitator — Helen Stevens-Jones, BCUHB
- Scribe — Wendy Hooson, BCUHB
- Scribe — Andy Rogers, BCUHB

2 DELIBERATION

Discussions and considerations

2.1 Introduction

This section details the deliberative process undertaken to developing and appraising scenarios for the future service delivery around the Dyfi ward at Tywyn Community Hospital. Discussions employed the balanced room approach to ensure a fair and inclusive assessment.

Participants with diverse viewpoints engaged in thorough discussion. Each scenario was evaluated transparently and objectively using a structured scoring system and clear criteria.

2.2 Emerging Scenarios

Participants generated a range of “blue-sky” ideas for Penley Community Hospital’s future. A strong theme was creating a multi-disciplinary community health hub with integrated services. For example, staff proposed a hub where district nurses, physiotherapists, social care and third-sector teams could offer clinics and outreach together. Alongside this hub idea, there were calls for local diagnostics and outpatient care (blood tests, X-rays, minor injuries, chemotherapy infusions, etc.) so residents need not travel to larger hospitals.

Other ideas focused on bed-based rehabilitation: several groups suggested a 12–24 bed step-up/step-down facility for rehab or palliative care linked to local services (for example coordinated with the Rainbow Centre activities). Participants cautioned against duplicating existing services (noting the Rainbow Centre already offers physio, transport and meals) but said added beds could support patients discharged from the Maelor Hospital and relieve social isolation in this rural area.

Closely related was a push to partner with third sector and existing community services. The hospital could co-locate community support (memory or dementia clubs, mental health groups, befriending) and practical aids (help with blue badges, carer support) in the same building. Indeed, stakeholders noted Penley has no public transport and an ageing, digitally excluded population, so outreach and social support services are vital.

Several innovative service ideas also emerged: a few suggested a GP surgery in the building, supported living or warden-controlled accommodation, a mother-and-baby unit or autism support services. However, the overall message was to ensure any Scenario meets local needs, e.g. older people who cannot easily travel, and to avoid repeating what is already done elsewhere.

This exercise produced seven developed scenarios for assessment which reflect different approaches to balancing local needs, resources, and system priorities. In summary, these scenarios are:

1. **Health and Wellbeing Hub (Integrated)** – repurposing the hospital as a multi-professional hub where health, social care and potentially voluntary sector teams co-locate. The aim is to improve access to outpatient and preventative services closer to home, reducing travel and creating a focal point for care in Penley.

2. **Rehab / Step-down Facility with Beds** – restoring a bed-based function at Penley, focused on rehabilitation, step-down care from acute hospitals and possibly end-of-life support. This reflects community concerns about travel distances and the need for local recovery and respite beds.
3. **Health and Wellbeing Hub plus Third Sector Facility** – combining the integrated hub model with a more explicit role for third-sector partners. The proposal builds on existing strengths in the local voluntary sector to deliver health, wellbeing and social support alongside NHS-led services.
4. **Services in the Community (No Physical Building)** – redirecting resources away from maintaining a fixed site and investing instead in outreach and home-based services. This model prioritises flexibility and a "care closer to home" approach but carries risks if funding and workforce are not secured locally.
5. **GP Surgery** – using the building as a GP surgery, either as a new practice or as a branch of nearby practices. This option reflects public appetite for more accessible primary care, though feasibility depends on provider interest and patient demand.
6. **Care Home / Assisted Living** – converting the hospital into a care home or assisted living facility, providing supported accommodation for older people or those with additional needs. While this could address social care gaps, it raises questions about regulatory standards, capital investment, and whether it aligns with NHS priorities.
7. **Care Homes Providing Bed-Based Care** – meeting local demand through partnerships with existing care homes in the area, rather than re-using the Penley site directly. This option could expand capacity but has limitations around quality, inclusion, and whether it delivers the rehabilitative care that residents value.

Taken together, these options illustrate a spectrum of possibilities: from continuing an NHS service presence on the site (Scenarios 1-to-3), through alternative community service delivery (Scenario 4), to models that shift the function away from healthcare (Scenarios 5-to-7).

The next section provides a detailed assessment of each scenario based on the criteria, incorporating stakeholder input and group discussions.

3 OUTCOMES

The results of deliberations to reach consensus on selected scenarios.

3.1 Introduction

This section reviews each scenario by comparing pros and cons against key criteria. Using stakeholder input and group discussions, it aims to offer an objective assessment and underscore quality, sustainability, and practicality to guide suitable recommendations.

3.2 Consensus Discussion

Provided below is a summary of the discussion had to reach consensus on those scenarios against the essential criteria.

3.2.1 Scenario 1: Health and Wellbeing Hub (Integrated)

- **Quality and Safety:** An integrated hub was seen as a strong Scenario for quality care. Facilitating “multi-professional” teams under one roof can reduce risk and improve the patient experience. Participants noted this model is “proven to work” for involving partners and could improve clinical outcomes by providing care closer to home. However, success depends on the **service mix and staffing**: it “helps to reduce risk” only if sufficient therapy, nursing and social-work staff are provided, and if services are chosen wisely. In other words, the hub must include the right evidence-based services (e.g. rehabilitation, outpatient clinics) with enough registered staff to maintain standards.
- **Efficiency and Effectiveness:** A hub could streamline care by co-locating services and reducing duplicated effort. Stakeholders felt that by pooling resources (e.g. shared therapy staff, combined clinics) efficiency could improve for certain pathways. On the other hand, achieving efficiency is contingent on carefully designing the model: if the mix of services is poorly chosen, inefficiencies could arise. Workshop notes cautioned that the Scenario’s success was “subject to the services that are chosen to go there meeting the criteria”. Thus, while the integrated hub has potential for effective, joined-up care, it will require detailed planning to ensure it is not simply adding complexity.
- **Deliverability:** Delivering an integrated hub poses notable challenges. Participants queried whether it would add new services or simply relocate existing ones, and what estate works would be needed. A key concern was financing any refurbishment and ensuring the necessary workforce can be recruited or redeployed. The notes flag that “some investment might be needed” and that current estates requirements are unclear. In short, this Scenario is theoretically achievable, but only if capital funding is secured and partners commit resources. The hub’s deliverability also hinges on provider willingness – for instance, getting GPs, therapists and third-sector groups to contribute space/time.
- **Sustainability:** A well-designed hub could adapt to future needs by adding new clinics or programs. Having multiple partner organisations involved might help sustain it (through shared funding or staffing). Participants did not note major

sustainability red flags for the hub Scenario, but one caveat is reliance on partners. A diverse model is more robust, however there was a mention of potential vulnerability if any one organisation pulled out. Overall, with continued stakeholder engagement, the hub could be maintained over time, though it will require active coordination to adapt services as demand changes.

- **Accessibility and Inclusion:** This Scenario scored highly on access. By design, an integrated hub would provide a "broader range of the population" with local services. Bringing care into Penley (and offering outreach) directly targets the needs of older, rural residents noted in the longlisting. If well-promoted, it should improve equity – for example by hosting community nurses and therapists in the same building. One caveat is ensuring physical access: the hub location and any parking or transport arrangements must be suitable for less mobile or non-driving patients. Participants stressed that the design should consider deprived groups and those without internet, so the hub should be welcoming and well-signposted for all.

3.2.2 Scenario 2: Rehab/Step-down Facility with Beds

- **Quality and Safety:** Adding beds for rehabilitation or end-of-life care meets a clear local demand. A dedicated rehab unit can improve quality by allowing a smoother recovery closer to home. Stakeholders agreed this Scenario could be safe *if* done properly, but highlighted risks. They emphasised the need for adequate therapy resources (physio, OT) and clear clinical pathways: for example, "a discharge pathway should be in place before a patient is admitted". Safety depends critically on staffing levels and the type of care. As one note said, quality "will depend on what kind of care the beds are being used to provide". In other words, beds for complex rehabilitation require more specialist staffing and oversight than beds for simpler recovery. If these conditions are met, quality can be high, but otherwise patient outcomes could suffer.
- **Efficiency and Effectiveness:** A step-down unit can improve system efficiency by freeing acute beds and reducing delayed discharges. By providing local rehabilitation it should shorten hospital stays overall. However, efficiency gains depend on implementation: scribes warned it "must be implemented well and depends on who delivers the Scenario". The unit should be sized and staffed appropriately: notes repeatedly caveated that efficiency "depends on the number and type of beds". In practice, if too many or too few beds are commissioned (or the wrong specialisms), there is a risk of unused capacity or poor outcomes. Thus, while the model can be effective, it requires careful planning of capacity and partnership with acute and community teams.
- **Deliverability:** Delivering this Scenario has significant resource requirements. Stakeholders pointed out that both capital (to refurbish or refurbish for beds) and workforce (nurses, therapists, managers) must be secured. The appraisal notes repeatedly note deliverability "depends on the number and type of beds" and on who provides them. In a small community hospital, attracting sufficient staff can be hard. It also raises questions about funding the beds and who would commission and run them. In summary, this Scenario is plausible but only if financial and

workforce resources match the scale of the beds. There was no consensus on a specific bed-number, but it was clear that deliverability would hinge on detailed business planning and possibly partnerships with larger hospitals or care homes.

- **Sustainability:** Ongoing sustainability is uncertain and was noted as a caveat. If the step-down unit is financially viable (i.e. stays busy with referrals), it could be stable. However, scribes warned that sustainability "depends on workforce and finance". Aging demographics suggest some sustained demand for rehab beds, but any long-term plan would need built-in flexibility. For example, if patient numbers drop, the service could convert beds to another use (see Scenario 7 considerations). Longevity also depends on contract funding; changes in NHS priorities or social care funding could make sustainability precarious. In short, the bed model could last over time, but only with ongoing funding and an ability to adjust services.
- **Accessibility and Inclusion:** A local rehab facility scores well for access by definition – it brings care closer to patients who would otherwise have to travel out of area. Almost all participants saw this as an inclusive gain (easing family visits and reducing travel burden). The notes affirm it passed accessibility criteria without caveat. The only concern would be if beds fill up or are only for certain groups. In fact, scribes noted the unit should serve all ages, not just frail elderly, to maximise use. If properly commissioned, the facility should help vulnerable older and disabled people access step-down care without distant travel, aligning with community needs.

3.2.3 Scenario 3: Health and Wellbeing Hub plus Third Sector Facility

- **Quality and Safety:** This Scenario combines the integrated hub model (Scenario 1) with dedicated space or support for third-sector providers. The expected quality effects are like Scenario 1's. Stakeholders felt it could safely offer a broad range of services, as with Scenario 1. One additional note is that leveraging third-sector support (e.g. charities running day centres, dementia cafes) could enhance patient experience. No new safety-specific concerns were raised beyond those for the hub generally.
- **Efficiency and Effectiveness:** Merging NHS services and third-sector activities in one centre could boost efficiency by sharing space and referrals. For example, charitable activities (befriending, exercise classes) alongside clinical services can prevent hospital admissions and improve outcomes. The group noted this "dual model" could work well – using both commissioning and fundraising to deliver services. However, they cautioned that efficiency is linked to coordination: scribes asked "How susceptible is any third sector organisation?" meaning donor or volunteer groups can fluctuate. In summary, this Scenario may be very effective at providing wrap-around care if the partnership is strong, but it adds complexity in governance.
- **Deliverability:** Delivering this Scenario involves the same practical issues as Scenario 1 plus engagement with charities. It was noted that "some investment might be needed" and that the hub would require negotiation with any existing third-sector providers on site. One advantage is potential cost-sharing: local

charities may contribute space or fundraising. A downside is dependency on the third sector's commitments. The scribes point out that the sustainability of such a model hinges on the charities' stability. If a partner withdrew, NHS services might lose space or income. In other words, deliverability requires formal agreements and contingency plans but is achievable if partners align.

- **Sustainability:** The hybrid model's sustainability was a concern. On the positive side, funding streams are diverse (NHS budgets plus charitable funds), which can lend resilience. On the negative side, scribes explicitly noted a **susceptibility** risk for the third-sector element. For example, charities may rely on short-term grants; loss of a major funder could endanger services. Maintaining this Scenario long-term would thus require active support (e.g. integrated management, long-term leases, possibly a trust). Overall, it could be sustainable if formalised but would require oversight to avoid service gaps.
- **Accessibility and Inclusion:** As with Scenario 1, this model is very inclusive. By combining healthcare and community support in one place, it can reach people who might fall through the cracks. In workshops the hub-plus-third-sector idea was seen as highly accessible, reaching those most in need (elderly, disabled, isolated). The only caveat is, again, stability: if third-sector services were cut, some support groups might vanish. But in principle, this Scenario should improve access to health and social services for deprived or hard-to-reach residents.

3.2.4 Scenario 4: Services in the Community (No Building)

- **Quality and Safety:** This Scenario envisages re-focusing Penley's resource envelope onto home- and community-based care, without a central hub building. It was generally seen as maintaining a minimum standard of care. Participants felt that experienced community teams could deliver many services (e.g. therapy visits, outreach clinics) safely but noted that oversight is key. Quality would depend on having sufficient staff in the area; scribes flagged a question of whether redirecting funds outside Penley would leave gaps. In practice, providing safe care without a building is possible but requires strong coordination and protocols for patients (e.g. a clear substitute for hospital-based supervision when needed).
- **Efficiency and Effectiveness:** Removing the building might free up funding for community workers. This could improve efficiency if it reduces premises costs and allows more flexible service delivery. However, participants expressed caution: they asked whether such a model could achieve the intended health outcomes over time. Because there would be no local base, some loss of efficiency might occur (for instance, staff travel time). The scribes overall gave Scenario 4 a "Pass," but noted that it "high risk" unless managed well. Essentially, effectiveness will hinge on ensuring those redirected resources truly benefit Penley residents.
- **Deliverability:** In theory, this Scenario is easy to "deliver" because no construction or new facility is needed – existing community teams would just alter their focus. In workshops this was noted as a benefit (no capital needed). However, participants warned about **realistic resource use**. A note explicitly said deliverability depends on funding being "targeted at Penley and surrounding areas". In practice, this means the health board must commit to using the same

budget in Penley rather than elsewhere. So, deliverability is high only if stakeholders ensure that funds and personnel remain allocated to this community; otherwise Penley could lose services without the building to anchor them.

- **Sustainability:** Sustainability is a major concern here. While no building costs exist, this Scenario relies entirely on ongoing community funding. Workshop notes specifically question whether funding "would be maintained long term or ... removed". There is a risk that without a visible facility, community services could be seen as expendable in future budget cuts. Another risk is workforce: community staff may be redeployed elsewhere if no physical presence ties them to Penley. In summary, unless there is a clear guarantee of sustained investment, this Scenario could degrade over time, potentially leaving the community with fewer services.
- **Accessibility and Inclusion:** Without a local building, access could paradoxically worsen. All services would be "in the community," meaning people might rely on home visits or having to travel to scattered clinics. Workshop notes warn this is a high-risk scenario: if not carefully managed, it might "leave the community with less/fewer services". On the plus side, some outreach services (e.g. mobile clinics or visits) can be very inclusive, reaching housebound patients. But there are inclusion challenges: rural patients already struggle with transport, so having no central hub means fewer drop-in options. In conclusion, community-based care is accessible in principle, but it must be very well funded and organised to avoid inadvertently reducing access for vulnerable groups.

3.2.5 Scenario 5: GP Surgery

Quality and Safety: Establishing a GP surgery at Penley could provide strong primary care, but it hinges on GP participation. On paper, local GP access would improve continuity of care and preventive services. However, workshop participants flagged a major barrier: **provider interest**. Records show that a standalone new practice was deemed unviable. The Health Board did not approve plans for a new surgery combined with the hub, noting that "there is not the demand for another surgery in the area". Therefore, with no GP willing to set up there, quality cannot be realised. If a practice did operate, it would likely be a branch of an existing surgery (e.g. Overton or Hanmer), which might limit hours or service scope. Therefore, despite potential benefits, the workshop concluded that this Scenario fails on safety and quality deliverability due to lack of GP provision.

- **Efficiency and Effectiveness:** A local GP surgery could reduce demand on emergency and acute services by managing routine cases. Participants thought a branch surgery might bring efficiencies like shorter travel for patients. However, given the conclusion that a new practice is not viable, these benefits remain theoretical. In fact, the notes imply the alternative would be insignificant – using space for a part-time GP clinic rather than a full practice. In that scenario, efficiency gains would be minimal. In summary, if an existing practice simply ran occasional clinics, it might slightly improve access, but it would not transform local care pathways as hoped.

- **Deliverability:** This Scenario was judged undeliverable as proposed. Workshop notes bluntly state: “Scenario 5a: GP surgery – Outcome: Failed as GP not interested”. Stakeholders confirmed they “have not been allowed to take forward our GP practice plans by the Health Board”. In practical terms, no GP is available to lead the service, and one surmises patient numbers are too low to justify it. Even a branch surgery model was considered insufficient to use the space, implying poor utilisation. Therefore, deliverability is essentially zero: without a willing GP partner or a clear business case, this Scenario cannot proceed.
- **Sustainability:** If it were in place (e.g. a branch surgery), sustainability would depend on stable patient lists and funding. In rural areas this can be shaky; practices may close or reduce hours as rural populations fall. Since the workshop concluded “insufficient use”, any GP service in Penley would likely struggle financially and could be withdrawn. For these reasons, sustainability is questionable.
- **Accessibility and Inclusion:** A local GP would in theory improve inclusion by reaching homebound or immobile residents. The idea of not having to travel for routine appointments was noted as desirable. Yet, because the plan was rejected, patients must continue going to Overton or Hanmer. So, in effect, this Scenario as considered does not improve accessibility. The only potential model left (a satellite clinic) would have limited hours and only modest impact. Thus, while a GP presence was a popular idea at the outset, the workshops suggest it is not a viable path to better access.

3.2.6 Scenario 6: Care Home / Assisted Living

- **Quality and Safety:** This Scenario would convert the hospital into a form of housing with care (e.g. warden-controlled flats or an assisted living facility). In theory, such housing can provide safe, supportive living for older or disabled residents. However, stakeholders raised serious concerns. Workshop notes eventually rated this Scenario **“Fail: Viability is questionable. This Scenario would not meet regulatory standards”**. That implies significant quality/safety hurdles - current regulations for assisted living or care homes may not allow conversion of the hospital without major changes. Unless the facility underwent extensive upgrades and new licencing, it could not legally or safely operate as a regulated care home. Thus, although it was initially considered, later discussion concluded it falls short of necessary quality standards.
- **Efficiency and Effectiveness:** An assisted living model can be efficient in general by allowing people to live independently longer, potentially reducing hospital or full nursing home admissions. In context, this could free up NHS beds elsewhere. However, participants noted that making Penley into a care home would require significant additional services (nursing, 24/7 care, maintenance) – hence one scribble asked “capital to support it”. They did not see clear clinical pathways or NHS outcomes, since it is more of a social care model. In essence, while supported housing meets social needs, it is not an NHS clinical service per se, so its effectiveness in terms of health outcomes was unclear to the group.

- **Deliverability:** Deliverability is problematic. The initial longlist mark said outcome “Pass” with a caveat on capital, but the final workshop decision was that it could not proceed under current rules. Practically, converting a hospital into an assisted living facility would require raising large capital sums for renovation and ongoing care staffing, plus obtaining regulatory approval from social care authorities. The scribes mention that stakeholders had already tried moving forward but were blocked by the Health Board. In summary, this Scenario looks undeliverable unless significant policy or funding changes occur.
- **Sustainability:** If it could be delivered, an assisted living facility might be sustainable through rental income or social care payments. But given the viability doubts, sustainability is moot. The workshop notes imply that even if built, running costs and staffing would be high, and meeting care standards would require continuous oversight. One phrase said "viability is questionable" – suggesting that even long-term maintenance would not be assured.
- **Accessibility and Inclusion:** This model would target older or disabled residents needing support, which aligns with community needs. In theory, it would help some people stay in Penley. However, because it was deemed unworkable, it offers no actual improvement in access. Moreover, if it had proceeded, the type of occupants would likely be older pensioners, meaning younger or ambulant disabled people might be excluded. Participants did not specifically note inclusion for this Scenario beyond the viability issues, but one implication is that by converting to housing, the facility might exclude acute or rehabilitation patients. Ultimately, since it was rejected, no real accessibility benefits would materialise.

3.2.7 Scenario 7: Care Homes Providing Bed-Based Care

- **Quality and Safety:** This Scenario envisioned partnerships with local care homes to provide the “bed-based care” (e.g. rehab beds or end-of-life beds) that Penley lacks, instead of using the hospital itself. On paper, this could extend capacity without redeveloping Penley. In practice, however, stakeholders found it lacking. The appraisal gave this Scenario a **Fail**. Scribes commented that care homes would have to simply hold patients “in a bed” without guaranteed rehabilitative therapy, which would be of limited benefit. Quality concerns include variability in care-home standards and uncertainty that NHS-level care (therapy, monitoring) would be provided. Without strict agreements, patient safety and outcomes could not be ensured.
- **Efficiency and Effectiveness:** Relying on external care homes might seem efficient (using existing beds), but effectiveness is uncertain. Workshop notes highlight inefficiencies: sending patients to distant care homes prevents family visits and might slow recovery. Also, it could lead to NHS funds paying privately for minimal care. Since the Scenario failed, participants evidently judged it ineffective at improving outcomes.
- **Deliverability:** Formally, NHS commissioners could contract with care homes, so in theory it is deliverable. However, the failure of the Scenario suggests significant barriers. Local care homes may not have interest or capacity to take on NHS step-

down cases. Also, oversight is more complex when the beds are offsite. The scribes note “possible route via care homes coming closer”, but no solid plan was given. Essentially, this Scenario relies on negotiation with multiple private providers, which could be difficult.

- **Sustainability:** This model’s sustainability would depend on those care homes remaining open and willing to take patients. In practice, care homes can close or change services, so reliance on them is not very stable. The workshop implicitly judged it unsustainable, since the Scenario was marked fail.
- **Accessibility and Inclusion:** Participants explicitly noted this model would **compromise accessibility**. Few people would benefit – only those accepted by the contracted homes – and those homes may not be near Penley. The notes say it would benefit “a limited number of people” and that simply “keeping [someone] in a bed but not providing the rehab needed would not be beneficial”. In other words, it does not solve the accessibility issue for the broader community. Most community members would have to continue travelling for care, so inclusion goals would not be met.

3.3 Medium List of Scenarios

Following appraisal against the agreed essential criteria, four scenarios were assessed as meeting the minimum standards required to proceed. Each carried important caveats but was judged feasible in principle:

1. **Health and Wellbeing Hub (Integrated)**
   - Passed all criteria, seen as a strong model for co-locating multi-professional services.
   - Caveats: depends on which services are included, sufficient workforce availability, and clarity on estates investment.
2. **Rehab / Step-down Facility with Beds**
   - Passed all criteria, reflecting strong local support for bed-based rehabilitation and step-down care.
   - Caveats: quality and deliverability depend on the number and type of beds, and on securing adequate therapy and nursing staff.
3. **Health and Wellbeing Hub plus Third Sector Facility**
   - Passed all criteria, extending the hub concept by embedding voluntary sector organisations alongside NHS provision.
   - Caveats: sustainability may be vulnerable to fluctuations in third-sector funding and staffing.
4. **Services in the Community (No Physical Building)**
   - Passed all criteria in principle, offering flexible outreach and home-based care instead of a fixed hospital site.
   - Caveats: high risk if long-term funding is not ringfenced locally; could leave the community with fewer services if resources are diverted elsewhere.

APPENDIX ONE: SCENARIO APPRAISAL SUMMARY

Scenario	Quality & Safety	Efficiency & Effectiveness	Deliverability	Sustainability	Accessibility & Inclusion
Health and Wellbeing Hub (Integrated)	Stakeholders felt this model could reduce patient risk if well implemented, but success depends on offering the right mix of services and sufficient staffing and resources (some capital investment may be needed).	The integrated hub was seen as a proven model involving multiple partners; participants said it could increase efficiency by co-locating services, provided the right services are included.	Deliverability hinges on clarity about what's new versus existing services: estate requirements are unclear, and some investment might be needed.	Likely sustainable if initial funding and workforce are secured; no unusual long-term issues were flagged beyond the usual need for ongoing support.	Expected to improve inclusion: participants noted it could reach a broader range of the rural population.
Rehab / Step-down Facility with Beds	Quality depends on having sufficient therapy staff and a proper discharge pathway. For instance, participants stressed the unit should serve all ages, not only frail elderly.	Efficiency depends on strong implementation: stakeholders noted this model "must be implemented well" and success depends on the team providing the service.	Feasible if properly resourced: deliverability scales with the number/type of beds required (staffing and capital must match bed count).	Sustainability likewise varies with scale: funding and workforce must increase in line with bed capacity.	Could improve local access to step-down care, but transport and staffing constraints (e.g. specialist therapists) would still limit reach.

Scenario	Quality & Safety	Efficiency & Effectiveness	Deliverability	Sustainability	Accessibility & Inclusion
Health & Wellbeing Hub + Third Sector	Seen as safe by building on the integrated hub model; no special safety concerns were raised beyond those for Option 1.	Efficiency expected to be like the integrated hub; it leverages an existing hub, and no major efficiency issues were noted.	Generally deliverable by combining NHS and third-sector resources; no unique barriers identified aside from routine coordination.	Stakeholders highlighted a potential vulnerability: heavy reliance on third-sector funding could pose a risk to long-term stability.	Likely to enhance inclusion by adding voluntary-sector outreach, though no specific inclusion issues were noted in the workshops.
Services in the Community (No Building)	Considered safe under existing community services (all criteria passed in appraisal); no significant quality or safety issues were identified.	Viewed as effective, since it builds on home and community care to prevent hospital admissions (all criteria passed).	Easily deliverable using current local services, assuming funds are directed to Penley; participants raised no major feasibility concerns.	Major concern was funding continuity: participants asked whether resources would be maintained long-term, warning that cutting funds could remove services.	High risk noted if funding lapses - withdrawing support could leave the community with fewer services, compromising accessibility.

Scenario	Quality & Safety	Efficiency & Effectiveness	Deliverability	Sustainability	Accessibility & Inclusion
GP Surgery	Initial appraisal marked it as pass, but stakeholders insisted no new GP practice is needed: demand is lacking, and any surgery would likely be just a branch of existing local practices.	Inefficient idea: the building would be underused, duplicating nearby GP capacity. Stakeholders noted it would waste resources, as existing GPs (Overton/Hanmer) would run it.	Undeliverable: no GP was willing to establish a new surgery at Penley, so implementing this option was viewed as non-viable.	Not sustainable: the health board refused the standalone GP plans, and any attempt was scaled back, so long-term viability is effectively nil.	Would not improve access: without new providers, local GP access would remain unchanged, and rural patients would still face travel issues.
Care Home / Assisted Living	Rejected as unsafe/unviable: stakeholders said it would not meet care standards, and its overall viability was questionable.	Ineffective: cannot safely deliver community hospital care. It fails to meet clinical needs, so is not an effective use of resources.	Undeliverable without major investment: licensing and regulatory hurdles were noted, and capital costs make it unrealistic.	Not sustainable: it would be unable to maintain necessary staffing and standards long-term.	N/A (not applicable due to failure of concept; even if built, high costs and limited beds would mean minimal community benefit).
Care Homes Providing Bed-based Care	Rejected as unsafe: stakeholders warned that simply keeping patients in beds without rehabilitation is not clinically beneficial.	Not effective: it offers only bed occupancy without therapy, so patient outcomes would be poor.	Not deliverable in a beneficial way: essentially just a care-home model, which doesn't fit the community hospital remit.	Unsustainable: it has no long-term justification as a community service.	Compromises inclusion: only a few would benefit, and without rehab it "would not be beneficial" to patients.

Thank You

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