

HAMPSHIRE COUNTY COUNCIL

Report

Committee:	Health Overview and Scrutiny Committee
Date of meeting:	29 March 2011
Report Title:	Inquiries Received and Action Taken
Report From:	Chief Executive

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1. **Summary and Purpose**

1.1. This report provides Members with information about the issues brought to the attention of the Committee and the response to these referrals. It sets out the inquiries received, the source of this inquiry and any action taken. Where appropriate comments have been included and copies of briefings or other information attached.

1.2. The approach adopted provides the route through which Local Involvement Networks (LINKs) and other partner organisations (Hampshire district councils, NHS organisations, voluntary and independent sector providers and organisations that are representative of social care service users and carers) can raise issues with the Committee.

1.3. Where inquiries raised with the Committee are already subject to monitoring or other performance management activities the action taken will be focused on the local resolution of inquiries through appropriate sign-posting to the agency best placed to respond.

1.4. Where an issue cannot be satisfactorily resolved between the parties concerned then the Committee can consider options for further action.

1.5. New issues raised with the Committee, and those that are subject to on-going reporting are set out in [Table One](#) of this report.

- 1.6. The recommendations included in this report support the Corporate Strategy aim of maximising wellbeing through the overview and scrutiny of health services in the Hampshire County Council area.

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Table One: Inquiries Received and Action Taken

Topic/inquiry	Source	Action Taken	Comment
Hythe Hospital	Member for Dibden and Hythe	<p>A small Panel led by the County Councillor for Dibden and Hythe has been set up to oversee the formulation of proposals for redeveloping this community hospital.</p> <p>An update from NHS Hampshire is attached at Appendix One. (p.7)</p>	The panel is continuing to meet with local stakeholders to help shape the options.
<p>Recommendation: NHS Hampshire provide details of any additional information required to support the Panel as this work progresses.</p>			
Notice to withdraw Inpatient beds at Odiham Cottage Hospital.	NHS Hampshire	<p>NHS Hampshire will provide a verbal on progress with stakeholder engagement to develop options for providing services at Odiham Cottage Hospital. Correspondence from the local Parish Council and Odiham Cottage Hospital Trustees about this process is attached at Appendix Two (p.10).</p>	
<p>Recommendations: NHS Hampshire confirms:</p> <ol style="list-style-type: none"> 1. when the options developed through this process will be shared with the HOSC 2. how the views of local GPs are feeding into the engagement process 3. the evidence base being used to support the engagement process 4. how the LINK is involved in this process 			

Topic/inquiry	Source	Action Taken	Comment
East Hampshire Community Hospitals	HOSC Chairman and elected members	<p>An update from NHS Hampshire is attached at Appendix Three (p.34)</p> <p>This work should include engagement with local elected members and other key stakeholders.</p>	
<p>Recommendation:. NHS Hampshire considers any further action requested by Members.</p>			
Closure of inpatient beds at Andover Birth Centre	WEHT	<p>Review of Maternity Services in Hampshire report from the Director of Public Health is attached at Appendix Four. (page 36)</p> <p>WEHT will provide the HOSC with confirmation of the status of inpatient birth facilities at Andover and any further action to be taken.</p>	
<p>Recommendations: Members confirm if they are satisfied with the next steps in relation to :</p> <ul style="list-style-type: none"> - taking forward the review of maternity services proposed by the Director of Public Health - the provision of maternity services at Andover Birth Centre 			
Proposed GP branch surgery closure in Whiteley.	Fareham Borough Council	The GP practice based in Whitely is currently consulting patients and local stakeholders about proposals to close a branch surgery. (see Appendix Five page 74).	

Topic/inquiry	Source	Action Taken	Comment
Recommendation: Members confirm if they are satisfied with NHS Hampshire's and the options identified to support the population affected.			
Access to NHS Dentists in Hampshire	HOSC member	NHS Hampshire will provide an update on access to NHS Dental services across the County.	
Recommendation: NHS Hampshire provides any additional information requested by Members.			
NHS Equality Delivery System	HOSC Chairman	A briefing note is attached at Appendix Six (page 78) setting out how this work is being taken forward and the way in which members can comment on progress to date.	
Recommendation: Members provide any feedback on this work to the scrutiny office by 12 April.			

Section 100 D – Local Government Act 1972 – background papers

The following documents disclose facts or matters on which this report, or an important part of it, is based and has been relied upon to a material extent in the preparation of this report.

NB the list excludes:

1. Published works
2. Documents that disclose exempt or confidential information as defined in the Act.

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Appendix One: Hythe Hospital



Hythe Hospital Engagement Update 15 March 2011

1. Background

1. i. What has happened so far?

Since January 2009 the Totton and Waterside Practice-based Commissioning (PbC) group, led by Dr Phil Gregory and representatives from NHS Hampshire and Hampshire Community Health Care have been working with local stakeholders to develop plans for the future of services at Hythe War Memorial Hospital. This has been informed by a health needs assessment, which was completed by NHS Hampshire's public health team.

In November and December 2010, NHS Hampshire widened these discussions to the local community, with the aim of explaining the thinking to date and engaging local people in discussions about what services were important to them for the future.

These discussions took place at a range of engagement sessions across Waterside and Totton, in different venues and at different times of the day, to reach a wide range of communities and ages. Representatives from Hampshire LINK also attended each drop-in session, which helped to facilitate independent discussion.

173 surveys were completed either online or via a paper survey posted back. 50 comments were also received through a feedback form or via email. These were collated and a feedback report produced (enclosed).

1.ii. Hythe Hospital Stakeholder Group

The original stakeholder group at Hythe Hospital merged with the PbC stakeholder group in October 2010. From these members a stakeholder steering group was established in November 2010, to ensure the right group of representatives were guiding the engagement and informing the development of future options. This group now meets monthly and includes the following members:

- Cllr Brian Dash (Hampshire County Council)
- Cllr Maureen Robinson (New Forest District Councillor)
- John Carr (League of Friends)
- Martin Cox (Hampshire LINK and local resident)
- Caroline Coats (Age Concern New Forest East)
- David Shimpe (Hythe and Dibden Parish Council)
- Jane Physick, Area PbC lead.
- Representatives from NHS Hampshire and Hampshire Community Health Care

This group is at the heart of shaping the development of plans and options for Hythe War Memorial Hospital and will continue to be involved at every stage in the future.

2. Proposal for way forward based on views heard

The on-going involvement of local stakeholders and the more recent engagement exercise with the wider community has raised a number of key themes which are being incorporated into future planning.

These fall broadly into two categories:

- the first has been informative feedback about the longer term planning for the site and a range of positive and helpful suggestions for the services that local people would like to see on the site in the future.
- the second is concern about the future of bed based care in the area given the on-going closure of the wards at Hythe Hospital due to staff and environmental issues.

The section below sets out how we are proposing to respond to these issues.

2.ii. How are we responding to local views about the long term future of the site?

Local people have said that they would like to see outpatient services on the site extended to include:

- providing services locally for people who need immediate attention for things like minor accidents or illnesses;
- enhancing local diagnostic services such as ultrasound and X-ray;
- improving blood taking facilities; and
- providing more clinics locally and identify which are needed the most.

Furthermore, the following outpatients clinics are also being considered by local GPs for future development on the site:

- Enhanced ophthalmology
- Themed care days for conditions
- Local signposting and information services
- Respite care
- Improved dementia care and chronic illness management
- Personalised end of life care

Future planning will also include looking into alternative uses for the ward at Hythe Hospital through the provision of day case services, such as minor surgery and IV antibiotic treatment.

The PbC group will be working with the Hythe Hospital Steering group to develop a set of options for services at the Hythe Hospital site and these options will then be tested for feasibility and discussed with local people. Following these discussions, a business case will be developed for a preferred option which will go to our Board in the autumn 2011.

2.iii. How are we responding to local views about bed-based care?

Throughout the engagement people have told us that local bed-based care is wanted and that the right level of medical and nursing support is the main concern. Support to get home quickly was also important to people as well as the distance to travel to the bed-based care, with the majority feeling that three to seven miles was acceptable.

Given the staffing and environmental challenges at the Hythe site as it stands, we have been working with the Hythe Hospital Stakeholder Group to develop a proposal that will ensure that local people still have access to bed based care in the Hythe area. Importantly, only approximately a third of inpatients at Hythe War Memorial Hospital were from Hythe itself with others travelling from Totton and other areas of the Forest.

In response to local views that beds are needed in the immediate Hythe area we are now proposing to test the care home market to fund six re-enablement beds in Hythe area to ensure that local access is retained. These beds would replace the beds at Hythe Hospital and this approach has the support of the Hythe Stakeholder Group. In addition, funding for the ten existing beds at Forest Court, Tatchbury Mount for

patients from the Totton area will continue, and beds will continue to be available at Lymington New Forest Hospital for patients from the western Forest area.

This solution will allow us to move forward with the Stakeholder Group and the local community on the co-production of plans for the long-term future of health services on the Hythe site, through further engagement.

3. Timings

April - May	Feedback to stakeholders on phase 1 engagement and local bed-based care
June - end of September (with less activity over August)	Discussions re: long-term options for the Hythe Hospital site and the range of services provided
October	Strategic outline case to go to NHS Hampshire board and PbC group for preferred option
November - December	Feedback to stakeholders on outcome

4. Decision required

We ask the Overview and Scrutiny Committee to:

- 1) Consider and provide a view on the proposal to commission six additional re-enablement beds from a nursing home in the Hythe area. These beds and the beds at Tatchbury Mount will replace the inpatient beds, which are currently closed at Hythe Hospital.
- 2) Consider and provide a view on the proposal to conduct discussions about long-term plans for the future of the Hythe Hospital site, around an informed set of options, before a business case in the autumn.

Appendix Two: Odiham Cottage Hospital and Proposed NHS Services Changes in Odiham area

The following recent correspondence related to engagement process is attached for information

Item	Content	Date
1	Odiham Parish Council to NHS Hampshire and the HOSC	1 March
2	NHS Hampshire to Chairman of Odiham Cottage Hospital Charitable Trust	8 March
3	NHS Hampshire to Parish Clerk, Odiham Parish Council	8 March
4	Odiham Parish Council to NHS Hampshire and the HOSC	16 March
5	Odiham Charitable Trust to NHS Hampshire	16 March

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To the following addressees by email

Cllr Pat West Chairman HOSC

Mr Jonathan Montgomery Chairman NHS Hampshire

Ms Debbie Fleming Chief Executive NHS Hampshire

1st March 2011

Dear All

**Odiham Cottage Hospital
Notice of withdrawal of nursing services**

Odiham Parish Council (OPC) is one of the stakeholders being consulted about the withdrawal of nursing services from Odiham Cottage Hospital. OPC's representative has been working with concerned local residents, the Trustees of the Odiham Cottage Hospital Charitable Trust and members of the Hospital's League of Friends to try to make sure that the public consultation is fair and reasonable, and that it reflects what we understand to be the requirements of Hampshire County Council's Health Oversight and Scrutiny Committee (HOSC) for a thorough consultation.

We note that the minutes of the HOSC meeting of November 30th 2010 state:

"The importance of local people and key stakeholders being fully engaged in exploring the options for providing services at Odiham Hospital was stressed by Members.

There were some gaps in the material presented and Members reported variable feedback from local stakeholders about the level of engagement that has taken place- this would need to be addressed quickly by NHS Hampshire.

The options developed through this process should be shared with the HOSC in order that the timing and content of any public consultation required can be agreed.

Throughout this process there would need to be clear and consistent communications across stakeholders and with the wider public. This must include regular feedback on progress to the HOSC and local elected members."

We further note that:

NHS Hampshire has taken no notice of reasonable requests to alter their proposed survey so that it allows people to comment on a future for the cottage hospital. Indeed NHS Hampshire, at the recent Hart Locality Stakeholder Group on February 24th, stated that they are not considering options for providing services at Odiham Hospital, as HOSC

says they expect, but rather that they are considering services to address the health needs which are currently fulfilled by the hospital – a very different matter.

NHS Hampshire has put to the Hart Locality Stakeholder Group a series of options which are to be appraised by members of the Stakeholder Group during March. However NHS Hampshire has absolutely refused to entertain putting those same options to the public.

NHS Hampshire has further ignored requests to ensure the survey is seen to cover the whole catchment not just the “Odiham area” (which hardly applies to the larger settlements of Hook and Old Basing, or to the approximately equivalent sized village of Hartley Wintney).

NHS Hampshire has also ignored

requests to try to make the survey easy to answer with comprehensible scoring;

requests to make sure questions had a context for people answering - there is no point asking “If you need bed based care do you want it in a large hospital, in a community hospital, in a nursing home, or at home”, unless you know what people assume they have wrong with them;

OR asking “what would be a reasonable distance to travel for bed based care”.

In these last two cases the answers will obviously be dependent upon the situation or incident, but there is no way for respondents to state such assumptions.

NHS Hampshire requested views on how to reach members of the public. Yet of 5 drop in sessions, 3 are in Odiham, one is in Hook and one in Hartley Wintney. This covers approximately 7,000 households of the approximately 13,500 in the catchment and is quite unbalanced in favour of Odiham. Old Basing, one of the two largest catchments, has been totally ignored.

NHS Hampshire representatives came to the meeting of Odiham Parish Council on January 24th and described to OPC and members of our public a two stage, 6 week consultation, which even then they admitted was very short. This was firstly to be to gather feedback on the public’s view of their health needs, then to formulate options, then to gather the public’s feedback on the potential options. In practice there is just one survey which went live on two websites on February 23rd and responses must be back by 25th March. There is no 2 phase process to gather needs, derive suitable options and consult on those. The total time now allowed is a day under 4 weeks.

Even with this reduced consultation timescale, the next and last planned Hart Locality Stakeholder Group Meeting is set for March 24th. At that meeting stakeholders are supposed to agree a recommendation to be considered at the PCT Board meeting on 31st March (the following public meeting of the PCT Board only being on 26th May, which is clearly cutting it very fine against a 31st July end of notice for nursing services). Yet the final date for survey responses to be received is 25th March, so they clearly will not all be available by 24th March and possibly not by the PCT board meeting on 31st March

either. The full survey responses will certainly not be able to be considered by the Hart Locality Stakeholder Group Meeting on 24th March.

OPC considers this public consultation to be poorly prepared; not reflective of the stated expectations of the HOSC; not reflective of the reasonable input from stakeholder groups; and unlikely to result in a fair and robust response from affected residents. The timing has now been set so that NHS Hampshire cannot take the full public response into account in its decision making process.

Another glaring omission in the whole process has been the total lack of any financial transparency showing comparative costs for care elsewhere.

The Cottage Hospital is fortunate in enjoying the support of an active League of Friends which has undertaken to distribute the survey, even as it stands, to try to ensure that everyone in the relevant GP surgery catchment areas has a chance to respond despite the timescales. However, it should not been necessary for a charity to have to try to make good flaws in the NHS consultation process.

Yours faithfully

On behalf of Odiham Parish Council

Malcolm Leatherdale
Parish Clerk

Copied to

The Rt Hon James Arbuthnot, MP

Cllr Jonathan Glen,

Cllr Tim Southern,

Cllr Ken Crookes

Martin Combs, HCC

NHS Hampshire

Tracey Faraday-Drake, Non Exec Director

Susanne Hasselmann, Non Exec Director

Malcolm Heritage-Owen, Non Exec Director

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8 March 2011

Ms Daphne Bolton
Chairman
Odiham Cottage Hospital Charitable Trust
Odiham Cottage Hospital
Buryfields
Odiham
Hampshire RG29 1NE

Dear Ms Bolton

Thank you for inviting NHS Hampshire to a Public Meeting organised by the Trustees of Odiham Cottage Hospital on Thursday 3rd March 2011 which enabled those present at the meeting to express their strong desire for the hospital to remain open providing bed based nursing care.

It was good to be able to hear first-hand how very much the local community values their local services, and once again, I should like to commend the Odiham community for their tremendous support for the hospital over many years. I very much hope we can find a way forward which will enable the hospital - which is owned by the Trustees - to continue to provide health services in some form or another.

In the meantime, I thought it might be helpful to set out our position on this matter and to address some of the other points that were made at the meeting, given that there was limited opportunity to answer on the night.

Background

As you are aware, Hampshire Community Health Care has notified NHS Hampshire of its intention to end provision of nursing services at the hospital from 31st March 2011, although we have secured an extension of this notice period to the end of July 2011. The reason for the provider wishing to end this contract relates to the difficulty that they have had in maintaining safe and affordable staffing levels at the hospital, which has resulted in them becoming very reliant on the use of agency staff. Although the position has eased slightly in recent months, the

provider is clear that there will continue to be an unacceptably high risk of the problem occurring again in the future.

Whilst receipt of this notice has acted as a “trigger” for our attention, it should be noted that NHS Hampshire in its role as commissioner regularly reviews services to ensure they remain clinically and cost effective. We would therefore have expected to review the service provided from Odiham Cottage Hospital at some point in the future, even if this situation had not arisen.

It is important for local residents to understand that whilst NHS Hampshire has a responsibility for commissioning services on behalf of local people, we do **not** have a responsibility to maintain any specific buildings nor to support specific service providers. This is particularly relevant in considering the future provision of services in Odiham, given that the building is not owned by the NHS. Whilst we fully recognise our responsibility to work with you to ensure that appropriate services are commissioned and are accessible for local people, both now and in the future, the responsibility for maintaining Odiham Cottage Hospital on an on-going basis rests with the Trustees. I know that you are aware of this, but we are keen to ensure that that this is clearly understood by the local community as we seek to address our respective challenges.

It is also important to note that the NHS is not expected (nor allowed) to provide on-going subsidy to individual service providers. In fact, there is now more emphasis than ever before on the need for all providers of care to be able to meet the highest standards of performance – both clinically and financially – on a sustainable and independent basis. You may be aware that all NHS Trusts are required to become Foundation Trusts by 2014, as part of the drive to improve the on-going performance of providers.

Implicit in this approach is that no provider should expect to be paid more than the going rate for the services that they deliver, and in most cases, this is defined by the NHS National Tariff. Acute hospital providers have been working under the tariff system for some time, and this arrangement is expected to be rolled out to community and mental health providers in future years.

This will be a very important issue for the Trustees of Odiham Cottage Hospital, in that no provider will be able to provide services at a loss, and the PCT will not be expected/allowed to subsidise them. This would go against all the competition rules within which the NHS is required to abide.

Size of the Financial Challenge

The need to ensure that the services we commission are cost effective is set against a backdrop of a significant savings programme in the NHS, with £20 billion to be saved over the next three years. For Hampshire, this means that we will need to reduce expenditure by £365 million over the same period. Although the health service has been protected from much of the impact of the economic downturn compared to other public sector services, our situation is still very challenging. We have been used to around 5-6% growth over the past few years from which we have been able to meet our cost pressures – for example, the increased costs associated with the needs of an ageing population, and the high costs associated with the introduction of new drugs and new treatments.

We are now working with very little growth - almost a “flat cash” environment - yet we still face the same cost pressures. This means that in 2011/12, we need to find savings of around £105m - a significant challenge for commissioners and providers alike.

It is against this backdrop that we have to consider all our commissioning priorities and decisions; NHS Hampshire must ensure that we achieve value for money from every penny spent on behalf of our population.

Changing Models of Care

At the Public Meeting, we referred to a number of strategies and plans which we have previously consulted on, including “Healthy Horizons” and “Transforming Community Services”. These plans reflect the views of the public that whenever possible they wish to be cared for at home or as near to home as possible. As such, we have been building up our community services and now have a comprehensive set of home based services including Community Matrons, Community Nursing Teams, Rapid Response Teams and “Virtual Wards”. This latter term refers to an arrangement whereby local GPs are able to monitor the needs of vulnerable or acutely ill patients being supported at home, and ensure that resources are targeted to meeting their needs on a flexible basis. Community services nowadays are therefore better placed than ever before to support people at home who are acutely unwell or have been discharged from a large acute hospital after major illness or injury.

It is important to remember that nowadays, the majority of patients requiring support post-discharge from hospital will receive this type of care. This means that less community beds are required now than was the case in the past, and we expect to commission fewer community beds in the future. This is very much the published strategy of the PCT, as highlighted above, and we have to consider developments within Odiham in this context.

Whilst we accept that we need a range of hospital and community services to meet different needs, we would not now commission community hospitals solely to deliver nursing services. This is because we have a responsibility to deliver the best outcomes for patients and would expect this to be achieved through a clear care plan with measurable goals to support people to regain their independence - and this plan is likely to include provision of therapy services.

There are a number of ways this can be achieved, including home based care and reablement services in care homes. Where such a service is provided in a community hospital, it is likely that this would only be cost effective if this were to cover a larger number of beds and serve a much bigger population.

The review of services that has been prompted as a consequence of HCHC giving notice has exposed the fact that there is a lack of clarity as to the type of service being commissioned from Odiham Hospital, and the outcomes that are expected to be delivered. Listening to local people on Thursday, it is clear that the hospital is being used for a combination of purposes including recuperation/convalescence and continuing nursing care. Whilst this combination may on the face of it appear valuable, what it actually means is that there is no clear specification as to the service that is to be delivered, which in turn means that patients are probably not accessing the most appropriate care when they need it. For example:-

- the absence of rehabilitation staff and facilities means that patients with greater needs are not being given the same chance to be restored to maximum independence. Therefore, whilst these beds cannot be regarded as “rehabilitation beds”, the costs of this facility are still likely to be higher than other services such as reablement. Further, as the clinical needs of some patients mean that there is a requirement for two trained nurses to be on duty, this pushes up the costs of these beds compared with other facilities;

- reablement beds, which is the preferred model of care that we jointly commission with Hampshire County Council, are invaluable in ensuring speedy discharge from hospital and maximising the chances of individual patients regaining their independence. However, Odiham Cottage Hospital is not currently equipped to deliver this type of service;
- whilst some of these patients may be accessing continuing care services, it is now no longer acceptable for patients to receive this type of care in a hospital setting. Patients whose needs are significant enough to require on-going, long term nursing care should be offered a personalised care package, cared for in a more homely environment, in accordance with the standards laid down by the Care Quality Commission;
- whilst it may be that some patients at Odiham are simply there following a period in hospital, the NHS does not commission “convalescent” services. Of course, all patients require some form of support post-discharge – in particular, the elderly – and the level of support required will be agreed for each patient as part of an individual care plan. Many of these plans reflect the fact that patients would benefit from reablement services - hence our willingness to commission these services. Where patients just require “rest and recuperation”, then we would expect this to be achieved through the provision of additional temporary support within their own home.

Hopefully, from the above, you can understand how it is that the services provided from Odiham, whilst being much appreciated by local residents, cannot simply be commissioned from an alternative provider. It is for this reason that we have developed and agreed the current engagement exercise with the Hart Locality Stakeholder Group. This work has identified five potential options for meeting future health needs in the area, against which we wish to seek the views of local residents:-

- an inpatient bed based model, providing 24-hour nursing care and rehabilitation;
- a reablement facility;
- home-based care from community matrons, community nursing teams and “Virtual Wards”;
- integrated care with Social Care and the Voluntary Sector;
- outpatient/clinic based care.

We note that in the meantime and without discussing this with the PCT, the Trustees have distributed a further survey to the public which includes a variation on the options we have agreed with the Hart Locality Stakeholder Group. In this additional survey, three of the descriptors for the options refer to services being run from Odiham Cottage Hospital which may not be possible. This is potentially misleading to the public and may undermine the public engagement process. We are very concerned about this, as it may mean that we have to redo aspects of the engagement to clarify the position, which could lead to delays in the process.

Impact of GP Commissioning

During the course of the meeting, there was reference to the possibility of postponing any decision about the future of Odiham Hospital until the new GP Clinical Commissioning (GPCC) Groups are in place. It is therefore important to make you aware that we are already working closely with the Calleva GPCC, which includes the practices serving Odiham. This GPCC will be in shadow form from April 2011 and will therefore be able to play a full role in determining the right way forwards when the current provider ends their service to the hospital.

As a point of information, it is important to note that under the new resource allocation arrangements that will apply to GPCCs, practices within north and east Hampshire will face a further financial challenge. Compared with other localities across Hampshire, their likely future funding levels will be more greatly reduced as their relatively high historical spend is furthest away from the target generated by the national allocation formula (described locally as “fair shares budget”). We do not yet know how quickly GPCCs will be expected to work to the new formula, but given this situation, it is our expectation that Calleva will be just as committed as NHS Hampshire to ensuring that all its resources are used to the very best effect.

Meanwhile, it was encouraging to hear how much support there was from the community for their local GP practices, and the views of GPs are clearly very important in deciding the best way forwards. However, in addressing future commissioning decisions, it is essential that any potential conflicts of interest - for example, the fact that some of these practices receive an income directly from the current provider to deliver medical services to the hospital – are formally declared and managed.

Next Steps

In light of some of the comments that were made at the open meeting, I thought it might be helpful to confirm the next steps that we expect to follow:-

- we will produce a briefing note to (a) confirm the costs of providing care at Odiham Cottage Hospital over the past year and (b) confirm the number of patients that have been cared for within this facility. We will also provide additional information regarding the costs associated with alternative models of provision, including acute hospital care;
- we expect to complete the current engagement exercise by the end of March, and this should give us a clear picture as to what local residents value most in the provision of local services;
- we expect to update our Trust Board regarding progress at our meeting later this month, but no decision will be taken at that time regarding the services to be commissioned in the longer term. Once we have completed the engagement exercise, confirmed the usage of the facility over the past year and compared the costs of the various alternatives, we will be in a position to confirm our preferred option. We would then expect to work with the HOSC, and go out to consultation on that specific proposal, should the change be significant enough to warrant this.

Given the complexity of all the above, I cannot stress enough the significance of the current engagement exercise, which is intended to enable an open dialogue with local people, and to explain the constraints and opportunities.

Meanwhile, we very much hope that the Trustees will take this opportunity to consider the feedback from the public regarding the potential alternative models of care/support, whilst at the same time, considering other potential uses for the building. As you will be aware, we would also

like to encourage you to engage with other potential partners/organisations that might work with you in developing creative and innovative solutions to this challenge.

Finally, as Sarah Elliott has previously highlighted, whilst the possibility of securing a temporary alternative provider is being currently being investigated, we have to accept that these efforts may not be successful. We shall therefore be reviewing the capacity within the community teams and other local services in the area to ensure that appropriate care continues to be made available to the people of Odiham whilst this matter is resolved. I am pleased to confirm that we have secured additional reablement capacity this year in partnership with Hampshire County Council Adult Social Care Services. It is also encouraging to note that a large number of additional nurses have been recruited into the area over the past few months, which has significantly increased the capacity and capability of the community team.

I hope that this letter is helpful in clarifying the position of the PCT. We look forward to continuing to work with you in resolving this complex but very important matter.

With best wishes.

Yours sincerely



D.M. Fleming (Mrs)
Chief Executive
NHS Hampshire

DRAFT

cc: The Rt Hon James Arbuthnot, MP
Cllr Jonathan Glen
Cllr Tim Southern
Cllr Ken Crookes
Cllr Pat West
Martin Combs, HCC
Dr Hugh Freeman, Calleva
Jonathan Montgomery, Chair, NHS Hampshire
Tracey Faraday-Drake, Non Executive Director, NHS Hampshire
Susanne Hasselmann, Non Executive Director, NHS Hampshire
Malcolm Heritage-Owen, Non Executive Director, NHS Hampshire
Sarah Elliott, NHS Hampshire
Mel McKeown, NHS Hampshire

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8 March 2011

Mr Malcolm Leatherdale
Parish Clerk
Odiham Parish Council
The Bridewell
The Bury
Odiham
Hampshire RG29 1NB

Dear Mr Leatherdale

Odiham Cottage Hospital – Withdrawal of Nursing Services

Thank you for your letter of 1st March 2011 regarding the withdrawal of nursing services from Odiham Cottage Hospital. Within your letter you raise a number of concerns which I have discussed with the Director and team working on this project. I am concerned to see that we have a different perspective on a number of points and hope this letter will help clarify the position.

For ease of reference, I have used a table format to address each concern you raise.

Comment from Odiham Parish Council	Response from NHS Hampshire
<p>You refer to the minutes of the Health Overview and Scrutiny Committee of the 30th November 2010</p> <p><i>The importance of local people and key stakeholders being fully engaged in exploring the options for providing services at Odiham Hospital was stressed by Members.</i></p>	<p>We have always been fully committed to engaging local people and stakeholders in exploring options to provide services at Odiham Hospital and have put in place the Hart Locality Stakeholder Group as part of this. Membership includes Trustees and League of Friends from the hospital, District Council members, local GPs, the Parish Council, LINKs, County Council</p>

<p><i>There were some gaps in the material presented and Members reported variable feedback from local stakeholders about the level of engagement that has taken place- this would need to be addressed quickly by NHS Hampshire.</i></p> <p><i>The options developed through this process should be shared with the HOSC in order that the timing and content of any public consultation required can be agreed.</i></p>	<p>officers and members, Hampshire Community Health Care and the PCT.</p> <p>The group has overseen the development of a survey, programme of drop-in sessions, developed options/criteria and will be directly involved in the option appraisal exercise.</p> <p>In addition, we have sought to work directly with the Trustees to explore options for the use of Odiham Cottage Hospital building.</p> <p>As detailed above, NHS Hampshire has ensured that engagement activity has been explored and tested with the Hart Locality Stakeholder Group.</p> <p>The PCT has provided regular updates to the HOSC and last met with the Chair of the HOSC, Cllr. Pat West, and Martin Combs to discuss engagement work for Odiham Cottage Hospital on 17th February 2011. NHS Hampshire will continue to provide updates on the engagement activity and will be using the standard HOSC template in order that the HOSC can determine the timing and content of any public consultation.</p>
<p><i>NHS Hampshire has taken no notice of reasonable requests to alter their proposed survey so that it allows people to comment on a future for the cottage hospital. Indeed NHS Hampshire, at the recent Hart Locality Stakeholder Group on 24th February, stated that they are not considering options for providing services at Odiham Hospital as HOSC says they expect, but rather that they are considering services to address the health needs which are currently fulfilled by the hospital – a very different matter.</i></p>	<p>We believe that we have always made it clear that as the commissioner of health services, we have a responsibility to consider the health needs of the local population in determining future service provision in the area and as such the engagement cannot purely focus on Odiham Cottage Hospital. We have sought to achieve a balance here by including questions which explore what is important for local people when they consider bed-based care to inform options for meeting health needs.</p> <p>As a separate matter, the Trustees who own the hospital may wish to consult the public on the future use of their building.</p> <p>The Parish Council tabled an alternative</p>

	<p>survey at the Hart Locality Stakeholder Group on the 24th February 2011 which the PCT reviewed in detail and where possible incorporated the ideas enclosed in this. We believe this was approximately 80% of the content.</p>
<p><i>Indeed NHS Hampshire, at the recent Hart Locality Stakeholder Group on February 24th, stated that they are not considering options for providing services at Odiham Hospital as HOSC says they expect, but rather that they are considering services to address the health needs which are currently fulfilled by the hospital – a very different matter.</i></p>	<p>NHS Hampshire has never discounted the option of a new provider at the hospital and indeed has been active in speaking with potential providers of nursing services such as Basingstoke and Frimley Park Hospitals.</p>
<p><i>NHS Hampshire has put to the Hart Locality Stakeholder Group a series of options which are to be appraised by members of the Stakeholder Group during March. However NHS Hampshire has absolutely refused to entertain putting those same options to the public.</i></p>	<p>There has never been a refusal to put these options before the public. In fact this is very likely at the end of the current engagement phase once we have received feedback from the public on what is important to them.</p> <p>We note that in the meantime and without discussing this with the PCT, the Trustees have distributed a further survey to the public which includes a variation on the options we have agreed with the Hart Locality Stakeholder Group. In this additional survey, three of the descriptors for the options refer to services being run from Odiham Cottage Hospital which may not be possible. This is potentially misleading to the public and may undermine the public engagement process. This may mean that we have to redo aspects of the engagement to clarify the position which could lead to delays in the process.</p>
<p><i>NHS Hampshire has further ignored requests to ensure the survey is seen to cover the whole catchment not just the “Odiham area” (which hardly applies to the larger settlements of Hook and Old Basing, or to the approximately equivalent sized village of Hartley Wintney).</i></p>	<p>The survey has been sent via e-mail to clubs and societies within 10 miles of Odiham. It has also been sent by e-mail to Parish Councillors (via their clerks) representing the 21 Parish Councils within Hart District Council and to all Hart District Councillors. In addition, information to advertise both the survey and the drop-in sessions has also been sent to the GP practices in Hart.</p>

<p><i>NHS Hampshire has also ignored requests to try to make the survey easy to answer with comprehensible scoring</i></p>	<p>NHS Hampshire has considerable experience in conducting large scale surveys and uses a highly regarded web-based survey system. We believe it is the additional points in the survey that the Parish Council has requested which have added to the complexity in the survey design. Without the survey system we would be unable to analyse the information received as quickly as we need to.</p>
<p><i>NHS Hampshire requested views on how to reach members of the public. Yet of 5 drop in sessions, 3 are in Odiham, one is in Hook and one in Hartley Wintney. This covers approximately 7,000 households of the approximately 13,500 in the catchment and is quite unbalanced in favour of Odiham. Old Basing, one of the two largest catchments, has been totally ignored.</i></p>	<p>The drop-in session locations reflect the three main areas from which patients were referred into the OCH in 2010. Of the 93 admissions in 2010, 42 were Odiham residents, 17 were from Hook and 9 from Hartley Wintney. There were only two admissions from residents living in Basingstoke.</p> <p>We recall the Trustees and Parish Council previously expressing concern that if the drop-in sessions were held in a wider geographical area then this would skew the results as people living here would have no interest in the hospital.</p>
<p><i>NHS Hampshire representatives came to the meeting of Odiham Parish Council on January 24th and described to OPC and members of our public a two stage 6 week consultation, which even then they admitted was very short. This was firstly to be to gather feedback on the public's view of their health needs, then to formulate options, then to gather the public's feedback on the potential options. In practice there is just one survey which went live on two websites on February 23rd and responses must be back by 25th March. There is no second phase process to gather needs, derive suitable options and consult on those. The total time now allowed is a day under 4 weeks.</i></p>	<p>The current engagement is around local views on current and future healthcare in the area. The drop-in sessions offer residents an understanding of the types of alternatives offered for bed-based care. These include finding an alternative provider for Odiham Cottage Hospital.</p> <p>The next steps (following analysis of the current engagement) will be to ensure that we speak once again to the community about the possible options for the provision of future healthcare in the area. This will follow the option appraisal work being carried out by the stakeholder group.</p> <p>Furthermore, we have had to slightly reduce the initial engagement period due to the period of purdah which commences at the end of March 2011.</p>
<p><i>Even with this reduced consultation timescale, the next and last planned Hart Locality</i></p>	<p>We have referred to a paper being put before our Board, but until, we have the results from the engagement and the</p>

<p><i>Stakeholder Group Meeting is set for 24th March. At that meeting stakeholders are supposed to agree a recommendation to be considered at the PCT Board meeting on 31st March (the following Public Meeting of the PCT Board only being on 26th May, which is clearly cutting it very fine against a 31st July end of notice for nursing services). Yet the final date for survey responses to be received is 25th March, so they clearly will not all be available by 24th March and possibly not by the PCT board meeting on 31st March either. The full survey responses will certainly not be able to be considered by the Hart Locality Stakeholder Group Meeting on 24th March.</i></p>	<p>options appraisal, we have not stated that we will be asking for a recommendation to be agreed by the Board.</p> <p>We anticipate we will be providing an update only on the work to date at our March 2011 Board meeting. We will only take a paper on the preferred option for consultation when we are completely satisfied that all stages of the initial engagement and options appraisal exercise are completed.</p>
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I note also that you view the consultation as poorly planned and executed and not likely to result in a fair and robust response from residents. I am sorry that you feel this way but I am satisfied that the various officers of the PCT are doing everything possible to ensure a robust process is in place. It will continue to be important that we have your support in achieving this.

Thank you once again for raising your concerns and we look forward to our continued work with you through Helen Fleming's representation on the Hart Locality Stakeholder Group.

With best wishes.

Yours sincerely



D.M. Fleming (Mrs)
Chief Executive
NHS Hampshire

- c.c. Jonathan Montgomery, Chair
 Cllr Pat West
 The Rt Hon James Arbuthnot, MP
 Dr Hugh Freeman
 Cllr Jonathan Glen
 Cllr Tim Southern
 Cllr Ken Crookes
 Martin Combs, HCC
 Tracey Faraday-Drake, Non Executive Director
 Susanne Hasselmann, Non Executive Director
 Malcolm Heritage-Owen, Non Executive Director
 Sarah Elliott, Mel McKeown



The Bridewell
The Bury
Odiham
Hampshire
RG29 1NB

To the following addressees by email

Cllr Pat West Chairman HOSC

Mr Jonathan Montgomery Chairman NHS Hampshire

Ms Debbie Fleming Chief Executive NHS Hampshire

16th March 2011

Dear All

Odiham Cottage Hospital

We thank Ms Fleming for her response to, and Cllr West for her acknowledgement of, Odiham Parish Council's letter of March 1st.

The focus of this response by the Parish Council is to the detailed response of 8th March 2011 by NHS Hampshire to that letter.

We request that Cllr West of HOSC considers this response as an addition to our previous communication.

The Council comments that:

During the course of the stakeholder and public engagement to date, NHS Hampshire has equivocated and changed its position on key issues concerning the essence of the process.

On several occasions, representatives of NHS Hampshire have made statements in public which have later been retracted in private, and then sometimes re-stated after concerns have been raised formally with key stakeholders and Hampshire County Council's HOSC.

In consideration of our comments above we would draw your attention to the following:

- the proposed two stage consultation process, which your letter of the 8th March to the parish council now re-instates;
- the acceptance of the Trustees' additional question by the CEO, NHS Hampshire at the public meeting in Odiham on 3rd of March in front of more than 300 residents and the press, but which has not been followed through;

Tel: 01256 702716

website www.odiham.org.uk

email: clerk@odiham.org.uk

- the presentation by the NHS of the early version of the survey whose strap line was “Working together to provide a bright future for Odiham Cottage Hospital”;
- the presentation (by Hart PBC Locality Lead, Dr Steven Clarke, in association with NHS Hampshire Director of Commissioning Out of Hospital, Sarah Elliott) at the February 3rd Hart Locality Stakeholder Group meeting which focussed upon options for the use of Odiham Cottage Hospital;
- the changes in costs quoted for the current running of Odiham Cottage Hospital (budget £450k; over budget cost quoted at Stakeholder Group £540k; cost quoted at public meeting £600k);
- the changing costs provided by NHS Hampshire of the alternatives to care at OCH (Frimley equivalent bed per day £99 or £150 quoted at Stakeholder Group, £300 per day at public meeting).

NHS Hampshire has taken the trouble to reply in detail to the points we raised in our letter. You may not be surprised to hear that there remains a different perspective on a number of the detailed replies.

For continued ease of reference we have adopted your method of a table format for our response. For further clarity we have highlighted in italics the points on which we respond on the following pages.

Comment from Odiham Parish Council:	Response from NHS Hampshire:	Further response from Odiham Parish Council:
<p>You refer to the minutes of the Health Overview and Scrutiny Committee of the 30th November 2010</p> <p><i>The importance of local people and key stakeholders being fully engaged in exploring the options for providing services at Odiham Hospital was stressed by Members.</i></p> <p><i>There were some gaps in the material presented and Members reported variable feedback from local stakeholders about the level of engagement that has taken place- this would need to be addressed quickly by NHS Hampshire.</i></p>	<p>We have always been fully committed to engaging local people and stakeholders in exploring options to provide services at Odiham Hospital and have put in place the Hart Locality Stakeholder Group as part of this. Membership includes Trustees and League of Friends from the hospital, District Council members, local GPs, the Parish Council, LINKs, County Council officers and members, Hampshire Community Health Care and the PCT.</p> <p>The group has overseen the development of a survey, programme of drop-in sessions, developed options/criteria and will be directly involved in the option appraisal exercise.</p> <p>In addition, we have sought to work directly with the Trustees to explore options for the use of Odiham Cottage Hospital building.</p> <p>As detailed above, NHS Hampshire has ensured that <i>engagement activity has been explored and tested with the Hart Locality Stakeholder Group.</i></p>	<p>You will see attached to this email the table of comments recently sent to you on version 3 of the survey from 4 members of the Hart Locality Stakeholder Group: OCHCT, League of Friends; District Council, Parish Council.</p>

<p>Comment from Odiham Parish Council:</p> <p><i>The options developed through this process should be shared with the HOSC in order that the timing and content of any public consultation required can be agreed.</i></p>	<p>Response from NHS Hampshire:</p> <p>The PCT has provided regular updates to the HOSC and last met with the Chair of the HOSC, Cllr. Pat West, and Martin Combs to discuss engagement work for Odiham Cottage Hospital on 17th February 2011. NHS Hampshire will continue to provide updates on the engagement activity and will be using the standard HOSC template in order that the HOSC can determine the timing and content of any public consultation.</p>	<p>Further response from Odiham Parish Council:</p>
<p><i>NHS Hampshire has taken no notice of reasonable requests to alter their proposed survey so that it allows people to comment on a future for the cottage hospital. Indeed NHS Hampshire, at the recent Hart Locality Stakeholder Group on 24th February, stated that they are not considering options for providing services at Odiham Hospital as HOSC says they expect, but rather that they are considering services to address the health needs which are currently fulfilled by the hospital – a very different matter.</i></p>	<p>We believe that we have always made it clear that as the commissioner of health services, we have a responsibility to consider the health needs of the local population in determining future service provision in the area and as such the engagement cannot purely focus on Odiham Cottage Hospital. We have sought to achieve a balance here by including questions which explore what is important for local people when they consider bed-based care to inform options for meeting health needs.</p> <p>As a separate matter, the Trustees who own the hospital may wish to consult the public on the future use of their building.</p> <p>The Parish Council tabled an alternative survey at the Hart Locality Stakeholder Group on the 24th February 2011 which the PCT reviewed in detail and where possible incorporated the ideas enclosed in this. We believe this was approximately 80% of the content.</p>	<p>This notion has only been introduced at the Stakeholder meeting on 24th February. Prior to the meeting on 3rd February a first draft of the survey was produced with the strap line “<i>Working together to provide a bright future for Odiham Cottage Hospital</i>”; on the same day the presentation of options by Dr Stephen Clark in association with Sarah Elliott on February 3rd which focussed upon options for the use of Odiham Cottage Hospital – described on slide 4 as “Potential roles for Odiham within alternative models of care”.</p> <p>The alternative survey was tabled at the Hart Locality Stakeholder Group on the 3rd February 2011, following which a second opportunity was offered to the Stakeholder group to comment on the survey, with responses due by noon on Friday 11th February.</p> <p>Of 17 comments sent within the deadline by members of the Stakeholder Group (representing 4 Stakeholders), 3 became not applicable as the questions were removed; 5 changes were accepted, which included one typo; and 9 comments were ignored, including one requesting that the public be offered a chance to comment on the same options as the Stakeholder Group.</p> <p>A copy of a table (as referred to above) showing these comments and the action – or otherwise – taken by NHS Hampshire is attached for those interested in the detail.</p>

<p>Comment from Odiham Parish Council:</p> <p><i>Indeed NHS Hampshire, at the recent Hart Locality Stakeholder Group on February 24th, stated that they are not considering options for providing services at Odiham Hospital as HOSC says they expect, but rather that they are considering services to address the health needs which are currently fulfilled by the hospital – a very different matter.</i></p>	<p>Response from NHS Hampshire:</p> <p><i>NHS Hampshire has never discounted the option of a new provider at the hospital</i> and indeed has been active in speaking with potential providers of nursing services such as Basingstoke and Frimley Park Hospitals.</p>	<p>Further response from Odiham Parish Council:</p> <p>Odiham Parish Council is delighted to hear this – this is the most positive statement that we have heard on Odiham Cottage Hospital from NHS Hampshire.</p>
<p><i>NHS Hampshire has put to the Hart Locality Stakeholder Group a series of options which are to be appraised by members of the Stakeholder Group during March. However NHS Hampshire has absolutely refused to entertain putting those same options to the public.</i></p>	<p>There has never been a refusal to put these options before the public. <i>In fact this is very likely at the end of the current engagement phase once we have received feedback from the public on what is important to them.</i></p> <p>We note that in the meantime and without discussing this with the PCT, the Trustees have distributed a further survey to the public which includes a variation on the options we have agreed with the Hart Locality Stakeholder Group. In this additional survey, three of the descriptors for the options refer to services being run from Odiham Cottage Hospital which may not be possible. This is potentially misleading to the public and may undermine the public engagement process. This may mean that we have to redo aspects of the engagement to clarify the position which could lead to delays in the process.</p>	<p>At the last Stakeholder Group meeting on February 24th the chairman, Sarah Elliott, told the Stakeholder Group that she expected a decision to be made at the 31st March PCT Board Meeting, because it would be leaving it very late to wait for the subsequent meeting on May 26th. Although a second round of consultation had been promised when NHS Hampshire came to the January 24th meeting of Odiham Parish Council, the NHS Head of Communications informed our representative by telephone that because of time pressures there would now be just the one survey.</p> <p>We note that even now the additional presentation of options to the public only remains “very likely”.</p> <p>It is curious that in a previous answer above NHS recognises that the Trustees who own the hospital may wish to consult the public on the future use of their building. What could be more natural than that the Trustees should put to the public the latest version of the possible options originally presented to the Stakeholder Group on February 3rd by Dr Steven Clark in association with Sarah Elliott described on slide 4 of that presentation as “Potential roles for Odiham within alternative models of care”.</p>
<p><i>NHS Hampshire has further ignored requests to ensure the survey is seen to cover the whole catchment not just the “Odiham area” (which hardly applies to the larger settlements of Hook and Old Basing, or to the approximately</i></p>	<p>The survey has been sent via e-mail to clubs and societies within 10 miles of Odiham. It has also been sent by e-mail to Parish Councillors (via their clerks) <i>representing the 21 Parish Councils within Hart</i></p>	<p>NHS Hampshire must be aware that there is a clearly defined catchment area for the surgeries which currently have admitting rights to the hospital. This may or may not equate to a 10 mile radius of the hospital. It includes</p>

<p><i>equivalent sized village of Hartley Wintney).</i></p>	<p>District Council and to all Hart District Councillors. In addition, information to advertise both the survey and the drop-in sessions has also been sent to the GP practices in Hart.</p>	<p>parishes in Basingstoke and Deane, which was pointed out to NHS Hampshire at the very first Stakeholder Group.</p>
<p><i>NHS Hampshire has also ignored requests to therefore try to make the survey easy to answer with comprehensible scoring</i></p>	<p>NHS Hampshire has considerable experience in conducting large scale surveys and uses a highly regarded web-based survey system. We believe it is the additional points in the survey that the Parish Council has requested which have added to the complexity in the survey design. Without the survey system we would be unable to analyse the information received as quickly as we need to.</p>	
<p><i>NHS Hampshire requested views on how to reach members of the public. Yet of 5 drop in sessions, 3 are in Odiham, one is in Hook and one in Hartley Wintney. This covers approximately 7,000 households of the approximately 13,500 in the catchment and is quite unbalanced in favour of Odiham. Old Basing, one of the two largest catchments, has been totally ignored.</i></p>	<p>The drop-in session locations reflect the three main areas from which patients were referred into the OCH in 2010. Of the 93 admissions in 2010, 42 were Odiham residents, 17 were from Hook and 9 from Hartley Wintney. There were only two admissions from residents living in Basingstoke.</p> <p>We recall the Trustees and Parish Council previously expressing concern that if the drop-in sessions were held in a wider geographical area then this would skew the results as people living here would have no interest in the hospital.</p>	<p>The parish council queries the split of these figures. If you are registered with a GP in Odiham, you may book an appointment in either Odiham or Old Basing according to your & the GP's availability. We suspect that Old Basing residents are admitted as from Odiham Health Centre. The response from Old Basing to publicity does not tie up with total lack of awareness of the Cottage Hospital, which NHS assumes from these figures.</p> <p>And yet NHS Hampshire has ignored areas which currently do have rights to use the hospital while advertising the engagement to all GP surgeries in Hart and all parish councils in Hart, many of which do not currently have such rights, and to whom it will therefore currently mean nothing.</p>
<p><i>NHS Hampshire representatives came to the meeting of Odiham Parish Council on January 24th and described to OPC and members of our public a two stage 6 week consultation, which even then they admitted was very short. This was firstly to be to gather feedback on the public's view of their health needs, then to formulate options, then to gather the public's feedback on the potential options. In practice there is just one survey which went live on two websites on February 23rd and responses must be back by 25th March. There is no second phase process to gather needs, derive suitable options and consult on those. The total time now allowed is a day under 4 weeks.</i></p>	<p>The current engagement is around local views on current and future healthcare in the area. The drop-in sessions offer residents an understanding of the types of alternatives offered for bed-based care. These include finding an alternative provider for Odiham Cottage Hospital.</p> <p>The next steps (following analysis of the current engagement) will be to ensure that we speak once again to the community about the possible options for the provision of future healthcare in the area. This will follow the option appraisal work being carried out by the stakeholder group.</p>	<p>This was not the plan outlined at the last Stakeholder meeting on 24th February. Prior to that meeting NHS Head of Communications informed our representative that there would only be one survey.</p>

Comment from Odiham Parish Council:	Response from NHS Hampshire:	Further response from Odiham Parish Council:
<p><i>Even with this reduced consultation timescale, the next and last planned Hart Locality Stakeholder Group Meeting is set for 24th March. At that meeting stakeholders are supposed to agree a recommendation to be considered at the PCT Board meeting on 31st March (the following Public Meeting of the PCT Board only being on 26th May, which is clearly cutting it very fine against a 31st July end of notice for nursing services). Yet the final date for survey responses to be received is 25th March, so they clearly will not all be available by 24th March and possibly not by the PCT board meeting on 31st March either. The full survey responses will certainly not be able to be considered by the Hart Locality Stakeholder Group Meeting on 24th March.</i></p>	<p>Furthermore, we have had to slightly reduce the initial engagement period due to the period of purdah which commences at the end of March 2011.</p> <p><i>We have referred to a paper being put before our Board, but until, we have the results from the engagement and the options appraisal, we have not stated that we will be asking for a recommendation to be agreed by the Board.</i></p> <p>We anticipate we will be providing an update only on the work to date at our March 2011 Board meeting. We will only take a paper on the preferred option for consultation when we are completely satisfied that all stages of the initial engagement and options appraisal exercise are completed.</p>	<p>Further response from Odiham Parish Council:</p> <p>At the last Stakeholder meeting it was stated that a decision should be taken by the PCT Board on 31st March. The Parish Council is pleased that a more realistic approach is now being taken which will allow consideration of the results of the surveys before any recommendation is made to the Board.</p>

Yours faithfully

On behalf of Odiham Parish Council

Malcolm Leatherdale

Parish Clerk

Copied to

The Rt Hon James Arbuthnot, MP
 Cllr Jonathan Glen,
 Cllr Tim Southern,
 Cllr Ken Crookes
 Martin Combs, HCC



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odihamcottagehospital.org.uk

**Mrs D M Fleming
Chief Executive
NHS Hampshire
Omega House
112 Southampton Road
Eastleigh, Hampshire
SO50 5PB**

16th March 2011

Dear Mrs Fleming

Thank you and your NHS colleagues, for attending our public meeting on 3rd March, for your detailed letter dated 8th March and for your recognition of the support of our community for their cottage hospital.

I would like to assure you that the Trustees of Odiham Cottage Hospital Charitable Trust appreciate the obligations, constraints and challenges facing all NHS employees as well as the change in health care needs and have always endeavoured to communicate this to the community we serve. It was for this reason that, following discussion with local GPs, we approached HCHC managers in 2008 with a proposal to fund the provision of a rehabilitation facility on the hospital site. We believed that the community would benefit from having a wider range of services, both as in-patient and out-patient, locally. Diagnostic, rehabilitation and assessment services would all be possible and desirable here. HCHC appeared very interested in this and in fact then proposed the development of reablement services at the hospital. Because of this interest, the Trustees and Friends of the hospital funded a successful application for planning permission for a building project to provide the necessary physical facilities for this type of service.

At the stakeholder meeting on 24th March, 5 options are to be reviewed. These include 24 hour nursed care in a community hospital and reablement. The circulated

documents make no reference to any specific site but, as the stakeholder group was formed to consider the future of Odiham Cottage Hospital (OCH), it would be fair to assume that most of the members believe they are to review such services at that location.

This being the case, the current model of care at OCH remains one of the 5 options as does reablement. However, it seems clear from your letter that you have already decided that the PCT is not considering 24 hour nursed care at OCH with any seriousness and we are concerned that you appear to be saying the same about reablement. In your letter, page 3, paragraph 4, you say it is likely that it would only be cost effective in a large unit but have not provided any evidence for this. In paragraphs 6 and 7, page 3, you state that a lack of rehabilitation facilities is one of the reasons for this and yet we have repeatedly offered to provide both building and equipment. We recognise that rehabilitation services require therapists but understand all recent evidence suggests that investment in such care is good value for money.

We fully recognise that all services should be critically reviewed regularly but, in spite of your assurances that there has not been an agenda to withdraw from your contract with OCH, I am sure you can understand why the community is suspicious when the evidence suggests that a decision has already been made. As a consequence I agree that the public engagement process has been undermined. I am surprised that you raised concerns about the additional survey question as you stated at the public meeting that you did not have any problem with it.

We wish to add that we are aware that the NHS does not commission convalescent care, and we have not suggested that this service be offered at OCH and patients are not admitted for such currently.

Everybody understands the need for cost effectiveness so we are pleased that you propose to provide additional information regarding the costs of various services. Indeed the option appraisal process scheduled for the 24th would be impossible without it, so, can we assume that we will have the information in advance of this meeting so the figures can be studied and understood by that date?

You mention in your penultimate paragraph that “the possibility of securing a temporary alternative provider is currently being investigated”. The Trustees have contacted a number of potential providers but I am not aware that any have been approached by Hampshire PCT. Also I understand from Sarah Elliott, that the PCT has to go out to tender to find providers of services so it would be helpful to have more information about this process and how far it has been progressed.

We are pleased to see that you do not expect a decision about OCH to be made at your board meeting later this month. However the original extension of nursing services to 31st July was agreed to allow time to implement any change of service and we are concerned that this work will not be completed in a time frame that allows a seamless transition of services. We recognise HCHC has not withdrawn its nurses for funding

reasons alone but OCHCT is offering additional financial support of up to £200,000 pa for 2 years, to allow a further extension of nursing services to allow this complex issue to be resolved in a more timely fashion. This time would also allow Calleva to become more established and have a greater input into decisions about the hospital.

Finally we would like to reaffirm our commitment to working with the PCT to find a resolution to this issue and assure you that we appreciate and understand the importance of the other services you commission including additional support for people at home. I believe it is clear from our past record of working with the NHS that we are not against change but wish to ensure that OCH continues to provide a valuable, cost effective service for the community who support it.

I would welcome the opportunity to discuss this with you in person before our respective Trust Board meetings, on 31st March

Yours sincerely

Daphne Jamieson
Chairman

Copies to:

The Rt Hon James Arbuthnot MP
Cllr Jonathan Glen
Cllr Tim Southern
Cllr Ken Crookes
Cllr Pat West
Martin Combs, HCC
Dr Hugh Freeman, Calleva
Jonathan Montgomery, Chair, NHS Hampshire
Tracey Faraday-Drake, Non-Executive Director, NHS Hampshire
Susanne Hasselmann, Non-Executive Director, NHS Hampshire
Malcolm Heritage-Owen, Non-Executive, NHS Hampshire
Sarah Elliot, NHS Hampshire
Mel McKeown, NHS Hampshire
Dr Andrew Fernando, Hook GP Surgery
Dr Tony Weaver, Odiham GP Surgery

Health Overview and Scrutiny Committee Update – March 2011

East Hants Community Hospitals Project

This project is on-going, and stakeholder engagement is continuing. All the discussions are being influenced by and must take account of the emerging GP Commissioning Consortia.

The range of health services currently being provided at Petersfield and Chase Community Hospitals is being considered in partnership with the stakeholder groups. The overarching approach is to create two hospitals that will complement each other in providing progressive, sustainable and strong health services for their populations.

Services at Chase Community Hospital are being maintained and in some cases grown including a £125,000 refurbishment to improve facilities which is due to be complete in approximately four weeks time.

Chase Community Hospital Engagement Update

Further to ongoing engagement work with Chase Community Hospital Stakeholder Group a period of discussion with local people will commence at the beginning of May. This is to seek local views about how to develop the right services on the hospital site and make sure local people have access to the highest quality bed-based care. It is also to reassure the public that we do not intend to close the hospital site, as this is the concern held by many.

This engagement will be used to develop the right set of services to meet local needs in the future to ensure stakeholder feedback informs these proposals. Options can then be discussed in a second round of engagement to determine the correct approach for the future.

A draft Communications and Engagement Plan has been developed and this will be taken to the next Chase Hospital Stakeholder Group for discussion and approval.

Chase Community Hospital Stakeholder group

The Chase Community Hospital Stakeholder Group has met regularly for the last three years to discuss the hospital and, more recently, potential service options. We will continue to work closely with this group throughout the engagement and the development of options. Members of this group include:

- Damien Hinds MP
- Cllr Adam Carew (County and Town Councillor)
- Cllr Zoyah Faddy (District and Town Councillor)
- Cllr Richard Stone (Town Councillor)
- Cllr Kevin Cawley (Town Councillor)
- Cllr Dr Bill Wain (Town Councillor)
- Trish Bell, Whitehill Town Council
- Yvonne Parker-Smith, League of Friends
- Jo Bennett, Age Concern Day Hospital
- Wendy Shone, Community First
- Justine Powell, Sheltered Housing
- Sally Stoodley, Patient/Public representative
- Eileen Grinter, Hampshire LINK
- Ian Georgii, Pinehill Patient and Public Group
- Whitehill and Bordon Community Association

Engagement details

The engagement will comprise six drop-in sessions for the public. A number of venues have been identified and these will be agreed with the Chase Hospital Stakeholder Group. The sessions will be held at various times to ensure local people can attend. Potential venues include:

- Tesco
- Whitehill Village Hall
- Lidl
- Woodlark Pub
- Forest Community Centre
- Woodlands Inn

Information stands and a survey have been created for these sessions and these will be discussed with the Chase Hospital Stakeholder Group so they can provide comments to be included in the final versions. Feedback will be collected through the survey (either online or printed), through feedback forms and through a dedicated email address. There will also be a webpage on NHS Hampshire and Hampshire Community Health Care's websites.

These sessions will be widely publicised. Publicity activities will include:

- Sending letters and flyers directly to a wide range of stakeholders and local groups
- Distributing a press release to all the local media
- Highlighting the sessions on NHS Hampshire, Hampshire Community Health Care and East Hants District Council's websites
- Whitehill Town Council will be asked to promote the sessions online and in its residents magazine
- Local schools and colleges will be asked to promote the sessions in their newsletters.

Feedback and development

Feedback from these sessions will be used alongside a full health needs assessment which will be conducted through NHS Hampshire's public health team. This combined information will be reviewed with local GPs and stakeholders to develop the right set of services to meet local needs.

Appendix Five: GP surgery at Locks Heath Road – proposed closure



Hampshire Health Overview and Scrutiny Committee Update on the proposed closure of Locks Road Branch Surgery, Locks Heath

Background

Whiteley and Locks Road Branch surgeries form part of a single practice, Dr Whitaker and partners. The practice has 13,732 patients with a demographic that is younger than both the locality and Hampshire averages, reflecting the practice area which covers the recent housing developments at Whiteley.

The practice has seven partners and a further doctor. It employs five (2.5 WTE) practice nurses and 23 (14.25 WTE) administrative staff. Dr Whitaker plans to retire in April 2011 and the practice is understood to wish to take the opportunity to further skill mix their team and not replace him with a full time partner. A further partner has recently resigned and the practice is currently recruiting one replacement partner.

As a result of reviewing their options for future delivery of services under their GMS contract, the practice have considered a survey undertaken in 2008 which identified a range of work necessary to keep the Locks Road Branch Surgery at current standards. The building is owned by the partners and does not have expansion space. Whiteley Surgery is only five years old, rented from a third party and has significant expansion space.

The practice partners concluded that to achieve their aim to further skill mix, improve efficiency and avoid the need for further investment in a building with serious limitations, they wished to close the Locks Road Branch Surgery and consolidate all their services at the Whiteley Surgery.

Following discussions with NHS Hampshire the practice has undertaken both a footfall survey and patient engagement with regard to its preferred option to close the Locks Road Surgery.

Wider considerations

Fareham Community Hospital, which is designated under NHS Hampshire's estates rationalisation as a strategic site for the area, is within one mile of the Locks Road Branch Practice and there are three other GP practices within a two mile radius.

Fareham Borough Council Core Strategy has a planned increase in dwellings in the western wards of Fareham of 1,225 dwellings between 2010 and 2015 and a further 246 between 2015 and 2020. Whilst this is unlikely to be all new population the amount of social housing is at present unclear and could lead to an increased population over time of up to 3,000 patients. This could have a marked effect on local GP services within the next five years if economic factors improve and building recommences.

Patient and public engagement

During 2010 NHS Hampshire made clear to the practice the need for patient and public involvement in its planning. The practice undertook a footfall survey during the summer of 2010 to determine methods of access and proportion of patients who had or could use the surgery at Whiteley. This did not test the acceptability of that option and NHS Hampshire requested that further engagement work be undertaken. A letter and feedback form was sent by the practice to all their patients (one per household) in December outlining the practice's preferred option to close their branch surgery.

NHS Hampshire's Complaints and Comments Team received in excess of 80 concerns from Locks Road Branch Practice patients regarding the potential closure of the surgery. Although patients were encouraged to take part in the patient public engagement process, we are unable to ascertain how many of these patients have contacted the practice. These contacts continued on a daily basis after the date for return of feedback closed.

The practice received 33% response rate to their questionnaire but we are unable to ascertain if the 80 concerns received by us directly were included in 1,191 responses reported by the practice. The concerns raised include the distance and ability to travel to Whiteley and the availability of suitable alternative services if they do not want to travel to the main surgery.

In addition, we understand that a petition with 1,019 signatures opposing the closure was handed to the practice. An action group is known to have formed with the aim of securing continued services at Locks Road.

NHS Hampshire received written and telephone contact from Mark Hoban MP, which he has followed up with requests to be kept informed. Leader of Fareham Borough Council Cllr Woodward has visited the practice and asked them to delay their closure plans. NHS Hampshire has also had contact from the Mayor of Fareham on behalf of local residents.

The Portsmouth News has carried stories and letters about the closure.

Although it is not evident that the practice has engaged with Hampshire LINK a letter has been received from a member expressing particular concern at lack of alternative services and the dangerous roundabout to be negotiated to reach Whiteley. Hampshire County Council Transport Department is reported to have also received a significant number of letters on this point.

Patient Choice

Patient engagement and choice is a strategic goal for NHS Hampshire. If Locks Road Branch Surgery closes patients will continue to have a choice of GP Practices in the western wards of Fareham depending on where they live providing those surgeries have sufficient capacity to take on additional patients.

Some communication from patients has been received that implies that they do not regard a possible alternative service at Fareham Community Hospital to be within their area. However for many patients registered with Dr Whitaker and partners it would be within a mile of their home. For those living to the southeast of the current practice area Lockswood Surgery would be closer, but it is known to have capacity limitations which make growth of its patient list difficult at the moment.

The practice at Brook Lane may require investment to enable it to broaden the geographical area from which it currently accepts patients.

Next steps

We recognise Dr Whitaker and Partners' aspiration to close their Locks Road Branch Surgery and consolidate services at their main surgery in Whiteley.

We know that the practice has had discussions with its patients and that they have raised concerns including the distance and ability to travel to Whiteley and the availability of suitable alternative services if they do not want to travel to the main surgery.

NHS Hampshire has agreed with the practice that their planned closure will be deferred. Dr Whitaker and Partners have agreed to work closely with NHS Hampshire, local practices and patients to explore the availability and feasibility of all options for providing GP services for local people in the Locks Heath area, and will continue to provide General Medical Services from both the Whiteley and Locks Road Surgeries, whilst discussions with NHS Hampshire and other parties are ongoing.

The Hampshire LINK has agreed to carry out a period of engagement work and the feedback from this will be used during these discussions.

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“EVERYONE COUNTS”

**AN
EQUALITY DELIVERY SYSTEM
FOR THE NHS**

**A summary
for
regional consultation purposes**

February & March 2011

ABBREVIATIONS

CQC	Care Quality Commission
DH	Department of Health
EDC	NHS Equality and Diversity Council
EDS	Equality Delivery System for the NHS
EPIT	Equality Performance Improvement Toolkit
GEO	Government Equalities Office
GP	General Practice
LINKs	Local Involvement Networks
NHS	National Health Service
PCT	Primary Care Trust
QIPP	Quality, Innovation, Prevention, Productivity
SHA	Strategic Health Authority

ACKNOWLEDGEMENTS

The EDS is one of the first products of the EDC, formed in 2009, as a sub-committee of the NHS Management Board and chaired by Sir David Nicholson, the Chief Executive of the NHS. The EDC aims to provide visible leadership on equality issues across the NHS. It influences, encourages and empowers people throughout the NHS, Government and communities to drive real improvements in health and care outcomes.

Work on the EDS is led by Tim Rideout on behalf of the NHS Equality and Diversity Council. Tim Rideout is Chief Executive of NHS Leicester City on secondment to Sir David Nicholson's office, to work on commissioning development. A technical working group, reporting to Tim Rideout, has advised on the detailed proposals.

The design of the Equality Delivery System owes a great deal to work in the North West to put in place an evidenced system, the Equality Performance Improvement Toolkit, to help local NHS organisations evaluate and improve their equality performance.

AN EQUALITY DELIVERY SYSTEM FOR THE NHS

What the Equality Delivery System delivers

The EDC has prioritised the EDS as the best means of helping the NHS improve its performance for equality groups, as opposed to individual organisations finding their own solutions. The EDS will lead to greater consistency and greater sharing of good practice and lessons, while at the same time leaving it up to NHS organisations to identify their own priorities. Because the EDS has been designed to help organisations meet their duties under the Equality Act, it will help to ensure a coherent approach across the NHS with less likelihood of damaging and expensive consequences arising from EHRC formal action.

Once implemented the EDS will :

- Help the NHS deliver on the Government’s commitment to fairness and personalisation, including the equality pledges of the NHS Constitution.
- Deliver improved and more consistent performance on equality
- Help organisations to respond more readily to the Equality Act duty – something they will need to do in any event.
- Support commissioners to develop commissioning plans that meet the needs of their communities, and will help providers to respond better to CQC registration requirements.
- Improve efficiency and bring economies of scale by providing a national equalities framework for local adaptation.
- Retain a focus on fairness, personalisation and equality during transition

Who is the EDS designed for

The Equality Act is protects people from unfavourable treatment because of the following characteristics, some of which apply to everyone while others apply to groups of people :

- Age
- Disability
- Gender re-assignment
- Marriage and civil partnership
- Race including national identity and ethnicity
- Religion or belief
- Sex (that is, is someone female or male)
- Sexual orientation

(For parts of the Equality Act, pregnancy and maternity is also a protected characteristic.)

The EDS helps NHS organisations to comply with the Equality Act, and hence it covers the above groups. As a shorthand, the terms “*protected groups*” and “*protected people*” are used in this document to refer to people protected by the Equality Act. In the past, such groups and people have been called “equality groups” or “equality target groups” or something similar.

In addition, the EDS can be applied to groups of people not afforded protection by the Equality Act, but who often face stigma in life in general and when trying to access statutory services. Such groups include homeless people, sex workers, and people who use drugs and other groups who experience socio-economic disadvantage.

Design

The EDS has been designed for the NHS by the patients and staff of NHS, and other interests, at over a range of national and regional engagement events. When the EDS regional consultation events are concluded in 2011, it is estimated that over 2,000 people will have contributed to the EDS design.

The design of the EDS also draws on good practice in the NHS and beyond. Extensive work in the North West has resulted in a working and practical system to help NHS organisations in the region review and improve their equality performance. At the centre of this system is the “Equality Performance Improvement Toolkit” (EPIT). NHS North West tested and evaluated EPIT, and related processes, with over 60 NHS organisations, in order to arrive at an evidence-based and outcome-focused system to drive forward positive change in the region.

Scope

The EDS applies to both NHS Commissioners and NHS providers – both in the current NHS and the new NHS as set out in the White Paper and Health Bill. This means that the EDS applies to Primary Care Trusts (PCTs), until they are abolished, and to GP Consortia that emerge to take over the commissioning work of PCTs.

The EDS applies to NHS providers including Foundation Trusts, all of whom are registered to provide services by the CQC.

It may also be applied to all those healthcare organisations that are not a part of the NHS, but which may work to contracts issued by NHS commissioners. (This aspect will be confirmed in due course.)

Where provider organisations are large, with multiple sites and/or departments, they should ensure that the analysis of performance and resulting grades, takes account of different levels of performance across sites and departments. Such an approach can help to justify the awarding of a good EDS grade.

System alignment

NHS Operating Framework 2011/12

The NHS Operating Framework for 2011/12 advises the NHS as follows : “NHS organisations will need to comply with the public sector duty of the Equality Act 2010,

due to come into force in April 2011. The NHS Equality and Diversity Council is developing an Equality Delivery System to advise boards on how to maintain progress and demonstrate compliance with the Act”.

NHS Outcomes Framework

The five domains of the Outcomes Framework are built into the EDS outcomes, and organisations should use the Outcomes Framework indicators, disaggregated by equality group wherever possible, as evidence of their performance. The five domains are as follows :

- ❑ Preventing people from dying prematurely
- ❑ Enhancing quality of life for people with long-term conditions
- ❑ Helping people to recover from episodes of ill health or following injury
- ❑ Ensuring that people have a positive experience of care
- ❑ Treating and caring for people in a safe environment and protecting them from avoidable harm

In the guidance issued to the NHS about the Outcomes Framework, the Department of Health advises that “In selecting outcomes and determining how they should be measured, active consideration has been given to how the indicators can be analysed by equalities and inequalities dimensions to support NHS action on reducing health inequalities. In addition to the legally protected characteristics, particular consideration has been given to socio-economic groups and area deprivation as these are key drivers of poor health outcomes.” (DH, December 2010)

Quality, Innovation, Productivity and Prevention (QIPP)

NHS organisations are asked to improve the quality of care they deliver while making efficiency savings that can be reinvested in the service to deliver year on year quality improvements. This “challenge” results in QIPP plans for all organisations. In meeting the challenge, organisations are reminded that “it is crucial that we do not lose momentum in improving the standard of care we deliver. We need to protect and promote quality while releasing savings everywhere. In doing so we will continue to ensure that NHS values are at the heart of what we do and we remain committed to tackling inequalities and promoting equality” (DH, 2010)

When analysing their performance using the EDS, organisations are specifically asked to review the four elements of QIPP through an equality lens, if they have not already done so. Good EDS grades are achieved only if organisations are delivering high quality outcomes, in cost-effective and innovative ways, with a premium on prevention. As an extra safeguard, organisations should refer to their use of the EDS in the Equality Impact Assessments of their QIPP plans.

CQC Essential Standards

When evidencing their performance for EDS purposes, NHS providers should take account of the evidence they have provided to CQC to demonstrate compliance with registration requirements. Specifically, they should refer to the outcomes for service users set out in “Essential standards for quality and safety” (March 2010). (This CQC guidance tells providers how they can achieve compliance with the Section 20 regulations of the Health and Social Care Act 2008.) In some instances, providers may have to improve their evidence with regard to particular equality groups.

Authorisation processes for GP Consortia and Foundation Trusts

It is intended that the requirement for all NHS organisations to use the EDS will be included in the authorisation processes for both GP Consortia and Foundation Trusts. The EDS will also be added into other parts of the system architecture of the NHS, including model contracts and accountable officers’ responsibilities. (These points will be confirmed by the NHS Commissioning Board in due course.)

Transition - workforce

To support transition to the new NHS, organisations should refer to the “NHS HR Framework” (to be published shortly). Implementation guidance to PCT Clusters asks them to be mindful of the Equality Act, promote the EDS, and safeguard against adverse impact on the workforce (DH, 2011). Specifically, paragraph 38 asks that “all the appointment processes required for these changes should comply with the Equality Act 2010 and the principles of fairness with every effort being made not to lessen the representation of people of protected characteristics such as BME people and women in senior roles. It will be particularly important for the NHS to retain its expertise and intelligence on tackling health inequalities (including those arising from discrimination) during the transition. The SHA, in conjunction with its PCTs, should carry out an Equality Impact Assessment of these proposals.”

Timeline

- ❑ Following the successful engagement events of 2010, from February to May 2011, regions led by SHAs continue to consult and engage with local interests on the development and implementation of the EDS.
- ❑ The final version of the EDS is trailed in May 2011, and launched in June 2011, when the shadow arrangements for NHS Commissioning Board are in place. An evaluation process will be commenced.
- ❑ During the remainder of 2011/12, organisations prepare their Equality Objectives.
- ❑ At the same time, organisations work to ensure that local interests are empowered/supported to play a full part in the local implementation of EDS, and that evidence, including data and softer material, are developed and fully utilised.
- ❑ By 31 July, NHS organisations must publish sufficient information to demonstrate that they have complied with section 149(1) of the Equality Act across its functions. (To be confirmed)
- ❑ By 6 April 2012, organisations will be expected to have prepared and published Equality Objectives, to include their priority actions for 2012/13.

- ❑ The take-up of the EDS and early outcomes will be reviewed in 2012 by the NHS Commissioning Board. Early results of the evaluation will be taken into account. If take-up is not extensive, the Board will consider action to ensure that the EDS is used throughout the service.

How it works

Analysis of performance

At the heart of the EDS is a set of nationally agreed Objectives and Outcomes. The Objectives are common for both NHS commissioners and NHS providers. They are :

- ❑ Better health outcomes for all
- ❑ Improved patient access and experience
- ❑ Empowered, engaged and well-supported staff
- ❑ Inclusive Leadership at all levels

Within each Objective are a set of outcomes. There are 12 outcomes in total across the four Objectives. The outcomes are given below.

NHS organisations, with local interests, should analyse their performance against the outcomes for each group afforded protected status directly or by association by the Equality Act. (For example, a family carer of an individual afforded protected status by the Equality Act is also afforded protection because of her/his “association” with the individual.) The analysis must be evidenced-based and transparent.

For the purposes of the EDS, local interests comprise and but are not restricted to :

- ❑ Patients and those local groups that represent them
- ❑ Communities and the public in general
- ❑ NHS staff and Staff-Side (that is, unions such as Unison)
- ❑ Voluntary and community organisations

Organisations and local interests may work in a variety of ways when analysing and grading NHS performance. Whatever way is chosen, it must be a partnership of equals.

CQC Essential Standards

When making their analyses, providers should take account of the relevant outcomes cited in CQC’s “Essential standards of quality and safety”, and the evidence that they have provided to CQC to demonstrate their compliance with registration regulations. As they do so, they should use, review or improve this evidence particularly where it falls short for some equality groups.

Similarly, commissioners should refer to the outcomes of the “Essential standards”, when they and local interests review their performance against the EDS outcomes. Many of the providers that commissioners procure services from will be registered providers; so it is only appropriate for commissioners to take

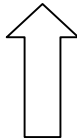
account of providers' achievements against the CQC outcomes when assessing their own performance. (The link between the EDS Objectives and Outcomes is given in the Annex.)

Grades

As a result of the analysis, the organisations and its local interests will award a grade for each outcome.

There are four grades, and a related RAG rating, to choose from :

- ❑ Excelling – **Gold Star**
- ❑ Achieving - **Green**
- ❑ Developing – **Amber**
- ❑ Undeveloped - **Red**



Each grade for each outcome will be described in sufficient detail so that different organisations, with their local interests, can apply them consistently at any one time and over time. (Note : the grading will be developed at a series of EDC workshops.)

First and foremost the grades will be designed to reflect the delivery of outcomes, with particular regard to the QIPP challenge, for protected groups and meeting the Equality Act duty. This approach means that :

- ❑ The better the delivery of outcomes, supported by evidence, the better the grade.
- ❑ The more that quality, innovation and prevention and cost-effectiveness can be proven in the delivery of these outcomes, the better the grade.
- ❑ The more, for example, the NHS fosters good relations between groups and communities, and can produce supporting evidence, the better the grade.

While the grades emphasise outcomes as experienced by patients, communities and staff, two processes are also reflected in the grades. The better the use of evidence from JSNAs and other sources, the better the grade. Likewise, the better the engagement of local interests, the better the grade. Lastly, the completeness and take up of issues raised by Equality Impact Assessments will also be a key factor in the award of grades.

In summary, local grades must reflect the extent to which, for protected groups :

- ❑ Good outcomes are delivered
- ❑ The QIPP challenge is met
- ❑ The Equality Act duty is met, including the fostering of good relations
- ❑ The NHS Constitution is delivered
- ❑ Effective use is made of JSNAs and other evidence
- ❑ Local interests are empowered, supported and actually take part.

The grades will also reflect to extent to which organisations use the social model of disability, which focuses on how a person's environment can limit their activities of daily living.

The design of the grades also takes account of NHS good practice, including EPIT, and the Equality Framework for Local Government,

The grading system of the EDS will be critical in supporting organisations to gauge their current position and the continuous progress they need to make in order to embed equality into mainstream business.

Before embarking on the assessments and using the grades, NHS organisations should be certain that local interests, especially patient and community groups, have been supported to understand the grades and how the process will work.

The grades are intended to help organisations clearly identify equality progress and challenges. While both good and poor performance should come to light, the purpose of the EDS and its grades should, in the first instance, be about helping good organisations maintain and further improve their performance, and helping poor organisations address and overcome their difficulties and so embed equality into mainstream business.

Evidence

When analysing their equality performance using the EDS, organisations should begin with the evidence contained within local Joint Strategic Needs Assessments (JSNAs), but also make full use of other evidence at their disposal, including soft and hard data. Providers, of course, will refer to the evidence they supplied for registration purposes. In summary local sources of evidence should include as a minimum :

- ❑ JSNAs
- ❑ Providers' registration evidence
- ❑ NHS Outcomes Framework indicators
- ❑ Quality Accounts
- ❑ CQC's patient surveys
- ❑ GP patient surveys
- ❑ CQC NHS staff surveys
- ❑ Public and Patient Engagement and Empowerment (PPEE) surveys

Where organisations are not able to assess their performance on an outcome because they do not have sufficient evidence, or have not made the best use of evidence, they should grade themselves as “Undeveloped”.

Over time, all organisations should plan to achieve and maintain the “Excelling” grade on all outcomes, bearing in mind that excellence implies a strong emphasis on partnership working with local authorities and innovation. Foundation Trusts should ensure that on each outcome, the agreed grade is “Achieving “ or “Excelling”. The wording for the grades will not only help organisations to gauge their current position; it will highlight how progress might be made and encourage continuous improvement

EQUALITY DELIVERY SYSTEM - OBJECTIVES AND OUTCOMES

Objectives Menu	Narrative : the NHS is asked to ...	Outcomes
1. Better health outcomes for all	Achieve improvements in patient health, public health and patient safety for all, based on comprehensive evidence of needs and results	1.1 Services and care pathways are commissioned or decommissioned, designed or re-designed, procured, provided and contractually monitored so that they meet the needs of patients, carers and local communities
		1.2 Public health outcomes are measurable, substantive and are developed through evidence-based strategies, developed with the involvement of patients, carers and local communities
		1.3 Patient safety outcomes are demonstrating measurable increases across all equality target groups, with the active participation of staff and managers engaging with patient groups and involving local communities
2. Improved patient access and experience	Improve accessibility and information, and deliver the right services that are targeted, useful, useable and used in order to improve patient experience	2.1 Patients, carers and communities are effectively accessing services, taking into account barriers that historically hinder equality of access
		2.2 Patients, carers and communities are provided with appropriate communications support and information about services, so that they can make informed choices and be assured of diagnoses and treatments tailored to their needs
		2.3 Patients and carers report positive experiences of the NHS, where they are listened to and respected, and the services they receive are safe, effective and personalised to their specific needs
3. Empowered, engaged and well-supported staff	Increase the diversity and quality of the working lives of the paid and non-paid workforce, supporting all staff to better respond to patients' and communities' needs	3.1 A workforce that is diverse within all occupations and grade levels through fair and flexible recruitment, development, and retention practices
		3.2 The workforce is supported to remain healthy, with a focus on addressing major health and lifestyle issues that affect individual staff and the wider population
		3.3 The workforce is confident, competent and feels empowered to deliver appropriate and, accessible services, and improved patient experience for all communities
		3.4 The workplace is free from actual and potential discrimination -from recruitment to retirement - and all staff are able to fully realise their potential
4. Inclusive leadership at all levels	Ensure that throughout the organisation, equality is everyone's business, and everyone is expected to take an active part, supported by the work of specialist equality leaders and champions	4.1 Corporate leadership demonstrates the commitment and knowledge to assure equality outcomes within the organisation and the local health economy
		4.2 The organisation develops and supports equality leaders and champions within the workforce to the standards of capability defined by the NHS Competency Framework for Equality and Diversity Leadership

Human Rights and the EDS

Human rights legislation in the UK is founded on five key FRED A principles. Human rights should never be a secondary consideration in the provision of NHS services or in the development of the workforce. They should underpin all NHS activity and indeed are at the heart of the NHS Constitution. They are also at the heart of the EDS, as the following box describes :

<i>Human rights principle</i>	<i>How reflected in the EDS for protected groups?</i>
Fairness	As and when organisations deliver on EDS Outcome 1.1 to meet the needs of all individuals and communities, tailored to their specific circumstance, and provide working environments where all staff are given equal chance to thrive (EDS Outcome 3.1), then the NHS will demonstrate its commitment to fairness to protected groups and beyond.
Respect	The EDS supports the NHS Constitution to help the NHS respect both patients and staff from protected groups and beyond. For patients, EDS Outcomes 2.1 and 2.3 focus on the promotion of safety and access. For staff, the EDS Outcome of 3.2 asks organisations to promote the well-being of their staff. Achievement of these outcomes will be a clear demonstration that individuals' rights to be respected are a priority for the NHS.
Equality	The whole of the EDS is designed to improve the equality performance of the NHS. EDS Outcomes 4.1 and 4.2 emphasise that strong and committed leadership, where equality in general, and equality champions in particular, are supported, is essential to the achievement of a fairer and more personalised NHS, staffed by a diverse, confident and competent workforce.
Dignity	For patients, EDS Outcome 1.3 asks the NHS to prioritise the safety of patients, and EDS Outcome 3.4 asks that working environments are free from discrimination. Achievement of these outcomes will ensure that the dignity of both patients and staff, from protected groups and beyond, will be upheld.
Autonomy	For patients, EDS Outcome 2.2 asks that people from protected groups and beyond are given sufficient information about the NHS and their diagnoses and treatments so that they can make informed choices for themselves. For staff from protected groups and beyond, EDS Outcome 3.3 seeks a workforce that is confident, competent and empowered to make decisions – with patients and within management / professional guidelines – on the most appropriate treatments or courses of actions

(More information on human rights and the NHS can be found in reports of joint work between DH, the NHS and the British Institute for Human Rights. (DH / BIHR 2010))

Health inequalities

Social class, poverty and deprivation are often closely related to the incidence of ill-health and the take-up of treatment. In addition, many people from protected groups are challenged by these factors, and as result experience difficulties in accessing, using and working in the NHS. For this reason, work in support of protected groups is best located in work to address health inequalities in general with a focus on improving performance across the board and reducing gaps between groups and communities.

This approach has two implications for organisations when using the EDS :

- ❑ When analysing the EDS outcomes, organisations and local interests should consider extending the analysis beyond the protected groups to other groups and communities who face stigma, and difficulties in accessing and using the NHS. It should be up to local organisations and interests to decide whether or not to take this approach; and if they do, which groups and communities to consider depending local needs and circumstances. Work on “Inclusion health” (DH, 2010) points to people who are homeless, sex workers and people who use drugs as potential targets.
- ❑ When working on Equality Objectives and priority actions, organisations should locate all work on in support of both protected groups and other groups facing stigma within their mainstream work on tackling health inequalities with regard to health conditions, health promotion, general issues of patient access, safety and experience, or workforce development.

Setting local objectives and priorities

As a result of the analysis of EDS Outcomes, NHS organisations and their local interests should agree on a small set of Equality Objectives for the coming business planning period.

Equality Objectives should result in a discrete number of prioritised actions for one or more equality groups. The more that both Equality Objectives and prioritised actions can make links between the different equality target groups the better. A single strand approach equality is becoming increasingly irrelevant in today’s world, where individuals are a mix of “protected” characteristics.

At any one time, it is recommended that an organisation focuses on all four of the EDS Objectives, but only addresses a handful of priorities. Tackling more objectives and scores of priorities could result in efforts being spread too thinly, where lasting outcomes are jeopardised. Many Single Equality Schemes were often undermined by being too wide-ranging and too comprehensive, as if every part of an organisation had to offer up an action or two, spread out across each equality group.

The chosen priorities should cover the most immediate and urgent concerns and be firmly based in evidence. Preventive action is not ruled out, if it can result in significant benefits for particular communities and the NHS down the line. However, some priorities could represent “quick wins”, which if achieved can pave the way for further success.

Choosing priority actions so that all equality groups are covered at any one time, can lead to tokenistic not realistic plans. Backed by evidence, and working with local interests, the EDS analysis should reveal the most pressing needs. It is these needs that should be prioritised. Over a three to five year period, it would be unusual for a complete range of equality groups not to feature among the chosen prioritised actions, especially if organisations are choosing areas of need that affect more than one equality strand at a time.

In the context of broader strategic plans, organisations should describe :

- ❑ How progress on prioritised action phased and related milestones, within the context of continuous improvement.
- ❑ How these priorities feed into, and support, corporate strategic goals, plans for tackling health inequalities – improving performance and reducing gaps - and related business plans.
- ❑ The grades that they hope to achieve over the business cycle for each outcome, indicating the progress to be achieved in each year.
- ❑ The local interests that it has engaged with in compiling the Equality Objectives and in verifying the assessment against the outcomes. Any disagreements or concerns should be recorded.
- ❑ The sources of evidence the organisation used in analysing its performance and identifying priorities, and its long-term plans to improve its collection and use of evidence, with explicit reference to the requirements of the Equality Act.

While the organisation may wish to provide a summary of the actual analysis against outcomes, the agreed grade for each outcome should be given a prominent place in the annual plans or related publications and publicity.

In developing and working on their Equality Objectives and prioritised actions, organisations should not only refer to EDS guidance but also to guidance about the Equality Act 2010, and how to respond to it, from the Equality and Human Rights Commission (EHRC), the CQC and other organisations. Some guidance on equality including that issued by NHS Employers in 2008, although pre-dating the Equality Act, is still relevant and useful.

Immediate priority actions and longer-term plans

Through the EDS, organisations identify and address critical issues for patients, communities and staff in a focused and planned way, as part of broader work on tackling health inequalities and as part of mainstream business. It is likely that the first analyses of NHS performance using the EDS will highlight a great many challenges for all organisations.

The EDS is meant to highlight the critical challenges and lead to plans / actions to address them. However, when focusing on these challenges, routine and other important work on addressing inequalities should not grind to a halt. Of course, organisations must

continue to remain legal and to deliver fair and personalised services to patients and communities at all times.

Process of working with local interests

Genuine engagement lies at the heart of this Government's approach to public services. It is an imperative of the Equality Act. It is the focus of the DH / NHS PPEE initiative. How to do it properly has been addressed in recent DH publications including "Inclusion health" (DH, 2010) and "A dialogue of equals" (DH, 2009).

Within the NHS there is a great deal of good practice; but this practice can be patchy and inconsistent across time, locations and protected groups. As part of EDS support to the NHS, the SHAs are commissioning a comprehensive piece of work to identify good engagement practice with regard to patients, communities and staff, including how evidence may be shared in accessible ways with local interests.

There are a number of engagement approaches that NHS organisations and their local interests will wish to explore, before deciding on the model that best suits local circumstances. For example, organisations might empower and enable patient, community and staff groups to attempt the first analysis and grading of NHS performance. This work can then inform a discussion with the NHS, leading to agreement of the grades and which actions should be prioritised. Alternatively, organisations may plan for all local interests to meet with managers to analyse and grade performance. There will be a range of models to choose from. The important point is that local interests must be fully engaged and informed.

Foundation Trusts (FTs) are already an important part of the NHS, and the Government plans for all NHS providers to achieve FT status in due course. FTs operate with a degree of independence from central direction. They are all accountable to members drawn from local and wider communities. The best FTs have broad-based memberships that reflect the diversity of the populations they serve. Governors are drawn from this membership, that work with Boards to set and review direction and performance. FTs should include their local members and Governors in all aspects of EDS implementation. If membership is diverse and representative, it provides FTs with a ready means of securing patient, public and staff views and responding to challenges.

Engaging and supporting local interests

Care should be taken to ensure that seldom-heard interests are as engaged as much as other interests, and supported to participate. Care should also be taken to include not only those spokespeople who already give so generously of their time to engage with NHS organisations but also those individuals who have important things to say but whose views are rarely sought or heard.

Any organisation that fails to engage with local interests in the analysis of its performance, subsequent grading and the setting of priorities, would automatically be graded as “Undeveloped” on each outcome.

Participating in public life can be expensive or difficult for local patients, communities and staff groups. Expensive in terms of time and possibly money. Difficult in terms of the practicalities of participating in meetings or discussions, especially for seldom-heard groups; and difficult for those patients and members of the public who may not be used to talking to NHS administrators and clinicians on equal terms about matters of healthcare strategy or planning. So that these local interests can be enabled and empowered, support and/or financial assistance will need to be provided.

Local co-ordinating role

Local Involvement Networks (LINKs), and their successors the new local Health Watch, have an important role to play in support local statutory agencies to engage with and hear the views of local people. They set their own priorities. It is hoped that they will prioritise the EDS. Their role will be to :

- ❑ Identify the local patient and community groups that should be engaged in the EDS, ensuring that marginalised and seldom-heard groups are not overlooked..
- ❑ Support these groups during the actual engagement process, ensuring that they are empowered and informed.
- ❑ Add their views to those of other local interests on the performance of the NHS.
- ❑ Relay the priorities and grades of individual organisations to Local Authority Overview and Scrutiny Committee, Health and Well Being Boards

If the EDS is not prioritised at all or in part, by LINKs and HealthWatch , SHAs and PCT clusters should seek alternatives. For example, NHS Champions and Patient Champions may have a role to play in EDS implementation and operation, as could voluntary sector groups or umbrella organisations such as Regional Voices and Councils of Voluntary Services.

Mainstream business

Equality Objectives and prioritised actions should be part of the business cycle of the organisation. Equality Objectives may be best set for a three to five year period, to match the cycle of Commissioning Strategic Plans. Prioritised actions may be reviewed annually, to link to the NHS Operating Framework and various other annual planning mechanisms. This review should include a re-assessment of the EDS outcomes.

While Equality Objectives and prioritised actions may be seen as discrete, organisations should resist publishing them as separate documents; rather they should be integrated into mainstream reports and publications. It should be made clear how achieving on Equality Objectives helps an organisation to deliver on its mainstream goals, including tackling health inequalities and reducing gaps..

NHS Commissioning Board

The NHS Commissioning Board, when it is established will be classified as a public body for Equality Act purposes. It may wish to set the national direction, tone and example for the EDS, by publishing its own Equality Objectives and prioritised actions.

From Equality Schemes to Equality Objectives

The process and content of the EDS map directly onto the general and public sector duties of the Equality Act. Hence, in responding positively to the EDS, organisations should respond more effectively to the requirements of the Equality Act.

During 2011/12, organisations should decide how best to migrate from equality schemes under previous equality legislation to the Equality Objectives of the Equality Act and the EDS. By April 2012, the migration should be completed. A good approach would be to review the action plans of current schemes using the EDS Objectives Menu and Outcomes, and narrow down the existing actions into a smaller set of critical priorities. In this way, organisations will remain compliant while moving from the old to the new equality duties.

Engagement and evidence used to support the development of current schemes can, if fit for purpose, continue to be used to support the new process. EDS guidance on these matters can help organisations to improve the transparency and evidence base of their planning, as required by the White Paper and the Equality Act.

A “route map” for migration is provided at Annex B. It has been developed by NHS South West.

Local disputes

Most NHS organisations already work well with local interests. For this reason, disputes about assessments against outcomes, and associated grades, and the selection of priority actions should be rare. Where disputes arise, every attempt should be made to resolve them locally. In this regard, organisations will remember that the NHS is all about patients and communities, and their experience of the NHS; it is not about how NHS leaders would like themselves and their services to be perceived. Where disagreements persist, they should be openly acknowledged, with the views of local interests taking precedence when it comes to the grades.

Working with local authorities

As set out in the White Paper, NHS organisations should work with local authorities in reviewing and improving their equality performance. Those local authority organisations that use the Improvement and Development Agency’s “Equality Framework for Local Government” will be good comparators and sources of inspiration, as the EDS (and EPIT) are designed with this Framework in mind, particularly the grading system. The

Joint Strategic Needs Assessments, conducted across local authorities and the NHS, and related structures of engagement and evidence gathering will all help the EDS to be implemented, and function more effectively, than would otherwise be the case. NHS organisations will also wish to work closely with local authorities on EDS outcomes focused on health improvement and public health. This latter point is particularly important given the Government's aim to migrate public health functions to local authorities as part of current NHS reforms.

An organisation would only be able to grade itself "Excelling" on any outcome, if it collaborated in peer reviews with another NHS organisation, and involved a local authority in thinking through its Equality Objectives and priority actions.

In the spirit of localisation, this EDS guidance is not prescriptive of how NHS organisations work with local authorities in ensuring the best use of JSNAs, the involvement of local authorities in helping NHS organisations to analyse and grade their performance, and the extent to which public health is included in the EDS. Rather, SHAs and PCT clusters should support organisations to find their own local solutions, taking the advice of local interests.

Local reporting process and consequences

Organisations' own Boards or corporate leadership should play a full part in the drafting and finalising of Equality Objectives and priority actions. They should be clearly seen to own these documents and their content.

Organisations' draft Equality Objectives and priority actions should, in the first instance, be reported to local interests including :

- ❑ LINKs / local Health Watch
- ❑ Members and Governors of Foundation Trusts
- ❑ Other established patient and community forums
- ❑ Local equality groups including Race Equality Councils or Equality Councils
- ❑ Local unions and other organised staff groups such as organisations' staff networks.

These interests should be invited to comment, and their views should be taken into account. With regard to the Equality Objectives and priority actions for 2012/13, this engagement should take place before April 2012 so that the plans can be agreed and published by April 2012.

Once finalised, Equality Objectives and priority actions should be confirmed to the above interests, and formally reported to the Local Authority Overview and Scrutiny Committee and the Health and Well Being Board. LINKs and HealthWatch can facilitate this process.

National reporting

For wider performance assessment / management purposes, from April 2012 :

- ❑ The agreed Equality Objectives of providers' will be reported to Health Watch England at CQC. Health Watch England will advise CQC of concerns so that these concerns can be taken into account in the Quality Risk Profiles for each organisation. Where there are concerns, the CQC will consider the most appropriate action, as it would do when in receipt of any potentially negative piece of information about a provider. The ultimate sanction for continued poor performance could be loss of registration. Concerns could centre on organisations with any "Undeveloped" grades and/or organisations that, over time, fail to achieve any "Achieving" or "Excelling" grades. [Drafting note : to be confirmed with CQC]
- ❑ In line with the role for the NHS Commissioning Board, the agreed Equality Objectives for commissioners will be reported to the NHS Commissioning Board for evaluation and management action.

Published results

All Equality Objectives, priority actions and grades should be published as stand-alone documents. As well as featuring prominently in these plans, each organisation should publish its grades in summary format against each EDS outcome at the same time.

The RAG ratings for all organisations should be published on the websites of the NHS Commissioning Board. Individual organisations should publish their results on their websites and in other accessible ways, and as part of routine reporting processes including Annual Reports for their local communities. They should do so in such a way that local interests can readily access the results and comment on them.

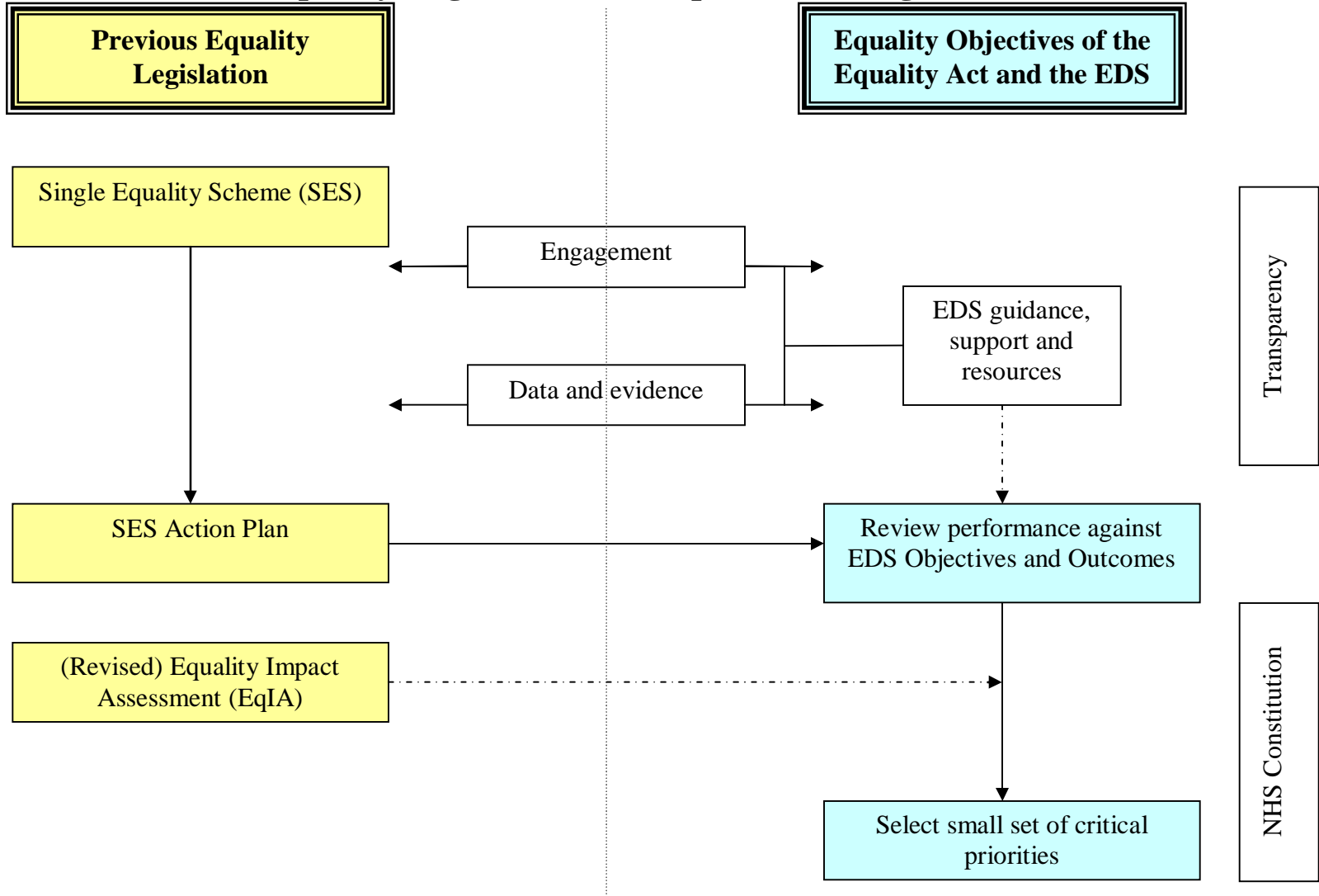
ANNEX A

EDS OUTCOMES AND CQC OUTCOMES FOR SERVICE USERS

<i>EDS Outcomes</i>	<i>Outcomes for service users, from “Essential standards of quality and safety”</i>
1.1 Services and care pathways are commissioned or decommissioned, designed or re-designed, procured, provided and contractually monitored so that they meet the needs of patients, carers and local communities	1.1a People who use services experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights (<i>Regulation 4, Outcome 4</i>)
	1.1b People who use services are supported to have adequate nutrition and hydration (<i>Regulation 14, Outcome 5</i>)
	1.1c People who use services receive safe and coordinated care, treatment and support where more than one provider is involved, or they are moved between services (<i>Regulation 24, Outcome 6</i>)
	1.1d People who use services and people who work in or visit the premises benefit from equipment that is comfortable and meets their needs (<i>Regulation 16, Outcome 11</i>)
	1.1e People who use services can be confident that their personal records are accurate, fit for purpose, held securely and remain confidential (<i>Regulation 20, Outcome 11</i>)
1.3 Patient safety outcomes are demonstrating measurable increases across all equality target groups, with the active participation of staff and managers engaging with patient groups and involving local communities	1.3a Service users are protected against identifiable risks of acquiring such an infection (<i>Regulation 12, Outcome 8</i>)
	1.3b People who use services are protected from abuse, or the risk of abuse, and their human rights are respected and upheld (<i>Regulation 11, Outcome 7</i>)
	1.3c People who use services will have their medicines at the time they need them, and in a safe way (<i>Regulation 13, Outcome 9</i>)
	1.3d People who use services and people who work in or visit the premises are in safe, accessible surroundings that promote their wellbeing (<i>Regulation 15, Outcome 10</i>)
	1.3e People who use services and people who work in or visit the premises are not at risk of harm from unsafe or unstable equipment (medical and non-medical equipment, furnishings or fittings) (<i>Regulation 16, Outcome 11</i>)
	1.3f People who use services can be confident that records required to be kept to protect their safety and wellbeing are maintained and held securely where required (<i>Regulation 20, Outcome 21</i>)
2.2 Patients, carers and communities are provided with appropriate communications support and information about services, so that	2.2a People who use services understand the care, treatment and support choices available to them (<i>Regulation 17, Outcome 1</i>)
	2.2b People who use services where they are able give valid consent to the examination, care, treatment and support they receive; and understand and know how to change any decisions about examination, care, treatment and support that has been previously agreed (<i>Regulation 18, Outcome 2</i>)
	2.2c People who use services, or others acting on their behalf, who pay the provider for the services they receive: know how much they are expected to

<i>EDS Outcomes</i>	<i>Outcomes for service users, from “Essential standards of quality and safety”</i>
they can make informed choices and be assured of diagnoses and treatments tailored to their needs	pay, when and how; know what the service will provide for the fee paid; and understand their obligations and responsibilities (<i>Regulation 19, Outcome 3</i>)
	2.2d People who use services wherever possible will have information about the medicine being prescribed made available to them or others acting on their behalf (<i>Regulation 13, Outcome 9</i>)
2.3 Patients and carers report positive experiences of the NHS, where they are listened to and respected, and the services they receive are safe, effective and personalised to their specific needs	2.3a People who use services can express their views, so far as they are able to do so, and are involved in making decisions about their care, treatment and support; have their privacy, dignity and independence respected; have their views and experiences taken into account in the way the service is provided and delivered (<i>Regulation 17, Outcome 1</i>)
	2.3b People who use services can be confident that their human rights are respected and taken into account (<i>Regulation 18, Outcome 2</i>)
	2.3c People who use services or others acting on their behalf: are sure that their comments and complaints are listened to and acted on effectively; know that they will not be discriminated against for making a complaint (<i>Regulation 19, Outcome 17</i>)
3.3 The workforce is confident, competent and feels empowered to deliver appropriate and, accessible services, and improved patient experience for all communities	3.3a People who use services are safe and their health and welfare needs are met by staff who are fit, appropriately qualified and are physically and mentally able to do their job (<i>Regulation 21, Outcome 12</i>)
	3.3b People who use services are safe and their health and welfare needs are met by sufficient numbers of appropriate staff (<i>Regulation 22, Outcome 13</i>)
	3.3c People who use services are safe and their health and welfare needs are met by competent staff (<i>Regulation 23, Outcome 14</i>)
	3.3d People who use services have their needs met by the service because it is provided by an appropriate person (<i>Regulation 4, Outcome 22</i>)
4.1 Corporate leadership demonstrates the commitment and knowledge to assure equality outcomes within the organisation and the local health economy	4.1a The registered person recognises the diversity, values and human rights of people who use services (<i>Regulation 17, Outcome 1</i>)
	4.1b People who use services benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety (<i>Regulation 10, Outcome 16</i>)
Note : there are no direct CQC outcomes for the following EDS outcomes : 1.2 “public health”; 2.1 “access”; 3.1 diverse workforce; 3.2 “healthy workforce”; 4.2 “supported equality champions”.	

Annex B : Equality Migration Roadmap for NHS Organisations



Appendix Five: