

HAMPSHIRE COUNTY COUNCIL

Report

Committee:	Health Overview and Scrutiny Committee
Date of meeting:	24 May 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.

Table One: Inquiries Received and Action Taken

Topic/inquiry	Source	Action Taken	Comment
<p>Merger of Winchester and Eastleigh Healthcare Trust with Basingstoke and North Hampshire Foundation Trust.</p>	<p>BNHFT</p>	<p>BNHFT to provide an update on progress towards the merger</p>	
<p>Recommendation: The Committee is provided with updates as appropriate on progress towards the merging of the Trusts.</p>			
<p>Notice to withdraw Inpatient beds at Odiham Cottage Hospital.</p>	<p>NHS Hampshire</p>	<p>NHS Hampshire has responded to the issues raised by the HOSC at the last meeting (see Appendices One and Two, pages 6 and 8). An update from the PCT setting out progress to date is attached at Appendix Three page 10).</p> <p>Additional correspondence received in relation to this matter has not been included with this agenda but is available in the scrutiny office or by e-mail.</p>	
<p>Recommendations: Members agree:</p> <ol style="list-style-type: none"> 1. next steps in progressing any options identified 2. any additional information or action necessary to support the next steps 			

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 Four (p.82)</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>Feedback from the HOSC and the response of WEHT is attached at Appendices Five and Six, pages 93 & 95 respectively.</p> <p>WEHT will provide the HOSC with an on progress with local engagement and involvement activities to date.</p>	
<p>Recommendations: Members confirm:</p> <ol style="list-style-type: none"> 1. any additional engagement and involvement activities should be considered by the Trust 2. WEHT provides a detailed report on the next steps in relation to consultation on the future provision of midwife led inpatient beds at Andover in July 2011. 			
Proposed GP branch surgery closure in Whiteley.	Fareham Borough Council	NHS Hampshire is currently exploring the options for providing primary care services in this area and will update the HOSC verbally at the meeting.	

Topic/inquiry	Source	Action Taken	Comment
<p>Recommendation: Members confirm there is any further action to be considered by NHS Hampshire and the options identified to support the population affected.</p>			
<p>Closure of Highview Surgery, Bordon</p>	<p>NHSH</p>	<p>NHS Hampshire has terminated the contract for this single handed practice due to the suspension of the GP from the Medical Register by the GMC and made alternative provision for all patients affected, see Appendix Seven, page 100</p>	
<p>Recommendation: Members note the information provided</p>			

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.

Appendix One: HOSC feedback to NHS Hampshire re: Development of Services at Odiham Cottage Hospital- 30 march 2011.

Thank you for attending the HOSC yesterday to provide an update on the engagement process you are leading in relation to the future provision of health services at Odiham Cottage Hospital. It was helpful to hear about the work that was being taken forward with key community stakeholders and local people.

When we were briefed about this last January it appeared that progress was being made through these activities. The exchanges of recent correspondence and the feedback shared at with us at yesterday's HOSC meeting suggested that, rather than moving forward, this process was beginning to stall. This is of concern to Members, particularly bearing in mind the positive progress that has been made in Hythe and Oak Park. We remain firmly of the view that the solution to this situation rests with the local community, commissioners and providers of services and hope that a way forward can be agreed as all have a contribution to make to planning these services for the future.

The update you provided us with was clear that you are not yet at a point where you are seeking a view from us about proposals to change services. This point will not be reached until the options have been identified, hopefully in time for our next meeting on the 24 May 2011. We will need to be clear about the extent of local support for the options presented as this will enable the HOSC to come to a view about the need for formal consultation and any further work required. In doing so we will give particular emphasis to the 4 'tests' identified by the NHS Chief Executive last summer: GP support, strong local engagement, evidence base and choice.

Given the conflicting views that seem to be emerging about some key issues we would ask that NHS Hampshire considers the following actions:

- That NHS Hampshire delegates maximum authority to the shadow GP consortium 'Calleva' to determine the right configuration of care to be provided at the Odiham Cottage Hospital in the future, working with the local community. If we are reaching the point where there is agreement about a range of options then this would seem to be the most effective way to build support for the way forward, particularly as it will ultimately be the GP Consortium that will be responsible for funding these services.
- That the uncertainty about the resources available to support services is addressed. Your briefing to us in November was clear on this point but there seems to be a real lack of clarity about this across stakeholders about how this resource is assessed. We have previously made the point about the need for clear and consistent messages in this respect.

- Should the engagement and consultation process extend beyond 31 July 2011 arrangements are made with HCHC for a further extension of the contract to provide inpatient nursing care at Odiham Cottage Hospital. This request takes account of the report to our meeting that the staffing pressures had eased and, as you clearly stated in your briefing note to us in November, the issue is not about resources.. We are not suggesting this as a long term solution but a means of providing continuity in this community until there is clarity about the way forward.

I look forward to hearing how you intend to progress this work.

Appendix Two: Development of Services at Odiham Cottage Hospital. NHS Hampshire response to the HOSC- 20 April 2011.

Thank you for your letter of the 30th March 2011 following the attendance of Dr Hugh Freeman, Mel McKeown and I at the HOSC on the 29th March 2011. I have delayed responding until now as we have had quite a lot of activity in the past couple of weeks which I would like to update you on.

I note your concern that progress with activities to determine how best to meet the health needs of people in the Odiham area might have stalled, and hope this letter will reassure you that this is certainly not the case. Since attending the HOSC on 29th March 2011, the PCT working with Calleva GPCC, has undertaken the following:

- Completed analysis of the survey and I enclose the headlines from this on the attached summary
- Held a special meeting to analyse the current costs for Odiham Cottage Hospital and the outline costs for the shortlisted options.
- Held a wider workshop with Community Groups, wider Parishes, and Voluntary Organisations to discuss the options and to enable colleagues and local people to weight the criteria.

These recent meetings have led to a view that there may be a sixth option for meeting the needs as a hybrid of three of the current options and we will be exploring this further with clinicians and the Hart Locality Stakeholder Group.

It is true to say that there continues to be a high level of interest and concern from those representing the residents of Odiham about the future of the Cottage Hospital, which we think must be expected given the strong attachment and unique relationship the community and its representatives have with the hospital. We are continuing to do everything possible to explore options that meet local health needs which include services which might be run from Odiham Cottage Hospital.

As you comment, we are not yet at a point when we are seeking a view from the HOSC about a proposal to change services but remain on track to have a recommendation about a preferred option(s) in time for the HOSC meeting on the 24th May 2011. We hope at this meeting you will be in a position to clarify if further Public Consultation is required, taking account of the NHS Chief Executives four "tests".

We note your comment about the PCT delegating maximum authority to the shadow GPCC Calleva to determine the right configuration for services, and they have certainly increased their involvement in the past month, since it has now been confirmed that Odiham Cottage Hospital falls within their catchment area (previously Hart and Rushmoor GPCC). The involvement of Calleva is enabling discussion about whether Odiham Cottage Hospital could serve a broader population than that historically covered by the hospital via its three referring GP practices and how this might fit with broader commissioning intentions.

As detailed above, a special meeting of the Hart Locality Stakeholder Group on 15th April 2011 led by our Deputy Director of Finance Mike Fulford considered the current costings of Odiham and potential future costs of the shortlisted options. It should be noted that the information about the budget and expenditure for Odiham belongs to the current Provider of the service Hampshire Community Healthcare (HCHC) who set their budget once their overall contract with the PCT is agreed. It was important for the meeting to understand that providers, and in particular Foundation Trusts, would not normally release this information,

although of course this could be made available if a Freedom of Information request was made.

The PCT shared a level of detail at the meeting which would not normally be in the public domain because of the commercial sensitivity of the information. There are a number of people in the Hart Locality Stakeholder Group who might have an interest in submitting a proposal if and when we need to tender for the service and so it has been important that colleagues understand this potential conflict of interest.

We note your request that should the consultation process extend beyond 31st July 2011 that arrangements are made to extend the contract with HCHC to provide nursing services to the hospital. The PCT and the Trustees have approached HCHC about this and I regret that they have advised that this will not be possible due to the ongoing concerns about patient safety. Katrina Percy, Chief Executive of Hampshire Partnership NHS Foundation Trust (incorporating HCHC) advises:

“However, I am afraid we must remain resolute in our decision as the reason we tendered our notice was because the clinical risk of running the services on this site remain, in spite of our best efforts over a number of years to mitigate these risks- the facts remain:

There are no supporting diagnostics or outpatient facilities on site and therapy services are limited to a small amount of physiotherapy activity. Any inpatient therapy is severely compromised by the lack of facilities.

There is a lack of facilities for patients, relatives and staff (no dedicated quiet room), very limited storage.

Because of these limitations, isolation and location of the site, recruitment and retention of qualified staff has always been a problem and has resulted in increased levels of bank and agency staff. This means that development and training of staff to provide safe services is not achievable to an acceptable standard.”

I hope you will understand that patient safety is paramount and neither the provider or the PCT is prepared to compromise this. As such we will be developing alternative arrangements for patients from the end of July 2011 until we have a new service available. As you know, we hope to have a decision on a preferred option(s) by the end of May 2011 and this may require a period of consultation. We are then likely to need to follow a procurement process for the new service which depending on the nature and value of the service could take three to nine months. We have always been clear about this timeline and recognise that this will cause concern for the community.

I hope this letter is helpful in updating you on progress with determining how best to meet the health needs of people in the Odiham area, and we look forward to sharing a report with you on the health profile, engagement process, options appraisal, costings and recommendation on a preferred option(s) ahead of the May HOSC meeting.

In the meantime, if you have any further comments or queries at this point, please do not hesitate to be in touch.

Appendix Three: The Redevelopment of Odiham Cottage Hospital. NHS Hampshire Update. 24 May 2011.



1.0 Introduction and Purpose

1.1 Introduction

1.1i This paper sets out the background surrounding the withdrawal of nursing services at Odiham Cottage Hospital in North Hampshire and the subsequent review of how best to meet the bed-based and nursed care needs of residents living in the area. It also proposes an option for meeting those health needs.

1.1ii The review has been guided by and carried out under the four tests described by David Nicholson, NHS Chief Executive. These require existing and future reconfiguration proposals to demonstrate:

**Support from GP commissioners
Strengthened patient and public engagement
Clarity on clinical evidence base, and
Consistency with current and prospective patient choice**

1.1iii David Nicholson sets out that ‘the goal of any change to services must be to ensure patients get the best care possible, delivered to the highest standards in the most effective, efficient and personalised way’.

1.1iv A grid demonstrating the extent that the review has met the David Nicholson four tests and the expectations on those tests as raised by Hampshire County Council’s Health Overview and Scrutiny Committee is attached at Appendix one.

1.2 Purpose

1.2i A paper will be presented to the Board of NHS Hampshire at its meeting on Thursday 26th May. This paper will ask NHS Hampshire Board to:

1. Note the withdrawal of nursing service by the current provider and to agree to commission interim services to replace the bed-based, nursed care to ensure that local health needs continue to be met;
2. Consider the outcome of engagement undertaken to date;
3. Agree to commission a new model of care which has emerged from extensive discussion with and involvement of local GP Commissioners and community stakeholders; and
4. Note the recommendations of the Health Overview and Scrutiny Committee regarding the extent of formal public consultation on this new model of care.

1.2ii Ahead of the Board meeting the purpose of this paper for the Health Overview and Scrutiny Committee is to:

- set out the reasons for the cessation of the current contract for bed-based nursed care at Odiham Cottage Hospital from July 31, 2011 and propose that those beds are closed from this date due to increased concerns over patient safety as set out in section 2 and the lack of an alternative provider of care.
- detail how these services will be replaced by a range of bed-based and community services as detailed in section 9;
- outline the engagement undertaken with the local community since the current provider of nursing care at Odiham Cottage Hospital served notice on their contract to provide nursing care at the hospital;
- set out how local GPs and community stakeholders have been involved in assessing options for how the bed-based, nursed care needs of people living in and around Odiham could be met and describe the preferred model of care that has emerged from this;
- provide assurance to the Committee on how the four tests of service reconfiguration have been met through the public engagement and options development process; and
- ask for the Committee's views on the extent of formal public consultation required on the introduction of the preferred model of care to replace the model of bed-based, nursed care currently in operation at Odiham Cottage Hospital.

2.0 Background

2.1 Odiham Cottage Hospital is situated in the village of Odiham, North Hampshire. The hospital opened in 1910, to serve the residents of Odiham, Hartley Wintney and other smaller communities in the area. It offers twenty-four hour registered nursing care, provided by Hampshire Community Health Care (now integrated with Hampshire Partnership NHS Foundation Trust as Southern Health NHS Foundation Trust) in 12 beds. Physiotherapy is provided at the hospital one day per week. The layout of the hospital is typical for the period and there are 10 parking spaces.

2.2 The hospital is well-supported and treasured by the community. When it was at risk of closure in 1998, the community mobilised against the proposal and formed the Odiham Cottage Hospital Redevelopment Trust. That year, following extensive fundraising the Trust purchased the hospital building, which it now administers.

2.3 In October 2010 Hampshire Community Health Care (HCHC) (the nursing care provider) informed NHS Hampshire, the commissioner, that it no longer wished to provide twenty-four hour nursing care at the site. The commissioner was informed that the decision was based around the fact that in order to provide safe services, significant mitigation of clinical risk was being made.

2.4 The letter HCHC sent stated that 'For a number of years it has proven impossible to recruit a qualified nursing establishment, which provides adequate and safe cover for the inpatient beds at Odiham. In order to try and provide continued cover we have ensured that there have been no budget limitations on the usage of agency staff, however due to the geographical isolation of the hospital; agencies have frequently been unable to supply nurses. It has become increasingly difficult to staff the ward by any available

means and HCHC can no longer provide the necessary assurance about the level of safety of the inpatient beds at Odiham’.

2.5 While remaining committed to commissioning healthcare in the Odiham area to meet the needs of patient cared for Odiham Cottage Hospital, NHS Hampshire recognised the difficulties in staffing the hospital and associated costs. It therefore commenced a process to secure a safer and more sustainable service for this area. This included:

- an intensive and rapid engagement process to determine how local people would want to receive nursed and bed-based care should they need it, and
- a review into how to provide bed-based care for the types of patients who are typically referred in to Odiham Cottage Hospital

2.6 Initially the provider served notice until March 2011, but following discussions with community stakeholders NHS Hampshire negotiated an extension on the contract to July 31st, 2011 to allow more time for the engagement process.

2.7 During the review and engagement process NHS Hampshire has been in on-going dialogue with Hampshire Community Health Care to ensure that the continued risks to patient safety are managed appropriately.

2.8 This has included some analysis of the patient safety incidents at the hospital over recent months by NHS Hampshire’s Lead Nurse and Medical Director which identified the following risks:

- Agency Nursing staff failing to arrive for shifts resulting in inadequate levels of nursing cover
- Agency nurses being unfamiliar with the procedures of the hospital leading to inappropriate admissions
- Difficulties in managing patients with dementia due to the environment lacking suitable facilities and poor observation

2.9 Given the impending cessation of the provider’s contract NHS Hampshire has also been made aware that from mid-May the hospital will be running at 36% of its required whole time equivalents. Existing staff and bank nurses are already providing extra hours to cover outstanding shifts. The provider proposes to temporarily deploy staff from other services and to further tighten the admission criteria to ensure patients can continue to be cared for safely. In light of this and in response to stakeholder questions about further extending the provider’s contract we have asked Calleva GPs and the Chief Nurse from South Central Strategic Health Authority to provide a view on the ongoing clinical safety at Odiham Cottage Hospital.

3.0 Health Needs Research

3.1 In order to carry out a full review NHS Hampshire has involved its Public Health Team to give an overview of health needs in the area. Odiham lies within the Hart District Council area so information is based on that gathered for the Hart region in the Joint Strategic Needs Assessment. The full Hart Health Needs Assessment is attached at Appendix two.

3.2 The key findings from this are:

- Hart has the highest life expectancy in Hampshire and the lowest mortality rate – 468 deaths per 100,000 people
- cancer is the greatest cause of death
- Hart has the third lowest rate of population growth in Hampshire
- The biggest demographic challenge for Hart is an ageing population
- Odiham Parish has a more varied demographic composition, with 33% of its population being aged between 25 and 44 years, and 28.5% being over 50. This higher than expected number of younger people is comprised of the servicemen and families of RAF Odiham

4.0 Choice in Local Health Services

4.1 Odiham sits in a rural area to the east of the M3. The largest town in the area is Basingstoke, which is seven miles away. Odiham village sits approximately eight miles from Farnham, Alton and Fleet.

4.2 Residents in the Odiham area requiring acute medical care would usually be referred to either Basingstoke and North Hampshire Hospital or to Frimley Park Hospital in Surrey. Both are high performing, independent NHS Foundation Trusts.

4.3 The area is served by two other community hospitals at Alton and Fleet.

4.3i **Alton Community Hospital** which is eight miles from the village of Odiham has a 24 bed inpatient facility which sits alongside a rehabilitation service and an outpatient department. Outpatient appointments are provided at the hospital Monday to Friday and it also has diagnostic services such as X-Ray and Ultrasound. The site has parking for approximately 70 cars.

4.3ii **Fleet Hospital** which is eight miles from Odiham is a small community hospital with 18 inpatient beds. These are used for general rehabilitation and GP use and sit alongside an outpatient department that provides outreach clinics for local residents. The hospital also houses a busy physiotherapy department and has X-Ray and Ultrasound services. The site has parking for 40 cars.

4.4 Community or out of hospital nursing and therapy services are provided by Southern Health NHS Foundation Trust (incorporating the former Hampshire Community Health Care) These services include Community Nursing, Community Matrons, “Virtual Wards”, Physiotherapy and Occupational Therapy.

4.5 NHS Hampshire and Hampshire County Council jointly commission reablement services from local Nursing Homes providing a six week period of intensive therapy to enable people to regain their independence after illness or injury.

5.0 Testing the market for alternative providers

5.1 NHS Hampshire's Director for Commissioning – Out of Hospital Services, Sarah Elliott, has held discussions with alternative nursing providers in the area. The discussions have been focused on determining whether they would be interested in providing the same nursing service as that currently delivered at Odiham Cottage Hospital.

5.2 These discussions have taken place as a possible 'precursor' to a tender opportunity. Although helpful, none of the providers has expressed an interest in providing nursing services within Odiham Cottage Hospital because of the potential difficulty in staffing a remote site and the associated costs.

6.0 Engagement process and findings (David Nicholson's test two - Strengthened patient and public engagement)

6.1 Working with stakeholders

6.1i A locality stakeholder group was established in January 2011 and has been meeting every three to four weeks. This group has helped formulate the engagement process which established a public survey and a series of drop-in sessions. In addition, the group created a set of criteria and options for the future provision of nursed and bed-based healthcare for the types of patients currently using Odiham Cottage Hospital.

6.1ii The stakeholder locality group is comprised of representatives from:

- Odiham Cottage Hospital (OCH) Trustees
- Odiham Cottage Hospital League of Friends
- Odiham Parish Council
- Hart District Council (councillors and officers)
- Hampshire County Council
- Hampshire LINK
- Hampshire Community Health Care (now Southern Health NHS Foundation Trust)
- Hart Practice Based Commissioning group (January to March 2011)
- Local GPs
- Representatives from Calleva (the GP Commissioning Consortia for Basingstoke and the surrounding areas) – from March 2011.
- NHS Hampshire

6.1iii There has also been representation at some meetings by parish councillors from surrounding parish councils such as Newnham and Hartley Wintney.

6.1iv Discussions at the stakeholder group meetings have been challenging with the majority of the group finding it difficult to discuss any future options that do not involve inpatient beds at Odiham Cottage Hospital. This has also permeated into the community. Those people who presented at drop-in sessions were angry and did not want to discuss their overall views on meeting healthcare needs. They were only focused on 'saving Odiham Cottage Hospital'. The challenges posed by the stakeholder group revolved around:

- the decision to end the nursing contract at the hospital;

- the decision not to go out to formal tender as an immediate response to the ending of the contract; and
- discussions around meeting future health needs of the local population not being based entirely around use of the hospital.

6.1v The robust discussions at the stakeholder group meetings have reflected very different perspectives between the commissioner and the local community. However the group has continued to be very well-attended and the contribution made by all parties within the group has enabled community stakeholders and GPs to be fully involved throughout.

6.1vi Alongside the process to determine the best way to meet the health needs of the types of people who currently access Odiham Cottage Hospital, NHS Hampshire has encouraged Trustees to consider other successful models for delivering healthcare in Hampshire (such as Fenwick 2). NHS Hampshire recognises that it has been difficult for the Trustees as their focus has tended to be on the continuation of current services.

6.2 Engagement with local people

6.2i In order to ensure objectivity NHS Hampshire commissioned Hampshire Local Involvement Network (LINK) to work with them on the engagement process. This process was informed by the stakeholder locality group and employed tools that would determine local views on how people would prefer to receive non-acute nursed and bed based care should they ever need it. A report from Hampshire LINK on the engagement activity is attached at Appendix three.

6.2ii A survey and series of drop-in sessions were suggested. These were promoted in the Parish newsletter, local shops, and via a direct mail campaign to all GP surgeries in Hart, voluntary sector groups and clubs and societies within a 10 mile radius of Odiham and to all the surrounding 21 Parish Council Councillors via Parish Clerks.

6.2iii A survey (available both on-line and in paper form) was developed and with the help of the stakeholder group, was distributed to residents in the local area. The survey was designed to help understand local views on how they want their nursed health care delivered. The information gathered was designed to help inform the possible options for future delivery of this type of care.

6.2iv At least 10,000 households were given the opportunity to comment during the open period of the survey - February 22nd 2011 to March 29th 2011. Some 3,238 responses to the survey were received. Some of the key findings are:

- 68% of respondents were female;
- Some 55% were aged over 61 years (34% were aged between 41 and 60 years, with 11% of respondents being 40 or under);
- Respondents were asked to rank what their top four preferences would be if they needed bed-based care – 86% (2,574 people) ranked 'in a community hospital' as their first or second choice and 80% (2,348 people) selected 'being cared for in their own home' as their first or second choice;

- Most respondents (58%) had no experience of Odiham Cottage Hospital, whilst 38% had experience through the admission of a friend or family member. 4% had been in-patients at the hospital;
- 96% of respondents thought it would be reasonable to travel up to 10 miles from home for in-patient facilities; and
- 84% of respondents had their own car, with a further 8% having access to a car via friends or family.

6.2v Hampshire LINK organised and promoted a series of five drop-in sessions over a two week period in early March. These took place in community venues such as doctors' surgeries. They were designed to give local people the opportunity to come and talk about nursed and bed-based care, as well as giving the chance for local people to ask questions about and complete the survey with the LINK's assistance. Although organised and managed by Hampshire LINK, the events were also attended by representatives from NHS Hampshire.

6.2vi Approximately 45 people attended the drop-in sessions. Most had already completed the survey and came to register their concern that the hospital may close.

6.2vii The Trustees of Odiham Cottage Hospital also organised a public meeting at the local school, at which they made their commitment to the hospital building very clear. A large number of people attended this meeting, with representatives from the Trustees, NHS Hampshire and local GPs present to answer questions from local residents.

6.2viii Those attending the drop-in sessions and public meeting made it clear that they would be unhappy with any proposal that would result in the removal of the inpatient beds at the hospital.

6.3 Engagement With and Support from GP Commissioners – David Nicholson's test one - Support from GP commissioners

6.3i NHS Hampshire began engagement with clinicians when notice was received from the former Hampshire Community Health Care. This was through the Hart Practice Based Commissioning (PBC) Group, the clinical commissioning group for the area, their clinical lead Dr. Steven Clarke and their manager, Robin Washington. At that time, Hart PBC Group covered the area that includes Odiham. There was also representation from the GP Practices who refer patients in to Odiham Cottage Hospital.

6.3ii At initial meetings it was clear that GP commissioners from the Hart Practice Based Commissioning Group would support options to meet the local health care needs in another way, rather than through beds at Odiham Cottage Hospital. However it was also clear that this may not be supported by the small number of local GPs who currently provide a service in the hospital.

6.3iii With the formation of the GP Commissioning Consortia, those practices who admit patients to Odiham Cottage Hospital have become part of the Calleva GP Commissioning Group and have therefore moved away from the Hart GP Commissioning Consortia.

6.3iv As a result clinical representation at the stakeholder locality group has changed, with Dr. Steven Clarke and PBC Manager, Robin Washington withdrawing from the meetings. Clinical representation at the stakeholder group now comes from the GPs who refer patients in to the hospital - including those who have a contract to provide medical services to the hospital - and from Calleva, the GP Commissioning Consortia for the Basingstoke area.

6.3v NHS Hampshire has asked Calleva the GP Commissioning Consortia covering this area for clarity over its future commissioning intentions once the nursed and bed based services provided by Southern Health NHS Foundation Trust (incorporating the former HCHC) are withdrawn at the end of July 2011.

6.3vi Calleva clinicians and managers, along with one of the local referring GPs, Dr. Andrew Fernando, were involved in the initial development of the options to meet healthcare needs. Following assessment of these options they have brought together the elements of the three top scoring options to create a hybrid preferred option – as outlined in section 7 of this report.

6.3vii The pathfinder GP Commissioning Consortia, Calleva, is clear that any future service provision must meet the health needs of local people and must be clinically and financially sustainable.

6.4 Engagement with staff

6.4i NHS Hampshire commissions nursing care at the hospital from Southern Health NHS Foundation Trust (HPFT), the organisation that acquired Hampshire Community Health Care on April 1, 2011 and as such, they are the employer of the staff at Odiham Cottage Hospital

6.4ii NHS Hampshire has been assured that staff have been engaged and receive regular updates via the Locality Manager. Discussions have included the potential for redeployment should the hospital close. Staff have been assured that the closure of the beds would not result in any redundancies. In addition, HCHC has been increasing their community nursing capacity and has recruited 21 new community nurses in North Hampshire in recent months. This follows a Hampshire-wide workforce review which identified some gaps in capacity in north Hampshire.

7 Developing Options

David Nicholson's test three – Clarity on clinical evidence base and test four - Consistency with current and prospective patient choice

7.1 The locality stakeholder group established and reviewed a set of possible options for meeting the nursed and bed based care needs of the types of patients currently cared for at Odiham. The Group also informed and developed the criteria against which stakeholders reviewed and scored these options. The five options that emerged were:

Option 1 Inpatient bed based model providing 24 hour nursing care and rehabilitation

- | | |
|----------|---|
| Option 2 | Reablement beds in nursing homes – commissioned with Hampshire County Council |
| Option 3 | Home based community nursing with community nurses and matrons |
| Option 4 | Integrated care with social care and voluntary sector |
| Option 5 | Outpatient/clinic based care |

7.2 These five options were then scored by the locality stakeholder group and three appeared as the options most likely to meet the needs of local people. The highest scoring options were:

- Home based community nursing with community nurses and matrons
- Reablement beds in nursing homes – commissioned with Hampshire County Council
- Inpatient bed based model providing 24 hour nursing care and rehabilitation

7.3 The stakeholder locality group favoured these three options but believed that the health needs would be best met through a combination of all three of these options. As a result a sixth option combining the options above began to emerge (option 6).

7.4 A wider stakeholder workshop was then held at which the criteria used to consider the options were scored. Attendees were given ten votes to score the criteria and this in turn informed the weightings to calculate the final scores. The criteria receiving the greatest weightings were:

- public acceptability
- helping people recover from episodes of ill health or following treatment
- enhancing quality of life for people with long-term conditions

7.5 During discussions at this workshop the newly emerging option 6 was considered and it was felt that this option should be ‘worked up’ and put forward as the preferred option.

7.6 NHS Hampshire and its constituent GP commissioners believe this new option (detailed below) satisfies the David Nicholson expectation that ‘the goal of any change to service must be to ensure patients get the best care possible, delivered to the highest standards in the most effective, efficient and personalised way’.

7.7 Option six – The Preferred Model of Care

7.7i Calleva, the local GP commissioners who will be responsible for commissioning the future model of care have developed an outline specification of the proposed new service model (see Appendix 4). This has been shared with the Hart Locality Stakeholder group and has their broad agreement. A more detailed specification for the Option six model of care is currently under development by Calleva.

7.7ii The underpinning principles will be to:

- meet the needs of those patients being discharged from acute settings with an emphasis of supporting patients back to maximum independence.

- meet the needs of those patients needing extra medical care to prevent an acute admission or those who with additional medical support would be able to remain at home during a period of ill-health

7.7iii Given the number of people currently using Odiham Cottage Hospital and the health needs of local people it is expected that the model of care will involve commissioning the following to replace the current provision at Odiham Cottage Hospital:

- A number of reablement beds via Hampshire County Council's Adult Services directorate
- A number of inpatient beds at local Community Hospitals
- Community nursed hours from a community nursing provider for the delivery of care in a patient's own home
- A number of continuing health care beds in the local area

7.7iv This option is also consistent with the joint commissioning model that NHS Hampshire has in place with Hampshire County Council. It will also meet patient needs by providing high-quality nursed care that is more cost-effective than that delivered via Odiham Cottage Hospital.

7.7v Any procurement will be conducted in line with procurement law and NHS Policy requirements in relation to procuring clinical services set out in the Department of Health *Procurement Guide for Commissioners of NHS Funded Services*.

8 The impact of implementing option six

8.1 Impact on Patients

8.1i There should be no adverse impact on waiting times.

8.1ii Based on current usage of inpatient beds at Odiham Cottage Hospital a maximum of 12 patients at any one time needing nursed care would be assessed and will receive the treatment that is most appropriate to their needs.

8.1iii With the survey identifying that 92% of respondents used a car as their main mode of transport and some 96% stating that they believed it was reasonable to travel up to ten miles for bed-based care, the use of beds in either Alton or Fleet Community hospitals would appear to be an acceptable alternative.

8.1iv For some this will have the positive impact of enabling them to be treated by qualified community nurses in their own homes. Other patients will be discharged from an acute setting into a reablement bed where they will regain the confidence and skills to return to their homes. Other patients will be admitted to an alternative community hospital (either Fleet or Alton) where they will receive bed-based care alongside the rehabilitation or physiotherapy services they will need for their recovery.

8.2 Impact on Family and Friends

8.2i Unless nursed at home, patients' friends and families will have a longer journey to either the nursing home or community hospital setting. Basingstoke is eight miles from Odiham, Fleet is seven miles away, as is Alton. Each has a journey time of around fifteen minutes.

8.3 Impact on Partner Providers

8.3i Hampshire County Council is involved in the project and is aware that there may be an increased need for reablement beds. They have indicated that they will be able to meet this additional demand.

8.3ii Hampshire Community Health Care (now part of Southern Health NHS Foundation Trust) provides the nursing care at both Fleet and Alton Community Hospitals. Fleet Community Hospital has an average occupancy level of 80%. Alton has an average occupancy level of 85%. Therefore both have capacity for additional patients and can offer patients rehabilitation and physiotherapy facilities without additional capital investment.

8.3iii The aim of the change will be to improve clinical and cost effectiveness of services for patients and the public. In addition, reablement beds result in a high number of people returning home who may otherwise have gone permanently into a nursing home (approximately 65% of those who use reablement facilities return home within six weeks).

9 Contingency Plan (for closure of beds July 31, 2011)

9.1 NHS Hampshire is committed to continuing its process of engagement and take forward any consultation proposed by the Health Overview and Scrutiny Committee. Equally, it is important to recognise that a firm date has been set by the provider for the withdrawal of nursing services from Odiham and therefore the PCT has an obligation to make contingency plans to ensure patient needs can be met.

9.2 The current provider has prepared a detailed plan to limit the risk of disrupting patients in Odiham Cottage Hospital at the end of July 2011 by a phased reduction in admissions in the coming weeks and progress discharge or transfer plans for remaining patients. The needs of patients in the hospital will be continually assessed during the run-up to cessation of nursing services and patients transferred to other services or hospitals according to their needs and in a timely manner. Patients whose needs can be met by alternative models such as community nursing or reablement beds would, irrespective of the availability of Odiham, be referred to those services in the normal way.

9.3 The needs of seriously ill patients have been given very careful consideration. Odiham does not admit patients with serious acute illness, who are admitted directly to the Basingstoke North Hampshire Hospital in Basingstoke. Equally, patients who are admitted and who then become acutely ill are transferred by ambulance to Basingstoke.

9.4 As with other community hospitals, Odiham Cottage Hospital does admit patients at the end of life for palliative care and all possible efforts will be made to ensure any moves are minimised for this group of patients and their families and carers. As above, this will include an assessment of the length of time likely for a particular admission and consideration of admission to an alternative community hospital, the local hospice or home based palliative care.

9.5 In line with the above, NHS Hampshire is making arrangements to commission on a temporary basis the following services pending a final decision on service configuration.

- 24/7 nursing services with rehabilitation from Fleet and Alton Hospitals (Analysis of bed occupancy rates shows that beds will be available for patients and the position is closely monitored to ensure that remains the case)
- Home based care including community nursing/Community Matrons/Virtual Ward
- Reablement beds in local nursing homes

9.6 In addition Continuing Health Care placements will be commissioned as necessary from local nursing homes.

10. Conclusion

10.1 In conclusion the current provider of nursing services at Odiham Cottage Hospital has given notice on their contract to provide the service. Following community and stakeholder concern NHS Hampshire has negotiated a four month extension to this notice period but the service will come to an end in July 2011. It is entirely consistent with the freedoms of NHS Foundation Trusts that they may serve notice on a contract in this way.

10.2 NHS Hampshire is committed to commissioning services to meet the healthcare needs of people living in this area and has therefore conducted a very comprehensive engagement process to determine how local people would want to receive nursed and bed-based care should they need it. This process has been challenging as local stakeholders have found it difficult to discuss any future options that do not involve inpatient beds at Odiham Cottage Hospital. This has in turn made it difficult to have productive conversations about a number of successful models that are in operation in other parts of the county.

10.3 Despite these difficulties a new model of care (Option six), offering a mixture of home-based care, inpatient beds with rehabilitation and reablement beds, has emerged as a preferred option from the engagement process and has the support of GP commissioners.

10.4 NHS Hampshire will continue to work with the trustees, local GP commissioners and stakeholders to further develop option six, but will also continue to work closely with the trustees to explore future healthcare uses of the hospital building.

10.5 Hampshire County Council's Health Overview and Scrutiny Committee is asked to:

- agree that the beds at Odiham Cottage Hospital are closed from 31st July due to increased concerns over patient safety as set out in section 2 and the lack of an alternative provider of care.

- agree that these services will be replaced by a range of bed-based and community services as detailed in section 9;
- consider, in light of the engagement with stakeholders, clinicians and local people, the proposed model of care for the delivery of bed based and nursed care as described in section 7.1 and Appendix 4.
- consider whether in its view the proposed change to service as outlined in option six meets the David Nicholson four tests.
- provide a view on the extent of formal public consultation required on the preferred model of care to replace the model of bed-based, nursed care currently in operation at Odiham Cottage Hospital.

Appendix one

Southampton, Hampshire, Isle of Wight and Portsmouth Health Overview and Scrutiny Committees: Arrangements for Assessing Substantial Change in NHS provision.

Purpose and Summary

- 1) The purpose of this document is to agree the arrangements for assessing significant developments or substantial variations in NHS services across the Southampton, Hampshire, Isle of Wight and Portsmouth (SHIP) Local Authority areas.
- 2) It describes the actions and approach expected of both the NHS and Local Authority Health Overview and Scrutiny Committees (HOSCs) when proposals that may constitute substantial service change are being developed and outlines the principles that will underpin the discharge of each parties' role and responsibilities.
- 3) The document refreshes the 'Framework for Assessing Substantial Service Change' originally developed with advice from the Independent Reconfiguration Panel (IRP) and updates the guidance relating to the key issues to be addressed by the NHS when service reconfiguration is being considered. Emphasis is placed on the importance of constructive working relationships and clarity about roles by all parties based on mutual respect and recognition that there is a shared benefit to our respective communities from doing so.
- 4) The legal duties placed on the NHS and the role of the HOSCs are included to provide a context to the dialogue that needs to be taking place between

NHS organisations and the relevant HOSC(s) to establish if a proposal is substantial in nature.

- 5) It is intended that these arrangements will support:
- Improved communications across all parties
 - Better co-ordination of engagement and consultation with service users carers and the public
 - Greater confidence in the planning to service change to secure improved outcomes for health services provided to communities across Southampton, Hampshire, the Isle of Wight and Portsmouth.

Background legislation

- 6) Section 242 of the NHS Act 2006 (formerly Section 11 of the Health and Social care Act 2001) places a statutory duty on commissioners and providers of NHS services to engage and involve the public and service users in :
- Planning the provision of services
 - The development and consideration of proposals to change the provision of those services
 - Decisions affecting the operation of services.
- 7) This duty applies to changes that affect the way in which a service is delivered as well as the way in which people access the service.
- 8) Section 244 of the NHS Act 2006 (formerly Section 7 of the Health and Social Care Act 2001) places a statutory duty on commissioners and providers of NHS services to consult Local Authority HOSCs on any proposals for significant development or substantial variation in health services. [NHS organisations will note that this duty is quite distinctive from the routine engagement and discussion that takes place with Local Authorities as partners and key stakeholders.](#)
- 9) Significant development and substantial variation are not defined in the legislation but supporting guidance is clear that the NHS body responsible for the proposal should initiate early dialogue with the HOSC(s) affected by the proposal to determine:
- a) If the HOSC(s) consider that the change constitutes a significant development or substantial variation in service
 - b) The timing and content of the consultation process.
- 10) Where it is agreed that the proposal does constitute a substantial change the response of the HOSC(s) to the subsequent consultation process will be shaped by the following considerations:

- a) Has the development of the proposal been informed by appropriate engagement and involvement of local people and those using the service. This should take account of the relevant equality legislation and be clear about the impact of the proposal on any vulnerable groups.
 - b) The extent to which GP commissioners have informed and support the change
 - c) The strength of clinical evidence underpinning the proposal and the support of senior clinicians whose services will be affected by the change.
 - d) How the proposed service change affects choice for patients, particularly with regard to quality and service improvement
- 11) NHS organisations will also wish to invite feedback and comment from the relevant Local Involvement Networks (LINKs) which were established by legislation to facilitate the involvement of people using health and social care services in their area. The LINK has specific legal powers, including the ability to refer issues of concern to the HOPSC(s) and to enter and inspect health and social care premises. Locally good working relationships exist with LINKs and HOSCs will normally expect evidence of their contribution to any proposals for varying health services from the NHS.
- 12) The framework attached at Appendix One identifies a range of issues that may inform both the discussion about the nature of the change and the response of the HOSC to the consultation process. The intention is that this provides a simple prompt for assessing proposals, explaining the reasons for the change and understanding the impact this will have on those using, or likely to use, the service in question.
- 13) The framework is not a 'blueprint' that all proposals for changing services from the NHS are expected to comply with. The diversity of the health economy across the SHIP area and the complexity of service provision need to be recognised, and each proposal will therefore be considered in the context of the change it will deliver. The framework can only act as a guide: it is not a substitute for an on-going dialogue between the parties concerned. It is designed for use independently by the NHS in the early stages of developing a proposal, or provide a basis for discussion with HOSCs regarding the scope and timing of any formal consultation required.
- 14) The development of the framework has taken into account the additional key tests for service reconfiguration set out by Sir David Nicholson in [July 2010](#) and included in the revised operating framework for 2010-11.
- 15) Although it remains good practice to follow Cabinet Office Guidance in relation to the content and conduct of formal consultation HOSCs are able to exercise some discretion in the discharge of this duty. Early discussions with

the HOCS(s) whose populations are affected by a proposal are essential if this flexibility is to be used to benefit local people.

16) Any request to reduce the length of formal consultation with the HOSC(s) will need to be underpinned by robust evidence that the NHS body responsible for the proposal has engaged, or intends to engage local people in accordance with Section 242 requirements. These require the involvement of service users and other key stakeholders in developing and shaping any proposals for changing services. Good practice guidance summarises the duty to involve patients and the public as being:

- a) Not just when a major change is proposed, but in the on-going planning of services
- b) Not just when considering a proposal, but in the development of that proposal, and
- c) In decisions that may affect the operation of services

17) All proposals shared with HOSCs by the NHS – regardless of whether or not they are considered substantial in nature - should therefore be able to demonstrate an appropriate consideration of Section 242 responsibilities.

18) Individual HOSCs will come to their own view about the nature of change proposed by the NHS. Where a proposal is judged to be substantial and affects service users across HOSC boundaries the HOSCs concerned are required to make arrangements to work together to consider the matter.

19) *Although each issue will need to be considered on its merits the following information will help shape the views of the HOSC(s) regarding the proposal:*

- a) The case of need and evidence base underpinning the change. This may include the health needs of local people (including public health equity audits as appropriate) and clinical best practice or guidance.
- b) The extent to which service users, the public and other key stakeholders including GP commissioners have contributed to developing the proposal. Regard must be given to the involvement of 'hard to reach groups' where this is appropriate, including the need for any impact assessment for vulnerable groups.
- c) The improvements to be achieved for service users and the additional choice this represents. This will include issues relating to service quality, accessibility and equity.

- d) The impact of the proposal on the wider community and other services. This may include issues such as economic impact, transport issues and regeneration as well as other service providers affected.

20) This information will enable the HOSC(s) to come to a view about whether the proposal is substantial, and if so, whether the proposal is in the interest of the service users affected.

21) The absence of this information is likely to result in the proposal being referred back to the responsible NHS Board for further action.

22) *If NHS organisations consider there is a risk to the safety or welfare of patients or staff then temporary urgent action may be taken without consultation or engagement. In these circumstances the HOSC(s) affected should be advised immediately and the reasons for this action provided. It should be clear when the service(s) affected will reopen.*

23) *If the HOSC(s) affected by a proposal are not satisfied with the conduct or content of the consultation process, the reasons for not undertaking a consultation (this includes temporary urgent action) or that the proposal is in the interests of the health service in its area then the option exists for the matter to be referred to the Secretary of State. Referrals are not made lightly and should set out:*

- *Valid and robust evidence to support the HOSC(s) position*
- *Confirmation of the steps taken to secure local resolution of the matter.*

Guiding Principles

24) The four HOSCs in Southampton, Hampshire, the Isle of Wight and Portsmouth have worked closely to build effective working relationships and share good practice.

25) HOSCs will need to be able to respond to requests from the NHS to discuss proposals that may be significant developments or substantial variations in services. Generally in coming to a view the key consideration will be the scale of the impact of the change on those actually using the service(s) in question.

26) Early discussions with HOSCs regarding potential for significant service change will assist with timetabling by the NHS and avoid delays in considering a proposal. Specific information about the steps (whether already taken or planned) in response to the legislation and the 4 tests outlined by Sir David Nicholson will support discussions about additional information or action required.

27) Some service reconfiguration will be controversial and it will be important that HOSC members are able to put aside personal or political considerations in

order to ensure that for the scrutiny process is credible and influential. When scrutinising a matter the approach adopted by the HOSCs will be:

- a) Challenging but not confrontational
- b) Politically neutral in the conduct of scrutiny and take account of the total population affected by the proposal
- c) Based on evidence and not opinion or anecdote
- d) Focused on the improvements to be achieved in delivering services to the population affected
- e) Consistent and proportionate to the issue to be addressed

28) *It is acknowledged that the scale of organisational change currently being experienced in the NHS coupled with significant financial challenges across the public sector is unprecedented. Consultation with local people and the HOSC(s) may not result in agreement on the way forward and on occasion difficult decisions will need to be made by NHS Boards. In these circumstances it is expected that the responsible NHS Board will apply a 'test of reasonableness' which balances the strength of evidence and stakeholder support and demonstrates the action taken to address any outstanding issues or concerns raised by stakeholders.*

29) *If the HOSC(s) is not satisfied that the implementation of the proposal is in the interests of the health service in its area the option to refer this matter to the Secretary of State remains.*

30) *All parties will agree how information is to be shared and communicated to the public as part of the conduct of the scrutiny exercise.*

Appendix One

Key questions to be addressed

Each of the points outlined above have been developed below to provide a checklist of questions that may need to be considered. This is not meant to be exhaustive and may not be relevant to all proposals for changing services

The assessment process suggested requires that the health body responsible for taking the proposal forward co-ordinates consultation and involvement activities with key stakeholders such as service users and carers, the relevant Patient and Public Involvement Forums, District Councils and other service providers affected by the proposal. The relevant HOSCs also need to be alerted at the formative stages of development of the proposal. The questions posed by the framework will assist the NHS and HOSCs in determining if a proposal is substantial, identify any additional action to be taken to support the case of need and agree the consultation process.

Name of Responsible (lead) NHS Body: NHS Hampshire

Brief Description of the Proposal: NHS Hampshire has received notice from provider Hampshire Community Health Care that they do not wish to renew their contract to provide nursing care to Odiham Cottage Hospital. NHS Hampshire now needs to explore how best to provide bed-based care for the community – whether this be by tendering for an alternative provider for the hospital or commissioning a different service to meet the bed-based health care needs of the local population.

Description of Population affected: Odiham is a parish within Hart District Council's area. It falls under the Calleva GP Commissioning Consortia. There are approximately 5,500 residents in the Odiham parish. The cottage hospital (which has 12 beds) also services the wider communities of Hartley Wintney, Hook, and smaller villages around the area. Referrals are made as 'step-down' referrals mainly from Basingstoke and Frimley Park hospitals or as 'step-up' referrals from **three** GP practices in Odiham, Hook and Hartley Wintney.

Confirmation of Health Overview and Scrutiny Committees contacted: HCC Health Overview and Scrutiny Committee.

Name of Key stakeholders supporting the Proposal: There is a Hart Locality Stakeholder Group comprised of representatives from the district, county, and parish council, along with trustees from the Cottage Hospital Trust, representatives from the League of Friends, clinicians from local referring GP practices and Calleva, the pathfinder GPCC, as well as representatives from both NHS Hampshire and Hampshire Community Health Care.

Date: May 2011

Criteria for Assessment	Yes/No/NA	Comments/supporting evidence
<p>Case for Change</p> <p>1) Is there clarity about the need for change (e.g. key drivers, changing policy, workforce considerations, gaps in service, service improvement)</p> <p>2) Has the impact of the change on service users, their carers and the public been assessed?</p>	<p>Yes</p> <p>Yes</p>	<p>1) The decision by HCHC to terminate the nursing contract at Odiham Cottage Hospital has prompted a review into how to provide bed-based care for the community in the area. The decision was taken following an ongoing over-reliance on agency staff that was resulting in clinical risks.</p> <p>NHS Hampshire is looking to determine whether an alternative provider can be found, but also needs to explore whether there are other ways of meeting the health needs of local people.</p> <p>2) Yes. Its impact was explored via drop-in sessions and through the use of an on-line and paper survey. These were also useful in determining how local people wanted their future health needs met.</p>

Criteria for Assessment	Yes/No/NA	Comments/supporting evidence
3) Have local health needs and/or impact assessments been undertaken	Yes	3) NHS Hampshire has involved its public health team and taken information from the Joint Strategic Health Needs Assessment to identify the health needs of the Hart population. These have shown that Hart residents have the highest life expectancy in Hampshire, with a predicted population growth of less than 1% by 2015.
4) Do these take account of : a) Demographic considerations b) Changes in morbidity or incidence of a particular condition c) Impact on vulnerable people and health equality considerations d) Potential reductions in care needs (e.g. falling birth rates) e) Comparative performance across other health providers	Yes	4) The Health needs considerations do identify and take account of: A) Demographics – Odiham village – 5,500 residents – 33% aged between 25 and 45 and 14% between 60 and 80. B) Incidence of a particular condition – Lowest mortality rate in Hampshire – 468 deaths per 100,000. – Cancer greatest cause of death C) Hart residents benefit from the best life expectancy in Hampshire, both for men and women. The biggest demographic challenge for Hart is an ageing population. D) Potential reductions in care needs are likely to relate to the very low predictions for population growth (0.98% to 2015). This is the third lowest rate of growth in Hampshire.
5) Has the evidence base supporting the change proposed been defined? Is it clear what the benefits will be to service quality or	Yes	5) Hampshire Community Health Care identified to the commissioner that it had patient safety concerns due to an inability to recruit and retain qualified staff and a subsequent over-reliance on agency staff. This was cited as the reason they were choosing to give notice on their contract.

Criteria for Assessment	Yes/No/NA	Comments/supporting evidence
<p>the patient experience?</p> <p>6) Do the clinicians affected support the proposal</p>	<p>Yes</p>	<p>A review of the types of patients using Odiham Cottage Hospital has identified that their needs could be met within other community hospitals with rehabilitation facilities, within reablement beds, or within their own homes through community nursing.</p> <p>6) NHS Hampshire began engagement with clinicians when notice was received from Hampshire Community Health Care. This was through the Hart Practice Based Commissioning (PBC) Group, their clinical lead Dr. Steven Clarke and their manager, Robin Washington. There was also representation from the GP Practices who refer patients in to Odiham Cottage Hospital.</p> <p>At initial meetings it was clear that any future decision to meet the types of health care needs currently being met at the Odiham Cottage Hospital in another way would be supported by the Hart Practice Based Commissioning Group, but may not be supported by the small number of local GPs who currently refer in to the hospital.</p> <p>With the formation of the GP Commissioning Consortia (GPCC), those practices who admit patients to Odiham Cottage Hospital have become part of the Calleva GP Commissioning Group and have therefore moved away from the Hart GP Commissioning Consortia.</p> <p>As a result clinical representation at the stakeholder locality group has changed, with Dr. Steven Clarke and PBC Manager, Robin Washington, withdrawing from the meetings. Clinical representation at the</p>

Criteria for Assessment	Yes/No/NA	Comments/supporting evidence
<p>7) Is any aspect of the proposal contested by the clinicians affected</p> <p>8) Is the proposal supported by GP commissioners</p> <p>9) Will the proposal extend choice to</p>	<p>Yes</p> <p>Yes</p> <p>Yes</p>	<p>stakeholder group now comes from the GPs who refer patients in to the hospital including those who have a contract to provide medical services to the hospital and from Calleva, the GP Commissioning Consortia for the Basingstoke area.</p> <p>Calleva has been involved in the stakeholder engagement and formation of the options since joining the Hart stakeholder locality group in March 2011. They have sent representation to subsequent meetings including:</p> <ul style="list-style-type: none"> • Option appraisal meeting of stakeholder group (March 24, 2011) • Stakeholder meeting (finance) (April 15, 2011) <p>Additional discussions around Odiham have taken place at GPCC transition meetings between Calleva and NHS Hampshire.</p> <p>7) Discussions have highlighted that there is a high level of support to retain Odiham Cottage Hospital from the limited number of GP practices that currently refer patients to the hospital.</p> <p>8) The pathfinder GP Commissioning Consortia, Calleva, is clear that any future service provision must meet the health needs, but must also be clinically and financially sustainable. Following the options appraisal process, Calleva and local GP Dr. Andrew Fernando have 'worked up' the preferred option – a hybrid of the three highest scoring options.</p> <p>9) NHS Hampshire is looking to ensure that a range of bed-based care</p>

Criteria for Assessment	Yes/No/NA	Comments/supporting evidence
<p>the population affected?</p> <p>Impact on Service Users</p> <p>10) Will there be changes in access to services as a result of the changes proposed.</p> <p>11) Can these be defined in terms of</p> <ul style="list-style-type: none"> a) waiting times b) transport (public and private) c) travel time d) other (please define) <p>12) Is any aspect of the proposal contested by people using the service?</p>	<p>Yes</p> <p>Yes</p>	<p>is established. This would include support to people in their own homes, reablement beds, and other community hospital provision with full rehabilitation services, such as those in Fleet or Alton for example. As well as meeting the health needs as currently met in Odiahm Cottage Hospital, this change of service would offer additional choice.</p> <p>10) Patients' access to services would either be in reablement beds in nursing homes in the Basingstoke area, in their own homes or in alternative community hospitals with rehabilitation services, such as Alton or Fleet.</p> <p>11) As above</p> <ul style="list-style-type: none"> a) There should be no adverse impact on waiting times. b) Unless nursed at home, patients' friends and families will have a longer journey to either the nursing home setting (Basingstoke is eight miles from Odiham) or beds in alternative community hospitals Fleet is eight miles away, as is Alton)) c) The journey to Basingstoke, Fleet or Alton takes approximately 15 minutes. <p>12) Having purchased the building in 1998, the Odiham community has a strong attachment to its cottage hospital. As a result, residents are likely to contest any proposal that does not involve NHS Hampshire placing a contract with a new provider of nursing care or supporting the</p>

Criteria for Assessment	Yes/No/NA	Comments/supporting evidence
<p>Engagement and Involvement</p> <p>13) How have key stakeholders been involved in the development of the proposal</p> <p>14) Is there demonstrable evidence regarding the involvement of</p> <p>a) Service users, their carers or families</p>	<p>Yes</p>	<p>development of a rehabilitation centre. The local community is reluctant to consider any other proposals to meet the health needs of the types of patients currently referred in to Odiham Cottage Hospital.</p> <p>13) A stakeholder locality group was established in January 2011 and has been meeting at least every three to four weeks. This group has helped formulate the phase 2 engagement plan and established a public survey and a series of drop-in sessions. In addition, the group created a set of criteria by which the options for future provision will be appraised and themselves participated in an option appraisal.</p> <p>The group is comprised of representatives from:</p> <ul style="list-style-type: none"> • Odiham Cottage Hospital (OCH) Trustees • OCH League of Friends • Odiham Parish Council • Hart District Council • Hampshire County Council • Hampshire LINK • Hampshire Community Health Care • Hart PBC group • Local GPs • GPCC Calleva <p>14) a) Service users, carers and their families have been approached via an</p>

Criteria for Assessment	Yes/No/NA	Comments/supporting evidence
<p>b) Other service providers in the area affected</p> <p>c) The relevant Local Involvement Network (s)</p> <p>d) Staff affected</p> <p>e) Other interested parties (please define)</p> <p>15) Is the proposal supported by the key stakeholders</p> <p>16) Is there any aspect of the proposal that is contested by key stakeholders? If so what action has been taken to resolve this?</p>	<p>No</p> <p>Yes</p>	<p>on-line survey heavily promoted in the Parish newsletter, local shops, and via a direct mail campaign to all GP surgeries in Hart, voluntary sector groups and clubs and societies within a 10 mile radius of Odiham and to all the 21 Parish Council councillors via their parish clerks. The direct mail also invited members of the public to attend one of the five drop-in sessions that took place in Odiham, Hook and Hartley Wintney in early March.</p> <p>b) The NHS Hampshire Director of Commissioning – Out of Hospital Services, Sarah Elliott, has been holding regular discussions with Hampshire County Council Adult Services Director, Gill Duncan, Hampshire Community Health Care and the Directors of Nursing at the two acute hospitals – Basingstoke and Frimley Park Hospitals.</p> <p>c) The Hampshire LINK has run and managed both the on-line survey and the drop-in sessions on behalf of the commissioner and their chairman, Frank Rust is a member of the stakeholder group.</p> <p>d) Staff have been engaged by their employer Hampshire Community Health Care (HCHC) and receive regular updates via the HCHC Locality Manager, Nicky Sargeant.</p> <p>15) Any decision that leads to the hospital's closure will not be supported by the key stakeholders. They have all, however, fully participated in both the development of and appraisal of possible options to meet local health needs.</p> <p>16) As above. The commissioner has taken soundings from other</p>

Criteria for Assessment	Yes/No/NA	Comments/supporting evidence
<p>Options for change</p> <p>17) How have service users and key stakeholders informed the options identified to deliver the intended change?</p> <p>18) Were the risks and benefits of the options assessed when developing the proposal?</p> <p>19) Have changes in technology, including new drugs been taken into account</p> <p>20) Has the impact of the proposal on other service providers been evaluated</p> <p>21) Has the impact on the wider community affected been evaluated (e.g. transport, housing, environment)</p>	<p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p>	<p>potential providers to determine whether they would be interested in a tender to provide nursing services at the hospital. To date (May 2011) no other providers have expressed an interest.</p> <p>17) Key stakeholders have shaped the possible options for future provision to meet local health needs. In addition, the views of local people were sought through the drop-in sessions and the on-line and paper survey and were considered in both the option formation and the option appraisal.</p> <p>18) An assessment of the risks and benefits of the five main options was carried out at a session with the stakeholder group on March 24, 2011.</p> <p>19) Changes in technology along with changes in the way health care needs are assessed and treated are all factors considered during the option appraisal process.</p> <p>20) HCC is involved in the project and is aware that there may be an increased need for reablement beds. They are able to meet this additional demand. Both Fleet and Alton Community Hospitals have capacity for additional patients along with full rehabilitation facilities.</p> <p>21) As above (question 5)</p>

Criteria for Assessment	Yes/No/NA	Comments/supporting evidence
<p>22) Have the workforce implications associated with the proposal been assessed</p> <p>23) Have the financial implications of the change been assessed in terms of: a) Capital & Revenue b) Sustainability c) Risk</p> <p>24) How will the change improve the health and well being of the population affected?</p>	<p>Yes</p> <p>Yes</p> <p>Yes</p>	<p>22) HCHC has been in regular discussion their staff. Discussions have included the potential for redeployment should the hospital close. Staff have been assured that the closure of the beds would not result in any redundancies. In addition, HCHC has been building their community nursing capacity and has recruited 21 new community nurses in north Hants in recent months. This follows a Hampshire-wide workforce review which identified some gaps in capacity in north Hants.</p> <p>23) A finance report has been presented to the Hart Locality Stakeholder Group. This covered the areas of capital and revenue, risk and sustainability.</p> <p>24) The aim of the change will be to improve the clinical and cost effectiveness for patients and the public. In addition reablement beds result in a high number of people returning home who may otherwise have gone permanently into a nursing home (approximately 65% of those who use reablement facilities return home within six weeks).</p>

Appendix Two

Hart Health Needs Assessment

Summary

Hart is not only one of the healthiest and wealthiest parts of Hampshire but also ranks highly nationally. In terms of health need, this is reflected in low mortality rates from all causes, long life expectancy, a deprivation profile that includes all wards in the most affluent half of the national rankings and a move away from coronary heart disease to cancers as the main cause of death.

The population is small and mobile and despite a partly rural environment, accesses many facilities in neighbouring districts and counties.

1. Introduction

This paper describes the health needs of the population of Hart District in the County of Hampshire. The data rely on national, regional and local sources, some of which are not available or valid for small populations. The district was formed on 1st April 1974 following the merger of Fleet and the Hartley Wintney Rural Districts. It took its name from the River Hart.

The largest town in Hart is Fleet with a population of just under 32,000, which developed as a result of the London and South Western Railway that opened in 1840. Traditionally Fleet has been a dormitory town for London commuters. However in recent years several business parks have developed. Recent housing developments, such as Elvetham Heath, mean that the population will increase by 20% in less than a decade to 36,000. Yateley is the second largest town in Hart with a population of 22,000. It developed as a coaching-hub between London and Reading. Outside these towns, Hart is largely rural with pretty villages and hamlets. Some land is owned by the Ministry of Defence and the Forestry Commission. About a thousand local buildings are listed and the district includes 32 conservation areas.

2. Demography

An estimated 91,187 people lived in Hart in 2010. This accounted for about 7% of Hampshire's population meaning that Hart is the second smallest district in Hampshire after Gosport.

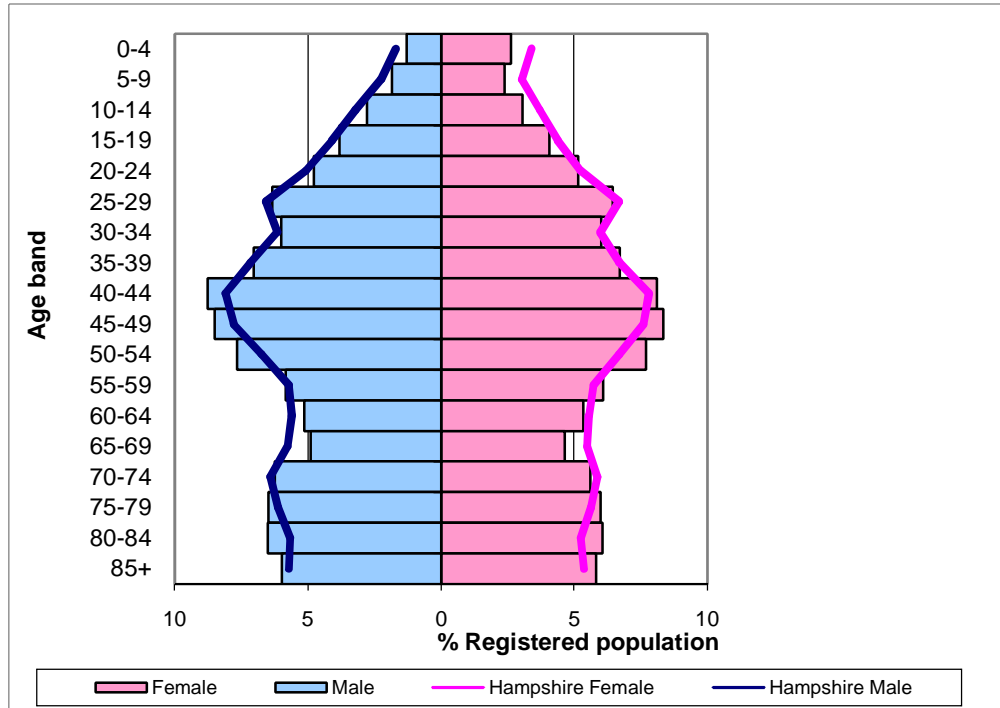
2.1 Population density

Three wards in Hart have population densities of between 70 and 140 people per hectare. Fleet Central, Fleet, Courtmoor and Church Crookham are all in the least deprived quintile nationally with between 10 and 30 people per hectare. The lowest population density in Hart is found in Eversley ward where between zero and 1 person

lives per hectare. In other wards the population density is between 10 and 30 people per hectare.

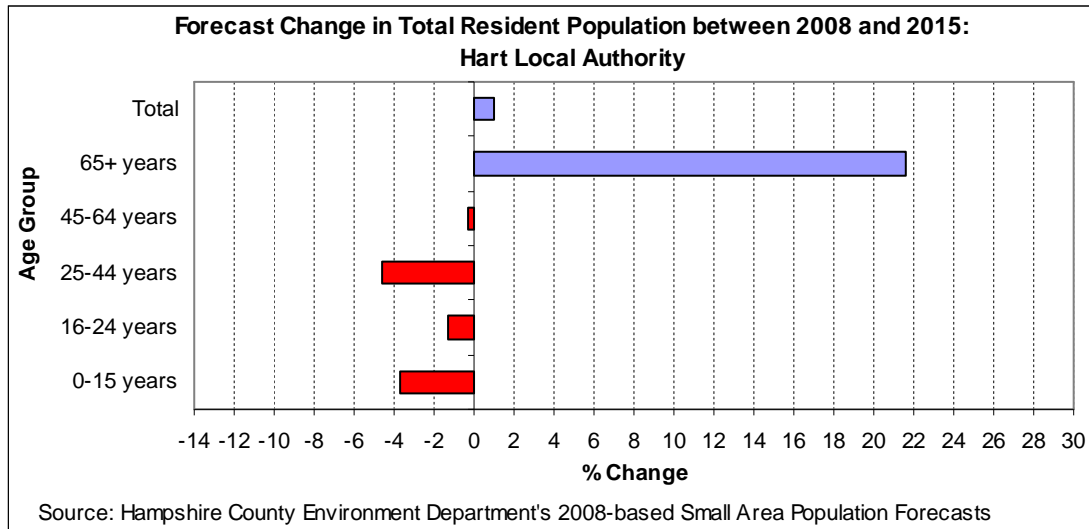
2.2 Age and Ethnic Structure

This population pyramid shows the GP registered population across Hart at October 2010.



Hart's GP registered population structure is similar to that of Hampshire as a whole. However the national population projections confirm the slightly more people in Hart in their mid life and fewer people in their 60s. The population projections suggest a minimal population increase over the coming few years of no more than 1% for Hart. This along with the healthy nature of the population will lead to an increase in the proportion of those aged over 65 years.

The ethnic make up of Hart by ward appears fairly consistent at about 2.3 % of the population. A count of gypsy and traveller caravans on 21/1/08 found 54 in Hart. Only Winchester (n=69) and New Forest (n=55) had more caravans. In 2006 it was estimated that there were 35 gypsy and traveller households on "tolerated" sites, and none on unauthorised sites.



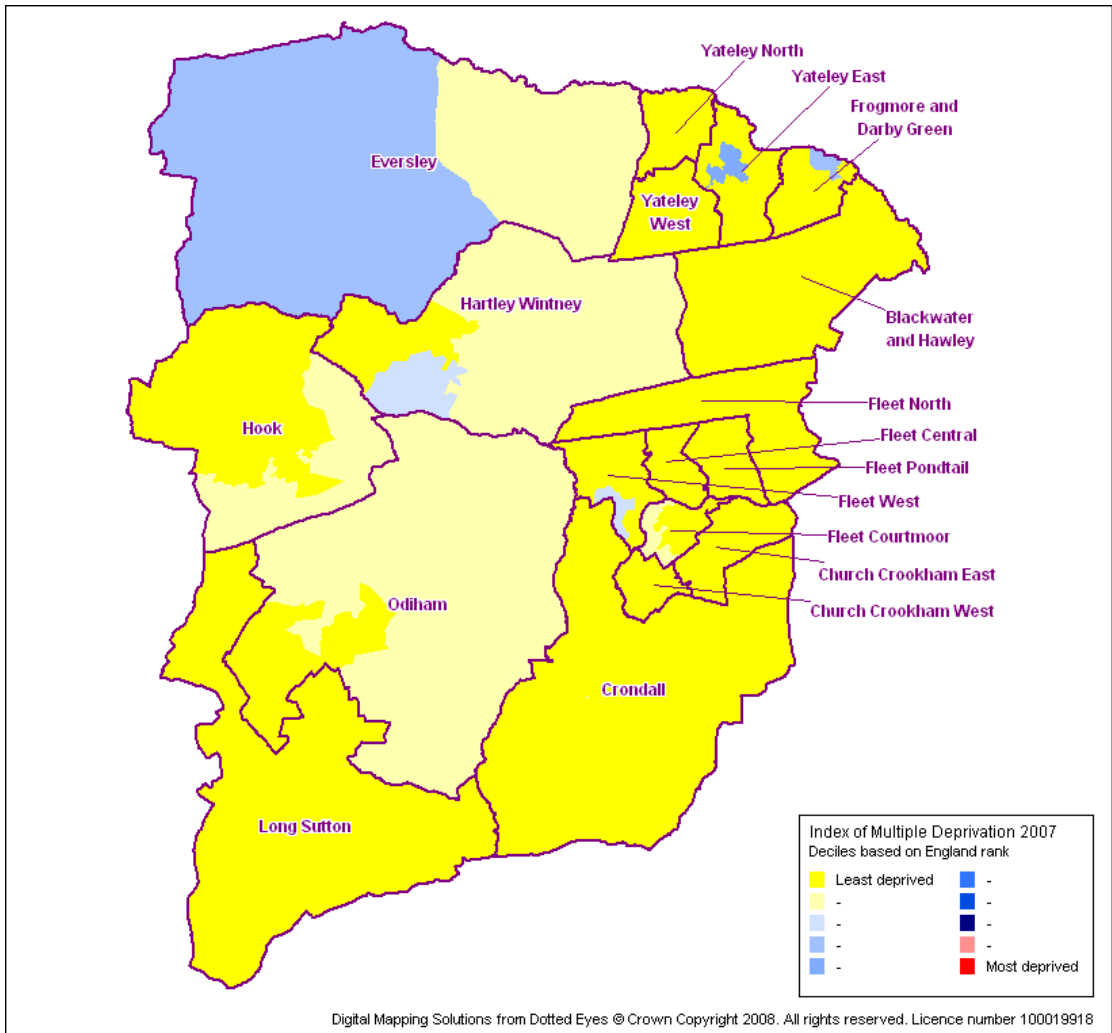
2.3 Life expectancy

Life expectancy is a statistical measure of how long someone born now could be expected to live if the current mortality rate applies. This gives a useful indicator of the general and relative deprivation of an area. In Hart the life expectancy of men, at 81.1 years and women at 85.3 years is greater than both Hampshire and England. However across the district there is a gap in life expectancy of up to 6 years for both men and women between the wards with the highest and lowest figures. The lowest life expectancy is seen for men in Yateley East and for women in Fleet West.

3. Deprivation

3.1 IMD

Deprivation is identified and mapped nationally by the Index of Multiple Deprivation (IMD) which combines a basket of indicators: education, skills and training; employment; crime and disorder; income; health, deprivation and disability; living environment; and barriers to housing and services. The map below shows the local picture by ward for the most recent version in 2007.



In 2007 Hart was the least deprived local authority in England out of 354 local authorities. Hart is unique in Hampshire as not having any areas in the most deprived half of decile ranking nationally. Although the two most deprived areas of the district are just above the mid ranking nationally. One is in Yateley while the second covers a large area of Eversley. Eversley ward is the least densely populated in Hart and this ranking will be influenced by the access to services indicator within the IMD. The most densely populated areas in Fleet and Church Crookham are in the least deprived quintile nationally.

Table: Index of Multiple Deprivation 2007

District	Rank in England* (Rank in Hampshire)
Hart	354 (11/11)
Basingstoke & Deane	304 (5/11)
East Hampshire	332 (8/11)
Rushmoor	268 (3/11)

* Rank in England. 1 represents most deprived local authority in England, and 354 the least
Source: JSNA 2008 pg 42.

3.2 Wellbeing in childhood

The Department of Communities and Local Government produced a local Index of Child Well-being (CWI) in 2009. In conception it is similar to the Index of Multiple Deprivation, though results are not available at small area levels. Domains that are incorporated into the CWI are: material well-being, health, education, crime, housing, environment, and children (at risk of being) in need.

Table: Index of Child Wellbeing scores by local authority

Local Authority	CWI average score	Rank in Hampshire	Rank nationally (out of 354 local authorities)
Hart	46.3	1/11	1

Source: Hampshire County Council website:

http://www3.hants.gov.uk/planning/factsandfigures/figures-economics/economic-labour_market_reports/child_wellbeing_deprivation.htm

This measure estimates that Hart is the best local authority in England for childhood wellbeing.

3.3 Index of resilience to public sector cuts

The BBC commissioned this work from Experian¹. The index looks at the ability of districts to respond to economic shocks, such as public sector cuts. The index lacks the validity of “official” statistics but provides an interesting view to complement the official data. Thirty three variables across four themes were used to generate a weighted result. The themes are:

- **Business.** This includes number of business start ups, whether economic activity is in resilient sectors of the economy, and insolvency rates. It has a weighting of 50% of the overall rate due to its importance in short term resilience.
- **Community.** This includes a broad range of measure including life expectancy, deprivation, and vulnerability to declines in disposable income. It has a weighting of 17% of the overall rate.
- **People.** This includes size of the working age population, skill levels, and the proportion of people in managerial roles as opposed to unskilled roles. It has a weighting of 17% in the overall rate.
- **Place.** This includes GCSE attainment rate, house prices, local crime rates, and amount of green space.

Table: Index of resilience to public sector cuts by local authority

District	National rank (out of 324 local authorities)	Rank in Hampshire
Hart	6	1/11

Experian estimated that only five local authorities in England were better placed to withstand public sector cuts than Hart, with Hart being the only one in Hampshire.

¹ <http://www.bbc.co.uk/news/business-11233799>

3.4 Work and unemployment

The median weekly income in Hart is the highest in the county of Hampshire. Hart has the lowest unemployment rate and percentage of residents on out of work benefits in Hampshire.

3.5 Groups who may need support

The Experian tool, Mosaic which is used in marketing to tailor advertising to target audiences, gives us further information about the people in an area. The predominant Mosaic categories in Hart are generally affluent. These are:

- Career professionals living in sought after locations. The largest proportion, 83%, is in the least deprived quintile nationally.
- People living in rural areas far from urbanisation. The largest proportion, 57%, is in the least deprived quintile nationally.
- Younger families living in newer homes. The largest proportion of these families, 50%, is in the least deprived quintile nationally.
- Independent older people with relatively active lifestyles. The largest proportion, 54%, is in the least deprived quintile nationally.

There are pockets of upwardly mobile families living in homes bought from social landlords in more urban areas. The largest proportion, 35%, is in the middle deprivation quintile nationally.

4. Mortality

4.1 Mortality rates

The mortality rates for the population of Hart are consistently lower than the national and Hampshire rates. Between 2003 and 2007 Hart residents had the lowest mortality rates in Hampshire, 486 deaths per 100,000. This is significantly lower than the rate for Hampshire overall, and significantly lower than any other district in North East Hampshire.

4.2 Mortality from different diseases

Table: Mortality rates per 100,000 (directly standardised) for the main causes

Disease → Area ↓	Circulatory			Cancer	Respiratory
	CHD ¹ (95% CIs)	Stroke (95% CIs)	Diabetes (95% CIs)	All cancers (95% CIs)	COPD ² (95% CIs)
Hart	74.6 (67.6-81.7)	41.7 (36.5-46.8)	4.4 (2.2-6.6)	166.1 (155.2-176.9)	17.7 (13.5-22.0)
Hampshire	84.0 (82.2-85.7)	50.4 (49.1-51.7)	6.2 (5.2-7.2)	163.4 (160.7-166.1)	27.7 (25.7-29.6)
England	95.0 (94.6-95.4)	50.0 (49.7-50.3)	7.2 (7.1-7.4)	175.6 (175.0-176.1)	34.1 (33.7-34.5)

¹ CHD: Coronary Heart Disease

² COPD: Chronic Obstructive Pulmonary Disease

* In this ranking the highest prevalence is ranked worst in Hampshire (11/11)

As might be expected from the general affluence of the population, mortality rates for CHD, stroke and COPD are significantly lower in Hart than in Hampshire as a whole and lower than England. However it is interesting to note that mortality from cancer is greater than that from coronary heart disease.

4.3 Avoidable Deaths

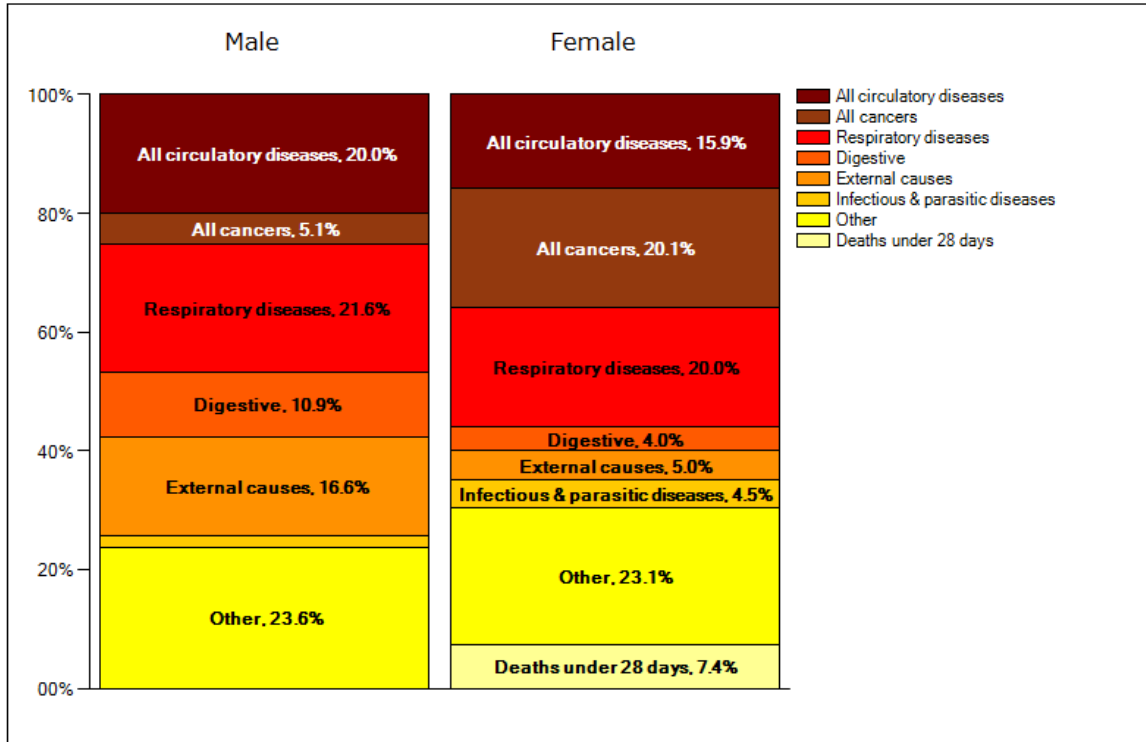
Trauma and injury are significant causes of ill health, disability and death and are significantly more of an issue the more deprived a population is. Hart has the median rate of road injuries and deaths in Hampshire. The number of people killed or seriously injured has remained fairly static across Hampshire over the last 5 years. An average rate of deaths from fractured necks of femur – often the result of falls in older people. These are avoidable through a comprehensive approach across the local community/neighbourhood.

4.4 The Inequalities Gap

The table below shows the London Health Observatory estimates of the contribution of different diseases on the life expectancy gap².

Chart: the diseases that account for the life expectancy gap between the most deprived and least deprived quintiles in Hart

² http://www.lho.org.uk/LHO_Topics/Analytic_Tools/HealthInequalitiesTool.aspx



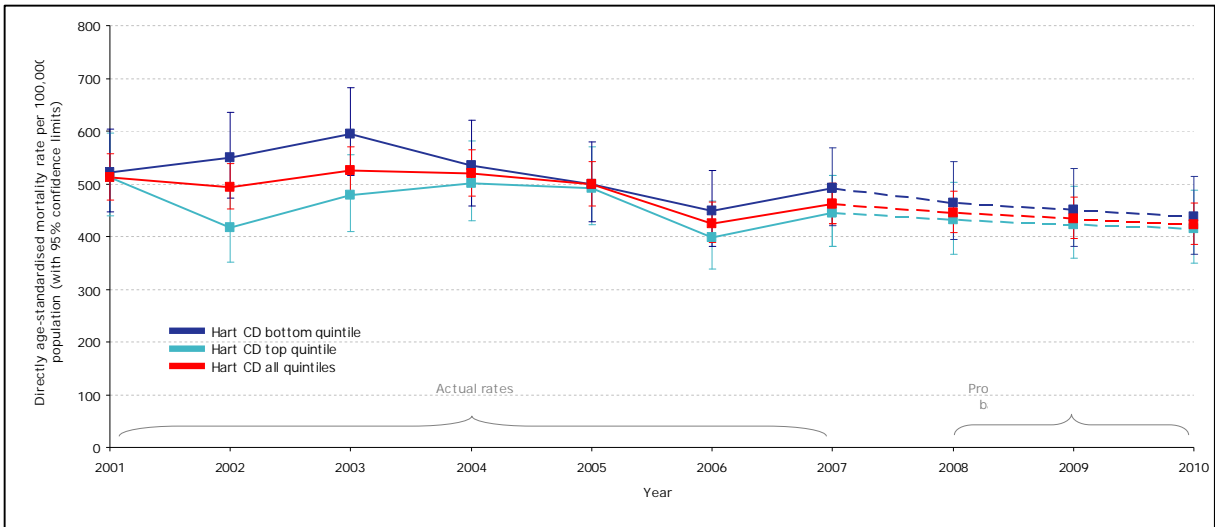
In most places circulatory disease and cancers dominate as the main causes for gaps in life expectancy. In Hart the most important disease categories are respiratory disease and “other” that includes endocrine, mental health, nervous system diseases amongst a list of less common diseases.

4.5 Trends over time

The South East Health Inequality Gap Measurement Tool provides trends in mortality inequalities over the past decade³. The charts below are age and sex standardised, allowing comparison of different populations.

Chart: trends in **all age all cause mortality** (directly standardised) between 2001 and 2010 for Hart overall, bottom quintile and top quintile for deprivation

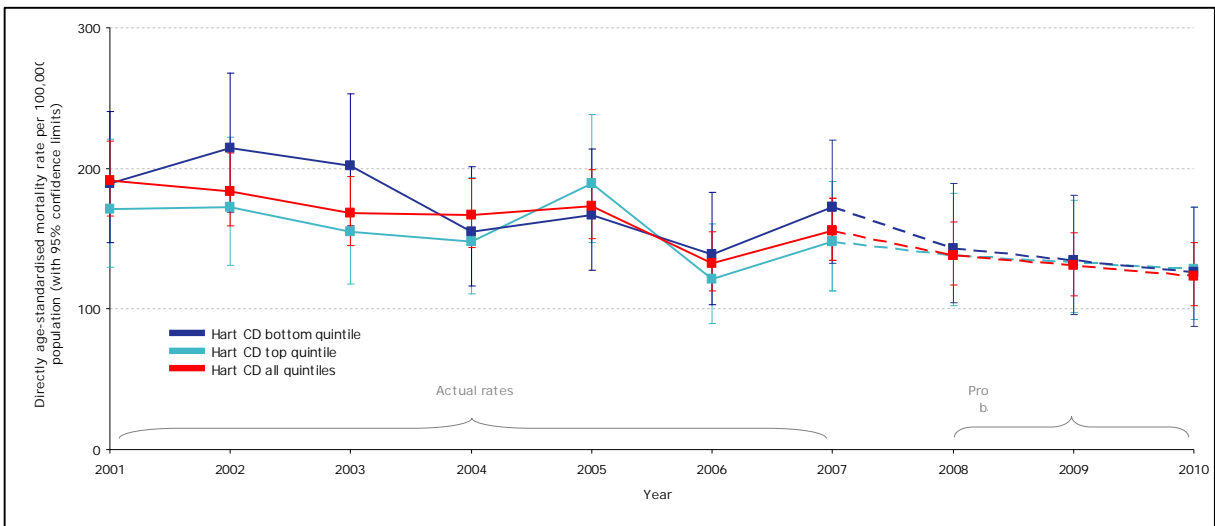
³ <http://www.sepho.org.uk/viewResource.aspx?id=10965>



The all age all cause mortality (AAACM) rate across all deprivation quintiles has dropped from 511.9 deaths per 100,000 in 2001 to an estimated 423.1 deaths per 100,000 in 2010.

Circulatory disease

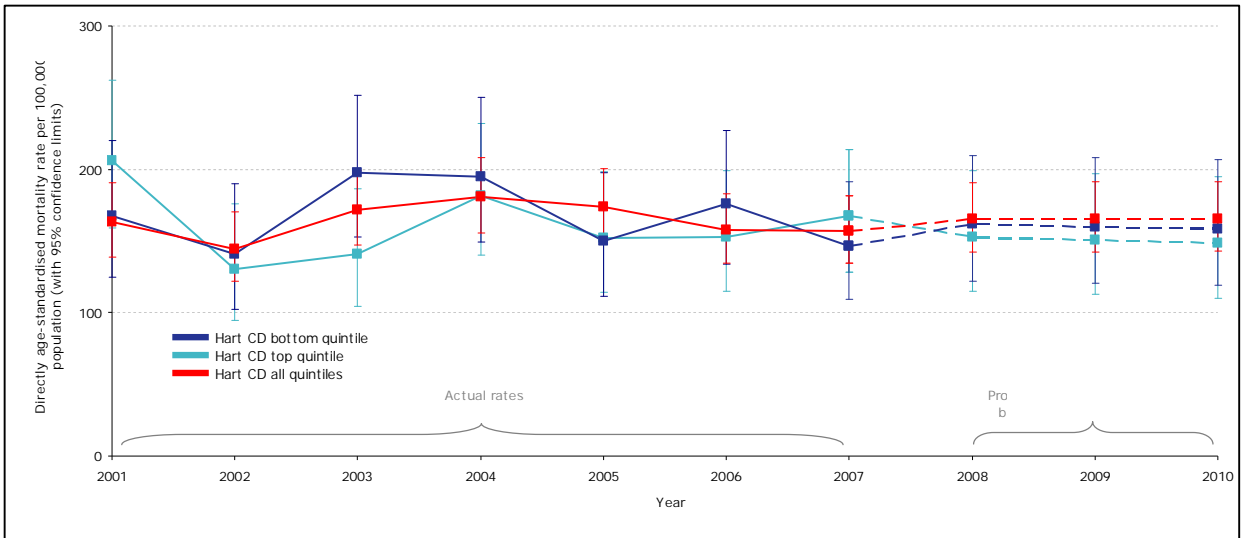
Chart: Trends in all circulatory disease mortality (directly standardised) between 2001 and 2010 for Hart's bottom quintile versus top quintile for deprivation



As was the case with AAACM there appears to have been a convergence in the mortality rates from circulatory disease across deprivation quintiles. In 2001 the circulatory mortality rate was 191.5 deaths per 100,000 for all quintiles. By 2010 it is estimated that the mortality rate had fallen to 123.4 deaths per 100,000.

Cancers

Chart: Trends in all cancer mortality (directly standardised) between 2001 and 2010 for Hart's bottom quintile versus top quintile for deprivation



Mortality rates from cancer have been fairly static in the past decade. Overall the mortality rate was 163.4 per 100,000 in 2001 and is estimated to be 165.7 per 100,000 in 2010. This may be because people are avoiding or surviving circulatory disease and so living long enough to develop cancer.

5. The profile of illness across Hart

The population of Hart is generally healthy and the spine chart identifies both illnesses and other health issues affecting this small population. For the majority of these indicators Hart fares better than average or so close to average that it is not statistically significantly different.

Public Health GP Practice Profiles - Locality Level
HART

	Indicator	Locality number	Locality Value	PCT Average	PCT Worst	PCT average				PCT Best
						Worst	25th Percentile	75th	Best	
Estimated Prevalence	1 Estimated prevalence of CHD	2473	2.6	3.8	6.8					1.2
	2 Estimated prevalence of Stroke	1309	1.4	1.8	3.3					0.6
	3 Estimated prevalence of Hypertension	20792	21.9	24.2	34.3					12.5
	4 Estimated prevalence of COPD	1524	1.6	2.4	4.7					1.0
QOF Registered Prevalence	5 Registered prevalence of CHD	2609	2.7	3.4	6.0					1.2
	6 Registered prevalence of Stroke	1292	1.3	1.7	3.7					0.3
	7 Registered prevalence of Hypertension	12256	12.6	13.7	24.0					5.5
	8 Registered prevalence of Heart Failure	486	0.5	0.7	2.1					0.1
	9 Registered prevalence of Atrial Fibrillation	1291	1.3	1.6	3.3					0.3
	10 Registered prevalence of COPD	983	1.0	1.3	2.6					0.3
	11 Registered prevalence of Asthma	6104	6.3	6.1	8.9					3.4
	12 Registered prevalence of Diabetes	3327	3.4	4.0	7.2					2.1
	13 Registered prevalence of Cancer	1472	1.5	1.6	3.3					0.4
	14 Registered prevalence of Mental	489	0.5	0.6	1.5					0.3
	15 Registered prevalence of Dementia	367	0.4	0.6	3.1					0.0
Life-style	16 % of patients who are a current smoker	20837	26.6	28.5	38.3					17.5
	17 % of those with a BMI record > 30	7478	9.6	9.8	21.5					4.0
Screening	18 Breast: 50-52 year olds screened in 3 years	784	40.3	55.3	1.8					83.9
	19 Breast: 53-64 year olds screened in 3 years	5754	81.4	80.3	53.8					89.3
	20 Breast: 65-70 year olds screened in 3 years	2322	81.8	79.8	51.7					88.3
	21 Cervical: 20-24 year olds screened in 5 years	215	9.6	6.6	0.0					30.2
	22 Cervical: 25-64 year olds screened in 5 years	20006	82.0	81.6	68.3					88.8
	23 Diabetic retinopathy screening	3123	93.9	92.4	76.5					99.7
Mortality	24 All age, all cause mortality (DSR)	2915	418	480	1136					277
	25 Under 75's, all cause mortality (DSR)	971	186	219	543					134
	26 All age, all circulatory disease mortality (DSR)	956	131	153	369					72
	27 Under 75's, all circulatory disease mortality (DSR)	234	45	52	163					17
	28 CHD mortality (DSR)	437	61	69	144					28
	29 Stroke mortality (DSR)	258	34	43	191					0
	30 COPD mortality (DSR)	111	15	20	65					0
	31 All age, all cancer mortality (DSR)	954	148	151	228					83
	32 Under 75's, all cancer mortality (DSR)	490	92	96	169					44
	33 Lung cancer mortality (DSR)	169	27	29	69					4
Hospital Activity	34 A&E first attendances (DSR)	3982	8311	7399	15761					3531
	35 Elective hospital admissions (DSR)	36768	11240	11162	20708					7292
	36 Emergency hospital admissions (DSR)	18904	5910	7450	14012					4853
	37 Hospital admissions for circulatory diseases (DSR)	3755	1031	1102	1898					698
	38 Hospital admissions for CHD (DSR)	1201	325	351	668					185
	39 Hospital admissions for atrial fibrillation (DSR)	490	133	123	273					12
	40 Hospital admissions for stroke (DSR)	390	99	112	253					40
	41 Hospital admissions for COPD (DSR)	370	98	121	396					18
	42 Hospital admissions for cancer (DSR)	6711	1974	1993	3277					948
	43 Primary hip replacement procedures (DSR)	284	77	91	165					35
	44 Primary knee replacement procedures (DSR)	348	92	93	208					39
	45 Cataract removal procedures (DSR)	1996	487	437	897					258
	46 Over 65 hospital admissions for fractured neck of femur	171	329	407	2529					104
	47 Over 65 hospital admissions for falls (DSR)	763	1502	1438	3457					790

5.1 Table: Limiting Long Term Illness and morbidity, 2001

Area	% of residents with a LLTI	Standardised Morbidity Ratio (95% Confidence Interval)	Rank in Hampshire for Standardised Morbidity Ratio
Hart	11.1	64.7 (63.4-66.0)	1/11
Hampshire	14.9	80.2 (79.8-80.6)	-

The Standardised Morbidity Ratio is based on the number of residents reporting LLTI, with the English average set at 100. Anything less than 100 is better than the England average. All districts in Hampshire had significantly lower levels of morbidity than the English average. At the time of the last census Hart residents had significantly lower rates of limiting long term illness than residents in Hampshire overall. We look forward to the data from the Census underway at present.

At a national level the Marmot Review into health inequalities¹, shows that people living in the most deprived neighbourhoods have about 21 years of disability at the end of their (shorter) lives compared to the 9 years of disability people living in the least deprived neighbourhoods have. People in more deprived neighbourhoods may not live as long, but these extra years of poor health put a disproportionate pressure on NHS services, and their funding. If the NHS increases life expectancy, but that extra life is not healthy, then NHS costs will increase.

Below are some examples of morbidity where data are available.

5.2 Dementia

Table: number of over 65s with dementia, projected trends from 2009 to 2030

District	2009 (rank)	2020 (rank)	2030 (rank)
Hart	902 (2/11)	1342 (2/11)	1929 (2/11)

Source: Projecting Older People Population Information (POPPI) www.poppi.org.uk

Hart is estimated to have the second lowest number of older people with dementia in Hampshire which is in keeping with it being the second smallest district. The number will increase considerably over the coming years as the district has a relatively young age profile compared to Hampshire as a whole.

5.3 Mental illness

QOF data covering schizophrenia, bipolar disorder and other psychoses show that GPs record Hart as having lower rates of severe mental illness than Hampshire overall, 0.4% vs. 0.6%.

5.4 Neurotic disorders

The Association of Public Health Observatories has estimated the rate of neurotic disorders (phobias, depression, anxiety, Obsessive Compulsive Disorder, and panic disorders) for Hampshire's districts.

Table: Estimated rates of neurotic disorders, and the number of residents who may benefit from IAPT

District	Rate of neurotic disorders per 1,000	Rank in Hampshire	Number of people in district suitable for IAPT
Hart	111.0	1	7,147
Hampshire	130.4	-	118,990

Hart has the lowest rate of minor mental health problems in Hampshire.

5.5 Suicide

By definition suicide is a cause of mortality. However it is included in this section on mental health problems as it is one of the few objective measures available for gauging the extent of severe mental health problems. Hart has the lowest rate of suicide which is significantly lower than that for Hampshire as a whole.

5.6 Dental decay in children

In Hart five year olds have an average of 1.1 (95%CI 1.0-1.2) DMFT.

Admission rates in older people for injuries from falls are just worse than the county median, though the admission rate for hip fractures is better than the county median. Hart has the lowest unintentional and deliberate injuries rate in Hampshire.

6. Lifestyle, and it's impact on local health

6.1. Vascular health related behaviour

Table: the impacts of smoking, alcohol, and obesity on health in Hart and how the NHS is responding

Lifestyle factor	Prevalence	Impact on local health
Smoking	<ul style="list-style-type: none"> - In 2003/5 the estimated prevalence was 16.0% (95%CI 14.0%-18.3%). - This was second lowest in Hampshire, and significantly lower than the national prevalence of 24.1% (95%CI 23.4%-24.7%). 	<ul style="list-style-type: none"> - In 2004/6 Hart had a rate of 169.8 deaths per 100,000 (directly standardised) that were attributable to smoking. - This was the 4th lowest rate in Hampshire. The overall Hampshire figure was 181.4 deaths per 100,000. - Hart had a death rate for lung cancer of 32.5 (95%CI 27.5-37.5) per 100,000 in 2006/8, the 4th lowest in Hampshire.
Alcohol	<ul style="list-style-type: none"> - Binge drinking. Hart had the 3rd highest prevalence in Hampshire in 2003/5, 16.4% (95%CI 14.2%-18.9%). - Hazardous drinking (more than sensible levels, but no health issues yet). In 2003/5 Hart had Hampshire's highest (sic) level of hazardous drinking, 22.0% (95%CI 20.1%-23.9%). This 	<ul style="list-style-type: none"> - Hart had the lowest male mortality from alcohol-specific conditions in 2004/6, 1.4 deaths per 100,000 (95%CI 0.0-3.4). - Female mortality from alcohol-specific conditions in 2004/6 was the 3rd lowest in Hampshire at 2.9 deaths per 100,000 (95%CI 0.1-5.7). - Hart had Hampshire's median alcohol attributable admission rate for men in 2006/7, 838.6 admissions per 100,000 (95%CI 757.7-925.7). The rate for women was the 4th lowest in Hampshire, 475.9 per 100,000 (95%CI 416.3-541.3). Both rates are significantly lower than the national average.

Lifestyle factor	Prevalence	Impact on local health
	<p>is higher than the national prevalence, 20.1% (95%CI 18.4%-21.8%)</p> <p>- Harmful drinking (more than sensible drinking, experiencing health problems). Hart had the 2nd lowest level in Hampshire in mid 2005, 3.4% (95%CI 3.0%-3.7%).</p>	
Obesity	<p>- In 2003/5 Hart had the 2nd lowest estimated prevalence of adult obesity in Hampshire, 20.4% (95%CI 18.4%-22.7 %).</p> <p>- Hart has the lowest 2nd prevalence of obesity in Year 7 in Hampshire. Between 2006/7 and 2007/8 the local prevalence of obesity increased slightly from 13.0% to 13.2%.</p>	<p>- There is no information on admission related to obesity, or obesity attributable deaths. However, there is information on obesity related to health behaviour.</p> <p>- In 2007/8 Hart had the highest proportion of adults doing at least 30 minutes of exercise at least 3 days a week in Hampshire after Hart, 28.4% (95%CI 32.3%-24.4%). Despite being relatively good this is still a disappointing figure.</p> <p>- Hart had the 3rd highest percentage of adults eating 5 portions of fruit and veg in 2003/5, 31.2% (95%CI 27.7%-34.8%).</p>

Data source for prevalence and impact on local health: Chapter 4 Lifestyle and risk factors.

<http://www.southamptonhealth.nhs.uk/publichealth/lhc/hantslhc2008/4lif/>

With the exception of deaths attributable to smoking. Data from JSNA pg. 89.

6.2. Cancer screening

Hart has the second highest uptake of breast screening in Hampshire and the highest uptake of cervical screening.

6.3. Sexual health

Information on sexually transmitted infections is not collected and hence not available at district level. However there is information on teenage pregnancies. Young people vulnerable to teenage pregnancy may have broader needs around improving their sexual health.

Table: Teenage pregnancy rates in 2006/8

Area	Pregnancy rate per 1000 in 15-17yr old females	Rank in Hampshire
Hart	19.8	1/11
Hampshire	32.7	-
England	40.9	-

Source: Under 18 conceptions data for LAD1 and LAD2 (all LAs inc. county councils, 2006/8)

Between 1998-2000 and 2006-2008 the rate of pregnancy in 15-17 year old females reduced from 21.0 per 1,000 to 19.8 per 1,000 meaning that in 2006-2008 Hart had the lowest teenage pregnancy rate in Hampshire.

6.4. Childhood immunisation

Table: Uptake of childhood immunisation

Locality	Coverage in 2 year olds (rank in Hampshire)*	Pre-school booster (rank in Hampshire)*
Hart	94.9% (1/11)	95.6% (2/16)
Range in Hampshire	86.7%-94.9%	82.9%-98.2%

* PMS practices excluded

Data from Purple Pages on Intranet: <https://datawarehouse.hampshire.nhs.uk/Pages/Immunisation.aspx>

Hart locality has high childhood immunisation coverage and the best in North East Hampshire. Immunisation coverage at 2 years is the highest in Hampshire, 94.9%, and pre-school booster coverage is the second highest in Hampshire.

7. Local health service provision

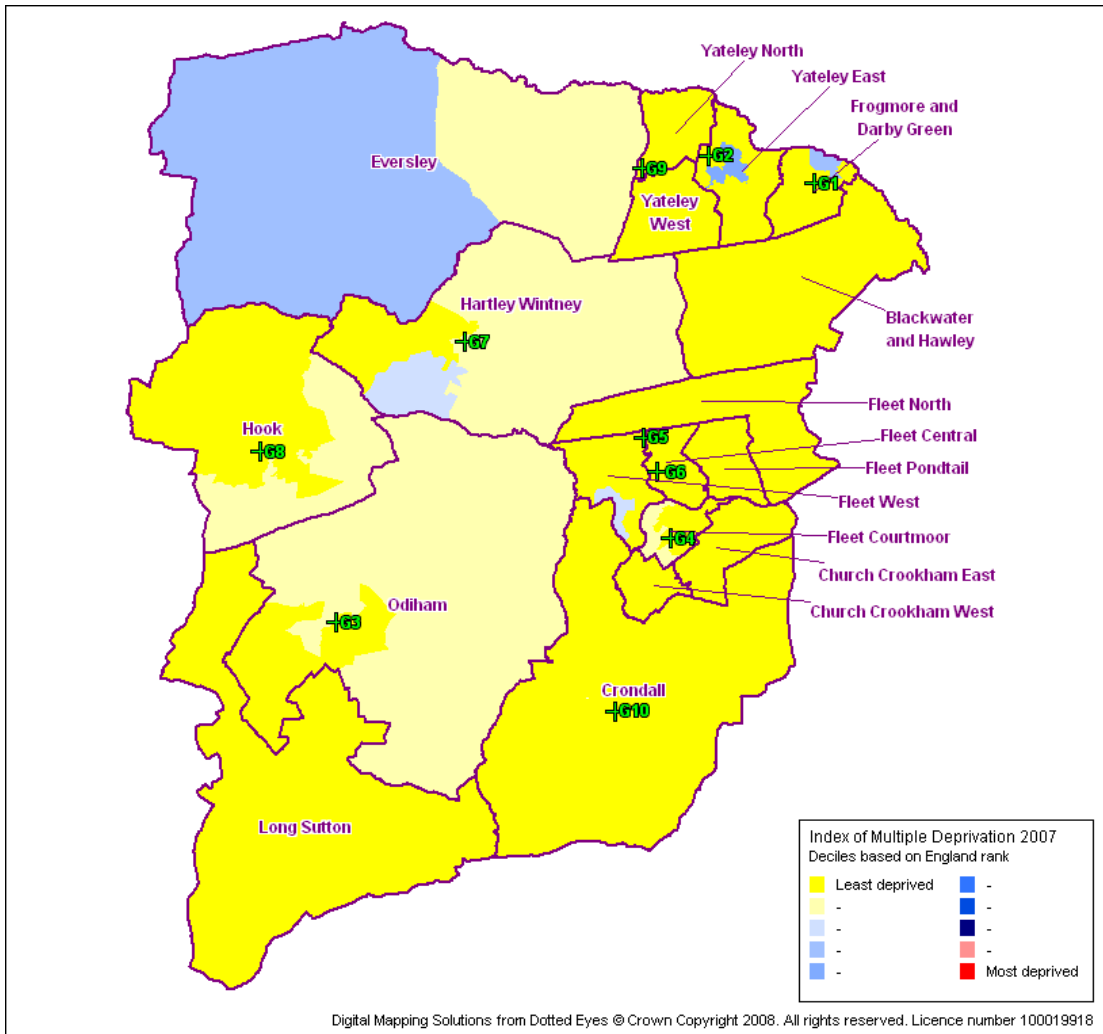
7.1 Acute Hospital services

The population of Hart mostly access either Frimley Park NHS FT or Basingstoke and North Hampshire NHS FT. Frimley Park takes 60.6% of Hart's elective inpatient spells. Basingstoke and North Hampshire NHS Foundation Trust take the next highest percentage, 22.2%. Portsmouth, Southampton and Winchester take 1.4% of elective inpatient spells between them leaving 15.7% of elective inpatient spells occurring in other hospitals. Use of acute hospitals by the population of Hart for planned admissions is greater than the national average and greater than the Hampshire average. Conversely hospital use for emergency admissions appears to be lower. This is particularly the case for planned and emergency use of cardiology services.

7.2 Community Hospitals

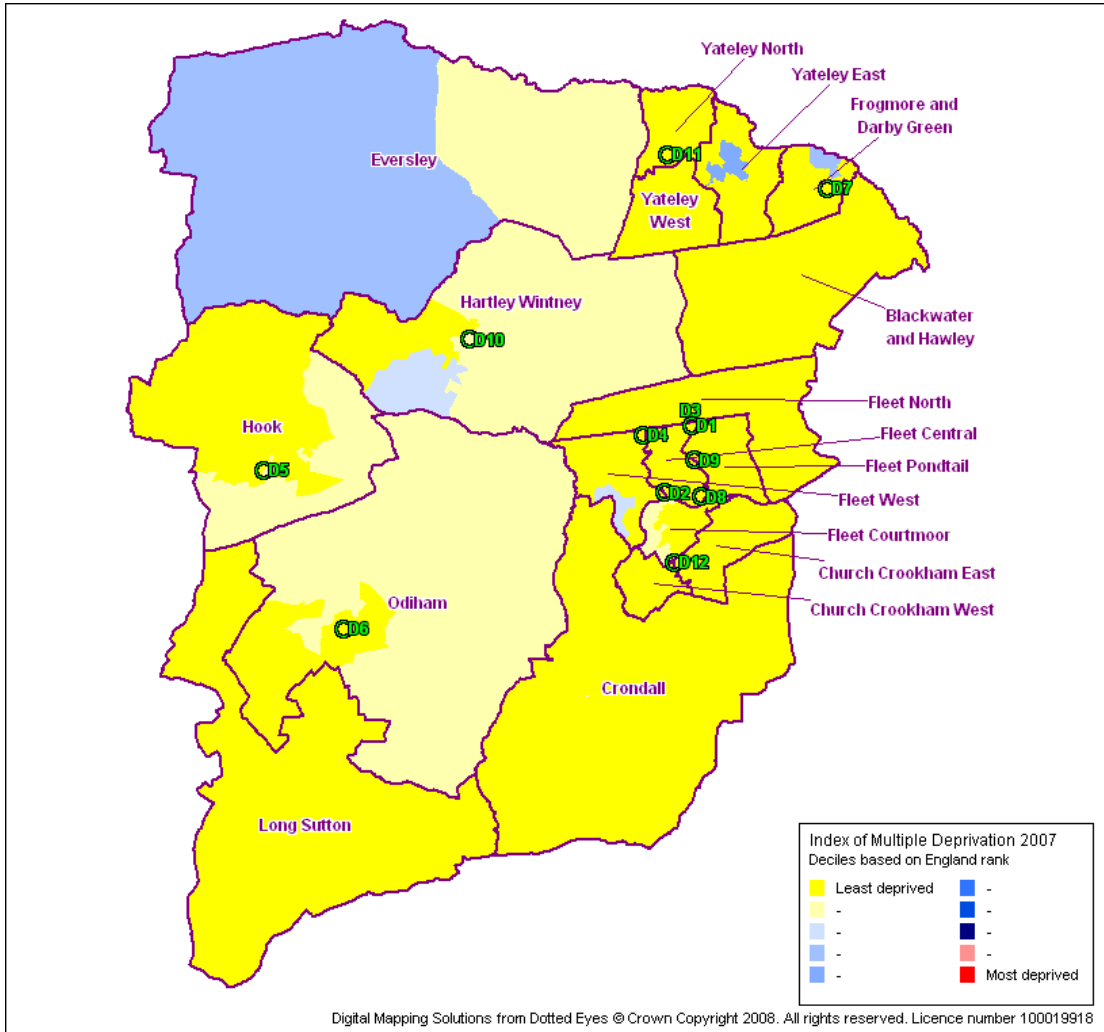
There is a cottage hospital in Buryfields, Odiham. The building is in an area that is in the least deprived decile nationally.

7.3 General practices



There are ten GP practices in Hart. Two are based in Fleet and one in Church Crookham, which are the areas of highest population density locally. The less affluent areas of Yateley are close to GP practices. However there is not a GP practice in Eversley ward, the west of which is the least affluent part of the district. Given the low population density in this ward this is probably appropriate.

7.4 Dentists



Hart has 12 dental practices, though these are less geographically dispersed than the district's ten GP practices.

Rushmoor	199 (11/11)	139 (8/11)	95 (3/11)	1768 (3/11)	139 (7/11)
----------	-------------	------------	-----------	-------------	------------

Source: Joint Strategic Needs Assessment 2008 (2002/3 to 2006/7) except cancer data from <http://www.southamptonhealth.nhs.uk/publichealth/lhc/hantslhc2008/> (2003/4 to 2007/8)

Given the low mortality rate and low estimates of disease prevalence in Hart it might be expected that admission rates were also low. This is the case for COPD (lowest admission rate in county), stroke (second lowest admission rate in county) and diabetes (fourth lowest admission rate in county). However admission rates for myocardial infarction are the third highest in Hampshire, and admission rates for cancer are also relatively high.

8.1 Emergency admissions

The National Clinical and Health Outcomes Knowledge Database (NCHOD) have used hospital (SUS) data to estimate emergency admission rates for conditions usually managed in primary care settings. Confidence intervals are wide for these numbers. However they are still useful. When assessed in conjunction with other information this data provide commissioners with some indication of whether the balance between primary care and acute care in an area could be improved.

Table: Emergency admission rates for conditions usually managed in primary care, 2007-8

Area	Acute condition admission rate* per 100,000 (95% Confidence Intervals)	Rank for acute condition admissions	Chronic condition admission rate* per 100,000 (95% Confidence Intervals)	Rank for chronic conditions
Hart	316.7 (280.2 - 356.8)	3/11	110.9 (90.2 – 134.9)	3/11
Hampshire	356.3 (346.3 – 366.5)	-	140.3 (133.9 – 147.0)	
England	426.7 (425.0 – 428.5)	-	178.4 (177.2 – 179.6)	

* Rate is indirectly standardised for age and sex to persons in 2005/6

Source: <http://nww.nchod.nhs.uk/>

Admission rates for acute and chronic conditions usually managed in primary care are significantly lower in Hart than is the case in Hampshire as a whole.

8.2 Emergency readmissions

Emergency readmission soon after being discharge from hospital can be entirely appropriate. However it may suggest that a patient was discharged too quickly, or that NHS support in the community was inadequate. Low readmission rates can be evidence of effective care pathways.

Table: emergency readmissions to hospital within 28 days of discharge, 2007/8

Area	Emergency readmission rate*, percentage (95% confidence intervals)	Rank for acute admissions

Hart	10.1 (9.3 – 11.0)	6/11
Hampshire	10.1 (9.9 – 10.3)	-
England	10.7 (10.6 – 10.7)	-

* Indirectly age and sex standardise to person 2003/4

Source: <http://nww.nchod.nhs.uk/>

Hart's emergency readmission rate, 10.1%, is the same as that of Hampshire overall.

9. Conclusions

In many ways Hart is an unusual local authority compared to others in Hampshire and nationally, mainly because of the great benefits it derives from its affluence.

- It is the least deprived local authority in England according to the Index of Multiple Deprivation 2007.
- It is the best place to grow up in England according to the Index of Child Wellbeing. The teenage pregnancy rate is now the lowest in Hampshire and uptake of childhood immunisation is amongst the best in Hampshire.
- In contrast to all other districts in Hampshire there are no areas in the lower half of the country for deprivation. Within the district, health inequalities are relatively low.
- Hart has the lowest overall mortality rate in Hampshire. At the time of the last census in 2001 it also had the lowest rate of self reported limiting long term illness.
- One of the important consequences of Hart's affluence is a change in patterns of mortality. Cancers have overtaken circulatory disease as the most important cause of death locally. The only other district where this has happened in Hampshire is Winchester. Affluence may protect people from premature mortality from circulatory disease, but leave them more exposed to developing cancer in old age.

Given the favourable socio-economic context in which most residents live the district council and its local partners should always aim to have the best health related outcomes in Hampshire. Being close to the county average for a health indicator should probably be seen as justification for improving a service. The constraint that public and third sector services always face in Hart is that the district is rarely seen as a priority for commissioners.

Given that there is always room for improving health and wellbeing the following could be considered as local priorities:

- Alcohol consumption. High levels of hazardous drinking and binge drinking may be related to relatively high levels of disposable income locally. Hampshire wide alcohol campaigns and services should be promoted locally.
- The early identification of cancer symptoms and increasing uptake of cancer screening. A national campaign for GPs relating to early identification is being developed by the Department of Health.
- The geographical distribution of primary care services. If there is ever a new GP practice, dentist or pharmacist in Hart they should be encouraged to locate in the rural west of the district.
- Dementia. Two thirds of residents with dementia in Hart are estimated to remain undiagnosed. Across Hampshire districts are facing a rapid increase in the number of residents with dementia. A county wide dementia strategy may be needed.
- Dental carries in children. Hart may be able to learn how to promote the dental health of children from districts with lower rates of tooth decay.

- Gypsies and travellers' health. Because Hart has the third highest caravan count in Hampshire there may be opportunities to run health improvement initiatives on authorised sites.
- More exercise and healthy eating. Even though Hart has the second lowest obesity rates for adults and children in Hampshire about two thirds of residents are not doing enough exercise or eating enough fruit and vegetables. Residents may be more receptive to health improvement messages in Hart than in more deprived districts.

Appendix Three Odiham Hospital Engagement
 March 2011



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Executive Summary

Background

Odiham Cottage Hospital is situated in north Hampshire and has served the residents of Odiham, Hartley Whitney and the surrounding area since it opened in 1910. It offers twenty-four hour registered nursing care, provided by Hampshire Community HealthCare, in twelve beds, providing both intermediate care and continuing care. The hospital is well supported by the local community. When it was at risk of closure in 1998, the local community formed the Odiham Cottage Hospital Redevelopment Trust. Following extensive, successful fundraising the Trust now owns and administers the site of Odiham Cottage Hospital.

In 2010 NHS Hampshire, who plans the healthcare services in Hampshire, received notice from Hampshire Community Health Care that they would not be providing inpatient care at Odiham Cottage after the end of July 2011.

This decision has been made because in order to provide safe services, “significant mitigation of clinical risk has to be made”¹. Difficulty in recruiting staff has led to high

agency staff usages, resulting in an unsustainable overspend on staffing costs; staff overspend was £45,543 at the end of month four, where the total overspend to that date was £46,346.¹

The resolution to no longer provide twenty-four hour nursing care at the hospital was taken following a period of engagement where all partner stakeholders acknowledged that it was inappropriate for services to continue in their current format.¹

As Odiham Cottage Hospital is highly valued and well supported by the local residents, NHS Hampshire asked Hampshire LINK to lead some impartial engagement; to gather their views on what the people would want from bed-based care in the area in the future, and what would be the best use of the hospital building. These views would then feed into plans for future healthcare options for Odiham, and the surrounding area.

Hampshire LINK was also asked to comment on the engagement process NHS Hampshire followed, to ensure as many people had the opportunity to comment as possible. The fact that 3,238 people took part in the initial survey and 3050 completed the additional question, most of which were returning respondents, shows that the engagement was widely publicised and in the LINK's view very effective. The Link could not think of any missed opportunity for engagement during this period. It is satisfied that NHS Hampshire had exhausted every avenue for the public to have their views heard and recorded. It looks forward to seeing the full report from NHS Hampshire in due course.

¹Odiham Cottage Hospital Communications & Engagement Plan October 2010 – April 2011

Engagement Plan

Hampshire LINK was asked to lead the engagement activity, following NHS Hampshire's engagement plan (see Appendix 1), to ensure that NHS Hampshire worked closely with the Odiham Cottage Hospital Charitable Trust, stakeholders and local residents to determine the future of healthcare in the area, especially those associated with the needs of people requiring bed-based care. As part of this process, options for the future of the Odiham Cottage Hospital building were to be considered.

Most comment was to be captured via the on-line survey. In addition feedback forms were made available at all drop-in sessions.

The Survey

A survey was posted on Hampshire LINK's website from 24th February 2011, running alongside public engagement events held in and around Odiham at different times of day:

- Odiham Health Centre - Monday 7th from 11am to 1pm
- Hook Health Centre - Tuesday 8th March from 10am to 12noon
- The Old School, Odiham - Wednesday 9th March from 2pm to 4pm
- Hartley Wintney Surgery - Monday 14th March from 10am to 12noon
- The Old School, Odiham - Monday 14th March from 2pm at 4pm

Surveys were also positioned in and around Odiham at:

- Off Licence
- Newsagent shops
- 'Friends of Odiham Hospital' shop
- GP Surgeries
- General Stores
- Pharmacies

all of these surveys were supplied with pre-paid freepost envelopes.

Summary of responses

- 3,238 people took part in the initial survey, of which 99.6% completed the whole survey, and 3050 completed the additional question.
- 88.6% of the respondents felt that they, or a member of their household, did not have a health need that could be better met.
- 8.5% were carers.
- 84.3% owned their own car, so were not dependent on public transport.
- Of the range of possible outpatient services, 68.9% wished there to be Physiotherapy services available in the Odiham area.
- Just over half, 58.3%, had never had any experience of Odiham Cottage Hospital.
- Only 10.6% of respondents were under 41 years of age, although across the population of Hart as a hole 20.8% of the population is unde16 years².
- 69.7% of respondents were women

² Hart Local Health and Inequality Profile, Robert Pears, Consultant in Public Health
29/1/10

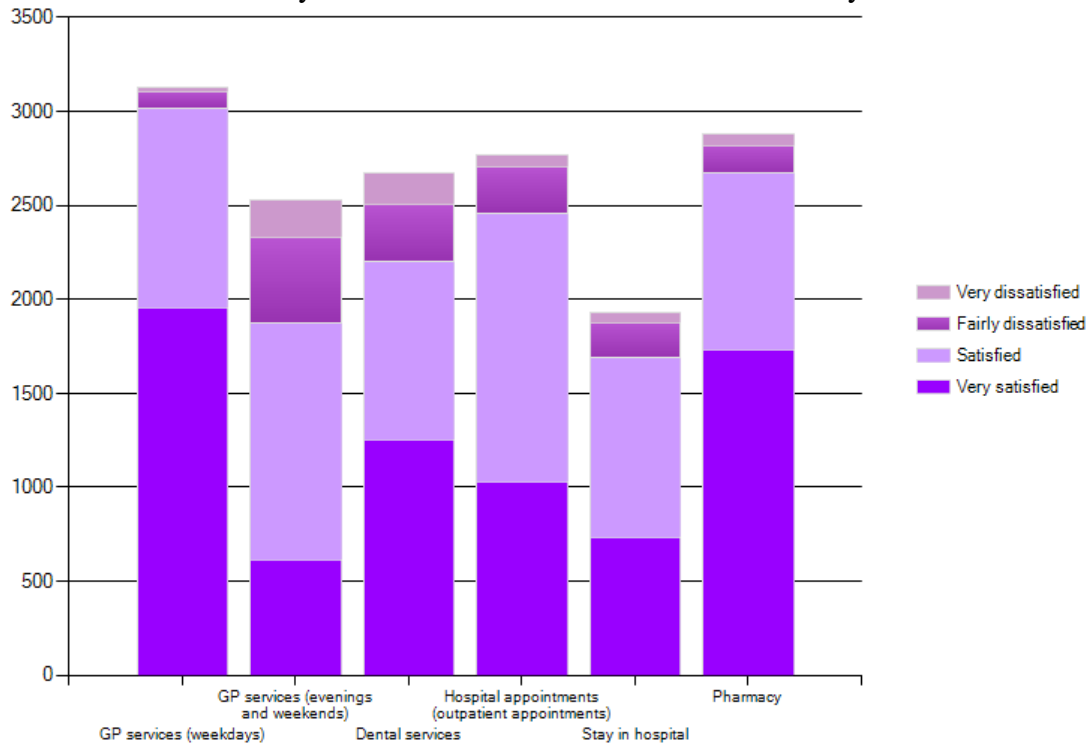
The survey consisted of seventeen initial questions, plus an additional question on the importance of access to five different services locally.

The questions had a variety of formats, depending on the style of question and some questions allowed for additional suggestions and information in free text.

The responses to the survey was as follows:

Question 1

Please tell us how satisfied you are with current healthcare services in your area.

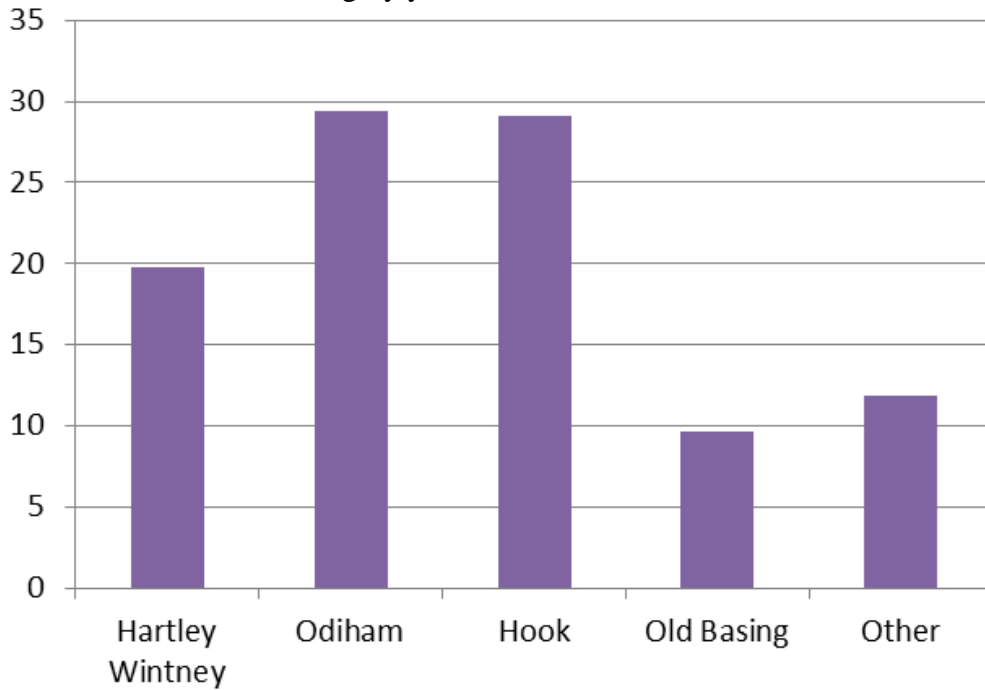


The vast majority of people are satisfied or very satisfied with current healthcare services. The percentages of people who answer satisfied or very satisfied are:

- GP services (weekdays) – 96.4%
- GP services (evenings and weekends) – 74%
- Dental services – 82.3%
- Hospital appointments (outpatient) – 88.6%
- Stay in hospital – 87.6%
- Pharmacy – 92.8%

Question 2

Please tell us which GP surgery you attend:



Question 3

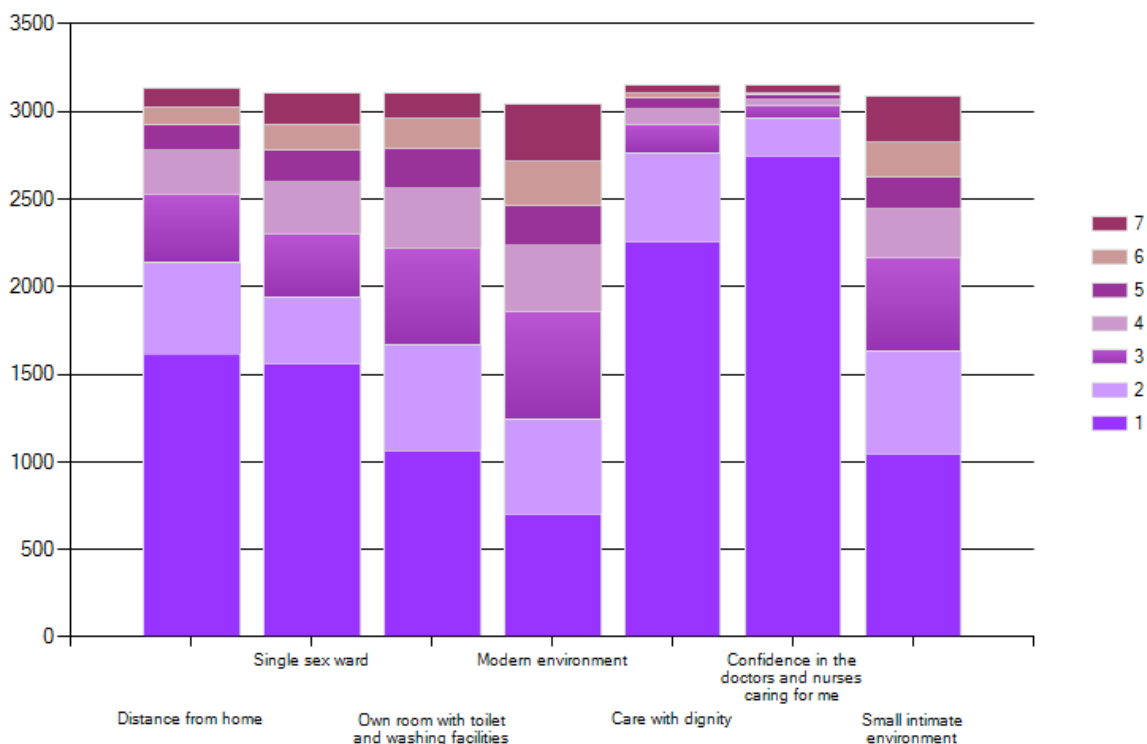
Do you (or a member of your household) have a health need that could be better met?
88% felt that their health needs were satisfactorily met

Question 4

Are you a carer for a member of your family?
Only 8.5% were carers.

Question 5

Sometimes when people have an illness or injury, they may need bed-based care either in a large hospital, community hospital or another facility, such as a nursing home. If you needed bed-based health care, what would be the most important aspects of this type of care to you? Please rank the responses below from 1 to 7 with 1 being the most important and 7 the least.



	1	2	3	4	5	6	7
Distance from home	% 51.4	% 16.8	% 12.5	% 8.1	% 4.6	% 3.2	% 3.4
Single sex ward	% 50.3	% 12.1	% 11.7	% 9.6	% 5.9	% 4.5	% 5.9
Own room with toilet and washing facilities	% 34.1	% 19.5	% 17.7	% 11.2	% 7.2	% 5.4	% 4.7
Modern environment	% 23	% 18	% 20.2	% 12.6	% 7.4	% 8.2	% 10.7
Care with dignity	% 71.7	% 16.2	% 4.9	% 3.0	% 2.2	% 0.9	% 1.2
Confidence in the medical staff caring for me	% 86.9	% 6.8	% 2.3	% 1.2	% 0.8	% 0.5	% 1.4
Small intimate environment	% 33.8	% 19.2	% 17.2	% 8.9	% 5.9	% 6.6	% 8.3

Question 5 (continued)

It is clear that care with dignity and confidence in the doctors and nurses caring for people has a very high priority with 71.7% and 86.9% respectively choosing this as their priority.

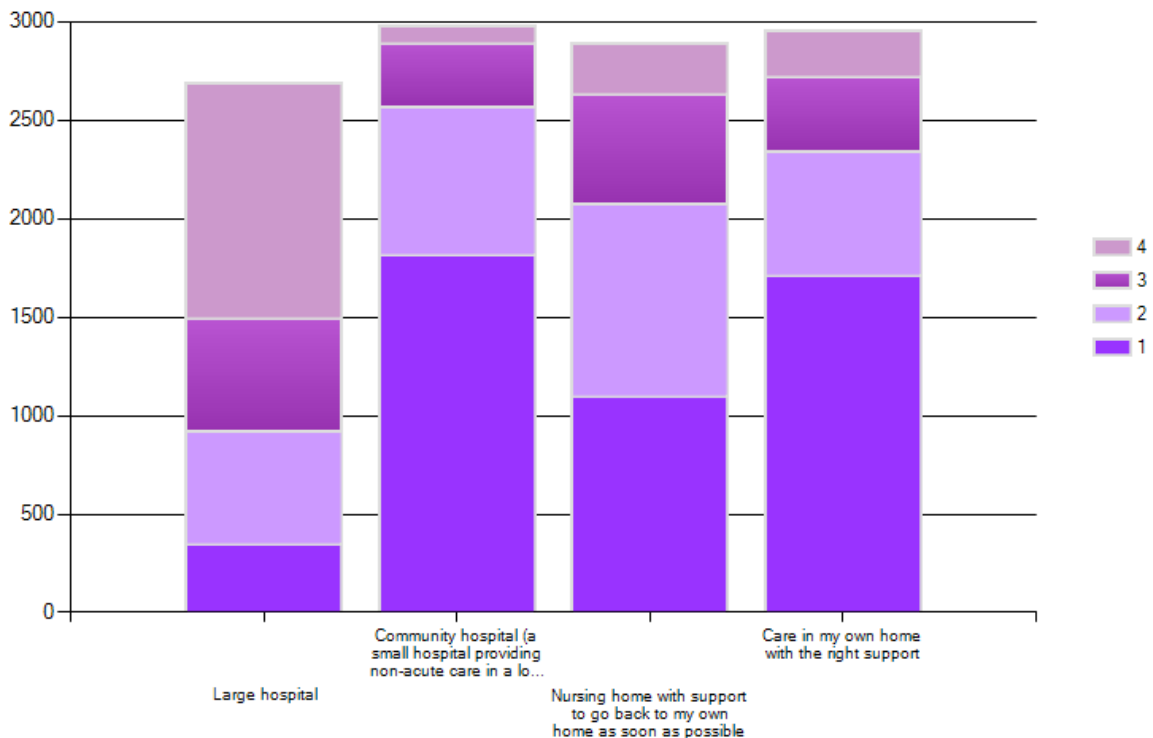
The second most important aspects were having your own room with toilet and washing facilities with 19.5% choosing this, and a small intimate environment with 19.2% rating this as the second most important aspect.

The third most important aspect was being in a modern environment with 20.2% selecting this. Interestingly, this was also the least important aspect with 10.7% rating this as relatively unimportant.

Question 6

Sometimes when people have an illness or injury, they may need bed-based care. This could be in a large hospital, a community hospital, a nursing home or in their own homes. If you had to do this, which of the following would be your preference as a patient?

Please rank the responses below in order of preference - with 1 being the most important and 4 the least important.



Question 6 (continued)

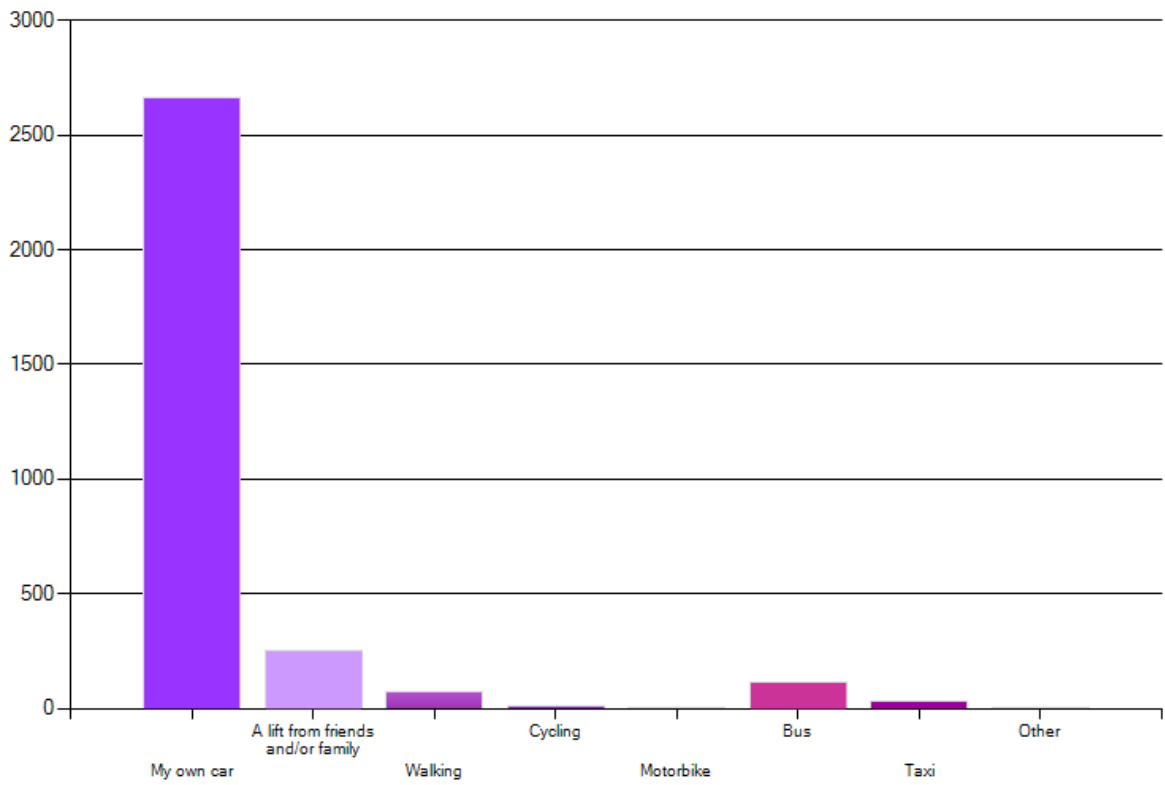
	1	2	3	4
Large hospital	% 13.2	% 21.4	% 21.1	% 44.4
Community hospital	% 61.1	% 25.4	% 10.8	% 2.8
Nursing home with support to go back to my own home as soon as possible	% 38.1	% 33.8	% 19.2	% 8.8
Care in my own home with the right support	% 58.1	% 21.6	% 12.8	% 7.5

44% of people would choose a large hospital as their last option of where they would like to be for bed based care, whereas 61% of people would put a Community Hospital as their first choice, followed by 58% preferring to be cared for in their own home.

Question 7

What would you consider to be a reasonable distance to travel for bed-based care?
56.2% felt that up to seven miles is reasonable, 39.6% were willing to travel up to ten miles and just 4.2% felt that a distance of over ten miles was acceptable.

Question 8



92% of respondents use cars as their usual form of transport, with 84% using their own cars and 8% having a lift from friends and/or family.

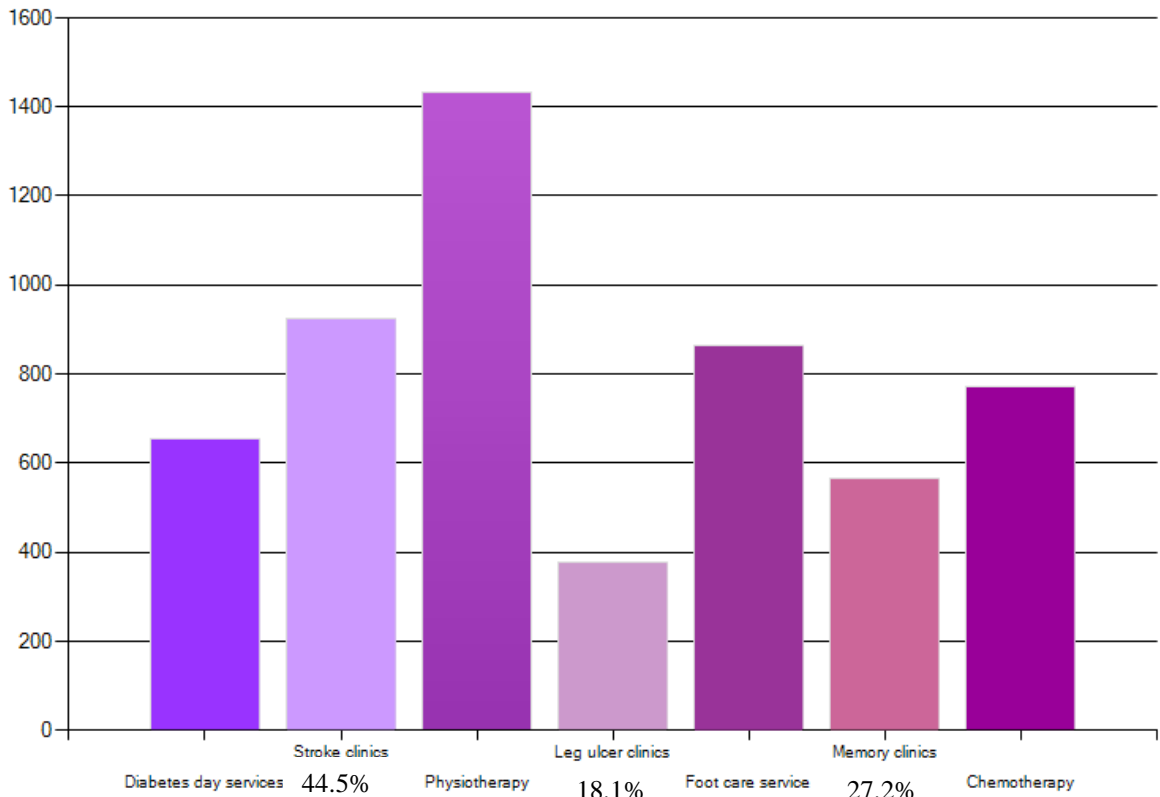
Question 9

Would you like to see additional outpatient facilities in the area?

79.5% of people responded “yes” to this question.

Question 10

If yes, are there any particular outpatient services you would like to see in the Odiham area?

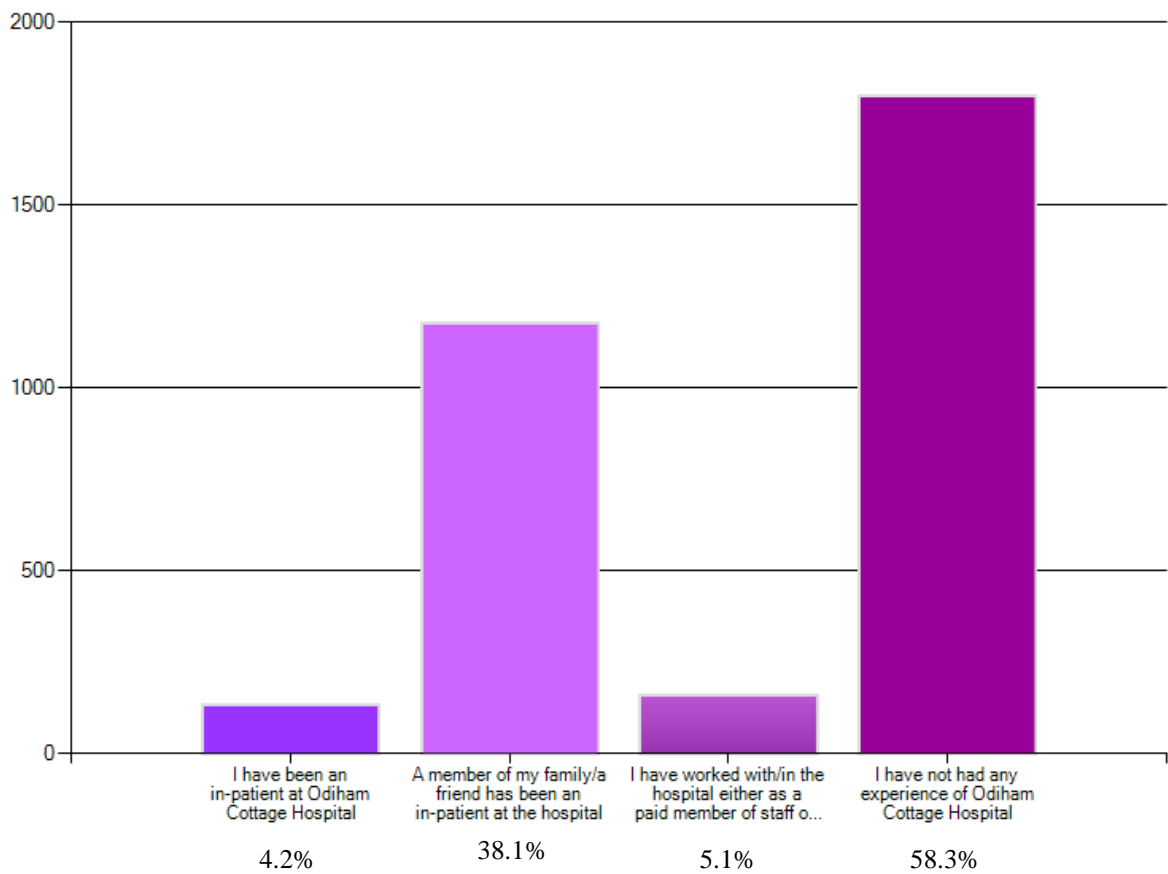


The above examples suggested 31.4%, 44.5%, 68.9%, 18.1%, 41.6%, 27.2% and 37.1% respectively, and more responded to...

- However other suggestions included:
- renal units/dialysis
 - weight clinics
 - x-ray
 - fracture clinic
 - dentistry
 - asthma clinic
 - drop-in centre

Question 11

Please tell us about your experience of Odiham Cottage Hospital



It is interesting that 58.3% have had no experience of Odiham Cottage Hospital, yet have taken the time to complete the survey and give their views.

Question 12

If you or a family member/friend have been an inpatient at the hospital, please tell us about your experience

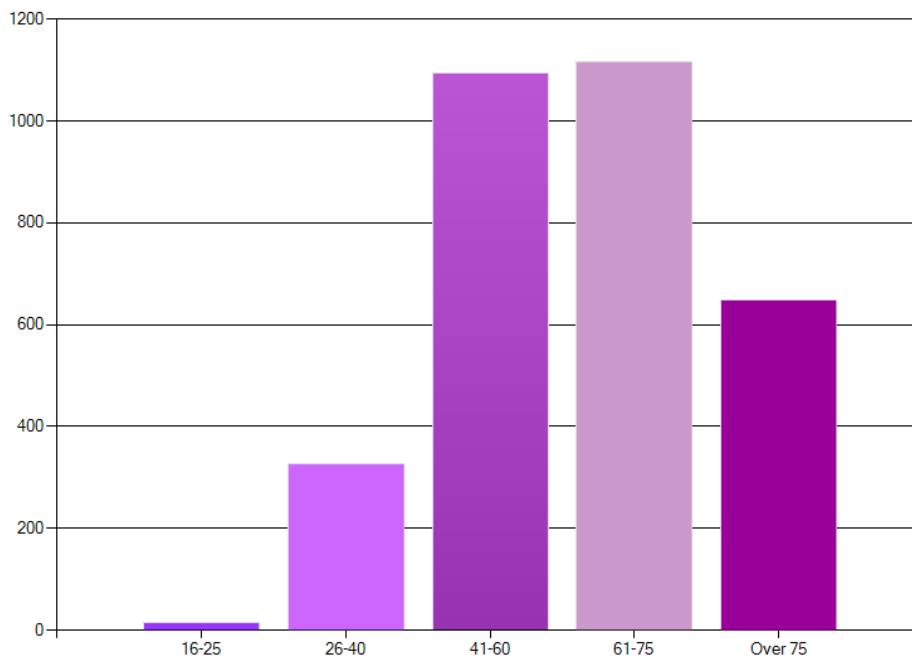
	Excellent	Good	Satisfactory	Poor
I have been an inpatient at Odiham Cottage Hospital	% 75.9	% 20.6	% 3.5	% 0.0
A member of my family has been an inpatient at Odiham Cottage Hospital	% 83.6	% 14.2	% 1.3	% 0.9
A friend has been a patient at the hospital	% 78.4	% 19.0	% 2.3	% 0.3

This question follows on from Question 11.

- 96% felt their own experience was Excellent or Good
- 97.4 rated their friend's experience as Excellent or Good
- 97.8% rated their family member's experience as either Excellent or Good
- 8.3% rated their experiences as an inpatient themselves, a friend's experience or that of a family member as satisfactory or poor

Question 13

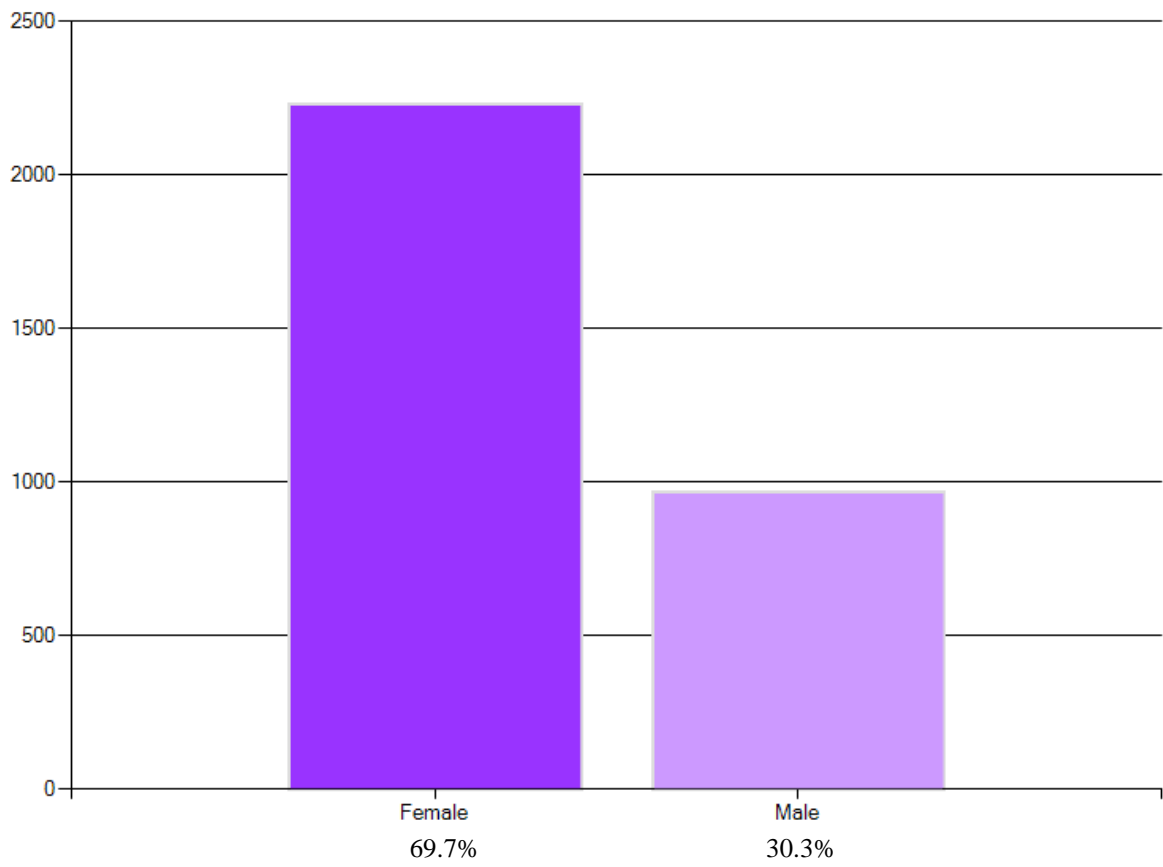
Please tell us your age



89.4% were over 40 years of age.

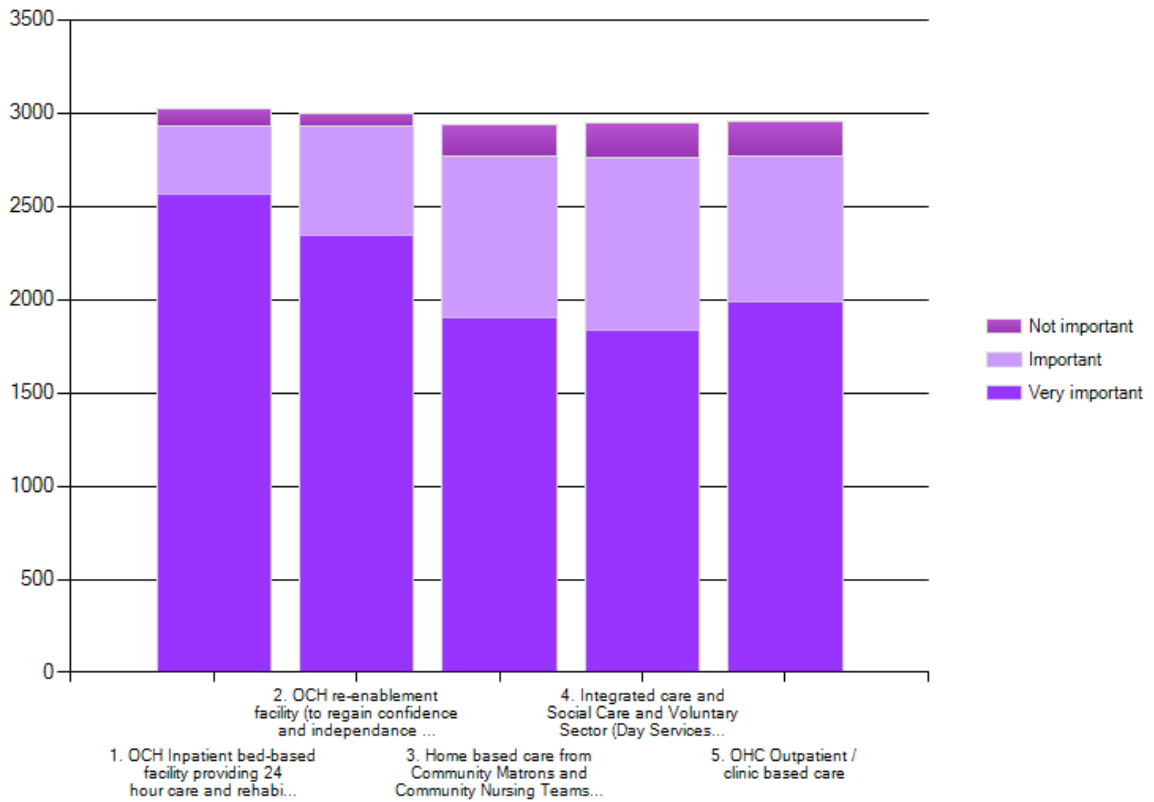
Question 17

What is your gender?



Additional Question

Please rate how important it is for you to have the following services locally?



	Very important	Important	Not important
OCH Inpatient bed-based facility providing 24 hour care and rehabilitation	% 84.9	% 12.1	% 3.1
OCH re-enablement facility (to regain confidence and independence for living at home)	% 78.3	% 19.7	% 2.0
Home based care from Community Matrons and Community Nursing Teams (Virtual wards)	% 64.7	% 29.6	% 5.7
Integrated care and Social Care and Voluntary Sector (Day Services at OCH)	% 67.2	% 26.6	% 6.2

Conclusions

Engagement process

Hampshire LINK were asked to comment on the process NHS Hampshire followed, to ensure that as many people as possible have had the opportunity to comment and have input into the future of services delivered from Odiham Cottage Hospital.

The fact that 3,238 people took part in the initial survey and 3050 completed the additional question, most of which were returning respondents, shows that the engagement was widely publicised.

People were also engaged at public drop-in workshop sessions and it became clear at these that feelings were running very high and a large number of people were angry at what they *believed* to be being proposed. This is supported by the statistic that 58.3% of people completing the survey had no experience of Odiham Cottage Hospital.

It would appear that people had not been in possession of the full facts that at no time was the service being removed, but the way the services are to be delivered needed to be discussed. When NHS Hampshire was given the opportunity to outline the facts, people were generally receptive to them. Negativity of a few had fuelled negativity in the community.

Comments such as

“Were do I sign?” (referring to a petition to save the hospital – received at a Hook GP surgery).

The LINK also witnessed personal attacks on an NHS Hampshire representative’s professionalism and integrity on more than one occasion at the drop in events. The LINK had to step in to bring discussion back to the matter at hand. It would like to compliment NHS Hampshire’s staff on the way she responded.

Clearly the service offered by Odiham Cottage Hospital is greatly appreciated by local residents and they are keen for it to continue to provide for the community beyond July 2011. One way this might be possible is by using the building to accommodate a drop-in centre which could offer a range of services.

Conclusions from the survey

Satisfaction with healthcare services

The percentage of people who answered satisfied or very satisfied with their GP services were:

- GP services (weekdays) – 96.4%
- GP services (evenings and weekends) – 74%

The percentage of people who were satisfied or very satisfied with other healthcare services were:

- Pharmacy – 92.8%
- Hospital appointments (outpatient) – 88.6%
- Stay in hospital – 87.6%
- Dental services – 82.3%

Health needs

- 88% felt their health needs were satisfactorily met
- 8.5% were carers for a member of their family

Important aspects of bed-based care

- First most important –
 - having confidence in the medical staff – 86.9%
 - Care with dignity – 71.7%
- Second most important –
 - Own room with toilet and washing facilities – 19.5%
 - Small and intimate environment – 19.2%
- Third most important –
 - Modern environment – 20.2%

Preferences for where your bed-based care should be:

- Most preferred was Community Hospital – 61.1%
- Second most preferred was Care in your own home with the right support - 58.1%
- 44% of respondents ranked a large hospital as their least preferred location for bed-based care

Travel

- 56.2 % felt that travelling up to seven miles is reasonable
- 39.6% were willing to travel up to ten miles

- 4.2% felt that a distance of over ten miles was acceptable.
- 92% use cars as their usual form of transport
 - 84% own their own car
 - 8% have lifts from friends and/or family

Additional Outpatients facilities

- 79.5% said they would like to see additional outpatients facilities
- The most popular services selected from suggestions listed in the survey were:
 - Physiotherapy – 68.9%
 - Stroke clinics – 44.5%
 - Foot care – 41.6%
- Other services that were suggested by 314 respondents were:
 - Renal units/dialysis
 - Weight clinic
 - Radiology
 - Fracture clinic
 - Dentistry
 - Asthma clinic
 - Drop-in centre

Experiences of Odiham Cottage Hospital

- 58.3% had no experience of Odiham Cottage Hospital
- 4.2% had been inpatients themselves
- Over 96% rated their experiences as an inpatient themselves, a friend's experience or that of a family member as Excellent or Good
- 8.3% rated their experiences as an inpatient themselves, a friend's experience or that of a family member as satisfactory or poor

Age and gender

- 89.4% were over 40 years of age
- 69.7% were female

Appendix 1

NHS Hampshire Phase 2 Engagement Plan

Activity	Details	Key dates	Person/organisation responsible	Additional notes/information
Create survey on local health services	To be created as an on-line survey (can also be printed and used in face to face interviews)	Survey agreement by Friday 11/02/11 Amendments made Monday 14/02/11 Survey to go live on Tuesday 15/02/11	NHS Hampshire (to be reviewed by locality stakeholder group) Survey then to be run by Hampshire LINK – mainly through face to face interviews at drop in sessions	Survey explores local views on health care/bed-based care as well as gathering views on what the hospital building should be used for in the future
Stakeholder Workshop	Workshop for parish, district, and county councillors, local MPs, local GPs, hospital trustees, League of Friends volunteers	Workshop to be held		
Drop-in sessions for members of the public	Minimum of six drop-in sessions at locations in and around Odiham	Drop-in sessions to commence week of 21/02/11	Hampshire LINK with NHS Hampshire	Members of the public will be encouraged to complete a paper version of the survey
Web pages	Web copy to be added to NHS Hampshire and Hampshire LINK websites – to highlight drop-in sessions & link to on-line survey	Web copy to go live Tuesday 15/02/11	NHS Hampshire to produce web copy	Web copy can be made available to Odiham Parish Council, Odiham Cottage Hospital and surrounding parish councils (key parishes = Hook, Greywell, Hartkey Wintney, Dogmersfield, Crookham Village, Long Sutton and South Warnborough)
Storyboards	Story boards to be used at drop in sessions in and around Odiham	Copy & images selected by 11/02/11 Boards to NHS Creative by Tuesday 15/02/11 To be ready by 22/02/11 at latest	Hampshire LINK/NHS Hampshire	

MP briefing paper	Initial briefing paper to be ready for start of engagement period	MP briefing to be ready by Tuesday 15/02/11	NHS Hampshire	Briefing paper to give background and next steps
Staff updates	Update on engagement activity (including dates and venues of drop-in sessions etc)	Staff update to be ready by Thursday 17/02/11	Information to be provided to HCHC by NHS Hampshire Staff briefing to be drafted and delivered by HCHC	
HOSC briefing	HOSC meeting on March 29, 2011		MM for NHS Hampshire	To include <ul style="list-style-type: none"> • Health Needs Assessment/ • Initial survey feedback • Report on all engagement activity
Journalist briefings	Meet with reporters from Basingstoke Gazette and Basingstoke Observer	Tbc (week commencing 14/01/11)	NHS Hampshire (Mel & Sarah)	At start of engagement & to report initial findings from the survey
Produce stakeholder update newsletter	First newsletter to be issued at start of engagement – identify drop-in session dates and point to on-line survey	Friday 18/02/11 or Monday 21/02/11	Hampshire LINK	Copy to be agreed with NHS Hampshire
Update website with survey responses	Report findings of survey on website of NHS Hampshire and Hampshire LINK	From Monday April 04, 2011	NHS Hampshire	Advice all database members (via email) that survey findings are live on website
On-line survey to be sent to members of Hart District Council's Citizens' Panel	Can be chosen according to postcode of panel members – allowing selection of only those members in Odiham and the surrounding areas	From Monday February 21, 2011	Hart District Council	On line survey to be emailed with a return by date

Hartlife article	Hartlife is available on-line as a resident's e-zine.	Copy deadline Feb 20, 2011. Publication date tbc	NHS Hampshire to provide copy	Article to advise residents of how they can get involved in the engagement process
Promote drop-in sessions via Hart District Council	Sessions to be advertised on the events page of Hart District Council's website	Copy promoting the events to be sent to Hart District Council by Friday 18/02/11	NHS Hampshire to provide copy	List of drop-in sessions
Article for Parish newsletter	Advise that the engagement will run between 15/02/11 and 25/03/11	Copy deadline 09/02/11	NHS Hampshire to provide copy	Article to advise residents of how they can get involved in the engagement process
Schools newsletters	Buryfields Infants Mayhill Junior Robert Mays Secondary Lord Wandsworth College	Send information to school secretaries or receptions	NHS Hampshire to provide copy	Article to advise residents of how they can get involved in the engagement process

Appendix four

Outline of the Development of the Hybrid Model for Odiham Cottage Hospital

The following is a brief outline for discussion of the Hybrid Model for the Odiham Cottage Hospital following the dialogue undertaken at the Hart Locality Stakeholder Group meetings on the 15th April and the 18th April. The idea for the Hybrid Model was to take the present five options that have been consulted upon listed below and combine these in a manner which would provide and comprehensive local service. Focusing mainly on the combination of options 1, 2 and 3

- Option 1 – In patient bed based model with 24/7 nursing and rehabilitation
- Option 2 – Reablement services
- Option 3 – Home based care from Community Matrons/Virtual wards etc
- Option 4 – Integrated care with social care/voluntary sector
- Option 5 – Outpatient/ clinic based care

It was also suggested that if it would aid in the continuance and further development of the services to the Odiham and Hart area, if admission to the hybrid service could be offered to the total Calleva GPCC catchment area and if capacity allowed to other local GPCCs.

Developing the Hybrid Model could give the opportunity to implement with a local interpretation the wider emerging model for care of patients in the community,

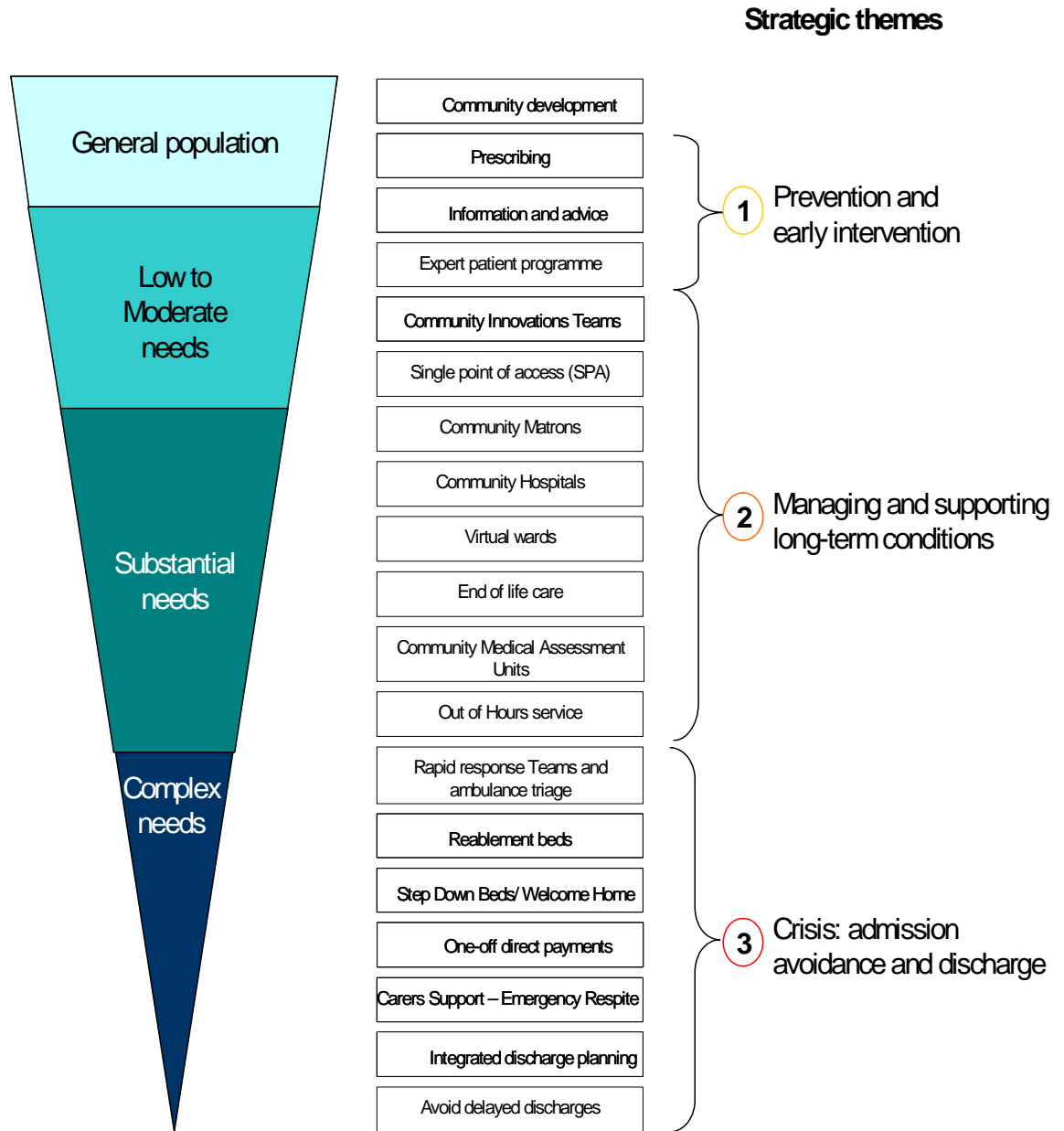
particularly those with a long term condition (LTC) and older people, being developed elsewhere in NHS Hampshire and particularly within the Calleva GPCC.

The diagram in appendix one suggests the menu of services that need to be available for a defined population and as can be seen the elements of the hybrid model are included within this. This menu of service needs to be accessed by a single point of referral (SPR). A pilot to accomplish this is being trailed by HCHC in Hart and Rushmoor. It is expected that this is to be rolled out to the Calleva area in the summer of 2011. The model also depends on good joint commissioning arrangements with Hampshire Social Services. Discussions are being held between Calleva and HSS to develop these, building on these at present in place with Hampshire PCT. The effect of the jointly commissioned services should be the greater integration and joint provision of the service within the menu by all the individual providers.

The hybrid model will explore the availability of the menu of service in the Hart Locality, their present cost and resource and suggest ways in which greater integration and joint provision of these services by all the individual providers can be accomplished, concentrating initially on those suggested in the consultation options. The relationship and cooperation of some of these services with those in other catchments areas will also be examined in particular the provision of health and social service community beds.

Another opportunity within the hybrid model that may be able to be developed using the Odiham Cottage Hospital beds is to use it as the hub for the some of the community service required. This may allow a flexible team of nurses and other therapists supported by local GPs to outreach from the hospital but use the hospital provision to undertake care on a day stay basis or if needed an overnight stay as and when clinically required. This will need to be aided by a clearer understanding gained from local clinicians as to the type of patients that would be able to take advantage of this flexible approach and defined clinical protocols to support the care.

It is hoped this short paper provides an insight into the work to be undertaken in developing the hybrid option and gives a vehicle to gain initial comment from the stakeholder group.



**Appendix Four: East Hampshire Community Hospitals redevelopment:
HOSC update. 24 May 2011.**



**Hampshire Health Overview and Scrutiny Committee
Update on 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 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 recent £125,000 refurbishment to improve facilities. This has provided a brand new physiotherapy department which opened to patients in mid April.

Chase Community Hospital Engagement Update

Further to the ongoing engagement work with Chase Community Hospital Stakeholder Group a period of discussion with local people commenced on May 16. This is to seek local views about how to develop the right services on the hospital site and make sure local people have appropriate access to high 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 a set of options about providing the right set of services to meet local needs in the future. This process ensures stakeholder feedback informs these options. The options can then be discussed in a second round of engagement.

A Communications and Engagement Plan has been developed and approved by the Chase Hospital Stakeholder Group.

At its last meeting, the last Chase Hospital Stakeholder Group was shown draft information stands and a draft survey. Both were discussed in detail with members, including Cllr Carew and Cllr Wain, making comments about the details in both documents. All of the feedback was incorporated into revised versions which were shared with the group by email. Subsequent comments were received from four members

including Cllr Carew and Cllr Wain and this feedback has been used to produce the final versions.

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 of online survey supported by five drop-in sessions for the public. A number of venues have been identified and agreed with the Chase Hospital Stakeholder Group. The sessions (detailed below) are being held at various times to ensure local people can attend. Members of both the Project Team and Chase Hospital Stakeholder Group will attend the sessions.

- Thursday, May 26 from 1pm to 5pm at Tesco Express, Liss
- Saturday, May 28 from 10am to 2pm outside Bordon Care Shop
- Wednesday, June 1 from 4pm to 7pm in Liphook Millennium Hall
- Wednesday, June 8 from 10am to 2pm in Forest Community Centre, Bordon
- Thursday, June 16 from 4pm to 7pm in The Woodlark Pub, Bordon

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's website.

The engagement period, sessions and how to get involved have been widely publicised and publicity activities included:

- Sending posters directly to a wide range of stakeholders and local groups
- Distributing a press release to the local media
- Highlighting the sessions on NHS Hampshire and East Hants District Council's websites

- Asking Whitehill Town Council to promote the sessions online
- Asking local schools and colleges to promote the sessions to parents.

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 options that will be tested in a second round of engagement.

Additional documents

The following documents accompany this update:

- Communications and Engagement Plan
- Information stands artwork
- Drop-in sessions poster
- Engagement survey
- Engagement period press release



Chase Community Hospital Communications and Engagement Plan

Introduction

Engagement has been occurring around the future of Chase Community Hospital services for the last three years. A representative stakeholder group has been meeting during this time and has been discussing potential service options.

A period of discussion with local people will now commence to seek local views about how to develop the right services on the hospital site and make sure that people have access to the highest quality bed based care.

Background

Chase Community Hospital is based in Whitehill and Bordon, a town with a high population of military families, and a growing population of young people and families. Whitehill and Bordon is the second biggest town in east Hampshire and is currently looking to develop as an eco-town. Transport links in the local area are poor and there is a higher rate of deprivation than the nearby towns of Alton and Petersfield.

Chase Community Hospital currently provides a range of services including:

- 12 inpatient beds (8 currently in use)
- A range of outpatient clinics
- Antenatal classes
- Leg ulcer clinic (due to be launched in March 2011)

The site is also a base for:

- Chase Day Centre
- Pharmacy
- Thames DOC Out of Hours
- Youth Service

There is also a refurbishment taking place in the Outpatient Physiotherapy department at the hospital, which will see a brand new reception area and some disused rooms reopened to accommodate the increasing number of local people using the service.

The inpatient ward at the hospital provides three types of care:

1. 'Step up' admission avoidance
2. 'Step down' rehabilitation following an admission to an acute hospital
3. End of life care for patients who choose to die in a community hospital setting.

In the last three years there has been a significant reduction in the average length of stay for inpatients. In 2007 the average length of stay for an inpatient admission was 36 days. This has now reduced by around 30% to approximately 20 days. Occupancy rates also vary throughout the year from 92% down to 58%.

The provision of routine only diagnostic tests and the absence of round the clock medical cover at community hospitals limits the range of patients that can be cared for safely and appropriately. Therefore patients with more complex needs do not meet the clinical admission criteria for a community hospital and need to be treated elsewhere.

In addition Hampshire Community Health Care has been working to develop services that allow patients to return home as soon as possible which avoids unnecessary stays in hospital. Early supported discharge services have been introduced to support this. Community nursing and therapy staff now also work together in integrated teams and provide assessments and care in patients homes. The teams are able to respond to someone in crisis at home within one hour and are able to support them to remain at home until they regain independence and avoiding admission to hospital, including a community hospital.

The changes in the needs of patients and the ways in which healthcare staff can support their needs in their own homes means that current inpatient services at Chase Community Hospital are underutilised.

In contrast newly developed services that provide assessment and treatment for patients with long term conditions have seen an increase in demand. The Rapid Assessment Service at Chase Community Hospital provides treatment for patients with long term conditions. In addition medical advances means patients can now receive the treatment they need, such as blood transfusion and intravenous therapy, as a day case instead of needing to be admitted to hospital.

These popular and cost effective services have traditionally been fitted into small areas on the wards where the beds are not currently open. This means that there are often inadequate clinical and waiting room facilities that do not meet current privacy and dignity standards. The hope is to develop these services more in the future by reducing the need for inpatient beds.

Purpose

The purpose of this communication and engagement plan is to:

- Ensure engagement regarding services at the hospital occurs before future options are developed 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.
- Ensure that there is an open, clear, consistent and co-ordinated approach to informing and involving stakeholders in the review of future services at Chase Community Hospital.
- Outline how the views and ideas of service users and stakeholders will be heard and acted upon.
- Establish the process by which key communications messages are agreed by all agencies.
- Proactively manage media interest in the project to protect and enhance the reputation of each organisation.
- Ensure the need to meet statutory duties to involve (Section 242 NHS Act 2006) is met and/or exceeded and that we are compliant with equality legislation.
- Ensure all activities comply with the Secretary of State's four tests:
 - Support from GP commissioners
 - Strengthened public and patient engagement
 - Clarity on the clinical evidence base
 - Consistency with current and prospective patient choice
- Ensure compliance with the Hampshire Health and Overview Scrutiny Committee Framework.

Stakeholders/Audiences

The critical stakeholders/audiences for this plan are:

Internal

- NHS Hampshire Management Board
- Hampshire Community Health Care Board
- HCHC staff/JCNC
- South East Hampshire APAC Chair
- PBC locality leads
- Emerging GPCC leads
- Local GPs

External

- Town, District and County Councillors including Cllr Adam Carew
- Damian Hinds MP
- Whitehill Town Council
- East Hampshire District Council
- Health Overview and Scrutiny Committee
- Chase Hospital Stakeholder Group
- League of Friends – Yvonne Parker-Smith
- Pinehill PPG
- Hampshire LINK
- Local media – Bordon Herald
- Hampshire County Council Adult Services Department – Gill Duncan
- East Hants District Council Health Lead
- SCAS – patient transport services
- Hampshire Partnership Foundation Trust
- South Central Strategic Health Authority
- LMC/LPC/LDC/LOC
- Voluntary sector organisations including Age Concern, Community First and Whitehill and Bordon Community Association
- Local schools, colleges, play groups and Childrens Centre
- Whitehill Bordon Opportunity Community Facilities and Amenities Specialist Group (covering the health aspect of the Whitehill Bordon Eco Town project)

The majority of the above stakeholders sit within the Chase Community Hospital Stakeholder Group.

Communications and engagement activity

Engagement with Chase Community Hospital stakeholders began three years ago to begin to discuss how different services could be developed. This now needs to be taken forward to provide structured discussions around Chase Community Hospital inpatient and outpatient services as a whole. The combined feedback can then be used to inform the development of a set of future options working with the stakeholder group.

These options can then be tested in a second round of engagement to determine which will be the best option for patients in the area.

East Hants District Council will be in Purdah from March 24 to May 5 so the engagement period will start on Monday, May 16 and run until Friday, June 24.
 Dates in the chart below are subject to change.

Activity	Details	Key dates	Lead	Additional notes
Develop a stakeholders database	Database of contact dates	Ongoing	EH	
Web pages	Web copy to be added to NHS Hampshire to highlight drop-in sessions and link to on-line survey	Complete	EH	
	Produce report findings of survey and publish on website of NHS Hampshire	By July 8	EH/GH	Advice all database members (via email) that survey findings are live on website
Develop survey on local health services, current hospital surveys and potential future services	To be created as an on-line survey (can also be printed and used at drop in sessions)	Complete	EH with Chase Community Hospital Stakeholder Group	Deadline for comments Friday, June 24.
	Update website with survey responses from hard copies received	Ongoing from May 16	EH	
Develop and produce storyboards	Story boards to be used at drop in sessions in and around Bordon	Complete	EH with Chase Community Hospital Stakeholder Group	
Hold two Stakeholder Workshops 1. Clinicians 2. Stakeholders	Workshop for local GPs and clinical staff	15/06/11	GH/JG	

	Workshop for town, district, and county councillors, local MP, local GPs, League of Friends, etc	TBA	GH/JG	
Organise drop-in sessions	Five drop-in sessions at locations in and around Bordon	Ongoing	EH with Chase Community Hospital Stakeholder Group	Members of the public will be encouraged to complete a paper version of the survey
	Ask Hampshire LINK to attend the events	Complete	EH	
	Book a variety of venues on different days and times	Complete	EH	Venues to be discussed with Chase Community Hospital Stakeholder Group
	Details of drop-in events to be shared with Chase Community Stakeholder Group	Complete	EH	Group members invited to attend drop-in events

	Take hard copies of online survey to sessions	Print copies	EH	
Briefings	Briefing to HOSC meeting on March 29, 2011	Complete	EH	To include <ul style="list-style-type: none"> • Health Needs Assessment • Report on planned engagement activity
	Brief MP	Complete	EH/GH	Briefing to give background and next steps
	Brief reporters from Bordon Herald and Bordon Post	Complete	EH	
	Brief stakeholders	Complete	EH	Briefing to give background and next steps
	Update briefing to HOSC meeting on May 24, 2011	Papers submitted	EH	To include update on planned engagement activity
	Attend the Whitehill Town Council Community Facilities and Amenity Specialist Group	Complete (May 20, 2011)	GH/EH	

	Update briefing to HOSC meeting in July	Papers to be submitted one week before	EH/GH	
Promote drop-in sessions, online survey and how to get involved in the engagement process	East Hants District Council website (easthampshire.org)	Complete on May 16	EH	
	Digital units in town centre	Complete	EH	Drop-in poster artwork used Displays in Forest Community Centre, Bordon Care Shop and Phoenix Theatre
	Whitehill Town Council's website	Complete	EH	
	Poster and article to be sent to local groups for websites, newsletters and noticeboards	Complete	EH	
	Poster and article sent to local schools, college and Childrens Centre for websites, newsletters and noticeboards	Complete	EH	
	Posters sent to local GP practices	Complete	EH	
	Posters sent to seven local pharmacies	Complete	EH	
	Posters sent to leisure centre, library and three local halls	Complete	EH	
	Press release issued	Complete	EH	
Staff	Update on engagement activity (including dates and venues of drop-in sessions etc)	Complete	EH	To be in NHSH and Southern Health staff updates
	Briefing session for inpatient services staff	Ongoing	Lesley Munroe	Staff regularly briefed

Key Messages

The success of this project will depend on multi-agency partnership working and consistently following agreed messages. These are:

- We want your views on how to develop services at Chase Community Hospital
- Your views will be taken into account when planning services
- We have been working with representatives from the local community
- Local GPs and clinicians are at the heart of discussion about future service development
- Health services to meet the clinical needs of the local population

Communications Protocol

- All communications will be shared with Richard Samuel, Sara Tiller, Dr Barbara Rushton and Gill Harrison for comment prior to publication/distribution
- All communications will reinforce the agreed key messages within the storyboards
- All staff enquiries will be referred to [WHO]
- All media enquiries/approaches will be referred to the NHS Hampshire Communications and Engagement Team. Subsequently, those people identified to talk to the media about the project are:
 - Richard Samuel

Evaluation

The effectiveness of the communication and engagement plan will be evaluated as part of the post project evaluation. Local media will be monitored to identify the percentage of positive and negative coverage.

Appendix Five: Andover Birth Centre: HOSC feedback to WEHT- 30 March 2011.

Thank you for attending the HOSC yesterday with your team. As you will have ascertained from the discussion members were deeply concerned that the Andover Birth Centre will not reopen as intended at the beginning of April, despite your assurances to us last November. You provided no information on the views of the MSLC or the local midwives on this proposal and we had to ask for the report of the engagement process that you went through earlier this year. I trust this will be with us imminently.

We are firmly of the view that there is a preference amongst women for the choice of a standalone birth centre. One of the main reasons for the low birth rate is lack of confidence and this choice not always being offered to women. This view is supported by independent research at Crowborough Birthing Centre in West Sussex which showed that uncertainty as a result of the threatened closure of the unit affected women's birth place choice making, and the number of babies born at the birth centre fell. Once the birth centre had a secure future however, the number of births rose significantly. ABC has been subject to repeated closures and uncertainty over many months and the decision of the Trust to extend this closure does nothing to provide reassurance to local women that their preferred place of birth will be available.

There were some significant issues of concern in the Trusts responses to questions from members:

- The presentation shows that Ashurst Birth Centre is an option for women in your catchment area. Our understanding is that this is not an choice offered to local women. Could you please clarify what the position is and the numbers of women that have accessed this service in the last year.
- We highlighted the need for there to be consideration of the population of Basingstoke and the surrounding villages when we discussed the engagement process in November. This would support the forthcoming merger discussions. It was clear at yesterdays meeting that this work had not taken place and there had not even been a recent discussion with North Hampshire Hospital about this option.
- The assumptions about population growth presented in the report did not take account of significant new developments in Andover. Up to 6,000 homes are likely to be built in this area in the next 5 years
- It was stated that the 'Domino' staffing model was not safe and sustainable, even though this is used in other areas in Hampshire and the Director of Public Health suggested that this could be an option to explore further. This is deeply unhelpful given that the Trust is proposing to keep the ABC closed on the grounds of patient safety and we would appreciate clarification of the reasoning behind this statement at the earliest opportunity.

- There was no indication of the support of GPs for this proposal.

The grounds for temporary urgent closure of the unit have now moved to be continued closure subject to the outcome of consultation on models of care and the wider exercise being taken forward by our Director of Public Health. You will understand, given our previous conversations, that the option exists for us to refer this matter to the Secretary of State. As stated at our meeting we are not currently pursuing this course of action as it would undermine local decision making and could reflect negatively on the forthcoming merger. The Trust does however have considerable ground to cover if the term 'safe and sustainable' is not to be interpreted as opportunistic financial cuts."

Appendix Six: Andover Birth Centre- WEHT response to the HOSC. 15 April 2011.

Thank you for your comments and concerns which arrived in time to be shared with our Trust Board on Wednesday 30th March.

You mention that we had not provided views from the MSLC or local midwives. We have, of course, been in regular contact with both groups – and can provide meeting minutes if requested - but the point of our engagement exercise was to try and find out what was influencing the birthplace choices of local women. There was no 'proposal' as such to take to the MSLC or local midwives.

In particular, we wanted to find out what kind of midwife-led birth women wanted, given these two facts:-

- 1) the number of births at the ABC has been around four per week for around 20 years now – even before the suspensions of the past 18 months and;
- 2) we could find no evidence that the ABC wasn't being offered as a choice for women who were clinically suitable.

On your specific points:-

- Ashurst is and always has been an option for women - we support a woman's choice to use Ashurst, but it is geographically remote from our normal catchment so doesn't arise very often.
- Our online survey was open to all women, including those in Basingstoke - it was promoted by NCT members and NHS Hampshire across the county. We are considering a new survey which will definitely include women in the Basingstoke area.
- Discussions with BNHFT in recent years have not resulted in women from that Trust's catchment area being encouraged to use the ABC. The criteria for a home birth and delivery at the ABC are exactly the same which is why BNHFT has preferred to encourage home births instead. If a woman from the Basingstoke area is suitable for a home birth, this is likely to be preferable to travelling to the ABC. However, the Trust will involve BNHFT colleagues in discussions again in light of the merger in case the prospect of a joint maternity service makes a significant difference. Of itself, the coming together of two organisations will not alter the population's need or desire for a midwife-led birth service at Andover.
- You are right to highlight the omission of the most recent planning permissions – this is being addressed by NHS Hampshire and will be added into the forecast for potential births.
- I do not recall any of the panel saying that the Domino model was unsafe. Our concern is the likelihood of being able to run this model of care safely

and consistently, referring to staffing levels rather than practices. We can give you our assurance that we will revisit this model and consider carefully whether or not we can implement it. Safety will be the overriding factor but we must also consider any impact on other aspects of our whole maternity service, such as our commitment to maintain home births and to provide a comprehensive range of ante and postnatal services.

- We have been in regular contact with GPs – as can be seen on agenda items from PBC meetings (they can be supplied) – but have not had written support or opposition about the continued suspension of births at the ABC. Dr Keith Foote has attended meetings with GPs at Andover and WINCAR where they were supportive and I have personally spoken to the relevant GP leads who understand the reason for the suspension. It has not been easy to persuade GPs to commit their opinions to paper. The latest advice from primary care colleagues is to visit practices in the Andover area and seek a statement summarising the discussions. We have been advised that it would be wise to do this once a model is worked up but we will issue an invitation to all our primary care colleagues (and BNHFT's) to be involved in the development of the new model.

Your letter mentions closure and members mentioned 'mothballing' the ABC. We have been very clear that the ABC remains open. It is a vibrant and welcoming place for a comprehensive range of ante and postnatal services. These include drop-in availability and consultant appointments. It is a high quality and well-regarded service which benefits around 140 women and their families each week. Please advise if you think we have not been clear enough on this point to members.

Finally, whilst I understand that the continued suspension is unpopular, it is important to be clear that our number one priority remains clinical safety. Our commitment to this is demonstrated by our CNST 2 level in maternity, the same for acute care and our recent positive CQC inspection. Indeed, our bottom line might have been in better shape if we had prioritised money above safety!

There have and always will be budgets to work within but the issues at the Birth Centre are about the model of care; the choice of women and the equity of our whole maternity service – taking into account a wider post-merger population.

Our pledge was to update you in May. Meetings with stakeholders are booked and resource (from staff who are currently not working clinically) has been identified for a review to begin and so we hope to meet our second pledge which is to share a more detailed proposal with you in July which will take into account the points raised by you and addressed herein.

We are grateful for your support but mindful that clinical and not political or personal pressures should come to the fore as we develop a safe and sustainable model for midwife-led births

**ANDOVER BIRTH CENTRE – UPDATE REPORT TO HOSC
May 2011**

Subject	<i>Andover Birth Centre</i>
Purpose of Paper	<i>To inform the Health Overview and Scrutiny Committee of recent work undertaken into new models for a midwife-led birth service</i>
1.0 Executive summary	
1.1	<p>This paper sets out the current situation regarding midwife led births provided by Winchester and Eastleigh Healthcare NHS Trust (WEHCT). A fuller paper will come to the HOSC in July.</p> <p>Andover Birth Centre (ABC) is part of WEHCT and is a stand alone midwife led unit providing care for women in pregnancy, birth and after delivery. The unit has historically had 200 (approx) births per year and five postnatal beds. It does not have obstetricians, anaesthetists, paediatricians or access to other emergency medical care (other than via ambulance transfer).</p> <p>The centre has been underused by the local population for many years, despite efforts by the Trust to market it. The vast majority of women in the area - 75% - have their babies at the Royal Hampshire County Hospital (RHCH). The remainder choose other facilities (Salisbury or Basingstoke) or to have their babies at home.</p> <p>The criteria for a home birth is the same as the ABC. It is for low-risk births only and any women whose labours become complicated are transferred to the RHCH before, during or after labour at the ABC. Approximately one third of the four women using the ABC each week (for births) are transferred.</p> <p>The Trust has continued to support home births and is proud to have the highest rate in Hampshire – 6%. The Trust is also proud of the maternity service provided in Andover. A comprehensive range of ante and postnatal services are used by around 140 women each week.</p> <p>Staffing issues across the Trust's maternity service have led to suspensions of the inpatient service (births) at the ABC. The suspensions have given the Trust and its commissioner, NHS Hampshire, an opportunity to consider other models of care that would meet the aims of both organisations to provide a midwife-led birth service that is less disproportionate in terms of resource and more robust and reliable, ie no more suspensions.</p>
2	<p>Other models of care</p> <p>The Trust's Head of Midwifery has visited the Head of Midwifery at Portsmouth Hospitals NHS Trust (Gill Walton) and followed this up with several conversations to find out more about their midwife led birth service.</p> <p>These are the key points we have learnt so far:-</p> <ul style="list-style-type: none"> • The midwife to mother ratio at PHT is higher (partly because WEHCT's midwives are with women in theatre)

	<ul style="list-style-type: none"> • PHT's midwife-led births are provided by a midwife and a maternity support worker – WEHCT currently manages its midwife-led births with two midwives • The model at PHT does not include a postnatal stay (the aim is for women to leave within a few hours of birth) • The home birth rate at PHT is much lower, indicating that the Trust may prefer to operate with a higher critical mass of staff and women at its birth centres instead of supporting births at home • The maternity support workers required a tailored training package in addition to that normally required.
<p>3.</p>	<p>Resources</p> <p>Previously presented figures have shown that a birth at the ABC costs around twice as much as at the RHCH. This is due to the staffing model and usage. At the ABC there are two midwives on duty 24/7 even if there are no women using the unit to give birth.</p> <p>When midwives work at the RHCH they provide higher value for money simply because the there is a higher level of activity there.</p> <p>There is a national shortage of midwives which has affected the Trust's recruitment at times.</p> <p>The Trust has a savings target of £9.4m in 2011/12 and can therefore not afford to overspend on any of its services, including maternity.</p> <p>Relocating inpatient services from the ABC would release at least £150,000 which could be reinvested at the RHCH where the majority of women from Andover and across our catchment area have their babies.</p>
<p>4.</p>	<p>Facilities</p> <p>The Andover Birth Centre has been refurbished but the underlying fabric of the building means that further investment will be required over time. It is also isolated at times when the rest of the hospital is closed.</p> <p>The Trust is upgrading its labour ward theatres at the RHCH and part of this work includes the creation of two more 'home from home' rooms, one of which has a birthing pool. These are due to be completed in late 2011/early 2012, taking the number of rooms for midwife led birth to four, two of which have pools.</p>
<p>5.</p>	<p>Engagement</p> <p>The Trust is pleased to have the support of NHS Hampshire whose engagement lead is supporting work in this area. The Trust has also freed up a member of its maternity service and together they are identifying groups and individuals to engage with. This will be across WEHCT's catchment area because both Trusts are interested in a service that is as equitable as possible.</p> <p>The Trust continues to keep the Natural Childbirth Trust (NCT) and Midwife Supervisory Liaison Committee (MSLC) and GPs informed of progress towards a new model for midwife-led births.</p> <p>Additionally, the Trust is holding a 'Question Time' event on Tuesday May 17 to hear the views of interested stakeholders and provide as much information as we can on our</p>

	work towards a new model for midwife-led births.
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**Hampshire Health Overview and Scrutiny Committee
Briefing on engagement with registered patients at Highview Surgery,
Bordon**

Background

Highview Surgery in Bordon is a single handed GP practice with a registered population of approximately 1,200 patients. The practice contract was held by Dr Booth.

The General Medical Council has suspended Dr Booth from the Medical Register for a period of 18 months and she is therefore unable to practise as a doctor in the United Kingdom.

We believe it is highly unlikely that Dr Booth will be able to meet her contractual obligations in the foreseeable future and in light of this have terminated the contract for this practice and have made temporary alternative arrangements for patients.

Forest and Badgerwoods Surgeries, a well respected local practice, are currently providing services at Highview Surgery. This arrangement will continue whilst NHS Hampshire engages with Highview Surgery patients about the future options for access to high quality Primary Care medical services locally.

Patient engagement

Patients have been informed about Dr Booth's suspension, the termination of the contract and the arrangements made with Forest and Badgerwoods Surgeries.

We are currently engaging with registered patients regarding access to primary care medical services locally and what they value from these services. This feedback will be used to develop future options ensuring stakeholder feedback informs these proposals.

All registered patients have been sent a letter (one per household) detailing how they can give us these views. This can be done either through an online survey, requesting a paper survey (for those without internet access) and/or coming to three drop-in events being held in the local area. These drop-in events are those

held in Bordon about Chase Community Hospital and staff from the Primary Care Team will be attending.

Patients will receive a further letter when the options have been developed, explaining these and asking for any further feedback before a final decision is made.
