Agenda Item 7

HAMPSHIRE COUNTY COUNCIL

Report

Committee:	Health Overview and Scrutiny Committee
Date of Meeting:	29 November 2011
Report Title:	Proposals to Develop or Vary NHS Services
Report From:	Chief Executive

Contact name: Denise Holden

Tel: Ext 7338 **Email** denise.holden@hants.gov.uk

1. Summary and Purpose

1.1. The purpose of this report is to alert Members to proposals from the NHS to vary or develop health services provided to people living in the area of the Committee.

1.2. Proposals that are considered to be substantial in nature will be subject to formal public consultation. The nature and scope of this consultation should be discussed with the Committee at the earliest opportunity.

1.3. The response of the Committee will take account of the Framework for Assessing Substantial Change and Variation in Health Services agreed by the Hampshire, Isle of Wight, Portsmouth and Southampton Joint Committee in November 2010. This places particular emphasis on the duties imposed on the NHS by Sections 242 and 244 of the Health and Social Care Act 2006 and takes account of key criteria for service reconfiguration identified by the Department of Health. The 'Framework' can be found on the website at http://www3.hants.gov.uk/scrutinyfallsframework.pdf

1.4. This Report is presented to the Committee in 2 parts:

- *Items for action:* these set out the actions required by the Committee to respond to proposals from the NHS to substantially change or vary NHS services.

- *Items for information:* these alert the Committee to forthcoming proposals from the NHS to vary or change services. This provides the Committee with an opportunity to determine if the proposal would be considered substantial and assess the need to establish formal joint arrangements

1.5. This report and recommendations provide members with an opportunity to influence and improve the delivery of health services in Hampshire and therefore support the delivery of the Corporate Strategy aim of maximising well being.

Items for Action

2. **Southern Health NHS Foundation Trust: Improving Outcomes for Hampshire's Adult Mental Health Services.**

2.1. In July 2011 Southern Health outlined to the HOSC the wide ranging stakeholder engagement that had taken place to support plans for improving the outcomes for adult mental health services in Hampshire. The HOSC supported the direction of travel outlined by the Trust, and, taking account of the engagement activities that had already taken place to support service redesign, agreed a shorter consultation period to test the resultant proposals in greater depth.

2.2. The consultation document published in September 2011 suggested a reduction in inpatient beds of up to a third with ambitious savings targets but provides little information on the grounds on which these proposals are based. This point was reflected in the response of the HOSC to the consultation, dated 12 October 2011.

2.3. Given previous assurances by the Trust about the extent of stakeholder support for the redesigned service it is of concern that the proposals contained in the consultation document have generated significant negative feedback from key stakeholders, including carers, local MPs, the RCN and Hampshire Adult Services.

2.4. Responses shared with the HOSC indicate a strong view across stakeholders that more information is needed to ensure that the scale of change proposed by the Trust is fully evidenced and able to achieve the improvements initially envisaged. These points, and a number of further issues raised by stakeholders, need to be addressed by the Trust before it moves forward with any proposals to change these services. Any revised proposals will need to be subject to further public consultation as appropriate.

2.5. The Trust has already established 2 key stakeholder groups in order to address the issues raised during the consultation.

2.6. Issues raised by the HOSC in relation to the proposals contained in the consultation document and the interim response from the Trust are attached at Appendices One (page 5) and Two (page 8) respectively. Issues raised in relation to the New Forest by the local MP in a debate in the House of Commons are attached at Appendix Three (page 9) . Southern Health's analysis of the responses to the consultation and proposed next steps are attached at Appendix Four. (page 16)

Recommendations

2.7. Members confirm:

- If they are consider that there has been appropriate stakeholder engagement in the development of the proposals for improving outcomes for adult mental health services in Hampshire.
- If they are satisfied with the next steps proposed by the Trust.
- Any additional information to be provided by the Trust

2.8. The Trust provides an update on progress with the further stakeholder engagement activities at the HOSC on 24 January 2012.

3. **Southern Health NHS Trust: Care Quality Commission (CQC) reports- local action plans**

3.1. Further to the publication of a critical report about the quality of care provided at Antelope House the Chairman worked with Southampton HOSC to convene an informal joint meeting to discuss the steps proposed by the Trust. This was held on the 26 October 2011. The correspondence outlining the concerns of the Chairman and the response from the Trust is attached at Appendices Five (page 27) and Six (page 28) respectively. The outcome of the meeting and proposed recommendations are attached at Appendix Seven (page 30) for consideration by the Committee.

Recommendations

3.2. Members endorse the draft recommendations for follow-up by the Trust

3.3. Evidence of the action taken is considered alongside any future proposals for redesigning adult mental health services.

Items for Information

4. **National Specialist Commissioning Board: Consultation on the Configuration of Children's Heart Surgery Services.**

4.1. The Judicial Review brought by the Royal Brompton in relation to the consultation process has been upheld by the courts. A statement from the 'Safe and Sustainable team detailing this is attached at Appendix Eight (page 35). It is not clear what impact this will have on the decision making of the Joint PCT.

Recommendation

4.2. That the Panel, working with other HOSCs as appropriate, continues to oversee the response of the national team this issue and reports back to the Committee as required.

5. **NHS SHIP Cluster: Review of Stroke, Major Trauma and Vascular Services.**

5.1. The correspondence relating to the feedback from the HOSC on these proposals and the response of the SHIP Cluster is attached at Appendices Nine (page39) and Ten (page 43) respectively.

5.2. As noted at the last meeting the HOSC will require clear information about the proposals for the configuration of vascular services, based on the available clinical evidence. This shall include information about the impact of any changes on other clinical services provided by the Trusts affected and will be aligned across SHA boundaries as appropriate. On receipt of this information the HOSC will be in a position to ascertain if the changes proposed in relation to vascular services are substantial in nature.

Recommendations

5.3. The SHIP cluster confirms the process for taking forward the changes proposed in relation to stroke services and how this will affect current patients' pathways. This will enable the HOSC to determine if the change is substantial in nature.

5.4. Information relating to vascular service reconfiguration is provided as requested in 5.2 above.

5.5. The Committee works as appropriate with other HOSCs in responding to these proposals.

Section 100 D - Local Government Act 1972 - background documents

The following documents discuss facts or matters on which this report, or an important part of it, is based and have been relied upon to a material extent in the preparation of this report. (NB: the list excludes published works and any documents which disclose exempt or confidential information as defined in the Act.)

Document	Location
None	

IMPACT ASSESSMENTS:

1. Equalities Impact Assessment:
N/A

2. Impact on Crime and Disorder:

N/A

Appendix One: Improving Outcomes for Hampshire's Adult Mental Health Services: HOSC response to public consultation- 12 October 2011.

I am writing in response to the public consultation that you initiated in September in relation to the above services.

You will recall that one of the reasons that the HOSC agreed to a foreshortened consultation was the extent of stakeholder engagement that the Trust reported had taken place in shaping this proposal and the support this had generated for the redesign of services set out in the document. I understand however that a number of issues have been raised in response to these proposals at the public meetings and would be grateful to have a summary of what these are and the response to them of the Trust, when this information is available. I would also be grateful if you could confirm if these proposals are supported by GPs and the extent to which the service redesign proposed will extend patient choice. This will help to inform us when we consider this matter at our November HOSC meeting.

We are aware of the wide ranging variation in bed usage in mental health services across the country and note that page 11 of your document highlights this fact. It is however difficult to extrapolate this point to the case that you make for £4.4 million in direct cost efficiencies, of which just one third would be reinvested in the new service. We are not aware of any evidence that suggests a target in terms of number of beds per head of population or an optimum length of stay for people using acute adult mental health services.

In making this point we acknowledge that the direction of travel set out in the document reflects best practice in delivering Adult Mental Health Services and the budgetary pressures that the NHS, along with all public sector services, needs to manage. We do not feel that there is sufficient information in the consultation document for us to understand how you have arrived at these potential savings, and our overarching concern is whether we can be confident that it is the improvements in quality and the effectiveness of delivery of these services is the driver of change, rather than the need to meet cost efficiency targets. Reducing bed numbers and achieving savings must not be an end in itself.

Our understanding is that the balance between inpatient acute mental health services and rehabilitation services is key. How have you assessed the closures of the rehabilitation beds envisaged? What impact will this have on current service users and their carers? It would also be helpful to understand what effect the proposed move of Abbott's Lodge - which does not appear in the consultation document - would have on this balance and the extent to which this proposal is supported by carers and key stakeholders.

From a HOSC perspective Members were disappointed with the lack of tangible information about the way in which the new services would work and, given the title of the document, what improvements in outcomes would actually be achieved. I would be grateful therefore if you could respond to the questions set out below to inform our November discussion.

- Where do the Trust's services feature when set alongside the national bench-marking information produced by the Audit Commission in 2010?

- What are the current levels of staffing in community teams and how is this broken down across early intervention, community mental health teams, AOT and CRHT?

- What additional resource would these teams have as a consequence of the changes you are proposing?

- How do existing community teams contribute to ensuring that admissions to - and discharge from - inpatient services is appropriate? How would this change?

- What arrangements are in place to ensure that there is effective communication across the teams and other service providers (e.g. social care, housing, primary care)?

- How are communications managed to ensure that assessments are appropriately shared across the teams and with other care providers?

- Does the Trust have organisation wide protocols in place to ensure there is clarity about the roles and responsibilities of all involved in the care pathway for these service users?

- What are current bed occupancy rates and lengths of stay? How does this breakdown across acute and rehabilitation inpatient services?

- What are the outcome measures that would be used to demonstrate improvements in services?

- What teams would be accessible on a 24/7 basis?

- What would the response times be for each team?

- What support would be provided to carers should the changes be implemented?

- How frequently does the Trust have to place patients outside Hampshire?

- What alternatives to admission to inpatient care exist and how would these change if the proposals were implemented?

- What is the current usage of agency and bank staff across these services?

- There is evidence that the prevalence of some mental health conditions can increase in times of economic downturn: how has this been factored into your proposals?

- The consultation document suggests that Southern Health wish to move to a more holistic approach to mental health treatment, but it is not stated how the Trust will work with its stakeholder partners (e.g. Hampshire County Council, District and Borough Council community housing teams, third sector providers) in order to achieve this.

A number of the above points reflect the very specific concerns highlighted in the CQC report and I know we are meeting to discuss this further on the 26 October. Whilst this is a separate matter from the consultation I am sure that you will appreciate that we will need to be confident that there has been robust and sustainable action taken by the Trust to ensure that issues such as care planning and risk assessment are firmly embedded as part of an integrated patient pathway that is clear and understood by all.

Yours sincerely

Cllr Pat West

Chairman, Health Overview and Scrutiny Committee

CC
Hampshire HOSC Members
Cllr V. Cappozzoli, Chairman, Southampton City Council HOSC
Debbie Fleming, Chief Executive SHIP PCT cluster
Carol Bode, Chairman, Southern Health NHS Foundation Trust
Gill Duncan, Director, Hampshire Adult Services

Appendix Two: Southern Health NHSFT- Interim Response to Hampshire HOSC.

Further to our recent meetings and your letter of 12 October 2011, I am writing to confirm the proposal we discussed to move forward with the Adult Mental Health public consultation in Hampshire. May I start by recording my thanks for your constructive approach and helpful advice, which has been so important in our planning of the next steps.

We recognise that the proposals we have made are challenging and that while the broad direction of travel is supported, there are significant anxieties about the detail and in particular the transition from our current model to our proposed new model of acute care. It is our view, therefore, that we need to take time to reflect on what we have heard through the consultation. In order to do this, we are establishing stakeholder groups in East and West Hampshire respectively. The intention is that these groups will work through the key themes and develop ideas and solutions together. Invitations for membership have been sent to key agencies and individuals, including LINks, HCC members and officers, PCT commissioners, GP Leads, Trust Governors and also to Dr Julian Lewis MP.

The feedback analysis we have undertaken is currently being reviewed and validated by LINks. I propose that we return to the HOSC meeting at the end of November and present a written report which describes the consultation feedback themes, the progress we have been able to start to make through the stakeholder groups, and suggestions as to next steps. The report will also address the specific questions which you raised in your letter of 12 October 2011.

I hope this is a fair reflection of what we discussed at our meeting on 19 October 2011 and that this way forward continues to have your approval.

May I also take this opportunity to thank you for the constructive way in which you steered the meeting regarding the Antelope House CQC inspection, alongside Cllr Capozzoli. We found the discussion and the recommendations very helpful in shaping further work on this important agenda.

Appendix Three:

House of Commons debate secured by Dr Julian Lewis on 10 November 2011 (Hansard extract)

http://www.publications.parliament.uk/pa/cm201011/cmhansrd/cm111110/debtext/111110-0004.htm#11111084000001

2. Woodhaven Hospital

Motion made, and Question proposed, That this House do now adjourn.—*(James Duddridge.)*

(1) 6.2 pm

Dr Julian Lewis (New Forest East) (Con): I am particularly pleased to see the Minister on the Front Bench tonight. I know of his care and compassion on the topic of mental health.

Woodhaven hospital is a state-of-the-art mental health unit set in a therapeutic, semi-rural but easily accessible location in my constituency. Its acute Winsor ward has, unusually, en suite facilities for all 24 in-patients and other top-of-the-range features. It was a proud and happy moment for me when I cut the ribbon to open the new hospital just eight short years ago. Now, to the immense distress of service users and their carers, Woodhaven is threatened with closure.

Currently, 165 acute in-patient mental health beds are available to the Southern Health NHS Foundation Trust. They are in six units throughout Hampshire, as follows: 50 beds at Antelope House in Southampton, 25 each for men and for women; 20 beds at Elmleigh in East Hampshire, 10 each for men and for women; 24 beds at The Meadows in Fareham, 10 each for men and for women and four more, known as flexible beds, which can be used for either; 23 beds at Melbury Lodge in Winchester, 13 for men and 10 for women; 24 beds at Parklands in Basingstoke, seven for men and 16 for women, plus one flexible bed; and finally, the 24 beds at Woodhaven in my New Forest East constituency, 10 each for men and for women, plus four flexible beds.

The foundation trust proposes to close Woodhaven, which is virtually brand new, and The Meadows, which is also quite modern. That would reduce the total available beds in the region from 165 to 117. However, of the 50 beds at Antelope House that have been available for acute cases up to the present, 10 are to be allocated to long-term, challenging in-patients, effectively reducing the total number of acute in-patient beds that will be available in future to only 107. The foundation trust has suggested that some of the future occupants of the 10 beds might come from other acute beds out of the 165 total, but it seems much more likely that the 10 beds at Antelope House will be allocated to residents from Abbotts Lodge, a different kind of unit that is not included in the 165-bed total and will be shut. For that reason, the real reduction in available acute in-patient beds will be from 165 to only 107.

Those 107 acute beds will contain two distinct categories of in-patient: those who are voluntary and those who have been detained. On what I believe to have been a typical day in mid-October, and on a similar day this month, when 153 beds were in use across the whole trust area, no fewer than 88 were occupied by in-patients detained under the Mental Health Act. That constitutes 53%—just over half—of the existing 165 available acute beds. With only 107 beds available in future, that 53% figure will rise to approximately 82%. Conversely, the proportion for voluntary in-patients who are acutely mentally ill will fall from

about 47% to just 18%. In practice, there will be only about 19 beds left for the whole of the trust area in Hampshire for acutely mentally ill people who voluntarily go into hospital.

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That will have a huge and negative effect on patient choice. There will be little chance of choosing or obtaining an acute in-patient bed, as four fifths of them will be occupied by people who have had to be detained because they will not voluntarily agree to admission. Indeed, someone who desperately wants an in-patient bed would be well advised to create sufficient mayhem in order to be sectioned, if they are to have a reasonable chance of gaining admission. Once admitted, the voluntary in-patients will find that the effect of the greatly increased preponderance of detained in-patients in each of the four remaining units in Hampshire will be to make their wards significantly less therapeutic. Should the trust be thinking of such a huge reduction in bed totals at all?

I should say at this point that there is no fundamental philosophical disagreement between me and the representatives of the district and county councils on the one hand, and the management of the trust on the other. The trust's spokesmen consistently agree that some acute in-patient beds will always be needed. For our part, my colleagues and I have no doubt of the value of strong community, assertive outreach, crisis resolution and early intervention services at home.

The key question that must be resolved—I hope that it will be resolved as a result of this debate—is simply what is the correct number of acute in-patient beds in Hampshire. Naturally, the trust maintains that by investing in extra services at home some people will be prevented from deteriorating to the point where they need to occupy acute in-patient beds, but I believe that stripping out more than one third of the existing beds, as the trust proposes, cannot possibly be justified.

Of course, the trust ought to make efficiency savings. It states that closing two out of six acute in-patient units in the area will save £4.4 million, £1.5 million of which is intended to be invested in what was previously described as a "virtual ward" but is now more sensibly described as a "hospital-at-home" service. The remaining £2.9 million is, of course, an easy way to make a significant annual saving, but it is not an efficient way, especially when one considers that, according to an Audit Commission survey, Hampshire already has the highest number of staff per 1,000 of the population in community mental health teams out of 46 trusts examined. Cutting front-line services and making efficiency savings are two very different things.

Twenty-six acute beds per 100,000 people is the current average among the 46 mental health trusts surveyed. The Southern Health NHS Foundation Trust has 28 beds per 100,000 and expects that figure to go down to 21 if the two units, including Woodhaven hospital, are closed. I believe that the actual total would be just under 20 beds per 100,000 people. At the moment, with 28 beds, we are in the top 19 of the 46 trusts. Whether we go down to 21 acute beds per 100,000 or to just 20, we shall be in the bottom six, and that is an immense gamble to take with the welfare of people who, almost by definition, are at risk of losing their lives.

Every day, the trust files a record of how many beds were vacant out of the total of 165, and at my request it has provided a print-out for the past three months. This shows, beyond any doubt, that bed occupancy levels are consistently high. Let us remember that we are considering 165 beds, spread over almost all of Hampshire and serving hundreds of thousands of people. The trust's tables give a breakdown of the numbers of male and

female beds vacant each day, and the numbers of so-called "leave" beds temporarily empty. Leave beds are those that have already been allocated to in-patients, but that are not being used for short periods, because their occupants are spending typically one, two or three nights at home. Even when leave beds are counted together with genuinely vacant beds, the total number of empty beds throughout the area is low—often, indeed, in single figures. Thus, from 21 September to 6 October this year, the overall daily totals were respectively nine, seven, five, five, seven, three, three, three, four, 11, nine, nine, eight, nine, seven and six empty beds out of 165. When one excludes the leave beds, however, as one should because they have not been genuinely vacated, one is left with numerous instances of 100% acute bed occupancy for the whole region. For example, there were no vacant male beds at all on 2, 7, 10, 11, 17, 18, 20 to 24 and 26 September; in the same month, there were no vacant female beds on 7, 10, 11, 16 to 18, 20, 23, 24, and 26 to 29; and on September 3, 4 and 25, gender information not being available for those three dates, there was either only one male and no female acute beds available, or only one female and no male beds available in the entire trust area in Hampshire.

Of course, one can debate how much use can safely and regularly be made of at least some of the leave beds that are temporarily vacant.

Mr Charles Walker (Broxbourne) (Con): My hon. Friend will know from previous debates that one can have occupancy rates above 100% because sometimes, in emergencies, leave beds are drafted into use.

Dr Lewis: I am extremely grateful to my hon. Friend for making that important point, as I am for him being here to support me tonight. I know of his great interest in the subject.

Using the trust's own figures, I have calculated the average acute in-patient bed occupancy over the three months from August to October. Even if all the leave beds are counted as available, which they are not, bed occupancy was 91.9%, and the figure would be higher if weekends were excluded, given the number of people who go home for short periods at those times. When only the genuinely vacant beds are considered, the average occupancy rate is seen to have been a remarkable 96.7%.

One of the most extraordinary assertions in the consultation document on the proposed changes is to be found on page 11, where it declares:

"The time that people are spending in our…hospitals is longer than the national average (our average length of stay is 51 days (including leave) compared to below 30 days (excluding leave) in other Trusts)."

That is an extraordinary manipulation of the data, as it contrasts the total of days spent on and off the wards in our trust area with the total of days spent only on the wards in other trust areas. A glimpse of the true situation is again to be found in the tables drawn up by the Audit Commission. In referring to all mental health admissions in the Hampshire PCT area, which is not quite the same as the foundation trust area but is a reasonable general guide, the Audit Commission states:

"Hampshire PCT is below the national average"

for length of stay. I do not know whether the trust's blatant and gross failure to compare like with like was deliberate, but the public, their local representatives and Ministers are surely entitled to ask what the average length of stay excluding leave is in Hampshire's acute beds, and what the average length of stay including leave is in the acute beds of other trusts, so that real rather than bogus comparisons can be made.

Time prevents a more detailed dissection of other dubious claims made by the trust. Its spokesmen refer to the acutely mentally ill suffering "disempowerment" as a result of spending what is usually a relatively short time on an in-patient ward. Most frequently, it insists that

"people have consistently told us they want to be at home".

Such claims fly in the face of what we hear from service users and especially from carers, who want the assurance that an acute bed will be available when it is needed. I have yet to discover what, if any, systematic survey was undertaken to arrive at that conclusion. Who carried it out? How many people were surveyed? What questions were asked? The trust says that its soundings showed a desire for:

"Care within a community setting where possible, and avoiding going into hospital unless it is necessary."

Well amen to that; we can all sign up to that, but that is a very different proposition from wishing to see a more than one-third cut in available beds that have an average occupancy rate of between at least 91.9% and 96.7%.

Only five out of the 46 trusts listed by the Audit Commission have 20 beds or fewer per 100,000 of the population. Southern Health NHS Foundation Trust wishes us to follow that example. Its consultation says that that small minority of trusts

"deliver good or excellent standards of care",

and it recently identified four of those five trusts in a presentation to me and others. Although the overall ratings for those four trusts are, indeed, good or excellent, the picture is different where in-patient services are concerned: none of the four is rated as excellent, two are rated as good, a third is rated only as fair, and the fourth is rated as weak.

At meetings with the trust, I and my colleague, County Councillor Keith Mans— a former and distinguished Member of this House—have stressed the need for the new hospital-at-home model to be piloted before any of the six in-patient units is closed. If this exercise is really about "Improving Outcomes for Hampshire's Adult Mental Health Services"—as the consultation document is entitled—rather than about saving £2.9 million a year, then acute in-patient beds should not be discarded until pilot projects clearly show significant reductions in the current very high levels of acute bed occupancy.

We need a step-by-step approach that clearly rules out the present plan to remove not just one but two modern mental health units, including Woodhaven hospital, right at the start. It is distinctly probable that the overview and scrutiny committee of Hampshire county council may decide to refer this matter to the Secretary of State. This evening, I look to the Minister for two assurances.

First, I want an assurance that Woodhaven hospital, which is so valued by our community, will not be closed until objective and independent surveys have been carried out assessing whether there really are dozens of people

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in beds for the acutely ill in Hampshire who do not need to be there. Secondly, I want an assurance that Woodhaven will remain open until a pilot scheme has demonstrated that the proposed hospital-at-home scheme is starting to reduce the current high levels of acute bed occupancy. It cannot be right that in-patient beds should be cut to 107 for the whole trust area in Hampshire, so that we are left with a woefully inadequate total of about 19 for voluntary in-patients once all those detained under the Mental Health Act have been accommodated. People's lives are at stake.

(2) 6.20 pm

The Minister of State, Department of Health (Paul Burstow): I congratulate my hon. Friend the Member for New Forest East (Dr Lewis) on securing the debate and on being, as ever, so thorough and detailed in his exposition of the case that he puts before the House. I take this opportunity to pay tribute to the hard work of the staff who work within the NHS in his constituency.

I want to set out the current position, as I understand it from the briefings that I have had over the past few days, and to respond to several of my hon. Friend's specific points. I assure him that under the proposals for adult mental health redesign set out by Southern Health NHS foundation trust, Woodhaven hospital will not close but will change the nature of what is provided. I want to make it clear that there is a continuing NHS future for the facility, albeit not the one that he believes to be appropriate.

While the trust recommends that the acute adult mental health ward is withdrawn from Woodhaven, the excellent hospital which my hon. Friend opened eight years ago and which the community should rightly be proud of will continue to offer specialist adult mental health services. The aim of these changes is to provide the right mix of community and bed-based care—this debate centres on what that balance is—and ultimately the best possible support for people in his constituency who use these services.

My hon. Friend will be aware that during the 18-month engagement with the public that took place prior to the statutory consultation, the majority of patients consulted said—this is one of the areas that he challenges—that they wanted to be treated in the community. As a general principle in any field of health care, the more we can focus on prevention and on supporting people in their homes so that they retain their independence and stay connected with their communities, the better the outcomes we can achieve. The principles behind the trust's proposed redesign can therefore be pinned squarely to the views of local people, and this is where I want to reassure my hon. Friend a little further. I understand that, through the consultation, the trust has been told this on repeated occasions. I have a quote from one service user:

"I was unfortunate enough to need the services of the home treatment team over Christmas 2008 and New Year 2009, but due to the care I received from the team I didn't need to be admitted to hospital and I was able to stay at home with my husband and son."

Clearly, my hon. Friend disputes the evidence that the trust is putting forward about whether patients want to be treated at home, but it is for this reason that it is recommending the integrated model for mental health services in Hampshire and the reinvestment of savings

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from acute services into community services. However, I will ensure that he is supplied with further evidence on these points so that he can satisfy himself and his constituents that the trust is basing its decisions on reasonable evidence.

Additional community services will ensure that patients receive flexible and bespoke care packages in their home wherever possible, even when acutely unwell. The intention of the proposals will mean that people are admitted to hospital only if it is clear that hospital is the best place for them to receive their treatment. The trust tells me that treatment and care for patients will be provided in the most appropriate and therapeutic environment for the patient and that acute beds should be available for those who need them. However, when local trusts propose changes to existing services, the public should be closely consulted. Again, my hon. Friend obviously feels that that is not what has happened. In the case of Southern Health NHS foundation trust, service user involvement projects and carers' groups from across the county have worked closely with the trust to develop the proposals for the redesign.

I want to deal with a couple of the specific statistical points that my hon. Friend set out so clearly. He has demonstrated something that does not always happen in these debates, in that someone has done a lot of detailed research to try to nail the issue that he is most concerned about. First, I want to deal with the proportion of people detained versus those in voluntary admission. He referred to two days' worth of data that he had collected and his conclusion that 53% of people were detained in those circumstances. However, I understand that over the past six months, on average, 22% of people admitted to the trust's adult acute beds have been detained under the Mental Health Act. I have asked the trust to write to my hon. Friend with those figures so that he can see more data.

Dr Lewis: The trust did fax me some figures of that sort. However, they did not make sense because when they were added up, the total was way below the number of beds that had been occupied. I honestly think that the trust is wrong on these proportions.

Paul Burstow: That is why I think it is right for the trust, having read this debate, to follow it up by writing to my hon. Friend. I know that he has been engaging with it face-to-face as well, and I am sure that he will continue to do so.

My hon. Friend made a point about the trust anticipating the effectiveness of the whole clinical pathway and about the focus on the most unwell reducing the number of people admitted under the Mental Health Act, in addition to reducing voluntary admissions.

My hon. Friend mentioned the issue of whether one counts leave beds. It is common for people who have been detained in hospital to have a period of leave from the ward before they are discharged. That can vary from a few days to several months. The beds for leave patients are not kept empty, but are made available for other acute admissions, as my hon. Friend the Member for Broxbourne (Mr Walker) said. It is therefore important to count leave beds when considering capacity. My hon. Friend the Member for New Forest East set out clearly his concern about bed occupancy and the impact of leave beds. I will make sure that the trust considers this

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issue carefully as it draws together the feedback from the consultation before its forthcoming discussion with the Hampshire overview and scrutiny committee. I will ensure that his concerns about length of stay, which he set out so clearly, are put to it.

My hon. Friend made a request for a pilot. Although I will not go quite as far as he would like tonight, it might help if I provide him with some information about the process that the trust has put in place to evaluate and assess the proposed changes. I understand that it has invited the Centre for Mental Health to do an independent review of the proposals, which is expected to be complete within a month. The trust's research and development department is also completing a thorough evaluation of proposals, comparing a range of quality measures at baseline and after implementation.

On the next steps, the trust has been in discussions with the Hampshire health overview and scrutiny committee, and it has been agreed that the trust will hold a number of stakeholder meetings. It is expected that the trust will return to the health overview and

scrutiny committee at the end of this month and present a written report that describes the themes from the consultation feedback and the progress that has been made in those meetings. The trust will then make suggestions on the next steps, which it will agree with the health overview and scrutiny committee, with a view to reaching final decisions in early 2012. As I understand it, any changes will be implemented by the trust in a phased, transitional approach over a period of time, not as a big bang.

The trust will, of course, keep my hon. Friend fully informed. I know that he has been diligent in pursuing the trust with his concerns. I encourage him to carry on that dialogue. I again congratulate him on securing this debate and for clearly articulating his concerns on behalf of his constituents. I hope that I have been able to articulate some of the points that the trust has put to me and I look forward to a conclusion of this matter in the new year.

Question put and agreed to.

(3) 6.28 pm

House adjourned.

Appendix Four: Southern Health NHSFT: Adult Mental Health Responses to consultation

IMPROVING OUTCOMES FOR HAMPSHIRE'S ADULT MENTAL HEALTH SERVICES

1. Purpose of This Paper

This paper is intended to:

- confirm the completion of a period of formal consultation in relation to proposals for the development of Adult Mental Health services in Hampshire;
- set out the feedback themes arising from the consultation process;
- describe action taken since the close of consultation;
- set out the proposed next steps and timetable.

2. Background

Following agreement at the July meeting of the Hampshire Health Overview and Scrutiny Committee (HOSC), Southern Health NHS Foundation Trust (SHFT) undertook a six week period of public consultation from 5th September 2011 to 14th October 2011.

The consultation covered a series of proposals relating to the reconfiguration of Adult Mental Health services, with specific reference to a new pathway of care for people with acute needs – i.e. those people who are in need of intensive support and for whom a hospital admission is being considered. The consultation followed an extensive period of engagement in which the proposals for bed reductions had been widely discussed. The proposals are based on the joint commissioning intentions of Hampshire County Council and NHS Hampshire, as described in the Draft Joint Commissioning Strategy which was itself subject to public consultation in 2010.

The proposals would mean that:

- the options for people with acute needs to be cared for outside hospital would increase, as a result of increased investment in community-based 'Hospital at Home' services;
- the options for people with rehabilitation needs to receive care in their own homes would increase in the New Forest, as a result of increased investment in a reablement team
- acute beds would reduce by 48 across two sites, Woodhaven in Calmore and The Meadows in Sarisbury Green
- rehabilitation beds in the New Forest would be reduced by 8, meaning the closure of Copper Beeches in New Milton

The intended outcomes of this reconfiguration are:

- More choice for people to be treated at home by offering more flexible packages of care and reflecting individuals' needs and aspirations
- A wider range of home treatment services by bridging the gap between community and inpatient care and helping people to stay at home or come home sooner. These interventions could include intensive day support, increased use of flexible budgets and assistance in accessing mainstream support services
- Better liaison and continuity between ward and home treatment services by staff being managed as a single team, with their skills matched to the needs of service users
- Better support for carers, especially during a time of crisis
- Lower rates of admission and shorter lengths of stay
- Better value for money through cost savings of approximately £2.9 million to the health economy

3. Themes Arising From The Public Consultation

The formal consultation attracted widespread public interest in our proposals, in particular in the New Forest in relation to the proposals for Woodhaven. Appendix A

gives details about the events we ran, numbers of participants, as well as a range of meetings offered to individuals and/or attendance at other meetings such as Borough and District Councils and Hampshire LINks.

The Trust has reviewed the feedback from the 6 week formal consultation period. See Appendix B for summary.

The proposals for the future configuration of services have received support, in principle, from key stakeholders such as Hampshire County Council, NHS Hampshire, Clinical Commissioning Groups and service user forums.

However, there are significant concerns raised by a number of local people in relation to the proposal to withdraw from Windsor Ward in Woodhaven. Taking into account the total population for the Woodhaven catchment area this is a relatively small proportion of people raising concerns. Dr Julian Lewis MP has been prominent in his opposition to the reduction in acute beds, as well as fears for the loss of a purpose-built facility. He presented a petition of 1,085 names during the process of consultation. Dr Lewis also initiated an adjournment debate in the House of Commons, to which Paul Burstow MP (Minister of State, Department of Health) responded. The Minister supported a local decision making process and the Hansard transcript of the debate is attached.

The most consistent message amongst all feedback is that the transition from the current to the proposed model should be very carefully managed if it goes ahead, maximising opportunities for piloting new ways of working before existing services are altered, and working closely with partners to secure the best possible outcomes. With this assurance, there is support for the clinical model. In particular, respondents sought details about:

- the alternatives to hospital care
- the support for carers, including transport considerations
- the transition plans
- the potential future use of Winsor ward at Woodhaven and The Meadows in Sarisbury Green

Overall, SHFT has concluded that the direction of travel is broadly supported. However it has received powerful messages that work to test out the new model before reducing bed numbers is key to moving forward with support.

4. Action Since Closure of Consultation

Following the closure of consultation, discussions with a number of key stakeholders took place to agree what should happen next. Serious consideration was given to extending the period of consultation, given the strength of feeling in the New Forest in particular. However, the conclusion was reached that there was no clear added value in doing this as it was unlikely to reveal any new information or views. Instead, it was agreed that we would take time to reflect on what we had heard through the consultation and consider our next steps carefully.

We communicated this decision in writing to every person who responded to us, including those who signed the petition. A number of people have thanked us for this communication, and similarly a number contacted us saying they did not recall signing the petition or what it was for.

In order to aid this period of reflection, we established a Stakeholder Group in East and West Hampshire respectively. At the time of writing, the groups have met three times each. Membership includes County and District Councillors, Dr Lewis, Trust governors, service user and carer representatives, commissioners, clinicians and managers. GP Leads have also been invited, and membership has been sought from the Police and Housing in West Hampshire. The Terms of Reference are attached at Appendix C. The groups are working through the key themes that have arisen and been described above,

and SHFT has provided extensive detail about the evidence used to influence its proposals from national and local sources. It has also provided information about the work that is already being piloted to test out new ways of working, such as the very successful Intensive Day Support service in the New Forest. 119 people have utilised this service over the last twelve months, and for some people this has assisted in them either leaving hospital early or prevented hospital admission completely.

In addition to the Stakeholder Groups, we have continued to engage with a wide range of people through various settings and in one-to-one meetings, including:
- HOSC
- Hampshire LINks
- Parish Councils
- Trust Governors
- MPs
- GPs
- Statutory partners including commissioners

5. Proposed Next Steps
The next steps we propose take into account the feedback we have received, balanced alongside the service risks which are associated with a period of transition and uncertainty.

Acute Care
In relation to the proposals that we expand home treatment capacity and reduce acute beds in Hampshire, we propose to:
- continue to use the Stakeholder Groups to work through the issues of concern, which are significantly more apparent in the New Forest than in East Hampshire
- extend the piloting of the proposed pathway of care, e.g. extension of the Intensive Day Support service beyond the New Forest; roll-out of the discharge facilitation role beyond North Hampshire; improving our work with carers
- begin this extended piloting in January 2012, to be phased across all geographical areas between January and March 2012
- continue to monitor the impact of these measures on bed usage and lengths of stay as well as key quality outcomes to include service user and carer experience
- develop plans for a phased reduction in acute beds to begin in March/April 2012, subject to review and further discussion with the HOSC at the end of January 2012. The pace of this phasing will be influenced by the impact of the pilot work. Final decisions about affected units will not occur ahead of the January HOSC meeting.
- articulate clear plans for the potential re-use of Winsor ward at Woodhaven by the end of January 2012 at the latest
- finalise plans for formal service evaluation by January 2012
- seek an independent view from the Centre for Mental Health, in London, as to our proposals for reconfiguration.

The extent to which it is feasible to ‘double run’ the current and proposed new pathways in their entirety is being scoped at present. This will be influenced by factors such as availability of additional staff and funding.

We hope that these proposed next steps illustrate the seriousness with which we have taken the feedback from the public consultation process. We welcome the input we have received and believe our proposals are stronger as a result. We are mindful of the clinical and operational risks which can arise during a period of uncertainty in services, for example in safe staffing levels and continuity of care. Therefore it is important that together we commit to the next steps, in whatever form those may be agreed, without significant delay.

Rehabilitation

We propose to work towards the closure of Copper Beeches by the end of January 2012. This is for a number of reasons:

- the move towards community-based rehabilitation is longstanding and is broadly accepted as a model which enables a return to independent living. It has occurred in other parts of the county over several years
- the care plans of the current service users at the unit mean that they are all expected to move on by mid January as part of their individual recovery, regardless of the status of the unit. Working to this timetable means that no current service user will be adversely affected by this change
- the lease on the building is due to expire at the end of the financial year
- permanent staffing numbers have reduced as staff have decided to seek more stable employment. Temporary staffing arrangements are in place to ensure that the unit remains safe. However this is not expected to be sustainable beyond January 2012
- it will allow us to establish the community-based reablement function ahead of the proposed changes in the acute care pathway and thus allow time for 'bedding in'

We are providing assurance to the local Clinical Commissioning Group that this service change does not entail a shift of costs into NHS continuing care, which was their only concern raised through feedback.

There were two key themes to the public feedback in relation to Copper Beeches from our public consultation process. These were:

- Concern there is limited accommodation for people in the New Forest if Copper Beeches closed. In response, we are committed to supporting people as close to home in a variety of settings. We have set up a specific project in conjunction with the Strategic Health Authority which is looking to work with a range of accommodation providers to ensure no geographical area is disadvantaged through this proposal.
- Concern the closure of Copper Beeches will have a negative impact upon existing service users and carers. In response, if approved to proceed within the timeline suggested, it means that no current service user will be adversely affected by this change as each person is due to be moving on anyway.

We believe that these proposed next steps represent a sound response to the feedback we received through consultation, which address the call for a thorough and safe transition period, alongside the need to maintain momentum around essential decisions for the future of our services.

6. Considerations

The Trust would appreciate the Hampshire Health Overview and Scrutiny Committee's consideration of the following:

- approval of the conclusion of the formal consultation regarding the reconfiguration of Adult Mental Health services in Hampshire
- the seriousness with which the Trust has taken on board the concerns expressed through consultation and the efforts made to address them
- the work of the Stakeholder Groups to examine concerns in depth and work towards shared solutions
- support for the proposed next steps for acute care, with a clear review in January 2012 before final decisions are made
- support for the proposed next steps for rehabilitation in the New Forest, including support for the closure of Copper Beeches in New Milton in January 2012, subject to final approval by the Board of Clinical Commissioners and SHFT Trust Board

- the Trust response to Chair of Health Overview and Scrutiny Committee (letter dated 12 October 2011) sent under separate cover
- the Trust response to Councillor Hindson and Gill Duncan's Letter dated 14th November 2011 sent under separate cover

Dr Lesley Stevens Anna Lewis
Clinical Director Divisional Director
18 November 2011

Appendices
Appendix A Details of Public Consultation and communications
Appendix B Summary of feedback from 6 week consultation
Appendix C Stakeholder Meeting Terms of Reference

Appendix A
Communications with Stakeholders - Engagement Phase
Events
Area Date Time Venue Attendees
North 07.04.11 2pm - 4.30pm Irish Centre, Basingstoke 8
West 11.04.11 9.30am - 12pm Lyndhurst Community Centre, Lyndhurst 8
East 12.04.11 9.30am - 12pm Fareham United Reform Church, Fareham 25
West 13.04.11 3pm - 5pm United Church, Winchester 11
East 18.04.11 10am - 12pm Waterlooville Community Centre 28
North 19.04.11 2pm - 4.30pm Irish Centre, Basingstoke 13
Southampton 27.04.11 9.30am- 11.30am Antelope House, Southampton 13
Letters sent out offering a form of contact
Area/Trust Contact Name Position
Solent Dr Ros Tolcher CEO
Solent Mr Mike Brody MD
WEHT Dr Chris Gordon CEO
WEHT Dr Jeremy Hogg MD
SCAS Will Hancock CEO
SCAS MD
SUHT Mark Hackett CEO
SUHT Dr Michael Marsh MD
Basingstoke Mary Edwards CEO
Basingstoke Dr Andrew Bishop MD
Portsmouth Hospital

Trust
Ursula Ward CEO
Portsmouth Hospital
Trust
Dr Simon Holmes MD
South Central Julie Kerry
Wessex LMC Dr Nigel Watson CEO
MP Basingstoke Mrs Maria Miller
MP Bracknell Dr Philip Lee
MP East Hants Mr Damian Hinds
MP Eastleigh Mr Chris Huhne
MP Fareham Mr Mark Hoban
MP Gosport Ms Caroline Dinenage
MP Havant Mr David Willetts
MP New Forest East Dr Julian Lewis
MP New Forest West Mr Desmond Swayne
MP North East
Hampshire
Mr James Arbuthnot
MP North West
Hampshire
Sir George Young
MP Portsmouth North Ms Penny Mordaunt
MP Portsmouth South Mr Mike Hancock
MP Romsey and
Southampton North
Mrs Caroline Nokes
MP Southampton,
Itchen
Mr John Denham
MP Southampton, Test Dr Alan Whitehead
MP Winchester Mr Steve Brine
MP Meon Valley Mr George Hollingbery
Simon Hunter APAC Chair
Andrew Douglas APAC Chair
Hugh Freeman APAC Chair
David Chilvers MH Lead
Nicola Decker MH Lead
Dr Tony Kelpie GPCCs
Dr Dan Tongue GPCCs
Dr Stephen Townsend GPCCs
Dr Phil Clarke GPCCs
Dr Amir Mehrkar GPCCs
Dr Chris James GPCCs
Dr Hugh Freeman GPCCs
Dr Lisa Briggs GPCCs
Responses were given to those who responded

Consultation Phase

Consultation Events

Area Date Time Venue Attendees

West 22nd Sept
2011
6.30pm - 8.30pm United Church, Winchester 13
West 28th Sept 2011 6.30pm - 8.30pm Greyfriars Community
Centre, Ringwood
11
North 29th Sept 2011 1.30pm - 3.30pm Irish Centre, Basingstoke 15
East 29th Sept 2011 6.00pm - 7.15pm United Reform Church,

Fareham
9
West 30th Sept 2011 11.30am -
1.00pm
Calmore Community
Association, Totton
54
East 3rd Oct 2011 2.00pm - 4.00pm Waterlooville Community
Centre
9
West 6th Oct 2011 6.00pm - 8.00pm Tatchbury Mount, Calmore 74
East 10th Oct 2011 2.00pm - 4.00pm Thorngate Centre, Gosport 21

Meetings

Governor Information Meeting 07.04.11
New Forest Carers Group 08.04.11
GP Day 06.05.11
Eastleigh Friendship Club 11.05.11
Hampshire County Council (Director of Adult Services,
Assistant Director, Adults Services, Assistant Director LD/MH
Adult Services)
24.06.11
Southampton City Council (Executive Director of Health & Adult
Social Care)
24.06.11
Portsmouth City Council (Adult Services, Strategic Director) 24.06.11
Cllr Hindson & Lucy Butler 08.07.11
Governors Development Day 10.07.11
Test Valley Borough Council 11.07.11
New Forest District Council (Health & Wellbeing) 12.07.11
Dr David Chilvers (CCG mental health lead) 14.07.11
Dr Jenny Allinson (CCG mental health lead) 28.07.11
Dr Hugh Freeman & Others 30.07.11
Meeting with Southampton GPs Aug/Sept
Fareham Borough Council 29.09.11
Making sense of Service Redesign (Service User Network
event)
06.09.11
Eastleigh Borough Council 17.10.11
Dr Nigel Watson 26.10.11
New Milton Town Council 28.11.11
Netley Marsh Parish Council 16.11.11
Support Our Mental Health Services (Dr Lewis' group) Ongoing
HLinks Meetings Ongoing

Meetings offered

The list above is not exhaustive. Individual meetings were and continue to be offered to a number of people who expressed an interest. This has included GPs, MPs, carers, governors, partners.

Appendix B

Analysis of the feedback received from the Public Consultation
'Improving Outcomes for Hampshire's Adult Mental Health Services'

Consultation period between 5th September to 14th October 2011

1. Introduction

This report analyses the feedback received as a result of the public consultation on the proposed changes to current adult mental health inpatient provision within the East and West Areas of Hampshire adult mental health (AMH) services. The proposals put forward a comprehensive redesign of existing community mental health services including the development of alternatives to hospital admission such as 'Hospital at

Home', which enable the withdrawal of acute inpatient beds from 2 of 6 hospitals. The Trust proposed withdrawal of acute inpatient beds from The Meadows (Sarisbury Green – 24 beds) and Woodhaven (Calmore – 24 beds), alongside the cessation of existing Reablement inpatient beds at Copper Beeches (New Milton – 8 beds).
The purpose of this report is to collate the various formats of feedback received, analyse this feedback and provide a summary.

2. Background

Following a period of extensive engagement over an eighteen month period which included conversations with Hampshire Health Overview and Scrutiny Committee and Southampton Health Overview and Scrutiny Committee, written and verbal briefings to GPs, emergent GP/Clinical Commissioning Consortia, District Councils, Section 75 Local Authority partners, LINks (Local Involvement Networks), a range of local third sector providers and Commissioners together with service users, carers and our staff, the public consultation ran for six weeks from 5th September 2011 to 14th October 2011.
The Trust undertook a period of intensive key stakeholder engagement where key stakeholders were engaged including MPs, lead GPs, Local Authority, District and Parish Counsellors, Trust Governors and Members and Service User Groups. Every effort was made to engage this group using written communication, email and personal contact.
To ensure people had the opportunity to ask questions or explore the proposals further, the Trust held a series of public events in the areas most likely to be affected by the proposals. Initially six events were planned however in response to requests / demand a further two meetings were held (one in Gosport and the other in Calmore). The public events were held as follows:

Area Date Time Venue

West 22nd Sept 2011 6.30pm to 8.30pm
United Church, Winchester
West 28th Sept 2011 6.30pm to 8.30pm
Greyfriars Community Centre, Ringwood
North 29th Sept 2011 1.30pm to 3.30pm
Irish Centre, Basingstoke
East 29th Sept 2011 6.00pm to 7.15pm
United Reform Church, Fareham
West 30th Sept 2011 11.30am to 1.00pm
Calmore Community Association, Totton
East 3rd Oct 2011 2.00pm to 4.00pm
Waterlooville Community Centre
West 6th Oct 2011 6.00pm to 8.00pm
Tatchbury Mount, Calmore
East 10th Oct 2011 2.00pm to 4.00pm
Thorngate Centre, Gosport

The consultation was also publicised via local media, for example Daily Echo, GPs, local councillors, Local Authorities, The Trust website, to all local NHS organisations, MPs, circulation of email and flyers to third sector organisations, LINks and at other events e.g Flu Jab day at Crossfield Hall in Romsey.
Attendance (excluding Trust employees at each public event was:

- West 22nd Sept 2011 13
- West 28th Sept 2011 11
- North 29th Sept 2011 15

- East 29th Sept 2011 9
- West 30th Sept 2011 54
- East 3rd Oct 2011 9
- West 6th Oct 2011 74
- East 10th Oct 2011 21

TOTAL:
206

Responders to the consultation had a variety of formats in which to provide feedback. These were:

- During Q&A sessions at public events
- During bespoke Q&A sessions set up with specific stakeholder groups (e.g. Borough and Parish Council and GP Consortia meetings)
- Completion of the feedback form at a consultation event
- Completion of a 'survey' on website
- Completion of downloaded feedback form from website
- Writing to Engagement Office using Freepost address
- By email to the Engagement Office email address
- By telephoning the Engagement Office or Trust Headquarters

3. Analysis of feedback

Feedback was received as follows:

- 8 Q&A public event write ups
- 33 feedback forms (0 – North, 18 – West, 7 – East and 8 – not attributable to an Area)
- 34 emails
- 26 letters
- 5 telephone calls
- Survey Monkey on website – 18 responses (41% general public, 12% staff and 25% Carers)
- 1 petition from West Area (1,085 signatories)

Summary of Key Themes (in no specific order)

- There was a high regard for the current services provided and the quality of the interventions with support for the overall direction of the proposed model.
- Request for more detail around the community alternatives to inpatient stays specifically in relation to Hospital at Home and community team staffing
- Concern the proposals would lead to a great demand on carers to provide support
- Concern carers would need to travel further in those Areas where the inpatient beds were withdrawn
- Concern about the pace and impact of the proposals
- Concern the proposals are a direct consequence of budget 'cuts' and 'cuts' to the services
- Concern about the future closure/mothballing of NHS buildings and resources

Key Themes from Feedback by Area

North Area (2 total feedback)

- Small number of responses with no clear theme

West Area Themes (77 total feedback)

- Considerable number of people did not wish to see Woodhaven close
- Concern the proposals for alternatives to hospital and community infrastructure have not been fully articulated or explained to make informed decision
- Concern carers and relatives would be required to travel further to visit relatives if admitted to inpatient facility
- Concern of an increased reliance upon carers to support relatives/service users
- Concern access to inpatient facilities would become more difficult, thus increased impact upon family and carers
- Challenge as to why Woodhaven given this is a relatively new and purpose built inpatient facility

- Concern there is limited accommodation for people in New Forest if Copper Beeches and Woodhaven close
- Concern the closure of Copper Beeches will have a negative impact on existing service users and their carers

East Area Themes (19 total feedback)

- Concern population figures planned to rise in Fareham & Gosport – the proposal to close Meadows does not appear to have taken this into account
- Concern the alternatives to hospital had not been fully articulated or explained to make informed decision
- Concern carers and relatives would be required to travel further to visit relatives if admitted to inpatient facility
- Concern increased reliance upon carers to support relatives/service users

Sally Probert, Pam Sorensen and Carra Smith 17th October 2011

Appendix C

TERMS OF REFERENCE FOR STAKEHOLDER GROUPS

Background and Purpose

A stakeholder group will be established in East and West Hampshire respectively. The groups are being set up in order to take forward the work of the service redesign programme in Adult Mental Health, about which a period of public consultation has been undertaken. The groups are intended to facilitate engagement with key stakeholders who have participated in the consultation process to date.

While groups are being established in each area to promote a sense of localness, it is important that there are opportunities to share information across the areas. As a minimum this will include the sharing of agendas and meeting notes. If there is interest in doing so, it may helpful to offer a joint meeting of the two groups periodically.

Objectives

Objectives are related to the specific themes which have emerged during the consultation process:

o To understand and contribute to the detailed design of the community alternatives to inpatient care

o To understand and contribute to details in terms of support to carers, including travel implications. Support should recognise the importance of balancing the needs of carers with those of service users

o To contribute to the transition planning to ensure that service outcomes are not weakened by the process of redesign

o To contribute to the planning for the potential future use of the Woodhaven and Meadows estate respectively, including the impact on shared site services (e.g. ECT and catering at the Meadows)

The objectives do not pre-suppose that a decision has been made about the future of our services. Rather we see this as a time to 'hold' those decisions, work through the concerns and then return to the proposals themselves. We hope that by addressing the concerns and working together to strengthen the proposals, public confidence can increase.

Membership

The stakeholder groups will be led by the Clinical Director, with support from the Divisional Director as well as Area Managers, Clinical Service Directors and other key members of the Area Leadership Team.

The proposed membership in addition to the above is as follows.

East Hampshire

Bob Blackman, Carer & Trust Governor
Dr David Adey, GP & Trust Governor
Dr David Chilvers, CCG GP Mental Health Lead
Dr Jenny Allinson, CCG GP Mental Health Lead
Cllr Liz Fairhurst, Hampshire County Council
Tracey Nicholls, Service User Network

Julie Parker, MIND
NHS Hampshire representative
Hampshire County Council representative
Hampshire LINks Representative
West Hampshire
Cllr Di Brooks, New Forest District Council
Cllr Keith Mans, Trust Governor & Hampshire County Council
Dr Julian Lewis MP
Helen Keats, Trust Governor
Dr Jim Rose**,** CCG GP Mental Health Lead
Kerry Hearsey, Chief Executive, Princess Royal Trust for Carers
Barbara Allen, Service User Involvement Co-ordinator, Andover MIND
NHS Hampshire representative
Hampshire County Council representative
New Forest District Council Housing representative
Police representative
Hampshire LINks Representative

Format

We are mindful of the time commitment involved in this work and the busy schedules of every proposed member. Equally, we wish to provide ample opportunity for key stakeholders to be involved in the detailed development of our proposals. As such we are proposing a weekly schedule of activity, but we understand that not all members will be able to attend every week.

We propose to hold a weekly meeting in East and West Hampshire respectively, in the form of a working group, which will address one of the objectives identified above per session.

In addition, we propose to offer opportunities to members to see our services in action at first hand. This may involve shadowing a member of staff, visiting a team or a ward. We will tailor the opportunities according to individual requests.

The proposed format will be discussed at the first meeting of the groups to confirm support.

Frequency

As described above.

Outputs

The groups' first output will be to contribute to the proposals that we will take back to the Hampshire Health Overview and Scrutiny Committee at the end of November. We will then take stock of the success of the groups and consider next steps together.

Appendix Five: Southern Health NHS Foundation Trust- Joint HOSC Meeting: Antelope House- 7 October 2011

Thank you for confirming your attendance at the above Joint HOSC meeting. This will be held on the 26 October 2011, commencing at 5.00 p.m. The venue will be the Wellington Room here at the Castle in Winchester. Directions are available at http://www3.hants.gov.uk/map/ .

As per the previous e-mails on this topic I can confirm that the meeting will be jointly run by representatives of Hampshire and Southampton HOSCs. The issue that we want will to consider in greater depth is the recent report from CQC relating to Antelope House. In part the concerns expressed by Members about this report have been sharpened by the current consultation on proposals to reconfigure Adult Mental Health Services across our respective areas. Both Committees agreed to a foreshortened consultation period on the grounds that the proposals had wide-spread stakeholder support and would improve the quality of care and support available to service users. It is this latter point that we will wish to explore further at this meeting.

Preparatory to the meeting we have reviewed previous CQC reports and other publically available reviews relating to Adult Mental Health Services provided by Southern Health. This has helped us to focus on the key issues identified in the CQC report from this September, some of which appear to be recurring themes in this documentation. Specific areas we would wish to cover at the meeting include:

- The steps that have been taken to ensure that individual care plans are up to date and how the Trust ensures staff take the required action in response to these plans
- The rigour of assessment of service users - including risk assessment - and how this is evaluated
- The action taken to ensure that informal patients are not inappropriately detained
- Staff training in relation to roles responsibility and decision making
- Staff access to training

I would also be grateful if you could confirm if there are any further reports pending from the CQC and the issues these are likely to raise. Additionally I would appreciate confirmation of any impact or risk assessment undertaken by the Trust in relation to the proposals currently out to consultation.

If any of this information is available for sharing with us prior to 26 October that would be helpful however I do understand that the lead-in time for the meeting is relatively short and this may not be possible.

Please do contact me should you have any queries about the above or the meeting on 26 October 2011.

Yours sincerely

Cllr Pat West
Chairman, Health Overview and Scrutiny Committee

Appendix Six: Southern Health NHS Foundation Trust- Joint HOSC Meeting: Antelope House- Response to the HOSC letter dated 7 ocotber 2011.

Thank you for your letter of 7 October 2011, and our subsequent and very constructive meeting on 19 October 2011.

In advance of the special joint meeting of the Hampshire Health Overview and Scrutiny Committee and the Southampton Overview and Scrutiny Panel on 26 October 2011, I thought it would be useful for you to have an initial response to the issues you have raised, which we can then discuss in more detail at the meeting. I will respond to each point in turn.

- *The steps that have been taken to ensure that individual care plans are up to date and how the Trust ensures staff take the required action in response to these plans.*

Following the inspection at Antelope House, we took immediate steps to check that every care plan and risk assessment was up to date for every inpatient in adult mental health services. Next, we developed and implemented a flowchart for use in every unit which sets out the process for reviewing care plans and risk assessments on a regular basis. Then, we devised a weekly 'spot check' audit tool which tests out compliance with the process, and implemented it across all of our mental health and learning disability services. This is undertaken by the Matron or other senior nurse. In addition, we are in the process of reviewing our annual care planning audit, to improve the tool we use and to ensure that it tests the quality of care plans.

We will also increase the frequency of this audit. We are also looking at what is required to strengthen the care planning skills of our staff at Antelope House. Supervision is another opportunity to check the quality of individual care plans as well as practitioner skills, so we have reviewed our arrangements in this respect too.

- *The rigour of assessment of service users - including risk assessment - and how this is evaluated*

In addition to the above actions which all help towards a more rigorous process, we have undertaken a programme of risk practice development over recent months in Adult Mental Health, which has been led for us by an external consultant with nationally-recognised expertise in positive risk practice. This has focussed on developing risk assessment skills, as well as exploring with practitioners what barriers they face in their daily practice. This work is being used to inform further development of the risk assessment policy and training in the Trust.

Beyond our inpatient services, enhancing skills in assessment is a key feature of our redesigned pathways, as we recognise that high quality assessment is essential in determining the right package of care for any individual. So we have a range of measures in place to develop a standardised assessment tool and process through our new Access and Assessment teams (single point of entry).

- *The action taken to ensure that informal patients are not inappropriately detained*

This issue relates to the locking of doors on wards which are not ordinarily locked. This is a complex area of practice which presents dilemmas about safety versus freedoms. As such it is essential that our policy gives very clear guidance to staff who make these decisions. We have reviewed the policy to improve its clarity, and this has been disseminated across all relevant services and staff. The weekly spot check

referred to above covers compliance with the Locked Door Policy. We have also reviewed and improved the notices we display on the wards when doors are locked, so that service users who are not detained are clear about how they can leave if they wish.

- *Staff training in relation to roles, responsibility and decision making*

Ward staff have been reminded of their professional responsibilities in managing a 'locked door', and the updated policy has been cascaded. We have delivered bespoke 'Safeguarding' training for all staff at Antelope House. Other training requirements (e.g. care planning, risk assessments, managing dual diagnosis) have also been identified, with some training already delivered and other training being designed and planned to occur over the coming months.

- *Staff access to training*

We have put in place actions to review training compliance, identify shortfalls and address these on an individual basis. Checks are being made through supervision.

- *Further CQC reports*

In Adult Mental Health, the CQC inspected Elmleigh in Havant on 12 September 2011. A draft report has been received and we expect the final version to be published within the next two weeks. The unit was compliant with two of the standards inspected. However moderate concerns were raised in relation to two standards and a minor concern was raised in relation to one standard. We have started work on an action plan in response, as well as taking some immediate steps to address concerns. I will ensure you receive a copy of both the report and our action plan when they are finalised.

Crowlin House received an unannounced CQC inspection on Thursday 20 October 2011. We understand this was in response to staff raising a concern direct with the CQC. Whilst we have not received the draft response we understand the issues are around Care Planning and Management of medication. We can discuss this further at our meeting.

- *Impact Assessments*

These have been completed and we will review them in light of the consultation themes that have emerged.

I hope this information is useful in advance of our meeting on 26 October 2011. I look forward to seeing you then.

Appendix Seven:

Care Quality Commission Report
Adult Mental Health Services
Hampshire and Southampton Health Overview and Scrutiny Committees
Joint Meeting
Wednesday 26th October 2011, 5pm

Meeting Note

Attendance: Cllr Vincenzo Capozzoli *(Southampton City Council),* Cllr Phryn Dickens *(Hampshire County Council),* Cllr Liz Fairhurst *(HCC)*, Cllr Pam Mutton *(HCC),* Cllr Brian Parnell *(SCC),* Cllr Warwick Payne *(SCC),* Cllr Pat West *(HCC).*

Officers in Attendance: Katie Benton *(HCC),* Jane Brentor *(SCC),* Anna Lewis *(Southern Health NHS FT),* Katrina Percy *(SH NHS FT),* Caronwen Rees *(SCC),* Pam Sorensen *(SH NHS FT),* Dr Huw Stone *(SH NHS FT)*, Dr Ray Vieweg *(SH NHS FT)*, Diane Wilson *(NHS Hampshire).*

Observing: Richard Barritt *(Solent Mind)*, Carol Bode, *(SH NHS FT),* Harry Dymond *(Southampton LINk)*.

1) Welcome and Apologies for Absence

Members and officers were welcomed, and a short health and safety briefing was given.

2) Declarations of Interest

Cllr Phryn Dickens	Husband and son employed by NHS
Cllr Pam Mutton	Daughter employed by NHS Member, League of Friends, Andover WMH
Cllr Pat West	Daughter-in-law employed by NHS

3) Chairman's Communications

Members had met to consider the recent report by the Care Quality Commission (CQC) on Antelope House, and Southern Health's resulting action plan in relation to the concerns raised. Members did not consider the wider-ranging adult mental health consultation, as it was felt that this was a matter for the formal Hampshire and Southampton HOSCs to consider.

The Joint Chairmen welcomed the three observers attending the meeting. Introductions were made between all Members and officers in attendance.

4) CQC Report - Antelope House

(Take in attached presentation)

- Southern Health opened their presentation by accepting that some of the adult mental health services they provided had fallen short of the essential standards expected of them by the Care Quality Commission (CQC), and, to

this end, they understood the concerns voiced by Members. However, Southern Health did not believe that the areas requiring improvement were of a serious nature, and were not of the scale seen on recent documentary programmes (e.g. Panorama programme on Castlebeck).

- Overall, a shift in the culture of the organisation was needed, and bad practices of the past needed to be left behind. The recruitment process for new staff was changing, and the Trust was embarking on a programme to provide clinical leadership to services and facilities that will help bring about a culture shift. This included changes to the appraisal process and a leadership development programme.
- Southern Health stated that they had been too ambitious in expecting facilities to provide their own quality and clinical governance based on centrally published policy – work would now be progressing to ensure that all services had the same set of processes in place.
- Internal inspections were currently ongoing across the whole Trust, which has close to 200 individual adult mental health services and facilities. This round of inspections would be completed within six months. Southern Health were using the CQC's compliancy standards approach to inspection, and have a full-time team of dedicated governance staff undertaking this work, with support from others across the organisation. The Trust are keen for external stakeholders to be involved in these inspections, and are communicating with commissioners, governors, and other organisations/individuals to see how this can be taken forward.
- After the initial draft report on Antelope House from the CQC was received by Southern Health, an audit and completion of all care records was undertaken by staff on the wards within 12 hours, and all other facilities had completed similar care record inspections within three working days.
- Since this time, all care plans have been and are now subject to unannounced regular spot-checks.
- A large amount of work has gone into practice-based development with staff, and this has been built into training and courses for both current and new employees. All staff that work in adult mental health facilities must receive mandatory training, including on safeguarding – and this isn't just exclusive to clinical and care staff.
- Training has been one of the main focuses of the action plan, with some immediate sessions having already been undertaken for staff, and other scheduled for the near future.
- A locked door is a complex dilemma for staff – the issue at Antelope House was that the correct use of the Southern Health Trust policy was not being evidenced when staff felt it necessary to lock the doors of informal patients.
- Patient experience is important. Southern Health want to return the confidence and trust of service users, carers and other stakeholders in the services provided.

In response to questions, Members heard:

- That the first six months of internal inspection will be a benchmarking exercise, which Southern Health expects should find most services compliant with the CQC's standards. Those that have been shown to have compliancy issues will have an action plan drawn up and implemented. All services will be subject to further inspection at a future date, as part of a rolling audit process.
- That the CQC cannot guarantee a re-inspection of a service which has previously been found not to be compliant with essential standards. However,

CQC are happy to receive internal inspection reports from providers and will add this to a case of evidence to inform any future visits.

- Southern Health will have completed their action plan by December and will consider what other evidence they can provide.
- When Hampshire Community Health Care (HCHC) and Hampshire Partnership NHS Foundation Trust (HPT) merged to form Southern Health NHS Foundation Trust, the new strategic management team decided to take the best policy and practices from each of the organisations to form a new set of quality and clinical governance policies and practices. One of the areas of best practice included a process of mock inspections of services from HCHC, which has been used to inform the current internal audits occurring in all Southern Health mental health facilities.
- That one of the areas that has received financial investment rather than reduction in the Trust has been quality governance, under which heading the current and rolling inspections are placed. This means that staff will be adequately funded and resourced to ensure this area of best practice can be continued for the next three years.
- A large number of the improvement actions for Antelope House focus on changing staff culture – some staff have developed bad practices despite being well-meaning and conscientious in their role. Clinical leadership is needed to embed a culture and attitude in staff that reflects the essential standards expected in a modern adult mental health facility.
- Staff who feel that they wish to report a lack of compliance in an essential standard or a safeguarding issue can use the Southern Health whistle-blowing policy, or, alternatively, can communicate with the Chief Executive to voice their concern. Southern Health has confidence that this system works, and has experience of both methods of reporting having been used.
- The Director of Workforce is responsible for training, a lot of which is mandatory for staff working in the field of adult mental health. Southern Health are currently refreshing the staff appraisal process, in order to ensure that training attended is embedded into practice, and to highlight future development needs.
- Residential adult mental health facilities are moving to a system of filling spare working shifts with their own vetted bank staff, rather than agency staff, which ensures that all of those working in the service have had the same induction and training.
- Staff are receiving refresher training on the ‘Locked Door’ policy, and informal service users are being made aware of their rights to ask to leave a facility or room with a locked door in place, both verbally and through signage.
- A very senior nurse has been brought into Antelope House to provide the clinical leadership needed to implement and see through the action plan drawn up in wake of the CQC report.
- Services users are heavily involved in their own care plans, and in assessing the quality of services they receive. A weekly group meeting is held in Antelope House which presents an opportunity for service users to flag issues on the ward for action by staff. The CQC unfortunately did not speak with service users whilst undertaking their inspection.
- Once the report on Antelope House was received by Southern Health, a meeting was called with the current service users in the facility in order to explain what had been found and how the Trust planned to implement improvements to meet standards.

- As previously mentioned, Southern Health have welcomed the idea of external stakeholders taking part in internal inspections of adult mental health facilities, but this is also true of service users who wish to help audit other services in Hampshire.
- Staff morale in some facilities is currently quite challenging, but the way to improve this is to invest in staff and highlight the positive aspects of the way they care for patients. Southern Health are currently proposing to hold an 'Oscar night' style event which rewards outstanding staff with the recognition of a job well done.
- Currently Southern Health are operating an annual staff turnover of 10%. The organisation is especially interested in those staff that leave within the first year of employment, and have set up a series of processes to capture why staff are leaving relatively quickly after receiving induction and training packages.

Members heard from observers:

- That the Southampton LINk is willing to partake in internal inspections of Southern Health adult mental health facilities.
- That adult mental heath commissioners in Hampshire will also be partaking in internal inspections.
- Commissioners felt the action plan could be strengthened if some of the culture change actions were articulated in the plan.
- That Solent Mind are pleased to see that the cultural direction of adult mental health services is one that focuses on service users being the leaders of their own care.
- That the questions asked by members have been similar to those asked by the Southern Health Board of Governors. The Chairman of the Board did not feel that the Trust was starting from scratch in terms of meeting standards in adult mental health facilities such as Antelope House, but rather striving for continuous improvement of services.

RECOMMENDATIONS

(i) That a report on the progress of action plans under each of the following five workstreams be reported individually to the Hampshire and Southampton HOSCs:

a) Individual care plans.
b) Assessment of service users.
c) Inappropriate detainment of informal patients.
d) Recording of critical incidents and observations.
e) Staff access to training.

That the first of these reports be received in January 2012.

(ii) That a separate report is provided to both HOSCs on the impact of CQC reports on current plans for Adult Mental Health service re-design.

5) Other CQC reports pending

- There are currently two other CQC reports pending for mental health services provided by Southern Health NHS Foundation Trust. These are for Elmleigh,

an adult mental health acute admissions ward in Havant, and Crowlin House, an adult mental health rehabilitation unit in Totton.

- A draft CQC report on Elmleigh had been commented on for accuracy by Southern Health, who were currently awaiting the final version of the report. Southern Health had carried out an internal inspection of Elmleigh prior to the CQC's unannounced visit, but had not implemented a drawn-up action plan to resolve compliancy issues, which were of a similar vein to those found at Antelope House. Southern Health were disappointed that they had not been able to implement these changes quick enough, but were also aware that some of the changes suggested would have taken time to embed.
- The inspection of Crowlin House had only recently taken place, and therefore Southern Health were only able to confirm that the CQC had flagged some initial compliance issues.
- The risk and equality impact assessments that have been undertaken on the adult mental health proposals currently subject to public consultation will be refreshed in light of all of the CQC reports and their findings. These will be provided to both HOSCs in due course.

RECOMMENDATION

(iii) That the Hampshire and Southampton HOSCs write to the Care Quality Commission asking them to formally seek their views when following up on any inspections or reports filed on Southern Health Adult Mental Health facilities.

(iv) That the Hampshire and Southampton HOSCs receive any risk or equality impact assessments undertaken in relation to the adult mental health proposals currently subject to public consultation.

6) Summary and next steps

Members would be taking recommendations back to their formal HOSC meetings, where next steps would be decided.

Appendix Eight: Safe and Sustainable Judicial Review verdict

Monday, 7th November 2011

Reaction to the ruling by Sir Neil McKay, Chair of the JCPCT

I am disappointed that the Judge decided to quash the consultation on an obscure technical point that had no material bearing on the JCPCT's choice of consultation options. We respectfully intend to appeal the Judge's decision based on his misunderstanding of the review process.

I am very sorry for the delay that this ruling may bring to the process of review given the continued anxiety and frustration amongst parents of children with congenital heart disease across the country and NHS staff working in the surgical centres. I would like to provide an absolute reassurance that the work of the JCPCT will continue and that a final decision on the future configuration of services will be made in the Spring of 2012.

I am, however, pleased that the Judge rejected most of the grounds on which the RBH based their claim. Our responses to the Judge's verdict are set out below and I would like to take this opportunity to explain how *Safe and Sustainable* will continue the process for reaching a decision in 2012.

The Judge rejected the following claims put forward by RBH:

Pre determination and Irrationality

RBH claimed that the JCPCT had secretly decided that there would be only two surgical centres in London as far back as 2010 and that as such the public consultation was a sham. RBH also claimed that the JCPCT's preference for two centres in London was 'irrational'.

The Judge rejected these claims and found that the JCPCT had entered consultation with an open mind and had clearly demonstrated a genuine commitment to consider all viable options before a final decision is made. The Judge also said "*the JCPCT was entitled to identify and to consult upon its preferred options which did not include a three London centre model and which excluded the RBH*".

In making an accusation of pre-determination (including an accusation in legal documents that this was a '*classic back room stitch up')* the RBH was making serious allegations of impropriety against all of the JCPCT members, members of the Steering Group including respected children's doctors, the secretariat and others. This was particularly offensive and I call upon Mr Bob Bell, the RBH Chief Executive, to apologise in public on behalf of his Board.

Misinformation

The Judge rejected claims that the consultation document was fundamentally flawed and had misled the public. Specifically, the Judge rejected claims that the exclusion of foreign private-funded patients from the JCPCT's deliberations had disadvantaged the RBH or had misled the public.

Impact to paediatric respiratory services at RBH

In witness statements RBH clinicians told the Court that respiratory services for children at RBH would have to "close" and that they were in "little doubt" that the RBH "would be unable to survive as a hospital". Similarly the RBH Chief Executive, Bob Bell, told the Court that "closure would be inevitable" for respiratory services were RBH to lose paediatric cardiac surgery.

The Judge rejected these claims by finding that the JCPCT had properly considered the impact to paediatric respiratory services at RBH. The Judge absolutely rejected the suggestion that "*something had gone wrong*" with the process as RBH had claimed and praised the JCPCT for convening the independent panel of respiratory experts chaired by Adrian Pollitt. He said "*the decision to constitute the Pollitt panel was an appropriate response to representations made by RBH and serves to demonstrate the manner in which the process of consultation can and should work*".

The Judge acknowledged that "*the panel concluded that all respiratory services would remain viable; that the great majority of paediatric respiratory activity would continue to take place at RBH; but that arrangements would need to be put in place for some rare and complex cases*".

I recognise that the *Safe and Sustainable* proposals, if implemented, would have an impact on a small number of children with respiratory problems, and NHS commissioners in London will work closely with patients and their representatives and relevant hospitals to ensure this small group of patients would continue to receive high quality specialist care, regardless of which hospital they visit. It should be remembered that the benefits of collaborative working to provide care for respiratory patients were highlighted in a joint 2009 report between the RBH and Great Ormond Street Hospital for Children.

Bias and role of the Steering Group

RBH had claimed that senior clinicians from Great Ormond Street Hospital for Children and the Evelina Children's Hospital, who sit on the *Safe and Sustainable* Steering Group, were actively biased against RBH. The RBH had also claimed that the Steering Group was a secret gathering of clinicians making clandestine decisions and that the JCPCT had been improperly influenced by the Steering Group. The Judge rejected these strange claims and found that the Steering Group had provided objective advice on relevant clinical issues in accordance with the group's terms of reference and that the JCPCT – as the true decision making body -had properly considered this advice.

It is particularly disappointing that RBH sought to undermine the review process by questioning the personal integrity of highly regarded and respected children's heart doctors who work in London hospitals often in partnership with clinicians at RBH.

The finding against the JCPCT: score for 'research and innovation'

Of all the claims made by RBH against the JCPCT, the Judge upheld only one. The Judge found that the JCPCT's process for assessing the RBH's compliance with the standards relating to 'research and innovation' (which was found to be 'poor') was flawed.

We respectfully disagree with this finding, and it is particularly disappointing that the Judge upheld this claim as he conceded that the sub-score for 'research and

innovation' had no material bearing on the JCPCT's choice of consultation options. The Judge acknowledged that even had RBH been awarded the maximum possible sub-score for 'research and innovation' it would not have altered the JCPCT's preference for Great Ormond Street Hospital and Evelina Children's Hospital as these two hospitals would have still scored higher than RBH against the other criteria.

The Judge said that "*if at this stage the RBH Trust had been scored the same as GOSH for 'research and innovation' its total score on the inter London centre scoring would have been 303, as against 347 for GOSH and 364 for the Evelina*".

So why did the Judge make this ruling? Well,75% of respondents to public consultation agreed with the JCPCT's preference for two centres in London. But the Judge suggested that had RBH been given a higher sub-score for 'research and innovation' then fewer people across the country may have agreed with two centres and more may have instead opted for three centres in London.

On this basis alone, the Judge decided to quash the consultation.

What happens next?

The JCPCT met on 25 October to begin to consider the outcome of consultation, including consideration of new options proposed during consultation.

Safe and Sustainable and the work of the JCPCT continues with the objective of making a final decision as soon as possible in 2012. The JCPCT will meet as planned on 8 November, 17 November and 14 December 2011.

We respectfully do not agree with the Judge's conclusion that the consultation was unlawful. I believe that the 75,000 respondents to consultation and the three-quarter of a million people who signed petitions should be heard and their views taken into account. I am genuinely saddened that this court action has delayed a process that will deliver vital changes needed to improve outcomes for children across the country. We are therefore preparing for the process to appeal the court's decision.

But I am aware of the need to conclude the review in a reasonable timeframe given the anxiety and frustration that the ongoing uncertainty brings to parents and NHS staff across the country. So, at the same time as preparing for an appeal I have today written to the Chief Executives of all the surgical centres inviting them, if they so wish, to re-submit fresh evidence relating to their ability to meet the standards relevant to 'research and innovation'. I will ask Sir Ian Kennedy's panel to consider the new evidence in December and to advise the JCPCT on whether the centres' scores for research and innovation should be changed.

Should it prove necessary these new scores, if any, will be taken into account by the JCPCT when it meets to identify a preferred configuration option.

There are two alternative scenarios that explain how the JCPCT will reach a decision:

If the JCPCT is successful on appeal

The JCPCT will make a final decision on the preferred option at a meeting in public. The date of the meeting in public will be published once the appeal is heard (but may not be on 14 December as planned given the court time table).

If the JCPCT is not successful on appeal

OR

the JCPCT decides to hold a further public consultation because an appeal would take too long

The JCPCT will hold a meeting in public – probably in the new year - to identify a preferred option (including a consideration of new options and new evidence around research and innovation) and will then put the preferred option – and other options – back out for public consultation before making a final decision at a further meeting in public.

In any event, the JCPCT plans to make a final binding decision by Spring 2012 at the latest.

Jeremy Glyde, *Safe and Sustainable* Programme Director said:

““The case for change has never been stronger. We need fewer, larger centres carrying out children’s heart surgery. We need hospitals to work collaboratively in the interests of patients, not themselves. The results of the public consultation earlier this year show there is significant support for the principles of the review and the national quality standards. Expert clinicians, professional bodies and national heart charities all agree that change is long overdue.

“Members of the Joint Committee of Primary Care Trusts will meet tomorrow, again later in November and in December to continue the process for change. We stand ready to make a decision by the Spring of 2012 at the latest”.

Appendix Nine: Stroke, major trauma and vascular surgery engagement document: Hampshire HOSC response

Thank you for providing us with an opportunity to comment on this document. This prompted a lively discussion at our meeting on the 27 September and I am grateful to Sara Tiller, Beverly Meeson and James Kennedy for their considered input.

The points below form our response to the 'engagement' document. Our strong recommendation is that the PCT clusters- as the commissioners of these services- are mandated to determine the next steps in relation to these services, working with the network leads as appropriate. We are of the view that much of the confusion that has arisen about these services in the last 6 weeks has been generated by the SHA initiating action without taking advice from the clusters.

It is regrettable that the document went to the media before it was shared with us and we would urge that there are lessons learnt from this experience.

The additional information that we had from the SHIP cluster was helpful and demonstrated that a considerable amount of preparatory work had been undertaken in relation to each of the three services referred to in the document. It is disappointing that this was not used more fully for the purposes of this exercise. Hopefully this will be addressed as the next steps are taken forward by the various PCT clusters affected.

Overall we found the document to be muddled and confusing in its presentation: the content and layout causing more uncertainty in an environment where there were already a number of concerns being raised about vascular services. The case(s) for change needs to be articulated in a way that makes sense for the populations that will be affected. The lack of clarity about who is driving this work needs to be addressed.

Even as an 'engagement' document we would have expected that there would be evidence to demonstrate that it has taken account of the national requirements for reconfiguring services. It should also have been fully tested with the PCT clusters affected and other key stakeholders prior to being launched.

We do not believe that stroke, vascular and major trauma services should have been bundled up together in this way. Other examples exist of consultation about these services (e.g. Cheshire and Merseyside) that sets the case for changing these services much more effectively and we would commend these to you as you consider your next steps.

Major trauma services were discussed with South Central HOSCs last July. Their collective view at that time was that changes envisaged did not represent a major service variation and had the potential to significantly improve the outcomes of patients needing this level of care. We have confirmation from the relevant SHA Associate Director that this work was being progressed. We do not therefore understand the purpose of including this service in a document of this nature.

The points set out below represent our response to the 'engagement document'. The additional information received from the SHIP cluster has clarified a number of issues (e.g. the clinical leads are for each service) and we would expect to work with the

SHIP cluster to agree the next steps for each of these services, with involvement as appropriate with other key stakeholders.

If the proposed vascular network arrangement between St Richards and Portsmouth Hospitals Trust is considered to be a viable option then this work needs to be aligned with the development of the network across South Central and South East Coast SHA boundaries. Our understanding is that the time frames to which South East Coast SHA are working will mean that this will not be completed until November. It would be helpful to have confirmation about the way in which this work will be progressed and the associated time frames.

Specific feedback with regard to the 'engagement' document includes:

General

1. Additional information is required about the way in which it is envisaged that the networks will function and how responsibility for leading these will be managed by the clinicians involved.

2. It would be helpful to have information about how the services provided to local people are currently performing against the national standards/guidance or how the proposals will impact on this performance.

3. Health needs information and an indication of the numbers of patients that will be affected by the possible changes should be included.

4. Issues relating to the co-dependency of services have not been considered.

5. The emphasis is on the sites that will provide the services rather than the development of a service specification that sets out clear commissioning intentions.

6. There is no discussion about the workforce implications associated with the proposals. These will impact on the sustainability of the proposals. The comment relating to finance at 3.2 is not sufficient in this respect.

7. Information relating to stakeholder engagement is weak across each service area, even though this exists in other related documents. We would expect to see evidence of a wide ranging process to secure clinical views from across the services affected as well as engagement with key 'expert patient' and patient support groups as appropriate.

8. Consideration of the options stops at the SHA boundaries even though the option relating to St Richards has been discussed for some months (in South Central if not South East Coast). It would be useful to understand what the current patient flows to these are, both inward and outward to Trusts just over our borders.

9. The case studies seem to us to be patronising.

Stroke

10. Are far as we can asses the information provided in the document there is little difference in the current and proposed patient pathway?

11. It would be useful to know how currently services are performing against the national standards or the quality of care being provided.

12. The presentation of the graph setting out the % of patients spending 90% of their time on a stroke unit needs context and local information.

13. It would be helpful to have additional information about the stroke pathway or the way in which services work together to ensure that patients are treated in the most appropriate care setting.

14. It would be helpful to see the evidence relating to time to treatment of high and low risk TIAs.

15. The implications of the forthcoming merger of Basingstoke and Winchester Hospitals need to be considered.

16. It would be useful to have had more information about the level of support to the populations affected in terms of access to rehabilitation and follow-up in either in a community or local hospital setting. National guidance is clear that this element of the care pathway is critical. Additionally information to patients and GPs is not considered. The service needs to be considered as a whole across the entire care pathway in SHIP if the benefits outlined are to be achieved.

17. There is not sufficient information about the extent to which the proposals will impact on current patient pathways to enable the HOSC to come to a view about the nature of the change.

Major Trauma

18. There is no distinction between the treatment pathways for children and adults and no reference to whether this is appropriate or not.

19. A&E departments are not homogenous in the services or level of care they provide- this is not reflected in the discussion presented.

20. It is not clear if there are any areas in Hampshire where it is difficult for a patient to get to a major trauma centre within 45 minutes.

21. Although the above information would be of interest Hampshire HOSC has confirmed its support for the view that the reconfiguration of Major Trauma services is not substantial in nature.

Vascular Surgery

22. It would be helpful to have information on the current pattern of provision across our area in relation to the service specification- for example what services are not currently able to provide cover by vascular surgeons on a 24/7 basis?

23. There should be evidence of wider stakeholder engagement with these proposals beyond the panel referred to at 6.3

24. It would be helpful to know the number of patients that would follow a different care pathway as a result of these proposals.

25. There is reference to a service specification but the extent to which the options identified demonstrate compliance with this is not clear. The suggested variations on page 34 do not give any indication of the extent to which these will comply with the service specification.

26. The impact of these changes on other services currently provided by the Trusts affected needs to be evaluated and included in any future documentation.

27. There is not sufficient information to come to a view as a HOSC about the extent to which the options for configuring vascular services will impact on our population. Issues relating to the quality of care must be considered as well a workforce and other issues that will affect the sustainability of these services in the future.

I am sorry that we cannot be more positive about this document. Clearly there is strong evidence base underpinning the changes proposed for each of these services and a significant amount of work has already taken place. As a HOSC we would be keen to contribute to agreeing the next steps and look forward to hearing the outcome of this 'engagement' exercise.

Yours sincerely

Cllr Pat West

Chairman, Health Overview and Scrutiny Committee

Cc:
Hampshire HOSC Members,
Debbie Fleming, Chief Executive, SHIP PCT Cluster
Ursula Ward, Chief Executive, Portsmouth Hospitals NHS Trust
Mark Hackett, Chief Executive, Southampton University Hospitals Trust
Mary Edwards, Basingstoke &North Hampshire NHS Foundation Trust
Andrea Young, Chief Executive, South Central SHA
West Sussex HOSC, Southampton City HOSC, Portsmouth City HOSP
Isle of Wight HOSC

Appendix Ten: Southampton, Hampshire, Isle of Wight and Portsmouth PCT Cluster Review of vascular Surgery - November 2011

1 Background

Since the SHIP PCT Cluster appeared before the HOSC on 27 September there have been a number of important developments in the progress of our proposals for vascular surgery. The purpose of this paper is to bring the HOSC up to date, prior to our public consultation on vascular services.

2. Role of the SHIP PCT Cluster

The responsibility for commissioning this service on behalf of local people sits firmly with the SHIP PCT Cluster. We must therefore assure ourselves that all proposals are clinically safe and offer the best outcomes and quality of service for local people. We will only commission a service if it can clearly demonstrate the highest possible quality for local people.

3. Feedback from the engagement phase

An engagement period on proposals for major trauma, stroke and vascular surgery across the NHS South Central region was held between 23 August and 30 September. Since the end of the engagement phase the PCT Cluster has been in regular communication with commissioners in NHS Sussex , clinicians and chief executives of Trusts, local CCGs, LINks, HOSCs ..

A full report on the feedback from the engagement was considered at a meeting of the SHIP PCT Cluster Board on November 1 and has been made available to the public. The report is attached as an appendix to this paper.

One clear theme has been concerns about the implications for other services (such as renal and cancer) at Queen Alexandra Hospital, Portsmouth if the original option to provide emergency and elective complex inpatient vascular surgery from Southampton General Hospital were to go ahead.

There has also been interest in exploring the option for surgeons at Queen Alexandra Hospital to work with surgeons at St Richards Hospital, Chichester to provide a service to people living in the Portsmouth, South East Hampshire and Chichester areas.

4. Developing options for vascular surgery

In light of the engagement feedback a great deal of hard work has taken place behind the scenes between clinicians to develop these discussions into formal proposals. Out of these discussions three options emerged:

1) The original proposal for Southampton to become a vascular centre. Under this proposal all emergency and elective, complex inpatient vascular surgery would be performed at Southampton General Hospital.
2) A ‘network’ option for Southampton General and the Queen Alexandra to share vascular services across both hospital sites. This allows a vascular surgeon to remain on site seven days a week at the QA to provide cover for renal and cancer services.
3) An option for the Queen Alexandra Hospital and St Richard’s Hospital, Chichester to integrate vascular surgery provision across West Portsmouth, SE Hampshire and West Sussex.

5. Expert panel

An expert panel was held on Thursday 20 October, to consider options 2 and 3 above to ensure that they meet the national specification. Option 1 has already been considered in detail by an expert panel and was not re-examined. A summary of the panel's views on each option is below:

1. Portsmouth/St Richards proposal

Portsmouth Hospitals NHS Trust presented a proposal for the development of a vascular service across the St Richards and Queen Alexandra Hospital sites. The panel felt that the proposal would be clinically viable for the present time. However they agreed that it would not meet the new specification of the Vascular Society for 2011 and was not the ideal solution for patients in the long term. It was clear to the panel that the impact of the proposal on Sussex Vascular Services has yet to be tested and that some clinicians and the management from St Richards Hospital had not been involved in the development of the proposal. The panel's main concerns were the lack of involvement from St Richard's clinicians and management on key issues such as staffing, and the ability to satisfy the minimum requirements for interventional radiology. As a result it was felt the proposal could not be delivered and as such was aspirational. Subsequently NHS Sussex and Western Sussex Hospitals NHS Trust have confirmed that they do not support this proposal.

2. Southampton/Portsmouth proposal

University Hospital Southampton NHS Foundation Trust presented some new developments to their original proposal which have come about as a result of further discussion between surgeons and interventional radiologists across the two sites. Their proposal would still mean that a network would be formed with clinicians across Southampton and Portsmouth working together and the most serious emergency vascular surgery cases being carried out at Southampton. However, further provision has been made to ensure there is vascular support in Portsmouth to cover outpatient clinics and services such as cancer and renal.

The panel felt that this option of a single vascular service offered from the two hospital sites would provide the best chance for long term sustainable vascular services for local people. The panel concluded that it was clear that work had taken place to develop the proposal since the expert panel considered the initial proposal in December 2010. In particular it was clear that the interdependencies with cancer and renal services at Queen Alexandra Hospital had been given greater consideration. However the panel underlined the need for more constructive dialogue between the clinical teams to implement the service, putting the benefit of patients at the heart of their discussions.

For your information the minutes of the expert panel meeting are attached as an appendix to this paper.

6. The 'stand alone' option

In further discussion with Portsmouth Hospitals NHS Trust and Portsmouth City Council about developing vascular proposals for consultation the Trust has said that it believes it could make the necessary changes to meet the standards laid down within the Service Specification in its own right, rather than in a network model with University Hospital Southampton NHS Foundation Trust or with St Richard's Hospital.

In considering this development we need to take into account the fact that delivering vascular services will become much more challenging for providers in future. Portsmouth Hospitals NHS Trust would have to recruit a number of additional vascular consultant surgeons, a number of additional interventional radiologists, and invest in a number of other areas to ensure that the Service Specification was met, and to ensure that patients could achieve significantly better outcomes than at present.

Having reviewed the situation carefully, it can be seen that there is potentially a large enough population to support three stand-alone vascular centres across the south coast – that is, within Brighton, Southampton and Portsmouth. To establish a vascular centre in Portsmouth serving the population of Portsmouth, South East Hampshire and Chichester represents a significant challenge for Portsmouth Hospitals NHS Trust. However given that they are keen to prove the viability of this model we have asked Portsmouth Hospitals NHS Trust to provide a detailed case for how they will meet the service specification.

7. Working with NHS Sussex

During the engagement period, some concerns were raised about planning for vascular surgical services across Strategic Health Authority boundaries. NHS Sussex are also in the process of undertaking a review of vascular services and in the last few months we have been working closely with them to make sure that any proposals developed for the SHIP area are compatible with Sussex's plans. This has included seeking clarification from NHS Sussex about their views on the Portsmouth/Chichester option, which they have confirmed does not have their support.

We are now aligning the two processes across SHIP and Sussex so that when we consult local people on any changes they will be informed about the implications of all proposals across Sussex, Hampshire, Portsmouth, Southampton and the Isle of Wight.

7. Public consultation

It has always been our stated intention to conduct a formal public consultation on the issue of vascular surgery. Once we have assessed the viability of the Portsmouth Hospitals NHS Trust proposal we will take a decision about which options we will be able to present as part of the forthcoming consultation. We will be completely transparent about any decision about the viability of options and will ensure that the consultation document will include information on the financial, workforce and clinical implications of each option.

We had intended to begin consultation in December but informal feedback from stakeholders has suggested that starting consultation in January would be preferable. This will also enable us to support the wishes NHS Sussex to begin public consultation in January 2012 so that we can align consultation in the SHIP area with consultation in Sussex.

The HOSC are asked for their views on this approach.