Agenda Item 6

HAMPSHIRE COUNTY COUNCIL

Report

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

Contact name*:* Denise Holden

Tel: Ext 7338 **E-mail** denise.holden@hants.gov.uk

1. **Summary and Purpose**

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

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

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

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

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

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

Table One: Inquiries Received and Action Taken

Topic/inquiry	Source	Action Taken	Comment
Developing maternity services in South East Hampshire	Portsmouth Hospitals NHS Trust (PHT)	The head of Midwifery Services will attend to update members on proposals to develop services in south east Hampshire. A report setting out the work being taken forward is attached at Appendix One (page 5)	
Recommendations: Members confirm: 1. if they are satisfied with the engagement and involvement activities that are supporting this work. 2. if they consider that the changes are substantial in nature			
Andover Birth Centre (ABC): Outcome of consultation.	Winchester & Eastleigh NHS Trust (WEHT)	An update on the outcome of the recent consultation on the model of maternity care to be provided at ABC and proposed next steps for agreement by Members is attached at Appendix Two. (page 14)	
Recommendations: Members confirm: 1. if they are e satisfied that there has been appropriate engagement and involvement of local people and key stakeholders in developing these proposals. 2. if they are satisfied that the way forward in the interests of the population affected. 3. any additional information required and the timing of a further up-date on progress.			

Topic/inquiry	Source	Action Taken	Comment
Notice to withdraw Inpatient beds at Odiham Cottage Hospital.	NHS Hampshire	An update on progress with the development of the 'hybrid' model of care and supporting business case from Calleva CCG is attached at Appendix Three. Page 22)	
Recommendations: 1. Members confirm if they support progress to date and next steps outlined 2. any additional information required and the timing of a further up-date on progress.			
SCAS: Revised performance standards	HOSC Chairman	SCAS will attend to provide an update on recent changes to national performance assessment. A report setting out details of these changes is attached at Appendix Four (page 26) and details of local performance across rural and urban areas at Appendix Five (page 30)	Members will wish to be clear about the scope for local discretion in responding to these standards.
Recommendation: SCAS confirms that regular local performance reporting to the Committee, including rural/urban performance data, will be provided to the Committee.			

Section 100 D – Local Government Act 1972 – background papers
The following documents disclose facts or matters on which this report, or an important part of it, is based and has been relied upon to a material extent in the preparation of this report.

NB the list excludes:

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

Appendix One:

Portsmouth Hospitals NHS
NHS Trust

Maternity Services

'Nurturing Maternity Service Development'

November 2011

Name of Responsible NHS Body: Portsmouth Hospitals NHS Trust

Brief description of the proposal

The maternity service has launched a 2 year development programme. This is in line with the South Central Strategic Health Authority Maternity Programme and is being conducted in agreement with NHS commissioners, clinicians, stakeholders and users. The following priorities have been agreed :

- Promoting family centred maternity care.
- Providing one to one midwifery care in labour to maintain all options for place of birth (home, stand alone maternity centre's, integrated birth centre and consultant led labour ward.
- Develop and support efficient and effective obstetric and midwifery led antenatal services in partnership with GPs, health visitors and working through Children's Centres
- Provide additional care for vulnerable women with complex social, medical and obstetric needs to improve their outcomes.

These priorities will be achieved by ensuring care is evidenced based, flexible, affordable and evaluated.

Description of population affected:

Predominantly women residing in Portsmouth and East Hampshire who book with Portsmouth Hospital Maternity services.

The launch of the programme and the initial paper was presented to the joint Hampshire and Portsmouth Health Overview and Scrutiny Committee meeting on 24th March 2011.

Stakeholders supporting the proposal for change: Portsmouth and Hampshire NHS Commissioners; Solent Health Care; Maternity Services Liaison Committee; National Childbirth Trust; Bournemouth University; Portsmouth Children's Trust; Local authority Children's Centres; Friends of the Grange; Blake support group; Portsmouth Hospitals

NHS Trust board and clinical staff; Royal College of Midwives.

Introduction

Portsmouth Hospitals NHS Trust maternity service is a large complex service caring for more than 6000 mothers and babies each year. The acute service is based at the Queen Alexandra Hospital, which has an integrated midwifery led unit, in-patient antenatal, postnatal and labour care, obstetric scanning, fetal medicine and consultant obstetric care with access to a level 3 Neonatal Unit.

The community services provide midwifery and obstetric services from community units, children's centres and GP practices. There are also midwifery led birth centres at St Mary's Hospital, Blake and The Grange and community antenatal and postnatal care, parent education and a home birth service.

There are many examples of good practice in the service and notable achievements, such as the normal birth rate (unassisted vaginal birth, i.e. without instrument or surgery), which is higher than many of the Hospital Trusts across the South Central Strategic Health Authority. However, it has been expressed by commissioners, Portsmouth Hospital Trust staff, the Strategic Health Authority and, most recently, a peer review of the service that change is required. This will focus on improving clinical outcomes, particularly the caesarean section rate; improving access to antenatal and postnatal care, maintaining choice of place of birth (and maintaining the standalone birth centres) and ensure evidenced based, cost effective, seamless maternity pathways.

The Sustainability Team consisting of Hampshire and Portsmouth commissioners, PHT maternity services and the Maternity Services Liaison Committee have agreed a direction of travel for maternity services. This steering group is chaired by Linda Collie a Portsmouth GP. The priorities and work streams within this 2-year development programme are at Appendix 1.

Birth rate and neonatal outcome

The Portsmouth maternity service has seen a considerable rise in activity over the last 5 years. It is anticipated that whilst there are fluctuations in birth rate throughout the calendar year, the overall rate will stabilise over the next few years.

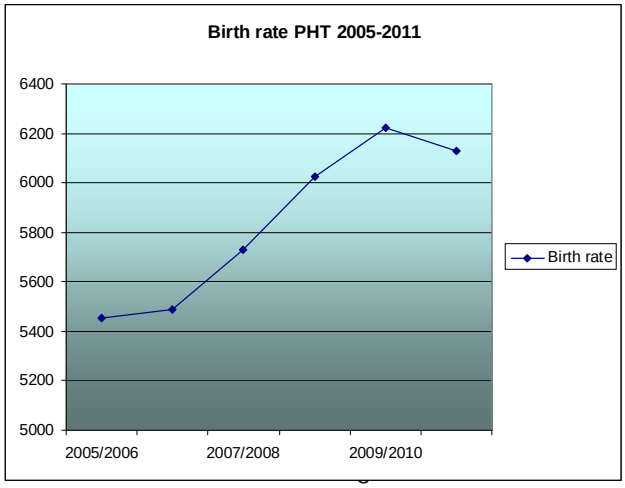


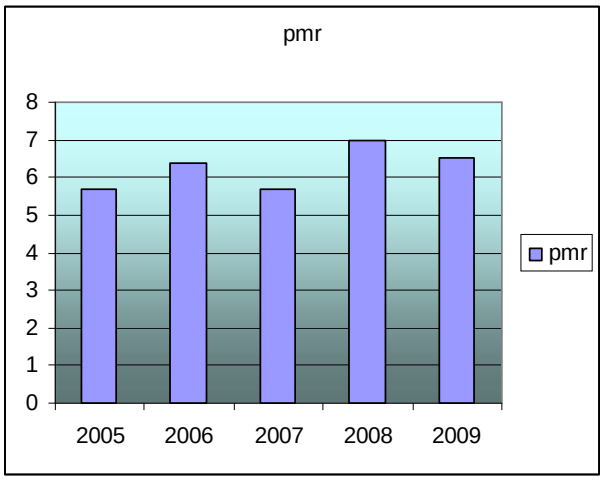
Fig 1

Total births for Portsmouth Hospitals Trust including home and birth centres

The ultimate measure of service safety is the Perinatal Mortality Rate (PMR). The national average is *6.8* perinatal deaths per 1000 births (stillbirths and neonatal deaths), South Central average is *6.0/1000* and PHT is *6.5/1000 from the latest report in 2009.*

The trend for PHT has been fairly static for the last 5 years with a small decrease in 2009 from 2008.

Fig 2



Perinatal Mortality rate for Portsmouth Hospitals Trust 2005-2009 (CEMACE 2009)

A compelling case for change

A review of the maternity service by the trust and commissioners has highlighted key areas for further development.

- Lack of user and stakeholder confidence in the longevity of the stand alone birth centres
- Lack of flexibility with the midwifery workforce to ensure one to one care in labour and support for ill mothers and babies, in all settings
- Inconsistent postnatal support in the community, particularly for vulnerable families.
- A higher than average caesarean section rate
- Women in normal labour cared for on the high risk labour ward, preventing access for ill women and those whose babies need intensive neonatal care.
- Services provided by PHT and not funded by commissioners (eg aquanatal, postnatal counselling, in-patient postnatal support for well mothers and babies)
- An increasing number of mothers with complex pregnancies, due to increasing age, obesity, medical advances, requiring intense multidisciplinary care.

- A growing number of socially vulnerable mothers and families, who need focused support to achieve positive clinical outcomes and support for positive parenting.
- Many other maternity services (Southampton and Oxford locally) have implemented a similar model of care with demonstrable improvement in outcomes.

Proposed change to service provision.

The main changes are summarised as follows:

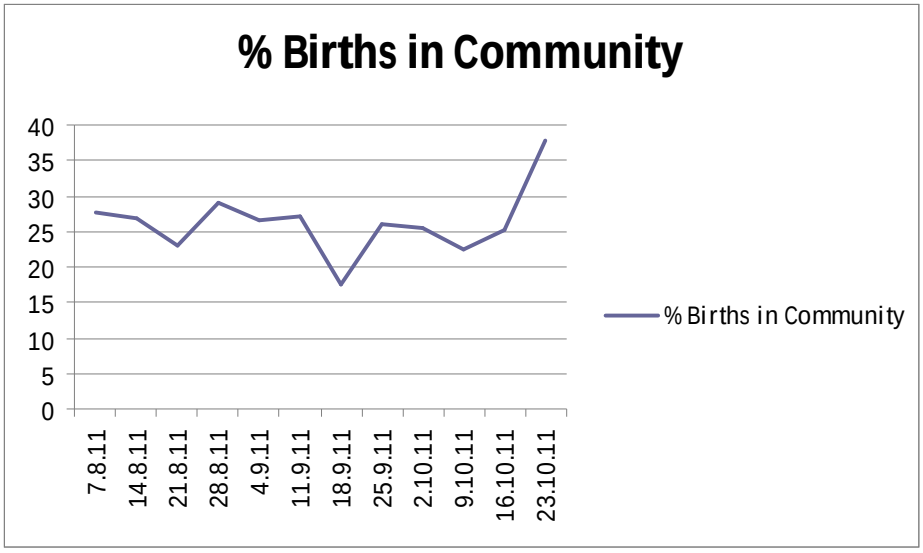
- The birth centres will be further developed into local maternity centres (St Mary's, Blake and Grange), with an increase in midwifery led antenatal care provision, education, information and delivery of enhanced services to vulnerable families (eg teenage groups, family nurse partnership). Focused postnatal support in clinics, breastfeeding and parenting advice.
- Births at the centres and at home will be further encouraged and provided 24 hours a day for women of low risk of complication.
- Women and babies who are well after birth will be encouraged to return home as soon as possible to their families (Keeping mum, dad, baby and extended family together) leading to a reduction in postnatal stay for well women and freeing up midwives to provide care for women in labour.
- Increased postnatal community support from an increased establishment of senior maternity support workers, trained to the agreed SHA competencies, supporting breastfeeding and early parenting, allowing more focused midwifery support for ill and vulnerable mothers
- Increased flexibility for the midwifery workforce to provide one to one care in labour in all settings
- An increase in community midwifery care delivered from Children's centres' as per the 'Pre Birth to Five Strategy'
- Development of stronger partnerships and integration with Health Visitors, G.P and midwives, within named teams. Clear focus of joint care planning for vulnerable families.
- Consultant led care for women with or at risk of complications to be mainly delivered at QA (peripheral obstetric clinics are being reviewed, some will be maintained)
- Unfunded services will be passed to 3rd party providers (eg aquanatal to local swimming pools)
- Internal strategies will be further developed to promote normal birth (eg encouraging vaginal birth after caesarean section and all women choosing QA who are low risk of complication start their labour journey on the Mary Rose integrated birth centre)

Improving outcomes.

Workstream 1: Service model and pathways (Chaired by Gill Walton, Head of Midwifery- community midwives, human resources, Supervisor of Midwives, Bournemouth University, maternity support workers)

- It is intended that following this change more Portsmouth and Hampshire mothers will have a choice of place of birth and will receive one to one care by a midwife.
- Fewer women will be denied their choice of place of birth.
- The labour ward capacity will be available for mothers who need that level of care, therefore reducing the number of mothers denied transfer from other units and potential improving out comes particularly for premature and sick babies
- Continued reduction in caesarean section rates and associated morbidity and increased vaginal birth rates
- Improved breastfeeding rates, current target is 80% of mothers initiating breastfeeding, the service is currently at an average of 78%

A step towards this change was implemented as part of a contingency to manage an increase in birth in August 2011. It has led to an increase in community births (from less than 20%) and a reduction in women being denied their choice of place of birth. An unexpected benefit has been an increase in mothers with babies requiring the neonatal unit being admitted to the labour ward.



Workstream 2: Normalising birth and reducing caesarean section (Chaired by Saumitra Sengupta- Consultant Obstetrician, midwives, obstetricians, commissioners from Portsmouth and Hampshire, Bournemouth University, anaesthetist)

- Reduction in labour and postnatal complications
- Increased satisfaction
- More empowered women
- Enhanced postnatal recovery

Workstream 3: Improving care in obstetric theatres (Chaired by Marie Flynn, Head of Nursing for theatres, staff from theatres and maternity, infection control, practice education, anaesthetics,)

- Increased efficiency
- Lower wound infection rates
- More responsive in an emergency

Workstream 4: Antenatal care (Chaired by David Davies, Chief of service, consultant obstetrician, midwives and obstetricians, ultrasonographer)

- Appropriate health profession planning care
- Improved continuity
- A reduction in unscheduled antenatal care
- All clinicians reaching consensus on antenatal pathways so that consistency is assured

Workstream 5 Developing Maternity Support Worker's and clerical teams. (Chaired by Jane Parker-Wisdom Midwifery Community manager, midwives, practice educators and Maternity Support Workers)

- Improved support for postnatal mothers in the community
- Increased breastfeeding continuation
- Increased midwifery support to vulnerable mothers
- Efficient use of resource

Workstream 6: Evidenced, based care, consensus and clinical leadership (Chaired by Sharon Hackett-Clinical Governance lead, obstetricians, midwives, Neonatal unit, Supervisors of midwives)

- Responsive service,
- Care based on evidence
- Consistency of support and advice

Conclusion

This change is well supported by service users, clinical staff and stakeholders. It is a cost effective sustainable change and seeks to reduce risk to mothers in labour, improve choice of place of birth and improve care to ill and vulnerable mothers.

Creating confidence in the service is key and developing the services within the birth centres is an important part of that plan. The main change to the service model is proposed for January 2012 and all changes will be evaluated.

Gill Walton
Head of Midwifery
Portsmouth Hospitals NHS Trust

References

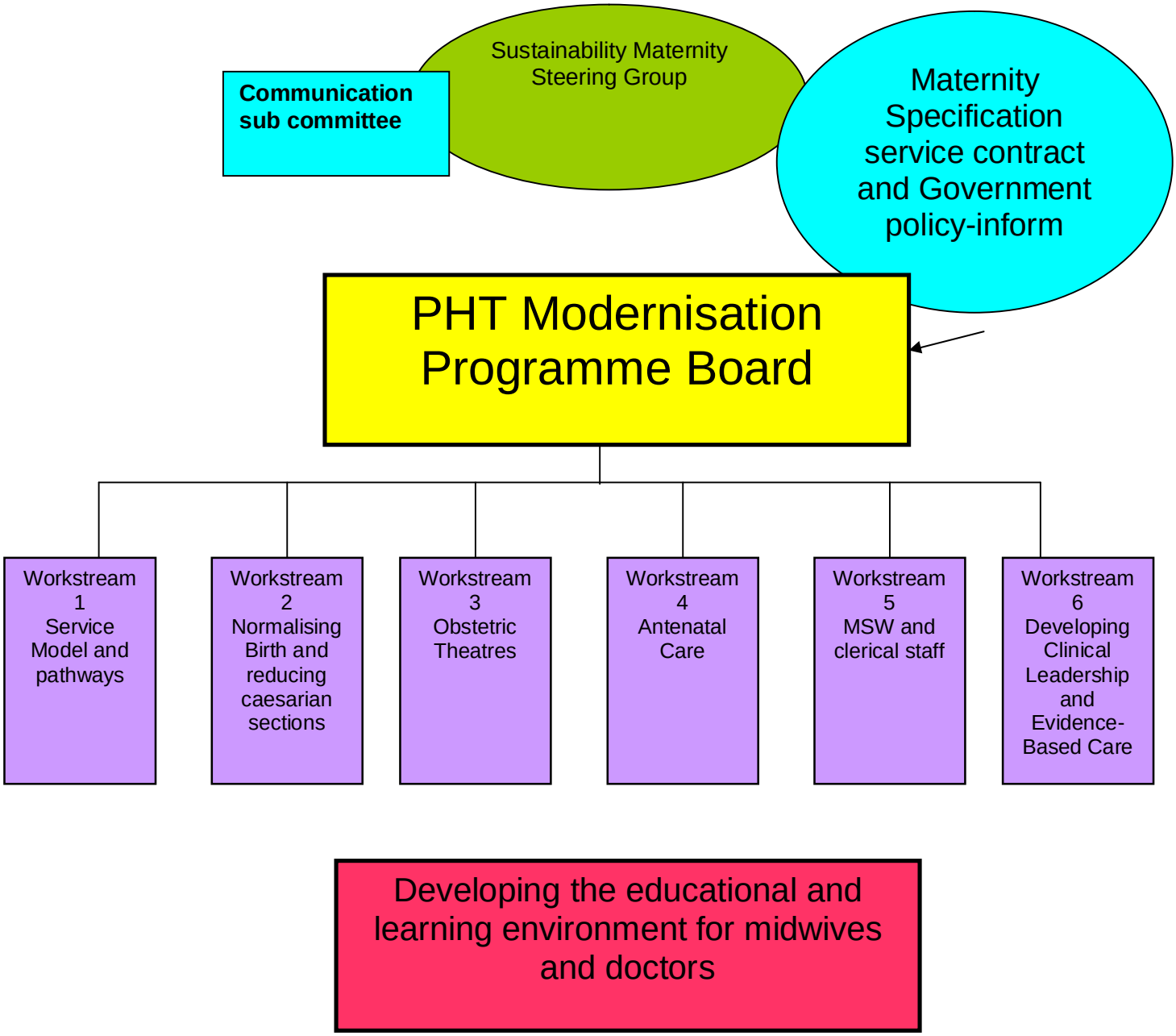
CMACE (2009) Perinatal Mortality Final Feedback Report, Portsmouth Hospitals NHS Trust

Appendix 1

Modernisation Programme Framework

Several workstreams have been indentified, which would come under the modernisation agenda, headed by a representative steering group.

Nurturing Maternity Service Development-Family Centered Care



1 Sustainability Maternity Steering Group and Stakeholders

This group has been established by the Sustainability Group in partnership with Portsmouth and Hampshire Commissioners and PHT maternity services. This group will respond to current maternity policy, NICE guidance, and targets to set the agenda for maternity service development, whilst ensuring outcomes are maintained and improved, and the service becomes cost effective.

2 Communication Subcommittee

Maternity services are the shop window of NHS services as most women who use the service have a positive outcome and therefore the NHS has an opportunity to influence the perception of local families about hospital and community services. Most people know someone who has had a baby and, for many families, it is the first time they have accessed NHS care. Investing in a comprehensive communication strategy for this programme is essential to maintain confidence in the service, which is being developed. A key to this will be the involvement of user and user groups at all levels of the programme, including small focus groups for some of the workstreams.

3 PHT Modernisation Programme Board

The main purpose of this group is to provide direction and governance to the workstreams. The Board will hold the workstream leads to account (through the project manager) for key deliverables. The Board will link to the Trust Governance Framework in order to ensure transparency and clear identification of risks and taking steps to mitigate these risks.

4 Workstreams

(i) **Service model and maternity pathways** - This will include a review of midwifery caseloads, staffing of the birth centres, minimum and optimum staffing in the acute unit, skill mix, the provision of community services and the development of a clear escalation for midwives to care for women in labour.

(ii) **Normalising birth and reducing caesarian sections** - there are many elements to this workstream. Having a one to one care in labour priority is fundamental to achieving normal birth and ensuring opportunities for low risk women to birth away from an acute labour ward, preferably out of hospital. This will also include senior obstetric support on the labour ward, VBAC pathways, induction of labour and the environment of birth.

(iii) **Obstetric theatres** - developing the appropriate staffing model, efficient elective pathways and meeting obstetric theatre guidelines.

(iv) **Antenatal Care** - This will include care in the right place, ie Consultant led care in the acute unit and community antenatal care through children's centres and the birth centres. A key part of this workstream is ensuring clear antenatal pathways, enhancing the use of specialist midwives and developing midwifery led care for moderate risk women. This workstream will also include access and unscheduled antenatal care.

(v) **Maternity Support workers and clerical staff** - Developing supporting roles in the priority of all the workstreams. The focus will be on postnatal care in the community in order to release midwives to provide care in labour and improve antenatal continuity.

(vi) **Developing clinical leadership and evidenced based care** - In order for women to have access to a dynamic and responsive service there requires a focus on developing clinical leadership in both obstetrics and midwifery. The underpinning evidence for all pathways should clear and agreed by the multiprofessional team.

5 Underpinning Themes

(i) **Family Centered care: involving fathers** - This is an emerging priority for maternity service, with clear evidence that involving fathers enhances their experience and their approach to parenthood.

(ii) **Developing the educational and learning environment for midwives and doctors** - There are many opportunities for learning which can be enhanced. Developing the ability for midwives and obstetricians to learn together is key. The service is one of the largest in the South of England and provides an ideal opportunity for our own staff and the sharing of our experience with others.

(iii) **Developing contemporary midwifery** – As advocates for women, whichever pathway they are on is the key role of the midwife. Midwifery is an autonomous profession, more closely aligned to medicine than nursing. Understanding the uniqueness of midwifery in ensuring clear and empowered decisions with women and families, whilst developing a clear professional image, is the direction of travel.

Appendix Two: Andover Birth Centre consultation report

Winchester and Eastleigh NHS
Healthcare NHS Trust

Midwife-led birth services for mid Hampshire

1.0 Introduction

1.1 Members will recall that HOSC agreed in July to support two months of formal consultation by Winchester & Eastleigh Healthcare NHS Trust (WEHCT) about three agreed options for the future provision of midwife-led maternity services across mid Hampshire.

1.2 This consultation took place in September and October and was organised jointly by WEHCT and the engagement team at NHS Hampshire. It included:

a. presentations and discussions at public, staff and stakeholder meetings;
b. online consultation using the NHS Hampshire online engagement tool;
c. wide circulation of the consultation materials via NHS, local authority and community premises; and
d. media coverage and other publicity including links from the WEHCT and NHS Hampshire website home pages, storyboards, posters, leaflets and emails.

1.3 The consultation materials received considerable praise for their comprehensiveness and clarity, and were regarded as being a helpful summary of the options and trigger for discussion.

1.4 This report outlines the findings of the consultation and explains how WEHCT intends to move forward.

2.0 The three options explained

2.1 WEHCT consulted on the following three options after confirming that all three were clinically and financially sustainable:

a. Centralise midwife-led births in 'home from home' birthing rooms at the Royal Hampshire County Hospital under the care of hospital midwives
b. Centralise midwife-led births at the Royal Hampshire County Hospital **and** introduce a Domino service there (see below Domino service explanation). Women could choose between care from hospital midwives **or** from community midwives through the Domino service
c. Maintain midwife-led births at the Royal Hampshire County Hospital **and** introduce Domino services at the Royal Hampshire County Hospital and Andover Birth Centre

***Domino**: in a Domino service the community midwife liaises with the mother-to-be when she goes into labour; meets her at whichever hospital has been chosen for the birth; cares for her throughout labour and the birth; and oversees mother and baby's return home, typically within six hours of the birth. A Domino service is only suitable for the same low-risk births as home birthing.*

3.0 The consultation process

3.1 *Public and staff consultation*

WEHCT adopted a comprehensive approach to consultation. Activities included:

- attending ante and post natal support groups run at Children's Centres and in community venues by organisations such as the National Childbirth Trust;
- targeting specific groups e.g. fathers, young mothers, partners/wives of Armed Forces personnel, black and minority ethnic communities, and the deaf community; and
- setting up displays and discussion points at children's centres, supermarkets and shopping centres.

3.2 The consultation team discussed the three options with more than 500 people in these meetings and open sessions, and encouraged them to submit their views via online and paper versions of the consultation questionnaire.

3.3 A further eight meetings aimed specifically at WEHCT midwives and midwifery support staff were attended by almost all 180 staff members. All staff received a copy of the consultation documentation even if they did not attend a meeting.

3.4 In total 161 people (public and staff) completed the consultation questionnaire. Sixty three per cent identified themselves as Andover residents and a further 16 per cent as Winchester residents. The remaining respondents were spread fairly evenly across the rest of mid and north Hampshire.

3.5 Stakeholder consultation

Copies of the consultation material were sent to a wide range of local stakeholders together with letters and emails encouraging them to submit a formal response to the consultation. In addition Keith Foote, Divisional Director for Family Services for WEHCT, attended a meeting of GPs from Andover and surrounding villages.

3.6 Written responses to the consultation were received from Eastleigh Borough Council, North Hampshire Maternity Services Liaison Service and West Hampshire Clinical Commissioning Group Board.

4.0 Consultation findings

4.1 *Public and staff consultation*

The public and staff consultation produced the following result:

- Option 1 was supported by 5 per cent of respondents (8 people).
- Option 2 was supported by 11 per cent of respondents (17 people).
- Option 3 was supported by 84 per cent of respondents (132 people).

4.2 The small number of respondents means that some margin of error can be expected but would not have a significant impact given the overwhelming preference for option 3 (e.g. at a 95 per cent confidence level the margin of error would be +/- 8.5 per cent)

4.3 The main reasons given for people's preference for option 3 were:

a. closeness to home (as against the perceived time and cost of travelling to one of the main maternity units);
b. a belief that it could deliver a safe, personal birth experience;
c. a desire to maintain maximum choice; and
d. support for the Domino service model.

4.4 Respondents could also submit 'free text' comments via the questionnaire. The most common responses urged WEHCT to keep Andover Birth Centre open (which has always been our intention) and to promote it more actively, particularly to second time mothers and Armed Forces families. A full summary of the questionnaire responses is available on request.

4.5 *Stakeholder consultation*

Eastleigh Borough Council supports option 3. The Council's paramount concern is the safety of mothers and babies; within that constraint it is keen for women and their families to be offered birth choices that reflect childbirth as a natural and (where possible) non-medical event through services which are provided as locally as possible. The Council also feels that option 3 offers the best prospects of mothers initiating breastfeeding and continuing to breastfeed past 6 weeks.

4.6 North Hampshire Maternity Services Liaison Committee (MSLC) says in its response that option 3 is the only option that keeps Andover Birth Centre open and offers choice across mid Hampshire for women (although WEHCT has been very clear that Andover Birth Centre is not under threat of closure under any of the options; it is only the in-patient service that is unsustainable).

4.7 The MSLC is concerned that quick discharge following a Domino birth may impact on mother-baby bonding and breast feeding establishment. It also regards the timing of the consultation and possible changes as regrettable given the planned integration of WEHCT with Basingstoke and North Hampshire NHS Foundation Trust in early 2012, and believes more should be done to encourage other commissioners to offer the Birth Centre as an choice for other women.

4.8 West Hampshire Clinical Commissioning Group Board agreed Option 2 as its preference, with the proviso that it wished to ascertain and consider the views of

Andover GPs before making a final recommendation. The Board has subsequently obtained those views and its final recommendation is for option 2, although Andover GPs are divided between supporting option 2 and option 3.

4.9 Copies of the stakeholder responses are included as appendix 1.

5.0 WEHCT's proposed response to the consultation results

5.1 The consultation has indicated very clearly option 3 is preferred by the majority of the people and organisations consulted.

5.2 It has also identified a number of concerns (particularly those raised by North Hampshire MLSC and Eastleigh Borough Council) that must be addressed when implementing any revised model of service.

5.3 Members of the WEHCT Trust Board have discussed the consultation outcomes informally. The Board will receive a report at its formal meeting on 30 November when it is expected to confirm a recommendation from officers that the Trust implements option 3 as the best way to secure a sustainable, affordable midwife-led birthing service for mid Hampshire.

5.4 In making this decisions the Board will be asked to recognise that pursuing this option will have a number of consequences. These include:

a. a likely degree of criticism that women will in many cases be admitted into an otherwise empty unit, often at night time;
b. a potential fall in the home birth rate as the same cohort of low-risk women will in future be choosing between Domino and home birth;
c. opportunity costs including non-availability of space within Andover Birth Centre that could have been used for a family centre, and some potential cost-savings no longer being available for other maternity service initiatives.

5.5 Maternity service clinicians and managers are nevertheless confident that Domino services can be introduced successfully at Andover War Memorial Hospital and the Royal Hampshire County Hospital, and plans are well in hand to implement them in 2012, subject to ratification by the WEHCT Trust Board.

5.6 It is not possible to give an exact start date at present as a further round of formal consultation with midwifery staff and their representatives is necessary because the new model requires changes to the current staffing model.

6.0 Sustainability of the proposed new model

6.1 The proposed new service model will be sustainable in staffing and clinical terms (although WEHCT must reserve the right to take such temporary measures as are necessary if safe clinical operation of the service is ever compromised through exceptional circumstances) and is affordable within the existing cost envelope.

6.2 Its viability will depend ultimately on local women using the Domino service in sufficient numbers. The time required for formal staff consultation would be used to publicise and promote the extension of maternity choice through the introduction of Domino services, and encourage mothers-to-be to use them.

6.3 Plans are on track for WEHCT and Basingstoke and North Hampshire NHS Foundation Trust (BNHFT) to come together in January 2012 as Hampshire Hospitals NHS Foundation Trust.

6.4 Basingstoke and North Hampshire NHS Foundation Trust is committed to maintaining locally based services for women in and around Andover, including home births and antenatal and postnatal care.

6.5 Although the Foundation Trust currently has no formal responsibilities in this matter, it has seen this report and noted both the consultation findings and WEHCT's recommended preferred option. These will be taken into account as part of any planning for the future provision of services at Andover Birth Centre.

6.6 The new Domino service would be audited after six months to ensure that it is operating effectively and successfully. WEHCT will recommend that this audit is overseen by a stakeholder group that includes representatives from commissioning bodies, local GPs, the MSLC and the Royal College of Midwives.

7.0 Recommendations

7.1 HOSC is invited to:

a. note the findings of public, staff and stakeholder consultation and the strong preference among all respondents for option 3 (introduction of Domino services in Andover and Winchester);
b. note that the WEHCT Trust Board will be asked on 29 November to ratify the implementation of option 3 in 2012; and
c. support the implementation of option 3.

Dr Chris Gordon
Acting Chief Executive, Winchester & Eastleigh Healthcare NHS Trust
November 2011

Appendix 1: Formal consultation responses from stakeholders

Eastleigh Borough Council response

We believe the paramount concern is the safety of women and children.

It is also important that women and their families are offered genuine choices in where and how they give birth, and that unless medically necessary, childbirth is treated as a natural and non-medical event.

Where possible services should be provided as locally as possible. It is odd that while many health services are looking to decentralise (reducing the costs of acute care) and improve community provision, this service may be moving in the opposite direction.

We understand that prior to the suspension of birth services at ABC the service was being promoted to increase take-up. It would help to understand how much and what kind of promotion took place.

The costs given for each kind of birth bear greater scrutiny. What kinds of overheads are included in each figure? Given that in any case ABC is to remain open during the day and therefore any overheads would be shared with other services (for ante- and post-natal services), it is unclear why an ABC birth should be much more expensive than a home birth. It would not be necessary to staff ABC around the clock; as the consultation document suggests, community midwives could be brought in as and when women are approaching the moment of birth.

Further demands should be made on Government to increase the numbers of midwives.

We feel that the prospects of mother being supported to initiate and continue to breastfeed past 6 weeks are likely to be enhanced in Option 3.

We support Option 3.

Diccon Bright, Area Co-ordinator and lead officer for Health, on behalf of Eastleigh Borough Council Leader, Lead Members for Health, and the Chief Executive.

North Hampshire Maternity Services Liaison Committee response

I currently chair North and West Hampshire Maternity Services Liaison Committees (MSLCs). The committees are made up of lay users as well as representatives of lay users (for example; breastfeeding counsellors, doulas and antenatal teachers) and staff from the trusts including senior team members. Our aim is to feed back service user opinion and ideas to help inform the maternity service and improve the service that we can offer women and their partners. In my capacity as chair, I attended the July meeting at Winchester where we considered the options appraisal process.

Andover falls geographically within the North Hampshire MSLC area and Winchester falls in to West Hampshire MSLC. As such, both committees have an interest in the current consultation of birth services in mid Hampshire.

We use our bi-monthly meetings to gauge opinion and feedback ideas from the general public. At our recent meetings our service users and other members have had lots of questions about the proposals which are going forward in the consultation, Janie Pearman has been helpful in aiding our understanding of the process and the relevant issues. Service users have fed back to me during the meetings and afterwards via email and from this I have compiled a list of issues that we feel should be considered.

Points to consider
The timing of the consultation is generally felt to be poor. It is known that if the acquisition goes ahead between BNHFT and WEHCT that the executive team at BNHFT are planning a thorough review of maternity services and how they will be delivered across both trusts. We feel that any option that looks at closing Andover Birth Centre (i.e. option 1 or 2) is inappropriate at this stage as it will reduce the options for the merged trusts.

If the acquisition between BNHFT and WEHCT *did not* go ahead it is unclear if women outside the WEHCT catchment but near to Andover (e.g. Whitchurch and Overton) would be able to use ABC as BNHFT midwives would not be working to the domino model. In the current (though suspended) model any woman from out of area can birth at ABC though we know that women are not generally signposted to ABC from out of area.

Andover is close to borders of other trusts as well as BNHFT, this model appears to make it difficult for women from other nearby areas to use ABC unless agreements have been made between trusts (as a result of the domino model). If this is the case would this model limit the chance of ABC increasing births from out of area which seems to be critical to its sustainability?

In the consultation document a figure of £2389 was quoted per birth at ABC and £1873 at Winchester. What part of the total are the fixed costs of running the units? How would the cost per birth at ABC be affected based on a more sustainable 300 or 400 births per year?

The consultation seems very focussed on the domino model – how will this very quick discharge affect skin to skin, initiation of breastfeeding and breastfeeding support? It is clear that the time immediately after birth is critical in getting good support for breastfeeding mothers. Would the domino model with women being discharged within 2-4 hours of giving birth give enough support to women – it would interrupt skin to skin and early breastfeeding - would this model negatively affect breastfeeding rates at a time when we are raising our targets?

Assuming the acquisition goes ahead, the domino model is quite a radical change to the current model used at BNHFT and WEHCT – what if management at BNHFT do not like the domino model – is there any point in a change of style of working so close to knowing the outcome of the acquisition?

At both the Options Appraisal meeting in Winchester on the 18th July and at the MSLC meetings there has been concern expressed that this consultative work is going on at a time when the trust boundaries are likely to change, a time of uncertainty. It has been suggested that this work would be better undertaken once the outcome of the acquisition is known. Option three is the only option that keeps ABC open and offers choice across mid Hampshire for women.

Mindy Noble
Chair, North Hampshire Maternity Services Liaison Committee (MSLC)

West Hampshire Clinical Commissioning Group response
Thank you for asking the West Hampshire CCG to comment on the proposals for the Andover Birth Centre. The Board based its deliberations on the three proposals in "Developing sustainable birth services for mid Hampshire" prepared by WEHCT and feedback from discussions between WECHT, myself as a board representative and lead GPs from the six Andover Practices. There is broad agreement that round-the-clock midwifery cover for deliveries based at the Andover Birth Centre is not viable given the small number of deliveries that occur there.

The West Hampshire Board favour option two (to centralise midwife-led births at the RHCH). The Andover GPs support was split between this option and option three (to maintain midwife-led births at the RHCH, and introduce Domino services at RHCH and ABC) approximately equally. As a board we support the provision of antenatal care at the Birth Centre but have concerns about option three. These centre on the practical aspects of co-ordinating the arrival of women in labour and midwives at the Andover Birth Centre particularly out of hours, the requirement for ambulance transfers to RHCH if intra-partum complications develop and the cost implications for the health economy since a delivery at the Birth Centre is significantly more expensive that a birth at RHCH. The main concern expressed by local GPs was the increase in travelling that centralising births at RHCH would involve. This was seen as particularly an issue for young parents and their families.

Dr Jim Rose, Derry Down Clinic, on behalf of West Hampshire Clinical Commissioning Group and Andover GPs

Appendix Three: Progress Report to Hampshire Health Overview and Scrutiny Committee from Calleva Clinical Commissioning Group and Hampshire County Council Adult Services (Basingstoke) on the Local Development Plan for Hart and Odiham to Implement the Hybrid Model

November 2011

Introduction

Calleva Clinical Commissioning Group (CCCG) and Hampshire County Council Adult Services (Basingstoke) (HCCAS) brought a progress report to the HOSC in September on the Local Development Plan for Hart and Odiham to Implement the Hybrid Model. It was agreed at the HOSC Committee on the 27th September that a further progress report would be submitted to its November meeting. This short report is submitted for your information and consideration and describes progress on the two main areas of work being undertaken. These are to develop an Integrated Care Team for the Hart and Odiham area and to develop services in and from Odiham Cottage Hospital.

Odiham Cottage Hospital

The potential use of Odiham Cottage Hospital is part of the local development plan being undertaken by the ICT and will be progressed collaboratively with the local GPs, the local stakeholder group and the OCH trustees and volunteers. The Trustees and owners of OCH have proposed that initially they will work with three preferred partners, although others may be considered in the future:-

- The Integrated Care Team to use the location for specialist clinics, day hospital activities and team base
- St Michael's Hospice for a range of palliative services
- Odiham Consolidated Charities, (the local alms-houses) who have identified the need for social/respite care day club services for the physically and mentally frail

Developing Business Case

Southern Health FT is leading the development of a business case for the use of OCH by the ICT with the intention for the Hospital to provide services for the community with the introduction of community clinics and by providing a hub for the Integrated Community Team. To achieve this, it is proposed that SHFT will re-locate one of the 6 Integrated Community Teams (ICT) and some support staff into OCH to ensure they are strategically well positioned to serve the cluster of practices in West Hart. This will include the social worker and any other ASD staff. The intention is to integrate the delivery of health and social care by co terminus working of community staff, older person's mental health staff, palliative care and HCC's adult services. The majority of the current ICT team (Maple) is based in Odiham Health Centre and this situation does not naturally lend itself to being a true ICT, serving the entire West Hart cluster. Transferring the Maple ICT in the hospital will bring them in to the heart of the community and place them in the perfect position to provide onsite clinics and work with others uses of the site. The setting up a range of clinics in OCH provides an opportunity to keeping people supported in the community and out of secondary care.

Proposal
Initially, it is planned to introduce tissue viability and continence clinics, these will be achieved by end of Jan 2012, with the potential for some therapy clinics following on shortly afterwards. In the longer term IV therapy, IV antibiotics and a falls service. In order to achieve this it is proposed to utilise the treatment room and 2 other areas within the hospital for general and specific clinics

It is then proposed to transfer the ICT which will include staff from Hampshire County Council, Adult Services into the Outpatient building of the Cottage Hospital, this will enable the team to have 24/7 access and provide a discreet area for the team to operate. This will then serve as the hub for delivering community services for West Hart cluster. It is planned to transfer the team by the end of Jan 2012.

There have been a number of discussions between SHFT and OCH Trustees to enable this to happen. The requirement to implement a new leasing arrangement between the two organisation and ensure there is a clear understanding of the individual organisations' responsibilities has taken longer than expected, therefore the hope of some services being onsite in this calendar year will not occur. There has also been a need to ensure such areas as health and safety, building control, and infection control where fully addressed. This has included a requirement to have the building inspected for asbestos which is still outstanding and any implications of this report will need to be factored into the timescales for completing the building work. SHFT would also need to demonstrate a value for money comparison for the leasing arrangements for the building before the lease can be signed. It was therefore not felt appropriate for any services to commence before this was achieved.

However a letter of intent has been exchanged between SHFT and OCH Trustees and the lease agreement is being negotiated. A Business Plan developed by SHFT was discussed at the Calleva CCG Board on the 03/11/11 and was agreed in principle but further work was felt to be required on the financing of the new model of care.

Odiham Consolidated Charities
The agreement between the Odiham Consolidated Charities and OCH Trustees for the need for local day club to offer social contact to the isolated elderly and respite care for those with substantial needs has progressed. The Trustees of Rosefield Day Club, currently located in Hartley Wintney, have agreed to relocate to OCH as, following minor building works; it will offer enhanced, dedicated and secure facilities for their client group. HCC, who fund 55 sessions at the day club, have inspected and approved these plans and the group will relocate by the end of January 2012. All parties feel the opportunities for inter working and patient care between the Day Club and the ICT offer the opportunity to enhance the care of those attending.

St Michael's Hospice
St Michael's Hospice is expected to slot into these overall arrangements for the services that they have purposed to run from the site when the ICT and Day Clubs are established.

These being bereavement counselling and complimentary therapy sessions, following which, over a period of time it may be possible to develop joint physiotherapy/occupational therapy clinics and place some social day care provision in the hospital. Ultimately patient support groups and living well programmes could also be developed.

Integrated Care Team
Calleva's CCG designated lead GP Dr Fernando for the ICT for the Hart & Odiham Area has been working with his team to develop a case management process for those clients in need of complex care. He will be holding a workshop with the ICT and local practices on the 22nd November to further develop the new methods of working. This process is being informed by the wider work on ICT's in Calleva and as part of the Strategic Health Authority LTC initiative. Plans for specific developmental training for the newly formed teams are being considered for the New Year.

Adult Services
Further to our initial report in September a number of meetings have been held to refine the operational elements of the Integrated Care Teams between HCC AS and Calleva CCG. This has included the development of information needs around activity, finance and performance. The Social workers to be attached to the 2 pilot Integrated Care Teams are being appointed. Additionally discussions are underway involving the in-house Community Reablement Service (CRT) and the potential for this service in the Calleva cluster area to be organised around the 6 Integrated Care Teams. These discussions are at an early stage.
The work between CCCG and HCC AS is being developed and monitored by the Joint Commissioning Board (Basingstoke) which held a first meeting earlier this month and which a senior manager from ASD attends.

Stakeholder Engagement
A stakeholder group was set up by NHS Hampshire at the beginning of the debate on the future of local services for the Odiham and Hart area which would take account of the use of OCH. This is continuing to meet but is now hosted by Calleva CCG. At its last meeting which was attended by two local GPs on the 28th October it was very supportive and pleased with the progress on the plans described in this paper. It was agreed for another meeting to be held in late January when service should have started or be about to start at OCH and the team would have been working together for a few months.

Finance
The financial model and sources of revenue where presented in the earlier report. The OCH budget is seen to be a part year sum of around £185k for this financial year and an on-going revenue figure of around £500 subject to the national funding formula for the NHS for next year. There is an expectation that the on-going revenue for the service will be agreed predominantly with SHFT in the 2012-13 contract in April 2012 for the new emerging services.

This year's money has been allocated against a number of short term developments and supporting activates which include:

- Junior Doc or GP just of training scheme to advance clinical practice in OCH and home based community care working to lead ICT GP
- Data Analysis/ IT to assist the develop health needs assessment using QaF and PH data and tie to ICT case loads (high priority to assist in Dementia needs assessment)
- Expert in Stakeholder management and community development to assist in its develop in Hart and Odiham
- Equipment for Oxygen service and other clinical equipment
- Payments for the additional activity in primary care to establish the new services and needs assessment.
- Communications

Conclusion

It hoped that the information contained in this report demonstrates that further progress has been made in developing the 'hybrid model of service for the Hart and Odiham community and for the use of Odiham Cottage Hospital in its implementation, with the collaboration and full engagement of all parties involved. The Committee is requested to confirm its continuing support for the developments outlined.

Philip Burgess
Integrated Care Commissioning Manager
Calleva CCG

Appendix Four: Changes in Ambulance Services Performance Reporting Regime

South Central Ambulance Service NHS
NHS Trust

One of the most common reactions we hear from patients is that in an emergency they want the ambulance to arrive quickly. Delays (perceived or otherwise) in receiving the care they need may also seem worse by the anxiety and stress of the situation. Ambulance trusts recognise this and understand that response time is important, but faster responses to patients are only one part of a process to deliver improved outcomes for patients. Ambulance trusts therefore need to focus on providing the best care at the most appropriate time and, where possible, to resolve issues on the first occasion. We appreciate that sometimes ambulance staff have to focus on the most critically ill patients (i.e. those with life-threatening conditions) but it is important that there are effective systems and the right level of resource to cope with all patients who call 999.

We are publishing a new set of ambulance clinical quality indicators that aim to provide patients with the information they need to be able to see the quality of care being delivered by ambulance services. These indicators will be published regularly and will be made available by each individual ambulance trust. This will mean that there will be information available to allow comparisons between one ambulance service and another. The set of indicators is designed to give a comprehensive picture of the quality of care but importantly also includes the views of service users on the care the ambulance trust has provided. Patient and public feedback is key to facilitating continuous improvement; and trusts will need to take account of this when looking to learn lessons and improve the service they offer. A first-class ambulance service is always keen to hear about suggestions for improvements in care.

The ambulance clinical quality indicators are not just about providing information, they also aim to encourage discussion and debate amongst ambulance staff, NHS managers, commissioners, and the general public about how good the care being provided locally is and how it can be improved.

Eleven clinical quality indicators will be measured from April 2011, and the remainder of this where this document sets out how these specific indicators will improve care.

Service Experience Indicator – most, if not all, ambulance trusts already undertake patient satisfaction surveys. We are now asking them to go beyond simply reporting the results of such surveys, and ambulance trusts will be required to demonstrate and publish how they find out what people think of the service they offer (including the results of focus groups, interviews and patient

forums, rather than simply patient surveys) and how they are acting on that information to continuously improve patient care.

Outcome from acute ST-elevation myocardial infarction (STEMI) indicator - STEMI is an acronym meaning "ST segment elevation myocardial infarction," which is a type of heart attack. This is determined by an electrocardiogram (ECG) test. We know that, for many conditions, your recovery will be more likely and quicker if you receive early treatment.
Early access to reperfusion (i.e. where blocked arteries are opened to re-establish blood flow) and other assessment and care interventions are associated with reductions in STEMI mortality and morbidity. Measuring patient outcomes in this way will allow services to place performance in context and stimulate discussion on how to continually improve.

Outcome from cardiac arrest: return of spontaneous circulation indicator – This indicator will measure how many patients who are in cardiac arrest (i.e. no pulse and not breathing) but following resuscitation have a pulse/ heartbeat on arrival at hospital. We recognise that providing resuscitation as early as possible to those in cardiac arrest is likely to improve the chances of recovery. Clearly, the higher the survival rate the better.

Outcome from cardiac arrest to discharge indicator – We know that the ambulance service play a vital role in saving patient's lives, but it is important to understand the effectiveness of the whole system in managing those patients who are in cardiac arrest. We will know from the indicator above how effective the ambulance service was in responding to and treating patients in cardiac arrest when the ambulance arrives at the hospital – but what about after the patient is in the care of the hospital? That is why this indicator measures the rate of those who recover from cardiac arrest and are subsequently discharged from hospital as a patient outcome.

Outcome following stroke for ambulance patients indicator – The Stroke: Act F.A.S.T campaign has been very successful in raising awareness to the public on the signs of a stroke (as well as TIA's (Transient Ischaemic Attacks or "mini-strokes"), and we know that prompt emergency treatment can reduce the risk of death and disability. The campaign promotes that when a stroke strikes act F.A.S.T:

- **F**acial weakness - can the person smile? Has their mouth or eye drooped?
- **A**rm weakness - can the person raise both arms?
- **S**peech problems - can the person speak clearly and understand what you say?
- **T**ime to call 999 for an ambulance if you spot any one of these signs.

This indicator will require ambulance services to measure the time it takes from that all important 999 call to the time it takes those F.A.S.T-positive stroke patients to arrive at a specialist stroke centre. We know that patients should be arriving at specialist stroke centres as soon as possible so that they can be rapidly assessed for thrombolysis, delivered following a CT scan in a short but safe time frame; this has been demonstrated to reduce mortality and improve patient recovery.

Proportion of calls closed with telephone advice or managed without transport to A&E indicator - Ambulance trusts are exceptionally good at handling and responding to 999 calls. But calling 999 does not necessarily mean that a 'blue light' emergency response is the best one. Similarly, with ambulance staff becoming increasing skilled in treating patients at the scene even if an ambulance is sent, the front-line crew may be

able to treat the patient then and there without the need to take them to an A&E department. On the other hand, alternative healthcare options, other than A&E, may be more appropriate for the patient.
This indicator should reflect how the whole urgent care system is operating, rather than simply the ambulance service or A&E, because it would reflect the availability and provision of alternative urgent care destinations and treatment of patients in the home. Knowing this will help improve urgent and emergency care services so that they offer the right treatment to patients in the right location at the right time.

Re-contact rate following discharge of care Indicator – if patients have to go back and call 999 a second time it is usually because they are anxious about receiving an ambulance response or have not got better as expected. Occasionally it may be due to an unexpected or a new problem. To ensure that ambulance trusts are providing safe and effective care the first time, every time this indicator will measure how many callers or patients call the ambulance service back with 24 hours of the initial call being made.

Call abandonment rate – the vast majority of people who phone 999 do so because they need to access emergency healthcare. If people do not get to speak to the ambulance service quickly they may hang up or try to receive the care they need elsewhere, for example turning up at A&E. This indicator will ensure that ambulance trusts are not having problems with people phoning 999 and not being able to get through so that 999.

Time to answer calls – It equally important that if people/patients dial 999 that they get call answered quickly. This indicator will therefore measure how quickly all 999 calls that are received by the ambulance service get answered. The quicker the ambulance service answer the call, the quicker they can establish what is wrong with the patient so that the best type of response can be given. Answering the call quickly also provides reassurance to often very anxious and scared callers, who have called 999 because it is a real emergency.

Time to treatment by an ambulance-dispatched health professional – it is important that if patients need an emergency ambulance response that the wait from when the 999 call is made to when an ambulance-trained healthcare professional arrives is as short as possible, because urgent treatment may be needed.

Category A, 8-minute response time – In truly life-threatening situations, the speed of an ambulance arriving could help to make the difference between life and death. This indicator measures the speed of all ambulance responses to the scene of potentially life-threatening incidents and importantly measures that those patients who are most in need of an emergency ambulance gets one quickly.

Each ambulance service will be publishing their results against each of these indicators from April 2011, along with an explanation of their local circumstances to place these results in context. This will help to explain any local reasons as to why the results may be different from other ambulance services, but it should also explain how they are working to continuously improve the quality of care they deliver to patients.

Appendix Five: New SCAS Performance Report to Q2 2011/12

Hampshire Division Red 8min Performance				
	Performance %			
Area	Q1 Apr-Jun	Q2 Jul-Sep	Q3 Oct-Dec	Q4 Jan-Mar
BASINGSTOKE AND DEANE	74%	77%		
EAST HAMPSHIRE	74%	72%		
EASTLEIGH	77%	76%		
FAREHAM	77%	78%		
GOSPORT	82%	82%		
HART	55%	62%		
HAVANT	83%	82%		
NEW FOREST	79%	80%		
PORTSMOUTH	87%	87%		
SOUTHAMPTON	83%	83%		
TEST VALLEY	79%	78%		
WINCHESTER	73%	75%		

Hampshire Division Red Incidents				
	Incidents			
Area	Q1 Apr-Jun	Q2 Jul-Sep	Q3 Oct-Dec	Q4 Jan-Mar
BASINGSTOKE AND DEANE	761	809		
EAST HAMPSHIRE	620	542		
EASTLEIGH	765	710		
FAREHAM	723	772		
GOSPORT	677	639		
HART	87	71		
HAVANT	1003	1011		
NEW FOREST	1318	1256		
PORTSMOUTH	1978	1991		
SOUTHAMPTON	2454	2368		
TEST VALLEY	684	606		
WINCHESTER	661	654		

Hampshire Division Red 8min Performance

	Performance %											
Area	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
BASINGSTOKE AND DEANE	77%	70%	76%	77%	77%	78%						
EAST HAMPSHIRE	71%	73%	77%	71%	75%	68%						
EASTLEIGH	79%	75%	76%	74%	74%	79%						
FAREHAM	76%	78%	78%	83%	75%	76%						
GOSPORT	80%	83%	82%	78%	86%	82%						
HART	58%	66%	44%	53%	79%	61%						
HAVANT	81%	86%	83%	86%	80%	80%						
NEW FOREST	79%	80%	78%	79%	82%	79%						
PORTSMOUTH	88%	88%	86%	89%	87%	86%						
SOUTHAMPTON	84%	85%	79%	80%	83%	86%						
TEST VALLEY	84%	76%	76%	80%	75%	80%						
WINCHESTER	74%	73%	72%	77%	73%	75%						

Hampshire Division Red Incidents

	Incidents											
Area	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
BASINGSTOKE AND DEANE	252	269	240	264	285	260						
EAST HAMPSHIRE	210	222	188	196	166	180						
EASTLEIGH	262	257	246	278	212	220						
FAREHAM	221	250	252	268	259	245						
GOSPORT	230	226	221	222	225	192						
HART	26	29	32	34	19	18						
HAVANT	306	346	351	352	331	328						
NEW FOREST	452	435	431	447	395	414						
PORTSMOUTH	648	661	669	656	660	675						
SOUTHAMPTON	840	864	750	751	766	851						
TEST VALLEY	234	236	214	201	214	191						
WINCHESTER	211	246	204	215	231	208						

Hampshire Division Red 19min Performance

Area	Performance %			
	Q1 Apr-Jun	Q2 Jul-Sep	Q3 Oct-Dec	Q4 Jan-Mar
BASINGSTOKE AND DEANE	96%	97%		
EAST HAMPSHIRE	89%	89%		
EASTLEIGH	97%	98%		
FAREHAM	98%	99%		
GOSPORT	97%	97%		
HART	91%	94%		
HAVANT	98%	99%		
NEW FOREST	89%	87%		
PORTSMOUTH	98%	98%		
SOUTHAMPTON	99%	99%		
TEST VALLEY	92%	92%		
WINCHESTER	93%	94%		

Hampshire Division Red Incidents

Area	Incidents			
	Q1 Apr-Jun	Q2 Jul-Sep	Q3 Oct-Dec	Q4 Jan-Mar
BASINGSTOKE AND DEANE	761	807		
EAST HAMPSHIRE	619	542		
EASTLEIGH	765	709		
FAREHAM	723	770		
GOSPORT	677	638		
HART	87	71		
HAVANT	1002	1010		
NEW FOREST	1311	1253		
PORTSMOUTH	1968	1988		
SOUTHAMPTON	2453	2368		
TEST VALLEY	682	603		
WINCHESTER	661	652		

Hampshire Division Red 19min Performance

	Performance %											
Area	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
BASINGSTOKE AND DEANE	97%	94%	97%	96%	96%	99%						
EAST HAMPSHIRE	90%	89%	87%	88%	86%	92%						
EASTLEIGH	98%	96%	97%	98%	98%	99%						
FAREHAM	99%	98%	98%	99%	99%	98%						
GOSPORT	97%	99%	96%	96%	98%	98%						
HART	88%	86%	97%	94%	100%	89%						
HAVANT	98%	99%	98%	99%	99%	98%						
NEW FOREST	89%	90%	87%	86%	89%	88%						
PORTSMOUTH	97%	99%	98%	99%	98%	98%						
SOUTHAMPTON	99%	99%	98%	98%	99%	99%						
TEST VALLEY	91%	92%	93%	95%	90%	90%						
WINCHESTER	94%	93%	92%	93%	96%	92%						

Hampshire Division Red Incidents

	Incidents											
Area	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
BASINGSTOKE AND DEANE	252	269	240	264	284	259						
EAST HAMPSHIRE	210	222	187	196	166	180						
EASTLEIGH	262	257	246	278	211	220						
FAREHAM	221	250	252	267	259	244						
GOSPORT	230	226	221	222	225	191						
HART	26	29	32	34	19	18						
HAVANT	306	345	351	351	331	328						
NEW FOREST	450	434	427	446	394	413						
PORTSMOUTH	644	661	663	654	660	674						
SOUTHAMPTON	840	864	749	751	766	851						
TEST VALLEY	233	236	213	201	213	189						
WINCHESTER	211	246	204	214	231	207						