**Appendix One**

Hampshire County Council

14 November 2011

*Room 102, Chief Executives*
*Hampshire County Council*
*The Castle, Winchester*
*Hampshire, SO23 8UJ*

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(by e-mail)

Dear Debbie

**Fast Track Continuing Health Care in Hampshire.**

Thank you for arranging for members of your team to attend our seminar on 7th November to discuss the above topic. We covered a lot of ground and I know the discussion was quite challenging on occasion. Nevertheless I think that good progress was made and we are clear about the way forward. I thought it would be helpful to confirm the conclusions that Members have reached and the recommendations they will be making to the HOSC.

We appreciate that this is a difficult and emotive area of work however I think it is fair to say there was agreement across all contributors that our local arrangements for managing those patients requiring fast track access to continuing care need to be revisited. We have asked for additional information about where Hampshire sits in terms of the national benchmarking that is undertaken by the SHA however there was real concern that- across Hampshire- it was reported that just fewer than 100 patients had been accepted as fast track referrals in the year to date. This includes 5O patients from the Basingstoke pilot.

The difficulties described by clinicians from both the acute and community sector in accessing fast track services for patients in the last days or weeks of their life need to be addressed as a matter of urgency. We understand that the PCT needs to ensure that patients are only ‘fast tracked’ when it is appropriate to do so- but in the absence of any feedback about the appropriateness or otherwise of the referrals made by responsible clinicians it is difficult to understand if it can be demonstrated that this process is both fair and transparent. Early action is also needed to build jointly agreed operational protocols and training programmes. We believe these actions would work in the interests of all concerned.

Rather than look back and attempt to comment on the current arrangements in such a complex area of care I will be suggesting to the HOSC that we undertake a more in-depth review in the coming year with a specific focus on how we build on the commitment and enthusiasm of all the contributors to our seminar in the future.

The one area where there seems to be general agreement is the benefits that have been generated through the Basingstoke pilot- although the good practice that exists in the current arrangements in Southampton and Portsmouth were also highlighted. The intention to build on this work and roll it out by the end of February is to be welcomed however there are filters in the current system that are causing considerable frustration that could be addressed sooner and we will ask that the PCT gives careful consideration to best way to address this point.

The joint independent review that has been commissioned to look at local processes in greater detail will be helpful in shaping the way forward. Although it is disappointing that this was not commissioned before this juncture was reached it is a helpful development and we will ask the findings are shared with us when it is complete.

Good working relationships based on mutual respect and trust are fundamental if the fast track process is to work well and this point was endorsed by all contributors. Confidence that the patient is truly at the heart of any arrangements for fast tracking patients who are reaching the end of their life needs to be rebuilt. There is genuine commitment across all partners to rebuilding a fast track system that is clear, transparent and accessible for those who need it. This commitment needs to be harnessed and supported by jointly agreed operational processes that are regularly audited and assessed as well as a defined programme for joint training.

Members were clear that, to the fullest extent possible, people should be able to die in the place of their choice, with the support they require. There is evidence that this is not always the case under the current arrangements. I do not believe that this is acceptable to any of us. We do need to take account of the financial pressures we are all facing- but this must not turn into a process that prevents people from accessing the services to which they are entitled.

If there are disputes these should be resolved between the parties concerned, as described in the national guidance. In the meantime the patient and their family should be given access to the package of care that their responsible clinician has determined they need. It is not acceptable that patients are denied the opportunity to die in the place of their choice because of cross organisational wrangling and ‘second guessing’ by clinical staff that have no direct knowledge of the patients or their individual circumstances.

I am also mindful that the seminar concentrated on the patients in the acute sector. There would appear to be further issues in relation to referrals from community services that need to be identified and addressed to ensure that resort to an acute admission is not the only way in which a patient is able to access fast track continuing care.

We would also ask that consideration is given to supporting carers to avoid the need for hospital admission whenever this is possible. It was clear at the meeting that many hospital admissions could be avoided through ensuring that the right services are in place to enable people who are reaching the end of their life to stay at home or in a community setting.

Our seminar only provided an opportunity for a 'snap shot' look at this challenging area of care. By way of follow-up I am therefore suggesting the following recommendations are presented to our HOSC on 29 November:

1. That the PCT, working with Adult Services, rolls out the Basingstoke pilot across Hampshire, taking account of the good practice identified in Southampton and Portsmouth. This should be taken forward as soon as possible and the timetable for implementation shared with the HOSC in January.

2. That the HOSC is advised of the timeframe for conducting and completing the independent review of these services. The report should be shared with the HOSC with a supporting action plan.

3. With immediate effect – in the event of a dispute- the support recommended by the responsible clinician is put in place until the dispute is resolved. If the PCT is unable to respond to this request we would expect, as a minimum, that there is rigorous audit of the triage system that has been put in place. This should be shared with clinicians, Trusts and the HOSC. Individual clinicians will also be advised in written or electronic format of the reasons why any request for fast track referral is declined.

4. Referrals are routinely audited and feedback regularly provided to Trusts and clinicians about the appropriateness of the use of the fast track tool

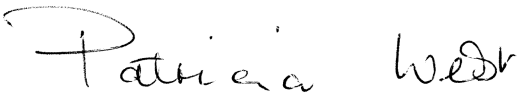
5. Arrangements are put in hand to ensure that referrals from the community and other service areas are dealt with appropriately

6. Joint training arrangements are put in place to ensure that all care providers are aware of the purpose and application of the fast track tool

7. Joint operational protocols are agreed to support the delivery of the fast track policy, and all existing NHS Hampshire operational policies on Continuing Healthcare are updated to reflect these protocols.'

I will be asking the HOSC to formally endorse these actions and will suggest that arrangements are put in place to review the implementation of these recommendations in the coming year. I would also like to invite you to nominate a PCT non executive director to act as an observer to the Review Panel appointed to oversee this work.

Yours sincerely



**Cllr Pat West**
**Chairman, Health Overview and Scrutiny Committee**
Cc Gill Duncan, Director, Adult Social Services
All contributors to the 7th November seminar