Agenda Item 7

HAMPSHIRE COUNTY COUNCIL

Report

Committee:	Health Overview and Scrutiny Committee
Date of Meeting:	24 July 2012
Report Title:	Proposals to Develop or Vary NHS Services
Report From:	Chief Executive

Contact name: Katie Benton, Scrutiny Officer
Marie Mannveille, Scrutiny Officer

Tel: 01962 847336
01962 845018

E-mail: katie.benton@hants.gov.uk
marie.mannveille@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:

1. *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.

2. *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: Adult Mental Health services – update on implementation

2.1 The Committee last received an update on the implementation of changes to Adult Mental Health services in Hampshire from Southern Health NHS Foundation Trust at its 27 March 2012 meeting, where it heard that the phased closure of the Meadows, Sarisbury Green, was ongoing, and that staff from this Unit were being transferred into the Hospital at Home teams in the East Hampshire area. The same phased closure had not been applied to Woodhaven, Calmore, at this time.

2.2 The Adult Mental Health working group set up by the Committee to explore concerns raised in the course of the March meeting reported at the 22 May meeting. This working group informed the Committee that it did not have any significant concerns regarding the change in service, but did make a number of recommendations to the Trust, and requested supplementary information to be brought to the 24 July meeting. These included:

- That in addition to the male and female bed data graphs, information is also included on how many beds can 'swing' from male to female occupancy if required.
- That the Trust collect and provide any feedback from social care and other mental health providers in Hampshire regarding the impact of the new model of care.
- That the Trust state which of the remaining Adult Mental Health acute units include en-suite facilities, and, if some units do not, to inform the Committee of whether providing such facilities will be considered as part of any future capital improvements.
- That the Trust provide further detail regarding:
  a) The timescales within which Mental Health Act Assessments are required to be undertaken.
  b) The Hampshire performance for the past year.
  c) What work the Trust and its partners are undertaking to improve the time taken to commence Mental Health Act Assessments.
  d) Within what timescale the HOSC could expect improvements to Mental Health Act Assessment access to be demonstrated.

2.3 Responses to these requests for supplementary information, alongside an update on the implementation of proposals, can be found at Appendix One (page 8).

Recommendations

2.4 Members confirm:

- If they are satisfied with the Trust's response to the supplementary information requested, and whether they require any further information on these.

- If they are satisfied with the progress of implementation reported by the Trust for the new adult mental health service model of care in Hampshire.

Items for Information

3. **Southampton, Hampshire, Isle of Wight and Portsmouth PCT Cluster: Vascular Services – update**

3.1 As previously reported by the Chairman at the 22 May HOSC, Southampton, Hampshire, Isle of Wight and Portsmouth Primary Care Trust (SHIP PCT) Cluster held a seminar on vascular services on 11 June, which aimed:

- To review progress with the development of local vascular surgical services.
- To clarify the position on outcomes data and receive an independent national perspective on the future of vascular services.
- To clarify the future commissioning arrangements.
- To provide an opportunity for Trusts to share their perspective on the opportunities and challenges of working in a network model.
- To agree next steps.

3.2 This seminar was attended by both Portsmouth and Southampton Hospital Trusts, commissioners – including SHIP PCT Cluster, specialised commissioning and clinical commissioning groups, LINk representatives, independent experts and Members of SHIP area HOSCs. The Chairman and Vice Chairman of the Hampshire HOSC were in attendance on behalf of the Committee.

3.3 SHIP PCT Cluster have drawn together a note of the meeting with proposed actions, which can be found at Appendix Two (page 28). Representatives of the SHIP PCT Cluster will be in attendance to answer questions.

Recommendations

3.4 That the Chairman, on behalf of the Committee, write to SHIP PCT Cluster outlining any further information or updates required following the seminar.

4. **University Hospital Southampton NHS Foundation Trust – Relocation of Elderly Care Beds**

4.1 Communications have been received from University Hospital Southampton NHS Foundation Trust (UHS) regarding plans to relocate elderly care beds from Southampton General Hospital to the Royal South Hampshire Hospital, run by Solent NHS Trust (Appendix Three, page 36). The move is designed to vacate beds at Southampton General Hospital for planned surgery, as there have been demand pressures in this area arising from an extended period of high urgent care demand.

4.2 Representatives from both UHS and Solent NHS Trust will be in attendance to answer any questions from Members regarding this change. Members will wish to understand how the relocated ward will operate, given that patients will still be initially admitted to Southampton General Hospital. The committee will also wish to test whether this is anticipated to be a temporary arrangement.

Recommendations

4.3 Members confirm:

- Whether the proposals constitute a substantial change in service.
- Whether an update is required, or any further information.

5. National Specialist Commissioning Board: Children's Congenital Heart Surgery

5.1. The Committee last received an update on this national review at the 22 May 2012 meeting, where it was reported that the Judicial Review decision had been quashed; resultantly the Joint Committee of Primary Care Trusts (JCPCT) planned to take a decision on the future provision of services for children with congenital heart surgery as originally scheduled.

5.2. At a public and webcast meeting on 4 July 2012, the JCPCT considered the feedback received during the consultation period, as well as further evidence presented during the course of the review. After eight hours of discussion, the JCPCT took the decision to establish seven children's congenital heart networks across England. These networks can be found at Appendix Four (page 37).

5.3. The JCPCT's decision on the shape of future networks will result in the following centres ceasing to provide surgery, although some may become children's cardiology centres:

- Glenfield Hospital, Leicester
- Leeds General Infirmary, Leeds
- Royal Brompton and Harefield, London
- Oxford Radcliffe, Oxford (although this Hospital had already ceased to provide surgical services as of 2010)

The closure of these units is not with immediate effect – the JCPCT will now look to draw up an implementation plan, likely to lead up to 2014.

5.4. As Southampton General Hospital (SGH) will continue to provide children's congenital heart surgery, there will be no perceived change in service for patients in Hampshire requiring access to this specialist provision. The designation of SGH as the lead surgical centre in the South Central network may lead to an increase in patient flow to the hospital, which could result in the further development of the service.

5.5. A national review of service provision for Adults with Congenital Heart Disease (ACHD) has also been recently initiated. While these patients have different needs, the HOSC understands that currently the same surgeons undertake both children's and adult's congenital heart surgery at SGH. Therefore the outcome of the children's heart surgery designation could have an impact on the likelihood of SGH performing sufficient (combined) procedure numbers to meet the developing standards for ACHD surgery. The HOSC will continue to monitor and contribute to this national review.

Recommendations

5.6 That Members welcome the JCPCT decision to retain Southampton General Hospital as a specialist surgical centre in the South Central network model for Children's Congenital Heart Surgery.

5.7 Members confirm that the outcome of the 'Safe and Sustainable' review is considered to be in the best interests of the Hampshire population affected, and therefore does not constitute a substantial change in service.

5.8 That the Committee monitors the ACHD national review, and working with other HOSCs as appropriate, provides a full response to proposals, as and when they are available.

CORPORATE OR LEGAL INFORMATION:

Links to the Corporate Strategy

A. Hampshire safer and more secure for all:	yes
Corporate Improvement plan link number (if appropriate):	
B. Maximising well-being:	yes
Corporate Improvement plan link number (if appropriate):	
C. Enhancing our quality of place:	yes
Corporate Improvement plan link number (if appropriate):	

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:

a) No implications arising from this report

2. Impact on Crime and Disorder:

a) No implications arising from this report

3. Climate Change:

- *How does what is being proposed impact on our carbon footprint / energy consumption?*

  No implications arising from this report

- *How does what is being proposed consider the need to adapt to climate change, and be resilient to its longer term impacts?*

  No implications arising from this report

Appendix One

Southern Health NHS
NHS Foundation Trust

HEALTH OVERVIEW AND SCRUTINY COMMITTEE PAPER – 24 July 2012

Distribution: **Hampshire Overview and Scrutiny Committee [HOSC]**

Submitted by: **Adult Mental Health Division, Southern Health NHS Foundation Trust [SHFT]**

Date: **10 July 2012**

Purpose This paper provides information requested in the letter dated 15th May from Cllr West on behalf of the HOSC Working Group and serves as an update of progress since March 2012 in relation to the redesign of adult mental health services [AMH] provided by Southern Health NHS Foundation Trust, across Hampshire.

1. Update on Progress

Access and Assessment Teams (AAT's)

Our Access and Assessment Teams were rolled out during April this year, and are now in place in all areas, with the exception of Petersfield, which will be in place by the Autumn. Work is still ongoing to finalise the office environments for some of these teams, but new referrals are now being received via a single point of access, with the teams offering brief interventions, crisis support and transfers for new and known service users.

We continue to have positive feedback from referring GPs and service users accessing the new teams.

Community Treatment Teams (CTTs)

The phased transition to community treatment teams is now complete, with work ongoing to monitor the transfer of caseloads from the old teams to the new, so that service users receive treatment and support in a timely and co-ordinated way.

Clinicians within these teams provide interventions to improve the wellbeing of service users and their overall level of functioning.

Acute Care Teams (ACTs)

The acute care teams consist of acute inpatient units and a Hospital at Home service working closely together. The hospital at home service is an extension of the previously successful home treatment provision, but service users now have access to a higher intensity and tailored range of multidisciplinary therapeutic interventions which can also be delivered in their own home, during periods when they are acutely ill.

Hospital at Home service (H@H)

During March the division finalised its plans for the phased roll out of the Hospital at Home teams. On 2 April the first H@H service was launched in the East, followed by the West mid April and then the South during May and June. In the North the home treatment team has continued to deliver a service as part of the acute care team and, transition to the Hospital at Home model is planned to be completed by the end of the Summer. Work continues to embed clinical protocols and practices across all areas to ensure we continue to deliver a consistent service across all areas.

Intensive support programmes

The intensive support programme is a concentration of community interventions consisting of individually-designed psychological therapies to enable service users to take a central role in their own recovery, either in a one to one or group format, or both. This is well established in West area, and from May the roll out to other areas has been supported by staff training.

Acute Transfer Facilitators

This role was originally called a Discharge Facilitator. In line with local and national best practice we have now reframed the role as an Acute Transfer Facilitator to reflect the focus and value that this role brings in facilitating and underpinning the collaborative approach across and between inpatient, Hospital at Home, community and social care teams during a service user's journey.

The final reconfiguration of our workforce, due to conclude in the North and the West by September, will ensure all areas have a dedicated Acute Transfer Facilitator. These individuals will work collaboratively across the region to support the early identification of admission objectives and unblock those issues that could delay appropriate discharges, such as lack of suitable accommodation or the need for a home support care package. The ultimate goal being to create timely and well supported discharge.

Inpatient Services

The closure of the Meadows unit was successfully completed on schedule, at the end of March, with all but the Electroconvulsive Therapy Service [ECT] relocating to Elmleigh in Havant. The ECT service will remain at the Sarisbury Green site until October when the building works at Elmleigh have been completed to accommodate the service. Our bed capacity across the Division was consequently reduced, but a continued focus on efficient and effective use of beds, the involvement of our Acute

Transfer Facilitators, alongside the launch of the Hospital at Home service has allowed us to create further capacity.

From June onwards, we have been able to continue the phased reduction in bed capacity and to date (10 July 2012) nine beds have been closed at Woodhaven. We remain on schedule to complete the remaining bed closures there by the end of July. We anticipate that there may be four service users currently residing at Woodhaven who might need to be transferred to other units during July. We are working with these individuals, their carers, consultants and care co-ordinators to ensure the plans in place are safe and clinically appropriate. The division will continue, as it has done throughout the redesign programme to make a commitment that if someone needs a bed, they will be able to access one. [See bed occupancy graphs attached in the Appendices].

2. Monitoring of redesign

Since March and throughout the phased implementation, the division has continued to monitor and manage issues and risks associated with the redesign on a regular basis. The division has communicated progress and performance to the Trust and Commissioners through standard reporting mechanisms and also continued to communicate outside of the organisation to stakeholders, via briefings and meetings on the programme's progress against key milestones.

As the division moves from the implementation and transition stages to the day to day operational delivery of new acute care pathway across Hampshire, work is being undertaken to establish a review of the redesign project to establish what went well and what did not go so well, so that lessons can be learnt and any outstanding issues addressed in a proactive and effective way.

3. Information requested in the letter dated 15 May from Cllr West on behalf of the HOSC Working Group

1. *That in addition to the male and female bed data graphs, information is also included on how many beds can 'swing' from male to female occupancy if required.*

Please find attached the bed data graphs. The division currently has five swing beds. We have initiated a review of our contingency and swing beds in order to identify additional capacity.

2. *That the Trust collect and provide any feedback from social care and other mental health providers in Hampshire regarding the impact of the new model of care.*

Initial feedback from our partners has been positive. In addition to our planned review of the redesign programme, a clinical service evaluation will be undertaken, led by Dr Rathod that will compare a range of service quality measures before the services changes occurred, with an evaluation six months after the changes. This piece of work will include carer and GP surveys, service user experience and clinical

outcomes. Dr. Rathod will provide HOSC with a report by the end of the calendar year on the findings of the service evaluation.

3. *That the Trust state which of the remaining Adult Mental Health acute units include en-suite facilities, and, if some units do not, to inform the Committee of whether providing such facilities will be considered as part of any future capital improvements.*

At Elmleigh in Havant and Antelope in Southampton all our acute single bedded rooms have en-suite. Melbury in Winchester and Parklands in Basingstoke each have only one en-suite facility within the respective units. As part of the review of contingency and swing beds we are assessing the facilities available in each unit, and considering the scope for improving the environment as part of a future AMH capital investment programme

4. *That the Trust provide further detail regarding:*
    - *The timescales within which Mental Health Act Assessments are required to be undertaken.*
    - *The Hampshire performance for the past year.*
    - *What work the Trust and its partners are undertaking to improve the time taken to commence Mental Health Act Assessments.*
    - *Within what timescale the HOSC could expect improvements to Mental Health Act Assessment access to be demonstrated.*

Service users assessed under the Mental Health Act (MHA) may be admitted to our acute beds after a joint assessment has been carried out by a Local Authority Approved Mental Health Professional (AMHP) and a Doctor/s. Over recent months there has been considerable national and local attention to the Governance and availability of the 'Place of Safety' as a function of section 136 of the MHA. Traditionally practice has involved the use of the police station as the receiving venue for an individual following their arrest under this MHA Police power. However a great deal of energy is now being invested to ensure that the Police station is the exceptional venue for an individual who is deemed in need of immediate care and control. There are currently national requirements to report performance information on s136 Mental Health Act Assessments, however legislation requires an assessment to be carried out within 72 hours of the person's arrival at the place of safety.

From a Southern Health perspective we have begun to collate information on how long a service user has to wait for s136 Mental Health Act Assessment and the outcomes for our service users once assessed and admitted under our care.

The SHA, via the Regional 136 Group chaired by Olga Senior, Director of Corporate Affairs have asked all the agencies involved to pull together activity information and we are two months into the journey. The SHA work is alongside the Hampshire and Isle of Wight Criminal Justice Group work plan geared towards supporting a shift across the whole Section 136 pathway which includes reference to the various recommendations of the Royal College of Psychiatrists report on the standards of

the use of a Section 136. A key aspect of the work plan is to collaboratively collect a robust set of shared Police and Trust data, which includes MHA assessments and associated performance metrics. It is hoped that the accumulation of the data should, over time offer a clearer understanding of the whole system, where the various agencies are interdependent, and ensure the pathway and its component processes are as efficient and effective as possible. The work plan identifies that the data will be presented as an audit report to the Group in the Autumn of 2012.

Southern Health remains keen to continue to work with all the agencies involved in the whole system approach and the Section136 audit, the findings of which should later this year enable all the collaborating agencies to identify where the obstacles are, and actively work towards freeing up delays in the process.

5. Re-use of Woodhaven as an Acute Low Secure Service

As was presented at your last meeting, we have identified a gap in provision for Acute Low Secure Services in the Hampshire area. Currently the majority of people who require this service access it from outside of the Hampshire area, which is not ideal for relatives and carers who may live locally, and also costs the NHS much more than it would if services were provided in the area. Southern Health already provides medium secure services and low secure rehabilitation services for adults, so this development would also complement the entire secure services pathway of care. As you are already aware, it is being proposed that the Woodhaven site will be used for a 26 bedded facility for the delivery of Acute Low Secure services.

Currently, the business case for the re-provision of services at the Woodhaven site is currently with our Executive Team for final Trust approval. While this business case is being approved, plans are continuing to progress in order that the service can be running by April 2013. However, at this stage all of the plans are subject to final trust signoff.

The trust has made, and reiterates, that the building at Woodhaven will continue to be used for health and at this stage plans are progressing on time and as expected.

7. HOSC Considerations

The Trust would ask the HOSC to consider the following:

- Note progress to date and the continued engagement with internal and external stakeholders
- Note the progress to date on the reduction in bed occupancy
- Identify what members would wish the Trust to report on at the next HOSC

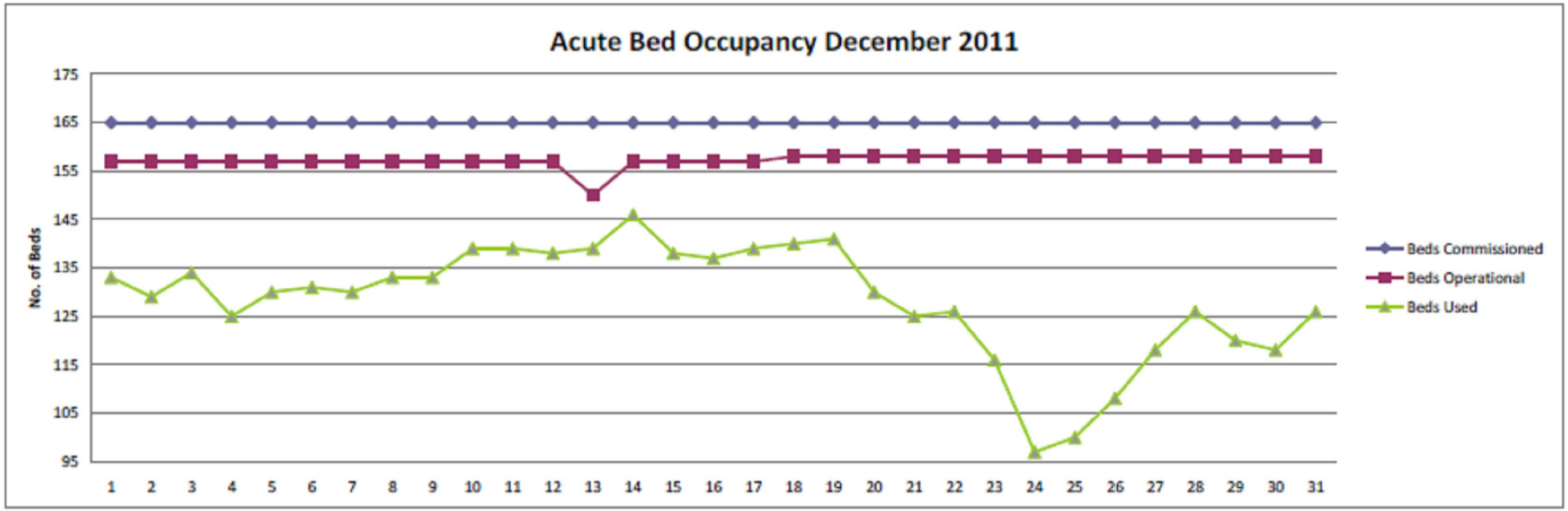
8. Annexes

1. Bed Occupancy Report and Milestones Dec 2011 to June 2012
2. Male and Female Bed Availability March to May 2012
3. 11 May Southern Health paper responding to the HOSC Working Group of 23 April 2012

Beds Occupancy December 2011 -May 2012

Dec-11

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Beds Commissioned	165	165	165	165	165	165	165	165	165	165	165	165	165	165	165	165	165	165	165	165	165	165	165	165	165	165	165	165	165	165	165
Beds Operational	157	157	157	157	157	157	157	157	157	157	157	157	150	157	157	157	157	158	158	158	158	158	158	158	158	158	158	158	158	158	158
Beds Used	133	129	134	125	130	131	130	133	133	139	139	138	139	146	138	137	139	140	141	130	125	126	116	97	100	108	118	126	120	118	126



Jan-12

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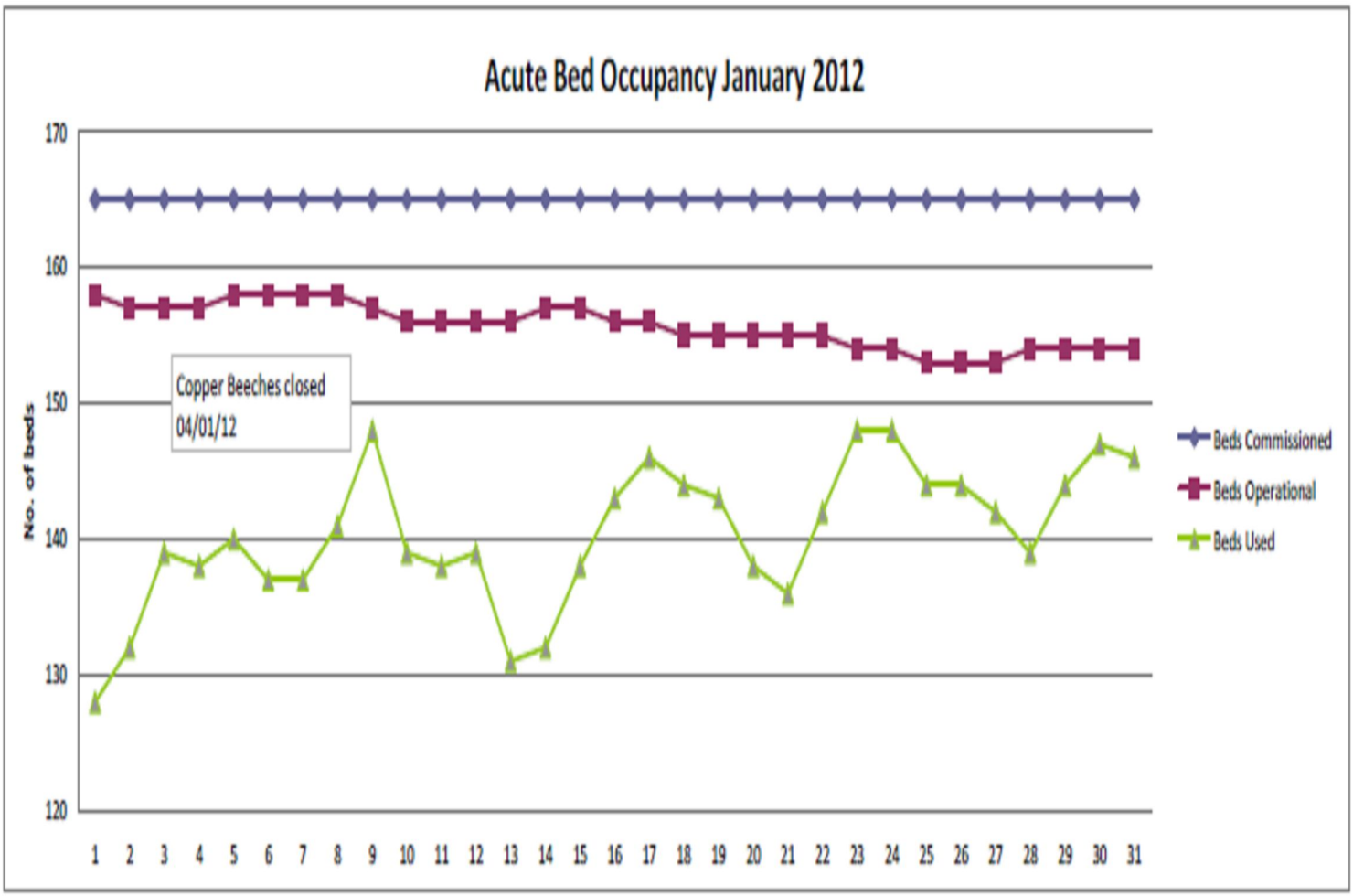
Beds Commissioned	165	165	165	165	165	165	165	165	165	165	165	165	165	165	165	165	165	165	165	165	165	165	165	165	165	165	165	165	165	165	165
Beds Operational	158	157	157	157	158	158	158	158	157	156	156	156	156	157	157	156	156	155	155	155	155	155	154	154	153	153	153	154	154	154	154
Beds Used	128	132	139	138	140	137	137	141	148	139	138	139	131	132	138	143	146	144	143	138	136	142	148	148	144	144	142	139	144	147	146



Feb-12

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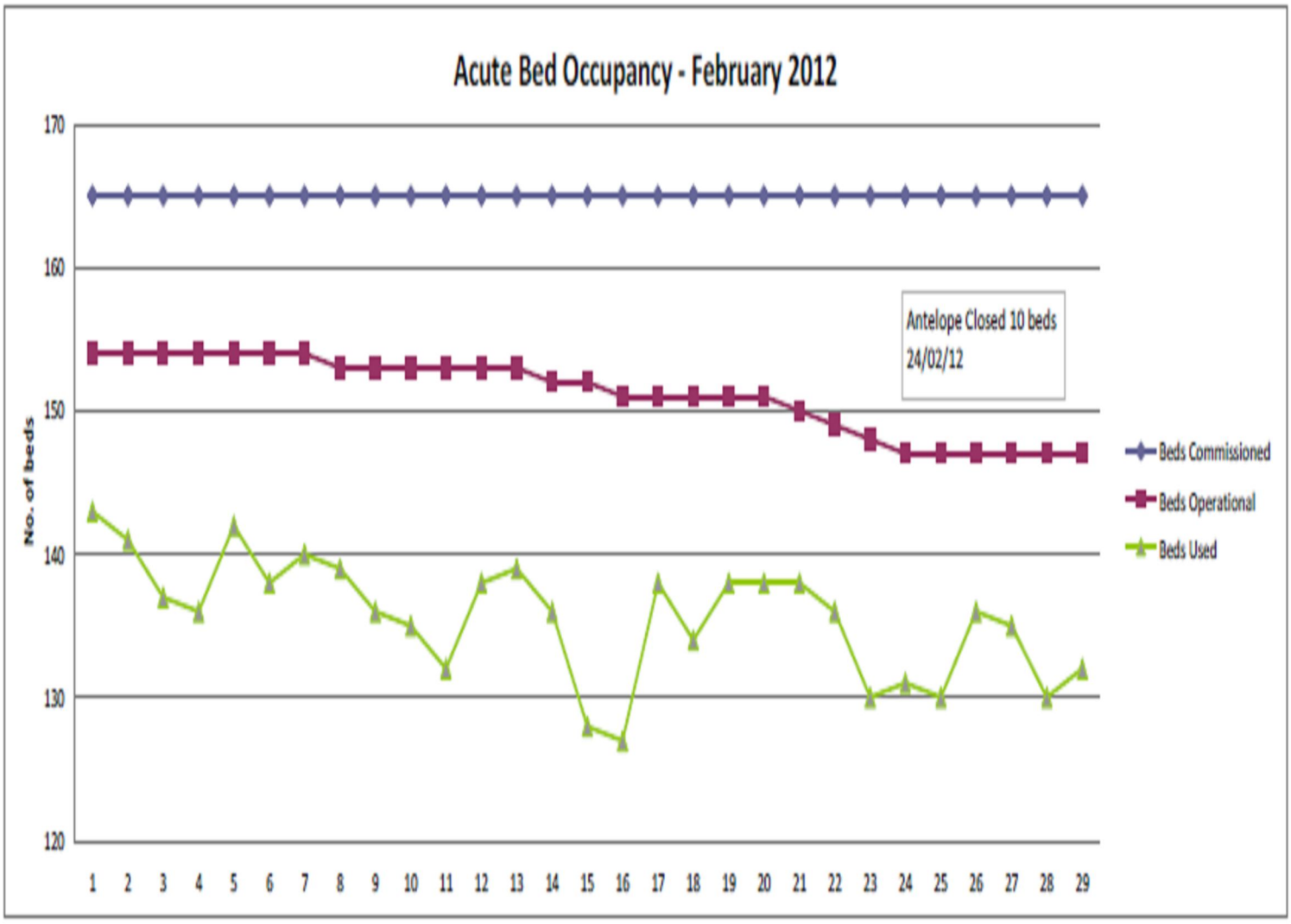
Beds Commissioned	165	165	165	165	165	165	165	165	165	165	165	165	165	165	165	165	165	165	165	165	165	165	165	165	165	165	165	165	165
Beds Operational	154	154	154	154	154	154	154	153	153	153	153	153	153	152	152	151	151	151	151	151	150	149	148	147	147	147	147	147	147
Beds Used	143	141	137	136	142	138	140	139	136	135	132	138	139	136	128	127	138	134	138	138	138	136	130	131	130	136	135	130	132



Mar-12

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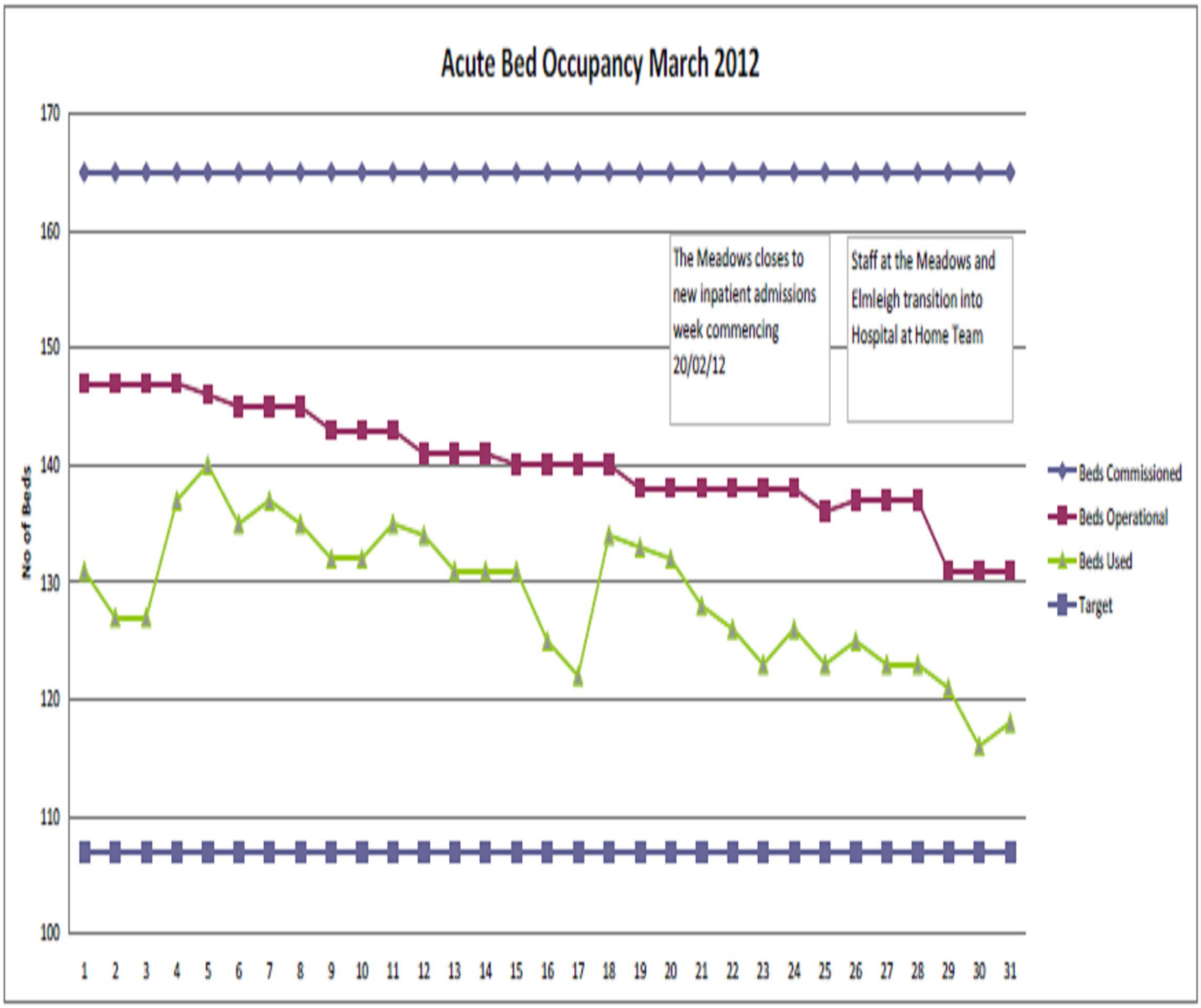
Beds Operational	147	147	147	147	146	145	145	145	143	143	143	141	141	141	140	140	140	140	138	138	138	138	138	138	136	137	137	137	131	131	131
Beds Used	131	127	127	137	140	135	137	135	132	132	135	134	131	131	131	125	122	134	133	132	128	126	123	126	123	125	123	123	121	116	118
Target	107	107	107	107	107	107	107	107	107	107	107	107	107	107	107	107	107	107	107	107	107	107	107	107	107	107	107	107	107	107	107



Apr-12

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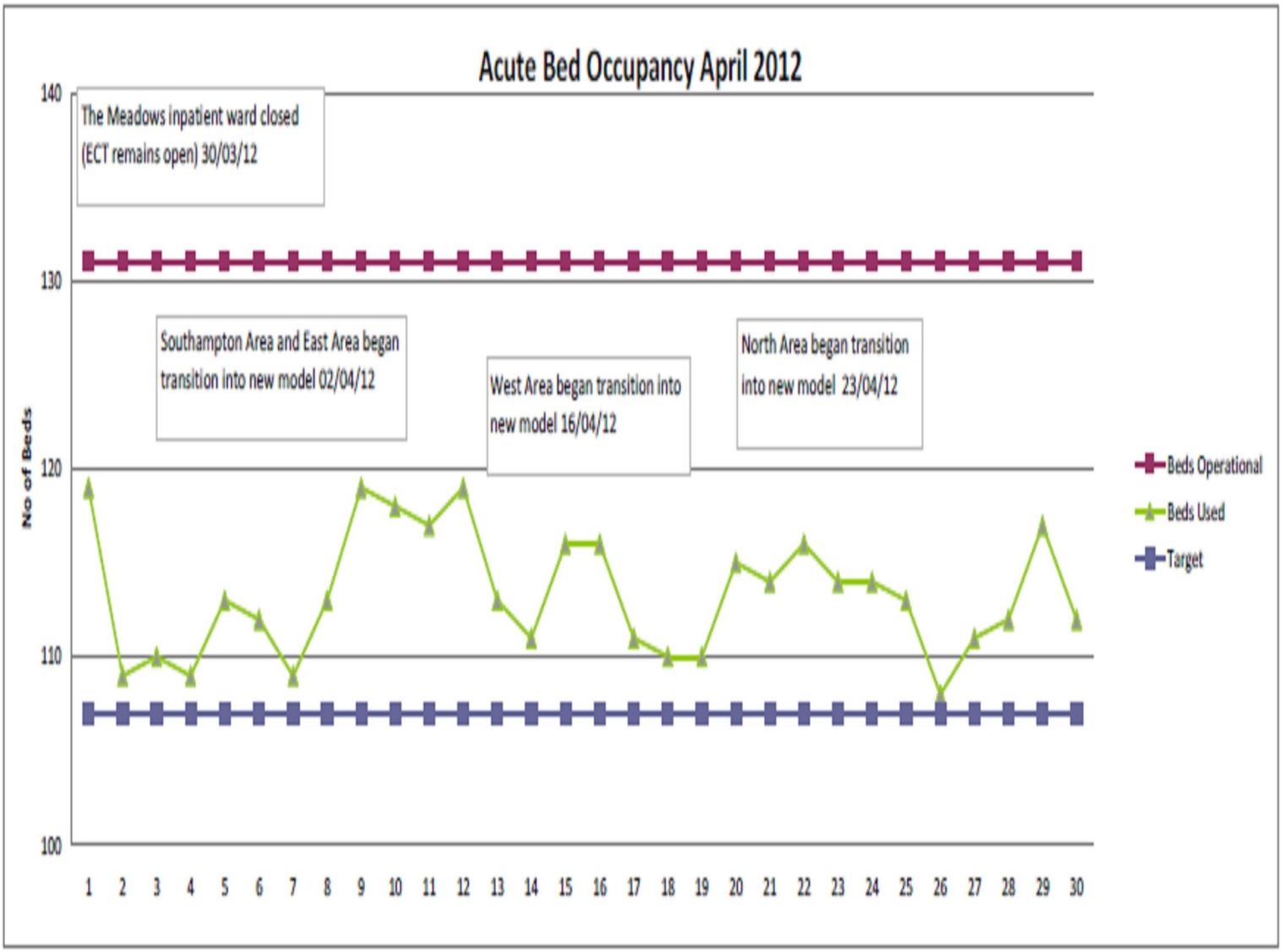
Beds Operational	131	131	131	131	131	131	131	131	131	131	131	131	131	131	131	131	131	131	131	131	131	131	131	131	131	131	131	131	131	131	
Beds Used	119	109	110	109	113	112	109	113	119	118	117	119	113	111	116	116	111	110	110	115	114	116	114	114	113	108	111	112	117	112	
Target	107	107	107	107	107	107	107	107	107	107	107	107	107	107	107	107	107	107	107	107	107	107	107	107	107	107	107	107	107	107	



May-12

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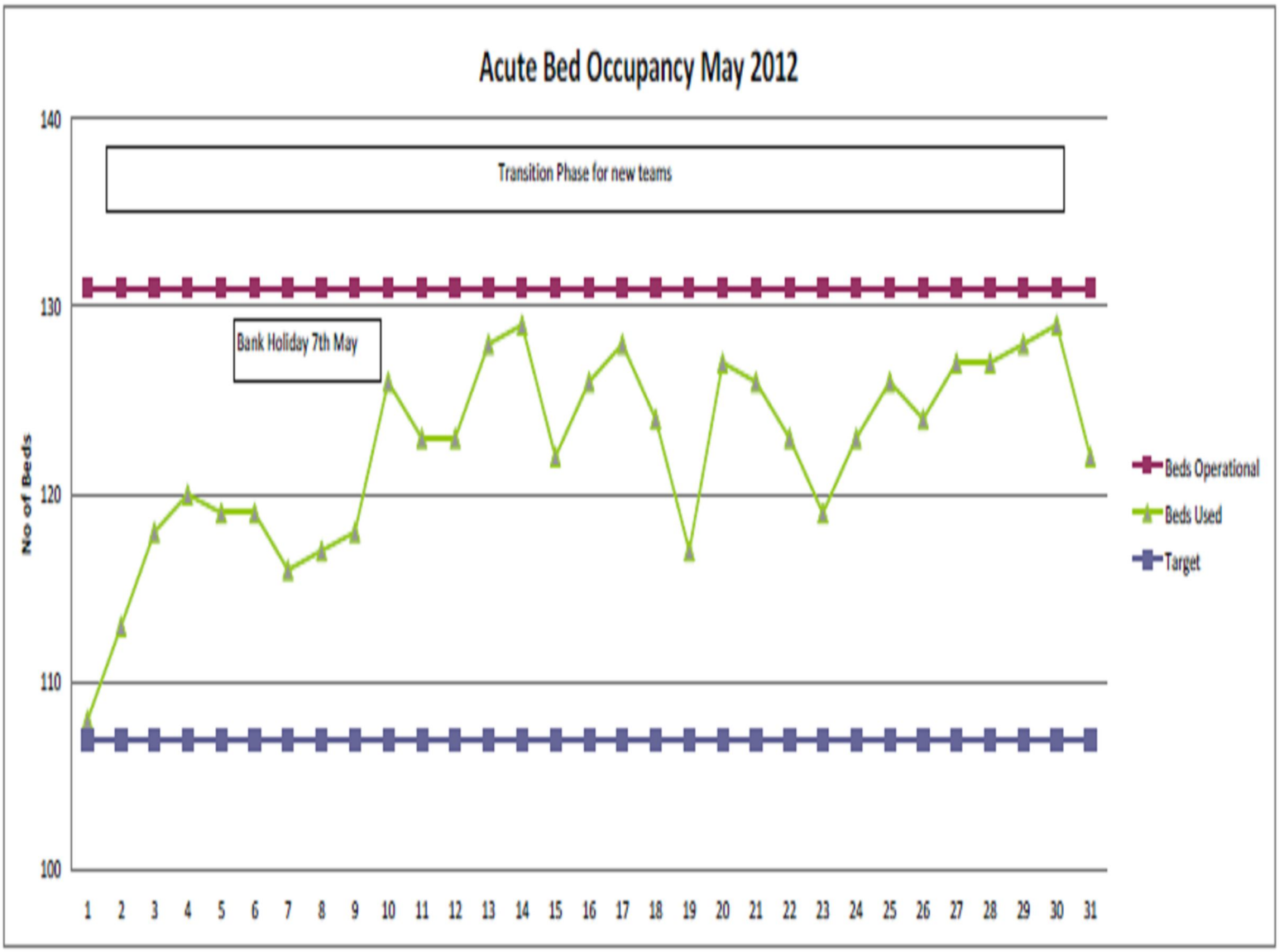
Beds Used	108	113	118	120	119	119	116	117	118	126	123	123	128	129	122	126	128	124	117	127	126	123	119	123	126	124	127	127	128	129	122
Target	107	107	107	107	107	107	107	107	107	107	107	107	107	107	107	107	107	107	107	107	107	107	107	107	107	107	107	107	107	107	107



Jun-12

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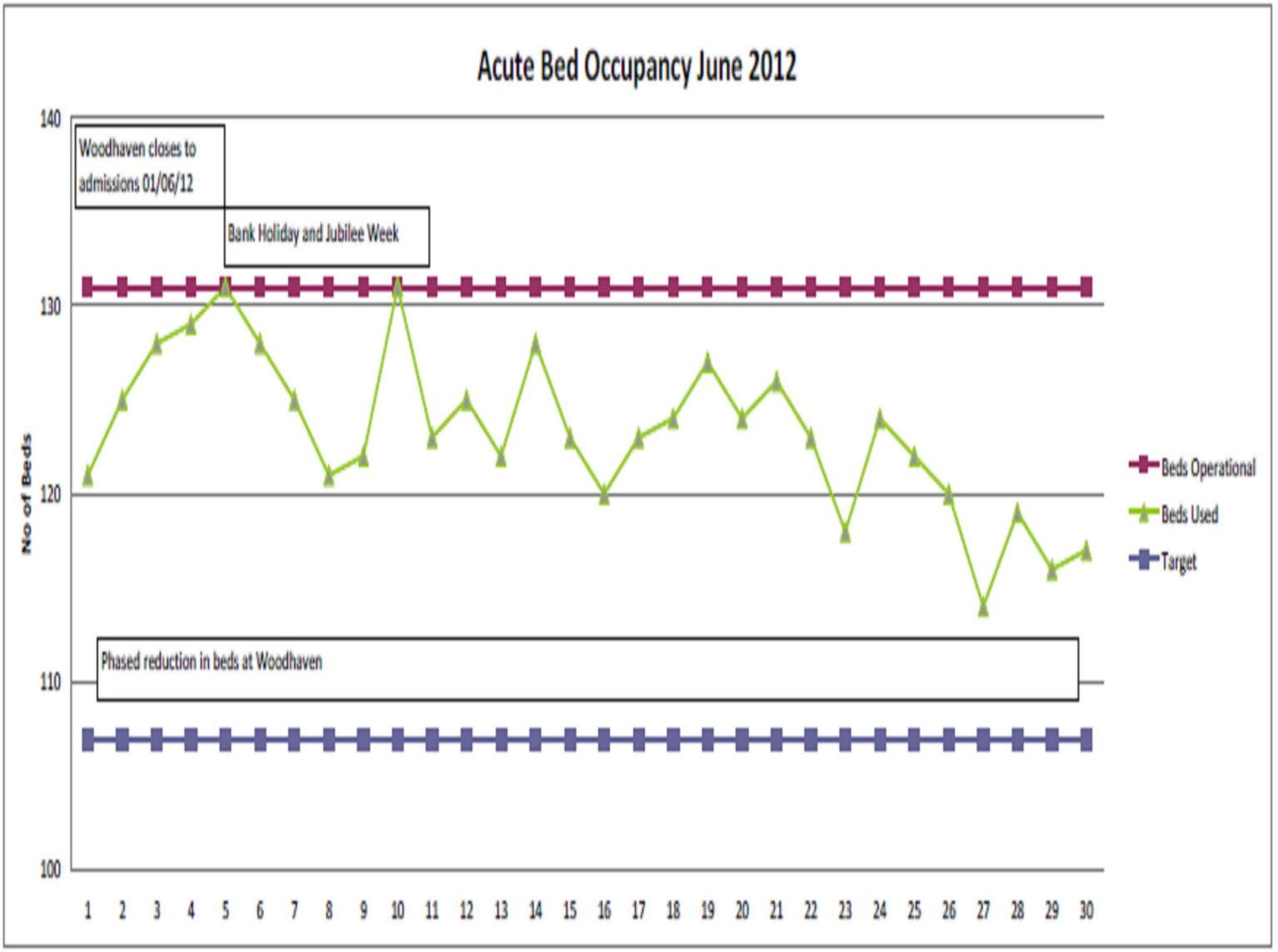
Beds Operational	131	131	131	131	131	131	131	131	131	131	131	131	131	131	131	131	131	131	131	131	131	131	131	131	131	131	131	131	131	131
Beds Used	121	125	128	129	131	128	125	121	122	131	123	125	122	128	123	120	123	124	127	124	126	123	118	124	122	120	114	119	116	117
Target	107	107	107	107	107	107	107	107	107	107	107	107	107	107	107	107	107	107	107	107	107	107	107	107	107	107	107	107	107	107



Annexe 2 to Appendix One

Bed Availability March 2012 - May 2012

Mar-12

Date	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Male	7	8	8	5	1	3	4	6	7	7	5	2	4	1	1	6	7	0	1	1	4	3	1	2	0	1	2	3	2	5	4
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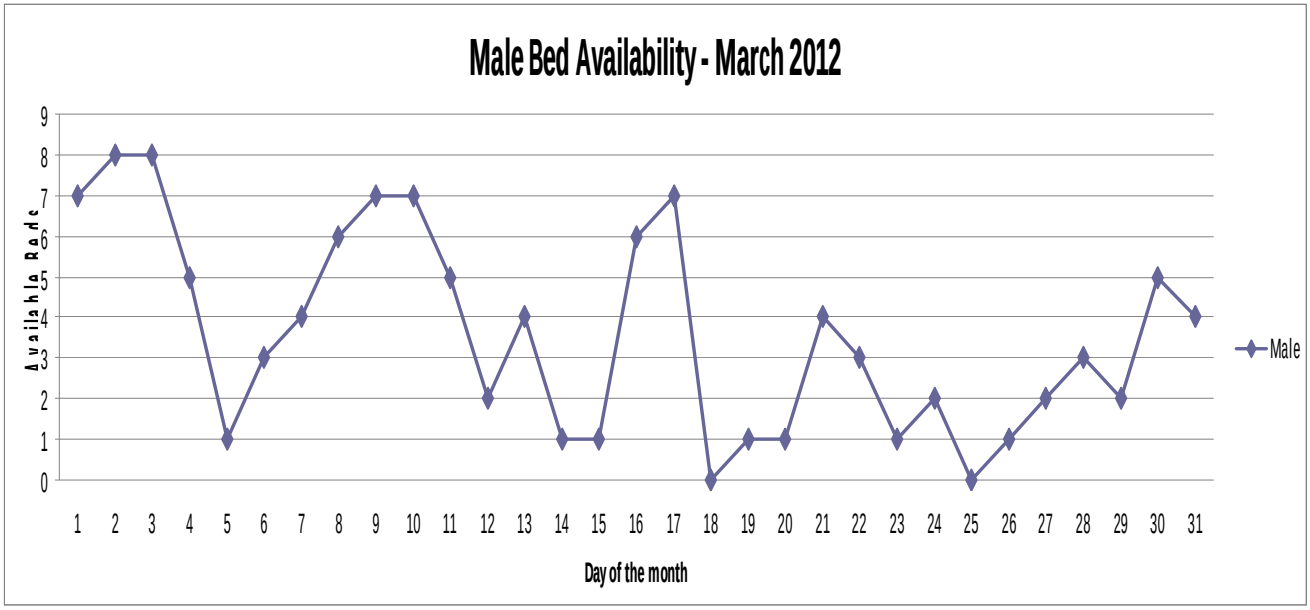

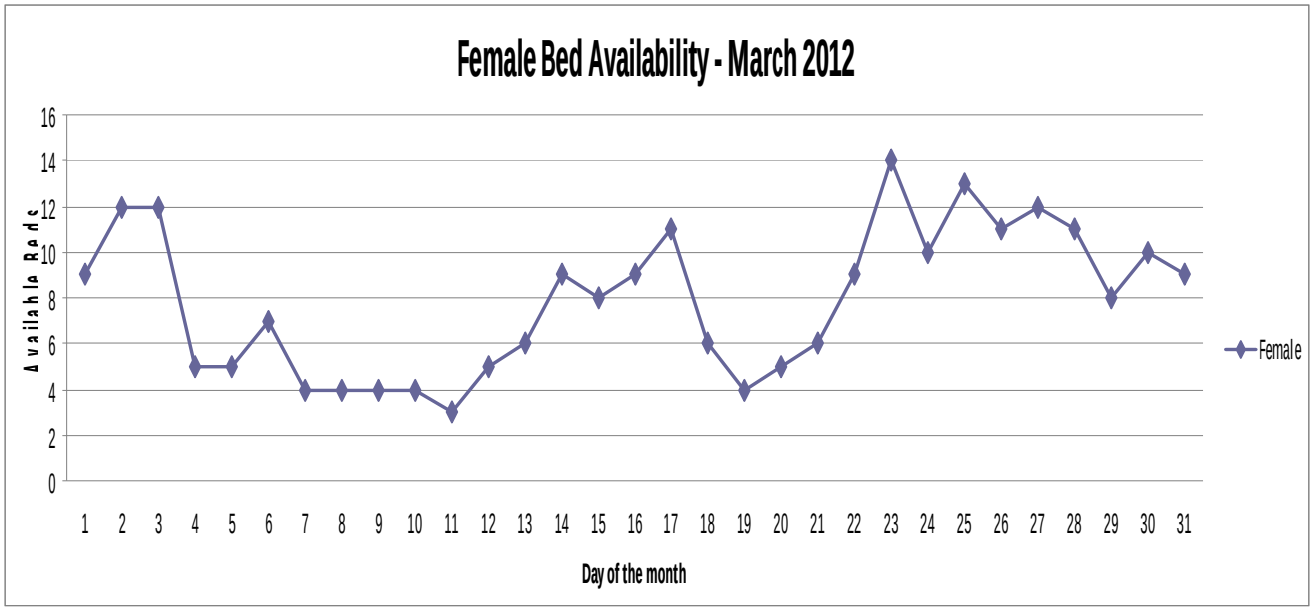

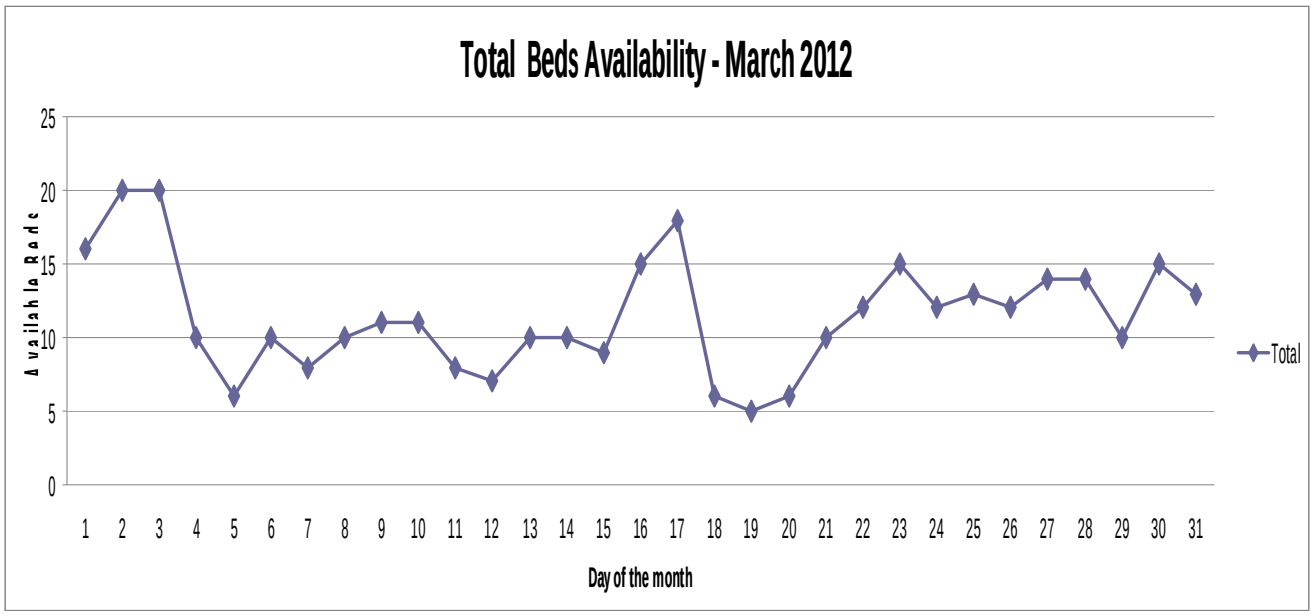

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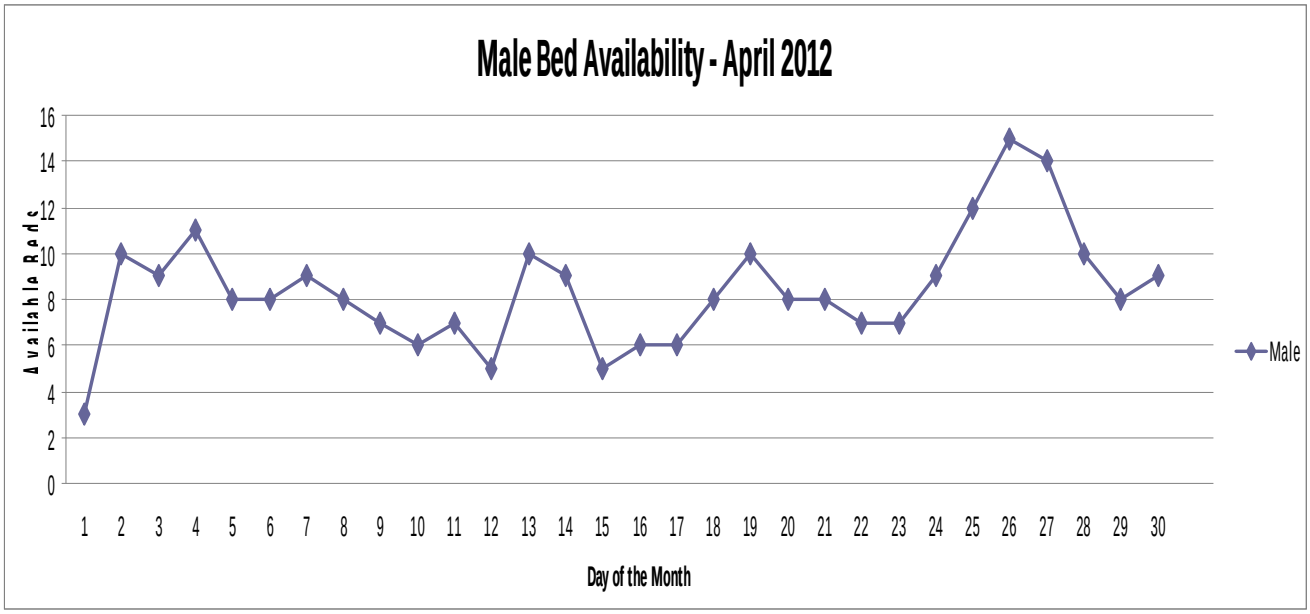

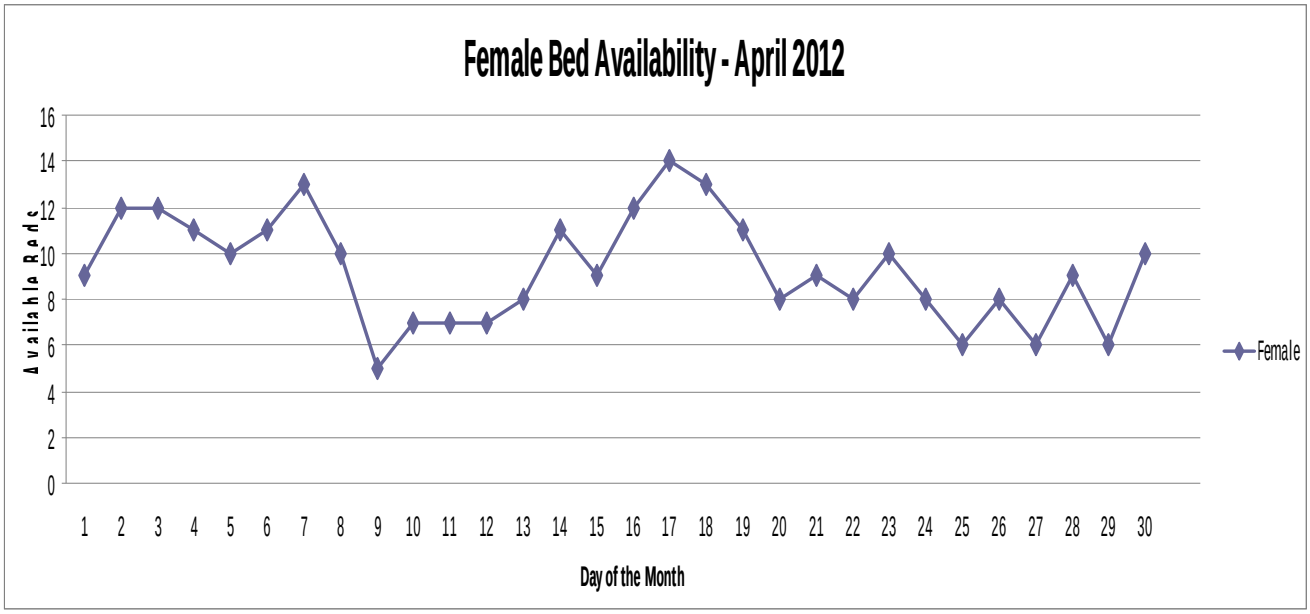
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2
4
6
8
10
12
14
16
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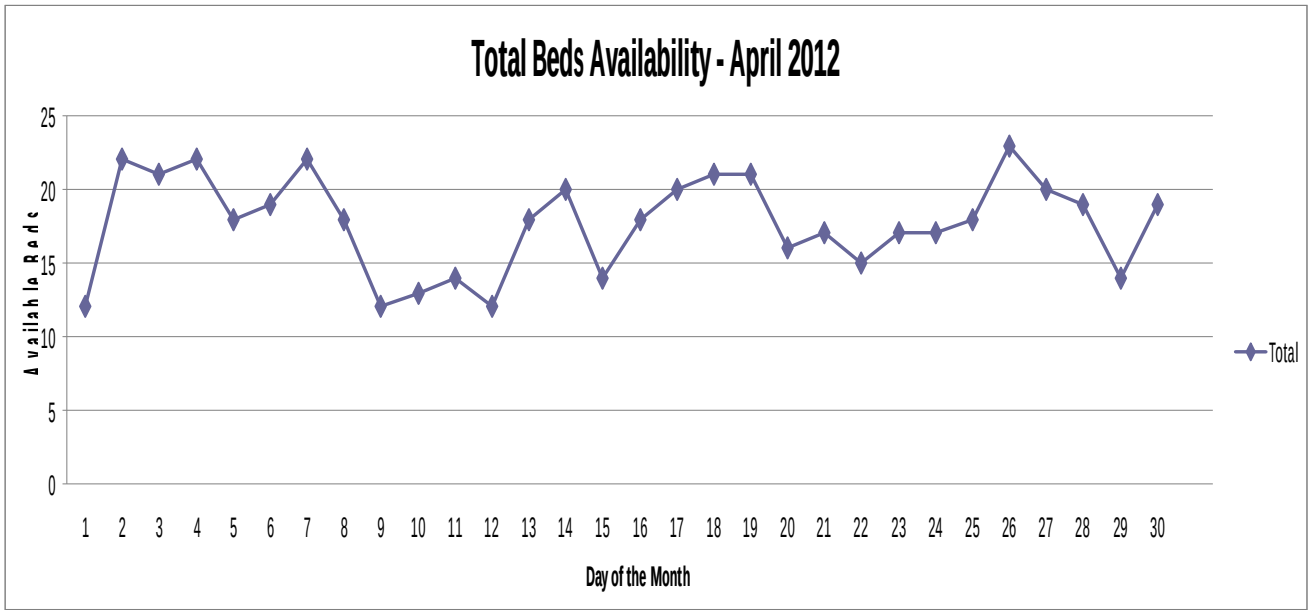
Day of the Month
Female


Total Beds Availability - April 2012
Available Beds
0
5
10
15
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25
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30
Day of the Month
Total

HEALTH OVERVIEW AND SCRUTINY COMMITTEE PAPER – 22nd May 2012

Distribution: **Hampshire Overview and Scrutiny Committee (HOSC)**

Submitted by: **Adult Mental Health Division, Southern Health NHS Foundation Trust (SHFT)**

Date: **11th May 2012**

Purpose: This paper responds directly to the points raised by the HOSC Working Group on 23rd April 2012.

a. Details of the outcomes that the Trust will use to measure the performance of the new model for adult mental health services.

We monitor our performance centrally through a Divisional Performance Group and Divisional Service Board.

Some of the things that we will be recording and considering, to enable us to monitor if our model is realising the redesign benefits and that our systems are working properly are:

- The number of people referred/coming into the service and the number of people currently in the service, compared to the amount of staff available in certain parts of the service to meet this demand.

- The caseload that a team and/or a member of staff may have at any one time, compared to the number of service users in the system.

- The length of stay for a service user in different parts of the service alongside the number of discharges that take place.

- Auditing care plans and clinical pathways to ensure we are delivering the right care in the right place, at the right time for our service users.

- Measuring specific metrics that our commissioners and regulators want us to measure our work against, such as occupied bed days, rates of admissions, gate-keeping of admissions and follow ups.

- Checking that staff have the right tools and support to enable them to deliver their roles by reviewing staff training and development needs as well as sickness and vacancy rates.

- Reviewing quality outcomes against NICE guidelines, as well as learning from incidents and complaints, by peer-group inspections. Investigating every incident and actively learning lessons and implementing best practice through transparent, open dialogue across our services and with our service users.

- Rolling out of the INSPIRE tool which is designed to assess service users experience of the support they receive from mental health works in line with their recovery.

a.3. **Information is attached as requested:**

- Acute bed occupancy, including key milestones
- Separate bed data graphs for male, female and 'swing' beds
- Percentages of voluntary vs. detained inpatients
- Average length of stay for inpatients

In summary, acute bed occupancy data demonstrates that since the closure of the Meadows at the end of March 2012 we have continued to make steady progress in creating capacity in our acute care wards, with between 12 and 22 beds available every day in April.

The male and female bed availability charts demonstrate that there are fluctuations in demand for these beds, as we expect, with particular pressure in March on male beds. However, in April the availability of beds has been evenly distributed between men and women.

Our length of stay has fallen since October 2011. It is also noteworthy that in April, following the closure of the Meadows and reduction of acute beds by 10 in Southampton, the proportion of detained patients in our acute inpatient units has not increased. This is because the work to support people in community settings and reduce people's length of stay has been effective for voluntary service users and those who may be subject to the Mental Health Act.

b. The process that the Trust follows to establish the right capacity to be built into the system for the population of Hampshire is 107 beds

As HOSC members will be aware, in addition to consulting with our staff, services users and stakeholders we carefully examined our internal data. We also considered information from the Audit Commission, and Consilium Strategy Consulting as well as local and national sources to help us make a decision on how many beds were required in the future redesign model. Some of the tools we used in addition to establish the number of beds appropriate for the population of Hampshire included:

- Modelling the length of stay profile for each Adult Mental Health unit, as well as for the service as a whole;

- Our admission rates, length of stay profiles and occupancy rates, and external benchmarking of other leading mental health trusts in England.

- Analysis of the population trends and demand over the next five years.

- The mental health needs index (MINI) published by the Centre for Mental Health, to provide a relevant 'weighted population' calculation. (MINI takes the 'raw' 15-64 year olds population and weights the total by a series of factors linked to the incidence of severe mental illness such as poverty, unemployment and social isolation).

c. How will the Trust measure and monitor the impact of the new model of care, including the reduction in inpatient beds, on other social care and mental health providers in Hampshire

We regularly formally feed into the Partnership Operations Group, where we regularly share information with our social care colleagues as part of our Section 75 contract monitoring arrangements.

In addition to the measures and monitoring forums detailed in section (a) of this paper the Division will also be monitoring over time the following care outcomes:

- Care Quality Commission (CQC) inspection reports;
- Patient survey results;
- Measures of service user recovery, for example occupation, employment, living conditions, accommodation via Health of the Nation Outcomes Scales (HoNOS) - measured where appropriate at admission or Care Programme Approach (CPA) reviews;
- Closer working relationship with other care providers, measured by structured feedback from other service providers in the local community e.g. social services, children social services, criminal justice services, housing departments, third sector organisations;
- Evidence of service user involvement in our processes e.g. clinical and business meetings and development sessions via the Mental Health Foundation instruments;
- Data from qualitative interviews with service users, carers, staff, referrers and commissioners.

d. The executive summary or conclusions of the 'Consilium Strategy Consulting' report on inpatient capacity.

Please find attached the Consilium Strategy Consulting report.

As you are aware the document was one of a number of data sources, some of which have been outlined in section (b) of this paper, that have informed what has been a complex and detailed analysis of a variety of data sets, reports and national guidance and benchmarking to draw conclusions about the service redesign.

You will note that the data in respect to Woodhaven was not included in the Cons Ilium Report. This was noted by the Trust and Adult Mental Health Management team. Additional information was reviewed to validate the original Consilium conclusion (see below).

	Weighted Population 16-59/64 (age)	Admissions rates per 100,000	Average Length of Stay (days)
Woodhaven	77,040	389	40

The additional information for Woodhaven demonstrates that the conclusions of the original 2011 external benchmarking exercise remained unaffected (i.e. Southern Health could reduce AMH acute and PICU beds from a total of 190 to between 108 and 131). The total number in the redesigned service will be 133 (including PICU beds).

In fact the inclusion of the Woodhaven data illustrated a potential to reduce acute and PICU beds beyond the proposed AMH plans.

In response to your questions (e) to (h) regarding the therapeutic environment at Woodhaven:

We believe that all patients, regardless of their legal status, should expect and receive a high quality therapeutic environment. All of the remaining inpatient units, as part of the redesign,

are of a standard that we are clinically satisfied will provide an environment to help recovery and service users return back into the community as soon as possible.

In terms of the physical environment within our hospitals, we participate in the Patient Environment Action Team (PEAT) programme (Health and Social Care Information Centre 2011), which considers the physical environment, food and privacy and dignity. Our units are consistently rated as 'good' or 'excellent' on these assessments.

However, a therapeutic environment is not created by the physical environment alone. A large part of the environment that aids recovery is created by the staff and therapies that a service user receives. Our wards are staffed by multidisciplinary teams including doctors (as part of the service redesign we now have dedicated acute care consultants in every unit), nursing staff, psychologists, occupational therapists, pharmacists and health care support workers. Development of our staff is a priority, and is occurring through our training programmes, strengthening of practice development in teams, and the delivery of a leadership development programme for our senior ward staff and other leaders across the service.

Melbury Lodge benefits from other advantages to Woodhaven. The inclusion of a Mother and Baby unit and an Older People's Mental Health ward at the site encourages staff to support each other and share best practice. The advantages of being on the Royal Hampshire Hospital site at Winchester, is that public transport links are good. It also means that if someone needs acute care they can receive it quickly and safely as working relationships with acute care services are very good.

All our inpatient wards are implementing the Productive Mental Health Ward programme, a national programme which aims to improve the efficiency of wards, with a focus on releasing time to care.

Our units also actively seek feedback from service users, and use the feedback to improve services. We have robust arrangements in the West for involving service users in any decisions affecting Adult Mental Health Services. The Service User Involvement Project, commissioned through Andover Mind, facilitates community meetings and is well established within the area's management structures. If we were to undertake any major works at any our of adult mental health sites, we would use our stakeholder groups to gather feedback into our plans.

i. A plan setting out the actions that are being taken by the Trust and its partners to improve access to out of hours mental health assessments.

There are two types of mental health assessments:

1) A Mental Health assessment is carried out to determine someone's mental state and to inform the development of a care package, if it's needed. In our new model, in most cases new service users would have these types of assessments done by our Access and Assessment Teams.

2) Mental Health Act assessment is a statutory process which is carried out by a team of multi disciplinary professionals in the event of someone refusing admission to hospital when an assessment of their mental state indicates a high level of risk to someone's health, safety or protection of others.

One of the key goals of the service redesign was to improve access to Adult Mental Health Services out of hours. We are now rolling out a 24 hour single point of access in each area to which GPs can refer new service users. For those service users already known to our

service, they will now experience a smoother journey to the most appropriate team or service provider that best meets their needs. It is early days for these services, which launched in April 2012, but we have already had positive feedback from GPs as to the benefits of the single point of access.

In March 2011, alongside our own service redesign, we also began to work with key partners to improve out of hours service access to Mental Health Act (MHA) Assessments. We are currently taking part in a three month trial in East Hampshire alongside our colleagues in social services to improve the Approved Mental Health Professionals (AMHP – these people are employed by social services and can complete MHA assessments) provision.

In addition to this, a joint-working group has been set up and aims to:

- Ensure the equitable quality of AMHP Service delivery at all times of the 24 hour day across all seven days;
- Deliver a service which minimises the disruption to the service user and his or her family taking into account the 'service user experience';
- Provide a service which is accessible and limits the potential variation in practice promoting local governance and leadership;
- Deliver efficiency in the provision of a sufficient number of AMHPs to meet recorded demand.

Whilst working with our AMHP colleagues we are also mindful of the various other agencies which play an interdependent role in providing out of hour services to our client groups. With our partner agencies we have developed a comprehensive work plan for in- hours and out-of-hours services, which is being monitored by a multi-agency Section136 Group. This work plan is derived from National Guidance and provides a broad focus including waiting times, staffing, training, associated with for example ambulance services and arrests under Section 136, and many others change programmes.

Clarify whether night discharging occurred within the acute inpatient mental health units.

The Division does not undertake planned discharge of service users during the night

Appendix Two

Notes on Vascular Seminar 11th June

Attendees:

Please see attached list

Introductions

Debbie Fleming, Chief Executive of the SHIP PCT Cluster, began the meeting by introducing the attendees and the various individuals/organisations making presentations. She also thanked Hampshire County Council for hosting the seminar. Debbie then set out the purpose of the meeting and some suggested ground rules (slides attached). Debbie then invited Sarah Elliott, Director of Nursing for the SHIP PCT Cluster, Jonothan Earnshaw, Clinical Director of the national AAA screening programme and James Palmer, Medical Director for specialised commissioning in NHS South of England, to give background and context before the two Trusts gave their presentations. Debbie invited the attendees to ask questions of Sarah Elliott, Jonothan Earnshaw and James Palmer before the Trusts proceeded with their presentations.

From Sarah Elliott, Director of Nursing, SHIP PCT Cluster

Sarah set out why the vascular review was initiated, the timeline of events since then, including the involvement of local people and how the Cluster reached the conclusion that it would continue to commission the current services for the time being (see attached slides). She stressed that the Cluster has high aspirations for local vascular services. This includes meeting and exceeding the standards of the Vascular Society of Great Britain and Ireland, embracing new technologies and creating a model that is sustainable for the future.

From Jonothan Earnshaw, Clinical Director for the national AAA Screening Programme

Jonothan talked about his involvement in the national and local review of vascular services. This included his role in developing the VSGBI standards which current vascular services have been assessed against and his participation in the expert panels held locally that supported the creation a network with complex arterial surgery carried out at UHS.

As such he stressed that whilst he could offer an independent view, he was very familiar with the situation and challenges within the SHIP PCT Cluster area. He is also the national clinical director for the abdominal aortic aneurysm (AAA) screening programme so his motivation is to ensure that there is an infrastructure of good services to which screened patients can be referred. He is a practising vascular surgeon in Gloucestershire and is currently going through a similar review in his local area.

Jonothan stated that the driver for the quality programme of the national vascular society has been to reduce mortality levels to those in the rest of Europe, particularly for abdominal aortic aneurysms. However mortality comparisons at local level do not illuminate the picture when deciding how to redesign services. This is because arterial operations are relatively rare and each centre's results could vary significantly from year to year, even if only a couple more deaths occur in any given year. The good news is that the aims of the Vascular Society are well on the way to being met with the national rate of mortality for elective AAA reducing from 7.5% in 2007 to 2.5% in 2010.

Jonothan said that the key to improving quality is system-based change. This means that an area should have vascular centres with:

- A sufficient volume of procedures to deliver expertise (small units do not deliver the best outcomes)
- Well trained staff
- Up to date and adequate facilities

Reviews have been happening around the country with the original 100 or so hospitals now reduced to 70, with the expectation that as national specialised commissioning of vascular services develops, that number will reduce to 50.

Jonothan explained that there are two potential models of care:

1. centralisation of surgery to high volume arterial centres
2. a network of hospitals delivering high quality vascular care but with complex arterial surgery occurring on one site

He said that every area is different and some areas have far greater challenges than the SHIP area. However he stressed that a sustainable model, delivering improved outcomes was possible everywhere but this takes will and enthusiasm from the local clinical teams and their organisations. He believed that there was an opportunity in this area to create an 'advanced network'. This is partly reflected by what was proposed in the revised local network model which suggested a vascular surgeon on-site at QAH 24/7 in office hours. Jonothan felt that with some flexibility and creativity a more sophisticated network could be developed than has been the case in other areas to date.

From James Palmer, Medical Director, specialised commissioning NHS South of England.

Around 60 specialised services will be commissioned by the National Commissioning Board in future. There will be four teams doing this specialised commissioning and the architecture for which will be in place by October 2012. A Clinical Reference Group has been set up for each of these 60 services, now called 'prescribed services'. Vascular services have not traditionally been within this group but as of this year are included. However, it is clear that there will in future be a single operating model and a single specification and set of quality standards for every prescribed service. The national service specification will be the 'only game in town'; in other words providers will have to demonstrate that they can meet the

specifications in order to be commissioned. The aim in Year One is to “safely land” existing services but it is expected that there will be 3 to 4 years of incremental change to achieve the full blueprint for new services.

Questions:

How much has interventional radiology contributed to the improvement in outcomes?

Interventional radiology has contributed but IR only accounts for about half of procedures and these tend to be the more straight forward operations. More complex cases are still done with open surgery.

Changes in vascular services will result in changes to the workforce, how will this impact locally and is this being taken into account?

The numbers of surgeons required is clearly set out in the VSGBI guidelines. We know that vascular surgery is a shrinking specialty, vascular disease is going away so we have an overprovision of surgeons. The VSGBI guidelines are also clear about the number of IR specialists required in centres to establish 24/7 IR cover, but that is currently aspirational and won’t be happening by next April. Nevertheless, Trusts should be planning for this to be in place within the next three to five years.

Tell us more about the requisite number of operations that each centre is supposed to perform and how does this relate to patient choice?

Research suggests that 32 operations per year is the minimum, but that 50 operations per year results in better outcomes. Equally, the research suggests that centres performing over 50 operations each year have the same sort of outcomes as those doing around 50, so there is little benefit in higher numbers. Other areas have therefore opted for centres performing 50 operations per year to ensure that services are sustainable over 3-5 years. Research also suggests that patients are prepared to travel further if informed by evidence about the outcomes at various centres (ie. people will travel to a centre that offers them a better chance of survival/recovery)

If mortality rates vary from year to year why don’t you look at mortality rates over a longer time period to ensure your data is robust?

This doesn’t work for vascular services as the technology/surgical techniques have changed so much over the last few years.

Can you give us any clues on the new national service specification? Will our local services meet the specification?

The aim is to ‘land’ existing services safely and then work to meet the new service specification through remodelling over the next few years.

We’ve talked a lot about outcome/mortality data for AA surgery but is it true that outcomes for other vascular operations, such as carotid endartarectomies or revascularisation for diabetic foot disease, improve with greater numbers?

Improved outcomes are linked to increased activity for all vascular operations.

Portsmouth Hospitals NHS Trust (PHT) presentation

Ursula Ward, Chief Executive officer for PHT introduced a presentation by Simon Holmes, Medical Director, saying that the Trust were absolutely committed to meeting the VSGBI guidelines.

Simon Holmes then gave a presentation (attached) which outlined that the current position of vascular services at the Trust.

University Hospital Southampton NHS Foundation Trust presentation

Mark Hackett, Chief Executive officer of University Hospital Southampton NHS Foundation Trust introduced his team and Professor Cliff Shearman gave a presentation on the opportunities and threats facing vascular services (attached).

Questions:

The Portsmouth HOSP were supportive of the major trauma centre but we were led to believe that vascular services weren't dependent on a major trauma centre, have we been misinformed?

No, you can have a vascular service, without a MTC, but not a MTC without an onsite vascular service. As Southampton General Hospital has the region's major trauma centre, it must have a vascular service on site.

What are the advantages and disadvantages of a network?

Portsmouth Hospitals NHS Trust responded that they are concerned that the advantages of a network have been overestimated and the disadvantages underestimated.

UHS commented that the disadvantage of a network for PHT was the perceived loss of income and the perceived threats to other services such as renal and cancer. The problem for both Trusts is developing mutual trust and working for the benefit of patients.

The biggest advantage of a network is the potential to develop a world class service. PHT has a good service and so does UHS but together they could be much better. The disadvantage of the network for UHS is a huge increase in workload. The Trust believes that if you have some operations at one site and the rest at another it will be difficult and will mean patients have to wait longer to be treated as surgeons will be working across the two sites.

Are all vascular services going to move to Southampton General Hospital under the network model?

Jonothan Earnshaw commented: All models are different, but usually the vascular centre has all the inpatient surgery, with day case and other activity still available in

the other hospitals in the network. Most networks aren't big enough for a vascular surgeon to be available seven days a week at a second hospital. So you could develop a more advanced network here, with a more sophisticated model.

Portsmouth Hospitals NHS Trust commented that carotid endarterectomise only involved an overnight stay and local anaesthetic and could therefore stay at PHT.

Can the financial issues be overcome through good commissioning?

Jonothan Earnshaw commented: The ultimate challenge from the new specialised commissioning specification will be an economic one for the Trusts, as it may not be cost effective to deliver a consultant led service to the new specification.

It will always be difficult when you have two large services, relatively close to one another…this is a unique situation. It will be difficult if you try to implement changes as a 'big bang'. My recommendation would be to evolve the service over time through a staged process that moves you flexibly in the right direction. This could involve splitting cover for carotid endarterectomies across the two sites, with a vascular surgeon on site at PHT, seven days a week.

Why haven't you been clear on the criteria which the Trusts have to meet, evaluated their practice against these criteria and made recommendations? Outcome data is the only criteria that we've been given. There should be other criteria that any changes support the existing services and add to their success. My concern is that the network does not seem to support PHT.

Sarah Elliott commented: The Vascular Society Guidelines are a very clear set of criteria and they are evidence based but we do also want to use our patient experience group to evaluate patient issues such as travel times and patient information.

You've told us that there is no evidence that centres performing over 50 operations a year have better outcomes than those performing about 50, so why the drive for bigger centres?

Jonothan Earnshaw commented: Case load/activity is one issue but there are others which support a larger centre such as having a robust consultant rota so that you can deliver a consultant led service.

It's disappointing that there is still such disagreement between the two Trusts as to what a network might look like. I understand that there is a detailed service specification so why can't commissioners start with that and ensure the Trusts are meeting it?

Debbie Fleming commented: The service specification is included in this year's contract with both providers and we are monitoring the Trusts to ensure that they have plans to meet the specification.

PHT asked for some pragmatism about the complexity of the local situation and the fact that in their view, the evidence is not that compelling. The Cluster has given PHT

a period of grace in which to meet the specification and PHT felt this should not be withdrawn at this stage.

Do you envisage that West Sussex patients would choose to come to Southampton if the Network went ahead? What happens if Chichester patients do not choose to go to PHT?

PHT stated that patients from Chichester had chosen a PHT service for other specialities rather than travel to Brighton and they felt this would be replicated in vascular services.

What are the staffing implications of your proposals?

UHS said that a network would increase the staff numbers across the two sites initially but in time, they would expect to see a reduction in staff numbers.

PHT stated that they are working to have six vascular surgeons and already have six interventional radiologists, but there were no other implications.

We've conflicting views about the impact of vascular services on other services at QAH so we need an authoritative answer from experts in these fields.

Beverley Meeson commented: In the October Expert Panel, we asked experts in cancer care and renal care for their assessment of the impact of a network model on their services. They all agreed that the network model was the most sustainable for all services.

My sense if that the current PHT service is safe but not sustainable and we need something locally that is both. As a local clinical commissioner, we therefore need to be clear about exactly what the network model would look like for PHT and how any specialised commissioned service will integrate with other parts of the pathway.

Specialised Commissioning stated that it would not lose focus on the entire pathway and would want to work with clinical commissioners to commission a model of care for local services and specialised services.

We've heard lots of erudite expositions and compelling arguments but they are diametrically opposed. How do we move forward from here?

Debbie Fleming commented that the SHIP PCT Cluster believes the network model will serve the local population best, but commented that a network model cannot be imposed if the providers won't agree to it. The Cluster put forward a compromise model, agreed with local clinical commissioners, which PHT agreed to but UHS did not. The Cluster is now concentrating on ensuring that the services specification is met and believes it is perfectly reasonable to give organisations time to put their plans in place to meet the specification. We have introduced quarterly monitoring to allow us to do this.

We remain committed to supporting local providers to push back the boundaries and take forward the concept of an advanced network model which would allow providers to continue to reach and exceed standards for vascular services.

Conclusion

The seminar provided an opportunity for all stakeholders to be updated on the vascular review and future commissioning arrangements. The PCT Cluster and CCGs have made their intentions clear that they wish to commission a network model of service as this will provide the most sustainable service for patients going forward. A local specification is being prepared for this and will be developed in line with the national specification when this is published. The timing of this is likely to coincide with the Specialised Commissioning Team of the new NHS Commissioning Board reviewing the national configuration of services and providers will be required to meet the standards in the new national specification.

In the meantime, providers are encouraged to continue their dialogue and the commissioners will continue to monitor the quality of existing services.

Attendees

HOSC Chair Southampton City Council	HOSC Cllr Southampton City Council	Officer Southampton City Council
HOSC Chair Portsmouth City Council	HOSC Cllr Portsmouth City Council	Officer Portsmouth City Council
HOSC Chair Hampshire County Council	HOSC Cllr Hampshire County Council	Officer Hampshire County Council
HOSC Chair IoW Council	HOSC Cllr IoW Council	Officer IoW Council
SHIP PCT Chair	SHIP PCT Cluster Chief Executive	SHIP PCT Cluster Medical Director
SHIP PCT Cluster Dir of Nursing	SHIP PCT Cluster Dir of Comms	CCG Chair West
CCG Chair Southampton	CCG Chair Portsmouth	CCG Chair IoW
CCG Chair South Eastern Hampshire	CCG Chair Fareham and Gosport	LINk Chair/representative Southampton
LINk Chair/representative Portsmouth	LINk Chair/representative Hampshire	LINk Chair/representative IoW
UHSFT Chief Executive	PHT Chief Executive	Specialised Commissioning Representative
UHSFT Medical Director	PHT Medical Director	Lead Manager, Cardio Vascular Network
UHSFT Vascular Surgeon	PHT Vascular Surgeon	Independent Expert Vascular Surgeon
UHSFT Interventional Radiologist	PHT Interventional Radiologist	Medical Director, South West Specialised Commissioning
Executive Director, Southampton	Executive Director, South Eastern Hampshire	
Director of Public Health, Portsmouth	Director of Public Health, Southampton	

Updated 14 May 2012

Appendix Three

Solent NHS
NHS Trust

University Hospital Southampton NHS
NHS Foundation Trust

Chief operating officer
Trust Management Offices
Southampton General Hospital
Tremona Road
Southampton
SO16 6YD

Cllr Pat West
Chair, Health Overview and Scrutiny Committee
Hampshire County Council
The Castle
Winchester
SO23 8UJ

13 June 2012

Dear Councillor West,

We are writing to inform you about a change we are planning to make to the medicine for older people service provided at Southampton General Hospital (SGH).This change is urgently needed to increase bed capacity at the hospital.

Over the last three years and more notably in the last 12 months we have experienced a sustained increase in demand for emergency and urgent care which has made it increasingly difficult to treat patients coming to the hospital for planned surgery. As you know we share the commitment made in the NHS Constitution to treat all patients within 18 weeks of their referral by a GP. Despite taking a number of steps to increase capacity by reducing the length of hospital admissions and improving efficiency, we still do not have enough beds available to meet the present demand.

In order to maintain good access to our services for all patients we need to create additional space to treat people needing planned surgery. Having considered a number of options we are proposing to move 24 elderly care beds from ward G8 at SGH to the Royal South Hants (RSH) hospital which is managed by Solent NHS Trust. The vacated space at SGH will be used to open 24 surgical beds to treat patients who need to be admitted for planned procedures.

This physical relocation of the ward will not affect the type or level of care that patients receive. We plan to take our existing clinical staff (medical, nursing and therapies) to the RSH to care for the patients in the same way as they are currently cared for at SGH. This move has been discussed with our lead commissioner and other healthcare providers. It enables us to develop further opportunities for clinical integration with community services for the benefit of patients.

We have begun a process of consultation with up to 50 staff involved and hope to move the ward during July 2012. We will be transferring some existing patients to the RSH using ambulance transport and will be admitting further patients there as appropriate. The ward will not be taking direct admissions and all patients will have been admitted to SGH initially.

We would welcome further discussion with you about how we could involve you in this proposal and would wish to understand your views or any concerns you have about it.

Yours sincerely

Steve McManus
Chief operating officer
University Hospital Southampton NHS Foundation Trust

Sarah Austin
Director of Strategy
Solent NHS Trust

www.uhs.nhs.uk

Appendix Four

The JCPCT decided the following configuration for Congenital Heart Networks:

The North

- Specialist Surgical Centre: Freeman Hospital, Newcastle
- Potential Children's Cardiology Centre: Leeds General Infirmary

The North West and North Wales

- Specialist Surgical Centre: Alder Hey Children's Hospital, Liverpool
- Existing Children's Cardiology Centre at Royal Manchester Children's Hospital

The Midlands

- Specialist Surgical Centre: Birmingham Children's Hospital
- Potential Children's Cardiology Centre: Glenfield Hospital, Leicester

London, East Anglia and the South East

- Specialist Surgical Centres: Great Ormond Street Hospital for Children and Evelina Children's Hospital
- Potential Children's Cardiology Centre: Royal Brompton Hospital

The South West

- Specialist Surgical Centre: Bristol Royal Hospital for Children
- Existing Children's Cardiology Centre at University Hospital of Wales, Cardiff

South Central

- Specialist Surgical Centre: Southampton General Hospital
- Potential Children's Cardiology Centre: John Radcliffe Hospital, Oxford