AT A MEETING of the HEALTH OVERVIEW AND SCRUTINY COMMITTEE of the COUNTY COUNCIL held at The Castle, Winchester on Friday, 22 March 2013.

**PRESENT**

Chairman:
p Councillor Pat West

Vice-Chairman:
p Councillor Liz Fairhurst

**Councillors:**

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| p Ray Bolton | a Peter Edgar |
| p Ann Buckley | a David Harrison |
| a Graham Burgess | p David Keast |
| p Rita Burgess | p Pam Mutton |
| p Roz Chadd | p Jenny Radley |
| p Brian Collin | a Angela Roling |
| p Phryn Dickens | p John Wall |

**Co-opted Members:**

Councillors:
p Tonia Craig
p Alison Finlay
p Tim Southern
a Dennis Wright

In attendance at the invitation of the Chairman:

Cllr Adam Carew, County Councillor for Bordon, Whitehill and Lindford
Cllr Felicity Hindson, Executive Member for Adult Social Care
Frank Rust, Chairman of the Hampshire LINk

150. **APOLOGIES FOR ABSENCE**

Apologies were received on behalf of Councillors Graham Burgess, Peter Edgar and Co-opted Member Dennis Wright, all of whom were on Borough Council Business, and Councillors David Harrison and Angela Roling.

151. **DECLARATIONS OF INTEREST**

Members were mindful that where they believed they had a Disclosable Pecuniary Interest in any matter considered at the meeting they must declare that interest at the time of the relevant debate and, having regard to the circumstances described in Part 3, Paragraph 1.5 of the County Council's Members' Code of Conduct, leave the meeting while the matter was discussed, save for exercising any right to speak in accordance with Paragraph 1.6 of the Code. Furthermore Members were mindful that where they believed they had a Non-Pecuniary interest in a matter being considered at the meeting they considered whether such interest should be declared, and having regard to Part 5, Paragraph 2 of the Code, considered whether it

was appropriate to leave the meeting whilst the matter was discussed, save for exercising any right to speak in accordance with the Code.

152. **MINUTES**

The Minutes of the Meeting of the Committee held on 29 January 2013 were confirmed as a correct record, and signed by the Chairman.

153. **DEPUTATIONS**

The Committee received the following deputations in order in relation to Item 7 on the agenda (Proposals to Develop or Vary Services – South East Hampshire Clinical Commissioning Group: Chase Community Hospital – proposals for future service provision):

Dr John Rose, GP at Badgerswood Surgery, Bordon. The Chairman lifted standing orders to allow Members of the Committee to ask questions of the deputee.

Ms Norma Scott, Member of the League of Friends at Chase Community Hospital. The Chairman lifted standing orders to allow Members of the Committee to ask questions of the deputee.

Reverend Wendy Mallas, Assistant Priest at St Matthew's Church, Blackmoor and Whitehill, and St Mark's Church, Bordon. The Chairman lifted standing orders to allow Members of the Committee to ask questions of the deputee.

Ms Fiona Jackson, Chase Community Hospital Bed Campaigner. The Chairman lifted standing orders to allow Members of the Committee to ask questions of the deputee.

Written representations were also circulated to Members of the Committee.

154. **CHAIRMAN'S ANNOUNCEMENTS**

The Chairman did not make any announcements on this occasion.

155. **WORK PROGRAMME**

The Chief Executive presented the Committee's Work Programme (Item 6 in the Minute Book).

*RESOLVED:*

That the Committee's Work Programme be approved.

156. **PROPOSALS TO DEVELOP OR VARY NHS SERVICES**

The Chief Executive presented a report on proposals to develop or vary health services in the area of the Committee (Item 7 in the minute book). The report was presented in two parts which comprised items for action required by the Committee to respond to proposals from the NHS to substantially change or vary NHS services, and items for information which alerted the Committee to forthcoming proposals from the NHS to vary or change services.

***Under Items for action details were given on:***

**South Eastern Hampshire Clinical Commissioning Group: Chase Community Hospital – proposals for future service provision**

Representatives of South Eastern Hampshire Clinical Commissioning Group together with colleagues from Southern Health Foundation Trust (community service provider at Chase) provided the Committee with the final business case for the redevelopment of Chase Community Hospital (see Appendix 1 to Item 7 in the Minute Book and accompanying presentation). Members were informed that since the request of the November 2012 Health Overview and Scrutiny Committee (HOSC), the Clinical Commissioning Group had finalised a business case which would seek to reassure Members with evidence that local community concerns had been met.

The current model of care consisting of eight available inpatient beds at Chase was not considered a sustainable model due to factors such as staffing requirements. It was noted that the sustainability of the twelve beds which were currently commissioned for inpatient care was not viable, as the minimum number of beds required for staffing resilience is twenty four. Members heard that the services of agency staff were utilised when workforce issues occurred such as sickness, and nurses were dealing with insufficient patient numbers to guarantee that their clinical competency was maintained. While agency staff were currently needed to staff the ward, recruitment difficulties in the community nursing team had not been experienced.

It was highlighted that after a period of public engagement and a series of workshops, agreement focused on the option of redesigning existing services at the Chase to best serve the local population. The current and projected health needs of the population of Whitehill and Bordon had been taken into account, including the proposed development of an Eco-Town in Whitehill and Bordon which was predicted to increase the existing population from around 14,000 to circa 24,000 by 2031. Conclusions from the engagement process indicated that all stakeholders had agreed that the status quo would not be viable in the interest of sustaining care, and closing the hospital would also not be in the interest of the local population.

Members heard that since the meeting of the Committee in November 2012, the Clinical Commissioning Group had considered two additional options for the future of Chase Community Hospital. It was explained that option one (the preferred option) would redesign the hospital and provide a new model of bed based care, which would result in the type of patients currently using the inpatient beds at Chase being supported in their homes instead, or if

necessary at a nursing home in Liss. Members heard that this new model of care would impact the population by enhancing care delivered at patient's homes, and allowing patients who expressed a wish to die at home to do so with the support of community care teams.

It was explained that option one would also include the expansion of outpatient services provided at Chase. It was noted that those attending additional outpatient appointments following the expansion of outpatient clinics would have reduced journeys compared to current arrangements. The current model of care provided by Chase enabled 136 people a year to utilise the inpatient beds, and as a result of the proposed reconfiguration, a smaller proportion of this number would require nursing home care and increased journeys outside of the local area. The Clinical Commissioning Group emphasised that the redesigned model of care would centralise outpatients, clinical community services, community team base, primary care and mental health service on one site. The Committee heard that a capital investment of £2.5 million would be required to take this forward.

It was explained that options two and three would expand the number of beds currently at Chase. Option two would increase the number of step up and step down beds to 24 and would cover a wider catchment area and co-locate mental health services and community services on site. Option three would increase the number of beds at Chase to 12 step up and step down beds and 12 end of life care beds to cover a wider catchment area. Members heard that while options two and three would maintain the provision of inpatient beds at Chase, there were a number of factors which were considered when assessing the impact to the population locally and of the wider area. The significant issue was that the population of Whitehill and Bordon did not meet national guidelines for the minimum number of patients required to sustain a 24 bed ward. Additionally, a survey of GPs in the East Hampshire area that do not currently refer to the Chase were asked if they would use beds if available, but they indicated they wouldn't as they preferred to continue with existing arrangements. Further reasons for not selection option two or three as the preferred option included a lower number of outpatient clinics at the Chase, additional capital investment of £1.4 million to meet the standard for specialist palliative care, less patients would be treated at home, and more patients would die in hospital which contradicts evidence showing that the majority of patients would choose to end their life at home.

Members were informed that an options appraisal workshop took place in February 2013 with key stakeholders which assessed the three options and identified option one as the preferred option. It was noted that the criteria for assessing the options had been developed previously by key stakeholders in October 2011, and the key stakeholders included local councillors, community representatives, local clinicians, NHS providers and commissioners.

It was reported that the proposed new model for bed based care had been developed around the 'virtual ward' model of patient care. It was highlighted that a 'virtual ward' had operated successfully in the Fareham area for six years, and therefore this model of care was not a new concept. The community matron representative indicated that patients would receive the

same level of care in a home setting, which had been proven to achieve better results for the patient. It was noted that the level of care required on a virtual ward was extremely high as most of the patients are very ill. Members noted that a figure of £100,000 had been set aside in the business case to mitigate the additional pressure on social care services in supporting patients in their home environment.

The proposed new model of care would involve the expertise and skills of GPs, community matrons, nurses, physiotherapy services and also the support of the voluntary sector. It was highlighted that the final decision to where end of life care would take place ultimately rested with the patient, and hospice care would be provided if this was the patient's preference.

It was acknowledged that an on-going concern for the local population was the retention of inpatient beds for bed based care. Members heard that in the absence of a nursing home in Whitehill and Bordon, the Clinical Commissioning Group had identified two nursing homes in Liss, and was committed to purchasing beds from these to ensure that local people had access to nursed bed care if this was clinically appropriate. Members commented that in previous cases of closures of community beds, there had been a gap before beds at a nursing home had been commissioned. The Clinical Commissioning Group provided assurance that in this case, an existing relationship with a provider in Liss meant additional beds could be purchased swiftly. Members were informed that the Clinical Commissioning Group were committed to funding a sustainable transport link for relatives and carers to Liss, and overnight accommodation at the nursing homes would be available for relatives of end of life patients.

Members heard that two options were being explored to realise the potential for a nursing home in the Whitehill and Bordon area. The Quebec Barracks site had recently been sold to the Homes and Communities Agency who were planning to submit a planning application by the end of 2013 to include the potential for a nursing home, which would be completed by 2015. In addition, a local nursing home provider had identified the potential for a smaller nursing home in the Whitehill and Bordon area.

It was explained if support was given to implement option one, redevelopment of Chase Community Hospital would be completed by March/April 2015. It was noted that the Clinical Commissioning Group's Governing Body, which included local GPs, had agreed the Business Case (subject to the views of the HOSC), and that local GPs had been involved in the workshops about the new models of care and the redesign of Chase.

Councillor Adam Carew, County Councillor for Bordon, Whitehill and Lindford was invited to address the HOSC as the local Member for the area affected by the proposals. He commented that the strength of public opposition to the removal of the inpatient beds at Chase remained high, and many residents were sceptical about the proposed provision of improved services and also the sustainability of these. He queried the period of time needed to fulfil the proposal of a nursing home in Whitehill and Bordon, and also highlighted that public transport was poor in the area.

As a result of the November 2012 meeting the HOSC had established a working group to consider the Chase proposals in further detail (see Appendix 2 to Item 7 in the Minute Book). Members of the Working Group had made several recommendations to the Committee, which were considered following the debate.

In response to questions, Members heard:

- That the Clinical Commissioning Group had engaged fully with local GPs including the Chair visiting local practices to hear their concerns.
- That the Clinical Commissioning Group were committed to producing a Charter for the local population, to include an explanation of the expanded outpatient services to be provided. The steering group would continue and could hold the NHS to account against the Charter.
- That in response to GP concerns about the capacity of the community care team, a group had been set up to examine ways of developing this, and as a result, an additional seven nurses have been recruited and additional training provided for community team staff.
- That staff absence wouldn't result in a virtual ward being interrupted, as a daily community care team handover ensures that all aspects of patient care are covered.
- That if a patient being supported at home had an urgent need, twenty four hour nursing care could be provided if necessary, an out of hours GP could be called out, and if their condition had significantly deteriorated, they could be admitted to an acute hospital, as per current arrangements.
- That patients, relatives and carers would be provided with a direct number to the community team, so someone could come out to them straight away if needed.
- That the implementation of the new model of care would enable the local population to have access to a wider range of clinical specialities, which would benefit and meet the needs of a larger number of the local population.
- That previously consultants had withdrawn from providing clinics. Members were reassured that the Clinical Commissioning Group would use their commissioning powers to build penalties for withdrawing from clinics into contracts with providers.
- That the Clinical Commissioning Group would commit to provide transport for relatives and carers of patients in the nursing home in Liss, for as long as those beds are commissioned. Funds for this had been allocated in the Business Case.
- That a winter contingency plan is operational. Where travel for patients or nurses is required, then the use of four wheel drive vehicles and the assistance of Hampshire Fire and Rescue Service is implemented.
- That the proposed model of care was not a disinvestment in the Whitehill and Bordon area as the savings from the closure of the inpatient beds would be reinvested in the outpatient services and the community team. The proposals were designed to use available funds more effectively.

- That the Chairman of the Local Involvement Network (LINk), confirmed that LINk representatives had been involved in the process, and had given reluctant support to the proposal, as it was the only viable option available.

*RESOLVED:*

1. There has been appropriate stakeholder engagement in the development of the proposals for Chase Community Hospital.

2. The changes to service provision are in the best interest of the local population.

3. The subsequent recommendations made by the Hampshire Health Overview and Scrutiny Committee Chase Working Group are agreed as listed below.

   - A further request was made that the option to provide x-ray facilities as part of the minor injuries service be investigated as part of the opportunities to expand diagnostics being considered by the Clinical Commissioning Group.

   - That beds are commissioned from a nearby nursing home prior to the inpatient beds at Chase closing (with an agreed specification of care in place), so there is no gap in inpatient provision for local people.

   - That the Clinical Commissioning Group draw up a Charter to confirm the agreed services to be provided from Chase and the arrangements for bed based care, and make this available to the public. This should include:
     - the number of nursing home beds that will be commissioned (and which home is to be used be communicated to local stakeholders when possible)
     - the details of transport assistance being offered and how local people can access this

   - That any adaptations to the Chase site to facilitate the provision of additional outpatient services are carefully planned so that service disruption is kept to a minimum.

   - That the Clinical Commissioning Group provide an update to the July meeting of the HOSC demonstrating how the areas requested by the Working Group have been progressed. (see below)

   - That the Clinical Commissioning Group considers an appropriate method of engaging with all local GPs regarding available community provision in the Whitehill and Bordon area.

   - That the Clinical Commissioning Group work with local stakeholders to increase confidence in the bed model – through making clear the support that will be available out of hours and from social care, and the support available to carers. Feedback from families who have experienced support from a ‘virtual ward’ model could be beneficial.

- That the Clinical Commissioning Group continues to facilitate the creation of a nursing home in the locality as a priority.

- That the Clinical Commissioning Group work with Adult Services to monitor the additional pressure on social care arising from increasing support of 'step up' and 'step down' patients in their own home.

- That the Clinical Commissioning Group ensure the impact on carers is considered, and the Clinical Commissioning Group work with Adult Services and the voluntary sector on support for carers.

*Councillors Tonia Craig, Alison Finlay, Jenny Radley and Tim Southern left the meeting at this point in proceedings.*

***Under items for information details were provided on:***

**National Specialist Commissioning Board: Children's Congenital Heart Surgery Update**

The update provided in the report (see Item 7, page 4) was taken as read.

*RESOLVED:*

That the Committee be kept informed of developments in relation to the future provision of services for children with congenital heart disease.

157. **INQUIRIES RECEIVED AND ACTION TAKEN**

The Chief Executive presented a report on enquiries received, the source of each enquiry and the action taken (Item 8 in the Minute Book). The enquiries related to:-

**Southampton, Hampshire, Isle of Wight and Portsmouth Primary Care Trust Cluster: Quality Handover**

A representative from Southampton, Hampshire, Isle of Wight and Portsmouth Primary Care Trust updated the Committee on work being undertaken to draw together the Primary Care Trust's Quality Handover document for submission to the Strategic Health Authority prior to 1 April 2013 (see presentation to Item 8 in the Minute Book).

Members heard that there were examples where quality risks had developed during previous health and social care reorganisations (for example at the Mid Staffordshire NHS Trust about which the Francis Inquiry had recently reported). It was noted that a number of principles had been established nationally to ensure a quality handover when commissioning arrangements changed in April 2013. These included a balance between documenting information and face-to-face meetings. Members heard that information about the quality of services would be triangulated based on data, the views of health professionals and patient experience.

It was reported that the Primary Care Trust had held a public board meeting on 26 February 2013 which constituted the public handover, which had been well supported. Benchmarking had taken place which had identified that Hampshire generally enjoyed good quality health services, however there remained some areas of pressure for example in A&E. Members heard that a risk analysis exercise had been undertaken and the Primary Care Trust were aware of the significant pressures on hospital services nationally, and had identified a number of risk areas brought about by organisational change such as potential loss of key staff which would be an area prioritised for action.

It was noted that the Primary Care Trust quality handover would involve the handover of four thousand contracts and Members were reassured that emphasis on newly commissioned services such as NHS 111 and Out of Hours would ensure these were closely monitored during the 'bedding in' process. It was also noted that some care pathways would be complex in future as different aspects would be commissioned by different organisations, such as health services for children.

In response to questions, Members heard:

- That the Wessex Local Area Team (representing the NHS Commissioning Board) would be commissioning primary care services including pharmacy services.
- That there had been a reduction in back office staff over a period of time. Members emphasised the importance of administration services to ensure health services ran smoothly and the Primary Care Trust assured the Committee that this issue would be addressed at a future meetings with NHS bodies.
- There would be greater patient input to considerations of service quality in future due to the 'would you recommend this service to your friends and family' test, for which results would be available more quickly than other types of feedback
- That a Quality Surveillance Group (including all health regulators) will meet monthly to identify potential warning signs of risks to quality of services, and swiftly implement a programme of action if required.

*RESOLVED:*

That the Committee be further updated once the new commissioning arrangements were in place.

**NHS Hampshire and Hampshire County Council Adult Services: Fast Track Continuing Healthcare**

Representatives from NHS Hampshire and Hampshire County Council Adult Services updated the Committee on the service delivery of Fast Track and Continuing NHS Healthcare (see appendix 1 to Item 8 in the Minute Book). The Committee last received an update in July 2012, at which time evidence was provided which showed an improvement in service delivery. The Committee had invited representatives to the March meeting to establish whether plans were in place to ensure this improvement was not lost when commissioning arrangements changed in April 2013.

Members heard that the Joint Operational Continuing Healthcare meeting involving NHS Hampshire and Adult Services will continue to take forward improvement after the 31 March 2013, when the Clinical Commissioning Groups assume statutory responsibility for the NHS Continuing Healthcare agenda. It was noted that a signed operational agreement would be entered into by all the Clinical Commissioning Groups.

It was highlighted that the Fast Track Continuing Healthcare pilot initiated in Basingstoke had been rolled out to the other hospitals in Hampshire, which Members welcomed. Members heard that emphasis on continuing communication between Adult Services and the Continuing Healthcare Team was a priority. A disputes resolution group had been formed to resolve difficulties which needed further investigation beyond that of front line practitioners.

In response to questions, Members heard:

- That GPs were able to refer patients for Fast Track without the need for an admission to an acute hospital, and the referral would automatically be accepted when referred by a clinician.
- That safe, quality care is paramount and the delivery of this service is not constrained by finance issues.
- That patients and carers should not be required to fill in multiple forms – access to Fast Track was via one short form, the majority of which would be completed by the clinician.

*RESOLVED:*

That the Committee receive a further update on Fast Track and Continuing Healthcare in six months time.

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Chairman, 16 April 2013