HAMPSHIRE COUNTY COUNCIL

Report

Committee:	Health Overview and Scrutiny Committee
Date of Meeting:	29 April 2014
Report Title:	Proposals to Develop or Vary Services
Reference:	5797
Report From:	Director of Policy & Governance

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1. Summary and Purpose

1.1. The purpose of this report is to alert Members to proposals from the NHS or providers of health services 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, last updated in April 2013. This places particular emphasis on the duties imposed on the NHS by Sections 242 and 244 of the Health and Social Care Act 2006, includes new responsibilities set out under the Health and Social Care Act 2012, 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/councilmeetings/advsearchmeetings/meetingsitemdocuments.htm?sta=&pref=Y&item_ID=4831&tab=2&co=&confidential=

1.4. This Report is presented to the Committee in 3 parts:

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

2. *Items for monitoring:* these allow for the monitoring of outcomes from substantial changes proposed to the local health service agreed by the Committee.

3. *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. The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust: inpatient oncology services – proposals

Background

2.1 The Committee were first informed of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust's intention to temporarily close the inpatient oncology service at the Royal Bournemouth Hospital, and transfer patients to Poole Hospital, in November 2012.

2.2 The Trust reported that it had been difficult to recruit and provide enough medical staff needed to look after patients who required complex oncology inpatient care on both sites, owing to a national shortage of suitably qualified staff. It was felt that by temporarily moving the inpatient service to Poole, the two Trusts would be able to pool staff resources to increase the medical staff available and ensure patients have access to the best care possible. This temporary closure had the support of the previous commissioners of this service, as well as emerging Clinical Commissioners.

2.3 The Committee has since received updates from the Trust in March 2013 and January 2014, and the Chairman met with representatives from the Trust in September 2013. A common theme of these discussions has been the need to continue the temporary closure, given that it had realised the benefits that were anticipated, such as the resolution of medical staffing shortages. It was acknowledged that the drivers for the temporary closure of the service had not altered and therefore would still need addressing if the temporary closure were to be lifted.

2.4 The impact of the Competition Commission's decision to prohibit the merger between The Royal Bournemouth and Christchurch Hospitals NHS

Foundation Trust and Poole Hospital NHS Foundation Trust was presented to Members in January 2014. Members at this time noted that work had taken place to reconsider the service in light of the merger decision, and which had led to outline proposals for the inpatient oncology service at the Royal Bournemouth Hospital permanently closing. Members resolved to invite The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust to return to the 29 April meeting of the Committee with detailed proposals for the future of the oncology service at Royal Bournemouth Hospital.

Update

2.5 The proposed future of inpatient oncology services at the Royal Bournemouth Hospital is contained within the report (Appendix 1, page 10). This sets out the intention to make the temporary change in service that the HOSC have been considering, where all patients requiring inpatient oncology care are treated at Poole Hospital, permanent.

2.6 The Committee will wish to consider whether this proposal constitutes a substantial change in service for Hampshire patients, being cognisant of the need for the proposals to take into account the Secretary of State for Health's four tests for service change:

- Support from GP commissioners
- Strengthened public and patient engagement
- Clarity on the clinical evidence base
- Consistency with current and prospective patient choice

Recommendations

2.7 Members confirm:

a. Whether the proposals constitute a substantial change in service for Hampshire patients.

b. If they are satisfied with the next steps proposed by The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust.

c. Whether they require any further information on this issue, and the timings for a future update.

Items for Monitoring

3. Hampshire Hospitals NHS Foundation Trust, NHS England (Wessex), NHS North Hampshire Clinical Commissioning Group, NHS West Hampshire Clinical Commissioning Group: maintaining high quality hospital services for the people of North and Mid Hampshire - update

Background

3.1 The Committee last received an item on proposals for hospital services in North and Mid Hampshire in January 2014. At this meeting, Hampshire Hospitals NHS Foundation Trust presented with commissioners proposals for the future of hospital services, together with the history of local services, and the national and local drivers for change (including the need to move to 24/7 consultant rotas, the desire to improve outcomes, and future financial sustainability).

3.2 Members noted early engagement with the public and work with key stakeholders and how this had led to the development of proposals for the future of hospital services in North and Mid Hampshire. It was heard that two options had been identified as potentially viable to meet the future needs of service users. These were to either:

a) centralise critical care services on the site of Basingstoke and North Hampshire Hospital and invest in Royal Hampshire County Hospital in Winchester as a general hospital treating the majority of patients in the local community; or,
b) build a new 300-bedded critical treatment hospital between Basingstoke and Winchester to treat the 15%-20% most sick patients or those at highest risk and invest in both the Royal Hampshire County Hospital and Basingstoke and North Hampshire Hospital as general hospitals treating the majority of patients in their respective communities.

3.3 Representatives of the Trust and commissioners set out that they wished to go out to a period of further engagement with stakeholders to ensure local residents were able to influence the development of options prior to consultation, which was proposed to be for a period of 12 weeks, based on Cabinet Office guidance. Members asserted the importance of ensuring that the consultation contained the level of detail required to ensure that all stakeholders are able to make a fully informed contribution.

3.4 The Committee resolved in January 2014 that the proposals constituted a substantial change in service, and that Members were satisfied with the plan for public consultation. The NHS Bodies presenting were requested to return to the Committee once the outcomes of the consultation were known.

Update

3.5 Since the Committee were last update in January, the substantial change programme has been entered into a ‘Gateway’ process, a review undertaken by an independent and expert Department of Health body. This review has highlighted areas where further work could be undertaken before public consultation begins. As a result, the timeline originally brought to the

Committee in January has been delayed, with the public consultation now due to begin after the local and European election in late May.

3.6 The report from commissioners and the Trust (Appendix 2, page 19) provides an update on progress made.

Recommendations

3.7 That the Committee receive a report on the outcomes of the consultation once this process has concluded.

4. Southern Health NHS Foundation Trust: adult mental health – update on progress with model of care

Background

4.1 A full background to the Southern Health NHS Foundation Trust adult mental health substantial change in service was provided to the Committee in January 2014. At this meeting, the HOSC continued to monitor the implementation of adult mental heath proposals.

4.2 Members have noted since they began monitoring this service change (in May 2012) that demand for inpatient adult mental health beds has regularly exceeded availability of beds within the Trust. The HOSC has received assurance from the Trust that beds have always been found for those that needed them (either through use of other beds within the Trust, or purchasing bed days from private providers). The Trust has identified delayed discharges as the predominant reason for an increase in pressure, and has provided assurance that improvement actions, once embedded, would decrease acute bed occupancy, and further progress community-based services.

4.3 The most recent interim monitoring item, received in January 2014, outlined to Members acute inpatient bed usage, recent Care Quality Commission inspections, and the future of the Woodhaven Unit in the New Forest.

4.4 Members heard that a number of work-streams were ongoing, both within the Trust and with commissioners, which would address the issues experienced with delayed discharge. Analysis of bed occupancy had revealed that admissions to acute beds had remained stable, but the ability of the Trust to discharge service users in a safe and timely way had had an impact on those requiring admittance. The Trust were investing in crisis house provision and medical provision within inpatient and community teams, and it was expected that the Trust would be able to demonstrate significant improvements to acute bed capacity by the next update in April.

4.5 In addition to this, the Committee were concerned to hear the outcomes of recent Care Quality Commission inspections at two of Southern Health's acute inpatients units; Antelope House in Southampton and Melbury Lodge in Winchester. The Committee robustly challenged the Trust on actions being taken to remedy non-compliance, and Members were keen to receive a further update on this area at their April meeting.

Update

4.6 A further report has been provided by the Trust (see Appendix 3, page 21). This provides an update on bed occupancy since the Committee last considered this item in January 2014. Data shows that bed occupancy continues to be above capacity, and the use of private beds continues.

4.7 Representatives of Southern Health and their commissioners will attend before the Committee in order to speak to this monitoring update, and to allow Members to monitor the implementation of the new adult mental health service model of care.

Recommendations

4.8 Members confirm:

a. Whether they are satisfied with the progress demonstrated by Southern Health NHS Foundation Trust on the use of acute beds in adult mental health services, and the implementation of community services.

b. Confirm if they require any further information to be provided by the Trust, and next steps.

Items for Information

5. South Eastern Hampshire Clinical Commissioning Group: Chase Community Hospital – update on progress with model of care

Background

5.1 A full background to the South East Hampshire Clinical Commissioning Group (SEH CCG) Chase Community Hospital substantial change in service was provided to the Committee in November 2013.

5.2 The CCG has previously reported to the Committee possible risks associated with the project related to new processes that must be completed before NHS Property Services can approve the building works at the Chase Hospital site. The CCG indicated that such processes are likely to add extra time to the

overall programme, and have committed to providing an updated programme timetable to the HOSC once this is available.

Update

5.3 The update report, attached as Appendix 4 (page 24), provides Members with progress on the Chase project since the Committee last considered a substantive monitoring item in September 2013. The Committee will wish to note the expected delay to the completion of the project, owing to revised costs and the need for providers to agree to the heads of terms for the future lease of space at the refurbished Hospital.

Recommendations

5.4 Members confirm:

a. If they are satisfied with the actions of South Eastern Hampshire Clinical Commissioning Group in implementing the proposals to date.

b. If they require further information or a further update on progress.

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.

Inpatient Oncology Service

1. Background

On 5 November 2012, The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust (RBCH or 'the Trust') made a temporary change to where its inpatient oncology service (emergency patient admission) was provided. It was moved from the Royal Bournemouth Hospital (RBH) to Poole Hospital, which is also home to the Dorset Cancer Centre

Prior to November 2012, both Poole and the Royal Bournemouth hospitals provided an inpatient oncology service. RBCH found it extremely difficult to recruit and provide enough of the appropriately trained medical staff that are needed to look after patients who need complex oncology inpatient care. This is because of a national shortage of suitably qualified doctors.

The service move was made on safety grounds. Both hospitals were able to pool its staff resources to increase the medical staff available and ensure patients have access to the best care possible.

No alternative options were considered. Historically Poole has always been the cancer centre for Dorset and the inpatient cancer service operated at the Royal Bournemouth Hospital as a satellite service, with consultants working across both sites. RBCH accepted that Poole was the natural site to relocate the inpatient service to.
Any risks associated with the inpatient oncology service are associated with a 'do nothing' option. The inability to recruit, and having less experienced staff, is considered a high risk for patients. The relocation of the service to Poole Hospital mitigates these risks because of the pooling of resources which has taken place.

Nationally, it is accepted as clinical best practice to have centres of excellence where services are provided to relatively small groups of patients.

Other oncology services
All outpatient, day care and open access call services provided at RBH are unaffected. Patients come in to, or call, the RBH in the same way that they always have. It is only if a patient needs admitting to hospital that they are admitted to Poole Hospital.

Patients remain under the care of their current consultant even if they are admitted to Poole Hospital as an inpatient. Consultants are very used to working at both hospital sites, as they do this already.

2. Proposal

The proposal is to make this temporary change permanent following presentation to the health overview and scrutiny committees in Dorset. This is given that the challenges indicated in section one remain and the benefits realised as set out in section three.

3. Clinical assessment of the temporary change to date

A clinical review meeting with staff from both the Royal Bournemouth and Poole hospitals was held in March 2013. The six month review concluded that the temporary arrangement had achieved the following benefits:

- it resolved the on-going problems in staffing the RBH oncology on-call service
- it resolved the medical staffing issues at RBH as there is no requirement to cover inpatient work on that site.
- enhanced inpatient and acute oncology service at Poole supported by Middle Grade staff - the enhanced presence of middle grade staff on the Poole site has increased presence in acute oncology and also on the wards enabling an enhanced service to be delivered.
- education and supervision of junior medical staff is enhanced - this is evidenced by formal discussions and meetings with this grade of staff. There is no longer an issue regarding unsupervised practice of F2s at RBH. General Medical Council (GMC) guidance is not to have FY2s unsupported which they were prior to the relocation.
- the increased Middle Grade cover and presence on inpatient wards improves the quality of inpatient management and support the drive to improve patient flow and reduce length of stay

A nursing and medical review also took place to ensure access to electronic patient records, so that patient information is available when a patient is admitted as an inpatient at Poole. The six month review found that it was generally working well and allows for immediate recording and cross site review of triage information.

The acute oncology service at Poole Hospital has been enhanced and is supported by daily consultant presence on the ward.

It was acknowledged that, as anticipated, the change of pathway was initially more challenging for patients who were in the middle of their treatment when the pathway was changed. Patients entering the pathway now are accepting of it and there are few problems associated with it, other than those detailed above.

Summary

The review group agreed that the change of service had been beneficial to patients and it had realised the benefits that were anticipated. It was also acknowledged that the drivers for the original change of service (i.e. recruitment challenges) have not altered and therefore would still need addressing should the decision be taken to move the service back to RBH.

The clinical view of the process is that patient admissions are being handled appropriately and well.

There have been very few issues with patients being able to access the appropriate pathway and those that have occurred have been successfully addressed.

There were two minor issues regarding the recording of patient information and the bleeping of middle grad staff during the night. These are being resolved.

4. Patients affected by the proposal

The proposed change affects a very small group of patients. Between 1 October 2011 and 30 September 2012 (prior to the temporary move), a total of 257 oncology patients had 346 admissions to hospital. Of these, 74 had elective admissions, allowing the vast majority of patients to plan for their hospital admittance. There were 207 emergency admissions.

In terms of residency our oncology inpatients came from:

- 47.4% (122 patients) are resident in Bournemouth
- 2% (5 patients) are resident in Poole
- 14.5% (37 patients) are resident in Hampshire
- 35% (90 patients) are resident in Dorset

The remaining percentage/number of patients resides in other areas of the country.

For the majority of patients, travelling the extra few miles further east will not significantly impact on their ability to access the inpatient service. While each individual patient is important to us, the patients that have to travel the furthest, from Hampshire, make up a small proportion of our total patients.

Of all those patients who were admitted to hospital as an inpatient, the average length of stay is 5.7 days. This means that any difference in travelling for family and friends is also limited to a short period.

5. Issues and engagement

5.1 Staff

Clinicians across both hospitals support a permanent move and have been engaged throughout the temporary process. Clinicians were involved in the assessment of the temporary change and identified a number of benefits (see section 3).

Consultant staff already work across both the Royal Bournemouth and Poole hospital sites therefore this has no impact on work location. European Working Time directives were difficult to meet prior to the relocation but pooling resources as improved this.

5.2 Stakeholders

Since the time of the temporary relocation of the inpatient service to Poole which have continued to brief our stakeholders, including overview and scrutiny committees and commissioners. Regular contract and commissioning meetings are held with CCGs in Dorset and Hampshire. Briefings were also distributed in November 2012 and April 2013 (see Appendix A).

5.3 Users

The majority of oncology patients coming in to hospital are those who are receiving regular chemotherapy who are generally quite well, but who might become unwell. They are then predominantly brought in to hospital as an emergency via ambulance, others may choose to self-present.

Since the temporary relocation in November 2012 one formal complaint has been received from a patient.

5.31 Access to the inpatient services

Oncology patients are admitted as emergencies so waiting times are not applicable. Following the temporary move of the inpatient service to Poole, and being able to increase consultant cover, the patient length of stay has reduced from 4.2 to 3.9 days on average. This also impacts positively on carers and relatives coming to visit patients while they are in hospital

Patients have to travel a further seven miles (usually via ambulance). Travel time can vary depending on the time of day. For carers and relatives this adds a further 15-30 minutes to their journey.

It is not uncommon for patients to travel further for specialist services and most are willing to do so. During the summer 2013, NHS organisations in Dorset carried out a joint listening exercise, (The big ask) asking local people for their views of the NHS in Dorset. We surveyed over 10,000 people (including those in our Hampshire catchment population). More than three-quarters of respondents either ‘strongly agree’ (39%) or ‘tend to agree’ (38%) that they would be prepared to travel further than their local hospital in order to be seen by highly skilled staff seven days a week for inpatient hospital stays.

More respondents disagreed than agreed that they are not prepared to travel further (-59% net agreement). While respondents support greater specialist care even if it may result in having to travel a little further within Dorset (+82% net agreement), they would also be prepared to travel to locations further afield, such as Southampton or London to receive specialist treatment (+68% net agreement).

5.32 Patient choice

When oncology inpatient services were provided on both hospital sites there were instances where patients admitted to RBH were subsequently transferred to Poole Hospital, as these services were only provided at Poole for e.g. for radiotherapy. Patients were not actively exercising their right to choose as the vast majority were admitted to RBH via ambulance as an emergency and would therefore be taken to the nearest hospital. The improved quality of service and care for patients outweighs any perceived small loss in choice.

5.33 Engagement

During April 2014 the Trust has engaged with existing RBH oncology patients for their views on the current and future location of inpatient oncology services and their experiences to date at Poole Hospital. This was not a formal consultation. This would be carried out if the proposed permanent change is deemed a significant variation.

Our communication was targeted to existing patients of the RBH. A letter and survey questionnaire were made available to all oncology patients attending RBH for an outpatient appointment or for day case treatment – this is the group of patients who either have been or potentially would be admitted to Poole Hospital as an oncology inpatient.

The engagement exercise was communicated to patients via the following:

- letter/survey in all outpatient and day treatment areas
- home page of our website with link to further information plus online survey
- social media – the Trust's Twitter page which has over 700 followers
- provided details of the engagement to Dorset Healthwatch

A total of 200 letters and surveys were made available with 55 responding (eight of which were online)

Patients were also invited to attend a focus group on 1 April. Only one patient took up the invitation to attend a focus group.

Survey findings
In summary, the survey found that the vast majority of patients and their families travelled to hospital by car and were therefore mobile. However, while some oncology patients do make their own way to hospital as an emergency when needed, the vast majority will arrive via ambulance.

The majority of respondents to the survey have had a very good experience of Poole Hospital.

Patients who are a resident in Bournemouth feel they should have access to services at RBH. Concerns relate to travel and parking, issues which any hospital has.

You can read a summary of the findings in Appendix A

Focus group findings
The focus group was attended by one person, the daughter of a 73 year old patient at the Royal Bournemouth Hospital. The individual gave feedback on the whole patient experience and therefore the points raised specifically on the inpatient oncology service can be found in Appendix B

6. Summary

While patients responding to the survey would prefer to have an oncology inpatient service at RBH, the Trust cannot sustain a safe high quality service for our oncology inpatients. This is because of the difficulties we have in recruiting and providing enough of the appropriately trained medical staff that are needed to look after patients who need complex oncology inpatient care on both sites.

The main reasons cited for wanting an inpatient oncology service at RBH relate to transport and parking. All outpatient, day care and open access call services are unaffected. These remain at RBH and patients come in to, or call, the hospital in the same way that they always have. Therefore comments on travelling further for

appointments and difficulties in parking at Poole are not relevant to appointments and day treatment.

It is only if patients need admitting to hospital, usually as an emergency, that they are admitted to Poole Hospital. In this instance, the majority of patients travel to hospital via ambulance.

The annual review of the temporary move cited many benefits that are still being realised for oncology inpatients, including better staffing, extended ward round and reduced length of stay.

The Trust is proposing to make the temporary move of the oncology inpatient service at Poole Hospital permanent for the reasons and benefits cited in this paper.

Appendix A

Oncology inpatient survey results

Respondents: 55

1. Travel

When asked how patients responding to the survey would travel it was found that the vast majority of patients are mobile and not dependent on public transport:

- car - 44
- public transport (bus or train) - 7
- other (taxi/patient transport) – 3

One did not respond.

When asked how family members would travel to see them in hospital the following responses were given:

- car - 47
- public transport – 6
- other (taxi) - 1
- Not applicable/did not answer - 2

(Some respondents listed more than one way in which their family would travel to hospital)

2. Inpatient experience

Since November 2012 of the 55 who responded to the survey, 23 had needed an overnight stay in hospital. 10 of which were admitted to Poole Hospital. Of those 10, when asked if they had any comments about their experience, the majority were positive:

- “I was cared for very well with great kindness”
- “Good”
- “It was a very high standard”
- “Excellent service and care”

Two other comments were received. One respondent said that there was “good care” but there were not enough beds available.

The other respondent did not give specific comments about their experience but had previously given feedback on “my dissatisfaction with the overall experience”. From the response we cannot be clear if the dissatisfaction is specifically with the oncology service or another part of the hospital experience. SANDBANKS WARD

When asked to describe the impact of having an inpatient stay at Poole Hospital rather than RBH, of the 10 respondents that had been admitted to Poole Hospital, the following responses were given:

- no impact – one respondent
- small impact – four respondents
- significant impact - four respondents

Of the four respondents that said the change had a significant impact, one gave the reason of parking and transport.

3. General comments

The following additional comments were received:

- I do feel it is inconvenient to expect visitors to have to travel from Bournemouth or even further afield but as I said previously, if that is where the care is then we have to put up with it
- what about monthly injections for Neuroendocrine Cancer patients – normally a monthly outpatient activity. I live in Ringwood, could I opt for Southampton for in patient stays rather than Poole?
- I would be very upset if I ever had to go to Poole for inpatient treatment because I live in Christchurch (Mudeford area). It's a stupid idea when you're building a state of the art outpatient oncology department but you don't have any inpatient facilities
- prefer Bournemouth hospital as it would be a long way to travel to Poole and not very convenient. We think Bournemouth is a wonderful hospital for care and attention
- too far to travel - when Bournemouth is where I live, added stress. You also get to know the nurses and doctors at Bournemouth who deal with you for months and then when there is a problem you end up at a different hospital with nurses and doctors who you don't know
- RBH is perfectly well equipped to continue its oncology department and upmost efficiency. Long may it live
- I would prefer to attend RBH which is very convenient and less traumatic. Thank you
- would rather stay at Bournemouth
- I much preferred the overall experience I received in Bournemouth than that received in Poole
- Poole Hospital is cold and I live 300m from Bournemouth Hospital so to go to Poole seems ridiculous
- whilst I stated 'no' on question 8 – however when I was taken ill in October 2013 it was a long journey when I was feeling so rough. I live near to the Royal Bournemouth hospital it would have been so convenient
- great service from both. Difficult to separate
- although the journey is long for family (husband and children) to visit with work and school. I have been cared for at Bournemouth and Poole hospitals with dignity and excellent medical care
- would find the journey to Poole a bit too far
- 35 minutes to park a car
- we live in Christchurch so Bournemouth would be better
- Poole parking a nightmare!
- prefer treatment locally in Bournemouth
- Poole not as accessible as Bournemouth, would put off reporting problems to ward 10 in case they said go to Poole
- further to travel, I am working and can take an hour off for appointment if I had to go to Poole – I would have to take am or pm off work
- please re-open a ward in Bournemouth

ONCOLOGY FOCUS GROUP FEEDBACK
1 April 2014
Patient attendees:
Female representing her father who is a patient (73 years) from New Milton, Hampshire

Key points raised:

- distance for treatment is not seen as an issue for the right care
- he'd like a central name of someone to deal with as currently confusing picture: under two doctors for oncology/surgical at Bournemouth/radiotherapy at Poole and is unclear to him where he should be going
- the individual attending the focus group would like the process explaining to patients but understands the need for oncology inpatient services to be relocated to Poole and believes it is the right thing if that means the best care
- it was explained to the attendee that social media feeds will be set up to support patients and a cancer website is being developed. She argued that her father is not online and would not use these tools of communication as this information will only reach those who are looking for them. She believes patients should have a dedicated care worker assigned to them
- the individual attending the focus group also mentioned that oncology is hard to find on the RBCH website – you have to put cancer into the search bar and there should be a 'catch all' tool.
- her father's view is that he'd rather go somewhere where care is consolidated but if that means it's further away its fine. He prefers to go to Poole by train as parking is not straightforward for him there. His consultant at Poole, Dr Brock, so far has been very good but his only concern is who he is registered with and where that is based.
- one further consideration is also transport links for those not able to drive between hospitals. An example of this follows:

    The attendee's father took the train and walked from the station at Poole to the hospital for a routine appointment. He was told at that appointment that he was under threat of kidney failure and needed an immediate catheter, however he would have to go to Bournemouth hospital for this treatment. He then walked back to the station, got on another train to Christchurch and had to get a taxi from Christchurch station to RBCH. However, upon his arrival a doctor was waiting for him, aware of his needs and ready to implement the treatment which was great. The family afterwards were just confused as to why his catheter couldn't be dealt with in Poole.
- the patient's oncology letters are headed by Royal Bournemouth Hospital yet he is under Dr Brock at Poole and technically he is registered at both so there is a confusing message to patients. However her father sees the NHS as a whole provider.
- ultimately the individual attending the focus group is supportive of the changes, thinks it makes sense and is keen to see a central point of contact for patients and clear communication is put in place.

Maintaining high quality hospital services for the people of North and Mid Hampshire

Update for the Hampshire Health and Overview Scrutiny Committee
Tuesday 29 April 2014

NHS West Hampshire Clinical Commissioning Group
NHS North Hampshire Clinical Commissioning Group
Wessex Area Team, NHS England
Hampshire Hospitals NHS Foundation Trust

1. The above organisations provided an update to the HOSC meeting on 28 January on their ongoing plans to make sure high quality hospital services for the people of North and Mid Hampshire are maintained now and for the future. HOSC resolved that the proposals constituted a substantial change in service and were generally satisfied with the proposals for public consultation, subject to a few areas of clarification for the committee.

   This update outlines the progress made this since meeting and the revised proposed dates for consulting with the patients, local people and interested groups and organisations.

2. During February and March, the two CCGs have been working with the Trust on a wide range of detailed information to present to local people through the consultation process. This includes making sure that all the issues raised by HOSC members in January are being addressed.

   In March, the three organisations, in conjunction with the Wessex Area Team of NHS England, identified an opportunity - before any further public engagement was undertaken - to ask a third party to review the project plan to identify any further work required prior to consultation. .

   West Hampshire CCG, on behalf of the four organisations, therefore invited an independent and expert Department of Health body called Gateway to carry out an advisory review at the end of March regarding areas of work that would benefit from further development. This report recognised that, while much work has been done, additional detail was recommended in a few areas before public consultation could commence. This will be completed shortly.

3. Engagement with local people has continued during this review period, with both West Hampshire CCG and the Trust attending a public meeting organised by Steve Brine MP on Thursday 27 March in Winchester, regular monthly meetings with the

Maternity Services Liaison Committee, and various other opportunities across the county to engage with the public. More activity will be taking place over the next few weeks in preparation for full public consultation.

4. We are also aware of the forthcoming local authority elections on 22 May and of the importance of avoiding that key period for any public consultation on this issue.

5. It is now proposed, that the public consultation programme will begin at the end of May and run for 12 weeks until mid-August 2014.

   The two options that will be consulted on remain those which were presented to HOSC in January:

   a. Centralising critical care services on the site of Basingstoke and North Hampshire Hospital and investing in Royal Hampshire County Hospital in Winchester as a general hospital treating the majority of patients in the local community
      OR
   b. Build a new 300-bedded critical treatment hospital between Basingstoke and Winchester to treat the 15%-20% most critically ill patients or those at highest risk and develop both the Royal Hampshire County Hospital and Basingstoke and North Hampshire Hospital as general hospitals treating the majority of patients in their respective communities.

   The consultation will:

   - Explain in detail what the proposed changes would be and their potential impact on both existing health services and, more importantly, patients and local people;
   - Gather views and preferences on these changes from GPs, local people, voluntary and community organisations and anyone else who would be affected by them, understand any possible unintended consequences of these changes and get people's views on how we should implement them in ways that address their concerns.

   Following feedback from HOSC members in January, the activity will include example scenarios that illustrate the changes in how these services might be provided so that people are clear about the implications of both options.

6. Once this consultation activity has been completed, a further report to the HOSC will be available to outline the response and the proposed way forward.

HEALTH OVERVIEW AND SCRUTINY COMMITTEE PAPER – 28 January 2014

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

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

Date: **14th April 2014**

Purpose This paper provides information requested in the letter dated 3rd February 2014 from Cllr West on behalf of the HOSC. The letter requested SHFT representatives to provide a progress report on the improvement actions being taken forward following the redesign of Adult Mental Health Services which were agreed by HOSC in January 2012.

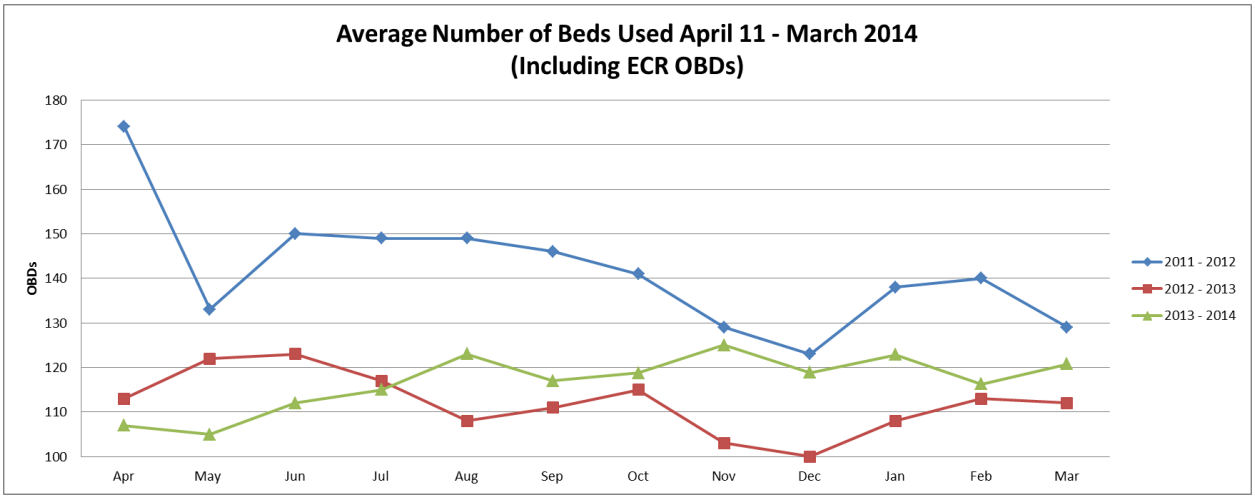
1. Inpatient Services

In our update to HOSC in January 2014, we reported that we have been experiencing an increase in pressure on our acute beds since July 2013, a year after the reduction in the number of acute beds that occurred as part of the redesign of services. We will always ensure that anyone who needs acute inpatient care will be admitted, and this is a priority with regards to maintaining safety. As a consequence we have had to place some individuals requiring acute admission in beds outside our Trust, usually in the private sector. The pressures on our acute beds have continued. In the past two months we have had building work in one of units (replacement of windows in Parklands hospital), which has reduced our bed capacity, and resulted in an increased use of out of trust beds. We take into account individual's preferences about whether they stay in the out-of-trust bed for the duration of their treatment, or return to a trust bed as one becomes available. Some prefer to remain in one place, and this has had an impact on our out-of-trust bed use in March. Our trust acute beds are now fully open.

The tables below contain information about 'occupied bed days (OBDs)' in Trust acute beds (including internal contingency beds), and OBDs in acute beds out of the Trust since October 2013.

	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Total
Acute OBDs in Trust	3202	3238	3340	3493	3484	3370	20127
Acute OBDs out of Trust	23	9	31	136	372	190	762
Total	3225	3247	3371	3629	3856	3560	20889
Average No. of beds used	108	105	112	117	124	119	
	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Total
Acute OBDs in Trust	3419	3312	3282	3453	2906	3228	19597
Acute OBDs out of Trust	336	498	424	355	349	516	2331
Total	3755	3810	3706	3808	3255	3744	21928
Average No. of beds used	121	127	120	123	116	121	

The chart below describes the average number of beds used each month since April 2011. This is calculated by adding the total number of 'occupied bed days' across the whole service (including those bed days occurring in contingency beds and in out of area placements) in a month, and dividing by the number of days in the month.



The increase in demand for acute mental health beds has not been due to an increase in demand for admission, and our admission rates have been quite stable. The change has been in our ability to discharge people in a safe and timely way. Audit has demonstrated consistently that 20 to 25% of people in our acute beds could be appropriately managed in a different setting, but discharge or transfer is delayed for a range of reasons. These include difficulties in accessing appropriate supported housing, impacts of housing benefits changes, particularly for younger patients, delays in accessing other specialist placements (e.g. low secure). We have also experienced challenges in staff recruitment locally, particularly for nursing staff, and this has resulted in increased use of bank and agency staff in some units, in order to maintain a safe service. However, our pathway is not as efficient as it could be in these circumstances.

We have concerns about the impact of admissions outside the Trust on both the patients and their carers. Our priority is to ensure that all of our patients requiring admission are treated within local services. This requires actions across the whole system, including strengthening the community support available for people at risk of admission, ensuring we have the right skillmix, including increased medical staffing in our inpatient units, improving the consistency of delivery of our acute care clinical pathway, working with commissioners and partner agencies to improve the housing and rehabilitation pathway and improving access to low secure environments. Nursing staff recruitment is a key priority, and we are looking at a range of methods to improve this.

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

We reported to the HOSC meeting in January 2014 that we had identified a gap in provision for Acute Low Secure Services in the Hampshire area. We proposed that Woodhaven be used for a 26 bedded facility for the delivery of Acute Low Secure services that would complement the existing secure services pathway of care and would enhance services for this group of people. We have not been able to progress this because of the change in the way these beds are commissioned. NHS England Local Area Team (LAT) funding streams have been established in such a way that funding for individuals in secure care sits with the LAT local to the secure unit and not with the

patient. This means there is currently no mechanism to allow transfer of patients between LAT areas. We understand that NHS England is considering these issues, which have a national impact. There is no progress to report with regards to this since the last update in January 2014.

3. HOSC Considerations

The Trust would ask the HOSC to note the progress to date following the redesign of Adult Mental Health Services.

South Eastern Hampshire
Clinical Commissioning Group

Hampshire HOSC Update

Chase Community Hospital Redevelopment

1 Introduction

1.1. The purpose of this paper is to update the Hampshire Health Overview and Scrutiny Committee on the progress of the Chase Hospital redevelopment project.

1.2. In addition to a general update on progress, the business case development and project risks, the paper also describes the emerging thinking for extending the use of the hospital to provide health and well-being services.

2. Background

2.1. Following on-going uncertainty about the future of Chase Community Hospital for a number of years, in 2011 the NHS held a six week public consultation on how to develop the right services on the hospital site and make sure that people have access to the highest quality care. This enabled a range of options to be considered.

2.2. The option selected was to create an integrated care team to provide care services to patients in their own homes, and commission four nursing home beds to provide inpatient care if needed. In September 2013 this new model of care was introduced and the inpatient beds at the hospital were decommissioned as a result.

2.3. The preferred option also proposed that the Hospital would be redeveloped to provide a vibrant range of services to meet the needs of local people. In particular the redevelopment includes:

- reconfiguration of the disused ward areas to accommodate two local GP practices;
- new accommodation for Adult and Older Peoples Mental Health services (which then facilitates the closure of the Elizabeth Dibben Centre);
- reconfiguration and refurbishment of the existing outpatient department, with a view to attracting more outpatient clinics to the Hospital and enabling a wider range of health and well-being services to be offered to the local community;
- downsizing of back of house catering facilities to enable additional office accommodation to be created for community team bases.

2.4. In March 2013 the CCG's Governing Body approved the Outline Business Case (OBC) for the redevelopment of the hospital, as did the Board of Hampshire PCT. The Wessex Area Team of NHS England has re-confirmed their

commitment to the project on a cost-neutral basis (as of June 2013). Also at its March 2013 meeting the Hampshire Health Overview and Scrutiny Committee (HOSC) stated its position that the changes to service provision are in the best interests of the local population, subject to a number of recommendations being delivered.

2.5. In September 2013 The CCG presented the project again to the HOSC reporting that on the 2nd September 2013 four nursing home beds providing step up, step down, and end of life care at Wenham Holt Nursing Home in Liss had been commissioned. This had enabled the inpatient ward at Chase Community Hospital to be decommissioned. At the same time the enhanced model of community based care with an Integrated Community Care Team working extended hours was implemented.

2.6. The HOSC reiterated its support for the project stating that the members were satisfied with the actions of South Eastern Hampshire CCG in implementing the new model of care to date and requested a further progress update in March 2014. This was then rescheduled for the meeting in April 2014.

2.7. On 21st October 2013 the CCG's Chief Quality officer visited Wenham Holt and feedback from this visit, and from GPs and stakeholders, was very positive, with patient experience and levels of care reported as good. Since that time stakeholder feedback, including reports from Steering Group members has remained extremely positive.

3. Progress

3.1. Since the last report to the HOSC in September 2013 there has been a great deal of progress on the detail of the project, particularly finalising the overall capital cost of the scheme, and the revenue running costs once it is complete.

3.2. Planning Application

Planning consent for the new dedicated entrance to the GP Practices and additional car parking spaces (20 standard bays with 3 accessible bays) was given on 23rd December 2013. No other external works are required to the Hospital, other than the insertion of a new double-door entrance to the area identified for the GP Practices.

3.3. Project Costs

The Outline Business Case (OBC) presented to the CCG Governing Body in March 2013 identified project costs as being £2.9m. Following the development of detailed designs over the autumn of 2013, project costs had escalated to £4.2m by December 2103. This triggered a first round of value engineering sessions. These sessions involved parties from NHS Property Services; the design team; and CCG representatives interrogating all project costs, with the aim of bringing the project value down to that of the original cost plan presented in the OBC of £2.9m.

In January 2014 a projected cost of £3.9m for the scheme was tabled to the Chase Community Hospital Project Board and Steering Group. The Steering Group tasked the project team with finding additional savings and efficiencies

By the 29th January 2014 after a number of review meetings, a reduction in the overall cost of £500k had been realised. It was agreed by all parties represented by NHS England, NHS Property Services, and the CCG that the current anticipated capital cost for the tabled scheme is now between £3.4m and £3.7m.

The cost challenges have primarily been due to having a greater understanding of the building fabric; the supporting infrastructure; rises in inflation and material costs; as well as a change in the way the NHS now accounts for VAT which was not a project cost in the OBC.

3.4. Business Case

NHS England is responsible for allocating capital for developments like the Chase Community Hospital and business cases under £3m can be submitted through a 'fast track' process. As the project value is now over the £3m threshold for 'fast track' process, the project will need to follow the £3m to £10m process, and be taken through the approval gateways for this workstream.

The project Business Case was due to be completed in January 2014, however due to the uncertainty around the overall project cost and the time taken to engage the GPs affected, this has not been possible. The timescales for delivery have been highlighted as a red risk on the project risk register, as the targeted completion in April 2015 is no longer feasible.

As part of the Business Case approvals process NHS England require all tenants to have signed an agreement to lease the parts of the building or rooms from which services will be provided, prior to the full business case being approved. As the agreement to lease has to include projected rental and service charges, these could not be calculated until the full scheme value has been established. We now have this information.

Therefore at this stage, neither GP practice nor Southern Health NHS Foundation Trust has had the opportunity to discuss and agree to the Heads of Terms to occupy space at Chase Community Hospital. It is anticipated that Southern Health will agree to the heads of terms for the Adult Mental Health Services, and other areas that they occupy. A surveyor negotiator has been appointed to liaise with the GP Practices to agree terms; a briefing for the surveyor is scheduled for late April.
Whilst we do not foresee any delays in Southern Health NHS Foundation Trust agreeing heads of terms and agreement to lease, it should be noted that the two GP Practices, whilst having an interest in the scheme and local Health delivery, are independent businesses and as such will wish to take the time that they think is appropriate to reach an agreement that best serves the interests of their individual businesses. To mitigate this risk the CCG will maintain local engagement with the GPs, and has requested appropriate support from the NHS England Primary Care team to enable a timely conclusion.

These combined factors will result in a delay to the project. The length of this delay is currently unknown as it is dependent on the issues outlined above.

3.5. Project Board Restructure

The CCG has taken the opportunity of changes to the project to refocus and restructure the project board membership, ensuring that the new structure

includes decision makers from partner organisations, notably NHS England's Wessex Area Team. The first meeting with the new governance structure took place on 20th March 2014 with attendance from East Hampshire District Council, Hampshire County Council, Community First, Age Concern and NHS partner organisations.

3.6. Out Patients

Since September, the CCG has undertaken a detailed mapping of the current clinics taking place at the Hospital. This has been completed and further work to ascertain the utilisation of these existing services is to be carried out.

A new musculo-skeletal and persistent pain service is due to begin operating from Chase Community Hospital shortly. The tender for a community ophthalmology service is currently being evaluated and although it has not been possible to stipulate Chase as a specific site for services, the tender does specify that a site in north Hampshire be provided as an operating location. The Independent Sector Treatment Centre contract is due to be tendered in July 2014 (for a one year period) and Chase Community Hospital has been specified as a site for that service to provide outpatient clinics.

3.7. Community wellbeing services

Following greater analysis of the outpatient clinics at Chase and the utilisation of those clinics there remains a risk that the outpatient department of Chase Community Hospital is unlikely to be fully utilised. Coupled with this is the development of more integrated, holistic services for patients with complex needs both in the community and at home, which mean that a traditional model of community hospitals offering solely medical outpatient clinics is unlikely to be sustainable in the longer term.

Following discussion with the Chase Hospital Steering Group it is proposed that the operating model for Chase Community Hospital be changed from a purely medical facility to also offer community well-being support services to the residents of the Whitehill and Bordon areas. In this model it is envisaged that medical services will be underpinned by wellbeing services offered by voluntary and community providers, to support the needs of the whole community.

This change of emphasis was discussed at the Project Board and Steering Group on 14th February 2014 and was met with very positive responses. The CCG is now working actively with Community First to explore this approach and a workshop 'Local Health – Local Wealth' with voluntary sector providers is due to take place on 30th April 2014. This workshop will explore the possibility of providers running health and well-being support services at the Chase Community Hospital alongside medical services and begin discussions about redesigning (if necessary) part of the space to support this model.

The types of services which the community/ voluntary sector could deliver, and will be further investigated

- Additional support, care and rehabilitation for stroke patients offered by the Stroke Association

- A Carers café bringing Carers together to share experiences, learn from supportive environment, get training, have a voice etc. Princess Royal Carers or Carers Together are organisations which support this activity
- Fitness classes targeting particular people with health needs to tackle falls prevention (for example) or as a general example of improving health and wellbeing and encouraging exercise. This could include Bordon Strollers group; encouraging parents with young children/babies to take up walking as a form of exercise – can be offered by a range of voluntary sector providers
- Information and support for people with dementia and their families provided through the Alzheimer's society
- Creative activities for people with mental health issues, such as Artscape a group who use art therapy to help people with a wide range of additional needs.
- Services for parents/grandparents particularly those who act as carers can be delivered by Children Centre services; (SureStart, HomeStart).

The use of technology is also being investigated and the CCG is in talks about how high-tech equipment on the site could provide more 'virtual' appointments and services. We have altered the IT specification to build in this development.

To facilitate increased use of the hospital by the voluntary sector, the CCG may need to subsidise an element of the room rental costs.

3.8 Nursing Home

Although the commissioned nursing home beds in Liss are working well the CCG remains committed to working with partners to endeavour to attract a nursing home provider to the town of Whitehill and Bordon. Since September we have met with colleagues from Hampshire County Council and East Hampshire District Council to facilitate this. East Hampshire District Council's Regeneration project is actively evaluating new population projections for the town and there is a further meeting on 1st May 2014 to better understand the viability of an economic case for a nursing home development, to inform the development of forthcoming development briefs.

4. Risks

4.1. The greatest risk to the project has been the lack of clarity around the project costs and subsequently the overall process for approval of the Full Business Case. This has impacted on the overall business case and project timeframe. It should be noted that the original completion date of April 2015 is not expected to be met.

4.2. Recent announcements of further NHS organisational changes within NHS Property Services have also added to the delay in preparation in the full business case.

5. Conclusion

5.1. The project is now subject to delay, due to the overall project value being higher than anticipated and issues regarding the completion of the Full Business Case. Completion is now expected in the summer of 2015 at the earliest.

5.2. The HOSC is asked to:

- note the progress made with detailed planning for the project;
- note the delay to the project;
- Support the concept of bringing community well-being services supported by the voluntary sector services, alongside with traditional medical services.