Agenda Item 5

HAMPSHIRE COUNTY COUNCIL

Report

Committee:	Health Overview and Scrutiny Committee
Date of meeting:	30 November 2010
Report Title:	Inquiries Received and Action Taken
Report From:	Chief Executive

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1. Summary and Purpose

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

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

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

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

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

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

Table One: Inquiries Received and Action Taken

Topic/inquiry	Source	Action Taken	Comment
Closure of G5 – End of life care ward	HOSC Chairman and Portsmouth Health Overview and Scrutiny Panel	Further to the Chairman's Communications at the last meeting Portsmouth Hospitals Trust will attend to provide members with a response to the key issues included at Appendix One with the position statement from NHS Hampshire. Detailed information form the Trust is included at Appendix Two. Portsmouth HOSP has referred this matter to the Secretary of State for Health who has asked for advice from the IRP.	
Recommendation: Members confirm: • If any additional information is required • If they are satisfied that the Trust has demonstrated that this change is in the interests of the patient population affected • Any further action is agreed working with the Portsmouth HOSP once the deliberations of the IRP have been published.			
Hythe Hospital	Member for Dibden and Hythe	The Chairman has written to NHS Hampshire setting out the Committee concerns about the grounds put forward for not reopening inpatient provision at Hythe Hospital now the staffing pressures have eased. This is attached at Appendix Three and the response from NHS Hampshire at Appendix Four.	

Topic/inquiry	Source	Action Taken	Comment
		A small Panel lead by the County Councillor for Dibden and Hythe has been set up to oversee the formulation of proposals for redeveloping the facility. The terms of reference for this group are included at Appendix Five.	
Recommendations: The Terms of reference for the Panel is agreed.			
Fordingbridge Hospital	NHS Hampshire	NHS Hampshire advised the Committee of the temporary closure of inpatients beds at the Hospital to allow for the heating system to be upgraded.	
Recommendation: NHS Hampshire confirms the completion of this work and the reopening of the beds at Fordingbridge community Hospital**.**			
Andover Birth Centre. Temporary closure and proposal to consult on relocating inpatient beds to WEHT	HOSC Chairman	Further to the discussion at the last meeting the Chairman wrote to WEHT setting out the views of the Committee (see Appendix Six) The response from WEHT is included at Appendix Seven and the engagement plan set out in form their next steps is at Appendix Eight.	
Recommendation:. Members are advised of the outcome of the further engagement planned by WEHT and the next steps to be taken in terms of formal consultation.			

Topic/inquiry	Source	Action Taken	Comment
Notice to withdraw Inpatient beds at Odiham Cottage Hospital.	NHS Hampshire	The HOSC has been alerted to action taken by Hampshire Community Health care to close inpatient facilities at Odiham Cottage Hospital at the end of March. The discussion paper supporting this is attached at Appendix Nine. This information has been shared with local County Councillors and Districts.	
Recommendation: Members determine if any additional information is required in relation to the proposals from HCHC to withdraw inpatients nursing services at Odiham Hospital.			
Changes to car parking charges	Portsmouth Hospitals NHS Trust	Changes to parking charges are set out in the press release from PHT attached at Appendix Ten. The response of the Trust to key questions raised by the Chairman on behalf of the HOSC are attached at Appendix Eleven.	
Recommendation: members note the response from the Trust			
Development of GP Commissioning Consortia	HOSC Chairman & NHS Hampshire	NHS Hampshire will provide members with an update on progress with the identification of	

Topic/inquiry	Source	Action Taken	Comment
		arrangements to support GP Commissioning Consortia (Appendix 12).	
Recommendation: Members are kept apprised of progress with the development of the consortia.			
Community Hospital Services (East Hampshire)	NHS Hampshire	Members are advised of plans to review the provision of services provided by Community Hospitals in East Hampshire. A briefing note is attached at Appendix Thirteen.	
Recommendation: the HOSC is advised of the outcome of the current review of community hospital services.			
Bitterne Walk-in Centre: Future of Services	NHS Southampton City	Consultation has been launched. The PCT is clear that closure of this service is not an option being considered and in all options proposed services will continue over weekends and bank holidays. The service is not used by a large number of Hampshire residents- most of which accessed the service over a week-end or bank holiday. Details of the consultation can be found at: (http://www.southamptonhealth.nhs.uk/bitterne) Bitterne Walk In Centre Consultation - NHS Southampton City	

Topic/inquiry	Source	Action Taken	Comment
Recommendation: Members are advised of the outcome of the consultation process.			

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

NB the list excludes:

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

Appendix One: Proposals to close G5 – NHS Hampshire statement: September 2010

The proposals for G5 ward at Queen Alexandra Hospital (QA) in Portsmouth involve closing the ward and using the nurses from the ward, who have developed advanced skills for caring for patients at End of Life, to support other staff caring for patients at end of life in all areas of the hospital.

G5 is a 14 bedded ward, relatively isolated geographically from other clinical areas. It is used for palliative care and approximately 25% of the deaths of those over 65 within QA occur on G5, i.e. 75% of deaths occur in other elderly care areas. It has comparatively high running costs in that it costs more to run than a 25 – 30 bedded acute medical elderly ward.

The implications of the ward closing are that;

- Patients will not be placed on a geographically isolated ward to be cared for at end of life;
- Patients will not need to go to a different ward to die but can be cared for on the same ward they are on (where this is their choice or where circumstances are such that their preferred place of death is not possible).
- The knowledge and skills of the G5 nurses will be used to educate and support other staff caring for those at end of life all areas of the hospital. This will improve equity and quality of end of life care throughout the hospital, rather than the best end of life care only taking place with the 25% of deaths on G5;
- Patients at end of life are not always identified as early as we'd like. Education and support of staff working across the hospital, by the G5 nurses, will support earlier identification of patients approaching end of life and therefore better provision for advanced care planning with patients and their families.
- The palliative care nurses from G5 will be able to support patients to die in their preferred place, including helping getting patients home quickly if desired;
- The closure of G5 is part of the PHT cost improvement programme, this component of which will deliver savings of about £500K per year.

NHS Hampshire understands that stakeholders such as the Portsmouth LINk, the PHT Patient Experience Council (which includes Hampshire residents) and the Council of Governors have been consulted with throughout the process. Trust staff have also been involved throughout.

As these implications fully align with the aims of the Joint Hampshire End of Life strategy, NHS Hampshire is supportive of the proposals to close G5 and utilise the skills of the palliative care nurses to improve end of life care in other areas of

the hospital and so improve the care and experience of all patients at end of life and their families.

Additional Information requested by the HOSC relates to:

- How are people that are reaching the end of life identified on wards and what is the mechanism for accessing the end of life team- it would be helpful if there could be an indication that the ambition to provide a consistent level of care was being achieved across this patient population. Has an equality impact assessment been undertaken to give a baseline in this respect?
- What direct care is being provided by the former G5 team- and what the availability of this service (e.g. 24/7)- or how is the care provided to these patients monitored/evaluated
- The extent to which all end of life patients are receiving care in line with agreed tools such as the Liverpool Care Pathway.
- How patients preferences- including DNR- are recorded and responded to. Is there scope for some patients to return home with short term intensive support.
- What training is provided to staff on wards to help them identify and respond to the needs of these patients and their families. What proportion of staff have received this
- Arrangements in place to ensure that patient's symptoms are managed/controlled
- Is there access to specialist palliative care advice and support across all ward areas
- How are the needs of carers identified and responded to
- What information is provided to patients and there carers about the care options open to them (any examples of this would be good)
- What arrangements are in place to ensure that patients who are dying have privacy and dignity
- Finally- on the basis that it will be important to have feedback about these services what are the views of carers about the service provided by the team?

Appendix Two: A New Model of Care for Older People at the End of Life

Background

Around 2,100 people die in the care of Portsmouth Hospitals NHS Trust every year, and over 1,900 of these patients are over the age of 65. In July 2010, a decision was taken to remodel the provision of dedicated end of life care for these patients.

The proposal involved moving from a dedicated inpatient ward for patients at the end of life (G5), to a Support Team model of experienced nurses.

Objectives

The principal objectives in moving to the new model of care were:

- To increase coverage of dedicated end of life expertise – G5 ward cared for around 25% of patients over 65 at the end of their life
- To enhance skills and support for clinical staff on general wards in caring for dying patients
- To ensure the needs of patients and relatives at the end of life are met, and provide an excellent experience of care
- To build better, more productive relationships with both the internal specialist palliative care team, and with community-based services for patients at the end of life
- To raise the profile of the end of life agenda, and encourage earlier appropriate decision making about when to pursue a palliative approach to care

Evaluation

A full evaluation of the service will be made at 6 months. The presentation from Portsmouth Hospitals NHS Trust to the Hampshire Health Overview & Scrutiny Committee on 30th November 2010 will detail the findings so far.

Julie Dawes, Director of Nursing
Dr Mark Roland, Consultant in Respiratory Medicine

Appendix Three: Closure of Inpatient Beds at Hythe Hospital: Letter to NHS Hampshire – 29 September 2010.

I am writing by way of follow-up to the HOSC yesterday as which the closure of the inpatient beds at Hythe was discussed. I think it would be fair to say that there was disquiet that the temporary closure of inpatient beds on the grounds of staffing levels had now somehow transformed into an on-going closure on the grounds that extensive refurbishment is now required to enable the beds to reopen. There has been no prior discussion with us about this and the papers- which were not received until after our agenda had been published - simply presented this as a 'fait accompli'. This is not satisfactory

The current physical environment at Hythe Hospital is the same as that which existed in May when staffing pressures required that the beds be temporarily closed. We were given clear assurances that they would reopen when these pressures eased. This has not happened. We are aware that circumstances change and have always been willing to discuss any problems that arise in order to agree a way forward. In initial discussions about Hythe Hospital after the closure we stressed the importance of involving local members in the development of options for the future provision of services. This has not happened. The papers included only vague references to what was happening in the way of engagement, who was involved or timescales for taking this forward. Inpatient services do not seem to be included in the options being developed. The assumption seems to be that we will simply accept that services can be closed without any accountability to the community affected simply because some local difficulties have arisen or an old building needs to be updated. I can assure you this is not the case and we will challenge the erosion of local services in this way.

We are entering a time of unprecedented pressures on services and real changes in the way our health services are organised. Inevitably there will be difficult discussions about how health services are provided and we are not unaware of the magnitude of some of the changes that may need to be made. We are committed to working with you to address these issues, as demonstrated in outcome achieved for Oak Park which is both exciting and innovative. We have also accepted the case of need for the closure of three of our four stand alone birth centres on the grounds of staffing pressures and increasing birth rates. Are we to expect that convenient reasons will now be found to make these closures permanent?

I would be grateful for an early response to these concerns to enable me to come to a view about how we should move forward with this.

Appendix Four

OP

NHS Hampshire

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26 October 2010

Cllr Pat West
Chairman, Health Overview and Scrutiny Committee
Hampshire County Council
Room 140
Chief Executives Department
Hampshire County Council
The Castle
Winchester
Hampshire
SO23 8UJ

Dear Pat

CLOSURE OF INPATIENT BEDS AT HYTHE HOSPITAL

Thank you for your letter dated 29 September 2010 regarding the inpatient beds at Hythe Hospital. I am disappointed to hear that you have a number of concerns regarding the ongoing temporary closure of the beds and I hope that I can offer some reassurance by way of this letter.

Firstly can I apologise that the papers arrived too late for your agenda, this was due to staff sickness. My understanding is that the papers were sent to you on 21 September 2010 so I was surprised to hear that members did not see the papers until they were tabled on the day of your meeting. We will endeavour to always get papers to you by the deadline set but if we are unable to do this for any reason we would be happy to forward papers direct to members as soon as they are available if this helps.

I hope that we have not given the Committee the impression that staffing difficulties at Hythe have transformed into environmental concerns. Our initial briefing to the Committee in May explained both staffing difficulties and environmental concerns at Hythe, indeed our press statement (attached) is clear that both issues caused the temporary closure.

I would also like to be very clear that there is absolutely no intention to present the future of services at Hythe as a 'fait accompli'. We have been talking to local community leaders, including the Hythe Hospital League of Friends, Age Concern, local LINk members, local GPs and elected members since the formation of the Hythe stakeholders group in 2009. I am very sorry that we have not shared the extent of this engagement with the Committee and have attached a detailed activity report to address this.

We are committed to building upon this work with a period of active community and patient engagement over the coming weeks to ensure all stakeholders are aware of all the issues at Hythe War Memorial Hospital and to have an opportunity to shape future planning. I have attached our plans for this work and would welcome your comments and involvement as we take this forward.

The outcomes and feedback from this engagement will then be used to develop potential options for further consultation. No decision about the future provision of services for the Waterside area will be made until this work is complete and we have had an opportunity to discuss this with the Committee and other key stakeholders.

As you rightly point out, we are entering a period of unprecedented change in the NHS and I very much welcome your commitment to work with us as we navigate these changes. I recognise that a temporary closure can undermine the confidence of patients and staff and I will therefore be writing to all local provider organisations asking them to ensure that any temporary closure is absolutely necessary and to involve local people and elected members in any proposals for longer term service change.

I can assure you that we will not use this period of change to find 'convenient' reasons to close services such as birth centres but we must recognise that large scale system and pathway redesign is required to ensure the future sustainability of services. We are committed to involving elected members, local communities, patients and their advocate groups, staff and other stakeholders in this work, something which I hope we have demonstrated over the years.

I hope that this reassures that Committee but please do not hesitate to let me know if you need further information or a more detailed briefing.

With best wishes

Yours sincerely

D.M. Fleming (Mrs)
Chief Executive
NHS Hampshire

Appendix Five: Hampshire Health Overview and Scrutiny Committee
Hythe and Dibden War Memorial Hospital Redevelopment
Panel Terms of Reference

Hampshire Health Overview and Scrutiny Committee (HOSC) have appointed a Panel to oversee and provide advice on the development of proposals to redesign the services provided at Hythe and Dibden War Memorial Hospital.

For the purposes of this specific piece of work the members of the Panel have been co-opted from the local community and comprise

- Cllr Brian Dash, elected member for Dibden and Hythe (Chairman)
- Martin Cox, LINk lead for south west Hampshire
- John Carr, Chairman of Hythe and Dibden War Memorial Hospital League of Friends

Acting on behalf of the HOSC the Panel will work with NHS Hampshire and other key stakeholders as appropriate to oversee the development of proposals for the redesign of services at Hythe and Dibden War Memorial Hospital. As this work progresses the Panel will advise the HOSC if it considers that the change constitutes a significant development or substantial variation in service. If so the Panel will make recommendations relating to the timing and content of any consultation process.

In coming to a view the Panel will take account of the following:

a) Whether the development of the proposal has been informed by appropriate engagement and involvement of local people and those using the service(s) affected. It is expected that NHS Hampshire will take account of the relevant equality legislation and be clear about the impact of the proposal on any vulnerable groups.

b) The extent to which GP commissioners have informed and support the change

c) The strength of clinical evidence underpinning the proposal and the support of senior clinicians whose services will be affected by the change.

d) How the proposed service change affects choice for patients, particularly with regard to quality and service improvement

The Panel will also be invited to advise the HOSC if it considers that the proposal is in the interests of the community affected. This will enable the HOSC to formally determine any further action that may be necessary in response to the proposal.

The Panel will have access to scrutiny officer support as appropriate and will take account of the ‘Framework for Assessing Substantial Service change’ agreed by the HOSC in the discharge of its duties.

Appendix Six: HOSC letter to WEHT re: Andover Birth Centre – 29 September 2010

Many thanks to you and Janie for attending the HOSC yesterday to give an update on what is happening with regard to midwife led births at Andover Birth Centre and your intention to go to public consultation on the relocation of these beds to the WEHT midwife led unit. We appreciated Janie's very helpful summary of the actions taken by the Trust to avoid the current closure. It is important that these two issues are dealt with separately and I have done so in the feedback below.

Suspension of midwife led births at Andover Birth Centre

You are very aware of the strong feelings this action has generated within the Andover population and the real concern that this is the start of an erosion of services at the Andover War Memorial Hospital. It was helpful to have your reassurances that this is not the case and to be reminded of the significant investment that has been made in the hospital to ensure that it continues to be a vibrant hub for the provision of health services to this community in the future. We noted the efforts that have been made to recruit additional midwives against a national backdrop of significant shortages and the fact that the current pressures on staff are unavoidable. The standards you have set with regard to the presence of a midwife throughout a woman's labour are important and we accept that this means that staff will need to be flexible and located where they are most needed. It is not a good use of this resource to staff a facility that is not being used whilst other services are under pressure. Antenatal and post natal services are continuing to be provided at Andover War Memorial Hospital and are well used by local women. The Trust is continuing to offer home births and the choice of a midwife led birth at WEHT. The HOSC was therefore satisfied that closure on the grounds of patient safety was necessary but would ask that a date is given for the reopening of the beds once the pressures on staff have eased.

Consultation on the relocation of midwife led beds to WEHT

It is unfortunate that this proposal has become enmeshed in the temporary urgent action discussed above. Inevitably this has fuelled the public concern about the Andover War Memorial Hospital Birth Centre. Whilst we understand that there are significant financial pressures on the Trust we would not accept such a move on the basis of cost alone and will be writing separately to NHS Hampshire to reaffirm our expectation that they continue to support choice and the provision of midwife led services in stand alone centres where these are used by women. The current inpatient service at Andover is not well used however- as acknowledged at the meeting - it is not clear if this is because there has been a loss of confidence in the availability of this service to women wishing to plan where they have their baby with a degree of certainty or a real exercise of choice

in deciding to opt for a co-located service. This point needs to be addressed in any proposal to relocate this service. Equally there needs to be clarity that any proposals are fully supported by GPs and an explicit evidence base. These points were not sufficiently robust in the paper provided to us and it is essential that this work is completed prior to options for the provision of this service being developed. In particular we will wish to understand how the views of women from across the catchment area of the Trust have shaped the options put forward for consultation, especially those living in the Andover area.

Appendix Seven: Response from WEHT to Hampshire HOSC – 8 November 2010

We were pleased to attend the HOSC meeting in September. Thank you for the opportunity and for the letter you sent afterwards, which I refer to below.

The Trust is very aware of the anxiety caused by the temporary suspension of inpatient services. I am pleased that we were able to share with you our rationale for this decision and that the HOSC understands that safety is our overriding deciding factor and that we are hopeful that the staffing situation will ease in Spring 2011. It may not be possible to give much more of an update on this until early 2011 – there has certainly been no significant improvement, particularly as some of the leave required by staff is long term.

Our efforts to recruit more midwives are continuing but as you know, this is against a national shortage. Figures discussed in the House of Commons last month put the shortfall of full time midwives at 4,800.

The issue of midwife-led birth services and how they might be provided in the future is the subject of a six week engagement exercise. We want to get a better understanding of what drives choice of birthplace. In particular we want to find out why only a quarter of women from the Andover area have their babies at the ABC.

Our engagement plan is in the public domain and was approved at our Board meeting on 3 November. It has a wide range of methodologies for gathering feedback and we will keep you updated on our progress.

It is important that proposals we develop on the future are based on what we learn from this engagement. As you know from our presentation, we want to provide a midwife-led birth service that is accessible to women and their families across the area covered by this Trust. We are canvassing opinion across this area and are being assisted by other trusts and working through local community networks, such as mother and toddler groups.

I am also pleased to tell you that the issue of midwife-led birth services is on the agenda of two Practice Based Commissioning group meetings so we hope to have feedback from our primary care colleagues too.

We welcome the continued interest of the HOSC and I would like to record my thanks for the supportive and helpful way in which you have worked with us over this issue.

Appendix Eight: Andover Birth Centre Engagement Programme

1. KEY MESSAGES

- ***The Trust wants to learn more from the public about the continued underuse of the birthing service at Andover Birth Centre (ABC) – more than 75% of women in the Andover area have their babies at Winchester or at home or elsewhere and not at the ABC.***

- ***The Trust is committed to providing a midwife led birth service for women across the area it serves.***

- ***U nderstanding what kind of midwife led service women want and will therefore make better use of in the future will inform the Trust's plans for its maternity service, and in particular the midwife led birth aspect of the service.***

2. INTRODUCTION

The Trust has begun 'pre-engagement' and now wants to embark on a much wider and more inclusive six week phase of active engagement from Monday 1 November until Sunday 11 December. The engagement will cover many different audiences and use a range of methodologies to find out what people think about the current maternity services and what ideas they have about future models of care. The Trust is keen to learn what determines birthplace choice and in particular why the majority of women from the Andover area do not use their local birth centre. The audiences included in the schedule are not exhaustive – it is hoped that more groups than are mentioned in the following pages will get involved in important discussions about our maternity services.

The Trust is following an engagement model used by NHS Hampshire which has the benefit of including a wealth of feedback from the public and service users in its options paper (which will be publicly available). The table below summarises the timescale. This may change, depending on guidance from Hampshire County Council's Health Overview and Scrutiny Committee.

Nov 1 to Dec 11	Comprehensive feedback programme
Dec 12 to Dec 31	Collation of feedback, development of options to reflect what has been learnt
January 2011	Presentation of feedback and options
February	Final options developed and presented to our commissioner NHS Hampshire for approval.
March	WEHCT Trust Board meeting (in public) where an option will be endorsed.

3. PRE-ENGAGEMENT ACTIVITY TO DATE (PRIOR TO NOV 1)

Much of the essential preparatory work for the engagement phase is underway, such as identifying local groups to meet with, finding venues, formulating questionnaires and gathering information for literature and display material. As far as identifiable groups, the chart below sets out what has been done prior to November 1.

who	**How**
Maternity staff	Meetings with Head of Midwifery, with CEO, with HR team, access to all Board papers and executive management team papers
Staff and staff side	Head of Midwifery attendance at Joint Consultative Negotiating Committee plus information on ABC available on Trust intranet (front page) as well as briefings given at Talking Point (monthly staff meeting – open to all)
HOSC	Board papers, presentation, meeting with CEO and Head of Midwifery, regular updates by phone. A key aspect of the work with the HOSC before (and after) Nov 1 is to give and seek assurance that the activity set out below is sufficiently robust and that our timescales are appropriate.
TVBC	Board papers, presentations re ABC given at full council and OSC meetings, Health and Wellbeing committee chair meeting with CEO
GPs	Email updates and Board papers sent plus two offers to attend practice and Practice Based Commissioning group meetings (one via Primary Care Liaison Manager, one from Divisional Director)
MPs	Board papers to Sir George Young and Caroline Nokes, plus Sir George Young meeting with CEO to discuss ABC
IPPIF	Board papers and discussion plus agreement for IPPIF to draw up a questionnaire for postnatal women to gauge feedback on quality of care and factors indicating choice of birth location
LINK	Board papers, presentation given by NHS Hampshire re maternity which included information on ABC. Further presentation booked for 19.11.10 and meeting with LINk's secondary care lead being set up
Andover Health Forum	Board papers, presentation (and future ones booked)
SHA	Board papers and communications strategy sent – Midwifery lead aware and kept informed
Royal College of Midwives	RCM representative lead has been kept informed by WECHT's Head of Midwifery and has seen all Board papers and will continue to be kept informed. The Trust will work closely with the RCM on developing options and will seek advised re best practice and optimal care models for midwife-led births
NHS Hampshire	Maternity lead has been kept informed by WECHT's Head of Midwifery and has seen all Board papers and will continue to be kept informed

	Board papers and communications strategy sent and plans to ensure effective joint working on comms aspects are well advanced
Media	Board papers and statements issued, interviews given and published/broadcast, local paper currently considering whether to run online survey re ABC
Wider public - Andover	Articles in local media. Poster in office of local MP (Sir George Young) to have information material available in his office for constituents and to display poster offering presentation/discussion with interested groups
E-Media	Trust use of Facebook and Twitter to publicise when new papers/statements are issued

4. **STAKEHOLDER LIST**

During November and December 2010 WEHCT plans to actively seek the views of these stakeholders: staff (and staffside representatives), services users and their families, Sure Start, Hampshire Children & Families Forum, Pre-School Learning Alliance, National Childbirth Trust, the ABC Facebook group, Andover Sound, Andover Advertiser, Heart FM, Hampshire Chronicle, BBC (tv and radio), ITV (Thames Valley Tonight),Teenage Pregnancy Implementation Team, MSLC, RCM, GPs and practice staff, MPs, IPPIF, LINK, NCT representatives and local groups, mother and toddler groups, antenatal classes, wider public, councils, academic bodies and organisations involved in training of midwives. This list is not exhaustive – the Trust will be offering to meet with local people and we expect to be able to add to this list before the end of November.

5. **NOVEMBER COMMUNICATIONS AND INVOLVEMENT**

Stakeholder group	**Means of engagement**	**lead**	**Date**
all	Leaflet distributed (hard copy and online) to set out current situations and options. Area on WEHCT website for ABC information (Q and A, Board papers, etc) – including link to survey (see below) on NHS Hampshire site	WEHCT comms	By Nov 1
Women and their families in Hampshire	NHS Hampshire online survey launched to better understand birthplace choices and preferred service models	Sara Tiller	Will launch in first week of Nov and run till Sunday 11 Dec.
ABC steering group	Steering Group will give overview and lend expertise during PPI and	NHS Hampshire	Potential members

	formal consultation. Aim is for impartial and strategic role and to ensure that the consultation document (to be issued in January 2010) is a fair reflection of feedback received.	Comms team	approached late Oct, ToR approved early Nov.
Postnatal service users	Paper questionnaire completed by women in GH ward – some also sent to women who have had babies at RHCH in last month. Aim is to gauge opinion on current service, to understand more about choice of birth location.		Will launch in mid November and run till 31 Dec.
Antenatal service users	Questionnaire to better understand birthplace choices and preferred service models, to be done via trackers and also using free-standing touchscreen	Janie Pearman and Pat Bull	Throughout November
Maternity staff	Continuation of staff meetings	Janie Pearman	Throughout November
Other staff	Updates via normal WEHCT comms	WEHCT comms team	Throughout November
Wider public - Andover	At least two public drop-in sessions in November at The White Hart Hotel or Town Hall (feedback recorded and trackers used to better understand birthplace choices and preferred service models). One weekday, one Saturday morning. Display material available at additional times and locations Online survey run by Andover Advertiser	WEHCT & NHS H comms teams Andover Advertiser	Display material ready by Nov 5. Survey - tba
NCT	Will be asked if they will facilitate at least one discussion following a presentation from WEHCT	Janie Pearman	Date(s) tba - to be between 01/11/10 and 11/12/10.
Mother and toddler groups	Will be approached and asked if they will facilitate a discussion following a presentation re ABC from NHS Hampshire		Between 01/11/10 and 11/12/10

Women in Andover	Invitation via all practical methods to attend discussion group in early Dec	Jane Gordon to arrange, session lead tba	Date(s) tba
Women in WEHCT area outside of Andover	Invitation via all practical methods to attend discussion group in early Dec	Jane Gordon	Date(s) tba
Andover Health Forum	Presentation and discussion (feedback recorded)	Caroline Smith	11/11/10
LINK	Presentation and discussion (feedback recorded)	CS/JP/KF	19/11/10
MSLC	Presentation and discussion (feedback recorded)	Janie Pearman	Date(s) tba
RCM	Will be asked to give official view on birthplace choices and preferred service models	Janie Pearman	Deadline is end of engagement - Dec 11
GPs	Discussion at Andover PbC group (feedback recorded via trackers) and also APAC (tbc)	Dr Keith Foote	Deadline is end of engagement - Dec 11
NHS Hampshire	Update presentation to Board (if required)	Dr Chris Gordon & Janie Pearman	NHS Hampshire Board meets on 25/11/10 – papers will be required sooner
HOSC	Briefing meeting in early Nov with Trust CEO and HOSC Chair plus offer to give an update presentation (if required) on the engagement – what the feedback has been so far, etc	Dr Chris Gordon (& Janie Pearman?)	Date of CEO meeting tbc HOSC meeting is 30/11/10
LINk members	LINk to contact members in the area and ask for views on birthplace choices and preferred service models. LINk website to contain link to NHSH online survey	NHSH comms with LINk officers	
NHS Hampshire members	Contact members in the area and ask for views on birthplace choices and preferred service models via NHSH online survey	NHSH comms	
Local Children and	Invitation via all practical methods	WEHCT &	

Families Forum	to attend groups	NHS H comms teams	

6. **DECEMBER COMMUNICATIONS AND INVOLVEMENT**

Stakeholder group	**Means of engagement**	**Lead**	**Date**
all	Leaflet distributed (hard copy and online) to set out current situations and options. Other versions made available if necessary Area on WEHCT website for ABC information (Q and A, Board papers, etc) – including link to survey (see below) on NHS Hampshire site Work starts on consultation document. Date set in December for public meeting in January and this will be open to all.	WEHCT comms	Leaflet and website information available until 11/12/10 Next phase of collating feedback and developing consultation document begins after 11/12/10
Women and their families in Hampshire	NHS Hampshire online survey launched to better understand birthplace choices and preferred service models	Sara Tiller	Until 11/12/10 – after which point analysis begins (using software)
Antenatal service users	Questionnaire to better understand birthplace choices and preferred service models, to be done via trackers and also using free-standing touchscreen	Janie Pearman and Pat Bull	Until Sunday Dec 11 – after which point analysis begins (using software)
ABC steering group	Steering Group views sought re breadth and depth of engagement and asked to suggest any gaps in audiences engaged with or methodologies used. The group will have sight of draft copies of the consultation document.	NHS Hampshire Comms team	Steering Group will remain in their role throughout December
Postnatal service users	Paper questionnaire completed by women in GH ward – some also sent to women who have had babies at RHCH in last month. Aim		Until 11/12/10 – after which point analysis begins and

	is to gauge opinion on current service, to understand more about choice of birth location.		will be done by the Forum.
Maternity staff	Continuation of staff meetings	Janie Pearman	Throughout December (as they are part of normal business)
Other staff	Updates via normal WEHCT comms	WEHCT comms team	Throughout December (as they are part of normal business)
Wider public - Andover	At least one public drop-in session at White Hart Hotel or Town Hall (feedback recorded and trackers used to better understand birthplace choices and preferred service models) Display material available at additional times and locations Online survey run by Andover Advertiser	WEHCT & NHS H comms teams Andover Advertiser	Survey to have closed on 11/12/10
NCT	Will be asked if they will facilitate a discussion following a presentation from WEHCT	Janie Pearman	Between 01/11/10 and 11/12/10
Mother and toddler groups	Facilitated discussion following a presentation re ABC from NHS Hampshire. Gathering and analysing of feedback begins		Discussion takes place between 01/11/10 and 11/12/10 followed by collation and analysis
Women in Andover	Invitation via all practical methods to attend discussion group in early December	Jane Gordon to arrange, session lead tba	Discussion takes place between 01/11/10 and 11/12/10 followed by collation and analysis of feedback
Women in WEHCT	Discussion group meet in early Dec	Jane	Discussion

area outside of Andover	(ideally enough numbers for more than one group)	Gordon to arrange, session lead tba	takes place between 01/11/10 and 11/12/10 followed by collation and analysis
MSLC	Presentation and discussion (feedback recorded)	Janie Pearman	Dates tbc – must occur before 11/12/10
RCM	Will be asked to give better understand birthplace choices and preferred service models	Janie Pearman	Deadline is end of engagement - 11/12/10
GPs	Discussion at Andover PbC group (feedback recorded via trackers) and also APAC (tbc) and other practices who have accepted our offer to attend their meetings or give presentations	Dr Keith Foote	Discussion takes place between 01/11/10 and 11/12/10 followed by collation and analysis of feedback
NHS Hampshire	Foreword for options document to be written by Debbie Fleming, CEO	Debbie Fleming	Mid December
LINK & TVBC	Calls to update on engagement so far	Louise Halfpenny	Early December
HOSC	Briefing meeting in early Nov with Trust CEO and HOSC Chair plus offer to give an update presentation (if required) on the engagement – what the feedback has been so far for HOSC meeting on 26/01/11	Dr Chris Gordon (& Janie Pearman?)	Early December – date tba

7. **PRESENTATION AND DISCUSSION OF OPTIONS – JANUARY 2011**

Stakeholder group	**Means of engagement**	**Lead**	**Date**
all	Options document distributed (hard copy and online) to set out options, highlighting any changes made, summarising feedback and pointing to where full feedback can be found. Area on WEHCT and NHS	WEHCT & NHS Hampshire comms teams	Options document ready and visuals ready from 01/01/11

	Hampshire websites (inc Facebook) will have options document uploaded. In addition, anyone/any group who has been involved in the engagement process will be encouraged to check both Trust websites from 1 Jan 2011. Throughout the engagement process, names and addresses (postal and email) of people requesting our options document will have been collected so that they can be sent document on or around 1 Jan 2011 and asked to attend a public meeting in January. The purpose of the public meeting is to present the options and to take any further soundings, new ideas or information etc. It will not be an opportunity for any party to repeat points previously aired during the engagement process.		
Women in Hampshire (possibly restricted to between 16 and 44 yrs – tba)	NHS Hampshire online survey analysis will form part of the feedback in the options document.	Sara Tiller	Options document ready from 01/01/11
Antenatal service users	Tracker and touchscreen analysis will form part of the feedback in our options document	Janie Pearman and Pat Bull	Options document ready from 01/01/11
ABC steering group	Steering Group views will form part of the feedback in the options document and give an opinion as to how well the feedback is reflected in the options	NHS Hampshire Comms team	Steering Group will remain in their role throughout December
Postnatal service users	Analysis from this questionnaire will form part of the feedback in the options document, meetings will be offered		Options document ready from 01/01/11
Maternity staff	Continuation of staff meetings and dissemination of options document	Janie Pearman	Throughout January (as

			they are part of normal business)
Other staff	Updates via normal WEHCT comms and dissemination of options document	WEHCT comms team	Throughout December (as they are part of normal business)
Wider public - Andover	A public meeting – venue dependent on likely numbers attending will be arranged to present consultation document and to take any further soundings, new ideas or information etc Display material available at additional times and locations	WEHCT & NHS H comms teams	Options document ready from 01/01/11
NCT	Views from NCT groups will form part of the feedback in the consultation document	options	Options document ready from 01/01/11
Mother and toddler groups	Views from these groups will form part of the feedback in the options document		Options document ready from 01/01/11
Women in Andover	Views from this group will form part of the feedback in the options document		Options document ready from 01/01/11
Women in WEHCT area outside of Andover	Views from this group will form part of the feedback in the consultation document		Options document ready from 01/01/11
MSLC	Views from this group will form part of the feedback in the consultation document – presentation/update session offered	Janie Pearman	Options document ready from 01/01/11 – date of subsequent meeting tba
RCM	Feedback from RCM will form part of the feedback in the consultation document		Options document ready from 01/01/11
GPs	Feedback from GPs (through either	Dr Keith	Options

	trackers or proper records) will form part of the feedback in the consultation document. One further meeting offered to discuss consultation document.	Foote	document ready from 01/01/11 Additional meeting tba
NHS Hampshire	Formal presentation to Board (if required by NHS Hampshire)	Sara Tiller and Louise Halfpenny to arrange, presenter tbc	Meeting date is 27/01/11 but papers required sooner
LINK & TVBC	Formal presentation to Board (if required by NHS Hampshire)	Sara Tiller and Louise Halfpenny	Date tbc
HOSC	Briefing meeting in early Jan with Trust CEO and HOSC Chair plus update presentation with consultation document	Dr Chris Gordon (& Janie Pearman?)	Meeting date is 25/01/11 but papers required sooner
WEHCT BOARD	Private session – discussion opportunity for full Board re options document	Dr Chris Gordon & Dr Keith Foote	Meeting date is 26/01/11 but papers required sooner

8. **NEXT STEPS**

A Board paper will be produced, summarising feedback to the options and containing final options for the approval of our commissioner (NHS Hampshire) and our Board. This paper will be publicly available ahead of WEHCT's Board meeting on Wednesday 2 March (in the Conference Room at Andover War Memorial Hospital, 2pm).

Appendix Nine: Discussion Paper for Hampshire Oversight and Scrutiny Committee

Odiham Cottage Hospital

Introduction & aims of this paper

This discussion paper aims to:-

- brief members of the Hampshire Oversight and Scrutiny Panel on recent developments in regards to Odiham Cottage Hospital
- outline the context and background to these developments
- provide a focus to begin discussions around next steps and
- ask the HOSC members for their suggestions and comments on the work to date and on plans for engagement with the community and stakeholders

NHS Hampshire has received notice from Hampshire Community Health Care on the provision of inpatient care at Odiham Cottage Hospital (OCH). NHS Hampshire acknowledges that HCHC reached this decision with regret and that very considerable efforts over several years have been made to provide safe inpatient services at Odiham. The PCT has begun discussions with the Hospital Trustees on the implications of this notice.

Difficulties in full recruitment to the trained nursing establishment have meant a reliance on agency staff and due to the geographical isolation of the hospital agencies have frequently been unable to supply nurses. Despite no budget limitations on the use of agency staff and flexible staffing from other HCHC services, it has become increasing difficult to staff the ward and this was a significant factor in HCHC's decision to serve notice.

As commissioner of this service, it is now for NHS Hampshire, together with GP commissioners and working with stakeholders, to determine next steps. This will include the consideration of potential options to ensure appropriate care is provided to the cohort of patients currently using OCH and of the wider health needs of the local community.

In addition to the beds, the only other NHS service provided at the site is outpatient physiotherapy one day a week. This is provided by the team based at Fleet Hospital.

This draft paper is intended to provide a starting point for discussion, setting out in brief the issues related to the OCH beds and outlining a range of potential options and plans for engagement with a range of stakeholders, along with an outline timetable for the work.

Odiham Cottage Hospital

OCH is situated in the village of Odiham, North Hampshire. The hospital opened in 1910 which, whilst undergoing improvement and refurbishment in recent years, remains a typical building from that period with associated challenges related to the environment. For example, patients undergoing rehabilitation are unable to practice stairs as there is no space on the ground floor for a set of steps to be situated and the building's stair case, being narrow and steep, is unsafe for patient use.

The building is owned by the OCH Charitable Trust, which raised funds to buy the building from the NHS in the late 1990's. The Charitable Trust is well supported by the people of Odiham and surrounding area and will form a key stakeholder in engagement going forward. The Trust has plans, currently on hold, to extend the facility to provide a rehabilitation area.

The hospital offers 24-hour registered nursing care in twelve beds, nominally allocated as 4 continuing care and 8 intermediate care, although these beds are designated flexibly according to needs of the patients at any one time.

Clinical risk - staffing & environmental

Difficulties in maintaining appropriate and safe staffing levels, particularly with regard to trained nursing staff, have been a feature of OCH over the years. Recruitment to the full establishment has not been possible and agencies often are unable to provide staff due to the geographical isolation of the hospital. Flexible use of staff from other HCHC services has been necessary, causing knock-on difficulties for those services and the situation has become increasingly untenable.

Despite best endeavours, it has been necessary at times to rely on agency trained staff, which has associated risks in terms of lack of familiarity with local procedures and practices.

It is important to note that no HCHC budget restrictions have been placed on staffing and that staffing issues are unrelated to costs. The premium rates charged by staffing agencies have been paid where it has been necessary to ensure appropriate staffing levels.

Whilst much has been done to improve the environment in recent years, a number of environmental challenges remain and the environment is not conducive to modern hospital care. This has become an increasing challenge as the frailty of patients increases.

There are no diagnostic facilities on site and the hospital is not compliant with a number of the accepted twenty five essential Community Hospital Standards.

Admissions

An audit of all admissions from 23rd July 2010 to 13th October 2010 show that these largely fall into 4 categories:-

- continuing care
- rehabilitation
- treatment for conditions amenable to care at home e.g. leg ulcers
- admissions from local hospices for palliative care

Costs

Whilst HCHC's considerations have focussed largely on patient safety elements it is right, particularly in the current economic climate, that the commissioners give due consideration to value for money in addressing the impact of HCHC's withdrawal from provision of the service.

The annual budget for OCH is £450K, after a £29K contribution from the Charitable Trust toward the running of the building has been taken into account. It is currently running at an average monthly overspend of £11.5K and the estimated total expenditure for 2010/11 is £585K, an overspend of £135K against budget.

Bed occupancy levels vary and this has an impact on costs, as can be seen in the table below.

	Total no of available bed days	No of admissions	Average admissions per day	Occupied Bed Days (OBD)	Average length of stay (LOS)	Bed occupancy %	Average cost per admission	Average cost per OBD	Current beds nos
April 2010	360	6	0.20	110	15	31	£8.5K	£466	12
Sept 09 – Aug 10 Average	4184	74	0.20	2,850	29	68	£7K	£182	11

The average cost per occupied bed day in the last year is £182, which equals £1,274 per week, significantly more that the social services rate of circa £370 per week for residential care (broken down as £296 for basic residential, £368 for elderly very dependant and £440 for elderly very dependant with dementia) and more than the £650 - £750 per week that is the NHS continuing care (i.e. nursing home) rate.

The average cost per admission – whether the £8.5K figure from April 2010 or the Sept 09 – August 10 average of £7K compares poorly with the average cost per admission of all our acute providers for the age range 70+ for all non-elective admissions of £2,600.

Community services and facilities

In common with national policy and with the direction of travel set out in the PCT strategy, Healthy Horizons, the PCT is increasingly looking to commission care out of hospital wherever clinically appropriate. Benefits of this approach to out of hospital care include less reliance on institutional care, which reduces dependency and increases independence. Significant stakeholder engagement undertaken in recent years tells us that the wish of people is to be cared for wherever possible in their own homes.

A comprehensive range of services are available to the local population to provide multi-disciplinary care for the locality in varied settings dependant on need, including the following examples, some of which are provided in conjunction with Hampshire County Council:

:

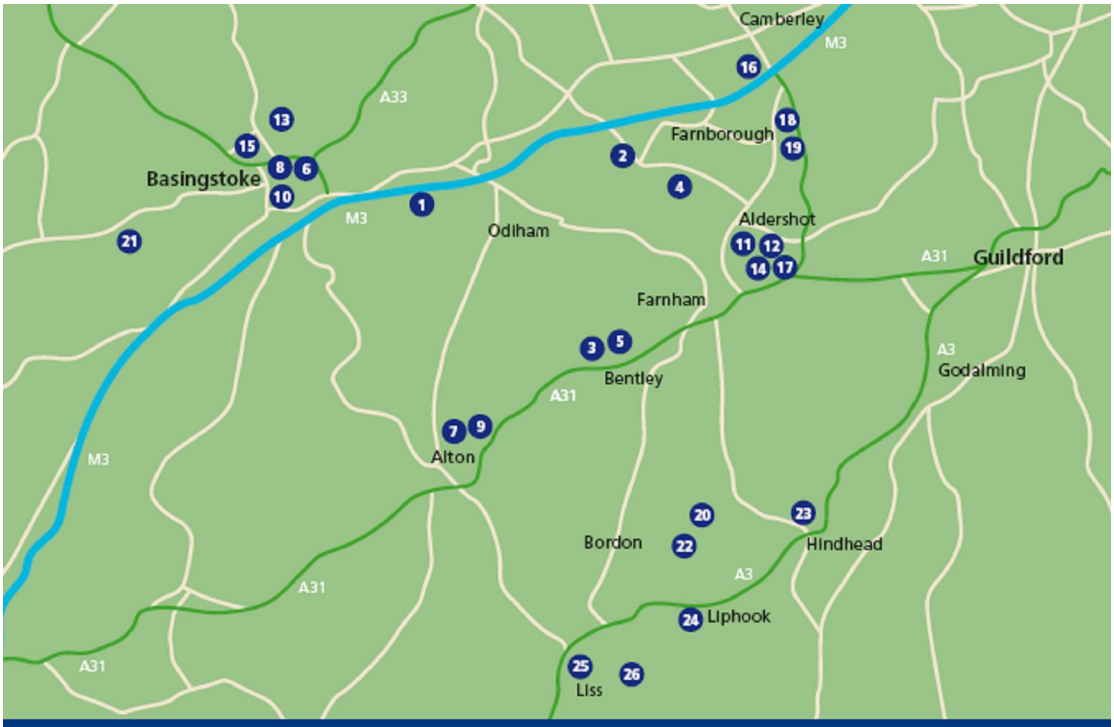
- Community Care Teams - A multi-professional team including community nurses, physiotherapists and occupational therapists, providing access to qualified support, care and treatment in the most appropriate place for the patient, between the hours of 8am and 11pm. Services provided: End of Life Care, wound care and tissue viability, IV therapy, rehabilitation, exercise programmes, falls management, long term condition management

- The CCT is lead by the Community Matron, a senior nurse also responsible for the Virtual Ward.
- Community Re-ablement beds – to support step down from secondary care and return to home.
- Rapid Response service – as part of the CCT the response service will provide varying levels of care to meet individual need negating the requirement for hospital admission (maximum 2 hour response time).
- Night sitters – overnight care
- Specialist Nursing – including Tissue Viability, Diabetes Care, Pulmonary rehab.
- Community Response Team – supporting re-ablement over a period of up to 6 weeks
- Community Innovations – signposting and support for those with less intense needs
- EOL care – Macmillan support, and Marie Curie over night care, Hospice care from both St Michaels and Phyllis Tuckwell hospices
- Fleet Community Hospital – providing inpatient, outpatient, clinic care and diagnostics

Bed-based care

In order to fully understand the picture of services and facilities available to local residents, the PCT has begun a mapping exercise and the initial map is shown below. It is important to recognise that this is a work in progress, currently it shows nursing homes with nursed beds (rather than residential homes) within 10 miles of Odiham.

Further information will be added to the map as work progresses and suggestions from the HOSC for any additional information they wish to be included will be welcomed. Additions currently under way are to show the community hospitals and the number of beds at each facility as well as some new nursing home beds that are due to come on line later this year/early next. The next iteration of the map will also show travel distances.



Registered Nursing Homes with Nursing Care, Odiham Area

1. **Crossways Nursing Home**
   Greywell Road
   Up Nately
   BASINGSTOKE
   RG27 9PJ
2. **The Briary Nursing Home**
   Reading Road North
   FLEET
   GU51 4AN
3. **Pax Hill Residential and Nursing Home**
   Pax Hill
   Bentley
   ALTON
   GU10 5NG
4. **Marlborough House**
   241 Aldershot Road
   Church Crookham
   FLEET
   GU52 8EJ
5. **The Quinta Nursing Home**
   Bentley
   FARNHAM
   GU10 5LW
6. **Oakridge House**
   Jefferson Road
   BASINGSTOKE
   RG21 5QS
7. **Marlfield**
   Gilbert White Way
   Wooteys
   ALTON
   GU34 2LF
8. **St Thomas' Nursing Home**
   St Thomas' Close
   Darlington Road
   BASINGSTOKE
   RG21 5NW
9. **Brendoncare Alton**
   Adams Way
   ALTON
   GU34 2UU
10. **Ashcombe House Nursing Home**
    65 Worting Road
    BASINGSTOKE
    RG21 8YU
11. **Maple House Nursing Home**
    23 Manor Road
    ALDERSHOT
    GU11 3D
12. **Marwa Nursing Home**
    27-29 Manor Road
    ALDERSHOT
    GU11 3DG
13. **The Grange Nursing Home**
    Vyne Road
    Sherborne St John
    BASINGSTOKE
    RG24 9HX
14. **Manor Place Nursing Home**
    116 Church Lane East
    ALDERSHOT
    GU11 3HN
15. **Homefield House Nursing Home**
    Homefield Way
    BASINGSTOKE
    RG24 9SE
16. **Abercorn House Care Home**
    Fernhill Road
    Blackwater
    CAMBERLEY
    GU17 9HS
17. **Ticehurst**
    Whitchurch Close
    ALDERSHOT
    GU11 3RX
18. **Knellwood War Memorial Home**
    83 Canterbury Road
    FARNBOROUGH
    GU14 6QN
19. **Lavender Lodge**
    10 Bruntile Close
    Reading Road
    FARNBOROUGH
    GU14 6PR
20. **Kenton House Nursing Home**
    Beech Hill
    Headley Down
    BORDON
    GU35 8NL
21. **Oak Lodge Nursing Home**
    Rectory Road
    East Oakley
    BASINGSTOKE
    RG23 7EL
22. **High Hurlands Nursing Home**
    Gentles Lane
    Passfield
    LIPHOOK
    GU30 7RY
23. **Green Gables Nursing Home**
    Church Lane
    GRAYSHOTT
    GU26 6LY
24. **Greenbanks Nursing Home**
    29 London Road
    LIPHOOK
    GU30 7AP
25. **The Grange**
    Farnham Road
    LISS
    GU33 6JE
26. **Rakelands Nursing Home**
    London Road
    Rake
    LISS
    GU33 7PH

NHS Hampshire

Previous engagement and discussions

Engagement Activities undertaken to October 2010

September 2008:
Meetings were set up in response to the findings from recent workshops where it was agreed that a small working party was needed to spend some focused time on addressing the future for the two community hospitals at Fleet and Odiham – Ideas generation at this stage. With input and engagement from Hart PBC, OCHRE and HCHC

During this time discussions with colleagues in HCC prompted development of some alternative models that resulted in the suggested model of a joint health and social care reablement centre/facility.

February 2009:
Development of options appraisal in conjunction with Hart PBC - paper was produced with input from Hart PBC and HCHC outlining the history of the site, current service provision, financial concerns and presented four potential options:

(A) Do nothing
(B) Minimal change
(C) Change in focus
(D) The Radical Alternative

The options appraisal involved the engagement of Adult Services (HCC) in jointly funding beds for both health and reablement purposes. The paper was shared with OCHRE and OCHRE trustees and local GPs

Several actions following circulation of paper including assessment of the site by Hampshire County Council re CSCI regulations as a potential residential site.
The options appraisal was debated informally at Board Seminar in April 2009.
Feedback for Trustees acknowledged and informed update to paper in June 2009

June and September 2009
Papers presented to the HCHC Board Seminars where the following was debated:

(A) Maintain the Current Service Model (Do Nothing Option)
(B) Removal of 24 hour registered nursing care with options for delivery of intermediate care.
(C) Closure of overnight beds
(D) Closure of the community hospital

It was agreed further discussion with commissioners needed to seek agreement regarding interim and longer term way forward e.g. amending admission thresholds in short term to mitigate clinical risks.

December 2009:
•OCHRE released a strategy document outlining their proposals for joint working with HCHC/PCT this was following successful application for planning permission for the integration and extension of existing separate ground floor physio room to provide a therapy area and additional office space, improved kitchens and pt facilities.

Following discussion with local stakeholders, i.e. GPs, PCT managers, nurses, the Friends of OCH and charity members, OCHRE 'recognised that the hospital needs to become more efficient to ensure it has a viable future and the current health economy makes this an urgent issue'.

Echoes previous favoured proposal for a rehab /reablement model jointly supported by health and social care

A series of meetings supported by an independent consultant took place monthly from Feb 10- June 10 when positive steps were taken to promote the model and progress with an integrated approach with HCC (Feb, March, April and June) culminating in an offer to host reablement beds during the refurbishment of Thurlstone House (HCC) decisions were required regarding continuing care beds onsite, medical provision, on call OOH provision, impact on GP contracts and proposed staffing.

Amicable and productive engagement from Hart PBC and the charity in trying to find a suitable solution for the site. All concerned including GPs are very aware that it is inappropriate for services to continue in their current format.

August 2010:
Hampshire County Council has now stated that Odiham Cottage Hospital does not fit with their strategic service delivery and as such reablement beds on the Odiham site are not an option.

Next steps & potential options
The PCT and GP commissioners are committed to working with the full range of stakeholders to identify the steps that now need to be taken and in the consideration of potential options for the future. In carrying forward this work, a number of factors will need to be considered. In addition to local issues specifically related to Odiham Cottage Hospital such as staffing, these will also need to include wider considerations such as the PCT's strategies - Healthy Horizons and Transforming Community Services, both of which were produced following extensive engagement with stakeholders and which signal an intention to increasingly commission services in the community and to prevent hospital admission where clinically appropriate.

It is also right, particularly in the current economic climate, that the commissioners give due consideration to value for money in addressing the impact of HCHC's withdrawal from provision of the service.

Three potential options have been identified at present:

1. **Source alternative provider to run inpatient beds at Odiham**
   North Hampshire Hospitals NHS Foundation Trust has previously been informally approached re this and have indicated it does not fit with their strategy to provide these kinds of beds in facilities such as Odiham. Similarly, Hampshire County Council have recently (August 2010) indicated that the Odiham site would not be clinically or financially viable for them to consider taking on the running of beds, either as they currently are or as a nursing or residential care facility.

2. **Commissioners (PCT and PBC) to work jointly to consider needs of both the cohort of patients currently served by Odiham and the wider locality with a view to commissioning services differently**
   This would fit with commissioner's stated strategy of commissioning out of hospital services wherever possible and reducing reliance on inpatient beds. The option needs to be worked up in detail and should include consideration of current community-based services, availability of nursing home beds in the area and potential for other community hospitals e.g. Fleet, Farnham, to admit patients requiring community inpatient treatment and rehabilitation from 1st April 2011.

   Hart PBC locality will be key in this work and any additional community services to be put in place due to loss of Odiham beds will be considered for 1st call from any savings released.

3. **Commissioners and HCHC to work with Odiham Cottage Hospital Charitable Trust to consider a long term future for Odiham (concurrently with option 2)**
   The Charitable Trust owns the hospital and, as such, it is entirely a matter for them to determine what the long term future for the building may look like. However, both HCHC and the PCT have a long and supportive relationship with the Trust and would wish to work with them, should they wish to work with us.

   The PCT has experience of working with the voluntary sector to redesign services, as in the case of the Fenwick which is a successful social enterprise with a building that houses a mixture of NHS, social care and private health-related services such as exercise classes, foot care and bathing services. It may be that the Trust wishes to explore this type of model for Odiham.

Engagement

A small working group made up of representatives from the PBC locality, the PCT and HCHC has been established to progress the work around inpatient beds at Odiham. The group also includes support from the PCT's communications team and a draft engagement plan has been drawn up, attached as Appendix A.

Stakeholders cover the entire range of individuals and organisations who have an interest in the work and include HCHC staff, PBC locality GPs, the practices providing medical cover to Odiham, the Charitable Trust, local elected representatives - MPs, District and Parish Councils as well as Hampshire County Council, local groups such as

The Odiham Society, voluntary sector organisations and local residents as well as local media.

Timetable

This will be worked up in the coming weeks, once the initial round of engagement has taken place and initial views gained, including from HOSC members and the Trustees of Odiham Cottage Hospital Charitable Trust. Commissioners will need to aim to agree plans for the future of services in the Hart locality before the New Year.

Appendix 10: Changes to car parking Charges at Portsmouth Hospitals NHS Trust

Dear Chairman,

As a valued community stakeholder I am writing regarding some changes to the parking charges in the patient and visitor car parks at Queen Alexandra Hospital.

From Monday 1 November Carillion, who manage the Trust's car parks, will increase the parking rates in the Multi-story car park, the North Car Park and for the spaces by the East Entrance.

Carillion have a contractual right to increase their charges, however the Trust has worked alongside Carillion to ensure the rises are fair, remain as low as possible and are in line with parking charges at other local NHS hospitals.

The table below compares the new car parking charges at Queen Alexandra Hospital to the charges at Southampton General Hospital and St Richard's Hospital in Chichester.

No of hours	QA
Up to 1 hour	£1.50
Up to 2 hours	£2.50
Up to 3 hours	£3.50
Up to 4 hours	£4.50
Up to 6 hours	£6.50
Up to 8 hours	£8.50
Up to 12 hours	£10
Over 12 hours	£15

No of hours	Soton General	St Richards
Up to 1 hour	£1.90	£1.60
Up to 2 hours		£2.60
Up to 3 hours	£3.60	£3.50
Up to 4 hours	£4.60	£4.00
Up to 5 hours	£5.60	(over 4 hours) £6.00
Up to 6 hours	£6.60	
Over 24 hours	£30	

This is the first time for six years (since 2004) that car parking charges at Queen Alexandra Hospital have risen. The Trust receives no income from these parking charges.

It is important to note that patients and visitors who need to attend the hospital or visit relatives for, or over, a long period of time, can still benefit from a reduced parking charge rate. This is at the discretion of the ward or clinic sister.

Patient care and the patient experience have always been, and remain, two of our highest priorities and parking at Queen Alexandra Hospital is an important part of the patient experience.
We want to make parking on site as easy as possible for patients and visitors; so in June we increased the amount of dedicated patient and visitor parking onsite spaces to 880 and increased the amount of disabled parking spaces to 100. We have introduced parking regulations to enable traffic to flow more freely around the site and for spaces to be more readily available for those who require them. Staff continue to use the Park and Ride facility at Fort Southwick, allowing us to provide more spaces for the public.

We will continue to look for ways to further improve the parking provision at Queen Alexandra Hospital for our patients and visitors.

Please don't hesitate to get in touch should you need further information or clarification.

Kind regards

Peter Mellor
Company Secretary
Portsmouth Hospitals NHS Trust
Trust Headquarters, F Level
Queen Alexandra Hospital Telephone 023 9228 6000

Appendix Eleven: Changes to Car Parking Charges: Response from Portsmouth Hospitals NHS Trust.

Has there been any assessment of the impact of these changes from an equalities perspective – if so could we see this?

Our concessions policy is in line with the NHS Confederation guidelines and the Ministerial statement dated 16.09.10 (attached), which highlights health conditions rather that equalities.

Car Parking ~ Ministerial statement

There are arrangements in place for expenses incurred during health treatment for people on low income, as part of a national scheme. The Department of Social Security manage the scheme and advise patients if they are entitled to discount, based on receipt of any of the below:

Income Support
Income based Employment and Support Allowance
Income based Job Seekers Allowance
Working Tax Credit (holding exemption card)
Pension Credit - Guarantee Credit
HC2 certificate
HC3 certificate

With regards to concessions for disabled people, please see extract from the Trust policy:

6.3 Disabled Persons Designated Bays 24 Hours

Designated spaces for disabled persons are provided and if these are fully occupied the Pay & Display / Pay on Foot area maybe used subject to the minimum charge. Any parking in an illegal area may result in the enforcement of civil ticketing or tow away.

Only staff with their own disabled badge may park in designated spaces for disabled persons. Staff with temporary disabled permits issued by Occupational Health may also park in designated spaces for disabled persons in staff areas for the period of the temporary disabled permit.

What information is published by the trust to advise patients and visitors of the availability of a reduced car parking rate? Is there any guidance for staff who may be approached about reduced car parking changes in order to ensure there is consistency in how this discretion is exercised? What staff are able to authorise a reduced car parking rate?

The below are also extracts from the Trust policy with regards to car parking concessions.

6.7.2 Exemptions
Exemptions to full car parking charges are those who are displaying current registered disabled stickers, or Trust approved exemption slips signed by an authorised staff member. These groups are subject to the Trust minimum parking fee.

Pease note the concession is advertised on www.porthosp.nhs.uk and at the pay and display machines in the car parks. The Trust is currently reviewing the format of appointment letters that are sent to patients and it is hoped to highlight the availability of concessionary charges within them.

6.14.3
At the discretion of an authorised Trust officer the Trust may agree to offer reduced car parking fees for patients OR their next of kin under the following circumstances:
A length of stay of greater than 7 days
A continuous clinical treatment requiring more than seven visits to the QAH.

Please see attached file, which includes the car parking concession form, which has to be signed by the Sister/Nurse in Charge of the clinical area.


Car Parking
Concessions ~ Oct 2(

How many patients/visitors were able to benefit from the arrangements for reduced car parking charges in the last year?

In the eleven months from November 2009 – September 2010, 63,510 patients/visitors were able to benefit from the arrangements for reduced car parking charges. Apologies we do not have the figures for Oct 2010 as yet.

How many complaints about car parking charges has the Trust had in the last year?

In the past year (Oct 2009-10) the Trust has received ten complaints about parking charges.

Appendix Twelve: LIBERATING THE NHS: WHITE PAPER UPDATE

1 INTRODUCTION

1.1 This report seeks to update the Board on the progress of the White Paper and developments within NHS Hampshire.

1.2 The key aims of the White Paper are "that patients will be at the heart of everything that the NHS does, that health care outcomes in England should be among the best in the world and that clinicians should be empowered to deliver results".

1.3 Although there has been a plethora of documents and publications about the White Paper from a wide variety of sources, the publication of key draft legislation and planning documents is still awaited.

1.4 The White Paper on Public Health is due to be published by December 2010.

1.5 The consultation closed on 11th October 2010; the Government's response is expected in December and the Health Bill is on course to be published at around that time.

1.6 The original timescales for implementing the structural and transactional changes described in the White Paper appear to be on course and may in some instances be brought forward to minimise the risks of organisational change.

1.7 Within NHS Hampshire significant progress has been made in planning for the White Paper Reform changes alongside delivery of the immediate Quality Innovation Prevention and Productivity (QIPP) agenda. Although this agenda is challenging, the sound foundations for Practice Based Commissioning (PBC) within Hampshire, coupled with productive relationships with the Local Medical Committee (LMC) and the Local Authorities puts the PCT in a strong position to deliver the required changes.

2 POLICY CONTEXT

2.1 The White Paper consultation closed on 11th Oct 2010, and a formal response from the Department of Health is imminent. The PCT has played an active part in working with other key players in the local Health & Social Care systems to understand the likely implications of the Reforms.

2.2 Key documents from the Department of Health are due to be published imminently. These include: an HR Framework, The NHS Operating Framework and an announcement to confirm the first General Practice Commissioning Consortia (GPCC) 'Pathfinders'.

2.3 Since the publication of the White Paper in July, the NHS has adopted a planning strategy of 'centralising to devolve' (Reform & QIPP plans). In addition to delivering the required efficiency and management cost savings, this will

effectively set a baseline from which the major structural changes can be put into place by 2013.

2.4 In line with the White Paper, the Regional Directors of Commissioning and Service Delivery have been appointed and for South Central these are; Charles Waddicor (previously Chief Executive of Berkshire West PCT) and Nick Yeo (previously Chief Executive of Hampshire Partnership NHS Foundation Trust) respectively.

2.5 It is understood that the Department of Health negotiations with the BMA (through the national GP Committee) are making progress. New agreements with GPs will form an important part of the Reforms.

2.6 The timetable for the implementation of the White Paper is summarised as follows:

- 2010/2011
  - GP Consortia to begin to form (shadow form)
  - SHAs separate commissioner and provider oversight functions
- 2011/2012
  - NHS Commissioning Board established in shadow form
  - Comprehensive system of shadow GP consortium established, taking on increased responsibility from the PCT
- 2012/2013
  - NHS Commissioning Board established as independent statutory body
  - Formal establishment of GP Consortia
  - SHAs abolished April 2012
  - Q3 - allocations for 2013/14 announced
- 2013/2014
  - PCTs abolished April 2013
  - GP Consortia fully operational, real budgets and contract

3 EMERGING GENERAL PRACTICE COMMISSIONING CONSORTIA (GPCCs)

3.1 NHS Hampshire fully supports the devolution of further authority and responsibility to GPs as Commissioners. Building on the strong PBC framework that has been developed in Hampshire it is anticipated that some emerging local GP consortia will be amongst the first in the Country to act as Pathfinders (GPCC in shadow mode).

3.2 The PCT has reviewed its executive and managerial structures and is developing a more devolved structure that will support the emerging consortia. This will also retain and enhance the strong partnership between clinician and manager in delivering the challenging Reform & QIPP plans. This is an emerging scene and it is recognised that further changes to current structures will be required.

3.3 It is understood that the current national policy of Practice Based Commissioning will remain in place until 2013. The 15 PBC localities in Hampshire have been provided with high level information on their budgets (indicative and Fair Shares, using the national tool). This allows localities to see how their current use of NHS

resources compares with the resources that would be allocated using national formulae. The outcome of this is likely to strengthen the case for GPCCs to consider risk sharing arrangements.

3.4 GPCCs will be expected to have robust methods for interacting with public and patients. The current framework for PBC in Hampshire embeds patient and public engagement into locality commissioning and should act as a firm foundation for the future development of the GPCCs.

3.5 The PBC localities continue to receive support through the PCT. This is a combination of resource that the localities directly employ, coupled with PCT resources such as information tools, financial and planning advice etc. The major emphasis this year has been to improve quality and the effective use of NHS resources (for example, improved prescribing, referring, and the use of joined up primary and community services). In addition, PBC clinical leads, along with the APAC Chairs play a full part in the PCT engagement with secondary care providers.

3.6 Developing GPCCs in the complex environment of Hampshire is understandably challenging, and the approach that NHSH has adopted can be described as 'facilitative, bottom up, with an emphasis on collaboration with key partners such as the County Council, the LMC and neighbouring PCTs. It is recognised that the rate of development for GPCCs will be differential across the County. All PBC localities are considering the current criteria being used to determine the early 'Pathfinders'. This includes:-

- ability to manage some aspects of the PCT Budget
- the emerging consortia has the support of all practices within it
- involvement in the QIPP plan
- the start of a relationship with the County Council to develop future commissioning together.

3.7 NHSH has developed a short bespoke development programme (with an experienced external facilitator) that is proving a successful vehicle for shared learning by PCT staff and clinical commissioners and will hopefully enhance the design options for GPCCs. At future sessions it will also provide the opportunity for the County Council to meet and jointly plan with the emerging leaders of GPCCs

3.8 The PCT recognises that Wessex LMC has an important leadership role in delivering these reforms and staff from the PCT have been invited to participate in LMC events when appropriate.

3.9 The PCT is also fully engaged in the emerging development programmes being run by the Regional Director of Commissioning and the SHA.

3.10 It is too early to be certain of the likely shape and size of GPCCs in and around Hampshire. There is also significant discussion around the options for GPCCs and also for structures that might provide commissioning support.

3.11 Through the current PBC structures and with some early analysis of possible options for GPCCs the PCT aims to transfer budget responsibility for some significant service areas as soon as it is feasible.

4 OPEN CONSULTATIONS

4.1 Two consultations – on Patient Choice and Information – have been launched by the Department of Health with the aim of providing patients with greater control over their care, from choice of GP to which consultant-led team they are treated by.

4.2 The proposals include:

- allowing patients to choose services from any willing provider;
- choice of provider for diagnosis;
- choice of which team, led by a named consultant, that they want to be seen by and what that treatment is after diagnosis
- extending maternity choice to include pre-conception, antenatal, and postnatal care;
- choice of treatment and provider in mental health services;
- improving the choice of end of life care, moving towards a national choice offer in the future to support those who wish to die at home.

4.3 The Government has also set out plans to increase access to information by providing data on all aspects of patient health and adult social care. Following the consultation process, the Department of Health will publish an information strategy and plans to put this information revolution into effect.

4.4 These consultations close on 14 January 2011. Further information is available from: http://www.dh.gov.uk/en/Healthcare/LiberatingtheNHS/index.htm

5 JOINT WORKING WITH LOCAL AUTHORITY PARTNERS

5.1 The White Paper and other announcements associated with the Comprehensive Spending Review means that the PCT is committed to working more closely than ever before with our local authority partners, to ensure that there is a joined up approach to delivering high quality services at the same time as achieving our savings programmes. We already have robust partnership arrangements in place within Hampshire to enable the planning, commissioning and delivery of joined up Children's services, Adult services and Older people's services, and intend to strengthen these with more joint posts and shared budgets. In this way, we will do everything possible to ensure that we maintain quality services whilst collectively spending less. Meanwhile, we must all work to ensure that our partnership arrangements deliver real benefits for local people.

6 PUBLIC HEALTH

6.1 The Public Health White Paper is due to be published by December and the Board will receive a full briefing on its impact in due course. There are significant implications for public health already identified in the NHS White Paper:

- The establishment of a new national Public Health Service (PHS)
- The ring fencing of public health budgets
- The establishment of the Director of Public Health employed by the local authority but accountable to the national PHS and the local authority
- Establishment of local authority based Health and Well Being Boards at upper tier and unitary levels; and
- Transfer of PCT responsibilities for local health improvement and health protection to local authorities.

6.2 The NHS White Paper implications for public health, which may impact differently in different areas, present a number of issues locally, including the following:

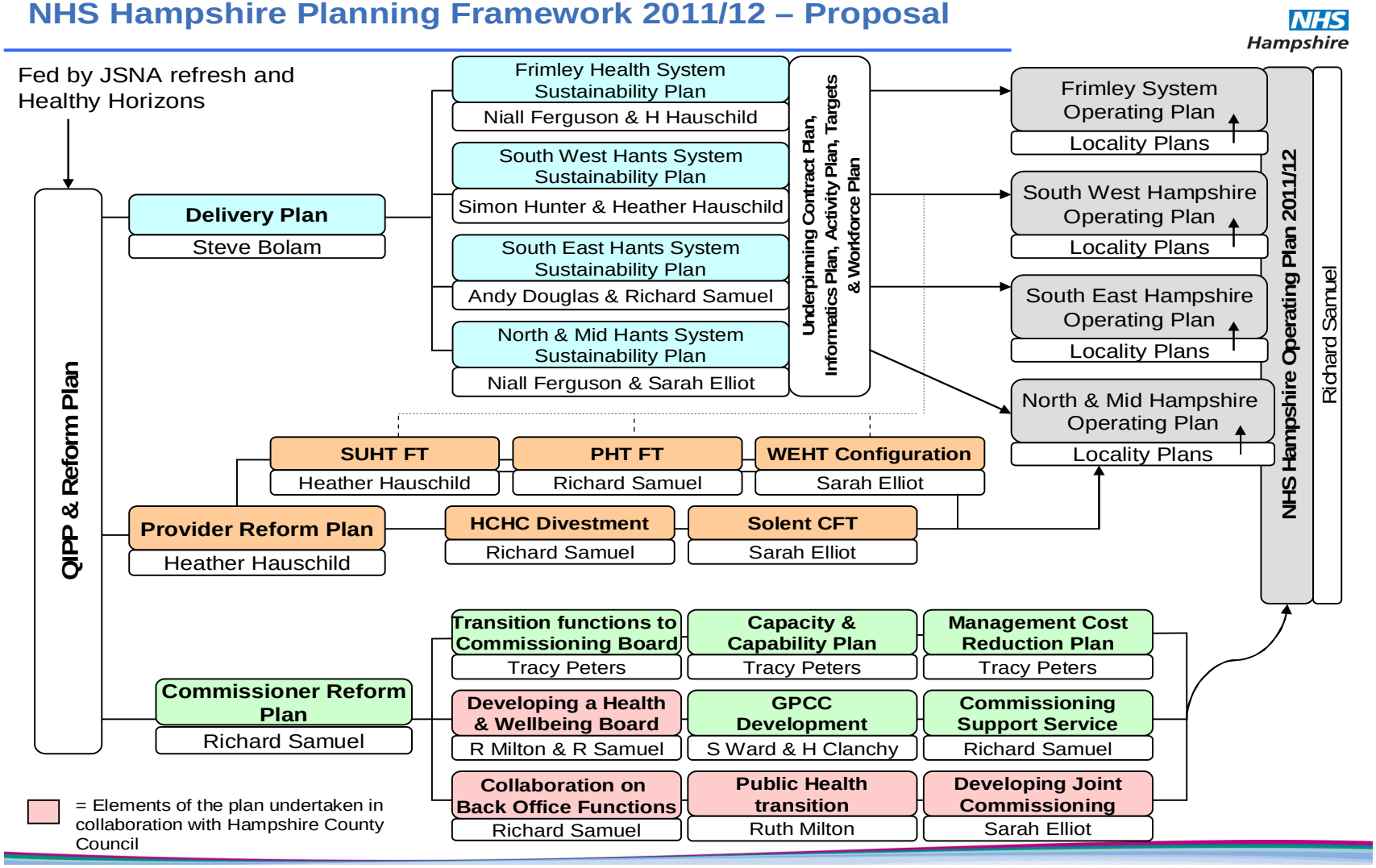
- Ensuring that public health in Hampshire is able to deliver its function fully as transition occurs.
- Ensuring that the public health intelligence assets (in the broadest sense) are best able to support public health, the PHS and GP consortia.
- The relationship for public health leadership/advocacy from the national PHS into the different models of local government governance.
- The role of public health in operating as patient/public/local community advocates: supporting the *Big Society* policy to ensure that the voluntary sector and communities are supported to become active in raising concerns over health and in determining the solutions and acting on them.
- Ensuring that during the transition period there is no risk to the effective operation and resilience of public protection arrangements and clarifying the arrangements to manage public health emergencies and support any major incidents in general.
- Ensuring the smooth transfer of public health to local authorities.

6.3 Within Hampshire, the PCT and the County Council are working closely together in conjunction with District and Borough Councils to enable the transition to take place.

7 NHS HAMPSHIRE PLANNING FRAMEWORK 2011/12 AND TRANSITION

7.1 The following diagram describes the Transition and Delivery Framework for NHS Hampshire over the next 3 years. It reflects the complexity of the environment and change agenda but has been welcomed by clinical commissioners in their considerations of the task ahead.

NHS Hampshire Planning Framework 2011/12 – Proposal



Appendix Thirteen: **East Hampshire Community Hospitals Review 2010/12**

AIMS OF THIS BRIEFING PAPER

This briefing paper will identify why Hampshire Community Health Care is carrying out a review of community hospital services in East Hampshire. It will:

- Outline the demographics for the East Hampshire District Council area;
- Set out the current health provision within the community hospitals;
- Identify community nursing services and other health services in the area
- Demonstrate stakeholder engagement that has already been undertaken
- Propose a pilot project for Alton
- Explore options for Chase Community Hospital

INTRODUCTION

East Hampshire covers a large geographical area but as a rural locality, has one of the lowest populations in the county (105,000). It is seen as a very well resourced area for community services, with three Community Hospitals (CHs) within a 13-mile radius. Whilst this may be viewed as a strength by the public, the duplication across the hospitals has in fact resulted in an historic under utilisation of the services in each which has proved costly both in financial terms and in having sustainable community services based at each.

HCHC has been working closely with the local Practice Based Commissioning Group in key areas in the locality to maximise the use of these valuable community resources and would like the support of the HOSC as it works with local people to develop the concept of **'East Hampshire Community Hospital – a virtual hospital across three sites'.**

The basis of this project is to develop a service model for each site that complements rather than competes with each other, and meets the health needs as defined by our health profiling. The relatively low population also gives potential that the services offered at each hospital site should aim to attract activity from the wider area, benefitting the whole health economy.

DEMOGRAPHICS FOR THE EAST HAMPSHIRE DISTRICT COUNCIL AREA

East Hampshire

Projected number of households (2011)	46,000
Population density	2.2 people per hectare
	(for comparison, Havant BC + 20.9)
Index pf multiple deprivation	
(1 = most deprived, 354 + least deprived)	332 (2007 figures)
Number of children & families	
on workless benefits (as % - 2006 figures)	8.3%

(for comparison - Havant = 19.9%, Hampshire overall = 10.7%, England average = 20%)

Petersfield and Alton's Community Hospitals are located in busy market towns, with similar population demographics and are of a similar sizes with outpatient / clinic facilities and two or more wards. Each has a relationship with its respective acute secondary care hospitals at Queen Alexandra Hospital in Portsmouth and Basingstoke North Hampshire Hospital acting as the main source for 'step down' admissions as well as consultant outpatient services and diagnostics e.g. radiology and phlebotomy.

Contrary to this, Chase Community Hospital sits equidistant to five acute hospitals (Basingstoke and North Hampshire Hospital, Frimley Park Hospital, Royal Surrey Hospital, St Richards Hospital in Chichester and Queen Alexandra Hospital in Portsmouth) yet does not have a 'relationship' with any one acute provider in particular. This is both a threat and an opportunity. Its local population is based in a 'garrison town' with 'eco-town' status, and has a growing population of young people and families. There is a prevalence of chronic disease evident in a younger population. Transport links in this area remain poor despite public lobbying and there is a higher rate of deprivation that sets this area apart from the affluent market towns of Alton and Petersfield.

The estate of each of the three hospitals is in a good state of repair with recent refurbishments to the ward areas and it is clear that the three sites provide excellent facilities for their role as a health services 'hub' for the local delivery of community and secondary care services.

CURRENT COMMUNITY HOSPITALS IN AREA

There are three community hospitals in the East Hampshire District Council area: Alton, Chase and Petersfield. They are commissioned to provide the following beds:

Alton	18 funded capacity on Anstey ward – 12 beds in use
	18 funded capacity on Inwood ward – 14 beds in use
Chase	12 funded capacity on Macilwain ward – 8 beds in use
Petersfield	16 funded capacity on Rowan ward – 20 beds in use

The inpatient wards focus on:

- providing 'step up' admission avoidance
- 'step down' rehabilitation following an admission to an acute hospital
- caring for patients at their end of life who choose to die in a community hospital setting.

We have been able to 'flex' the bed numbers at Alton and Chase dependent on demand from the acute sector. In addition to this, there has been a dramatic reduction in average length of stay of patients at Alton and Chase. In 2007 the average length of an inpatient admission was 36 days. This has now reduced by around 30% and is consistently achieving 20 days. Overall occupancy rates can also vary dramatically throughout the year, ranging from around 92% at best down to as low as 58%.

Whilst this model has traditionally worked well, the increasing complexity of conditions and prevalence of co-morbidities across patients means that the provision of only routine diagnostics and the absence of round the clock medical cover at a community hospital limits the range of patients that can be safely and appropriately cared for before they have to be sent to an acute hospital for treatment. Given the complexity of these patients, if they require a package of care to assist with personal care or have advanced dementia, for example, this may mean they are unable to comply with the programme of rehabilitation and therefore would not fit the criteria for admitting to a community hospital bed. This has resulted in a reduction in the usage of the inpatient beds, particularly given the close proximity to other inpatient facilities.

HCHC's key priorities are in avoiding unnecessary admissions to hospital and in supporting early discharge from secondary care. The community nursing and therapy staff have evolved into single integrated teams serving a number of GP Practices, able to provide assessment and care in the patients' homes or in a clinic model delivered in the community hospital, able to respond to someone in crisis at home within one hour and able to support them to remain at home until they regain independence and avoiding admission to hospital, including admission to a community hospital.

THE CHANGING LANDSCAPE IN HEALTHCARE

Over recent years, HCHC has experienced an increasing demand for patients to be able to access local services offering assessment and treatment for long term conditions.

Some developments which have occurred as a result of the changing needs of patients:

- Alton and Chase Hospitals have seen the development of a Rapid Assessment Service which has been steadily growing in referrals for patients with long term conditions or medical illnesses that would require assessment and treatment, often as day case e.g. blood transfusion and intravenous therapy. Previously, these treatments may have resulted in an admission for up to seven days in an acute hospital.
- Alton has also begun a leg care clinic for assessment and treatment of well leg care and other long term conditions as an alternative to home-based care. These clinics have proved so popular that they have already increased from one day a week to three, and there is potential demand to justify an increase in number of days.

These popular and cost effective services have traditionally been fitted into small areas on the wards where beds are not currently opened. This means that there are often inadequate clinical and waiting room facilities that do not meet current national privacy and dignity standards. It is felt that more room is required to build up these services.

STAKEHOLDER ENGAGEMENT TO DATE

There has been extensive engagement to date, in partnership with local GP's, through PBC and dialogue with the practices. There is a well established Alton Stakeholder Group and a well established Chase Stakeholder group which have members from the town and district councils, the voluntary sector, staff, local practices, patient groups and the LINk.

The Alton Group Stakeholder group has recently been involved in helping to develop a pilot project for Alton Hospital, which has been led by HCHC and local GPs (see below).

Winchester and Eastleigh Healthcare Trust (WEHCT) clinicians and managers support this proposal and wish to continue their relationship with the community hospitals. BNHFT is represented on the local Stakeholder Group and East Hampshire MP Damian Hinds has been briefed and all support the proposal.

The Alton Stakeholder Group has invited HCHC to have a stand at a local health fair and to speak to Patient Participation Groups linked to the GP Practices. So far the proposal has received extremely positive feedback from the public and is fully endorsed by the local GP's.

ALTON COMMUNITY HOSPITAL PILOT PROJECT

The first stage of developing an East Hampshire Hospital model would be a pilot around the Alton inpatient facilities. By consolidating inpatient activity into a single ward of 24 beds and using the ward space made available to create a day case unit, this will allow the hospital to offer a much richer range of healthcare services to the community, including:

- Rapid Assessment Unit (RAU) Consultant Geriatrician-led rapid access multi-disciplinary assessment service with access to diagnostics through BNHFT / WEHT
- Day case procedures e.g. IV antibiotics, blood transfusion referred in through RAU route
- Leg care clinic – three days/week, increasing to five days/week in partnership with GP practices
- Community nursing/therapy clinics for a range of long term conditions
- Falls assessments with direct referrals in the Falls Prevention/ Gait & balance classes

An important contigency that has been agreed with BNHFT and the providers of medical care, is the potential to increase the bed numbers, at short notice if required, to accommodate possible increased demand over the winter months. 'Flexi' beds will be provided on Inwood. The benefit of trialling this reconfiguration, will mean that the beds can still be available on demand if required.

Medical Cover will continue to be provided in hours through:

- 12 GP beds on the Alton bedfund

- 12 + intermediate care beds managed by Winchester & Eastleigh Healthcare Trust (WEHT) and this contract will allow for the, 'flexible' increase in capacity should it be required.

Medical cover out of hours remains with Thames Doc until such time that new contract is negotiated.

HCHC is asking the HOSC for their support of this pilot project, due to run from November 2010 to April 2011, and allow it to enter a phase of engagement with the local public about the proposed reconfiguration. This will be initially achieved through information leaflets and a series of open days at the hospital, as well as continued engagement with the HOSC and Alton Stakeholder Group.

The consolidation of the inpatient beds on a single ward and creation of a day case unit, if successful as a model, will realise significant savings back into the health system. The staffing plan integrates the nursing establishments from both wards and RAU budgets. The community services clinic based activity will be cost-neutral as it will be provided through transformation of the Community Care Team workload.

EXPLORE OPTIONS FOR CHASE COMMUNITY HOSPITAL

The Chase Hospital Stakeholder Group has been reviewing the current services delivered from the site and has begun to formulate ideas and options for the future service model.

It is clear that the current services at Chase are underutilised. Therefore, HCHC, working closely with PbC and NHS Hampshire would like to explore a range of options for services located at this site, that would serve the whole population of East Hampshire and beyond, and would be significantly different to those services offered at Alton and Petersfield. HCHC and NHS Hampshire, supported by the GP's would be keen to begin early engagement with the local population through open days and story boards to prompt discussion about what they would like the services at Chase hospital to provide. Chase already has a well established Stakeholder group, with good representation from GPs, patient groups and local councillors, and this group has been discussing potential service options for the last six months. We feel that we are now at a stage that we need to engage with the wider public to ask for their views.

Following this phase of engagement, a set of options will be created and further engagement will take place to establish what service model is the best. HCHC is therefore seeking approval from the HOSC to progress with the early public engagement to help shape the future services for Chase Hospital.