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

Update for the Hampshire Health and Overview Scrutiny Committee
Tuesday 28 January 2014

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

1. INTRODUCTION

The NHS in north and mid Hampshire aims to deliver the best quality health care services that meet the needs of local people and are safe, sustainable and of the highest possible standard.

Last year, NHS England launched its 'Call to Action', which sets out the challenges facing the NHS in the 21st century and calls on staff, stakeholders and, most importantly, patients and the public to engage in the process of designing a renewed, revitalised NHS. It emphasises the need to raise performance and ensure all services are safe, high quality and value for money. This change means a reshaping of services to put patients at the centre and to make sure services can meet the health needs of the future.

It is within this context that NHS West Hampshire Clinical Commissioning Group, NHS North Hampshire Clinical Commissioning Group, the Wessex Area Team of NHS England and Hampshire Hospitals NHS Foundation Trust have been working together to review current health care in their areas to make sure high quality hospital services for the people of north and mid Hampshire are maintained now and for the future.

This paper provides an update to the HOSC on this review as part of the statutory duty set out in section 244 of the NHS Act 2006, superseded by regulation 13 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 to consult with the Local Authority on proposals that may be a significant development and variation in health services.

2. BACKGROUND

Commissioning structure

Over the past year there have been significant changes to the way health services are commissioned. Hampshire Primary Care Trust has been replaced by local clinical

commissioning groups, while the local Strategic Health Authority has been replaced by the Wessex Area Team of NHS England. In Hampshire there are five clinical commissioning groups serving the local population. For this specific piece of work, the CCGs serving west and north Hampshire are working together to consider both the national and local challenges which need to be addressed to ensure safe and sustainable health services for the local population.

Each CCG has created a five-year Strategic Plan that sets out how it will improve the health and health care of everyone living in its area, supported by the two-year operating plan, which is updated every April on a rolling basis. A priority for CCGs is to consider how care can be delivered closer to home and ensuring that hospital services remain effective for those who most need them.

Between them, West Hampshire CCG and North Hampshire CCG cover an area that stretches from Fordingbridge in the west and Lymington in the south to Basingstoke, Hartley Wintney and the borders of Berkshire. They include 74 GP practices and, in addition to services provided by the main hospitals in Southampton, Bournemouth, Salisbury, Basingstoke, Winchester and Frimley Park, patients have access to a range of community services and community hospitals, as well as specialist care at other major hospitals further afield. Each year the CCGs spend over £820 million on purchasing these services for their residents.

Public health assessment

The public health assessment of the population primarily served by HHFT indicates that children and young people under 19 make up a quarter of the population while just over 8% of the population are over 75. The North Hampshire population is younger than average, while the Mid Hampshire population is slightly older.

While overall population growth over the next five years is forecast to be 2.25%-3.5% a higher proportion of the increase will be in the over 75 age group.

The population is generally affluent and healthy with a high proportion of people economically active. Good health outcomes and life expectancy are significantly higher than average for England.

Overall levels of socio-economic deprivation are low and this can make it difficult to identify and tackle the pockets of health and social inequalities that we know exist. A significant proportion of the population is affected by poor geographical access to services and despite this relative affluence just over one in ten children are growing up in poverty.

The population of disabled children using services is increasing, alongside increasing complexity of physical disability and associated need, as is the number of vulnerable adults with physical and learning disabilities requiring support from adult social services.

North Hampshire has a higher birth rate than average that reflects the younger population. Across the area the previous rise in births may be starting to level off.

The health and wellbeing of children and young people is generally very good but given the relative affluence of the population there is still significant room for improvement:

- Too many women are still smoking when they deliver their babies
- only 50-60% of babies are being breastfed at 6-8 weeks
- too many children are overweight and obese
- there are inequalities in oral health
- immunisation rates for MMR and dTaPIPV and school leaver booster do not reach the WHO 95% target to ensure herd immunity

Infant mortality rates are lower than the England average as we would expect for an affluent population. Child mortality rates are not available for local populations but we know that the UK lags behind Europe in reducing mortality rates for children from asthma, meningitis, pneumonia and diabetic ketoacidosis.

A&E attendances for children and young people are higher than average for the mid Hampshire population with a below average rate of emergency admissions. This is reversed for the North Hampshire population with lower than average A& E attendances and a higher rate of admissions. This suggests that many families with children may not be accessing unplanned health advice in the most appropriate way and that there is a need to review paediatric urgent care pathways to address this.

The estimated smoking prevalence amongst adults in all local authority areas in mid Hampshire is below the England average of 20% while it is in line with the national figure in Basingstoke and Deane.

Obesity rates in adults are similar to England except for Winchester district where they are significantly lower. Too many people have an unhealthy weight (about six in ten) and indications are that rates will continue to rise.

Estimates of the proportion of people who are drinking more alcohol than the government recommended level are lower than for England. There is a persistent upward trend in alcohol related admissions.

Modelled estimates suggest that there is significant under recording/under diagnosis of all long term conditions. There are likely to be significant numbers of people with undiagnosed coronary heart disease, stroke, chronic obstructive pulmonary disease and diabetes.

In contrast to England, cancer incidence rates have been stable in Hampshire in recent years. They are higher than average in North Hampshire and lower than England in mid Hampshire, where lung cancer rates are significantly lower. More people are surviving cancer and the number is predicted to continue to increase, reflecting improved life expectancy and improved survival from cancer. The needs of cancer survivors are becoming increasingly important.

About 1 in 6 of the adult population experiences mental ill health at any one time and 10% of children have a mental health problem. Half of lifetime mental illness is present by the age of 14.

Many people with a long term condition have poor mental health, accounting for 12-18% of the NHS spend on managing these conditions.

The recorded prevalence of dementia in mid Hampshire is 0.74% which is significantly higher than the national average while the prevalence is lower than average in North Hampshire (0.48%) reflecting the different population age structures. It is estimated that only about half of people with dementia are diagnosed. The number of people diagnosed with dementia is predicted to increase by about 30% by 2020.

The overall rate of hospital admissions as a result of falls and fall injuries in people aged 65 and over is lower in mid Hampshire than in North Hampshire while rates of hip fracture are similar.

Cancer was the leading cause of death accounting for 30% of deaths compared to 28% from circulatory disease in 2011. All-cause mortality across the area is significantly lower than the national rate but is higher in North Hampshire than in mid Hampshire. The trajectory continues downwards. For the first time in 2011 cancer was the leading cause of death accounting for 30% of deaths compared to 28% from circulatory disease.

Around 10% of the hospital services provided for people living in north and west Hampshire are classed as specialist care, like cancer and cardiac services. These are planned and purchased by the Wessex Area team of NHS England.

Hospital services

Acute hospital services in the area are provided by Hampshire Hospitals NHS Foundation Trust (HHFT) which was created in January 2012 following the integration of Winchester and Eastleigh Healthcare Trust and Basingstoke and North Hampshire NHS Foundation Trust. This integration was driven by the recognition that a population of at least 500,000 people would enable the organisation to maintain and further develop the most acute elements of its service mix, for example major trauma and treatments for heart attacks and strokes.

This foundation trust (FT) now delivers hospital services from its three hospitals in Andover, Basingstoke and Winchester. It also delivers services in community hospitals in Alton and Bordon, as well as some outreach services into patients' homes and some mobile facilities. It plans to offer local services in a facility in Eastleigh in the near future. HHFT also delivers some specialist (tertiary) services including:

- National pseudomyxoma centre
- Tertiary-referral liver and colorectal cancer surgery
- Regional haemophilia networked service
- Intraoperative breast cancer treatment

These services will continue to develop and are a crucial part of the service offering from HHFT.

3. THE DRIVERS FOR CHANGE IN NORTH AND WEST HAMPSHIRE

- Sir Bruce Keogh, National Medical Director of NHS England, has proposed **a new blueprint for urgent and emergency care across England** that would see a fundamental shift in the way urgent care is provided, with more extensive services outside hospital and patients with more serious or life threatening conditions receiving treatment in centres with the best clinical teams, expertise and equipment.

  The Keogh report proposes highly responsive, effective and personalised services provided outside of hospital for people with urgent but non-life threatening needs. These services should deliver care in or as close to people's homes as possible, minimising disruption and inconvenience for patients and their families. People with more serious or life threatening emergency needs should be treated in centres with the very best expertise and facilities in order to maximise their chances of survival and a good recovery.

  Highlighting opportunities to shift care closer to home, Sir Bruce says 40 per cent of A&E patients are discharged requiring no treatment; up to one million emergency admissions were avoidable last year; and up to 50 per cent of 999 calls could be managed at the scene. And citing modern treatment of the nation's two biggest killers – heart attacks and strokes – he points out that survival rates have improved significantly by taking patients to specialist centres that provide the best available hospital treatment.

- At the same time, **a succession of royal college reports have highlighted strong consensus and compelling evidence for the need to concentrate various specialist services into fewer centres.** These central settings would allow multi-disciplinary teams to be assembled to provide adequate medical cover and a better environment to develop clinical skills and experience. Both clinicians and managers suggested that a concentration of specialist services would provide them with the opportunity to be more flexible with rotas and increase the scope to deliver 24 hour a day, seven-day care with consultants always available – something that HHFT is currently not able to offer in a cost-effective way. A summary of the evidence is attached at Appendix 1.

  There has been a growing recognition, nationally and internationally, that greater specialisation leads to better patient outcomes. This was the driver for the NHS to reorganise cancer services over the last 10 years as well as the development of major trauma networks. This principle applies to the majority of medical specialties, particularly those required by the most acutely sick of our population, including access to consultant obstetricians for higher-risk pregnancies that require medical intervention.

- **The population is growing in numbers and more people are living longer.** These factors combined mean there is more demand for NHS services. The priority for the NHS is to enable as many people as possible to be cared for at home, or as close to home as possible; however, as we live longer we live with more long-term chronic illnesses and have periods where we become acutely unwell and need to have access to hospital services.

The NHS therefore needs to be able to change and adapt, offering a range of services to meet the needs of its expanding and ageing population. This will incorporate care closer to home, working in partnership with health and social care partners, as well as acute hospital care available 24/7 for life-threatening conditions. The opportunities posed by the national policy to develop integrated services across health and social care are well-timed and supportive. The Better Care Fund proposals in Hampshire will help us deliver better services for urgent and emergency care and ensure more patients are cared for out of hospital.

- **The local health economy must remain financially sustainable.** The costs of healthcare are constantly growing as medical technology and treatments advance and are provided to more people. The need to ensure that the local health economy can manage increasing costs whilst funding is plateauing is crucial for all of us. Solutions to the first two drivers therefore cannot be implemented without recognising that financial stability is also crucial. We need to deliver change in a financially-responsible manner.

4. WORK SO FAR

A Steering Group comprising the Wessex Area Team, West Hampshire CCG, North Hampshire CCG and the Trust was set up in September 2013 and meets on a monthly basis. Full details are shown on the attached appendix 2.

A high-level project plan has been developed and a series of sub-groups are in place, covering Quality and Clinical Services, Activity and Capacity Planning and Finance. These groups are working through the detail of the options to ensure any plans are realistic and deliverable. A communications programme is being led by a sub-group which has delivered an engagement programme and will steer future public engagement and consultation processes. Pre-engagement started in August as commissioners and HHFT undertook a series of focus groups to understand views and opinions, and also to inform the shape and structure of a wider engagement process.

An engagement process was then undertaken to gather feedback about hospital services based on five scenarios. This took place over ten weeks in October, November and December 2013 and included a range of face-to-face events and activities supported by a survey to capture responses. During this time partners, including GPs, hospital doctors, nurses, and other hospital and NHS staff as well as the public and stakeholders such as patient voice groups, responded to say what is important to them when accessing hospital services.

The wide-ranging engagement activity included public meetings in Alton, Andover, Eastleigh, Basingstoke and Winchester, staffed stands in supermarkets and shopping centres in each town and stands in outpatient departments and clinics at the hospitals in Andover, Basingstoke and Winchester. Activity was undertaken to engage with specific user groups including the Maternity Services Liaison Committee, Patient Voice Forum, Patient Alliance Forums and

Patient Participation Groups. Communications were sent to local Over 55 Forums, local authorities and CVS to ask for support raising awareness of the engagement among their networks. NHS hospital staff were involved through drop-in stands and at regular all staff forums. NHS staff could also choose to participate in a specific staff survey.

The survey was available on all three NHS organisations' websites and was promoted through the use of social media (Twitter) and through the MSLC facebook. The link was published in the local media.

In the period from 18 October-30 November there were 1,142 responses to the survey, of which 909 took the survey online and 131 completed it on paper. 84% of survey respondents were members of the public, 16% were HHFT staff. The majority of the HHFT staff who responded to the survey completed the public survey but 40 completed a staff survey. 61% of respondents provided details so they could be involved in further engagement activity and 67% wanted to be kept in touch.

Local media channels were used to raise awareness of engagement opportunities. This included coverage in local press and local radio.

Stakeholders were kept informed and aware with personal briefings provided to all local MPs and local authorities. Key NHS stakeholders have also been briefed to ensure any proposals are coherent with the rest of the health system. This includes University Hospital Southampton, Portsmouth Hospitals, Southern Health and the South Central Ambulance Service. We are also working closely with HCC Adult Services to ensure join up between health and social care. This has been enhanced by the desire to develop integrated care locally.

Many elements of the engagement activity worked well to encourage public input such as using an online survey, staffed stands in public places and working with interest groups and social media and we plan to replicate these in the public consultation. We also identified a number of areas that we can improve for the consultation process including more activity within GP practices and children's centres.

A full report of the engagement activity and its findings is available and will be made public. Key messages from the feedback indicate that the public recognises and values the benefits of centralising emergency care. At the same time, concern was expressed about travel, transport and accessibility for visiting families. Concern was also expressed about access to obstetric care in hospital.

5. DRAFT OPTIONS FOR CHANGE

The Department of Health has issued four key tests that any review must pass if it is to lead to service changes:

- Support from clinical commissioners
- A clear clinical evidence
- Robust patient and public engagement
- Support for current and future patient choice

In addition, NHS England published 'Planning and delivering service changes for patients', its good practice guide for commissioners on the development of proposals for major service changes and reconfigurations, in December 2013. These guidelines emphasise that the heart of any major service change or reconfiguration must be that the change will improve the quality of care and that it is clinically-led and based on a clear clinical evidence base. The NHS is accountable to the public, communities and patients that it serves; it has a duty to involve patients and the public in decisions about their care and in any plans to change how that care is delivered. Reconfigurations are often complex, requiring excellent leadership, effective programme management, partnerships and close collaborative working, and extensive and comprehensive engagement.

Sir David Nicholson, Chief Executive of the NHS, adds: ‘Reconfigurations of health services are part of a wider spectrum of changes that can deliver higher quality care, better health outcomes and improved population health. The new clinical commissioning system means we should be ambitious in how the delivery of care needs to modernise and in creating a 21st century health and care service for patients. That will be a collective challenge, for not only for commissioners but for organisations across the health and care system, and should be the vision and shared purpose which underpins the delivery of change.’

The three commissioners and HHFT have been working together to identify a range of options that could meet the challenges raised by the drivers for change in section 4 and also the concerns and issues raised by local people in the listening programme held from September to November last year. A summary of the options reviewed to date and those taken forward for more detailed testing is included at Appendix 3.

These options would need to meet these criteria:

- Guaranteeing consultant-delivered care for the sickest and most at risk patients 24 hours a day, seven days a week. This will lead to safer care and better outcomes for all.
- Delivering care in the most appropriate facility and improving the speed and ease of integrating hospital services with community and social care services.
- Providing local services for communities outside Winchester and Basingstoke such as Eastleigh, Andover, and Alton. This will reduce travelling distances and provide a better experience for patients.

Underpinning all these options are the principles that we agree that the case has been made for centralising critical care services and that the local health economy must remain financially sustainable.

Critical care services are those provided for the most sick/at risk people who need:

- emergency care for heart attacks, strokes or trauma
- emergency and complex surgery (including specialist tertiary liver and colorectal cancer and pseudomyxoma)

- critical/intensive care
- high-risk maternity services

We believe that this requires a significant change from the way that services are currently provided and how these are used by the public.

Two options have been identified as potentially able to meet this change. In similar situations, it is usual to include an option of ‘doing nothing’. However, we do not think this is a credible option because it does not meet the local and national drivers for change. Serious consideration was given to a third option: centralising critical care services on the site of Royal Hampshire County Hospital and investing in Basingstoke and North Hampshire Hospital as a general hospital treating the majority of patients in the local community. However, geographically, Southampton is already the designated trauma centre for Hampshire and a wide range of specialised treatment. Centralising the more critical treatment services for north and mid Hampshire to the north of Winchester as opposed to central Winchester gives easier access to the greater number of people. In addition, the constraints on the Royal Hampshire County Hospital site in Winchester would make it very difficult to provide a centralised critical treatment hospital there. Therefore this option is not included.

The two remaining options are:

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

6. ASSURANCE AND GOVERNANCE

The Governance of this programme has been agreed by the CCGs, the Wessex Area Team and the FT.

This review was already well underway before the latest guidance was issued in December 2013 and we are aware that this does not have to be implemented retrospectively. The Steering Group, however, decided to check that the good practice in the guidance is being undertaken. This includes the CCGs assuring themselves that any proposed change meets the needs of their population and delivers an improved service. The CCGs leaders are conducting this assurance in parallel with the other work described in this paper. The public engagement and consultation work will be a crucial part of this assurance.

A final element of the assurance of this programme will be to ensure the Health and Well-being Board has the opportunity to test the assumptions and proposals. The CCG leaders briefed the Board a few months ago and will be doing a further update shortly.

Each of these organisations are statutory bodies with their own responsibilities. The Steering Group reviews the joint work and ensures there is clarity about how decisions are reached at each stage. The Boards of the organisations have to agree any significant decisions that are reached by the Steering Group. The FT has responsibility for the decisions relating to funding and building of any new facility and must be cognisant of the longer term risks associated with commissioning plans.

7. NEXT STEPS

The next phase of the programme will need to oversee the following items:

- carry out detailed analysis of each of the two options, including the impact on clinical services and their quality, the projected activity required and the necessary service capacity and workforce to meet that activity, and a full financial evaluation
- Conduct a further engagement and then a consultation programme on the two options, involving local residents, stakeholders and staff and ensuring that they have many opportunities to share their concerns and views. This must meet the requirements set nationally by the Cabinet Office in its 'Consultation Principles' guidance and locally in the Hampshire Health Overview and Scrutiny Committee's (HOSC) guidance 'Arrangements for Assessing Substantial Change in NHS Provision'. Latest versions of both of this guidance were published in October 2013 and April 2013 respectively. The draft Consultation Plan is attached at appendix 4.

Timeline

An indicative timeline for completing the next phase of engagement and undertaking consultation has been developed and will be finalised once comments are received from the HOSC. This will ensure local residents have been able to influence the development of options prior to consultation.

- February: continue engagement
- Mid March: commence public consultation
- By end March 2014: complete the detailed clinical and quality analysis for each impacted specialty
- By end March 2014: complete the activity and capacity analysis
- By end April 2014: complete the full financial evaluations
- June 2014: complete public consultation
- July 2014: share results of public consultation with HOSC

8. RECOMMENDATION

The Health Overview and Scrutiny Committee is asked to consider the paper and decide if this represents a significant development and variation in health services.

The Committee is also asked to comment on and support the draft Consultation Plan which will be utilised once the engagement phase is complete.

APPENDIX 1

Evidence base for Urgent and Emergency Care change

This annex summarises the key evidence available from multiple sources relating to a number of relevant issues:

- Centralisation of specialist services
- Benefits of consultant-delivered care
- Benefits of community-facing general hospitals and integrated care
- Obstetric and maternity care
- Paediatric services

Centralisation of specialist services and benefits of consultant-delivered care

In June 2013 the NHS Confederation[1], National Voices[2] and the Academy of Medical Royal Colleges[3] report Changing Care, Improving Quality identified six key principles for most reconfiguration plans:

1. Healthcare is constantly changing
Health services cannot be allowed to stand still and now, more than ever, they will need to adapt to an ageing population and the proliferation of innovative treatments.

2. There are significant benefits to delivering new models of care
Clear evidence on better experience and outcomes for patients highlights that there is more to be gained than lost in changing many services.

3. 'Reconfiguration' is a catch-all term
Reconfiguration is a general term for a collection of different types of change, the drivers of which need to be understood to consider their potential benefits.

4. Patients can co-produce better services
Patients and their organisations need to be engaged as equals to critique current provision and redesign it to meet their needs and preferences, a practice known as ‘co-production’.

5. A 'whole-system' approach is essential
One service cannot be changed in isolation from the rest of the system. New models of care will require the health service to go beyond traditional borders in healthcare to deliver the most public value.

6. Change requires consistency of leadership
Strong leadership is needed to develop change with the local community. This collaboration relies on strong relationships to be formed between leaders, built on trust and experience.

The case for centralisation of specialist services was highlighted:

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[1] The NHS Confederation is the independent membership body for all organisations that commission and provide NHS services.
[2] National Voices is the national coalition of health and social care charities in England.
[3] The Academy of Medical Royal Colleges promotes, facilitates and co-ordinates the work of 20 Medical Royal Colleges and their faculties.

"A succession of royal college reports have highlighted strong consensus and compelling evidence for the need to concentrate various specialist services into fewer centres (see box on page 14). These central settings would allow multi-disciplined teams to be assembled to provide adequate medical cover and a better environment to develop clinical skills and experience. …. Both clinicians and managers suggested that a concentration of specialist services would provide them with the opportunity to be more flexible with rotas and increase the scope to deliver seven-day care with consultants always available. Considerable feedback highlighted that the variation in service quality from one day to the next was not yet fully recognised by the public and that greater awareness would likely intensify the need for change." Page 12

http://www.aomrc.org.uk/about-us/news/item/patients-clinicians-and-managers-join-forces-to-call-for-nhs-change.html

The Future Hospital Commission[4] report Future hospital: caring for medical patients published in September 2013 recommendations were:

- safe, effective and compassionate medical care for all who need it as hospital inpatients
- high-quality care sustainable 24 hours a day, 7 days a week
- continuity of care as the norm, with seamless care for all patients
- stable medical teams that deliver both high-quality patient care and an effective environment in which to educate and train the next generation of doctors
- effective relationships between medical and other health and social care teams
- an appropriate balance of specialist care and care coordinated expertly and holistically around patients' needs
- transfer of care arrangements that realistically allocate responsibility for further action when patients move from one care setting to another.

Page xxi

http://www.rcplondon.ac.uk/sites/default/files/future-hospital-commission-report.pdf

The Royal College of Physicians[5] report Hospitals on the Edge? Time for Action, published in 2012, highlighted the following priorities:

- We must redesign services
    - We must make difficult decisions about the design of services where this will improve patient care. In some areas, this will require service reconfiguration….
- We must change the way we organise hospital care
    - We must reorganise hospital care so that patients have access to efficient, high-quality, expert care regardless of their age or day of the week. This is likely to involve changes to working patterns and the way we organise wards and deploy physicians in hospitals and the community….

Page 8

4 In March 2012 the Royal College of Physicians established the Future Hospital Commission
5 The Royal College of Physicians is the professional body for physicians.

http://www.rcplondon.ac.uk/sites/default/files/documents/hospitals-on-the-edge-report.pdf

The reflections of the retiring Chair of the Independent Reconfiguration Panel[6] in Safety, Sustainability, Accessibility - striking the right balance, observed:

"In general, I think it is true to say that that the public has yet to be convinced of the benefits in healthcare that can be gained from greater centralisation of certain services. Yet, the Bolton footballer, Fabrice Muamba, who suffered a mid-match heart attack provides an excellent example. The decision to pass closer, local hospitals in favour of taking him to a specialist unit several miles further away was a major factor in his remarkable recovery. If any good can come from such a dreadful event, let it be that we see a more reasoned debate about the pros and cons of centralisation - for those services for which it is relevant - in future." Page 4

http://www.irpanel.org.uk/view.asp?id=100

The Kings Fund[7] reconfiguration briefing of 2012 identified four drivers for health service reconfiguration:

- Quality (including safety)
- Workforce
- Cost
- Access

http://www.kingsfund.org.uk/sites/files/kf/briefing-on-reconfiguring-hospital-services-candace-imison-kings-fund-september-2011.pdf

In 2013 the Royal College of Surgeons [8] report Reshaping surgical services: principles for change outlined the need to "ensure that local health economies provide the best possible surgical care – locally when possible but centrally, in specialist units, when necessary for the best patient outcomes." Page 5.

It identified 8 principles for reshaping surgical services. These include:

"2. There is clinical evidence that concentrating specialist surgical services into fewer, larger centres of excellence can save lives in certain circumstances. It is right that the NHS should look at the long-term benefits when considering any reorganisation.
…
4. More consideration needs to be given to how to support communities in rural areas who need access to good emergency surgery. Strengthening of ambulance services and emergency care networks will ensure that patients needing immediate access to emergency surgery or other specialised services can be routed appropriately and promptly.

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[6] The Independent Reconfiguration Panel are a advisory non-departmental public body who review contested NHS proposals for service change.
[7] The King's Fund is an independent charity working to improve health and health care in England.
[8] The Royal College of Surgeons is the professional body for surgeons.

5. The requirement for, and implications of, service change needs to be thoroughly and exhaustively researched. If services are to be changed, the whole pathway of care for patients with specific conditions must be considered. This should encapsulate how a patient would access services from primary care, to initial secondary care referral, diagnostic tests, hospital treatment, discharge, follow-up and rehabilitation.
…
7. Patient transport is key to the public's sense of security and belief in the reshaping of services. The most common cause for concern is transport links between the 'local' hospital and an element of the service that may be moved to another location. It is important that a transport infrastructure is in place for any reshaped service." (Page 22-23)

http://www.rcseng.ac.uk/publications/docs/reshaping-surgical-services/

The Royal College of Surgeons standards for emergency surgery, published in 2011, highlighted that the key elements of a high quality emergency surgical service included:

- The prioritisation of acutely ill patients over elective activity.
- A consultant-led service across all specialties.
- Timely input of senior decision makers (Certificate of Completion of Training holders (CCT holders)) according to the needs of the patient.
- A focus on patient-centred care, which involves consultant-led communication with patients and their supporters.

In August 2013 the Royal College of Surgeons and the Association of Surgeons of Great Britain and Ireland published their position statement on emergency general surgery. One of their key points was:

"The College and ASGBI believe that emergency general surgery should be delivered via operational networks of providers to enable collaborative working, common standards of care, and good patient transfer arrangements, according to clinical need. The network will enable the patient to be treated at the most appropriate hospital depending on the complexity of the case and the resources available to treat."

(Page 2)

http://www.rcseng.ac.uk/providers-commissioners/docs/emergency_general_surgery.pdf

Academy of Medical Royal Colleges[9] report of 2012 concluded that patients have increased morbidity and mortality when there is a delay in consultant involvement. The report states that the benefits of consultant-delivered care included:

- Rapid and appropriate decision making
- Improved outcomes
- More efficient use of resources
- GP's access to the opinion of a fully trained doctor
- Patient expectation of access to appropriate and skilled clinicians and information
- Benefits for the training of junior doctors.

(Page 5)

http://www.aomrc.org.uk/publications/reports-a-guidance/doc_details/9450-the-benefits-of-consultant-delivered-care.html

Later in 2012 The Academy identified three standards for seven day consultant care.

"Standard 1: Hospital inpatients should be reviewed by an on-site consultant at least once every 24 hours, seven days a week, unless it has been determined that this would not affect the patient's care pathway.

Standard 2: Consultant-supervised interventions and investigations along with reports should be provided seven days a week if the results will change the outcome or status of the patient's care pathway before the next 'normal' working day. This should include interventions which will enable immediate discharge or a shortened length of hospital stay.

Standard 3: Support services both in hospitals and in the primary care setting in the community should be available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be taken."

(Page 3)

http://www.aomrc.org.uk/publications/reports-a-guidance/doc_details/9532-seven-day-consultant-present-care.html

In November 2013 The Academy considered the implications of seven day consultant presence and the clinical requirements to implement the above standards. Key findings include:

- The majority of hospital inpatients will benefit from daily consultant review across the whole week, including at weekends, and the review will take less time if a patient is already known to the consultant; rota patterns which optimise continuity of care should be designed to ensure best use of consultant time
- Progression of the patient's care pathway following weekend consultant review in most specialty areas will require timely seven day access to:

[9] The Academy of Medical Royal Colleges promotes, facilitates and co-ordinates the work of 20 Medical Royal Colleges and their faculties.

- Investigations, including (but not limited to) laboratory services, radiology, ultrasound and cross sectional imaging
- Interventions, including (but not limited to) emergency surgery, anaesthesia, interventional radiology and therapeutic upper gastrointestinal endoscopy
- Support services within hospital, including (but not limited to) physiotherapy, occupational therapy, pharmacy, dietetics, specialist nursing, operating theatres, administrative and clerical support
- Patient transport and community support services, particularly social care teams, providers of equipment, community nurses and the ability to liaise directly with primary care.

Page 10

http://www.aomrc.org.uk/publications/reports-a-guidance/doc_details/9728-seven-day-consultant-present-care-implementation-considerations.html

There are many example of research showing that consultant delivered care improves patient outcomes, and the reverse. Recent examples reported in the media are:

Child weekend emergency admissions give 'no added risk'
http://www.bbc.co.uk/news/health-22383415

(A report on Effects of Out-of-Hours and Winter Admissions and Number of Patients per Unit on Mortality in Pediatric Intensive Care
Phil McShane, Elizabeth S. Draper, Patricia A. McKinney, Jillian McFadzean, Roger C. Parslow, Paediatric Intensive Care Audit Network (PICANet)
The Journal of Pediatrics (Vol.null) http://www.jpeds.com/article/S0022-3476%2813%2900380-6/abstract?source=aemf)

Surgery mortality 'peaks on a Friday'
http://www.bbc.co.uk/news/health-22698865

(A report on Day of week of procedure and 30 day mortality for elective surgery: retrospective analysis of hospital episode statistics
http://www.bmj.com/content/346/bmj.f2424)

In 2012 the annual Dr Foster [10] hospital guide found:

“Mortality rates for patients admitted at weekends are higher than for those admitted on weekdays. Higher levels of senior medical staffing at weekends are associated with lower mortality rates and we have seen a slight increase in weekend staffing since last year.” (Page 6)

http://drfosterintelligence.co.uk/thought-leadership/hospital-guide/

[10] Dr Foster Intelligence is a healthcare information provider to support benchmarking and monitoring quality in healthcare.

Urgent care

The pressure on Emergency Departments is continually in the media at present.

The Kings Fund's[11] recent monitoring report found that in 2012/3 nearly 6% of patients waited four or more hours in Accident and Emergency.

http://www.kingsfund.org.uk/publications/how-health-and-social-care-system-performing-june-2013

The NHS England[12] Urgent and Emergency Care Review summarised the evidence for change to urgent care in June 2013 to support the completion of a survey to gather the views and feedback of the public and professionals.

In Sir Bruce Keogh's foreword he highlighted that due to medical and technological advances "…there is now no A&E department in the country that can treat everything that comes through the door. In fact, most A&E departments can no longer offer the best treatments for the two major killers – serious heart attacks and stroke – because they now require a high level of specialist expertise and technology to offer the best chance of recovery." Page 7

http://www.england.nhs.uk/wp-content/uploads/2013/06/urg-emerg-care-ev-bse.pdf

The emerging principles for urgent and emergency care outline a system that:

1. Provides **consistently** high **quality** and **safe** care, across all seven days of the week;
2. Is **simple** and guides good choices by patients and clinicians;
3. Provides the **right care** in the **right place**, by those with the **right skills**, the **first time**;
4. Is **efficient** in the delivery of care and services.

Page 3

http://www.england.nhs.uk/wp-content/uploads/2013/06/uec-emerg-princ.pdf

The end of Phase 1 report of the Urgent Care Review sets out the vision for urgent care:

> Our vision is simple:
> Firstly, for those people with urgent care needs we should provide a highly responsive service that delivers care as close to home as possible, minimising disruption and inconvenience for patients and their families.

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[11] The King's Fund is an independent charity working to improve health and health care in England.

[12] NHS England is an arms length body whose main aim is to improve the health outcomes of the people of England.

Secondly, for those people with more serious or life threatening emergency care needs, we should ensure they are treated in centres with the very best expertise and facilities in order to maximise the chances of survival and a good recovery.

(Page 22)

The review proposes a two level service for emergency care to be introduced when urgent care services outside the hospital have been significantly improved. Emergency Centres will be capable of assessing and initiating treatment for all patients and safely transferring them when necessary. Major Emergency Centres will be much larger units, capable of not just assessing and initiating treatment for all patients but providing a range of highly specialist services.

The review states:
“These proposals are not about cutting existing urgent and emergency care services. … Our intention is to achieve a substantial shift of care out of hospitals and into community settings in order to create a comprehensive system of care across a network that will deliver good outcomes for all patients in a safe and effective way. As local communities achieve this, by re-designing their systems, some new services will be created and some old services will no longer be required. However, these decisions must be made in the context of local need and resources, and with the overall aim of improving the urgent and emergency care system.”

(Page 26)

http://www.nhs.uk/NHSEngland/keogh-review/Documents/UECR.Ph1Report.FV.pdf

In May 2013 The College of Emergency Medicine[13] report on their Quality in Emergency care Dashboard (QED) project recommended urgent action to redesign the system to manage workloads and decongest the Emergency Department.

http://secure.collemergencymed.ac.uk/Shop-Floor/Professional%20Standards/Quality%20in%20the%20Emergency%20Department/

In July 2013 the House of Commons Health Committee stated that:

“The bulk of the evidence we received made a strong case for centralisation of treatment for patients with certain conditions such as stroke care, cardiac care and major trauma. When implemented successfully, the creation of specialist centres enhances clinical skills and concentrates resources, with demonstrably improved outcomes for patients. Centralisation, however, is by no means a universal remedy for the ills of emergency care. Service redesign must account for local considerations and be evidence based. Some rural

[13] The College of Emergency Medicine is the professional body for Emergency Medicine clinicians.

areas would not realise the benefits from centralising services that London has, therefore the process must only proceed on the basis of firm evidence. The goal is to improve patient outcomes – centralisation should not become the end in itself." Page 6

http://www.publications.parliament.uk/pa/cm201314/cmselect/cmhealth/171/171.pdf

Benefits of community-facing general hospitals and integrated care

The NHS England[14] Urgent Care Review summarised the evidence for change to urgent care in June 2013 to support the completion of a survey to gather the views and feedback of the public and professionals.

In Sir Bruce Keogh's foreword he highlighted:

"The current concerns around A&E performance should be seen as a stimulus and opportunity to improve the way we offer care between our hospitals, primary and community care and social services. Better integration and communication between these services could reduce unnecessary attendances at A&E and enable people in hospital to return home sooner. This in turn could free up hospital beds so patients who need admission from A&E would not be kept waiting so long." Page 7

http://www.england.nhs.uk/wp-content/uploads/2013/06/urg-emerg-care-ev-bse.pdf

The end of Phase 1 report of the Urgent Care Review sets out the vision for urgent care:

"Our vision is simple:
Firstly, for those people with urgent care needs we should provide a highly responsive service that delivers care as close to home as possible, minimising disruption and inconvenience for patients and their families.

Secondly, for those people with more serious or life threatening emergency care needs, we should ensure they are treated in centres with the very best expertise and facilities in order to maximise the chances of survival and a good recovery."
(Page 22)

The review identifies proposes providing a highly responsive urgent care service outside of hospital so people no longer choose to queue in A&E. To do this the service needs to improve many services including:

- "Provide faster and consistent same day, every day access to primary care and community services for people with urgent care needs… We also need to ensure that GPs are better supported by hospital specialists so that they have access to a rapid, specialist clinical opinion, thus potentially avoiding the need to admit a patient in an emergency.
- Support the co-location of community-based urgent care services in coordinated Urgent Care Centres. … Urgent Care Centres may also be advantaged by co-location with hospital services, particularly in urban areas."
(Page 25)

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[14] NHS England is an arms length body whose main aim is to improve the health outcomes of the people of England.

http://www.nhs.uk/NHSEngland/keogh-review/Documents/UECR.Ph1Report.FV.pdf

In June 2013 the NHS Confederation[15], National Voices[16] and the Academy of Medical Royal Colleges[17] report Changing Care, Improving Quality identified that:

“Care pathways therefore need to be developed to establish a bigger role for services outside of the hospital, so they can deliver more care in the community and bridge gaps between care settings. … There is also an opportunity for hospitals to deliver more of their services directly in the community and have physicians working beyond the hospital walls with colleagues in primary and social care.” Page 10

http://www.aomrc.org.uk/about-us/news/item/patients-clinicians-and-managers-join-forces-to-call-for-nhs-change.html

In May 2013 The Department of Health published its commitment to integrated care. The case studies highlight how integrated care impacts on patients and their carers (Page 3 and 4).

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/198748/DEFINITIVE_FINAL_VERSION_Integrated_Care_and_Support_-_Our_Shared_Commitment_2013-05-13.pdf

In the 2012 Kings Fund[18] report, Transforming the delivery of health and social care: The case for fundamental change, stated that:

“Medical advances mean that those conditions that were previously impossible to treat are now amenable to medical intervention and that some diseases can be detected at an earlier stage. Technological advances have also enabled care to be provided in different settings, with more care being delivered on an outpatient or day-case basis and in general practice.” Page 13

http://www.kingsfund.org.uk/publications/transforming-delivery-health-and-social-care

[15] The NHS Confederation is the independent membership body for all organisations that commission and provide NHS services.
[16] National Voices is the national coalition of health and social care charities in England.
[17] The Academy of Medical Royal Colleges promotes, facilitates and co-ordinates the work of 20 Medical Royal Colleges and their faculties.
[18] The King's Fund is an independent charity working to improve health and health care in England.

Obstetric and maternity care

The Royal College of Obstetrics and Gynaecology (RCOG)[19] report High Quality Women's Health Care, published in 2011, included the following principles and values:

- care must be the right care, at the right time, in the right place and provided by the right person
- care should be provided closer to home (accepting this principle may require women to travel to access very specialist care)

Page 1

http://www.rcog.org.uk/high-quality-womens-health-care

Dr David Richmond, RCOG Vice President (Clinical Quality) said of the College's recent report, Patterns of Maternity Care in English NHS Hospitals:

"The initial set of indicators suggests wide variation in both practice and outcomes between maternity units which is a source of concern for the specialty as we cannot be sure that every woman is getting the best possible care.

"It highlights that specialist-delivered care must expand so that for women with complex obstetric needs – which may only become apparent during labour – care can be provided by trained clinicians 24 hours a day and 7 days a week."
http://www.rcog.org.uk/news/rcog-release-new-report-reveals-wide-variation-practice-and-outcomes-among-english-maternity-un

Patterns of Maternity Care in English NHS Hospitals
http://www.rcog.org.uk/our-profession/research-and-audit/clinical-indicators-project

The Women's Institute and National Childbirth Trust survey of women's experiences of childbirth published in 2013 found that:

"Only 12% of women had four choices of where to give birth." Page 9. The choices being at home, freestanding midwifery unit, alongside midwifery unit or an obstetric unit.

"very few women change their minds on location once they have made a decision. While medical complications may arise, these are not always behind the restriction of women's choices." Page 10

http://www.thewi.org.uk/campaigns/current-campaigns-and-initiatives/more-midwives/research-findings

In August 2013 the Cochrane collaboration published their review of Midwife-led continuity models versus other models of care for childbearing women. Their conclusion was:

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[19] The Royal College of Obstetrics and Gynaecology is the professional body for obstetricians and gynaecologists.

"Most women should be offered midwife-led continuity models of care and women should be encouraged to ask for this option although caution should be exercised in applying this advice to women with substantial medical or obstetric complications."

http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD004667.pub3/abstract

In September 2013 the National Perinatal Epidemiology Unit (NPEU)[20] published a birthplace study supporting expansion in choice of place of birth and promotion of midwifery led units (MLU) and home births as a safe option, especially for second time mothers.

http://www.rcog.org.uk/what-we-do/campaigning-and-opinions/statement/rcog-statement-results-npeu-birthplace-study

The NPEU study specifically found that there was no difference for babies and better outcomes for second time mothers if they delivered in a MLU or at home compared to an acute unit.

[20] The NPEU is a multi-disciplinary research unit which was established at the University of Oxford in 1978.

Paediatric services

In 2013 the Royal College of Paediatrics and Child Health (RCPCH)[21] published their report, Back to Facing the Future, included the recommendations:

- The College will work further to encourage units to provide better consultant (or equivalent) coverage when they are at their busiest. It is essential that paediatrics is a 24 hours a day, seven days a week specialty, and consequently the service should be organised around the child's needs.
- Urgent reconfiguration and new models of provision need to be explored…
- The RCPCH will continue to look at more innovative models of service provision, providing more care in the community, whilst centralising expertise.

http://www.rcpch.ac.uk/news/rcpch-publishes-new-report-children%E2%80%99s-health-services

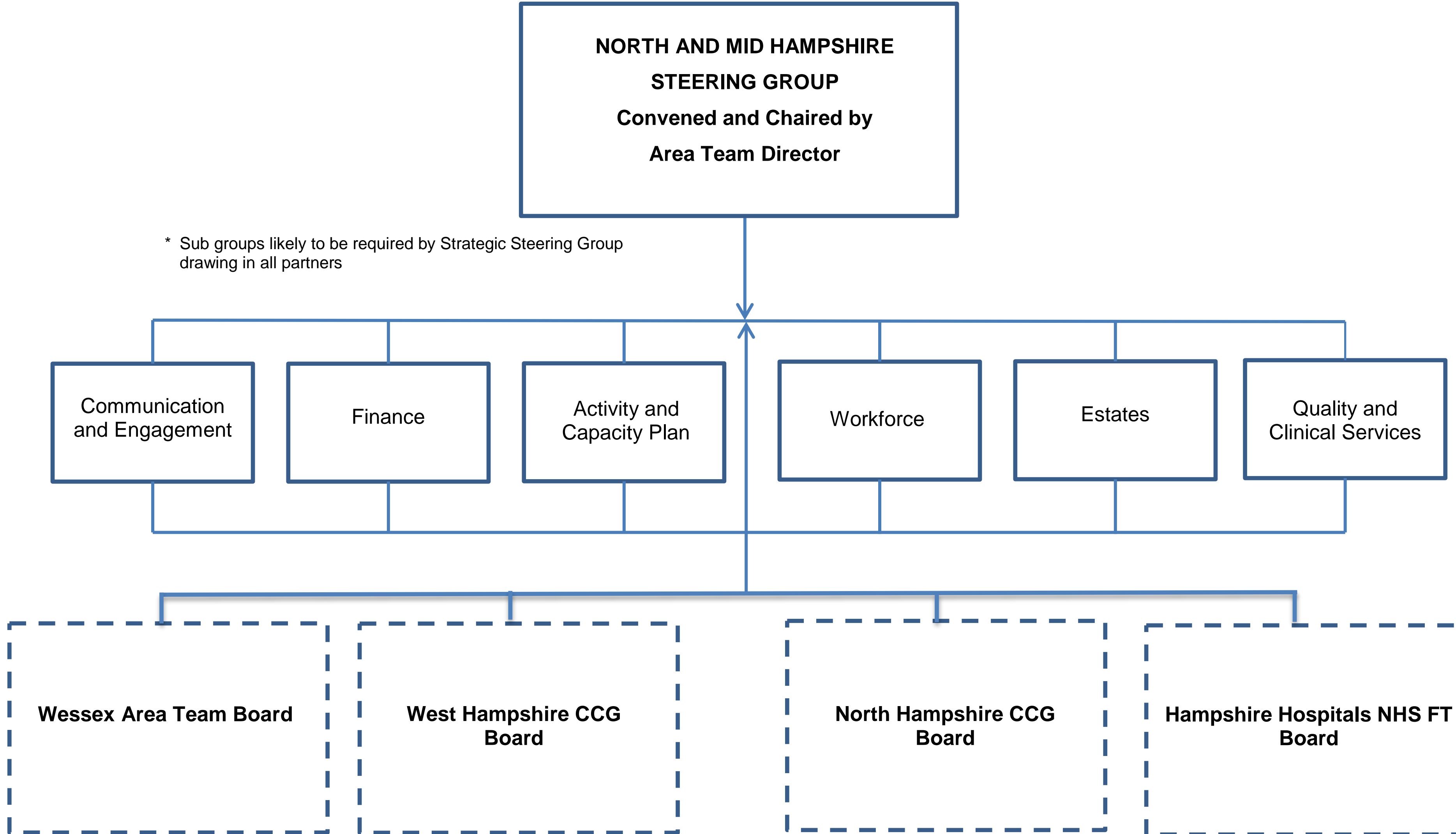
This followed their earlier 2012 survey report, Consultant Delivered Care: an evaluation of new ways of working in paediatrics. Key findings of the survey included:

- Of 53 people interviewed on the site visits, 79.2% believe consultant delivered care is a good service model, with better decision making, reduced admissions, good teaching and on the job training being mentioned in the responses.
- Senior nurses most frequently mentioned that this way of working led to better team working, better decision making and better communication

http://www.rcpch.ac.uk/cdc

[21] The Royal College of Paediatrics and Child Health is the professional body for paediatricians

ARRANGEMENTS FOR WORKING TOGETHER TO MANAGE HAMPSHIRE HOSPITALS SERVICE RECONFIGURATION PROGRAMME



APPENDIX 3

OPTIONS APPRAISAL

Introduction

Commissioners (WHCCG and NHCCG), Wessex Area Team and HHFT undertook an options appraisal to test a wide range of options to meet the challenges faced by much of the NHS in the future. This work built upon the work undertaken in 2011 to identify a clinical model for the soon to be created HHFT which was established in January 2012.

Assessment Criteria

The options appraisal identified a long list of 13 options which were assessed against four key criteria:

- Quality of care
- Access to care
- Deliverability of the solution
- Value for money

Long-listed Options and assessment

		Option	**Reason for short-listing or rejection**
1	Do nothing		***Rejected*** as not a good option against any of the criteria, but will be used for comparative purposes
2	Single site (900 bedded hospital) various options:		
2a		Greenfield – all on one new site	***Rejected*** as FT will not be able to raise adequate funding and there are disadvantages relating to access and loss of activity.
2b		Greenfield – retain only acute/complex services requiring hospital facilities (rest moves to alternative provider eg community)	***Rejected*** because access, loss of activity disadvantages similar to 2a while unlikely to significantly reduce capital costs and therefore FT will not be able to raise adequate funding
2c		Winchester	***Rejected*** due to site difficulties, would require high-rise development, inferior clinical adjacencies, emergency access difficult and FT will not be able to raise funding.
2d		Basingstoke	***Rejected*** because FT will not be able to raise funding and would cause

			access problems for population in south
2e		Andover	***Rejected*** due to site restrictions and emergency access difficult.
3	Two-site options:		
3a		Basingstoke hot	***Rejected*** as does not deliver clinical model or access objectives
3b		Winchester hot	***Rejected*** as does not deliver clinical model or access objectives
3c		Shared services across sites	***Rejected*** as too similar to 'do nothing' thus unlikely to deliver benefits and retains many of the current difficulties
4	CTH plus one general hospital options:		
4a		CTH Winchester + general hospital Basingstoke	***Rejected*** because of significant site development and emergency access difficulties for a large number of north and mid Hampshire residents
4b		CTH Basingstoke + general hospital Winchester	***Retained*** to explore 2 site option to ensure service for south of population and emergency access criteria
5	CTH greenfield site plus 2 general hospitals		***Retained*** because delivers clinical and efficiency criteria and most cost-effective to build
6	Large CTH + local hospitals (no inpatients, outpatient, day care, urgent care only)		***Rejected*** as inferior to option 5; does not deliver clinical criteria and reduces access to much of the population

Short-listed Options

Two options were therefore taken forward for further assessment and testing and will be included in the proposed public consultation exercise. These two are:

Option 4b: CTH Basingstoke + general hospital Winchester
Option 5: CTH (Greenfield) + 2 general hospitals Basingstoke and Winchester

APPENDIX 4

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

PLAN FOR PUBLIC CONSULTATION: DRAFT FOR DISCUSSION

1. INTRODUCTION

The purpose of this paper is to describe how we propose to consult through a public consultation. It is to be read in conjunction with the paper provided to the Health Overview and Scrutiny Committee (HOSC) which sets out the case for change and provides an update to the HOSC as part of the statutory duty set out in section 244 of the NHS Act 2006 superseded by regulation 13 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013, to consult with the Local Authority on proposals that may be a significant development and variation in health services.

2. GUIDANCE

It is important to ensure our consultation plans meet the requirements set nationally by the Cabinet Office in its 'Consultation principles' guidance and locally in the HOSC guidance 'Arrangements for Assessing Substantial Change in NHS provision.' Latest versions of both were published in October 2013 and April 2013 respectively.

It is notable that the local guidance sets out the four tests for service reconfiguration set out by the Chief Executive of NHS England and our plan for consultation is shaped by these:

- Support from GP commissioners
- A clear clinical evidence
- Robust patient and public engagement
- Support for current and prospective patient choice.

The guidance also touches on a number of principles, which are notable and inform our plans:

- Open policy making throughout the process
- Clear objectives for the consultation
- Aspects of the proposal that have already been finalised and not subject to change made clear
- Views genuinely taken into account

In addition, we are mindful of the guidance published by NHS England in December 2013 'Planning and delivering service changes for patients', describing good practice for commissioners on the development of proposals for major service changes and reconfigurations, in December 2013.

3. CONSULTATION OBJECTIVES

The objective for the consultation is to adhere in spirit and letter to the guidance to ensure as many people across Hampshire are aware of the consultation, are able to take part in it and are able to contribute in a meaningful way so that they may influence the way hospital services are developed. See our approach in section 7 for more information.

Scope of the consultation:

- To set out the options for how services could be organised
- To understand preferences and concerns for each of these options
- Listen to and reflect stakeholders' views and ensure these are considered by all four organisations along with the clinical and financial evidence.

4. ENSURING A ROBUST PROCESS

The consultation will be managed by West Hampshire CCG and North Hampshire CCG, working in partnership with Hampshire Hospitals NHS Foundation Trust. Our approach to conducting a consultation will be based on all the above stated guidance and principles.

We will appoint an external organisation experienced in delivering consultations to ensure we are following best practice in our approach to the consultation. The external agency will provide a robust methodology to ensure wide participation, will ensure independent analysis of the feedback and provide objective reporting on the findings. We would expect the external research agency to advise us on the most effective ways of engaging different audiences in this process. We have taken steps to appoint such an agency to support the consultation.

We will invite previous survey respondents, who said they wished to be involved in further research, to input their ideas on how best to consult with local people to help shape our approach.

We will make sure feedback received during the consultation is shared on an ongoing basis to enable us to respond to it and make changes to the consultation activity if needed and to inform any ongoing analysis.

To support as many people to take part in the consultation as possible we will:

- Be visible – we will raise awareness as widely as possible to ensure the consultation is visible so as many people as possible have the opportunity to take part. This will include a range of activity and will include the use of the local media, working in partnership with community groups to reach their networks and direct communication with stakeholders.

- Allow sufficient time for people to react and to respond – we will consult for the full twelve weeks to engage as many people as possible in a variety of meaningful ways and to give them time to reflect and respond.

- Be accessible – we will provide a range of ways to interact – so people can engage in a way that suits them – online, face to face, in writing (via letter and email) or by phone.

- Provide appropriate support to interact – for those who do not wish to write comments down we will have people on hand at exhibitions or people can telephone their feedback in. We will offer publications in large print, other formats and languages as requested.

- For those who would prefer to hear/see the rationale and context – there will be face to face opportunities which may include a mix of display stands, such as those held in shopping centres and leisure centres during the engagement phase, focus groups and public meetings. We will produce a short film to be available online.

- Provide appropriate context and questions in a language everyone understands – we are committed to plain English and jargon free language to enable as many people as possible to

actively engage with us. We will produce a short film available online via the website and You Tube as an alternative format.

- Reassure people so they are able to constructively contribute – we will be clear that change is required to maintain safety and improve the quality of care in services which require specialist staff and equipment. We will aim to reassure people that for planned surgery, midwife-led births, diagnostics, outpatients and urgent care, we intend to preserve the services provided by hospitals in Andover, Basingstoke and Winchester. In addition, we aim to provide as many services as possible locally, in the community.

- In addition to the advice and support from the external agency we will build on our learning from the engagement phase and will repeat the approaches that were particularly effective.

5. LEARNING FROM ENGAGEMENT PHASE

An engagement process was undertaken to listen to stakeholders and to gather feedback from local people about what matters to them about their hospital services. This took place over ten weeks in October, November and December 2013 and included a range of face-to-face events and activities supported by a survey to capture responses. During this time partners, including GPs, hospital doctors, nurses, and other hospital and NHS staff as well as the public and stakeholders such as patient voice groups, responded to say what is important to them when accessing hospital services.

In the period from 18 October-30 November there were 1,142 responses to the survey, of which 909 took the survey online and 131 completed it on paper. 84% of respondents were members of the public, 16% were HHFT staff. The majority of HHFT staff who responded to the survey chose to complete the public survey but 40 completed a staff survey. 61% of respondents provided details so they could be involved in further engagement activity and 67% wanted to be kept in touch. 15% of respondents to the staff survey said they would like to be involved in further research.

The engagement report findings will be made public. We will be learning from what worked well in the engagement phase and also where we can improve on it. Many elements of the engagement activity worked well. We also identified a number of areas that we can improve for the consultation process.

What worked well

There were a number of areas that worked well in encouraging public input and we will aim to replicate this in the public consultation, this included:

- Working in partnership

- Offering a wide range of ways for people to get involved and to respond to the consultation, to enable the widest number of people to respond including an online survey and working with interest groups and via social media

- Reaching people where they already are – whether that's in the GP surgery, in a hospital waiting room, at a local voluntary group meeting or in a shopping centre - rather than to offer just a series of one-off public events

- Working with HHFT governors to engage their networks

- We will stay engaged with all those respondents who requested to be kept informed or involved in further research.

Areas to improve

We also identified a number of areas we'd like to improve for the consultation process, these include:

- We will arrange displays at children's centres, as we only had a presence at one during the engagement programme due to scheduling.

- We will ensure we reach lower socio economic groups more effectively, although all demographics were reached through the hospital clinic population, and the shopping centres to some extent. We would wish this to be more focused for the consultation.

- We will ensure a greater reach within BME groups and among younger people and be more robust to ensure equality and diversity is considered.

- We will ensure that all parts of our geography including Alton, Andover, Basingstoke, Eastleigh, Romsey and Winchester are offered the same opportunities to respond and we will be alert to the need for some areas or audiences to have particular or additional activity. There were fewer public responses from those stating Winchester as their main hospital than Basingstoke overall, although we made every effort to make sure there were equal opportunities to be involved across our area.

- We will increase visibility for the consultation within GP surgeries

- We will respond to specific feedback received from the Maternity Services Liaison Committee to use QR codes more extensively on the public consultation materials.

6. AUDIENCES

During the engagement phase we were able to identify the audiences we were less able to reach. We intend to focus additional activities to better reach these audiences during the public consultation. We will be working with the external research agency to support us in reaching these groups. We will be particularly keen to ensure representation from those in lower socio-economic groups and BME groups.

We are committed to ensuring that the consultation is accessible to all including the elderly, those with a disability or language barrier. We will ensure there are multiple ways for patients and the public to feedback, recognising that a mix of mechanisms accommodates different needs. The table below sets out the audiences we seek to reach:

Audience	How we reached audiences during the engagement phase	Additional focus for consultation –phase
Patients	Staffed display stands with questionnaires were made available to hospital patients in Andover, Basingstoke and Winchester hospitals in outpatients and clinics including cardiac patients, stroke patients, ante-post natal clinics. emergency department, orthopaedics Staffed display stands at parent education classes. In addition, posters promoting the engagement were displayed in the hospitals and in GP surgeries.	More visibility in children's centres throughout our area, mobilising children's charity networks
Patient interest groups	The engagement was promoted to: GP patient group forums GP practices Patient Voice Forum Maternity Services Liaison Committee	Greater visibility among GP patient groups Further liaision with Maternity user groups
HHFT members and Governors	12,500 public members and 6,000 staff members via FT Newsletter direct email Governors' networks and groups – notably over 55's groups and GP patient groups Series of public and member roadshows held in Alton, Andover, Basingstoke, Eastleigh, Winchester	We seek HHFT Governors further support to actively engage their networks and groups and to feedback that engagement
The public	Public visibility in Alton, Andover, Basingstoke, Eastleigh, Winchester with staffed display stands at shopping and leisure centres and at above mentioned public meetings in these locations (advertised in local press) HHFT and CCG website promoted the engagement; promoted via MSLC facebook Tweeting (retweeted by others) Engagement promoted to CVSs	More active involvement of local voluntary community and church group networks and local branches of national charities including children's charities, voluntary forums, elder care charities, Local Authority Citizen's Panels Social media Parish councils Involving those who agreed to be involved in further research
Harder to reach groups / lower socio economic groups	Displays in public places and hospital clinics	Through partnership with CVS and directly with housing associations and food banks and other charity/voluntary

		organisations, GPs and staffed displays in public places
BME groups	Displays in shopping centres and clinics, members and patient groups	Local community and religious networks and groups
Young people	Via University of Winchester website	Engage with local colleges FE/HE, youth groups and forums
NHS staff	Staff were engaged through the all-staff briefings and departmental meetings. Hospital clinicians and GPs at Medical Professional Meetings	More direct opportunities for staff to be engaged face to face
GPs	Medical Professional Meetings and through CCG member networks	Further engagement with GPs
Healthcare providers	South Central Ambulance Service, University Hospital Southampton, Southern Health, Solent, HCC Adult Services through senior level briefings	Healthcare provider partners stakeholder briefings
Healthwatch	Attended public meetings	Inform and involve further
Local authorities	Briefings with Hampshire County Council, Winchester City Council, Basingstoke & Deane Borough Council, Test Valley Borough Council and Eastleigh Borough Council	Regular briefings and updates
Health and Wellbeing Board	Update presentation	Regular updates
MPs	All local MPs by letter and additionally where requested face to face briefings	Further regular briefing and updates
Media	Briefings and proactive release around public meetings – using media to promote online survey	Media updates

7. MATERIALS AND CHANNELS OF COMMUNICATION

We will develop a suite of products to help as many people as possible engage with the consultation. This is likely to include a mix of:

- Public consultation document – hard copy and online (including public FAQs)
- Public consultation summary leaflet (short) – hard copy and online (including public FAQs)
- Exhibition panels – for public events and online (based on short consultation document)
- Feedback form/survey – hard copy, online
- Context and rationale short film

We will also produce a range of products to encourage people to engage including:

- Posters (community and NHS settings)
- Press adverts or supplement and articles (in community magazines - parish, stakeholders, voluntary groups)

- Websites (CCGs, HHFT and other community partners) and Social media (interest group facebooks and twitter) wide use of QR codes

8. TIMELINE

The overall timeline is set out in the paper to the Health Overview of and Scrutiny Committee for which this paper is an appendix. An engagement and consultation timeline will be finalised once comments are received from HOSC.

It should be noted that there will be a number of production deadlines to enable commencement of the consultation on these dates which will include approvals from the three organisations (HHFT/WHCCG/ NHCC). The external research agency will be expected to develop a detailed project plan on the elements of the plan it is responsible for to ensure milestones are achieved.

9. NEXT STEPS

- Seek comment on and support for this consultation plan
- Identify responsibilities for delivery and seek confirmation of timescales
- Brief external research agency
- Develop a detailed action plan in conjunction with the appointed external research agency including responsibilities and timescales.