

HAMPSHIRE COUNTY COUNCIL

Report

Committee:	Health Overview and Scrutiny Committee
Date of meeting:	27 September 2011
Report Title:	Inquiries Received and Action Taken
Report From:	Chief Executive

Contact name: Denise Holden

Tel: Ext 7338

E-mail denise.holden@hants.gov.uk

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
Basingstoke & North Hampshire NHS FT	HOSC Chairman	The CX will attend to provide members with an update on progress with the acquisition of WEHT and the emerging model of clinical care.	
<p>Recommendation: Members confirm any additional information required and the timing of a further up-date on progress.</p>			
Notice to withdraw Inpatient beds at Odiham Cottage Hospital.	NHS Hampshire	An update on progress with the development of the 'hybrid' model of care and supporting business case from Calleva CCG is attached at Appendix One, page 7	
<p>Recommendations:</p> <ol style="list-style-type: none"> 1. Members confirm if they support progress to date and next steps outlined 2. Calleva attends the HOSC on 29 November as outlined in the report. 			
Hythe Community Hospital	HOSC Chairman and elected members	The update from NHSH on progress with identifying the model of care for providing services in the Hythe area is attached at Appendix Two page 15. This includes confirmation of the inpatient provision for the area and proposals for agreeing services to be provided from Hythe Community Hospital in the future.	Cllr Dash is the link local member for this work.

Topic/inquiry	Source	Action Taken	Comment
<p>Recommendation: Members confirm if they are satisfied with the model of care presented, including the planned provision of inpatient care in the Hythe area.</p>			
<p>'Any Qualified Provider' pilot</p>	<p>NHSH</p>	<p>The DoH has launched an initiative to trial the introduction of 'any qualified provider' of health services to local people. This will commence with a range of community services and be rolled out to other health services over the next 18 months.</p> <p>Details of the proposed pilot are attached at Appendix Three page 22.</p>	
<p>Recommendations: Members confirm any area that they feel would benefit from participating in this initiative.</p>			
<p>Drug therapy for macular degeneration</p>	<p>NHSH</p>	<p>NHSH has identified an alternative drug therapy for treatment of this condition that is equally effective but less expensive than the current branded drug.</p> <p>The evidence supporting the adoption of this policy and the anticipated benefit to the local health economy is attached at Appendix Four Page 24</p>	<p>This will be a clinical decision based on patients needs.</p>
<p>Recommendation: Members note the proposed action.</p>			

Topic/inquiry	Source	Action Taken	Comment
NHS Hampshire Hampshire Adult Services-continuing care services	HOSC Chairman	<p>Further to the discussion at the last HOSC a seminar has been arranged for 7 November to scrutinise fast track referrals to NHS continuing care in more detail.</p> <p>The Chairman has been in receipt of correspondence from clinicians within Hampshire highlighting concerns about access to the services</p>	Members previously flagged the need for more joint working and ease of access to fast track referrals as areas to be addressed.
Recommendation: NHSH provides any further information requested by Members			
Changes to local GP services	HOSC Chairman	NHSH has identified a number of minor service variations planned by GPs across Hampshire. Initial advice to NHSH has been that the relevant local Member should be the key point of engagement in relation to these matters. If there are issues that cannot be resolved locally then additional advice may be sought from the HOSC.	This formalises the process already in place (e.g. in relation with Locks Road surgery relocation)
Recommendation: Members note the information provided			

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: Odiham Cottage Hospital update

Progress Report to Hampshire Health Overview and Scrutiny Committee from Calleva Clinical Commissioning Group and Hampshire County Council Adult Services (Basingstoke) on the Local Development Plan for Hart and Odiham to Implement the Hybrid Model

1 Introduction

1.1 The last year has seen extensive engagement with local people on how best to meet their local health needs in the context of the future use of Odiham Cottage Hospital following notice from Southern Health NHS Foundation Trust to close the inpatient beds located there on the grounds of patient safety.

1.2 Initially five potential models of care for providing services from the Cottage Hospital were identified and discussed with local stakeholders. These were:

- Option 1 – In patient bed based model with 24/7 nursing and rehabilitation
- Option 2 – Reablement services
- Option 3 – Home based care from Community Matrons/Virtual wards etc
- Option 4 – Integrated care with social care/voluntary sector
- Option 5 – Outpatient/ clinic based care

1.3 Discussions at the Hart Locality Stakeholder Group meetings on the 15th April and the 18th April the idea for of a “hybrid” model of care was explored, drawing on elements of each of the five of the options outlined above.

1.4 It was also suggested that it would aid in the continuance and further development of the services to the Odiham and Hart area and at Odiham Cottage Hospital (OCH), if admission to certain aspects of the hybrid service could be offered to the total Calleva Clinical Commissioning Group (CCG) catchment area. Likewise patients from the area could access care if required in other areas of Calleva.

1.5 OCH has been temporally de-commissioned while the review and development of the Hybrid Model takes place.

1.6 At the Hampshire Health Overview and Scrutiny Committee (HOSC) meeting on the 25 May 2011 the committee confirmed its support for further work to be undertaken to develop the hybrid model of care and present that, with a supporting business case to the Committee’s meeting on 27 September 2011. The Calleva CCG undertook to take this work forward working with the local community. Local stakeholders present at this meeting strongly supported this approach.

1.7 The thinking involved in the development of the Hybrid Model has given the opportunity for Calleva CCG and Hampshire County Council Adult Services (HCC AS) to review the wider model for care of patients in the community, particularly those with a long term condition (LTC) and older people. The following paper describes the progress that has been made in developing a ‘hybrid model’ for Hart and Odiham taking account of the wider thinking in developing services in Calleva.

1.8 It is acknowledged that this report represents 'work in progress' rather than a specific model of care. Further work needs to be done to define this for the community and agree the business case supporting this proposal. It is anticipated that more developed proposals for providing services to this population will be agreed by the end of October, at which point the Calleva CCG will invite the views of the HOSC on any additional action required. At this point in time it is hoped that some services will be provided from the OCH site from November.

1.9 The HOSC is therefore asked to note:

1. The suggested next steps in developing the 'hybrid' model of care outlined above and associated timeframes
2. The support of the local community- including the local stakeholder group- for the continuation of this approach to agreeing the right model of care for this community
3. The significant amount of progress that has already been made in agreeing a solid foundation for this work.

2 Strategic Context

2.1 Calleva CCG and HCCAS have agreed the initial vision statement below, which will be expanded into joint strategic commissioning intentions and a service model to be agreed and implemented via local joint commissioning arrangements which have been confirmed and will be set up over the coming months.

2.2 The joint Calleva CCG and HCCAS vision is that Basingstoke and its surrounding area is a place where older people and those with Long Term Conditions live healthy fulfilled lives. When they are unwell or need support they are able to access the services they need as locally as possible in a timely way. Treatment and care is provided seamlessly. Services reflect current and future need and those providing care work with communities and individuals to empower and enable older people and those with Long Term Conditions to maintain personal responsibility for their health and wellbeing.

3 Initial Service Development

3.1 The initial service development to achieve these aims and produce an integrated service is the proposal to develop Integrated Care Teams (ICTs) for Older People and those with Long Term Conditions in Calleva CCG. It will also secure the ability to develop the appropriate combination of the five options making up the hybrid model. This will be a partnership between Calleva CCG, HCC Adult Services and their provider organisations. The ICTs will build on the substantial progress made by all providers of care to this client group which have included the Virtual Ward (community nurses working closely with a targeted group of patients with long term health needs), Rapid Response service (a specialist team of nurses providing urgent care to patients in the community) , multi-disciplinary discharge team (staff from the community, social services, and the hospital aiding patient discharge from hospital) based at Basingstoke and North Hampshire Hospital Foundation Trust (BHNFT and the development of reablement beds(short term beds in local nursing homes for patients discharged from BHNFT to give them additional rehabilitation and time to plan their long term care).

3.2 There is however a need to make these services available in a more coordinated manner and for the key services of primary care, community nursing and social care to be harmonized at the level of natural communities. There is also a requirement for the assessment of need for these areas to be more fully understood with the resulting

information informing the commissioning of services. This will take the form of a local development plan for each ICT area. The ICTs will also assist the gaining of the targets agreed with Calleva in the 2011/12 Quality Innovation & Productivity Plan which includes the end of life initiative designed to secure improved quality of care for patients at this stage of their illness. Account will be taken of the revision of front door services (Emergency Department, Primary Care Centre and Out of Hours Primary Care) at BHNFT and a Single Point of Access for all referrals into the ICT.

3.4 Particular emphasis will be placed on the further development of re-ablement, focus on domiciliary support and carer support by specialist therapies and night care/sitting. There is also a need to integrate the developing outreaching specialist clinician teams supported by Consultant medical staff from BHNFT for example for patients with respiratory problems and ensuring the effective use of community beds.

3.5 The ICTs teams will cover with slight realignment to account for the additional GP surgeries joining the Calleva CCG the present virtual wards (this term will be replaced by ICT) areas; this will entail the development of six teams in the following locations:

1. Oak Team Hackwood
2. Elm Team Gillies
3. Yew Team Holmwood
4. Ash Team Overton
5. Rowan Team Alton
6. Maples Team West Hart

3.6 Each team will be led by a tripartite of a lead GP (the medical responsibility will remain with the individual patient's GP), Social Worker and Community Matron who are being appointed. They will ensure care for the identified client group from the local practices and social care referrals are following assessment managed via a combined support plan and health care plan. This will be achieved by using resources from the local team and by accessing service from a menu of care provided by a range of providers to include specialist teams for particular conditions and ensure the key elements of the options of the hybrid model are made available to the local community.

4 Hart and Odiham Integrated Care Teams and Its Local Development Plan to Implement the Hybrid Model

4.1 Good progress has been made with the joint agreement between Calleva CCG and HHCAS to achieve an integrated service by the development of an Integrated Care Team for the Hart & Odiham area. In addition to the three professional leads the team will consist of a range of community nurses, professions allied to medicine (e.g. occupational therapy in both health and social care), social care staff and closer working with GP practice based staff. It is also hoped to align some mental health staff from Older People's Mental Health (OPMH)) to each team and Macmillan Nurses (for palliative care).

4.2 The potential use of Odiham Cottage Hospital will be part of the local development plan undertaken by the ICT and will be progressed collaboratively with the local GPs, the local stakeholder group and the OCH trustees and volunteers. There are a number of emerging ideas for the use of OCH which include it providing a base for some ICT members, outpatient clinics and day treatments. The need for community beds has been discussed and the arrangements for these for local patients will be part of the LDP, however due to the required clinical arrangements, potential value for money

and the growing list of ideas for the use of OCH during the day and in the evenings these are most likely to be provided on another site.

4.3 Calleva is undertaking a wider bed review across its catchment area with HCCAS which will inform the final decision. This is being led by senior managers from HCCAS, Southern Health and Calleva with the assistance of a nominated GP from Calleva who is already involved in the development of Alton Hospital. The concerns raised in the running of Odiham Cottage Hospital before its temporary closure will also be taken into account.

4.4 The initial plan is to get the ICT up and running by the end of September and to start to confirm the range of services to be offered including the use of OCH shortly after this, with an agreed implementation plan with all the major stakeholders by the end of October. It is hoped that some initial services can be provided at OCH by the beginning of November where no adjustment is required to the building, with others beginning in the new year following minor building alterations.

5 Progress to Date

5.1 The initial implementation of the 'hybrid model' via a Local Development Plan and supporting business case is being progressed by all the key stakeholders and providers of service. This has proved to be a complex task and by ensuring appropriate consultation and involvement of all parties to be taking longer than first expected. However there is now beginning to be a shared view of the services that will be required and how and by whom they may be provided. Progress to date is described below for each of the major stakeholders following discussions with them.

5.2 Odiham Cottage Hospital Trustees

The Trustees have two main responsibilities; firstly to deliver the Trust's main charitable object "the relief of sickness", and secondly to protect the community's interest and investment in OCH facilities and services. The Trustees must review any changes to hospital based services to ensure that they meet these responsibilities.

Whilst saddened by Hampshire PCT's decision to close of the hospital beds, the Trustees recognise that the hospital has a role to play in the future delivery of local healthcare services and are keen to work with accredited providers in the delivery of those services. To this end, the Trustees are able to draw on tremendous community support, through volunteer hours and financial generosity.

The Trustees propose that initially they will work with three preferred partners, although others may be considered in the future:-

- Calleva/HCCAD – the hospital may be used as a base for the "Maples Intermediate Care Team" and as a location for specialist clinics and day hospital activities
 - St Michael's Hospice – a range of palliative services could be offered which recognises the importance the community placed on end of life care at OCH
 - Odiham Consolidated Charities – the local almshouses who have identified the need for social/respite care day club services for the physically and mentally frail
- The hospital has, for many years through its long history, provided care to the frail elderly and people with long term medical conditions. These proposals would enable this work to continue and mean that the hospital is reaching a much greater number of community members than ever before.

5.3 Calleva CCG

One of the first actions the ICT will need to undertake is the identification of Client/ Patients with Long Term Conditions frail elderly and those at the end of life more explicitly within their catchment area in order to provide improved co-ordinated care to them. Calleva and Southern Heath NHS Foundation Trust have started to use an anticipatory pathway document which gives a snap shot of each patient being cared for with these complex needs. This will form the basis for a review by the newly formed and jointly lead ICT to assess their workload and confirm and develop services to meet these patient's needs. It is expected that a review meeting of these patients will be undertaken at each GP surgery attended by relevant members of the team. This process is being developed using good practice from the UK and abroad and is being led by a GP from Calleva who has volunteered to coordinate this initiative. Social Care, mental health and palliative care services will also input their own data into the process and shared (subject to individual patients/ client's consent) across the ICT.

Calleva CCG has designated a lead GP to each ICT and for the Hart & Odiham area this will be Dr Fernando. Calleva with its partners expects members of the ICT to be based at or hot desk at OCH. Calleva will also be ensuring that a specification for the ICT and the resulting health services will be developed and placed in the appropriate provider contracts next financial year.

Calleva is working with its providers to develop services at OCH and within the community but is particularly interested in developing outreach service from BNHFT for all LTC and older people. Initial discussions have already been held with BNHFT medical director and the Calleva Board as to how this may occur and agreement in principle has been reached. The development of services at OCH will be in the forefront of these developments.

5.4 Southern Health NHS Foundation Trust

Southern Health has been working closely with the Calleva CCG to develop the 'hybrid model' and confirm the following developments. Its community nurses have now extended their working hours so there is no longer a gap in care between 6pm – 7pm. This has allowed them to care for more patients and to keep them out of hospital where appropriate. Odiham practices can refer directly into Fleet Community Hospital and can also access Alton Community Hospital as a step down facility in which patients from BNHFT are discharged there for additional rehabilitation before they are sent home.

Southern Health NHS Foundation Trust have suggested the following ideas for discussion for the use of OCH, many based on similar service provided elsewhere where the protocols and procedures are already in place.

- Tissue Viability Clinic
- Continence Assessment Service
- Specialist clinics for LTCs , i.e. Parkinson's, Multiple Sclerosis and Chronic Obstructive Pulmonary Disease /Respiratory
- Falls/Balant assessment
- I.V.'s Therapy's (such as blood transfusions/hydration)
- Patient Education Group

- Phlebotomy Service
- Flu Vaccination Clinics
- Bereavement Support
- Diabetic education/annual review
- Mental Health outreach clinics, groups and treatment for older people and younger adults particularly those suffering from depression (as this is a high priority area for Calleva CCG)

5.5 Hampshire County Council Adult Services (HCCAS)

HCC AS has discussed with operational managers in the area relevant to Calleva the allocation of named social workers to the Integrated Care Teams. Two from the six Integrated Care Teams have been agreed for testing the model before roll-out to the other four. The two selected are the Maples Team in West Hart (covering Odiham) and the Ash Team (Overton). This process will help all stakeholders to understand how social and health resources care can be more successfully integrated.

It is expected that an apportionment of social work time will be allocated to each Integrated Care Team. The named social worker will attend the multi-disciplinary meetings, facilitate access to Adult Services (for example improving support to carers) and, the wider resources within Hampshire County Council (for example Children's Services, Trading Standards). The social worker will also assist – with their Integrated Team colleagues) in the development of new ways of working, new services and the improved use of available resources. In other words they will have a role to challenge existing practices in better shaping them to meet local needs.

Whilst the nucleus of each Integrated Care Team is the same it is anticipated that each Integrated Care Team will seek to build on these foundations to reflect differing local needs and the aspirations/resources available in each of the 6 areas. One example already exists within the Maples Team covering West Hart as Adult Services has established an Occupational Therapy Clinic for local people.

The opportunity to build on available 'social capital' – local community resources - and further co-ordinate both local and public sector resources is not lost within this model. Indeed, the success of the venture in part will be determined by how well local community resources are developed and built upon to help prevent the need for more costly services and provide an overall and better targeted response between what is already in the community. The West Hart area serving the community around Odiham of course could be an excellent example of just such a model.

Adult Services colleagues from the Performance Unit and Finance Department are supporting this work to ensure an appropriate set of shared performance measures can be developed to monitor progress and understand what changes are taking place as a result of this initiative. For example there is an expectation that emergency admissions to acute hospitals can be reduced along with an improved ability to help people remain independent – and at home – for longer.

5.6 St Michael's Hospice

St Michael's Hospice is extremely keen to work in partnership with OCH and has discussed with OCH how it could develop palliative and end of life services within the Oldham area using the hospital as an outreach base for the hospice.

Initially the placement of bereavement counselling and complimentary therapy sessions would appear to be feasible.

Following which, over a period of time it may be possible to develop joint physiotherapy/occupational therapy clinics and place some social day care provision in the hospital.

Ultimately patient support groups and living well programmes could also be developed.

5.7 Odiham Consolidated Charities

OCC is a long established charity that runs a number of almshouses based in and around Odiham and seeks to “relieve need in the Parish”. It also makes donations to the three local schools in the form of library grants.

OCHCT and OCC have a close relationship, not only through their geographical proximity but by virtue of OCH offering medical care to a number of almshouse residents.

Through discussions between the two boards of Trustees it has become clear that there is a need for local day club services which can offer social contact to the isolated elderly and respite care for those with substantial needs. OCC/OCHCT have approached a local provider of day club services who are interested in locating services to OCH.

5.8 The above are very much ideas in their early stages and subject to change and development, but it is hoped that some activities can begin in November where the present building would not need to be changed but other activities may need some building modification to facilitate their use. Other organisations maybe involved in the future but it is felt that the priority is to successfully set up with OCH Trustees three preferred partners in the first instance. Who will now work with the OCH Trustees to confirm their usage of the building and how they will operate from it to inform the implementation plan.

6 Stakeholder Engagement

6.1 A stakeholder meeting was held on the 17th August at which an early draft of this paper was discussed. There was general agreement with the ideas suggested in the local development plan (LDP) and agreement to continue with an active stakeholder process to support its development. There was however some concern as to the need for a more definite timescale for its implementation. An agreement was reached for the stakeholder group to meet at the end of October to review progress, provide input into and sign off an explicit implementation plan.

6.2 There is also a wish for the vibrant and loyal community of local volunteers to continue to assist in the running and fund raising for local health and social care services.

7 Financial Model

7.1 The Hart and Odiham Local Development Plan will require a detailed financial plan with the aim of beginning to understand what resources are being spent locally and

in the future for these to be influenced by local input from all major stakeholders. The identification of the number of patients needing case management by the team will be the first step in understanding the service requirements and how these are at present matched by local services and their costs.

7.2 The revenue for the plan will come from two main sources, that which is already spent in the area through primary care GMS monies, community services contracted from Southern Health, and money spent directly and indirectly by Adult Social Services. The majority of these services will remain the same but be better coordinated, targeted and managed and therefore become more effective. Hopefully this process will allow for some expansion in service.

7.3 The second source of the revenue will be will be the present revenue allocation used to run OCH in its former state and will aid the implementation of the new services taking place at OCH and outreaching from it.

7.4 In the medium to longer term it is expected that money spend on unnecessary acute hospital care will become available for the further development of local community services.

7.5 It is hoped that support will continue to be given as seen appropriate by OCH Trustees and the local League of Friends for capital investment and short term revenue into the local services.

8 Conclusion

8.1 It hoped that the information contained in this report demonstrates that considerable progress has been made in developing the 'hybrid model. of service for the Hart and Odiham community and for the use of Odiham Cottage Hospital in its implementation, with the collaboration and full engagement of all parties involved.

8.2 The Committee is requested to confirm its support for the approach outlined and the production of a full implementation plan by the end of October with any required business case accompanying this. The Calleva CCG will attend the HOSC in November to confirm progress to date and agree next steps. The expectation is that some services will be provided from the Odiham Cottage Hospital site in November.

Calleva CCG 16/09/11
Philip Burgess
Unscheduled Care Programme Manager

Appendix Two: Hythe Hospital update



Hythe Hospital Update September 2011

1. Purpose

The purpose of this paper is to update the committee on progress to:

- 1) develop sustainable inpatient beds in the Hythe area
- 2) develop plans for the future of services at the Hythe Hospital/Health centre site

Developing sustainable inpatient beds

2. Background

Feedback from our ongoing engagement with local people has shown us that:

- local bed-based care is wanted
- the right level of medical and nursing support is the main concern
- support to get home quickly is important
- the distance to travel to the bed-based care is also important

These matters were discussed with our stakeholder group, alongside a discussion with the Demand and Capacity Director from Hampshire County Council, to determine if local representatives felt the reablement model of care would deliver these needs for local people.

It was felt by the group that this form of bed-based care would be appropriate and the search for suitable beds in the Hythe area should commence. This search is underway and is being led by the team at Hampshire County Council. These searches focus on quality, safety and the right level of nursing support to meet the needs of the local population.

To support this a tour of other reablement facilities is being arranged for Cllr Brian Dash and a Hythe Hospital League of Friends member to allow them to experience and review the type of care this service will provide for local people.

3. Specification summary

This Nursing Home Community Bed Service is being commissioned to provide an opportunity for eligible patients to be taken into an intermediate nursing care

environment as “Step-Down” or “Re-ablement” - as a precursor to returning to the patient’s normal place of residence following discharge from an acute care facility.

This will be achieved by the procurement of care beds in one or more Nursing Homes within the Hythe area. It will provide eligible patients with the opportunity of a period of recovery and/or re-ablement with the aim of maximising the individual’s potential to return to their own home at the earliest opportunity.

Key objectives of this service are:

- To help avoid unnecessary acute care admission by providing timely intermediate care for patients in a nursing home setting
- To help facilitate timely discharge from hospital via effective early discharge planning arrangements
- To prevent health complications associated with immobility, disability or existing illness
- To participate in the rehabilitation of patients following surgery, disability, accident or illness event
- To deliver an evidence-based approach to all clinical activity and ensure all care provided to patients is safe and effective
- To liaise with rehabilitation teams, social services, voluntary agencies, acute trusts and other professionals and agencies to ensure seamless care to patients
- To work in partnership with GPs and other practice team members to provide safe and effective treatments for patients in an integrated and seamless way
- To provide accurate high quality information to patients, family members and carers in a culturally sensitive manner
- To maintain the dignity and privacy of patients at all times

All providers involved in this service will be knowledgeable in the management of patients with complex medical needs and the importance and implementation of care management plans for those with long-term chronic disease.

It will be open to admission of patients over the age of 60 requiring intermediate care support, as assessed according to the eligibility criteria below:

1. Be assessed as having potential to benefit from active Reablement, advice and support but do not have ongoing medical needs (Medically Stable) at the point of transfer.
2. Have experienced a major change of circumstances in their lives which prevents them from functioning independently in their own home (major change is inclusive of loss of confidence, social and emotional - of the individual and/or their family members.)
3. Have received the necessary acute treatment and have been assessed as medically stable and does not require ongoing intensive rehabilitation.
4. Have potential to benefit from a period of specialist Reablement in a residential setting.

4. Benefits

Hampshire County Council has found that 65-70% patients returned to their usual residence after a six-week period of reablement following an acute hospital episode, rather than accessing long-term nursing home or residential care.

Benefits include:

- Reduce hospital length of stay
- Reduce the rate of hospital readmission
- Prevent many patients from making long-term decisions from a hospital bed
- Give the patient a longer period of time to recover before returning home
- It helps the patient to gain confidence in participating with normal day to day activity.
- Gives the patient opportunity to recover in a more familiar environment than a hospital bed and therefore helps motivate them
- The patient is still under review and has access to a multi disciplinary team, for example: Occupational Therapists, Social Work Team, Nursing care and CRT Domiciliary care. This team are in place to help the client achieve the goals set at the beginning of their Reablement period, whether these are physical or emotional.

5. Beds secured

Alongside the ten beds at Forest Court Nursing Home in Calmore, Hampshire County Council has sourced six beds at Little Haven Nursing Home in Hythe and is looking to secure these over the next month, with a view to them being available from October 2011. Funding has been agreed and secured for all six beds.

This nursing home is located less than one mile from the Hythe Hospital site and can provide nursed care with support from community teams. A further meeting is taking place with the nursing home on September 20 to discuss details. An update will be provided at the meeting on September 27.

Conversations with Westcliff Hall Nursing Home have also taken place and these will be continued if for any reason Little Haven are unable to deliver all six beds.

6. Decision required

We ask the Overview and Scrutiny Committee to support the replacement of the beds within Hythe Hospital with six reablement beds in the Hythe area and ten at Forest Court. The beds at Hythe Hospital would therefore formally close as they will have been replaced with the new service.

Developing plans for the future of the Hythe site

The purpose of this section is to set out the high level strategy for the development of the Hythe site to facilitate the provision of improved local clinical and community health services.

7. Local demand for services at Hythe Hospital

NHS Hampshire, local practice based commissioning (PBC) and the emerging Clinical Commissioning Group (CCG) have undertaken a review for the future health needs of the local population in order to identify commissioning intentions.

An NHS report “Working together to build a bright future for Hythe Hospital” shared with the HOSC in November 2010, demonstrated local commitment to keeping Hythe Hospital open and ensuring the services it provides are sustainable, alongside detail of Local PBC GP leads created common vision with Hampshire County Council to:

- Promote health, wellbeing and independence.
- Avoid unnecessary hospital admissions.
- Prevent longer than necessary stays in hospitals.

This information alongside the public health needs assessment for the area is being used to determine what accommodation is required to deliver all of the health needs for the local population.

8. Hythe Health Site

Hythe Community Hospital and Hythe Health Centre are located in Beaulieu Road, Southampton and consist of an old building (the Hospital) and an attached, more modern flat roofed building (the Health Centre).

The estate at Hythe Hospital consists of the original war memorial building and adjoining extensions over various levels of the site. It is relatively accessible by car or bus and although near local shops, it is not part of the main shopping area of Hythe. There is a considerable backlog of maintenance although patient areas provide safe and clinically functional environment for delivering health services.

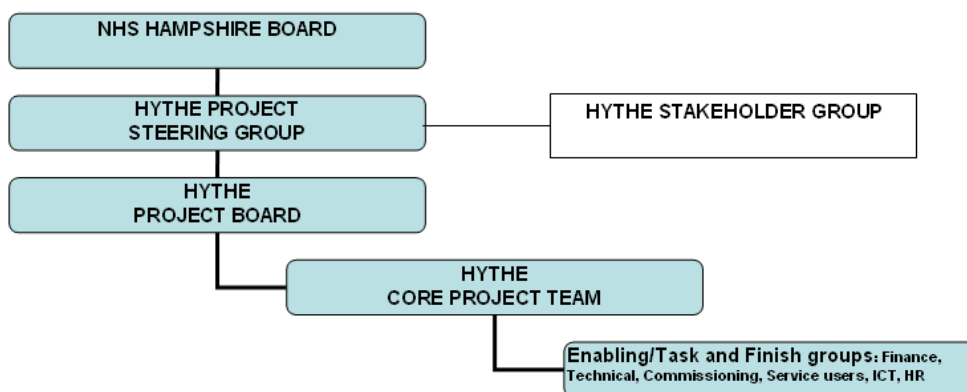
The Health Centre houses ambulatory healthcare services such as dental, podiatry, contraception and sexual health, ante natal services and the Solent branch of the Waterfront GP surgery.

The first floor of the Hospital is mainly meeting rooms, storage and office accommodation for community teams from Southern Health NHS Foundation Trust, Hampshire County Council and Southampton University Hospitals Trust (Maternity).

The site is 1.581 hectares. Of this, some 3500 m² is taken up by the health facilities and the remainder of the site is grassed/ woodland with some undulation. There are 40 marked car parking spaces including five disabled driver spaces.

9. Site Development

NHS Hampshire has assembled a project team to review the existing and future model of care against health facility needs in the Hythe location. This group is tasked to generate options for the continued delivery of services in line with commissioning intentions. This structure includes local representation linked to the Hythe Hospital stakeholder group, as below:



The need for a new estate solution for Hythe is outlined in the HPCT Estate Strategy (2008/09, 2009/10, 2010/11).

The project will produce a Strategic Outline Case (SOC) which, if approved would lead to the production of a Business Case Stage 1 and Stage 2. The SOC would detail the needs of the population, health services and estate infrastructure required to serve them. The SOC will include a high-level option analysis to compare estate solution options against service models including feedback from stakeholders and the public gathered through a period of local engagement. The options under consideration are:

- Option 1 – Do Nothing
- Option 2 – Minimal refurbishment of Hythe Community Hospital no structural or extension works
- Option 3 – Major refurbishment of Hythe Community Hospital to include structural and extension works
- Option 4 - Demolish existing facilities and construct new health care facility

The project is tasked to provide accommodation that will be sized to allow services to be provided in appropriate rooms, fit for purpose facilities to deliver modern health care services. The following is the suite of health services which will continue to be delivered from the Hythe site to meet identified local needs:

X-ray	Ultrasound
Phlebotomy	Rheumatology
Trauma and orthopaedics / Orthopaedic Choice	Urology
Therapies	Audiology
E NT	Pain management
Ophthalmology	Diabetic clinic
General medicine	Paediatrics
Dermatology	Pre school vision checks
Developmental paed	Dietetics
Gynaecology	Dental
Contraception and sexual health	Heart failure
Continence	Stoma care
Podiatry	Respiratory
Maternity	Health education/support groups
Leg ulcer clinic	Diabetes education programmes
Pulmonary rehab	Physio clinics
Falls exercise classes	Voluntary
GP Practice - Solent Surgery	

It is proposed that the activity for these services can increase and the following new services can be implemented over 2012 including:

- Breast screening services
- Birth centre support services

We do not yet have formal agreement for these additional proposals or a timeframe for their implementation, but this is one of the elements the project group will be taking forward over the coming months and we will ensure the HOSC remain updated.

10. Key Deliverables

The key deliverables of the project are indicated below:

Task	Projected completion date
Project Initiation Document	March 2011
Confirm services to be delivered from Hythe	August/September 2011
Stakeholder engagement	October/November 2011
Bed Based Care Paper to CCG to Executive Team to Project Steering Group	October/November 2011
Bed Based Care Paper to SHIP Board	November 2011
Ambulatory Care SOC Complete	End November 2011
Update to HOSC	29 November 2011
Ambulatory Care SOC to CCG to Executive Team to Project Steering Group	December 2011
Ambulatory Care SOC to SHIP Board	January 2012
Stage 1 (Outline) Business Case to SHIP Board	September 2012

11. Decision required

We ask the Overview and Scrutiny Committee to consider progress of the development for the Hythe Strategic Outline Case and support the direction of travel outlined above.

Appendix Three: 'Outline proposal for piloting 'any qualified provider' in Hampshire

Dear Colleague,

In the White Paper, 'Equity and Excellence: Liberating the NHS', the Government made a commitment to extend the choices people have over their healthcare, as part of its vision of patients and the public being at the heart of the NHS.

The goal is to enable patients who are referred for a particular service to choose, where appropriate, from a range of qualified providers and select the one that best meets their needs. Extending the choice of provider is expected to enhance quality, where patients have identified this as variable in the past and provides an opportunity to improve access and address gaps in inequalities.

For example, most forms of hearing loss do not involve illness or disease and therefore people do not need to be treated in hospital. Given a wider choice, many people with hearing problems may prefer instead to visit a provider located in the high street or a mobile clinic because it is more convenient and doesn't make them feel like they are 'ill'.

Increasingly we expect that patients will seek information about the quality of care when choosing which provider to select. Extending choice of provider will enable patients to access better quality services provided by a wider range of provider.

The roll out will start with selected community and mental health services from April 2012, with these in place by September 2012. We are now supporting a piece of work happening across the country which asks people their views on which of these service areas they think might benefit from having an extended choice of provider in terms of meeting the needs of patients and delivering quality improvements. This needs to be undertaken by the end of September this year and we have a communications and engagement plan in place to help us seek people's views on this issue. Based on what patients have said might benefit from extended choice of provider, these services are:

- Services for back and neck pain
- Adult hearing services in the community
- Continence services (adults and children)
- Access to diagnostic tests (such as scans, X-rays, ECGs) via your GP (without the need to be referred to a consultant)
- Podiatry (foot health) services
- Wheelchair services (children)
- Leg ulcer and wound healing
- Primary care psychological therapies - adults ('talking therapies')

Feedback from this engagement will help inform commissioners on which local community and / or mental health services would benefit from becoming an extended choice of provider. Under Government requirements, at least three local services need to be identified. Other services may be chosen which are higher local priorities, if there is a clear case to do so based on the views of service users and potential gains in quality and access.

I hope that you will be able to help raise awareness of extended choice of service provider and that you will encourage your members and networks to share their views on which local services would benefit from an extended choice of provider.

Comments can be made through our website at:
<https://engage.hampshire.nhs.uk>.

You can also email to yourviewscount@hampshire.nhs.uk or write to us at Freepost, NHS Hampshire.

Thank you for your assistance in this matter,

Yours faithfully
Keith Douglas
Director of contracting

Appendix Four: Drug therapy policy for patients with acute macular degeneration: proposed approach

Dear Colleague

I am writing to alert you to a new policy that the PCT Board will soon be considering and ask for your views on this.

The drugs Avastin and Lucentis have both be used in the treatment of wet age-related macular degeneration (AMD), a common condition causing visual loss or blindness, particularly for people in their late 50s onwards. The condition has the potential to get worse quickly if left untreated.

Evidence suggests that both drugs are as effective as each other in the management of the condition though one (Avastin) costs much less than the other (Lucentis) and there are therefore significant annual savings to be made in switching to Avastin.

The SHIP PCT Cluster Board is currently considering implementing a policy in which Avastin would be the preferred treatment. Lucentis would still be available and patients would be able to choose the most appropriate treatment for them in discussion with their eye specialist.

Local clinical commissioning groups (CCGs) have signalled their support for the proposal. Quality, outcomes and safety should not be compromised by any switch between one drug or the other, provided it is implemented appropriately. As part of this consideration plans are being discussed with clinicians, patients and the public with a view to implementing the change during the autumn.

I have attached some further information and would welcome your views on this issue so that the Board can take these into consideration when making its decision about whether or not to implement this policy. You can comment by email to

yourviewscount@hampshire.nhs.uk or in writing to Freepost, NHS Hampshire,

Yours faithfully
Dr Stuart Ward
Medical Director

Briefing Note: September 2011

AVASTIN AND LUCENTIS

What we are planning to do

Background

The drugs Avastin and Lucentis have both been used in the treatment of wet age-related macular degeneration (AMD), a common condition causing visual loss or blindness particularly for people in their late 50s onwards. It has the potential to get worse quickly if left untreated.

Evidence suggests that the two drugs have similar effectiveness in the management of the condition though one, Avastin, costs much less than the other, Lucentis. In other countries in Europe and for approximately half the patients in the USA, Avastin is used routinely in this eye disease as the first choice treatment.

However, Lucentis is the only one that has a specific licence for use in treating AMD and, because of this, it is the use of Lucentis that is currently supported by NICE (the National Institute for Health and Clinical Excellence) for use in England and Wales. Avastin was originally licensed as a cancer drug, and it comes in a high dose package, and can be used to treat several eye patients at a time. The drug manufacturer has not asked for a license to use Avastin in AMD patients.

Clinicians are generally expected to follow the guidance recommended by NICE in providing drug treatments. This means that currently most clinicians use Lucentis for the treatment of AMD, and their Royal College also recommends this.

Now, the four PCTs in the SHIP Cluster (Southampton, Hampshire, Isle of Wight and Portsmouth) are looking to implement a formal commissioning policy to use Avastin as a more cost effective alternative to Lucentis. Patients will still be able to choose the most appropriate treatment for them in discussion with their doctor. But being able to offer Avastin will save a considerable amount of money at the same time as being just as clinically effective as Lucentis. This should mean that more people can be treated and have their sight saved in the future.

Local clinical commissioning groups (CCGs) have signalled their support for the proposal. Quality, outcomes and safety should not be compromised by any switch, provided it is implemented appropriately.

What is wet age related macular degeneration (AMD)?

Wet age related macular degeneration occurs when abnormal changes affect the retina causing swelling, leaking fluid, and abnormal blood vessels to form in the back of the eye.

Partial or complete loss of central vision (the kind that's needed for reading, driving, and recognising faces, for example) becomes disabling in wet AMD and may lead to blindness or partial sight.

It's a condition that affects around half a million people in the UK with around 26,000 people each year developing the condition.

How can it be treated?

Specialists can combat wet AMD with a class of drugs known as VEGF (vascular endothelial growth factors) inhibitors that are injected directly into the eye to alter the growth of those blood vessels and to reduce the swelling at the back of the eye. Two drugs in particular are widely used worldwide. Lucentis (also known as ranibizumab) and Avastin (aka bevacizumab.) Clinical trials have found that the treatment arrests the course of the disease and sometimes improves vision as well.

Why isn't Avastin used more often in England and Wales?

There are issues around licensing and formal guidance for clinicians to follow that recommended the use of Lucentis rather than Avastin. By producing a clear commissioning policy on the use of Avastin, we hope to encourage clinicians to use it more frequently, and to make better use overall of NHS funding.

Given the tight economic situation for the NHS, the significant financial pressures we are facing locally and the requirement for primary care trusts to keep within our resource allocation, we cannot afford not to consider this change. As a drug, Lucentis is roughly ten times more expensive per injection than Avastin.

Wouldn't choosing Avastin mean going against NICE guidance?

NICE has not looked at Avastin for use in AMD, although we understand that it is under review as a cost-effective alternative to Lucentis, though any formal change in NICE guidance would probably take years to implement.

Clinicians often use 'off label' drugs on an individual patient basis – in other words they are permitted to use a drug to treat a condition for which it has not received approval by a regulatory agency, and so Avastin has been used in this way, particularly internationally and in this country privately. Prior to NICE guidance, Avastin was used routinely in Southampton patients for AMD and is still used for a range of other rarer eye conditions.

PCTs would not ordinarily deviate too far from NICE guidance unless there are exceptional circumstances. The exceptional circumstance here is one of cost, with no noticeable reduction in benefit by using Avastin.

What evidence is there to support favouring Avastin?

The evidence base on Avastin is already substantial and a trial called CATT in the USA has demonstrated equivalence between Avastin and Lucentis in the 12 month interim analysis.

Whilst there are no currently published studies directly comparing the clinical and/or cost effectiveness of Avastin and Lucentis for wet AMD, at least two randomised trials are currently addressing this question and both are well under way. Indirect comparisons between the two treatments suggest similar clinical effectiveness. There is extensive English and international experience of using Avastin for wet AMD, without significant safety concerns. Many ophthalmologists use Avastin for private patients in the UK but would not do so in their NHS practice, because of the NICE guidance.

How much money would be saved if there was a switch to Avastin?

The NHS continues to spend millions on Lucentis while in other countries in Europe and for almost half the members of Medicare in the USA, Avastin is used routinely in eye disease. In America, Lucentis is used less often than Avastin for eye treatments and yet it costs \$516million more.

Locally switching from Lucentis to Avastin across the SHIP area would help manage NHS resources effectively – it would save a lot of money, achieve equivalent clinical outcomes, and it may also reduce the total number of injections and increase productivity in eye services. Across SHIP this potentially frees up £4-5 million each year – a sizeable amount of money for the local health system to reinvest in health services.

What work is being done to discuss this with local clinicians and patients?

Doctors in Southampton, Hampshire, Isle of Wight and Portsmouth have been reviewing this option for several years. The SHIP Priorities Committee, which is made up of doctors and other medical experts who conduct detailed investigations into the clinical and cost effectiveness of various treatments, recommended the use of Avastin at the beginning of this year. GPs from across the area have also agreed that Avastin should be offered to patients. Ophthalmologists have also been in regular dialogue over this issue.

Patients attending Southampton General Hospital from the Channel Islands all get Avastin routinely, and they are being surveyed on their experience of having Avastin injections. Ophthalmologists in Southampton have also published their past results with Avastin treatment for AMD, demonstrating excellent outcomes and very few complications.

How can I comment?

Local patients and their representatives are being asked to give their views on the introduction of Avastin as an alternative treatment choice for AMD. You can share your views by emailing yourviewscount@hampshire.nhs.uk or by writing to Freepost, NHS Hampshire.

What happens next?

The SHIP PCT Cluster Board will consider the proposal at its public meeting on September 29th at the Riverside Centre, Newport, Isle of Wight. If the Board supports the proposal we will ensure Avastin is also offered, as well as Lucentis, because of the wider benefits of using a more cost-effective drug whenever appropriate.