Agenda Item 8

HAMPSHIRE COUNTY COUNCIL

Report

Committee:	Health Overview and Scrutiny Committee
Date of Meeting:	30 July 2013
Report Title:	Proposals to Develop or Vary NHS Services
Reference:	5092
Report From:	Director of Policy & Governance

Contact name: Katie Benton, Scrutiny Officer

Tel: 01962 847336 **E-mail:** katie.benton@hants.gov.uk

1. **Summary and Purpose**

1.1. The purpose of this report is to alert Members to proposals from the NHS to vary or develop health services provided to people living in the area of the Committee.

1.2. Proposals that are considered to be substantial in nature will be subject to formal public consultation. The nature and scope of this consultation should be discussed with the Committee at the earliest opportunity.

1.3. The response of the Committee will take account of the Framework for Assessing Substantial Change and Variation in Health Services agreed by the Hampshire, Isle of Wight, Portsmouth and Southampton Joint Committee in November 2010. This places particular emphasis on the duties imposed on the NHS by Sections 242 and 244 of the Health and Social Care Act 2006, includes new responsibilities set out under the Health and Social Care Act 2012, and takes account of key criteria for service reconfiguration identified by the Department of Health. The 'Framework' can be found on the website at http://www3.hants.gov.uk/councilmeetings/advsearchmeetings/meetingsitemdocuments.htm?sta=&pref=Y&item_ID=4831&tab=2&co=&confidential=

1.4. This Report is presented to the Committee in 2 parts:

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

2. *Items for information:* these alert the Committee to forthcoming proposals from the NHS to vary or change services. This provides the Committee with an opportunity to determine if the proposal would be considered substantial and assess the need to establish formal joint arrangements

1.5. This report and recommendations provide members with an opportunity to influence and improve the delivery of health services in Hampshire and therefore support the delivery of the Corporate Strategy aim of maximising well being.

Items for Action

There are no items for action for the Committee on 30 July 2013.

Items for Monitoring

2. Southern Health NHS Foundation Trust: Adult Mental Health services – outcomes of evaluation exercise

Background

2.1 Proposals by Southern Health NHS Foundation Trust, the major provider of adult mental health service in the County, were first presented to the HOSC in July 2011 when the Committee were informed of their intention to change how services were provided in the east and west of Hampshire. These changes were treated as a substantial change in service.

2.2 The Trust sought and received approval from the HOSC for a foreshortened consultation period on their proposals. This was due to the Committee being informed that a period of substantial engagement work had already been undertaken. The Trust consulted for six weeks in September and October 2011, and the HOSC made a response to the consultation paper

2.3 Full proposals, alongside outcomes of the consultation period, were submitted HOSC in November 2011. These proposals included reducing the number of available inpatient adult mental health beds across the east and west of the County, on the basis that a number of patients currently seen in an inpatient setting could be better supported by community based services. The Committee agreed with the Trust at this meeting that further evidence would be required in order to for the HOSC to agree to support the way forward outlined.

2.4 In January 2012 the HOSC received the evidence required to assure itself that the Trust had engaged and involved stakeholders in relation to the proposed changes; and that the changes proposed were in the interest of the population served.

2.5 Following deputations by Julian Lewis MP and others at the March 2012 meeting, the HOSC agreed to set up a working group to scrutinise the proposals in greater depth, and to examine the concerns raised by the deputees. This working group reported to the May 2012 meeting of the Committee, at which point the HOSC supported the conclusions of the working group that the plans could continue to go ahead. The working group requested a number of aspects be covered by the Trust in future reporting to the HOSC to provide further assurance.

2.6 The HOSC have monitored the implementation of the proposals since May 2012. In September 2012 demand for inpatient beds temporarily exceeded availability of beds within the Trust. The HOSC received assurance from the Trust that this was due to unusually high referrals from the criminal justice system, and that beds had been found for those that needed them (either through use of other beds within the Trust or purchasing bed days from private providers). Monitoring in January 2013 indicated that demand had returned to below capacity.

Update

2.7 The Trust have previously reported that they would be undertaking an evaluation of the changes, comparing a number of outcome measures from before and after the implementation of proposals. The Committee previously requested that the results of this evaluation be reported to it when available. The report is attached as Appendix 1, page 10. A presentation will also be made available at the meeting.

Recommendations

2.8 That Members confirm if they are satisfied with the actions of the Trust in implementing and evaluating the proposals to date.

2.9 That the Committee delegates the on-going monitoring of adult mental health services to the Chairman.

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

Background

3.1 Since 2009 discussions have been on-going regarding the future provision of services from Chase Community Hospital (in Whitehill and Bordon, East Hampshire), as evidence showed that the use of the inpatient beds had been declining and other space available at the Hospital was under-utilised.

3.2 Both the abolished Primary Care Trust (PCT) and current commissioners of the services at Chase, South Eastern Hampshire Clinical Commissioning Group (CCG), undertook various forms of engagement with local people and stakeholders over what they would like to see provided from Chase in the future.

3.3 During 2012 discussions moved into a phase of defining proposed service changes. The PCT and later the South Eastern Hampshire Clinical Commissioning Group (CCG) presented to the Health Overview and Scrutiny Committee (HOSC) on multiple occasions over the past two years, with the Committee treating the item as a substantial change in service.

3.4 In September 2012 the PCT/CCG presented outline proposals to the HOSC. The following was proposed for the future of Chase Community Hospital:

- The closure of the remaining eight inpatient beds and the introduction of a new bed-based model of care, which would include the introduction of a 'virtual ward' to the area, with the majority of patients

being supported in their own home or a nursing home bed by community teams (if clinically appropriate).
- An expansion of outpatient services and clinics provided from Chase, including the move of community-based teams into the hospital, following the reorganisation and refurbishment of existing ward space.

It was agreed at this meeting that the Committee would form a working group to test the evidence for the proposals listed above.

3.5 At the 27 March 2013 meeting of the HOSC, the Committee agreed to support the CCG's proposals for Chase Community Hospital, confirming that the working group had resolved that evidence had been presented which supported the HOSC's role in the process. These were to:
- Ensure that the NHS has engaged and involved stakeholders in relation to changes; and,
- Ensure that the changes proposed are in the interest of the population served.

Update

3.6 The Chase working group made subsequent recommendations which the Committee requested the CCG to consider and report back on to this meeting, alongside an update on the implementation of the proposals:
- That the option to provide x-ray facilities as part of the minor injuries service be investigated as part of the opportunities to expand diagnostics being considered by the Clinical Commissioning Group.
- That beds are commissioned from a nearby nursing home prior to the inpatient beds at Chase closing (with an agreed specification of care in place), so there is no gap in inpatient provision for local people.
- That the Clinical Commissioning Group draw up a Charter to confirm the agreed services to be provided from Chase and the arrangements for bed based care, and make this available to the public. This should include:
  - the number of nursing home beds that will be commissioned (and which home is to be used be communicated to local stakeholders when possible)
  - the details of transport assistance being offered and how local people can access this
- That any adaptations to the Chase site to facilitate the provision of additional outpatient services are carefully planned so that service disruption is kept to a minimum.
- That the Clinical Commissioning Group considers an appropriate method of engaging with all local GPs regarding available community provision in the Whitehill and Bordon area.
- That the Clinical Commissioning Group work with local stakeholders to increase confidence in the bed model – through making clear the support that will be available out of hours and from social care, and the support available to carers. Feedback from families who have experienced support from a 'virtual ward' model could be beneficial.

- That the Clinical Commissioning Group continues to facilitate the creation of a nursing home in the locality as a priority.
- That the Clinical Commissioning Group work with Adult Services to monitor the additional pressure on social care arising from increasing support of ‘step up’ and ‘step down’ patients in their own home.
- That the Clinical Commissioning Group ensure the impact on carers is considered, and the Clinical Commissioning Group work with Adult Services and the voluntary sector on support for carers.

3.7 An update report providing responses to these recommendations, alongside a general update on implementation, is attached as Appendix 2.

Recommendation

3.8 That Members confirm if they are satisfied with the response of the Clinical Commissioning Group to the recommendations of the Committee.

3.9 That an update is provided to 24 September meeting of the Committee following the implementation of the new bed-based model of care, and the closure of the inpatient beds at Chase Community Hospital.

3.10 That Members confirm if they require any further information.

Items for Noting

4. National Specialist Commissioning Board: Children’s Congenital Heart Surgery update

Background

4.1 As a result of a higher than expected number of deaths of children receiving heart surgery between 1984 and 1995 at the Bristol Royal Infirmary, the Kennedy report recommended in 2001 that specialist children’s congenital heart surgery expertise should be concentrated in fewer surgical units in England.

4.2 The National Specialised Commissioning Team, in its role as secretariat to the Joint Committee of Primary Care Trusts (the previous commissioners of this service), was asked to review children’s congenital heart surgery in May 2008 in order to consider whether surgery should be concentrated in fewer hospitals. The Safe and Sustainable team was established to manage the review process and put forth recommendations for consultation.

4.3 A four month consultation began in March 2011. The consultation proposed concentrating clinical expertise on fewer sites by reducing the number of surgical centres to six or seven centres. Concerns were raised about the content and detail of the consultation, and independent analysis noted that the impact of the proposed changes on other services had been raised as an issue during consultation. However, the JCPCT agreed that they would continue the review.

4.4 On the 4 July 2012 the Joint Committee of Primary Care Trusts (JCPCT) decided that seven managed clinical networks should be established across England. Each network would be led by a surgical centre – based in the Freeman Hospital Newcastle (north), Alder Hey Children's Hospital Liverpool (north west and north wales), Birmingham Children's Hospital (midlands), Bristol Royal Hospital for Children (south west and south Wales), Southampton General Hospital (south central) and Great Ormond Street Hospital for Children and Evelina Children's Hospital (London, East Anglia and the south east)

4.5 Following this decision, a number of HOSCs referred the Safe and Sustainable review to the Secretary of State, on the grounds that the JCPCT had not consulted adequately, and the proposals were not in the best interest of all patients. Resultantly the Secretary of State commissioned a full review of the Safe and Sustainable proposals from the Independent Reconfiguration Panel (IRP).

Update

4.6 The Committee last heard an update on the National Specialised Commissioning Team's review of children's congenital heart surgery at the 16 April 2013 meeting. At that meeting it was reported that the IRP was in the process of investigating the children's congenital heart surgery review decision and would be submitting their advice and recommendations to the Secretary of State for Health at the end of April 2013.

4.7 The advice of the IRP would determine whether the proposals for change under the review of children's congenital heart surgery would enable the provision of safe, sustainable and accessible services. Overall the Panel concluded that the proposals for change fell short of achieving this. As a result the Secretary of State suspended the children's congenital heart surgery review.

4.8 The Panel provided a number of recommendations to improve learning for future national reconfigurations of health services. The Panel's opinion was that the challenge for NHS England would be to determine how to move forward as quickly and effectively as possible. The deadline for NHS England (the new commissioners of this service) to respond to the Panel's recommendations is the 31 July 2013.

4.9 The Chairman of the IRP, Lord Ribeiro stated that "[t]he critical factor to consider, in the Panel's view, is that engagement of all interested parties is the key to achieving improvements for patients and families without unnecessary delay. There is now a real opportunity to involve patients, public and other stakeholders in taking work forward as set out in the Panel's recommendations".

Recommendation

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

4.11 That the Committee contribute to any future review of children's congenital heart surgery proposed by NHS England.

5. National Specialist Commissioning Board: Adult Congenital Heart Disease

Background

5.1 The National Specialised Commissioning Team, part of NHS Specialised Services, first published their intention to undertake a review of services for Adults with Congenital Heart Disease (ACHD) in early 2012, noting that a period of early engagement would take place from May to July 2012. An ACHD Advisory Group, which included patient representatives, clinicians and representatives from professional associations, developed a proposed model of care and draft national designation standards.

5.2 The draft model of care proposed that in future networks should be made up of three tiers of centre; specialist, intermediate and local. As with the children's congenital heart surgery review, it was proposed that only specialist centres undertake surgery, and had sufficient specialist surgeons to support a 1 in 4 rota, with each surgeon undertaking a minimum of 125 congenital heart operations per year (in adults and/or children).

5.3 NHS England, who now have responsibility for commissioning specialised services, undertook a further period of engagement from April to May 2013 in order to invite feedback on a revised proposed model of care and draft designation standards.

5.4 A copy of the HOSC's response to that engagement can be found at Appendix 3 to this report.

Update

5.5 The HOSC last received an update on the progress of the national review on Adult Congenital Heart Disease at its September 2012 meeting.

5.6 It is expected that there will be a national public consultation on the resulting short listed options in summer to autumn of 2013. It is anticipated that as with the children's congenital heart review this will result in a rationalisation of the centres currently performing adult congenital heart surgery.

5.7 A decision on the future of ACHD services is planned to be taken by the end of 2013, with implementation to begin in 2014. It is to be hoped that lessons have been learned from the children's congenital heart services review, if this review is to avoid becoming divisive.

Recommendations

5.8 That the Committee provide a response to the anticipated public consultation when available.

6. NHS England (Wessex) – Vascular Surgical Services: Portsmouth and Southern Hampshire

Background

6.1 The Committee has been aware of work on-going between specialist commissioners (now part of NHS England), Portsmouth Hospitals NHS Trust and University Hospital Southampton NHS Foundation Trust since 2011 to develop joint arrangements for the delivery of vascular services.

6.2 Members last received an update in April 2013, where it was heard that progress was being made through joint working between commissioners and providers of the vascular service in Hampshire towards compliance with the Vascular Society of Great Britain and Ireland standards.

6.3 NHS England at this meeting agreed that a vascular services network model would be the most sustainable way of meeting the needs of patients and achieving the best outcomes for them.

Update

6.4 A recent update letter from NHS England, the specialised commissioners of the vascular service in Hampshire, is attached at Appendix 4 (page 35) to this report.

Recommendations

6.5 That the Committee note the update from NHS England (Wessex) in relation to vascular surgical services.

6.6 That the Committee engage with HOSC colleagues across Southampton, Isle of Wight and Portsmouth in order to explore the feasibility of a Joint Health Overview and Scrutiny Committee, which would examine any proposals for the future of vascular services from NHS England (Wessex).

CORPORATE OR LEGAL INFORMATION:

Links to the Corporate Strategy

A. Hampshire safer and more secure for all:	yes
Corporate Improvement plan link number (if appropriate):	
B. Maximising well-being:	yes
Corporate Improvement plan link number (if appropriate):	
C. Enhancing our quality of place:	yes
Corporate Improvement plan link number (if appropriate):	

Section 100 D – Local Government Act 1972 – background documents

The following documents discuss facts or matters on which this report, or an important part of it, is based and have been relied upon to a material extent in the preparation of this report. (NB: the list excludes published works and any documents which disclose exempt or confidential information as defined in the Act.)

Document	Location
None	

IMPACT ASSESSMENTS:

1. Equalities Impact Assessment:

a) No implications arising from this report.

2. Impact on Crime and Disorder:

a) No implications arising from this report.

3. Climate Change:

- *How does what is being proposed impact on our carbon footprint / energy consumption?*

  No implications arising from this report.

- *How does what is being proposed consider the need to adapt to climate change, and be resilient to its longer term impacts?*

  No implications arising from this report.

Appendix 1

HEALTH OVERVIEW AND SCRUTINY COMMITTEE PAPER – 30 July 2013

Distribution: **Hampshire Overview and Scrutiny Committee [HOSC]**

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

Date: **16 July 2013**

Purpose: HOSC required that SHFT should return with details of the evaluation process and outcomes following a major service redesign that has been taking place since April 2012. This paper gives a brief background to members and provides an update on progress since our presentation to HOSC in November 2012. More detailed feedback from the evaluation will be presented and made available to members at the meeting.

1. Brief background

During 2011 and 2012 SHFT undertook significant engagement and consultation in relation to our proposals to redesign the way in which AMH services were provided in Hampshire. A number of key drivers were taken into consideration which included national policy guidelines, feedback from service users, (who consistently expressed a wish for more community focussed services (Care Quality Commission Feedback)), commissioning priorities and the need to consider quality and efficiency within budgetary constraints. Proposals included the development of Hospital at Home teams, streamlining community teams, and establishment of a single point of access in each area. These changes enabled the reduction of AMH inpatient beds across Hampshire.

The key to this proposed service change was development of a culture that supports people with serious mental illness to recover a life beyond illness. The service was selected to be a pilot site for the national 'Implementing Recovery – Organisational Change (ImROC) programme, which was launched alongside the national mental health policy '*No Health without Mental Health*'. Recovery oriented services work with individuals to foster a sense of hope for the future, build on strengths, develop self management skills, maintain independence and exercise choices around their health and social care.

In rehabilitation (reablement) services, as with all our services, we aimed to increase choice, reinvest the money spent on providing rehabilitation beds (that were not being used) and improve community reablement services in the New Forest area whilst strengthening the inpatient service provided in Havant.

2. Progress to date

Access and Assessment teams (providing a single point of access for each area), Community Treatment teams, and Hospital at Home teams (providing intensive multidisciplinary care for people with acute illness) were established in April 2012.

The Adult Mental Health beds at the Meadows unit (Sarisbury Green) and the Woodhaven unit (on the Tatchbury Mount site in Calmore, Southampton) were closed by the end of July 2012. Closure of these beds was phased over several months in order that the majority of service users could complete their care in the unit before being discharged home and thus avoiding a move to another unfamiliar unit.

3. Evaluation.

The local changes to mental health services reflect changes occurring nationally. However, we recognise that there is currently limited information available as to the effectiveness of these new models of care and so the aim of the evaluation project was to provide a robust and detailed independent review the impact of the service redesign. The evaluation project was led by the Research and Development department, and validated by the Mental Health Foundation.

The evaluation was conducted by a research team, and had ethics committee approval. Research questions were developed as indicated in the bullet points below. Please note a more detailed report against each question will be presented at the meeting:

- Do the centralised and specialist assessment processes lead to improved quality and access to services for service users, their carers, and referrers?
- What are service user experience and staff and carer perceptions of care outcomes?
- How does integration of Early intervention in psychosis and Assertive outreach team function into Community treatment teams impact on care delivery?
- Is inpatient bed usage appropriate to the needs of service users, leading to reduction in admissions and length of stay?
- What is the cost consequence evaluation of the redesigned services compared to previous services?

The evaluation aimed to answer these questions by triangulating qualitative feedback from service users, staff and GPs, with audit data and performance indicators.

4. Key Findings.

A. *Do the centralised and specialist assessment processes lead to improved quality and access to services for service users, their carers, and referrers?*

- A higher proportion of service users reported the changes through the redesign positively compared to General Practitioners (GP) and staff
- Recovery focus rated better
- Transitions rated difficult by clinicians

B. *What are service user experience and staff and carer perceptions of care outcomes?*

- Key elements of care quality were perceived to impact upon care delivered: management of information to support clinical care delivery, continuity of care for individuals and a truly patient centred approach with involvement from the service user to aim for recovery.
- Care plans are more regularly reviewed but clear goals for care being set is a work in progress.
- Transitions around the service can be difficult; lengthy, based upon capacity.
- Staff are focussed on the recovery model which is seen as a positive.

C. *How does integration of Early intervention in psychosis and Assertive outreach team function into Community treatment teams impact on care delivery?*

- Integration of the Assertive outreach (AO) function into integrated teams did not have a negative impact
- Shared care model positive
- Integration of Early intervention in psychosis (EIP) teams did not retain the function.

D. *Is inpatient bed usage appropriate to the needs of service users, leading to reduction in admissions and length of stay?*

- Number of admissions reduced
- 28 day readmissions did not increase
- Occupied Bed Days (OBD) reduced
- Bed occupancy increased
- The mean Length of Stay (LOS) at different sites was not significantly different (bit higher) except Southampton where it reduced
- Proportion of detained patients increased

E. *What is the cost consequence evaluation of the redesigned services compared to previous services?*

A full cost effectiveness was not conducted.

- Occupied bed days decreased costs for Q4 to Q4 comparison by 20%, a total of £889,608.
- Caseloads reduced continuously 9.4% across the quarter from a total of 37,010 patients to 33,537 with reductions across all teams.
- Staff sickness increased by 7.8%.

5. Next steps.

The evaluation supports the service model that is in place, and highlights some areas for further development. We are pleased that the majority of service users are reporting an improved experience.

We are engaging staff and service users to consider the implications of the evaluation results, and to develop plans to act on the valuable learning to arise from it, both across the service, and for local areas. The evaluation is also attracting national interest, as it provides a valuable addition to the evidence base, and the research team have been asked to share it at national academic meetings.

6. HOSC Considerations

The Trust would ask the HOSC to note progress to date and we would welcome their comment in relation to the evaluation project.

Appendix 2

HAMPSHIRE HEALTH OVERVIEW & SCRUTINY COMMITTEE

Chase Hospital Redevelopment Update

1. INTRODUCTION

1.1. Since 2009 the South Eastern Hampshire Clinical Commissioning Group (SEHCCG) and its predecessor, Hampshire Primary Care Trust, has been engaging with local people and their representatives to determine a sustainable future for Chase Community Hospital in Whitehill and Bordon, and for community services serving local people.

1.2 Discussions with the Hampshire Health Overview and Scrutiny Committee have been a central element of this work, culminating in March 2013 with a presentation of the Outline Business Case for the Redevelopment of Chase Community Hospital. At that meeting, the HOSC resolved that:

- There has been appropriate stakeholder engagement in the development of the proposals for Chase Community Hospital
- The changes to service provision are in the best interest of the local population
- Recommendations made by the HOSC Chase Working Group (see section 4 below) were agreed. A further request was made that the option to provide x-ray facilities as part of the minor injuries service be investigated as part of the opportunities to expand diagnostics.

1.3 The CCG was requested to return to the 30 July 2013 meeting in order to provide an update, prior to the expected closure of the beds. This paper provides that update and officers of the CCG, along with colleagues from Southern Health Foundation Trust, the major provider of community services to local people, will be in attendance at the meeting.

2. BACKGROUND

2.1 Chase Community Hospital is situated in Whitehill and Bordon and consists of a single building which was purpose built in 1991.

2.2 Health Need Whitehill and Bordon has a population of around 14,000, with an Eco-Town planned which will include some 4,000 new homes, 35% of which will be ‘affordable housing’. The population is projected to increase from 14,000 to 23,823 by 2031.

2.3 While the population of eastern Hampshire is generally healthier than the national average, the wards of Hangers & Forest, Whitehill Chase and Whitehill Deadwater are among areas with the highest health needs in east Hampshire. The local area also has higher proportions of under 16s and older people than the average in England.

2.4 Utilisation Over recent years, inpatient admissions to Chase Community Hospital have decreased. Changes in patients’ needs and the ways in

which healthcare staff can support these needs in patients' own homes means the demand and use of inpatient beds at Chase Community Hospital has declined. There were originally 24 beds open at Chase Community Hospital. Eight of these beds have always provided 'step up' and 'step down' care supported by GPs. The remaining 16 beds were used for different cohorts of patients over the years but this has declined due to changes in clinical practice and development of new models of care, which focus on treating patients in their own homes.

2.5 In response to these challenges and following extensive public engagement an Outline Business Case was developed and presented and discussed in detail at the March 2013 meeting of the HOSC and approved by the Clinical Commissioning Group at its March meeting. The Outline Business Case describes the case for change, analysis of health needs of the population and alternative models for meeting those needs. It also includes a description and analysis of the significant community engagement and feedback undertaken, as well as options appraisals and identification of the preferred option. The Outline Business Case can be accessed on the CCG's website at http://www.southeasternhampshireccg.nhs.uk/sehccg/yourccg/meetings/ (SEHCCG Governing Body Agenda March 2013).

2.6 In summary the Outline Business Case proposed a £2.9 million investment in the hospital to refurbish the interior, alongside an expansion of services available at and from the hospital. The preferred option includes plans to:-

- Bring at least one GP surgery onto the site
- Bring mental health, community and social care teams together into an integrated team operating from one base
- Make sure the hospital has the right IT and staff in place to support new outpatient services
- Expand outpatient services to include services such as:-
    - Adult mental health
    - Contraception and sexual health
    - Dermatology (skin)
    - Educations for patients with long term conditions such as diabetes
    - Frail elderly community clinics
    - Healthy lifestyle initiatives
    - Minor injuries service within the GP practice(s)
    - Paediatrics such as community children's clinics
    - Blood tests
    - Rehabilitation and physiotherapy
    - Screening
    - Voluntary services such as day centre
- Provide more care in people's homes and at a nursing home:-
    - Integrated Care Team made up of GPs, practice and community nurses and social workers, with input from therapists, specialist nurses and mental health nurses and with support from consultant geriatricians and in-reach nurses as well as domiciliary care, community independence team and with access to re-ablement beds.

- Purchase of up to four nursing home beds as locally as possible to ensure that people from the area who need to be cared for by nurses in a bed will retain access to this type of care.
- The CCG will work with potential nursing home developers and planning authorities to attract a nursing home to the town.

3. UPDATE

3.1 Since the approval of the Outline Business Case in March 2013 the project has been strengthened with the appointment of a dedicated project manager (May 2013), a review of the project structure has been carried out and a reporting structure put in place.

3.2 Amendments have been made to the Task & Finish Groups charged with working up the full detail of the project to inform the development of the Full Business Case prior to its formal sign-off in the autumn. The Groups cover a range of clinical issues (Integrated Care Team, Chase operations, Minor injuries, Outpatients) and supporting mechanisms (Communication & Engagement, Hospital Redevelopment, Commissioning, Contracting & Finance, Full Business Case Development). Reports from each of the groups are received monthly and discussed at both the Project Board and Steering Group – which includes local stakeholders such as elected members and patient and public representatives.

3.3 Overall, the project is currently rated as amber i.e. key activities have been identified, time-critical milestones have been achieved and risks have been identified. The project remains on track to deliver the two major milestones of:-

- 31st August 2013 for the implementation of the new model of community based care and the closure of beds; and
- April 2015 completion of all building and renovation works and all moves into the building.

4. PROGRESS AGAINST HOSC RECOMMENDATIONS

4.1 This section provides an update on progress made against each of the recommendations made by the Hampshire Health Overview and Scrutiny Committee to the CCG in March 2013.

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

4.3 Following a quality review of nursing homes within a 10 mile radius of the Chase, five nursing homes that were able to meet the requirements were invited to tender for the provision of beds. The tender process will be complete by the end of July and the CCG will be in a position to announce the successful bidder by the second week of August. The beds will be in place before the planned closure of the Chase Hospital beds on 31 August 2013. Medical cover for patients in those beds has been agreed with the GP Alliance and will be in place at the point the beds open.

4.4 That the CCG draw up a Charter to confirm the agreed services to be provided from Chase and the arrangements for bed based care, and make this available to the public. This should include:-

- **The number of nursing home beds that will be commissioned (and which home is to be used be communicated to local stakeholders when possible)**
- **The details of transport assistance being offered and how local people can access this**

4.5 The Charter – including the points above re the number of beds and transport - has been drawn up in partnership with the programme's Steering Group and published and circulated widely using a range of routes, such as websites, local media, patient newsletters, stakeholder publications etc. It is attached to this paper as Appendix 1.

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

4.7 This requirement has been included in the brief to the detailed design team and current non-ward services will continue to run throughout the renovation period. As building work progresses, some decanting around the building will be required. These moves will be carefully planned and kept to a minimum to ensure continuity of service.

4.8 That the CCG considers an appropriate method of engaging with all local GPs regarding available community provision in the Whitehill and Bordon area.

4.9 The engagement of local GPs has been, and will continue to be, a key theme running through the programme, with a range of methods used. These include updates and involvement at clinical forums such as the CCG's Clinical Cabinet meetings, and Commissioning Assembly (quarterly meeting with all GP practices represented). The CCG has also introduced a Chase newsletter aimed at local GPs and has been in correspondence via email re specific issues and giving general updates, membership of programme task and finish groups etc. A Communications log of key meetings, teleconferences and workshops with stakeholders, including GPs, is attached at Appendix 2.

4.10 Significant elements of the current engagement of GPs are focused around the planning for, and implementation of, the Integrated Care Team. A successful workshop style event was held on 3rd July with representation from all of the local GP Practices and there have been meetings with individual practices and GPs to discuss the detailed implementation. In addition, a website "portal", hosted by Southern Health and with input from all parties, is being established, allowing interactive discussions and hosting of key documentation in one place. GPs and other members of the teams will be able to access and use this facility.

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

4.12 Engagement with local stakeholders is another key theme running through everything we do. The Stakeholder Group meets monthly, updates are given and opportunities taken for Stakeholder input to every aspect of the programme. The main agenda item at the July meeting was a DVD presentation and discussion based around the experiences of a patient of a "virtual ward" in the north of Hampshire. This was felt to be very helpful in helping stakeholders understand the model and it is hoped – subject to availability – to invite a patient/client to the next meeting.

4.13 Engagement and communication with stakeholders and the local community has continued throughout the period from March to July and is detailed in the communication log referred to above, Appendix 2. As part of the new project arrangements a Communications and Engagement Task and Finish Group has been established, including stakeholder representatives and this group is now leading this agenda. Progress includes development of a database of stakeholder websites and publications who have received updates about the progress being made, publication of a further edition of Chase Times, PPG newsletter articles and media coverage surrounding the Charter.

4.14 A briefing note, agreed by the CCG and Adult Services, making clear the arrangements around the integrated care model has been circulated to the Steering Group. Paras 4.19 and 4.20 below refer to social care and domiciliary support. Once fully formed the integrated care team will – depending on patient's needs - visit patient's homes from 7am to 11.30pm, provide night nursing from 11pm to 7am if required and work with local GPs and the Out of Hours GP service to enable direct admission to hospital if the patient's condition deteriorates.

4.15 That the CCG continues to facilitate the creation of a nursing home in the locality as a priority.

4.16 Whilst the provision of nursing homes fall outside the remit of the CCG, we will continue to facilitate discussions wherever possible. The CCG has held discussions with potential developers on the importance of a local nursing home and encouraged expressions of interest on the current tender by the Homes and Communities Agency for redevelopment of the Quebec barracks site. We understand that the preferred developer is due to be announced in July 2013. The CCG remains committed to encouraging the creation of a nursing home in the locality.

4.17 That the CCG work with Adult Services to monitor the additional pressure on social care arising from increasing support of "step up" and "step down" patients in their own home.

And

That the CCG ensure the impact on carers is considered, and the CCG work with Adult Services and the voluntary sector on support for carers

4.18 People who are acutely unwell or who require palliative end of life care, including personal care, will receive a free service through the NHS. For end of life patients this would be through Macmillan Cancer Care and the

Rosemary Foundation. The NHS Community Rehabilitation Team offer short term support either on discharge from hospital or to prevent hospital admission where it is not clinically needed. This type of support helps to improve an individual's ability to function and be more independent again after a period when they have been unwell.

4.19 Social care in Hampshire is generally delivered through a care package arranged by Hampshire Social Services and is available to any adult who has needs for extra support because they are older, have learning or physical disabilities or mental health needs. Social care services are delivered by the Council's own in house service, the Community Response Team (CRT), or through a domiciliary care package arranged by the Council through an agency. Domiciliary care provided through the Council for those receiving these services on a longer term basis is normally chargeable in line with the Council's Contributions Framework.

4.20 There is a recognised gap in domiciliary care in the local area which affects the ability of current social care providers to set up packages of care at short notice to avoid a hospital admission or to support timely discharge. The County Council and East Hampshire District Council are working to encourage and promote recruitment to care agencies in the area and a partnership event is being held on July 18 to engage with potential providers. Other strategies for developing the domiciliary care market in the area include provider training events run by the County Council and new reablement services to be developed in the area next spring.

4.21 Detailed work has identified that the current and anticipated level of unmet need in regard to a rapid response is very low. The position will be kept under review and the CCG and Hampshire County Council are working closely together on this. Hampshire County Council Community Response Team's (CRT) capacity is being strengthened and a recruitment drive is under way to recruit additional staff for the North-East Community Response Team by the end of August.

4.22 Discussions have been held with carer's groups in various forums to understand their concerns and communicate the new model and links are being made through members of the stakeholder group. Information from groups such as Community First has been shared and representation invited onto the Steering Group. A Directory of Services, including signposting for carer support, assessment for carers and advice and information is on track to be published at the beginning of August. A proposal is being worked through with Adult Services, Princess Royal Trust and Carers UK, with the aim of having identified carer leads in each GP practice.

5. RISKS

5.1 A full risk log for the project has been developed and is kept under review, with appropriate action taken where required. The risk log is shared with, and discussed at the Stakeholder Group.

5.2 The current higher rated risk centres on a lack of clarity about the process for approval of the Full Business Case. This has been created due to recent

NHS organisational changes and delays in the publication of national guidance. This has led to a knock-on delay in the start of the detailed design work and the application for planning permission.

5.3 To mitigate this risk the CCG has agreed to fund the development of the Full Business Case ahead of the release of capital funds. The detailed work, including that required for the planning permission application, is now underway. While there may be a slight delay in the start of works on site it is important to note that slippage built into the programme means that the completion date of April 2015 remains achievable.

6. CONCLUSION

6.1 All of HOSC's recommendations to the CCG have been accepted and actioned. The CCG remains committed to continue to work on these recommendations as part of the project. The project remains on track to deliver on the two key milestone dates of August 2013 for implementation of the new integrated care model and April 2015 for the completion of redevelopment works at the Chase. Risks and appropriate mitigating actions have been identified and rigorous project management is in place to ensure delivery.

South Eastern Hampshire
Clinical Commissioning Group

A Charter for Health Services at Chase Community Hospital and for the population of Whitehill and Bordon and the surrounding communities of Blackmoor, Bramshott and Liphook, Grayshott, Greatham, Headley, Lindford, Oakhanger and Selborne.

NHS South Eastern Hampshire Clinical Commissioning Group is committed to keeping Chase Community Hospital open. We want to make sure that it is well used and provides a lively centre for health and related services in the surrounding area.

Over the next two years we plan to transform Chase Community Hospital and local community services and this Charter sets out what we promise to deliver.

Expanding services available at Chase Community Hospital

Our plans involve applying for a £2.9m investment in the Hospital building to refurbish the interior. We have applied for this funding and, once approved we will begin work on site.

The funding will be used to:

- Bring at least one GP surgery on to the site
- Bring mental health, community and social care teams together into an integrated team operating from one base
- Make sure the Hospital has the right IT and staff in place to support new outpatient services
- Expand outpatient services provided locally to include services such as:-
  - Adult mental health services
  - Contraception and sexual health services
  - Dermatology (skin) clinics
  - Education services for patients with long term conditions e.g. diabetes
  - Frail elderly community clinics (including IV antibiotics & oxygen assessment)
  - Healthy lifestyle initiatives and other wellbeing services for the public
  - Minor Injuries Service within the GP practice(s)
  - Nephrology (kidney) services
  - Older people’s mental health
    - Memory clinics
  - Paediatrics
    - Community children’s clinics
    - Acute children’s clinics
    - Children & adolescent mental health services
  - Phlebotomy (blood tests)

- Rehabilitation and physiotherapy
- Substance misuse
- Screening services such as breast screening
- Voluntary services such as day centre

Care in people's homes and at a nursing home

We will commission care in people's homes and at a local nursing home. This will be delivered by a new 'integrated care team' working in the community and at four nursing home beds in the local area.

This will involve closing the ward at Chase Community Hospital but we promise that patients from the above areas who need nursing care will still have this type of care.

The ward will not close until the new services are in place.

Integrated care team

The 'Integrated Care Team' will be made up of:

- GPs and practice nurses;
- 14 community nurses led by a community matron with input from therapists, specialist nurses and mental health nurses;
- support from consultant geriatricians and in reach nurses; and
- social workers, domiciliary care, community independence team and access to reablement beds.

The team will:

- visit patients' homes between the hours of 0700 and 2330, as required by their clinical need;
- provide night nursing between the hours of 2200 and 0700 if required;
- work with local GPs and the Out of Hours GP service to admit patients to an acute hospital if the patient's condition deteriorates and admission is deemed appropriate by the GP
- help patients admitted to hospital to get earlier discharge so they have the opportunity to regain and maximise independence;
- make links and work with other community services (e.g. domicillary care, community transport etc)

In the new model each patient will have:

- a designated care co-ordinator who will organise every aspect of the patient's care and act as a single point of contact for the patient and their carer and/or loved ones;
- a formulated care plan developed with colleagues in the integrated care team and with the patient; and
- a care plan that is shared with the out of hours GP service and the ambulance service.

Nursing home beds

The CCG will purchase up to four nursing home beds to ensure that people from the area who need to be cared for by nurses in a bed, still have access to this type of care. These beds will be available from Autumn 2013.

As there is currently no nursing home in Whitehill and Bordon the CCG will fund transport between the Chase Community Hospital and the nursing home for patients and their relatives. Overnight accommodation will also be made available at the nursing home for relatives of patients approaching the end of their lives.

Development of a nursing home in Whitehill and Bordon

The CCG will work with potential nursing home developers and planning authorities to attract a nursing home to the town. The CCG cannot guarantee at this stage that a nursing home will be built but is encouraged that there is interest in setting up a home and potential sites are available.

Acknowledgement

The CCG would like to thank local county, district and town councillors, the League of Friends, local voluntary services representatives and patient representatives who have helped us put this Charter together.

More information

For more information about the Chase Hospital project please visit www.southeasternhampshireccg.nhs.uk/sehccg/yourviews/chase-community-hospital-section/

or you can contact programme Manager Karen Pedley on 023 9228 2065

Alternative formats

For large print, Braille, audio versions or translations of this document please contact Karen Pedley on 023 9228 2065

Chase Community Hospital

Consultation Log

22 March 2013 onwards

Date	Event / Meeting / Other	Nos. Attending	Key Themes
22 March	HOSC Meeting	Members	To brief members on the work to date, the current position and way forward to obtain approval to progress to Stage 2 Business Case
26 March	Meeting	Redevelopment Group	Refer to Minutes
26 March	Letters	From Dr Barbara Rushton	To: Damian Hinds, Fiona Jackson, Steering Group Members, East Hampshire District Council, League of Friends and local GPs updating them on the outcome from the HOSC meeting.
27 March	Visit	Cllr Carew, Cllr Davison, Cllr Dash, John Carr (League of Friends) and Julie Gumbrell	Visit to Little Haven and Bickerley Green Nursing Homes in Hythe, together with Hythe Community Hospital. An opportunity for Steering Group members to view a similar model and ask questions of local Cllrs who have recently been through a similar process.
28 March	Meeting	Sara Tiller, James Bawn, Marie Preston, Mark Wingham, Pam Sorensen, Jill Angus	To review the outcomes from HOSC and discuss the way forward: e.g. review T&F Groups, Actions to be taken etc.
April 2013 – Formal emergence of the South Eastern Hampshire CCH			
3 April	E-mail response	Mark Wingham to Damian Hinds	Response to query raised by resident to Damian Hinds, MP on the redevelopment of CCH
5 April	Project Board	Members	Refer to Minutes
5 April	Steering Group	Members	Refer to Minutes
9 April	Meeting	Debra Purdy, Melissa Way, Lisa Cully and Julie Gumbrell	To update MW and LC on the CCH project; in particular the element around the provision of beds in the nursing home.
16 April	Meeting	Jo York, Sue Knifton, Julie Gumbrell	To update JY and SK on the CCH project; in particular the element around the provision of beds in the nursing home. Discussion around the requirement to provide transport for patients, accommodation for relatives and what the model should incorporate.
23 April	Meeting	Marie Preston, Julie Gumbrell, Teresa James, Natalie Clarke, Jack Long, Richard Wellcoat	To review the Project Proposal Indicative IT Cost document prepared in August 2012, Terms of Reference and Membership of IT/ Telephony strand of the Redevelopment Group. Refer to Minutes
24 April	Letter	To local GP Practice Managers from Dr Barbara Rushton	Inviting representation from each GP Practice on to the Steering Group

24 April	Chase Community Hospital Redevelopment-IT and Telecoms Task and Finish Group	Marie Preston - Project Manager, NHS PS, Teresa James - Senior Project Manager, NHS PS, Julie Gumbrell - Development Manager, SEH CCG, Jack Long, Interim Technical Projects Manager, SHFT, Richard Wellcoat - Technical Projects, HITs, Natalie - Clarke Team Administrator- Development, NHS PS	Refer to Minutes
25 April	Meeting	Qtr 4 Arpil 13 Maternity Service Contract Review – Agenda – Andrea Havey attending	The heads of Midwifery from PHT, HHFT, and Guildford have set up a North Hampshire Integrated Clinical Teams network. This group includes all the Heads of Midwifery and local midwife managers and will be looking at services delivered in that area. The aim of the network is to develop a team approach to maternity care within the area and deliver an equitable service to all women regardless of where they choose to have their baby.
29 April	Meeting	Lisa Cully, Debra Purdy, Julie Gumbrell	Discussion on requirements for Nursing Home Beds.
30 April	Meeting	Debra Purdy, Julie Gumbrell and Karen Pedley	To brief the new Programme Manager, Karen Pedley, on the project to date.
May 2013			
1 May	Communications and Engagement Task and Finish Group	Members (including stakeholders)	On-going discussions about wording for the Chase Charter, talk about content for the next issue of the stakeholders' newsletter Chase Times and having an 'independent' chair of the group.
3 May	Project Board Meeting	Members	Refer to Minutes
3 May	Steering Group Meeting	Members	Refer to Minutes
8 May	Meeting	Marie Preston, George Anderson (Hampshire Lift Contractor), Julian Le Good (Architect)	To discuss the pre-planning application
8 May	Meeting	Carole Rogers, George Anderson, Rohan Howard, Nicola Booth, Michelle Day, Diana Standing Natalie Clarke	To discuss the legal, finance and procurement aspects of the project. (To occur monthly)
8 May	Meeting	Karen Pedley Julie Gumbrell	To discuss the Chase Project in more detail and develop a reporting template for all T&F Groups to use.
9 May	Meeting	James Bawn, Marie Preston, Karen Pedley, Carole Rogers	Meeting to bring all up to date with the projects within Chase
13 May	Meeting	Karen Pedley Sara Tiller Julie Gumbrell	To review the comments provided by members of the Steering Group and Project Board for the Terms of

			Reference and Charter. To also begin developing the person specification for the joint chair of the Communications and Engagement Group
13 May	Teleconference	Redevelopment Group	CCH Redevelopment Group T&F - Design & Technical issues - Tender - Planning - IT & Telecoms - Equipping - Business Case - Finance - Risks - Programme
13 May	Meeting	Melanie Poulter, Helen Pinkham, Mrs Prout (Unison)	Meeting with Union Representative ahead of Consultation for staff and joint negotiation committee
15 May	Meeting	Karen Pedley Julie Gumbrell Debra Purdy	An overview meeting of the Chase Project
17 May	Meeting	Jo York, Melissa Way, Emma Fawell Dr. Jenny Allinson, Dr. Charles Walters Dr. Caroline Welch Jane May, Sue Hazeldine, Mike Korab	To discuss model of integrated care pilot delivery, agree next steps and actions. Refer to Minutes.
21 May	Meeting	Karen Pedley Julie Gumbrell Kieran Humphrey	Meeting with contracting to discuss the implications the of the Chase Project. X-ray identified as being taken forward now.
21 May	Meeting	Belinda Tan, Piers McGregor-Wood, James Bawn, Val Hudson, Carole Rogers, Natalie Clarke	Reviewing the schedule of accommodation and costs incurred relating to relocation of the surgery.
23 May	Meeting	Melanie Poulter, Karen Pedley, Jill Angus	Meeting with providers in order to establish the need for contingency plan to be identified
24 May	Meeting	Redevelopment Group – James Bawn (Chair)	CCH Redevelopment Group T&F - Design & Technical issues - Tender - Planning - IT & Telecoms - Equipping - Business Case - Finance - Risks - Programme
28 May	Teleconference		Catch up prior to CCH Project Board and Steering Group meetings.
June 2013			
3 June	Meeting	Alex Berry, Julie Gumbrell, Caroline Hadley, Sarah Malcolm, Karen Pedley, Marie Preston, Debra Purdy, Lauren Robinson, Melissa Way, Andrew Wood, Jo York	Inaugaural Meeting for the Commissioning, Contracting and Finance T&F Group to ensure that the commissioning, contracting and financial implications of the project are captured and that the necessary changes in the flow of money will support the services that are to be delivered.

4 June	Meeting	Carole Rogers, Michelle Day, Teresa James, Natalie Clarke	CCH Legal, Procurement & Finance T&F - Business Case - Contracting - Primary Care - Procurement - Capital Funding - Premise Budgets
4 June	Meeting	Chase ward staff, Melanie Poulter, Kathryn Salt, Jill Angus and Sarah Underwood	Launch of consultation paper with all staff and discussion around proposals for re-provision of services
5 June	Meeting	Janowska, Marcela; Gumbrell Julie - Development Manager; Couldridge, Anna; Spong Sandra - Community Matron; Prestleton Faye - Area Manager Fareham and Gosport; Angus Jill - Modern Matron; Emma Fawell – Integrated Care Workstream, Sue Knifton – ICT	To discuss what data could be made available to demonstrate the following points of assurance to the project board: 1) Current demand and potential capacity within the CCT 2) Performance and growth of the virtual ward, together with establishing the potential capacity 3) Demonstrate acuity and complexity within the virtual ward
5 June	Meeting	Tracy Mansfield Jo York Kim Smith Emma Fawell Sue Knifton Laura Stacey Emma McKinney Gill Harrison	1st meeting of Integrated care pilot project team. Project plan to be drawn up by Tracy Mansfield. Date for Bordon IC stakeholder event agreed.
6 June	Meeting	Barbara Ruston, Julie Gumbrell, Sarah Malcolm	To discuss outpatient services in general in order to further develop ideas for services that are wanted and needed by the local population.
6 June	Meeting	Sue Pidduck Ruth Dixon Richard Ellis Sara O'Rourke Sally Jones Jo York Emma Fawell Mellissa Way	Meeting with HCC colleagues to discuss procurement and contracting options for nursing home beds and community social care delivery.
7 June	Project Board Meeting	Members	Refer to Minutes
7 June	Steering Group Meeting	Members	Refer to Minutes
10 June	Visit	Julia Barton Melissa Way	Visits to: Chatterwood, Eastfield, Wenham Holt, Copper Beeches, Heathmount Nursing Homes. Quality reports to be presented in August to Quality Board.
11 June	Announcement	Clinical Discussion Forum for local GPs	Work on the project around the Chase Hospital and health services for the people of Bordon, Whitehill and surrounding areas is well into its second phase, with a number of task and finish groups established to work up the fine detail. Clinical input is key and we would really welcome

			more local GPs getting involved, especially in the work around the new community model (Integrated Care Teams & Nursing Home Beds) and Outpatients. We do appreciate diaries are incredibly busy, so we are happy to discuss alternative ways of working, eg keeping meetings to a minimum and at convenient locations and virtual working via email and phone. Please contact the project team if you want to get involved:- Karen.pedley@hampshire.nhs.uk Tel 02392 282071 Julie.gumbrell@hampshire.nhs.uk Tel 02392 282075
11 June	Meeting	Dr Andrew Douglas, Dr Antony Leung and Vicky McDonald Woods	Meeting to discuss the implications of Chase Project decisions on the End of Life Care pathways and alternative solutions required.
12 June	Meeting	Chase Community Hospital Redevelopment-IT and Telecoms	Please refer to Minutes
17 June	Communications and Engagement Task and Finish Group	Members	Talk about a dedicated Chase newsletter for GPs, the Chase Times, Chase Charter, updating the 'channels of communication' reference document.
17 June	Meeting	Emma Fawell, SE CCG, Sue Knifton, SE CCG, Jill Angus, Modern Matron Couldridge, Anna; Spong Sandra - Community Matron, Anna Couldrige, Ward Manager, Rosemary Gold, HCC, Shona Byrne, Shirley Apps, Ward Coordinator	Meeting of social care and SH stakeholders to establish operational interface of social and healthcare delivery, identify pressures, gaps and existing model of care delivery. To discuss and understand primary, community and social care services in general in order to further develop ideas for social care delivery and rapid response.
19 June	Meeting	Tracy Mansfield Jo York Alisdair Honeyman Emma Fawell Sue Knifton Laura Stacey Gill Harrison	Meeting of Integrated care pilot project team. Planning and preparation for Bordon ICT event underway. Risks log to be developed and implemented for ICT specifically.
19 June	Meeting	Emma Fawell Rosemary Gold Peter Carlow	Meeting between SE CG and HCC to discuss the ICT model in North Hampshire and understand the operation of the social work function within the pilot model and feasibility of replication of this model in Bordon in terms of delivery and function.
21 June	Procurement	Lauren Robinson (lead)	Invitation to bid. Portal open and logins confirmed for all interested parties.

24 June	Site Visit	Julie Gumbrell Carole Kelly	Visit of Chase Community Hospital site with representation from the Quality Team to assess outpatient department
26 June	e-mail	Julie Gumbrell and Sarah Malcolm	e-mail direct to all GPs inviting representation onto the Outpatients' Task and Finish Group and the Steering Group. Also advising date, time and location of all meetings will be at accommodated to their requirements.
26 June	Meeting	Jo York, Trudy Mansfield, Emma Fawell, Mel Poulter, Angela O'brien, Sue Knifton.	Weekly Project Meeting. Integrated Care Pilot. Items discussed include: Bordon Pilot, Whole system engagement, MDT meetings
July 2013			
1 July	Meeting	Commissioning, Contracting and Finance T&F Group	Refer to Minutes
1 July	Meeting	Chase ward staff, Melanie Poulter, Kathryn Salt, Jill Angus and Sarah Underwood	Outcomes of consultation paper with all staff and discussion around next steps and feedback
3rd July	Virtual Ward Meeting	Tina Palmer - CN, Karen Rubra - AP, Karen Disney - CPN, Jill Meech - Macmillan, Rae Maclennan – Social Worker, Claire Norris - OT,	Meeting to discuss patients on the Virtual Ward.
3rd July	Integrated care meeting	Alison Sutton, Rebekah Weaver and Social/Health Care providers and Commissioners for Bordon	Meeting to discuss service needs in Bordon.
3 July	Meeting/Teleconference	Chief Quality Officer, Karen Pedley, Assura, Julie Gumbrell, Southern Health, Care UK and Solent	To discuss the operational requirements to ensure quality/safety standards are met and maintained once the beds close at the end of August and during the refurbishment of the building
5 July	Project Board Meeting	Members	Refer to Minutes
5 July	Project Steering Group	Members	Refer to Minutes - included DVD to members of how the virtual ward model works out in the field.
9 July	Meeting	Karen Pedley, Julie Gumbrell, Sarah Malcolm	To discuss the selection criteria for outpatient services to be commissioned to ensure that they are wanted and needed by the local population without destabilising services provided at other localities.
10th July	Virtual Ward Meeting	Alison Sutton - CS, Shirley Apps - VWA, Rae Maclennan - Social Worker, Jill Meech - Macmillan, Karen Disney - CPN, Trish Phillips - HFN, Trish Norman - PT	Meeting to discuss patients on the Virtual Ward.
10 July	Communications and	Members	Encouraging greater interest/

	Engagement Task and Finish Group		awareness with young people; using a patient's experience to help tell the story of how integrated care teams do make a positive difference.
11th July	Liphook Village Surgery PHCT meeting	Alison Sutton, Health care providers and GP's	Meeting to discuss patients on caseload
11 July	Meeting	Redevelopment T&F Group Members	Refer to Minutes – key themes were: • Update on approvals to proceed with development of full business case • Programme and impact of delays • Catering options • IT requirements
12 July	Meeting	NHSPS Internal	Review of SoA for primary care with primary care premises lead.
12 July	Procurement	Lauren Robinson (lead)	Closure of tender process on online portal. All bids received by midnight.
17th July	Virtual Ward Meeting	Anna Couldridge - CM, Shirley Apps - VWA, Rae Maclennan - SW, Sarah Charlton - OT, Karen Disney - CPN,	Meeting to discuss patients on the Virtual Ward.
Throughout July 2013	A number of discussions / emails / correspondence regarding approval to proceed/ finance etc	NHSPS/SEHCCG/NHSE	Agreement for CCG to underwrite full business case development costs

Appendix 3

Date: 10 May 2013

To: Hannah Weaver
NHS England
(By email)

Health Overview and Scrutiny Committee
Elizabeth II Court, The Castle
Winchester, SO23 8UJ

Telephone: 01962 845018
E-mail: pat.west@hants.gov.uk
www.hants.gov.uk/scrutiny

For the attention of the ACHD Review Team,

Thank you for the opportunity to provide further feedback during the engagement phase of this review. As a Health Overview and Scrutiny Committee (HOSC) of lay Members, the Hampshire HOSC are not in a position to comment on the specific engagement questions. However, given our experience of scrutinising previous service reconfigurations, we have some comments to make on the revised proposed standards, as follows:

D1: Requiring an ACHD surgical centre to be co-located with a designated paediatric congenital heart surgical centre

The HOSC would support the designation of ACHD surgical centres which are also paediatric centres where possible, though we have some concerns over this being a strict requirement. It is unfortunate that co-location of adult and children's congenital heart surgery is being proposed now and was not taken into account as part of the 'safe & sustainable' review of children's congenital heart surgery.

Having both child and adult congenital heart surgery services on the same site would support a smooth transition for patients from children's to adult services. This would also be a potentially efficient model, as surgeons could take part in shared rotas covering both children's and adult's surgery. However, the HOSC has some concerns about the implications of this requirement (in combination with the other proposed standards) in terms of the accessibility of ACHD surgical expertise across the country.

Will the designation of ACHD surgical centres take into account centres being located in order that patients can access a surgical centre within a specified time period? Part of the designation process used in the 'safe & sustainable' review of children's congenital heart surgery was the application of the paediatric intensive care society standards that retrieval by ambulance could take place within 3 hours (4 hours for 'remote' areas). The HOSC would assume a similar requirement would be applied to potential ACHD surgical centres (unless it can be shown that speed of access is less critical for adult patients). If so, this will need to be factored in to the proposed requirement that ACHD surgical centres are co-located with paediatric surgical centres, in case the centres that are able to offer both services do not provide sufficient geographical spread for patients to access them in reasonable time.

According to the ‘safe and sustainable’ consultation document, under 900 surgical procedures are undertaken annually on adult congenital heart patients. If a centre requires a minimum of four surgeons undertaking 125 procedures each (Standard B8), this suggests only two centres would be viable to maintain sufficient volumes. If these patients were spread among centres also offering paediatric congenital heart surgery the number of centres could increase (as surgeons quota of operations can include both paediatric and adult procedures according to proposed standard B8). However, a number of the sites currently providing paediatric congenital heart surgery are Children’s Hospitals (Evelina Children’s Hospital, Birmingham Children’s Hospital, Great Ormond Street Hospital for Children and Alder Hey Children’s Hospital). If these sites are not able to offer the range of adult services required, the number of hospitals able to undertake ACHD surgery would only increase to three (if the safe & sustainable designation remains following the latest judicial review and Independent Reconfiguration Panel assessment).

The HOSC would be concerned whether three centres covering the whole of England would be sufficient, in terms of patients being able to access the relevant surgical expertise in time. It would be helpful for the next stage of this review to address this point, in terms of the likelihood of adult congenital heart patients requiring time critical care, and the anticipated access times for centres being considered for designation. While we would expect patients to be prepared to travel longer distances to access higher quality care, as more and more children with congenital heart problems are surviving into adulthood, patients will expect to access the majority of their ongoing care within a reasonable distance.

The other requirement that limits the number of centres that would be viable under the proposed model is the standard that each surgeon undertake 125 procedures per year. As this process moves forwards, the HOSC would expect NHS England to explain the evidence for requiring a minimum number of procedures per surgeon at this level. The evidence the HOSC has seen as part of the ‘safe & sustainable’ review indicates a trend with increasing procedure numbers, but not linked to a particular threshold.

The HOSC would caution the review team to make sure the data on current numbers of patients requiring ACHD surgery (and predictions of future demand) are robust, as this will be important to underpin proposals regarding the future number of centres required.

The Hampshire HOSC has consistently argued that the primary factor in designation should be the evidence that a potential centre will provide quality services. A track record of delivery of good outcomes for patients is an important indicator.

D2: Co-location of services on the same site

It is welcomed that issues of co-location are being addressed early in the process of this review. In the HOSC’s experience of other service changes, achieving clinical consensus about interdependent services has been an important aspect.

With regard to the services listed under D2, the HOSC would like to comment in relation to vascular services. Due to the recent publication of the national specification for vascular services, developments are currently underway to identify how these services will be provided in Hampshire in future. The outcome of this work will therefore impact on the ability of Southampton General to offer ACHD surgery. Commissioners involved with that work will need to be aware of this implication.

D3: Co-location of services (on the same site or within 30 minutes)

The HOSC would expect to see the clinical requirements for the co-location of these services e.g. is there potential for support to be required from these other disciplines during congenital heart surgery? If surgical accompaniment is not the reason, this explanation would need to justify why the presence of those services within the wider ACHD network of hospitals would not be sufficient.

Of those services listed, the HOSC supports the requirement for the co-location of an obstetric unit, as per our previous comments to the review team regarding appropriate support for ACHD patients when giving birth.

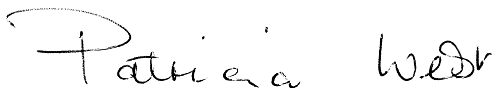
General Comments:

The requirements for co-location and the drive for fewer centres to concentrate expertise has set a direction of travel that will mean those hospitals that are successful in receiving designation for specialist services in this early phase will have an advantage in future phases of designation. Care needs to be taken regarding the potential consequences of this approach for the broader health system. Those that achieve designation for specialist services will need to ensure they have the capacity to absorb additional patient flows. Those hospitals that are not designated providers of specialist surgery will need a sufficient portfolio of other services that they remain financially viable and attractive to clinical staff.

The HOSC is supportive of service changes in the NHS that result in the provision of a higher quality of care for patients, and understands the evidence for pooling expertise in the rarer procedures. However, equally the HOSC would not like to see a local hospital de-stabilised by successive reductions in surgical procedures it can undertake, which could threaten the viability of the remaining services for local people. NHS England, in its role as the NHS Commissioning Board, will need to consider strategically the combined impact of the range of specialist commissioning standards, in terms of the viability of the broader health economy.

Please do not hesitate to contact me should you have any queries about the issues raised in this correspondence. We look forward to receiving further information as the ACHD review develops.

Yours sincerely



Cllr Pat West
Chairman, Health Overview and Scrutiny Committee
Hampshire County Council

cc Debbie Fleming, NHS England Area Director (Wessex)
Mark Hackett, Chief Executive, University Hospitals Southampton NHS FT
Simon Jupp, Director of Commissioning, NHS England Wessex Area Team

Appendix 4

NHS England (Wessex)
Oakley Road
Southampton
Hampshire
SO16 4GX

Email: debbie.fleming@nhs.net
Telephone: 023 8072 5600

16 July 2013

Dear Colleague

VASCULAR SURGICAL SERVICES - PORTSMOUTH AND SOUTHERN HAMPSHIRE

In line with our commitment to maintaining good communications, I should like to bring you up to date with some recent developments regarding the provision of vascular surgical services in Portsmouth and southern Hampshire.

As you will be aware, specialist commissioners (now part of NHS England) and local Clinical Commissioning Groups have been working for some time with Portsmouth Hospitals NHS Trust and University Hospital Southampton NHS Foundation Trust to develop joint arrangements for the delivery of vascular services. In this way, it was intended that the new national minimum standards (formally published in February 2013) would be met by the two Trusts working together to deliver a network solution, in the same way as other hospitals.

However, it has now been confirmed that the national specification requires that all complex vascular surgery takes place at one arterial centre, and Portsmouth Hospitals NHS Trust has recently informed us that it does not wish to take part in a network that involves such a move. As such, discussions between the two Trusts are no longer continuing.

I am aware that all those with an interest in this matter have been hoping that the two Trusts would be able to agree ways of working together that would enable the minimum national standards to be met, and for a while, this looked possible. Clinicians at both Trusts have made good progress in recent months in agreeing plans for a joint rota, which it was hoped would ensure that services could be provided 24/7 across both hospitals. However, the clinicians could not take this any further forwards without the full endorsement of the two organisations involved, and this has not been possible, given the longer term implications of introducing such a change.

Unfortunately, maintaining the status quo is not an option because the national minimum standards come into effect from 1 October 2013, and as commissioners, we must ensure that local Trusts meet these standards. In this way, we can be confident that we are securing safe, high quality services for patients on a sustainable basis.

It is important to note that a large number of service specifications have been developed, encompassing the whole range of different hospital specialties - not just vascular services. These have been devised and agreed by clinicians working within each particular specialty, from hospitals across the whole country. As such, they represent the consensus clinical view as to what comprises a good service, and how best outcomes can be achieved for patients.

As part of the national process, all NHS Trusts have now been asked to assess themselves against all these new national service specifications. Once this self-assessment work has been completed, NHS England will confirm the next steps and the timescales involved in ensuring compliance. Whilst all Trusts are required to meet these standards by 1 October 2013, an extension may be agreed in certain circumstances – but only where there is a robust plan in place to enable the Trust to meet the specification within a specific, designated timescale.

Clearly, with regards to vascular services, we have been aware that these new standards were coming for some time, and we have already carried out a lot of work to assess the implications for local Trusts. Under the national specification for vascular surgical services, vascular medical teams should consist of a minimum of six vascular surgeons, and in an emergency, patients should have immediate access to a full vascular team. In order to ensure that surgeons keep their experience levels up, at least 60 abdominal aortic aneurysm repairs should be carried out at the hospital per year (that is, each surgeon carrying out about 10 per year); and at least 50 operations to clear the carotid artery should be carried out at each hospital per year. Aortic aneurysm repairs should also be carried out in specialist centres, by experienced clinical teams.

Portsmouth Hospitals NHS Trust currently has only five surgeons taking part in the vascular rota, and the majority are not undertaking sufficient aneurysm surgery to meet the national standards. All other local hospitals work together as part of various vascular networks to ensure that six or more consultants are included on the rota.

You will recall that three independent panels have reviewed this situation over the past two and a half years, and all of these have concluded that a network model involving the two Trusts would provide the most sustainable solution for the people of Portsmouth and southern Hampshire. As it would appear that this is not going to come about through discussion and agreement between the two Trusts, we (as Commissioners) are now planning to consult on the options as to how we can commission a service that will ensure that all the minimum standards are met. Our intention will be to ensure that any new arrangements for vascular services meet the national standards, whilst at the same time, ensuring that as much activity as possible is retained within local hospitals. In this way, we expect to commission the best possible services for local people.

Now that the national process has caught up with our local work, we have decided to "dovetail" our work programme into the national programme, so that all the timescales align. Under the latest national guidance, all Trusts are required to complete their self-assessment by 19 July for consideration by the Area team. The outcome of this work across the country will then be assessed nationally. We anticipate receiving confirmation as to next steps and timescales in September, and once this has been received, we will be able to firm up our own timescale for consulting on this change.

Finally, it is recognised that the arrangements for the provision of vascular services locally have raised a number of concerns in the past - not least, the potential impact

upon other services at Queen Alexandra Hospital. To date, the advice we have received has been that there is no reason why there should be a detrimental impact on other specialties, provided that the vascular consultant rota makes provision for appropriate cover to the hospital. We are currently seeking further external advice on this matter, and will continue to test this as we take this work forwards.

In closing, I should like to reiterate that we are committed to informing and involving all stakeholders in this important work, and we will of course keep you apprised of further developments. In the meantime, if you have any specific queries or concerns, please do not hesitate to contact me.

Yours sincerely

D M Fleming (Mrs)
Area Director (Wessex)
NHS England

cc: Ursula Ward, Chief Executive, Portsmouth Hospitals NHS Trust
Alastair Matthews, Acting Chief Executive, University Hospital Southampton NHS Foundation Trust
Clinical Leads and Accountable Officers: Portsmouth CCG, South Eastern Hampshire CCG, Fareham & Gosport CCG, Southampton City CCG, West Hampshire CCG, Isle of Wight CCG