Update on plans for reprovision following removal of services from Odiham on 31 July 2011 – Update Briefing
As you are aware, Southern Health (formerly Hampshire Community Health Care) will be withdrawing from services at Odiham Cottage Hospital on 31 July 2011.

We would like to share with stakeholders the work that is currently going on at the hospital to ensure that patients, staff and stakeholders have minimal disruption during this period, and give our assurances of how patients who may have attended Odiham will now be cared for by Southern Health with the same level of quality and in the safest way possible.

Patients
There are currently no patients remaining in Odiham Cottage Hospital, with 2 being discharged this week and a third transferred to Fleet Hospital as planned. This is due to the current level of demand on the beds at the site. It has previously been agreed that there would be no further admissions after 15 July.

Every new patient admitted to the hospital was issued with a letter which explained that if their inpatient care was required past closure, there would be a requirement for relocation. To date, we have received no complaints regarding this.

Staff
Staff have been kept informed throughout the whole process through 1:1s with the Ward manager and meetings with Human Resources, and we had 11 substantive members of staff remaining at the site:

1 wte band 7
1.66 wte band 5
3.9 wte band 2

All staff contracts have been transferred to Calthorpe Unit, Fleet Hospital to ensure they have assurance that there a position for them in the organisation and are being supported with training and development where needed. These staff have now transferred to Fleet Hospital for a period of induction.

Contracts/Building
We are continuing to work with the OCH Trustees to go through all of the materials in the building and determine ownership.

Stores in the building have been maintained to minimum safe levels of stock and transfer of the remaining stock has been organised for 28 July.

Medicines Management
We have agreed with Basingstoke Hospital that where possible and safe to do so, stocks have been moved back to the hospital to be used within their existing supply. Again, where safe to do so, all safe and in date stocks have been recycled and redeployed into nearby inpatient facilities, such as Fleet Hospital, to be used there. Any materials we cannot re-use and controlled drugs have been destroyed on-site in accordance with Trust Policy. There are no drugs remaining on site.

Contracts
Notice has been given on all contracts to cease on 31 July or before where possible.

Patient Pathway
In order to ensure that patients in Odiham will still receive an excellent standard of care, and whilst Calleva and NHS Hampshire develop the hybrid model of care for Odiham patients, we are proposing the following pathways:

- rehabilitation

Where possible, we will be providing continuing care and rehabilitating patients within a community setting. The community care team has a wealth of knowledge and experience of this within patient's homes, and supported by a rapid response team (if there is a crisis) and a virtual ward (if a patient needs more intensive support), are all aiming to make sure that patients don't go into an acute hospital. We have also started using tele-health (allowing patients to monitor things like blood pressure and weight themselves daily and nurses being able to access this data centrally) which means that patients can take control of their care, but with the reassurance that nurses are available if there is anything untoward.

- treatment for conditions amenable to care at home e.g. leg ulcers

This care will be transferred to the patient's home or community clinics, if not house-bound. We have already had many successful examples of where community-based leg care clinics have significantly improved the healing time for leg ulcers, and cured conditions that have been unsuccessful in home-based environments. This is due to the fact that nurses can see more patients more frequently than they could if they were travelling between home bases.

- admissions from local hospices for end of life care

End of life care will now transfer to Fleet Hospital. In terms of bed capacity, it is expected that the hospital will be able to accommodate for the amounts of patients that needed, or requested to die in hospital. However, we know that a large amount of people choose to end their lives in the comfort of their own home, so our community care team will continue working with patients to ensure that they can end their life in the place of their choosing where possible.

What will remain?

Community Care Team (**CCT)**

Our CCT has been realigned with the Basingstoke team and is working with Calleva to support the relevant developments. It provides a variety of services to the local community, including:

Community Nursing -Nursing care and support for patients in their own home and also in a clinic setting (i.e. wound care clinic, continence).

Community Rehabilitation - Longer term rehabilitation to promote independence including Falls Prevention, Early supported discharge, prevention of admission and equipment advice and provision.

Support for palliative and end of life care - For patients undergoing palliative treatment, they receive ongoing support to reduce anxiety and address their needs and concerns and also prompt treatment of unpleasant symptoms. When they reach the end of life they and their families will have the reassurance that the service is committed to supporting them throughout this period and to achieving a dignified and peaceful death in their place of choice.

Virtual Wards - Working with partners in Primary and Social care, the "virtual ward" model identifies and case manages those patients needing complex chronic disease management or palliative care supporting the needs of the local community.

Rapid Response - For patients in crisis – short term intensive support to prevent hospital admission, with up to three visits a day if necessary.

Support for Long Term Conditions - Providing individualised care plans for patients with Long Term Conditions, so that their condition remains as stable as possible and, where appropriate, hospital admission is prevented and early discharge facilitated.

Health Promotion and disease prevention - Leading and participating in screening and needs assessment of individuals as required and undertaking health promotion and disease prevention activities with individuals or groups in line with the public health agenda.

Support for step up inpatient beds - In partnership with General Practitioners, providing seamless care for patients through step-up based care in the Community Hospital setting (Alton and Fleet)

Supporting Re-enablement beds – Therapy and nursing support to adult services' clients requiring a programme of care that facilitates and encourages return home rather than admission to long term residential or nursing home placements.

Community Innovations Team - Providing advice and support for people who are just starting to experience difficulties maintaining their independence and wellbeing, or are socially isolation with previous input from social services.

Inpatient Facilities

Fleet Hospital is approximately 7 miles away (20 minutes drive) from Odiham Cottage Hospital. The current bed capacity sits at approx 70 – 80%, so will be able to accommodate the additional patients who would have resided at Odiham.