Agenda Item 8

HAMPSHIRE COUNTY COUNCIL

Report

Committee:	Health Overview and Scrutiny Committee
Date of Meeting:	27 March 2012
Report Title:	Proposals to Develop or Vary NHS Services
Report From:	Chief Executive

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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 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/scrutinyfallsframework.pdf

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

2. **Southern Health NHS Foundation Trust: Improving Outcomes for Hampshire's Adult Mental Health Services.**

Update on Implementation

2.1. Southern Health will provide an update on the implementation of the proposals supported by the Health Overview and Scrutiny Committee at the 24 January 2012 meeting. The supporting paper (Appendix One, p.8) addresses the points raised via a supplementary letter to the Trust following this meeting. These were:

a) The latest developments in relation to the future use of Woodhaven.

b) Evidence regarding the outcomes of having additional community support in place in the New Forest.

c) Progress being made in implementing the community focused model of care elsewhere.

d) The latest bed demand figures to demonstrate if the reduction in demand reported in January has been sustained.

Recommendations

2.2. Members confirm:

- Whether the Committee continue to support the way forward proposed by the Trust in relation to Adult Mental Health services

- If they are satisfied with the actions of the Trust in implementing the proposals to date

- The information to be provided by the Trust at the July meeting

3. Southern Health NHS Foundation Trust: Older People's Mental Health Services

3.1. The HOSC received a presentation from Southern Health at the 24 January 2012 meeting, which provided an update on developments within the Older People's Mental Health (OPMH) service in Hampshire. Following this item, the Chairman wrote to the Trust confirming an invitation to present proposals on the future of the OPMH service at the 27 March 2012 meeting, and requesting further information which would be required by the Committee alongside the Trust's detailed proposals. These were:

a) Where OPMH beds are currently located and how this might change in future.

b) Trends in bed usage for OPMH, with data broken down by organic and functional illness.

c) How future demographic changes are being taken into account and what demand is expected for OPMH services.

d) The evidence base for moving to any community-based alternative model for OPMH, including examples of how service users can safely be supported in the community e.g. what support is available 24/7, crisis care, etc.

e) How resources will be organised to support an alternative model of care.

f) How service users are risk assessed to identify if inpatient care is needed.

g) How the proposals accord with the latest thinking nationally regarding good practice in OPMH.

h) What engagement has been undertaken with relevant stakeholders, and what is planned going forward.

i) What feedback has been received from service users and carers and how Southern Health are responding to any concerns raised.

j) How Southern Health are working in partnership with HCC Adult's Services.

3.2 A paper responding to these points, and including the detailed proposals for OPMH services, is attached (Appendix Two, p. 19)

Recommendations

3.2. Members confirm:

- If they consider that there has been appropriate stakeholder engagement in the development of the proposals for improving outcomes for older people's mental health services in Hampshire.
- If they are satisfied with the next steps proposed by the Trust.
- Any additional information to be provided by the Trust.
- That the Trust be invited to the July HOSC meeting to provide an update following consultation.

4. SHIP PCT: Vascular Surgery

4.1. Since the meeting of the HOSC on 24 January 2012, SHIP PCT has provided the Committee with a letter providing feedback on negotiations around a network vascular service model, and the SHIP PCT Cluster's decision to continue to commission the historical vascular service in South Hampshire (Appendix Three, p. 27). The Chairman responded to this communication, setting out the supplementary information that the HOSC would require following this decision (Appendix Four, p. 30), which included (annotated from text);

a) evidence which demonstrates that all Trusts providing vascular services in the South Hampshire region have specialist clinicians available 24 hours a day, 7 days a week, staffed by the recommended 1 in 6 surgeon rota, and shows that these arrangements will be in place across all Trusts from 1 April 2012, and will remain so going into the future.

b) the number of operations and procedures that would need to be performed annually at Queen Alexandra Hospital in order to meet the Vascular Society guidelines, and remain viable, going into the future, as well as details of how SHIP PCT will be working to 'maximise' activity levels at the Trust.

c) the position of NHS Sussex to be clarified on the flexibility of GPs in the West Sussex region to refer to Portsmouth Hospitals Trust.

d) the national outcomes data in relation to vascular services for all the Hospital Trusts retaining vascular surgery in the South Central region for comparative purposes, as well as a summary highlighting any difference in outcomes for both planned and unplanned care.

4.2. An update paper has been provided by SHIP PCT (Appendix Five, p. 32).

4.3. A letter of response has also been provided by SHIP PCT in response to the Chairman's letter, and is attached (Appendix Six, p. 35).

Recommendations

- Members note the decision to continue to commission the historical vascular service in Hampshire.

- Members consider whether they require any further information on this service, and the timings for a future update.

Items for Information

5. **SHIP PCT and HCC Children's Services: progress in relation to the provision of therapy for children with special educational needs**

5.1. The Chairman of the HOSC last wrote to SHIP PCT in November 2011, and asked for comments in relation to the following points raised:

a) what precisely will be commissioned, and what improvements should children experience? (Rec 1)

b) whether ways to make more effective use of existing resources have been identified in order to improve therapy input for children, and if so what these improvements are and what difference have they made? (Rec 4)

c) whether parents have been assigned a 'lead professional' to help them negotiate the system and respond to concerns: how has this been taken forward? (Recs 2, 3 & 6)

d) whether schools and therapy services have been involved in the development of the joint strategy: has their input been considered, and how satisfied are they that what you intend to commission will improve on the experience of the children? (Rec 1)

5.2. SHIP PCT and HCC Children's Services have provided a paper containing progress in relation to the provision of therapy for children with special educational needs (Appendix Seven, p. 39), following a verbal update given at the 24 January 2012 meeting.

Recommendations

- That members consider appointing a working group to explore the options outlined in the attached report.

- That members identify any additional information required following this update.

6. **SHIP PCT: falls review progress update**

6.1. An update on the falls review was last heard in September 2011, where initial plans were outlined following the submission of the HOSC's recommendations to SHIP PCT and HCC Adult Services. It was agreed that a further update be provided in March 2012, where the following points would be presented:

a) the agreed strategy and pathway;

b) the defined success measures;

c) who the Trust have consulted with; and,

d) composition of the 'Multi-agency Steering Group'

6.2 A paper updating the Committee on progress with the Falls Review is attached (Appendix Eight, p. 45).

Recommendation

- That members identify any additional information required following this update.

7. **National Specialist Commissioning Board: Children's heart surgery**

7.1. The Committee last received an update on this national review in November 2011, where the outcomes of the judicial review on the consultation undertaken on children's heart surgery was heard.

7.2. The attached report (Appendix Nine, p. 73) details the outcomes of a recent referral to the Secretary of State by Yorkshire and Humber Joint Health Overview and Scrutiny Committee (JHOSC) on the 'Safe and Sustainable' Review of Children's Congenital Cardiac Service In England. The Independent Reconfiguration Panel in considering this referral recommended that stakeholders have the opportunity to comment on the independent report undertaken by pwc for the National Specialised Commissioning Team on family travel analysis (entitled 'testing assumptions for future patient flows and manageable clinical networks'). The report attached includes for member's agreement a

draft response to the JCPCT in the light of the findings of this report (which was published after the HOSC's previous submission to the JCPCT).

Recommendation

- That members agree the response to be submitted to the JCPCT on the independent report on family travel analysis.

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:

N/A

2. Impact on Crime and Disorder:

N/A

Appendix One

Southern Health NHS
NHS Foundation Trust

HEALTH OVERVIEW AND SCRUTINY COMMITTEE PAPER - 27th March 2012

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

Submitted by: **Adult Mental Health Division, Southern Health NHS Foundation Trust [SHFT]**

Date: **15th March 2012**

Purpose
This paper serves to provide an update of progress since January 2012 in relation to the redesign of adult mental health services [AMH] provided by Southern Health NHS Foundation Trust across Hampshire.

1. Acute Care

Hospital at home service (H@H)

The acute care teams in the redesigned service consist of acute inpatient units and a hospital at home service, working closely together. The hospital at home service is an extension of the current highly successful home treatment provision, but they offer a higher intensity and range of multidisciplinary therapeutic interventions for acutely ill service users that are tailored to be delivered to individuals in their own home.

In February the division continued refining its plans for implementing the Hospital at Home service and the phased reduction in bed capacity; ensuring resource levels, clinical protocols and practices were appropriate and at a state of readiness to support the transition to the new acute pathway.

Staff at the Meadows will be part of the first wave of Hospital at Home teams and a comprehensive training programme on implement recovery has now been developed and will be rolled out from March onwards across the division, enabling staff in these teams to deliver high quality care to service users as soon as they are transferred back into a community setting.

The following developments are part of the hospital at home service:

Intensive day support programmes

The programme enables people with acute mental illness who would otherwise be admitted to hospital to get the support they need whilst continuing to live in

their own homes as part of our wider ‘Hospital at Home’ provision. The service offers individually designed alternative coping styles and programmes to enable service user to take a central role in their own recovery, either in an individual or group format, or both.

The Emotional Coping Skills Group at Woodhaven offers a 4 week rolling programme, with 2 sessions per week. The group runs every month and is facilitated by psychologists and trained nursing staff and mental health practitioners. Participants in the emotional coping skills group are referred from the ward, crisis response team and community teams, eating disorders service or GPs. If a service user in the group is in hospital at the start of the programme and is then discharged as part of their planned care package whilst still in the group, they are invited to return to finish the group sessions.
Service users are also offered the opportunity to return to the group, or attend other programme to continue to build their skills and improve their recovery.

Between February and December last year 79 services users benefited from the emotional skills programme. Of those service users who accessed the programme whilst receiving inpatient care, shorter hospital stays were identified, and for those service users being supported by community mental health and early discharge teams a 100% successfully competed the full programme and went on to achieve increases in their ‘mental health confidence’ and ‘living with my emotions’ scores; illustrating the positive impact the programme had on the psychological well being and day to day emotions and beliefs of those service users.

Since January our Consultant Clinical Psychologist, continues to work with senior managers and clinicians to roll-out the programme across the areas. A training programme will be launched from April onwards to a wider staff group, to enable them to deliver therapeutic programmes both in group format and individually.

Discharge facilitators

These roles help with the early identification of admission objectives and issues that could block appropriate discharge, such as lack of suitable accommodation or the need for a home support care package. They also ensure good communication between teams and with carers. The ultimate goal is to create timely and well supported discharge.

In addition to the discharge facilitators in post in the North and East areas of the county, since January 2012 a residential placement office has been recruited in the South. The remaining discharge posts in the South and West are being offered as redeployment opportunities to staff as part of the divisional workforce restructure programme.

Crisis funds

Funds are available to each of our current crisis resolution and home treatment teams (and later hospital at home teams when they are set up), to purchase items to either avoid inappropriate admission to hospital or help with early discharge.

Funds continue to be utilised effectively across the region, with 15 service users having benefited from the initiative since December last year. In half of cases funded, money has been used for the purpose of facilitating discharge from hospital by for example providing money to place a deposit on accommodation and arrange travel their from hospital to home. Other examples of payments have been to buy food provisions, purchase electricity credit and buy basic home furnishing to enable service users to start to build independence and improve self confidence, on their journey to recovery.

2. Community Teams

Access and assessment teams (AAT's)

Access and assessment teams will receive new referrals into the service and offer brief interventions, crisis support and transfers for new and known service users. Individuals who are assessed as acutely unwell by the team will be transferred directly to the Hospital at Home team for intensive support, or admission to hospital where required.

In each of the four areas of Hampshire the area managers have been working hard to fine tune the planning to facilitate the single point of access for services users who reside in their catchment area. The planning has included the mobilisation of staff to new accommodation and the allocation of equipment to support new efficient ways of working to ensure a seamless journey for the service user from the point of referral.

Clinical Service Directors have designed and produced GP Information Packs to support GPs in referring to the new acute pathway. These packs will be distributed during March as part a planned programme of events between local GPs and their mental health clinical colleagues.

Community Treatment teams (CTTs)

The community treatment teams are organised around distinct commissioning clusters linked to GP practices. They coordinate the care of service users in the community and facilitate the recovery process by linking in with other community resources to support independent living by offering treatment and information to services users in their communities.

Care coordinators within this team provide interventions to improve the wellbeing of service users and their overall level of functioning, whilst case officers focus support in the more practical areas such as advice around finance

and accommodation. The multidisciplinary team approach ensures services are delivered in a systematic and co-ordinated care orientated way.

Other functions of the community treatment teams, such as the current early intervention and assertive outreach teams, will in the first phase of the redesign continue to operate as separate teams across all areas, whilst managers complete the transition and integration of the community treatment teams to ensure there is a safe approach to the allocation of caseloads from April 2012 onwards.

3. Supporting mechanisms

Standard Operating Procedures and Clinical Pathways

The standard operating procedures and clinical pathways which articulate for staff what, where, how and when the new services will be delivered continue to be updated as clinical and non-clinical systems and process become more concrete. During March there has been a specific focus on the local clinical interfaces between the internal teams and external services and key systems, to ensure that service users receive equitable access where ever they reside in Hampshire.

By the end of March the content of the Operating Procedures will be transposed into illustrative materials and tools to support staff training, service user education and stakeholder communication events; which continue to be conducted in the West and East areas.

Staff induction

A comprehensive training programme on the recovery model is being rolled out to all staff from March onwards. In addition, facilitated by the Trusts Learning and Development Team further training and development events are being held on Assessment Skills, and divisional nurses and clinical staff are being provided with education materials, support and resources to empower them to deliver training at a local level across all disciplines.

Activity apportionment

Since January as part of the Trust's commitment to achieving quality and clinical outcomes in line with national and local targets the division has been participating in formal dialogue with commissioners regarding its contractual obligations and performance standards in light of the revised and improved acute care pathway. Detailed work is now being undertaken at project level and monitored at divisional and corporate levels to test assumptions, identify and mitigate risks and ensure that during each phase of the transition from the old ways of work to the new activity level are achieved, services are accessible, and the service user experience is not only maintained, but exceeded.

East and West Area Stakeholder Meetings

We continue to have monthly stakeholder meetings, in east and west areas. Attendees have included service users, carers, councillors, a local MP, and Trust governors, alongside staff from the Areas who are directly involved in delivering the service changes. These groups have discussed progress with the redesign of services, and considered some issues in more detail, including personalisation, communication plans and recovery.

Support for Carers

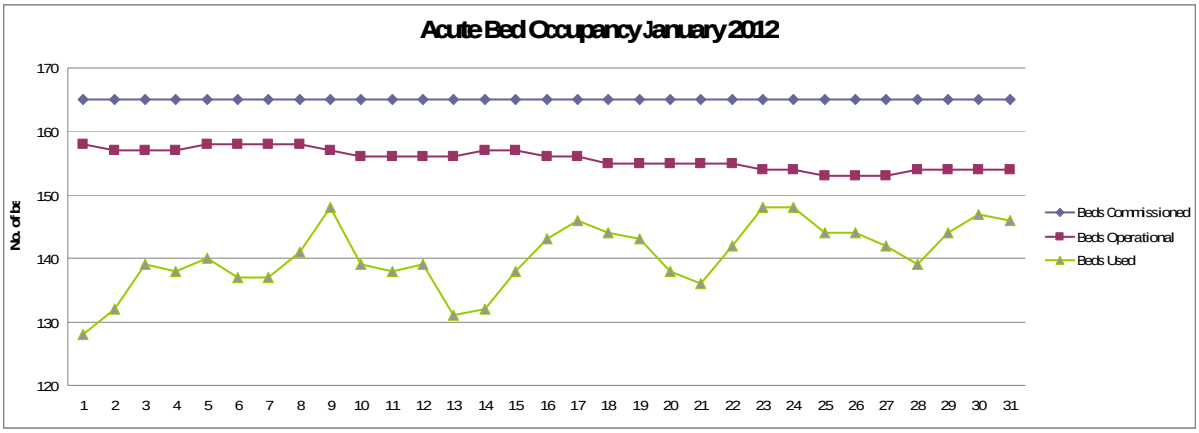
The Princess Royal Trust fro Carers has conducted a survey of carers of people who are receiving acute care in the community. The full report is attached (Annexe A), and describes feedback from carers that their concerns were listened to, and that the majority were happy with the treatment received.

In the last month Solent Mind appointed a project manager, on our behalf, to lead a carers project. The aim of the project will be to support staff to more effectively work in collaboration with carers.

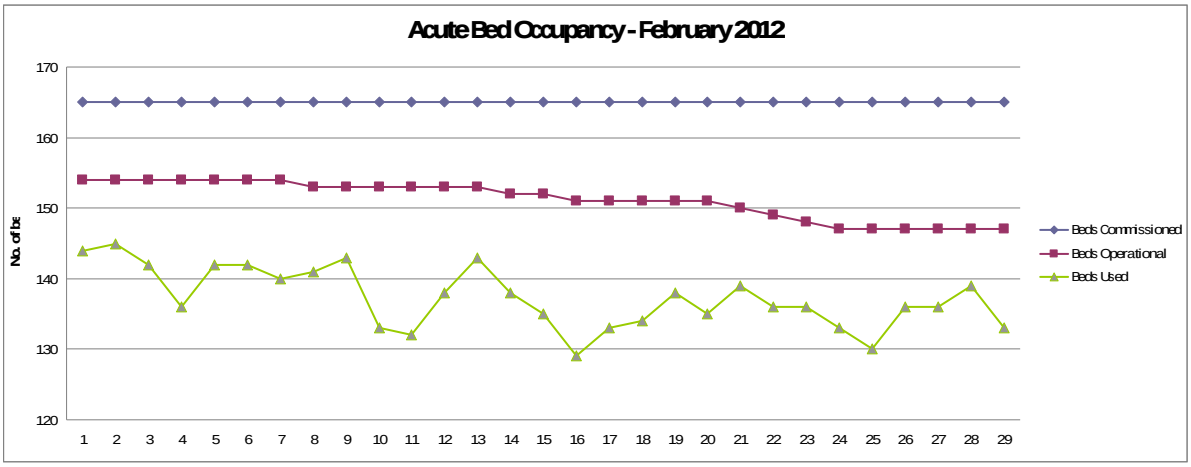
4. Phased Bed Reductions

Since reporting to the HOSC in January this year service users continue to have access to a bed as and when it is deemed clinically appropriate. During the phased transition to the new acute care pathway model the Divisional Management Team continue to carefully monitor patient flow and staff resources on a regular basis to ensure there is flexibility in the system and services users are safe.

Our commissioned bed capacity remains static at 165 beds across the region, with January's average bed occupancy at approximatley140 beds being occupied per day. Taking account of the fluctuations at weekends when patients are on leave or discharged February data illustrates an approximate average of 137 beds being occupied per day.



During February the divisional Acute Care Support Team provided intensive resource to the East area to support the phased reduction in beds at the Meadows. This has continued in a planned way with every service user provided the appropriate clinical and social care support as part of their comprehensive care plan, prior and post their discharge.



As the east reduces the number of beds at the Meadows, the Hospital at Home service in the east is launching. The east area aims to have all of the beds at the Meadows closed by early to mid April and will ensure that this is done in conjunction with bed capacity plans across the whole of Hampshire.

Similarly in the west the acute care support team are providing additional capacity into the wards to support the care packages of those west service users affected by the closure of beds at Woodhaven. With the success and lessons learnt in the east and the intensive day support programme available in west, management and clinical teams have built a detailed plan around the phased reduction and launch of the Hospital at Home service in this area.

The west plans include a comprehensive clinical review of all inpatient service users, the utilisation of bed capacity out of normal hospital hours, the use of step down facilities and interfaces with other community services and providers, and the safe and appropriate levels of staffing required both in the ward, and in the hospital at home teams to facilitate the peaks and troughs in activity.

4. HOSC Considerations:

The Trust would ask the HOSC to consider the following:

- Note progress to date and continued engagement with internal and external stakeholders

- Note the progress to date on the reduction in bed occupancy

- Note the attached Carer Evaluation of Crisis Resolution and Home Treatment Services undertaken by the Princess Royal Trust for Carers in Hampshire

- Identify what members would wish the Trust to report on at the July HOSC

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The Princess Royal Trust for Carers in Hampshire

Company no.2955846 Charity no. 1040518

Carers Evaluation of Crisis Resolution and Home Treatment services

50 carers were asked to complete these evaluations; carers contacted were those who have used CRHT from Andover, Winchester, Eastleigh and New Forest

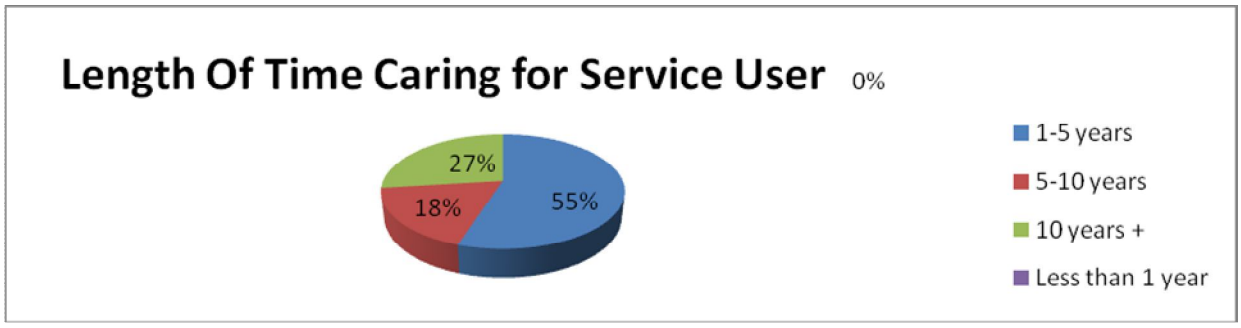
At this time 15 forms have been received back. 11 Evaluation forms have been returned completed to date and 4 Forms were returned from carers who did not want to take part in questionnaire. We therefore have received a 30% return rate and this was targeting carers direct often handing them the forms to be returned, we would have hoped for a bigger sample group but understand the time and constraints that are put on carers especially those that are in Crisis situations. We will continue to collect back any additional forms received and add to data as timescales permit.

Information has been collated from these evaluations below.

Service user conditions varied and many had more than one diagnosis. This is reflected in the table. Some individual service users had up to 7 conditions ticked.

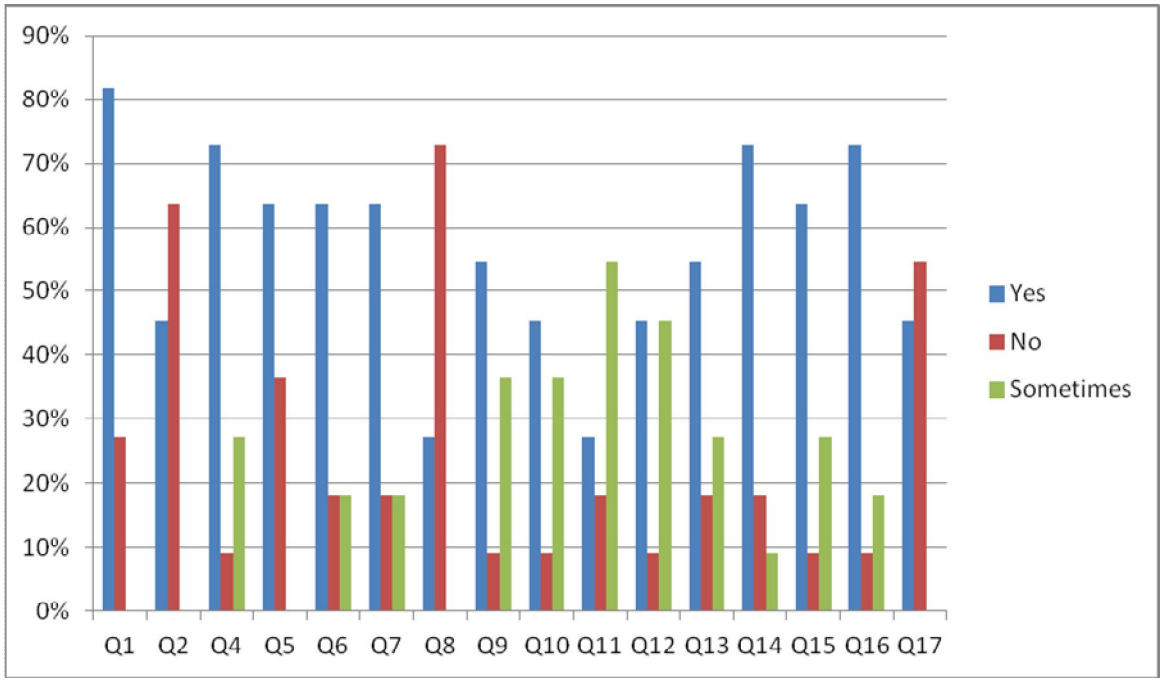
The results can be seen in the below table. It was clear to see that the majority under CRHT Had high levels of Suicidal feelings with Anxiety and Depression.

Anxiety	5	Phobia	1
Depression	6	Post-traumatic stress disorder PTSD	
Bipolar	2	Psychosis	4
Borderline Personality Disorder BPD	2	Schizoaffective disorder	1
Eating Disorder	1	Schizophrenia	3
Personality Disorder	1	Stress	1
Dissociative Disorder		Self-Harm	4
Obsessive – compulsive Disorder OCD	1	Suicidal Feelings	6
Panic attacks	3	Dual Diagnosis - Alcohol	1
Paranoia	4	Dual Diagnosis – Learning Disability	1
Other		Dual Diagnosis - Other	1



The overall feedback was positive 55 % of the carers questioned felt that the service could not have been improved upon at all. The remaining 45% gave some of the following suggestions within their comments. The families or carers would like to be involved from the start if possible and would find a speedy referral for the services such as carers support beneficial to support them. They would like involvement in the Care Plans from the start and to see more psychological input for the service user.

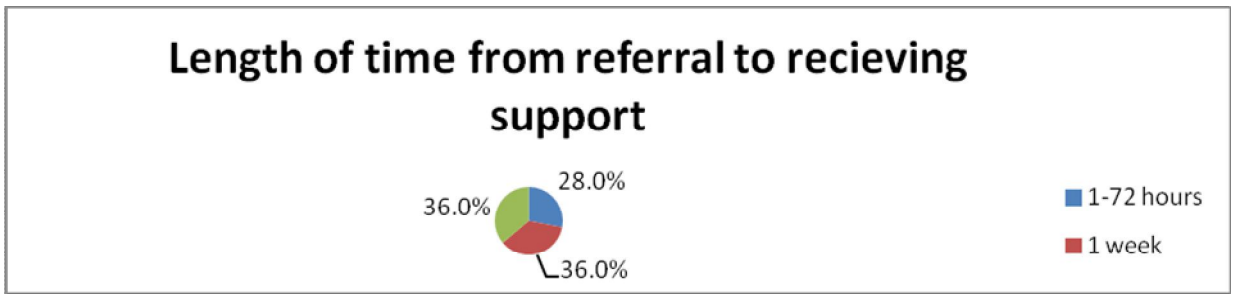
The chart shows the results in percentages to the individual questions asked.



A lot of positive feedback received as well as constructive suggestions. Note question 8 No would be seen as the positive answer with no negative impact on the caring role.

Breakdown of Results

1. Had the service user previously used MH services?
   Yes = 9 No = 3
2. Had the service user previously been an inpatient?
   Yes =5 No = 7
3. What was the length of time from referral for intensive treatment to receiving support?
   Less than 1-72 hours = 3 1 week = 4 2-3 weeks= 4



4. Do you feel the team listened to your concerns about the service user?
   Yes = 8 No= 1 Sometimes = 3
5. Do you feel the team have considered all the available treatment options?
   Yes = 7 No= 4
   Comments
   - No psychology group available
   - I felt everything was looked into and tried
   - Variable o different occasions when used team.
   - We were unsure that there were alternatives.
   - Our Son felt at first not listened too but once in place was happy with support provided.
6. Did you agree with the decision not to admit patient to hospital?
   Yes=7 No = 2 Not sure = 2
7. Did you find the Crisis support and home treatment team helpful?
   Yes = 7 No= 1 Sometimes = 2 unsure =1
   Comments: They were fantastic and a great help to X and myself.
   Wanted more support hours than was given.
8. Did this impact on your caring role? If yes please comment.
   Yes= 3 No = 8
   Comments:
   - People in and out of house all the time
   - Made me feel more stressed and I became unwell myself
   - It reassured me that I was being supported and felt listened to by the team which was fantastic.
9. Did you feel that you and the person you care for got the right level of support through this program as opposed to admission?
   Yes = 6 No = 1 Sometimes 4
10. Do you feel the information you are given is clearly explained?
    Yes = 5 No = 1 Sometimes = 5
11. Do you feel you are given the right amount of information about the service user's condition and treatment?
    Yes =3 No =2 Sometimes = 6
12. Do you feel the team involve you in making decisions about the service user's treatment?
    Yes = 5 No =1 Sometimes = 5

Comments:

- Sometimes don't feel listened too
- First impression was that we weren't listened too but once support was in place this improved.

13. Are you happy with the contact you and the service user received from members of the team prior to them taking over treatment and during treatment?
    Yes = 6 No = 2 Sometimes = 3
14. Are you happy with the treatment that has been received?
    Yes = 8 No = 2 Unanswered = 1
15. Did you feel you have the right amount of contact with the team?
    Yes = 7 No = 1 Unanswered = 3
16. Did you feel you could contact members of the team or an appropriate person such as your Carer support worker when you needed advice?
    Yes = 8 No = 1 Sometimes = 2
17. Do you feel the treatment could have been improved? If yes please provide suggestions.
    Yes = 5 No = 6
    Comments:
    - Would have liked someone to come out immediately when I called.
    - Felt admission would have benefited my husband more
    - Would have liked referral to my Carers worker straight away
    - Would have liked to be involved in care plan from the start.
    - Once initial contact with crisis team arranged then went better.
    - My carers support worker visits me often and I find this helpful I would think my daughter would benefit from more help and evenings and weekends
    - More Support worker staff available to take people out.
    - More psychology input

Conclusions

The main observations we can conclude from the evaluations received are that the carers did feel that their concerns were listened to 73 % of carers were happy with the treatment received and felt they were able to contact someone with their concerns.
All areas did have room for improvement and the comments made can be feedback and hopefully taken on board to be used to improve services as they continue to develop.
We would have hoped for a bigger sample group but understand the time and constraints that are put on carers especially those that are in Crisis situations.

Appendix Two

HEALTH OVERVIEW AND SCRUTINY COMMITTEE PAPER
27 March 2012

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

Submitted by: **Older Persons Mental Health Services, Southern Health NHS Foundation Trust [SHFT]**

Date: **15 March 2012**

Purpose

The purpose of this briefing paper is to provide responses to the letter sent from Cllr Pat West, Chairman of the Health Overview and Scrutiny Committee (HOSC) to Katrina Percy, Chief Executive of Southern Health NHS Foundation Trust (SHFT) on 1 February 2012. This followed a presentation from Dr Helen McCormack and Ms Amanda Horsman at HOSC on 24 January 2012. This briefing should be considered in conjunction with the presentation that will be given to the HOSC on 27 March 2012.

Introduction

Southern Health NHS Foundation Trust is seeking to commence a 12 week consultation on Older Peoples Mental Health Services in Hampshire. This would form the 3rd phase of delivery against the joint Hampshire commissioning strategy for older peoples mental health services which has already been delivered in the mid Hampshire and Eastleigh areas. The next phase of roll out is concerned with the services provided in the South East and West of Hampshire.

Current OPMH Inpatient Services

Inpatient care

The following wards are for people with organic mental illness, ie people with a dementia:

East Hampshire

- Daedalus Ward at Gosport War Memorial Hospital (17 beds)
- The Willows, Petersfield Community Hospital (10 beds)
- Summervale (for people with challenging behaviour) (20 beds)

West Hampshire

- Solent Ward at the Becton Centre, New Forest (15 beds)
- Stefano Olivieri ward, Melbury Lodge, Winchester (8 beds)

The following wards are for people with functional mental illness, ie severe depression, psychosis, schizophrenia, bipolar disorder:

East Hampshire

- Dryad ward, Gosport War Memorial Hospital (16 beds)
- Fernhurst, St James Hospital, Portsmouth (10 beds)

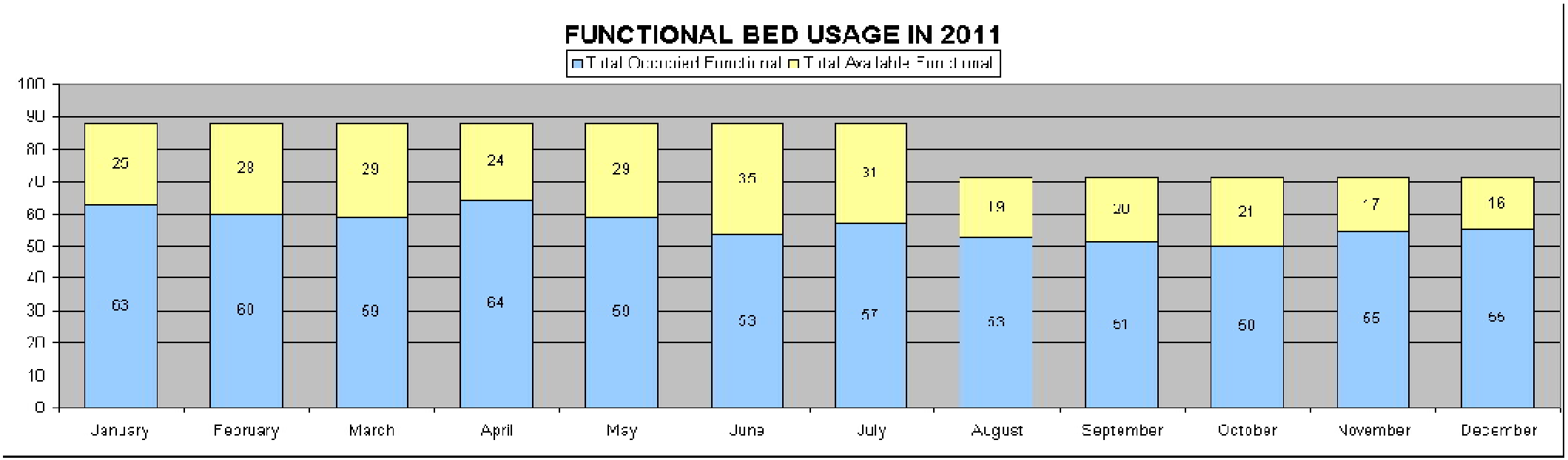
West Hampshire

- Key Haven, at the Becton Centre, New Forest (5 beds)
- Stefano Olivieri ward, Melbury Lodge, Winchester (7 beds)

In addition, emergency advice and support is provided by GPs and consultant psychiatrists, 24 hours a day.

Trends in bed usage for OPMH

There has been a decline in demand for inpatient beds as shown in the tables below.


FUNCTIONAL BED USAGE IN 2011
Total Occupied Functional
Total Available Functional
100
90
80
70
60
50
40
30
20
10
0
25
28
29
24
29
35
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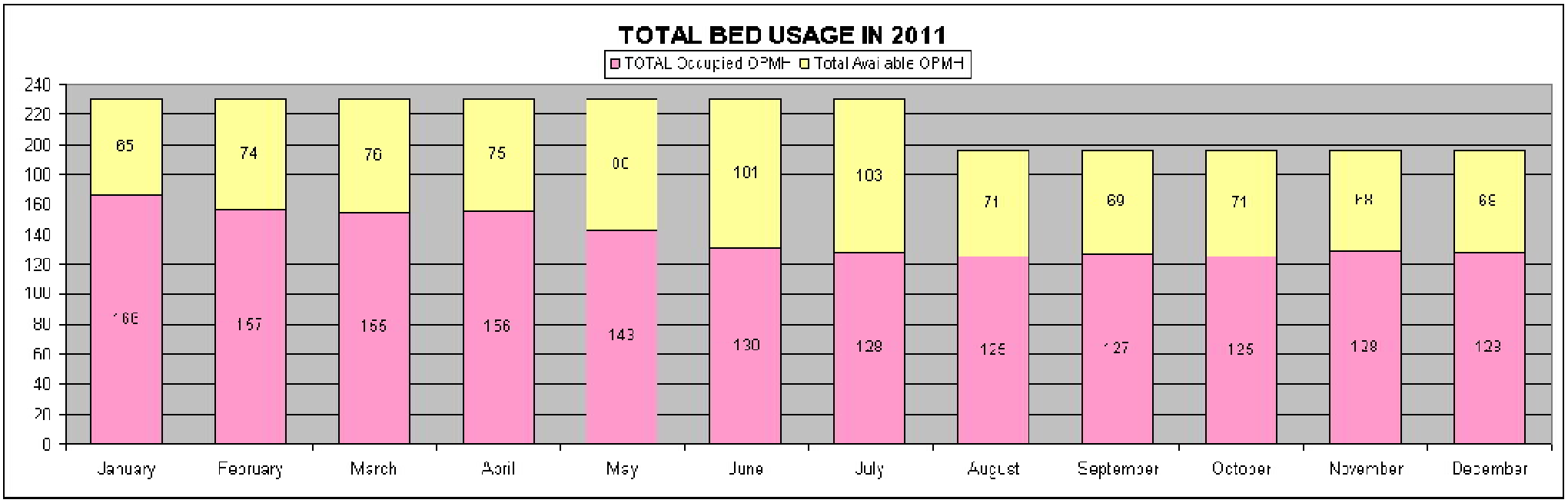
TOTAL BED USAGE IN 2011
TOTAL Occupied OPMH
Total Available OPMH
240
220
200
100
160
140
120
100
80
60
40
20
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65
74
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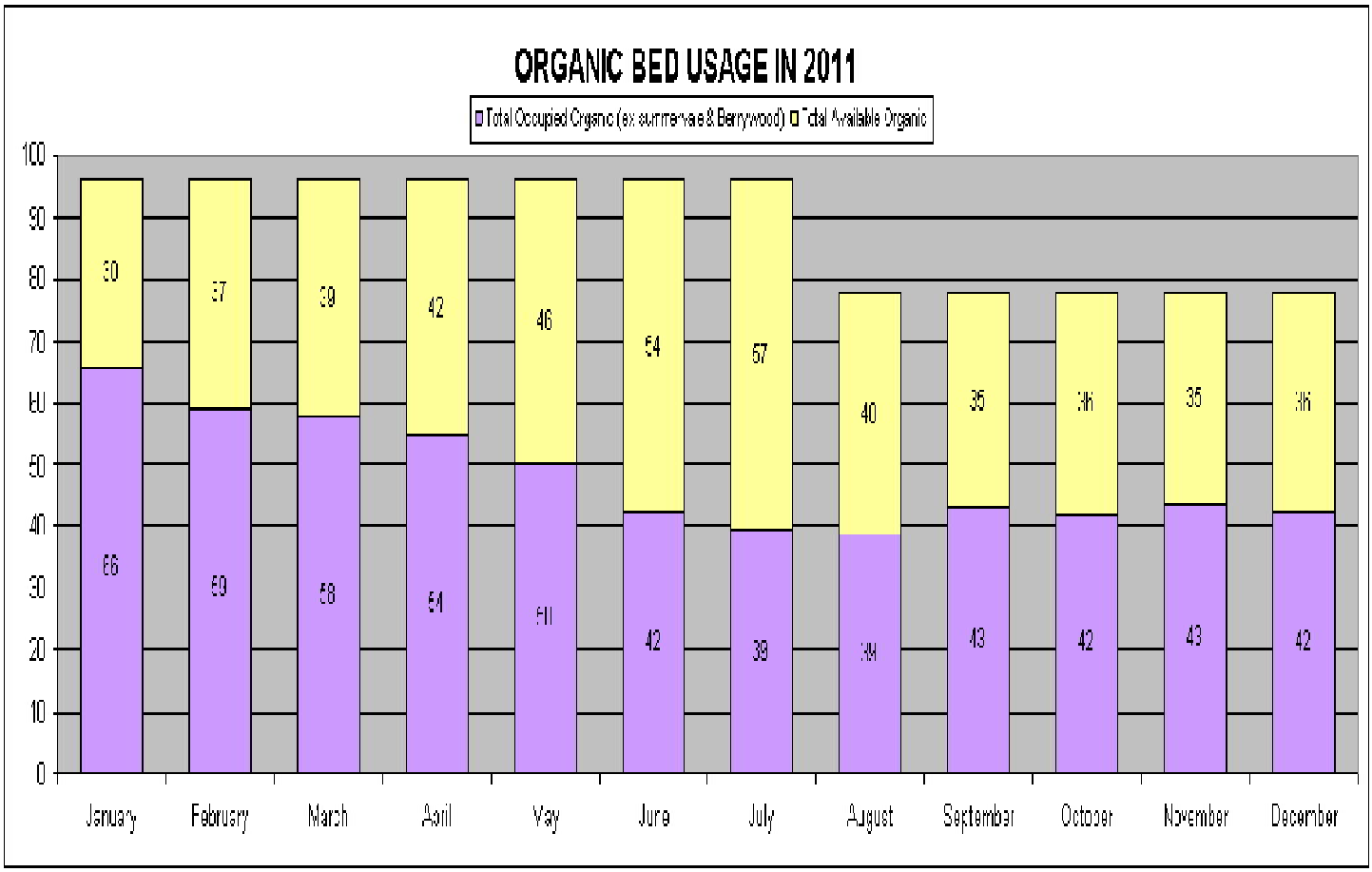
ORGANIC BED USAGE IN 2011
Total Occupied Organic (ex summervale & Berrywood)
Total Available Organic
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Demographic Changes

In Hampshire, 17% of our population are over 65. The population of over-65s will increase by 30% between now and 2020. In that same age group, it is anticipated dementia will increase by 37% and depression by 27%. Our aging population is a considerable challenge for the NHS, but we want to make sure we provide care and treatment which enables people to live well with mental illness in later life. Clinical evidence shows that the range of treatment available, including drug treatments, psychological and occupational therapies, now enables people to continue to live at home, or in residential care, for as long as possible, and often to the end of their life. Alongside seeing reduced demand for inpatient beds, we have seen increased demand for memory assessment services and psychiatric liaison.

We are aware of potential general increases in population with planned new housing builds, for example in the East of the county, and we are making sure any impact these developments may have are properly considered and reflected in our consultation.

Evidence Base

Nationally, clinical studies and evidence have shown that modern mental health care is changing and improving. Before considering these changes, we have considered the following policies and documents:

- the National Dementia Strategy (2009)
- the National Service Framework for Older People (2001)
- *Inpatient Care for Older People within Mental Health Services* (2011) by the Faculty of the Psychiatry of Old Age of the Royal College of Psychiatrists
- *Our health, our care, our say* (2005)
- *Everybody's Business* (2005)

All of these national documents have guided our planning. The common thread in these documents is the need for community based care for patients, as well as support for carers, and the need for earlier diagnosis and treatment.

How resources will be organised to support an alternative model of care

Because of the way in which we are providing community based services, we have seen the subsequent decline in demand on beds. We are planning to provide: -

- **More local rapid assessment for people with memory problems**. We know this is important as drug therapies are available for some memory problems, and early identification helps patients and carers make future plans. We already provide these assessments in outpatient settings and GPs' surgeries, but we want to do more and offer these assessments in more places.

- **Closer working with other services**. We want to work more closely with our own community care services for physical healthcare, Adult Services and make sure we work closely with acute hospitals and psychiatric liaison services

- **Improved care in care homes**. Working closely with colleagues at Hampshire County Council, we aim to continue to increase this role.

- **Access to drug trials.** Our memory assessment and research centre (MARC) in Hedge End is an internationally renowned research centre and we want to support patients to take part in drugs trials if they choose to do so.

- **Making sure our staffing meets the needs of our population**. We want to make sure our services are staffed in the most effective way possible so that the number of staff per head of population is equal.

- **Improved access to talking therapies by working closely with GPs**, and increasing access to therapies which we provide in the community.

- **Improved support to carers**. This will include services directly towards carers, recognising their role and providing improved information and support in caring for their family member or relative.

- **supporting GPs and other professionals** to recognise functional illness, such as depression, in older adults through training and access to specialist assessment

- **Work with Acute Hospitals** to provide secure and sustainable funding for psychiatric liaison services

How service users are risk assessed to determine whether inpatient care is required

All patients who are referred to our services are subject to comprehensive assessment including a risk assessment which is a dynamic and ongoing process throughout their treatment with us. In addition to this they have a care plan which is developed with them and if appropriate their family. This includes the formulation of a crisis plan which includes specific trigger factors that increase an individuals risk.

Best practice in OPMH Services

Our plans are based around the national documents described earlier, and also the local commissioning strategy for Hampshire together with feedback from stakeholders, service users and carers. The Department of Health has recently developed service specifications for some of the services that we provide and we are mapping our planned services around these national standards.

Engagement

Locally, we have undertaken a significant amount of engagement with our stakeholders, service users (including carers) and indeed our staff. We have also taken into consideration feedback from sources such as the National Patient Survey which is conducted annually and more recently we have conducted our own carer survey. In addition to this, the Hampshire Joint Commissioning strategy was widely consulted on prior to its launch. We have thus far held four engagement events, plus visits to a variety of groups and individuals, including GPs.

We have set up stakeholder groups in the East and in the West to help us ensure that our plans are robust and are influenced by local people. We have invited members of the Clinical Commissioning Groups and colleagues from LINks, Alzheimers Society, Governors, Carer Organisations (e.g. Carer's Together and Princess Royal Trust for carers) and others to attend. We envisage continuing these groups throughout and beyond consultation.

We plan to hold a wide-ranging consultation programme which will include public meetings, bespoke meetings with stakeholder groups, attendance at, for example, parish council meetings, on going discussion and update with LINks and we will also have a range of means for people to give feedback about our proposals. As with our previous consultation we will also be pleased to offer one to one meetings if this is what people would prefer and we would of course be pleased to offer regular updates to the HOSC.

Feedback

The feedback to date has generally been positive and people are supportive of our plans. In particular people are keen to see us stop spending money on empty beds. Transport is of particular concern and we have therefore developed detailed transport plans in each area and will ask for feedback about these as part of our consultation. Members of the stakeholder groups have been keen to work with us on these plans which is of course welcomed.

Other considerations we have been asked to take on board are: access to open air spaces (gardens), quality of environment, proximity of acute general hospital services and information and support to carers. In beginning to address these issues we are working initially with the stakeholder groups to identify which units may best placed to deliver to these requirements.

It has not yet become necessary but if during engagement and consultation any individual raises a concern about current care we will of course listen and take any necessary action to help resolve those concerns.

Partnership working with Adult Services

We have strong relationships with our colleagues in Adult Services and many of our colleagues have joined us in our public engagement events. We have a workshop planned (15 March 2012) with senior managers in Adult services to formalise plans for continued joint working in the areas where this consultation is taking place. As already mentioned, we have also been talking to our GPs and CCG leads about the plans.

HOSC Considerations:

The Trust would ask the HOSC to consider the following:

- Note progress to date in relation to engagement with internal and external stakeholders in connection with proposals for OPMH service development

- Note the continued evidence of the number of empty beds in OPMH services
- Advise the Trust with regard its wish to formally consult on proposals to reduce beds within OPMH services and to further develop community based services.
- To approve the proposal to formally consult for 12 weeks from 2 April 2012

Appendix Three

Southampton, Hampshire
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Headquarters
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Tel: 023 8072 5600

2 February 2012

Dear Colleague,

VASCULAR SERVICES

In my last update I promised to write to you as soon as I had received feedback from the Trusts with regards to their discussions about local vascular services.

Since the beginning of this process the PCT Cluster and local Clinical Commissioning Groups (CCGs) have listened to the concerns that have been raised about the original proposals to transfer all complex vascular activity to Southampton. In response, we modified the original proposal and asked the Trusts to work together to consider how a truly collaborative network for vascular services across the two hospital sites might work, ensuring that as much vascular activity as clinically safe is retained at Queen Alexandra Hospital.

The Trusts have been working hard to achieve this, and we have made every effort to facilitate these discussions. Unfortunately, I regret to have to report that the Trusts have been unable to reach an agreement.

The PCT Cluster and local CCGs recognise that both Trusts are working to develop services for their patients, amidst a range of challenges and different pressures. Therefore, whilst we are very disappointed with this outcome, we respect the differing positions of the two organisations.

As commissioners of vascular services, there are now limited options available to the PCT Cluster and local CCGs. We do not wish to consult local people on a model which the Trusts have said that they cannot implement. We could of course decommission vascular services from both Trusts and consult upon alternative models of care. However we believe this would be very disruptive for the organisations and the wider health system, and as such, would not in the best interests of the population at this time. The other alternative would be to push ahead with a consultation on the original 'network' model whereby all vascular complex activity is moved to Southampton General Hospital. However we have listened carefully to the views of local stakeholders and communities and are very clear that this option does not have the support of the Portsmouth and south east Hampshire community.

A positive outcome from the detailed debate and discussion with the Trusts, CCGs, HOSCs, other stakeholders and local communities over recent months is that we are now much clearer on certain aspects of the vascular service at Queen Alexandra. We acknowledge that Queen Alexandra Hospital is a large acute centre with a very large stroke service and we have also clarified the following key issues:

1. Outcomes at PHT for planned activity are better than the European average,
2. Vascular cover is required at QAH to support other specialities (including OOHs),
3. PHT does not serve the requisite 800,000 population but the number of operations performed does meet the vascular society guidelines.

This clarity has provided us with some reassurance that Portsmouth Hospitals NHS Trust is close to meeting the Vascular Society of Great Britain & Ireland (VSGBI) standards and the NHS South Central service specification and for this reason we have decided to continue to commission the current service at this time. As the service will remain unchanged we will not proceed with public consultation.

We remain committed to ensuring that the service at Queen Alexandra meets all the local and national standards not just the majority of them. This will allow us to be confident that people in this area are receiving the same quality of service as patients elsewhere in Hampshire and the Isle of Wight. We know that PHT currently does not have enough vascular surgeons to run the recommended 1 in 6 rota, nor does it currently serve a large enough population to comply completely with the VSGBI guidelines.

With this in mind, the SHIP PCT Cluster and local CCGs will be working with PHT to ensure that they have adequate consultant cover from April 2012, when the current arrangement with Chichester comes to an end.

We also know that there is a lot of change going on across the patch, and future GP referral patterns are unclear so we will continue to work with PHT to ensure that the activity levels at the Trust are maximised to ensure adequate volumes to meet the Vascular Society Guidelines. The situation will be kept under review as part of our on-going regular monitoring.

The existing network run by University Hospital Southampton NHS Foundation Trust already meets the service specification, so we're confident that people living in Southampton and south west Hampshire are already served by a vascular service meeting all current standards and we will continue to commission this service.

Finally I would like to stress that although we have not been able to secure an agreement between the Trusts at the current time, this review has been a very valuable listening exercise. We have received a great deal of useful and constructive feedback that has helped us to better understand the population that we are serving. All the views received to date have been carefully recorded and will be very valuable as we move forwards.

I hope that you will agree that we have made every effort to act on your views and ensure that our commissioning intentions for vascular services addressed the issues

raised. We will ensure that all the feedback gathered will be taken into account in the future commissioning intentions of local CCGs and the new National Specialist Commissioning team.

The engagement exercise has allowed us to engage in real debate with yourselves and local communities about the sustainability of vascular services and we will continue to have discussions with local groups about this important matter as we move forwards.

I hope that this letter clarifies the position of the PCT Cluster and CCG commissioners. However, if you have any further specific queries, please do not hesitate to contact me.
Yours sincerely

D.M. Fleming (Mrs)
Chief Executive
SHIP PCT Cluster

Appendix Four

Hampshire County Council

15 February 2012

Hampshire County Council
The Castle, Winchester
Hampshire, SO23 8UJ

e-mail: pat.west@hants.gov.uk

Debbie Fleming
Chief Executive
SHIP PCT Cluster
Trust HQ
Oakley Road
Southampton
SO16 4GX

Dear Debbie

Vascular Services

Thank you for your recent update letter, dated 2 February 2012, which provided the Health Overview and Scrutiny Committee with feedback on negotiations around a network vascular service model, and set out the SHIP PCT Cluster's decision to continue to commission the historical vascular service in South Hampshire. We mirror the disappointment expressed in your letter with the outcome of the network model negotiations held by the Portsmouth and Southampton acute Trusts. We hope that you can assure us that the SHIP PCT Cluster has, as the current commissioner of these services, considered all actions available to it to encourage a model which is in the best interests of the populations affected.

Although our Members have been kept well informed by your regular communications on the progress of the vascular service review, it is important that we consider your letter and the proposed way forward in greater depth at our next meeting. In particular, we would seek your response to the below concerns:

1. It is important that all Trusts providing vascular services in the South Hampshire region have specialist clinicians available 24 hours a day, 7 days a week, staffed by the recommended 1 in 6 surgeon rota, as noted in the South Central service specification and the Vascular Society guidelines. We wish to receive evidence which demonstrates that these arrangements will be in place across all Trusts from 1 April 2012, and will remain so going into the future. We understand that the financial sustainability of these arrangements is an issue for each Trust to manage, but wish to be assured that the SHIP PCT Cluster will take cost to the local health economy into account as part of your regular monitoring of vascular services.

2. Your letter states that Portsmouth Hospitals Trust do not serve a large enough population to meet the Vascular Society guidelines, but that the number of operations historically undertaken by the Trust do. We therefore wish to know the number of operations and procedures that would need to be performed annually at Queen Alexandra Hospital in order to meet the guidelines, and remain viable,

going into the future. It is indicated in your letter of 2 February that you will be working to 'maximise' activity levels at the Trust, and the HOSC will wish to understand how you expect to influence this.

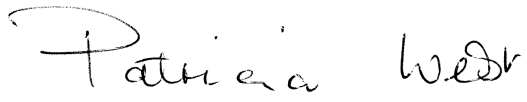
3. We understand that it is your intention to observe over the next 12 to 24 months how referral patterns from Chichester and the surrounding area will flow given the changes to the Sussex vascular service model. The HOSC will wish for the position of NHS Sussex to be clarified on the flexibility of GPs in the West Sussex region to refer to Portsmouth Hospitals Trust, given that the Trust does not currently meet all of the standards of the Vascular Society or the NHS South Central service specification. If it should become apparent that future referrals from the West Sussex region for specialist vascular surgical and endovascular care will be to the Brighton centre, we will require assurance that Portsmouth can remain sustainable given the reduction in their proposed catchment population.

4. We understand that national outcomes data in relation to vascular services will be published on 1 March 2012. We will wish to receive the outcomes data for all the Hospital Trusts retaining vascular surgery in the South Central region for comparative purposes, as well as a summary highlighting any difference in outcomes for both planned and unplanned care. It is important that the SHIP PCT Cluster's decision to continue to commission the historical services at Portsmouth and Southampton is supported by clinical evidence, and we would expect the outcomes data to provide a case for this.

As noted above, we propose to reconsider this matter at the HOSC meeting on 27 March, for which the deadline for papers is midday on the 15 March 2012. We would be grateful if you could ensure that answers to our above points are provided before this date, and if you could provide representation at our meeting to answer any questions Members may have.

Please do not hesitate to contact us should you require any additional information about our comments above.

Yours sincerely



Cllr Pat West

Chairman, Health Overview and Scrutiny Committee

Cc HOSC Members
Portsmouth, Southampton and West Sussex Chairmen of HOSCs
Frank Rust, Chairman, Hampshire LINk
Mark Hackett, Chief Executive, University Hospital Southampton
Ursula Ward, Chief Executive, Portsmouth Hospitals Trust

Appendix Five

Southampton, Hampshire
Isle of Wight & Portsmouth

Vascular services update March 2012
Southampton and Hampshire HOSCs

Background

The SHIP PCT Cluster and its component CCGs are fully committed to commissioning a vascular service that offers all local patients the best outcomes.

In order to achieve this a Vascular Review process started in April 2010 when the NHS South Central Cardio Vascular Network prepared a specification for vascular services. In December 2010, proposals were received from Southampton University Hospital NHS Trust (UHS) and Portsmouth Hospitals NHS Trust (PHT) about how they would go about delivering a vascular service in line with the specification. These proposals were reviewed by an expert panel of independent clinicians, GPs and lay members. The panel concluded that Portsmouth Hospitals NHS Trust did not meet the specification at that time and a 'hub and spoke' model between Southampton and Portsmouth vascular services with emergency and planned complex arterial vascular surgery carried out at Southampton was the best model to meet the specification.

The SHIP PCT Cluster Medical Director facilitated some discussions between vascular surgeons and interventional radiologists across UHS and PHT with the aim of developing such a model and at the time these discussions appeared productive.

The Cluster and the Network then arranged a second Expert Panel in October 2011 to consider the output from these discussions and a proposal from PHT to develop a network with St Richards Hospital, Chichester. Having considered the proposal the Panel concluded it was "aspirational" as West Sussex Hospitals NHS Trust had not given their support to the proposal. Again the Panel's recommendation was that a single vascular service offered from the two hospital sites would provide the best chance for long term sustainable vascular services for local people.

Subsequently a third expert panel was held on the 5th January 2012 to consider a "standalone" proposal prepared by PHT which the panel felt could meet the specification if recruitment to planned posts were made and PHT were able to attract patients from West Sussex. However, the panel reinforced the benefit of a network between UHS and PHT to provide a sustainable service for the future.

During January both Trusts worked hard to develop an acceptable network model, and the PCT Cluster have made every effort to facilitate these discussions. Unfortunately the Trusts were unable to reach an agreement.

Involving local people and stakeholders

Between August and September 2011 an engagement exercise took place to test emerging options with local people. Over 6000 people commented on the proposals and a full report of this engagement is available at http://www.southamptonhealth.nhs.uk/yoursay/safe-and-sustainable/

The engagement exercise identified concern about the original proposals to move all complex emergency and elective arterial vascular surgery to Southampton General Hospital. In particular there were concerns about the implications for other services (such as renal and cancer) at Queen Alexandra Hospital, Portsmouth and also a plea to recognise that Queen Alexandra Hospital was a large centre,

Local people also told us they wished to see a truly collaborative network model, with surgeons and interventional radiologists working across both sites, with some major vascular operations and complex interventional radiology retained at Queen Alexandra Hospital. In response the PCT Cluster expressly asked the Trusts to work together to ensure that as much vascular activity as was clinically safe was retained at Queen Alexandra Hospital.

While these discussions took place the PCT Cluster embarked on preparations for a public consultation. In the pre-consultation phase which ran throughout January a further 500 local people and stakeholders were directly engaged in discussion about the options that were under development. A detailed record of this activity is available on request. Stakeholders were also regularly updated through a series of letters.

During January 2012 both Trusts actively engaged in discussions with the local CCGs and the Cluster about how to work together to develop an appropriate partnership across the two hospital sites, whilst ensuring that the national clinical standards and guidelines that uphold patient safety continued be met.

However in early February the Trusts reported to us that they had been unable to reach an agreement about how a truly collaborative model would be delivered. The PCT Cluster concluded that it could not conduct a public consultation on a model which the two hospitals were not fully committed to and as such had little choice but to cancel the plans for consultation. The Cluster wrote to all stakeholders on February 2, 2012 to inform them of this decision.

Decision not to proceed to public consultation

A positive outcome from the detailed debate and discussion with the Trusts, CCGs, HOSCs, other stakeholders and local communities was that we developed a thorough understanding of the views of the community and its stakeholders. At the same time we were able to extend our knowledge of the vascular service at Queen Alexandra and its relationship with other specialties. We have acknowledged that Queen Alexandra Hospital is a large acute centre with a very large stroke service and we have also clarified the following key issues:

1. Outcomes at PHT for planned activity have improved since the initial review began and are better than the national target for 2013;
2. Vascular cover is required at QAH to support other specialities;
3. PHT does not serve the requisite 800,000 population but the number of operations performed does meet the Vascular Society guidelines.

This information provided us with some reassurance that Portsmouth Hospitals NHS Trust was very close to meeting the Vascular Society of Great Britain & Ireland (VSGBI) standards and the NHS South Central service specification. In addition we were conscious that the guidelines for vascular services and interventional radiology had evolved during the period of the review and were in the process of being refined by the various professional bodies. This combination of factors led to our decision to continue to commission the current service at this time.

Next steps

The PCT Cluster remains convinced that a network arrangement between UHS and PHT would provide a sustainable solution to meeting the needs of patients to deliver the outcomes for vascular patients we are seeking. As a result of the two Trusts being unable to agree this collaborative model we are continuing to commission the existing services. This does not represent an acceptance of Portsmouth Hospitals NHS Trusts' 'standalone model' but rather is designed to maintain the status quo of service configuration for now.

Portsmouth Hospitals NHS Trust firmly believe that their vascular services can meet the Vascular Society of Great Britain standards and the local specification for vascular services and this is a firm requirement of the PCT Cluster's contract with the Trust in the next year.

Portsmouth Hospitals NHS Trust has historically relied upon St Richards Hospital, Chichester for support with its vascular rota but this arrangement is due to finish at the end of March 2012 when St Richards' consultants join the Brighton vascular network.

In order to ensure that Portsmouth Hospitals NHS Trust and indeed University Hospital Southampton NHS Foundation Trust and Frimley Park NHS Foundation Trust continue to achieve optimum outcomes for patients accessing vascular surgery, the PCT Cluster, CCGs and the Specialised Commissioning team has committed to close monitoring of adherence to the Vascular Society of Great Britain guidelines.

A clinical governance framework has been developed which will ensure effective monitoring of workforce, activity and clinical outcome requirements.

The information will initially be reviewed by the GP Cardiovascular lead for South East Hampshire CCG, one of the Clinical Governance leads for Fareham and Gosport, Portsmouth and South East Hants CCGs and the Specialised Commissioning group for comment and recommendation to the SHIP PCT Cluster's Clinical Governance Committee.

A Patient Reference Group has also been established and meets bi-monthly. It includes representatives from Portsmouth, Southampton and South Eastern Hampshire. This group will be asked to share patient experience feedback with the Cluster's Clinical Governance Committee on a regular basis.

Decision required

The Committee is asked to note the arrangements for monitoring of vascular services and advise when a further update is required.

Appendix Six

Southampton, Hampshire
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Tel: 023 8072 5600

Cllr Pat West
Chairman, Health Overview and Scrutiny Committee
Room 105, Chief Executives
Hampshire County Council
The Castle
Winchester SO23 8UJ

15 March 2012

Dear Pat

VASCULAR SERVICES

Thank you for our very useful meeting last month and your letter dated 15 February 2012. My apologies for not replying sooner.

I have attached a short update paper which sets out the next steps for ensuring that local vascular services meet the Vascular Society guidelines and the South Central service specification. This will be monitored through the SHIP PCT Cluster Clinical Governance Committee and Vascular Patient Reference Group. Please let me know if you would like us to provide regular updates to the Committee on this work over the coming year.

I have also attached the outcome data that you requested, which was sourced from the NHS South Central Cardiovascular Network. I acknowledge that the recent publication of outcome data by the Vascular Society appeared to support the notion that outcomes at Portsmouth Hospitals NHS Trust are not as good as elsewhere in the area. However, the yearly mortality rates reported to the national database by the Trust have improved from 9.6% in 2008 to 7.5% in 2009 and 3% in 2010.

In response to your question about the size of population served by Portsmouth Hospitals NHS Trust and the number of operations undertaken, I can confirm that the Vascular Society guidelines recommend that centres serve a population of 800,000. It is also recommended that they perform at least 33 planned abdominal aortic aneurysm (AAA) procedures per annum and an annual volume of 35 carotid endarterectomies (CEA). Although the Trust only served a population of 600,000 last year the Trust performed 47 elective AAA repairs and 88 CEA, which means that it is already performing sufficient volumes of operations to meet the guidelines.

I can confirm that we will be monitoring referrals from the West Sussex area, particularly as the West Sussex Clinical Commissioning Group has already confirmed that it cannot be guaranteed that all Chichester patients will chose to go to Queen Alexandra Hospital. However, as can be seen from the figures above, Portsmouth Hospitals NHS Trust can meet the current standards for volume of activity without additional referrals from the Chichester area.

I hope that the update paper and this letter have helped to clarify the situation. However, please do not hesitate to contact me if you require further information.

Yours sincerely

D.M. Fleming (Mrs)
Chief Executive

SHIP PCT Cluster Encs

Mortality Rates for AAA Surgery in SHIP

Why is there a concern?

- Outcomes for abdominal aortic aneurysm (AAA) surgery are worse in this country than elsewhere in Europe where the mortality rate in 2008 was 7.9% in the UK compared to 3.5% in Europe
- National guidelines aim to halve the mortality rate for planned AAA surgery within 30 days of treatment in the UK to 3.5% by 2013.

What are the new standards?

- *Now* 6% or less people die within 30 days of planned surgery
- *By 2013* 3.5% or less people die within 30 days of planned surgery

Please note that over one year our local hospitals see between 50 and 80 patients. One or two deaths can therefore make a big difference to annual mortality figures. This means that in one year figures could look very good and in another quite poor. For this reason the figure of the last 100 cases is chosen as the benchmark by the national professional body for vascular surgeons. The local population may generally sicker in some areas and this may affect the probability of higher mortality rates in those areas.

How are we doing locally?

Provider of Services	Numbers of AAA planned operations in 2009/10	2010/11Mortality Rate (percentage)	Mortality Rate last 100 cases
University Hospitals Southampton Foundation NHS Trust (UHSFT)	76	0%	
Portsmouth Hospitals NHS Trust (PHT)	47	2.2%	2%
Frimley Park Hospital Foundation NHS Trust (FPHFT)	85	2.3%	
England Average	5.6% open surgery, 4,1% all types of AAA surgery		

This is from information provided by the trusts themselves in autumn 2011; England average from the AAA Quality Improvement Programme report July 2011

All hospitals are using new technology which involves less open surgery and this has the potential to further improve survival rates. Independent experts have reviewed the outcomes and have stated that they are all satisfactory.

What about emergency surgery?

- There is no national standard for outcomes for emergency AAA surgery
- Annual numbers of operations are much lower and more subject to fluctuation as noted above
- The national average figure is 33% and locally our figures are 33% (UHSFT), 59% (PHT) and 28% (FPHFT)
- The national AAA screening programme aims to detect abdominal aortic aneurysm earlier with a simple ultrasound test. This should mean that over time nearly all operations will be planned

What about other vascular surgery?

- There is no national standard for outcomes for other surgery
- There were 52 inpatient deaths last year following carotid surgery to prevent strokes, recorded for England by the national agency Hospital Episode Statistics

- There were 3 deaths last year from carotid surgery across Southampton, Hampshire, Isle of Wight, Portsmouth, Berkshire, Buckinghamshire and Oxfordshire and over 500 operations were performed
- AAA Elective Mortality Rates for the financial year 2010/11provided by Trusts to the cardiovascular network, November 2011

NHS South Central figures

AAA Elective Mortality Rates for the financial year 2010/11provided by Trusts to the South Central cardiovascular network, November 2011

Trust	Number	Deaths	%	3 year
Buckinghamshire HT	34	0	0	1.4%
Heatherwood and Wexham Park FT	19	1	5.2	
Royal Berkshire FT	16	0	0	
University Hospitals Oxford	111	none in 30 days 1 after 30 days	0	
University Hospitals Southampton FT	76	0	0	
Portsmouth HT	47	1	2.2	2%
Frimley Park FT	85	2 (EVAR)	2.3*	

- Please note that on such a low volume procedure one year activity will not be a statistically significant sample. Except where an asterisk is shown, It is also unclear if 30 day mortality rates are quoted. The network tried to obtain validating information from the national vascular database but was refused due to poor data quality in the mortality field.

Appendix Seven

March 2012
Report to Health Overview and Scrutiny Committee
Children's Therapies

Policy Context

- The Bercow Report: A review of services for children and young people with speech language and communication needs - Department for Children Families and Schools - (2008)
- Better Communication: an action plan to improve services for children and young people with speech language and communication needs - November (2008)
- Better Care: Better Lives. Improving outcomes and experiences for children, young people and their families living with life limiting and life threatening conditions – (2008)
- Locally commissioned reviews of children's therapies across Hampshire (2008 and 2010)
- Healthy Lives, Brighter Futures – the Strategy for Children and Young People's Health (2009)
- Parental Experience of Services for Disabled children: findings from the second national survey (2010)
- Special Educational Needs and Disability: Understanding Local Variation in Prevalence, Service Provision and Support (2010)
- "Support and Aspiration" A new approach to special educational needs and disability – (2011)

History

The issues with regard to children's therapies in Hampshire are well established. In 2008, Hampshire PCT and Hampshire County Council commissioned a review of "Therapy Services for Children across Hampshire incorporating Occupational therapy, Physiotherapy and Speech and Language Therapy." The report identified that there were key issues of equity of access, there was a perceived shortage of therapy services by users and a multiplicity and complexity of provision. Recommendations were wide ranging and not solely concerned with provision in special schools. It recommended that further work was undertaken looking specifically at the issues of therapies in special schools. This was one of the drivers which lead to the "Joint Review of therapy services for Children with Special Educational Needs" which was submitted to HOSC and CYPSC in May 2010.

Key recommendations included

- That a strategy is jointly developed between the key stakeholders to deliver a sustainable fair and transparent model of high quality integrated therapy in all parts of the county.
- That no parent should be disadvantaged by their social context or ability to negotiate the system effective support should be offered to all parents to help resolve concerns about their children and their education.
- That at a county wide level the child health services redesign programme seeks to achieve more effective and efficient use of existing human and physical

resources, including consideration of the appropriate use of skills levels and workforce development

- That the local authority and NHS demonstrate that they have taken fully into account the Lamb inquiry's recommendations in planning their child heath services redesign programme.
- That all key stakeholders demonstrate their commitment to providing a seamless experience for children with special educational needs such that therapy is fully integrated as part of the educational package across all parts of Hampshire.

Current Situation

Local Authority Spend

For the year 2011/12 Hampshire County Council (including schools) spent £1,015,200 on the provision of children's therapies.

1. Speech and Language Therapy - £681,020
2. Occupational Therapy - £330,660
3. Physiotherapy - £3,520

In terms of the spend for speech and language provision this covers three types of expenditure. The first element of expenditure is through the direct provision of services via two teams that sit within the Specialist Teacher Advisory Service who work with children in secondary mainstream provision to ensure that their speech, language and communication needs are met. It also covers the spend by special school heads for the delivery of speech and language therapy service in their schools, commissioned by them from health providers, where there is a perceived shortfall in what is being delivered by the NHS. The final part of the spend covers therapy commissioned by the local authority that arises from either a tribunal direction or to prevent a child's case going to tribunal (SENDIST).

Similarly for occupational therapy, the figure covers the cost of providing the Children's Services Department in-house children's occupational service which sits within the Children's Disability Service whose remit is to provide home assessments (rather than community based assessments as provided by the NHS). It also covers some additional funding for occupational therapy delivered via special schools in order to meet SENDIST requirements and some OT commissioned by schools.

The much smaller figure covering the council's spend on physiotherapy, covers the cost of a SENDIST direction for one child, and the purchase of provision by one special school.

Therapy	In-house Teams	SENDIST	Special School Heads	Total
Speech and Language Therapy	£472,340	£54,200	£154,480	£681,020
Occupational Therapy	£202,000	£64,700	£63,960	£330,660

Physiotherapy	n/a	£220	£3,300	£3,520

Further County Council Investment in Speech and Language Services

It has been recently announced that the council will be investing a further £900,000 to develop new services for children with speech language and communication needs. The money is to be divided into two distinct areas. £400,000 for the development of a service to children who attend one of the council's special schools, and £500,000 to be invested in a dedicated service for children's centres. This level of investment is welcomed and planning has commenced to ensure that this money is spent most effectively and efficiently in accordance with the wishes of the political leadership of the authority.

NHS Spend

The value of the NHS contracts for 2011/12 for children's therapies totalled £5,763,946. the breakdown per therapy is as follows

1. Speech and Language Therapy - £3,116,441
2. Occupational Therapy - £1,300,961
3. Physiotherapy - £1,346,544

These contracts are currently awarded to five different provider organisations who deliver services in differing areas of the county. During the process of the baseline review it became clear that there were a number of problems in these arrangements which have impacted on providers ability to deliver optimum services.

In our view this has led to the following problems which have impacted upon effective service delivery.

1. A lack of a standardised service specification has lead to a significant variance in terms of what is being delivered in different areas of the county.

2. Analysis of the different contract values indicates that there are funding inequities across the county.. For example, the unit cost for physiotherapy is different from one provider to another, which is a legacy of historic NHS block contracts that are currently under review.

3. Providers have developed different approaches to services including waiting list and caseload management, service priorities, and workforce skills mix.

Complaints and Tribunals

There is some evidence of stakeholder dissatisfaction with the level of provision of children's therapies in Hampshire – whether that is by the NHS or the local authority.. There appears to be a tension with expressed need for therapy from a variety of stakeholders and actual needs that can be and possibly should be met reasonably by therapy services. A recent analysis of complaints about therapies within a two year period in both the NHS and Hampshire County Council has taken place. Within a two year period the council had received two complaints (via the complaints system) neither of which was upheld. In addition to these formal complaints, concern has been regularly

raised by a special school about speech and language therapy provision. Within the NHS there have been 3 complaints within a similar timescale. The complaints that do arise appear to have two commonalities; concern about lack of speech and language therapy provision, and concern about how long it takes to receive an occupational therapy service. It is has long been recognised by a number of stakeholders that provision across the county is uneven. This is based on their own experience of receiving services, or of delivering a service which is dependent on certain levels of therapy being provided to the child.

In terms of special educational needs tribunal's the council's spend of £120,000 for 2011/12 on SENDIST direction indicates there is a mismatch between the demand for therapy services for children in special school, as defined by the tribunal - admittedly a far from precise science in which the perceived 'demand' for therapies can be bound up with a range of other complex issues - and the current levels of supply of services. There has been a historical lack of shared priorities between the council's SEN team and the NHS in jointly addressing this issue – as identified in the previous HOSC report. However, we believe that both organisations are now working much ,more closely on a range of joint commissioning and are joint partners in the SEN pathfinder in Hampshire; the proposals in this paper further demonstrate the development of shared priorities.

Our view is that the evidence above appears to indicate that there is sufficient capacity within the system but that this capacity could be re-directed in order to bring significant gains in service provision through re-specifying and, potentially, recommissioning the contracts for the provision of therapies.

Schools' budgets

At the end of 2010 central government chose to protect schools' budgets from the cuts planned under the comprehensive spending review. This has meant that whilst most public services, including local authorities and the NHS, have had to make significant cuts in expenditure across children's services, schools budgets have been relatively protected. Although there is understanding at continued frustration by the school staff at the level of therapy provision to their pupils, within this context it is important that schools recognise that they are in a protected position in fiscally challenging times.

Changing Population Needs

It is evident that with advances in neonatal medicine there has been an increase in the survival rates of children born very prematurely. This has meant that many more children are surviving with profound levels of disabilities and complex health needs. It is not surprising therefore that within the last few years it has been identified that there has been a steady increase in the number of children needing to access medical, educational and social services designed for children with disabilities. It is a trend that shows no signs of abating and it is vital that the council and the NHS work closely together to ensure that services are designed around these children's needs.

In terms of children's therapies it is clear that because children with complex needs are surviving longer there is, and will continue to be, increased demand on services. Children with complex health needs and disabilities will often need assessment and a treatment plan for all three of the therapies, and benchmarking with other areas suggests that an integrated approach to service delivery provides the most child

focussed services for this cohort of children. Hampshire are currently a pathfinder for the government's green paper on Special Educational Needs and disabilities, one aspect of which is piloting a new single assessment which will join up existing health social care and SEN assessments. This provides a cause for some optimism for the future but is not a reason to do nothing, rather it is a further driver for change in order to achieve better integrated services.

A Health Needs Analysis is currently being undertaken for children with physical disabilities and/ or complex health needs living in Hampshire. Early findings indicate that the three geographical areas with the highest concentration of children with this level of need are Basingstoke and Deane, the New Forest and Havant. With regards to the issue of "multiplicity and complexity of provision" identified in the HOSC commissioned review in 2010 there is a consensus view that the needs of children living in areas where there is complexity of provision (e.g. Basingstoke) could be better served by integrated therapy teams working to a uniform service specification.

Options Appraisal

It is very clear that there is a need for service redesign in order to ensure that issues of equity of access and provision across Hampshire are addressed. The approach to redesign will need to be robust and engage fully with stakeholders to ensure that

1. any revised service specification is developed with a strong sense of engagement and collaboration between parties e.g. commissioners, providers, schools, parents, SEN colleagues, GPs, CCG leads, health managers etc

and that

2. key performance indicators are developed so that measurement of progress and outcomes is meaningful.

To that end, it is intended to consult on how we can jointly take forward plans to reshape therapies across the NHS and the Local Authority. There are a number of ways in which this can be done and the table below sets out some commissioning options for consideration. It is not comprehensive but provides scope for initial discussions with stakeholders.

Clearly. HOSC will understand that the final decision on which option to pursue will be for the appropriate decision making authorities within the health service (including the 5 Clinical Commissioning Groups) and the Local Authority (via the Executive Lead Member for Children's Services). However, given HOSC's involvement in this topic in the past it was felt that it would be helpful if members were able to give a steer at this stage as to any preferred options. These are set out below.

	Model	**Benefits**	**Risks and Issues**
Option 1	Maintain status quo: work with existing budget, and existing providers.	• Known providers, some good relationships developed particularly with SALT managers. • In time of such NHS churn, it may be timely to allow "dust to settle" before an ambitious county wide commissioning process is	• Sensitivities and difficulties around re- proportioning of budget to address current cost/funding inequities. • Parents, children and other key stakeholders are unlikely to see the benefit and/or feel ownership

		attempted. This would allow CCG culture to develop	of process. • Doubtful if enough change would be able to be achieved, (or seen to be achieved.)
Option 2	Hampshire wide recommissioning and retendering of all three therapies as one integrated service.	• One overarching service specification, and contract leading to a centralised commissioning relationship. • Opportunity to remodel whole service, either fully or partially integrated with Child Disability/SEN services. • Chance for parents, children and other key stakeholders to be engaged in the tender process leading to greater sense of ownership of process and end result. • More time efficient than commissioning therapies separately.	• Potential that the recommissioning process to be very disruptive to current providers and staff. This could have an impact on service delivery. • Need to consider the impact of the sheer scale of the contract. A clear monitoring/auditing schedule would need to de tightly managed to prevent it becoming problematic.
Option 3	Recommission therapies individually.	• Commissioning process could be staggered over next three years. e.g. start with SALT • Stakeholder engagement in tender process. • Risks balanced across 2 or more providers. • 1/2/3 rather than 4 commissioning relationships	• Unable to make use of cost efficiencies with integrated contract, e.g. skills mix • Time inefficient for commissioners to manage
Option 4	Decentralised commissioning via the 5 CCGs.	• Local services developed to meet the need of local cohort.	• Issues of inequity of access and service delivery across the county highly unlikely to be addressed. • Likely that the relative immaturity of the CCGs, may not be able to deliver on the commissioning priorities. • Potential for multiple contracts and variance in specifications. • Time and cost inefficient in terms of centralised commissioning staff .

Conclusion

The report sets out early stage options to revise the way in which therapies are delivered to children by the local authority and the NHS. HOSC are invited to give their views on the options presented in order that this can be fed into the decision making process as these plans are developed further.

Appendix Eight

Hampshire

DRAFT Integrated Falls Prevention and Bone Health Strategy

2012 -2015

Index

1 Executive summary

This commissioning strategy provides a framework to reduce the substantial and growing impact of falls on individuals, families, communities and subsequently on services in Hampshire. It aims to result in improved bone health, to prevent new and recurrent falls and ensure improved treatment outcomes after someone has fallen. As the risk of falling and the impact of falls increases with age this strategy is primarily focused on older people.

Falls and subsequent fractures are a major cause of misery, disability and possible death. Both falls and fractures can be prevented by identifying risks and implementing risk reduction programmes.

The consequences of a fall and fracture cut across all agencies working with older people. Statutory, voluntary and independent service providers are all part of the solution; as well as the affected individuals and their families. All must be supported to maximise their contribution towards reducing the number and impact of falls locally.

There is already much good practice in Hampshire, with many people working hard to prevent falls and improve the outcomes for people who fall. However, there is still need to further join up the systematic approach to ensure that effective action is taken, both within the wider community and amongst those at higher risk from falls. This involves working with individuals and their families to maintain their independence within their own homes; and in community social settings with people in residential and care homes who may be more at risk if they are more physical frail or suffering from dementia, as well as those who require a hospital admission as a result of their fall.

The National Service Framework for Older People (March 2001) and subsequent national and local policies have identified the need for the NHS to work in partnership with local authorities and other agencies to take action to prevent falls and to reduce resulting fractures and other injuries in their population of older people.

The key objectives are to:

1. Prevent frailty, preserve bone health, and reduce accidents through preserving physical activity, healthy lifestyles and reducing environmental hazards

2. Offer early intervention to restore independence amongst those at risk of falls and fragility fractures

3. Respond to first fractures in order to prevent further fractures

4. Improve the outcome and improve the efficiency of care after hip fractures

The intention is to ensure that jointly commissioned services are outcome focused, based on prevention and early intervention, improve the quality of people's experience and consider a range of evidence-based options for service delivery across all four objectives.

2 Why are falls a problem?

The definition of a fall is: "An event whereby an individual comes to rest on the ground or another lower level with or without loss of consciousness." (NICE 2004a)

The risk of falling increases as people get older and falls represent the most frequent type of serious injury in people aged over 65. By 2018, it is estimated that over 25% of the population will be aged 60 or over.

Falls can result in bone fractures, most commonly of the hip. Hip fractures in turn can result in blood clots in the leg, infection and other medical complications. Fractures following falls are a major threat to mobility and independent living, with approximately 50% of people losing their ability to live independently after a hip fracture. Up to 14,000 people a year die in the UK as a result of an osteoporotic hip fracture.

The combined cost of social and health care for fragility fractures is over £2billion annually. Of this 45% can be attributed to acute health care, 50% to social care and long term hospitalisation and 5% for drugs and follow up.

Most falls do not result in serious injury but they can destroy confidence, leading to increased social isolation, deterioration in mental health and erosion of independence. The after-effects of even a minor fall can be significant, affecting an older person's physical and mental health. Hypothermia is a significant risk, as is pressure-related injury, especially when somebody who has fallen is unable to get up.

The number of falls and their negative consequences can be reduced by up to 30% if local health and social care communities work together effectively to address falls.

Falls affect about one third of all people over 65 and in very elderly people (those over the age of 85) this figure is nearly 40%. With advancing age, the incidence of falls increases, with women more likely to sustain a fracture than men. An ageing population means that the rates of falls and fractures are increasing and will continue to do so unless action is taken to prevent falls and their consequences.

Amongst the over 65 year olds in Hampshire we would expect that around

- 77,500 will fall each year
- 38,500 will fall twice or more
- 11,000 fallers will attend an accident and emergency (A&E) department or minor injuries unit (MIU)
- a similar number will call the ambulance service
- 5,500 will sustain a fracture; 1700 to the hip

Causes of falls in older people are complex; for example the combination of poor eyesight, uneven surfaces underfoot and osteoporosis make a fall and consequent fracture much more likely. Assessment of the wide range of factors that could affect an

individual's likelihood of falling is an essential part of a falls prevention pathway and service.
Many of the fractures older people sustain occur because they have increased bone fragility (osteopenia and osteoporosis). This is particularly prevalent in post-menopausal women. Studies have consistently reported that half of hip fracture patients have a history of a previous, clinically apparent fragility fracture such as wrist, ankle or vertebra.

Treatment of osteoporosis from the time of the first fracture in these patients would have prevented half of the subsequent hip fractures.

In Hampshire we estimate that there are around

- 220,000 post-menopausal women
- 70,000 post-menopausal women with osteoporosis
- 26,700 post-menopausal women with a prior fracture history
- 3,600 post-menopausal women with a new fracture each year

Identifying the 30,000 post-menopausal women with new and prior fractures and offering evidence-based assessment and interventions could prevent half of the potential future hip fractures in this group.

In care homes the rate of falls is almost three times that of older people living in the community. Injury rates are also considerably higher with 10-20% of falls resulting in a hip fracture, and 30% of people admitted to an acute hospital with a hip fracture coming directly from a care home.

There is considerable evidence for the effectiveness of interventions that reduce the risk of falling and for medications that reduce the risk of fracturing. Nationally it is estimated that if all services implemented this evidence in a fully integrated falls and bone health service it would lead to an estimated reduction of 4500 hip fractures and a saving of £34 million overall.

Hospital admissions for injuries from falls in people aged 65 and over
In the UK falls and fractures in people aged 65 and over account for 4 million bed days each year, and the healthcare cost associated with fragility fractures is estimated to be £2 billion a year.

In 2009/10 South Central Ambulance Service responded to nearly 24,000 emergency calls related to falls amongst Hampshire residents; 12,500 of which were from people over 65. Of these fallers aged over 65, around half needed hospital admission.

In Hampshire, in 2010/11 there were 10,782 emergency admissions to hospital for falls. Of these 71% occurred in the over 65 age group. This figure may under-report the extent of the issue due to the complexities of coding.

Table 1: Trend in Emergency Fall Admissions – Hampshire residents (all ages) at all hospital providers

Financial Year	Emergency Admissions with a Falls Diagnosis (Actual falls only)	% change year on year
2008/09	9268	
2009/10	10249	11%
2010/11	10782	5%

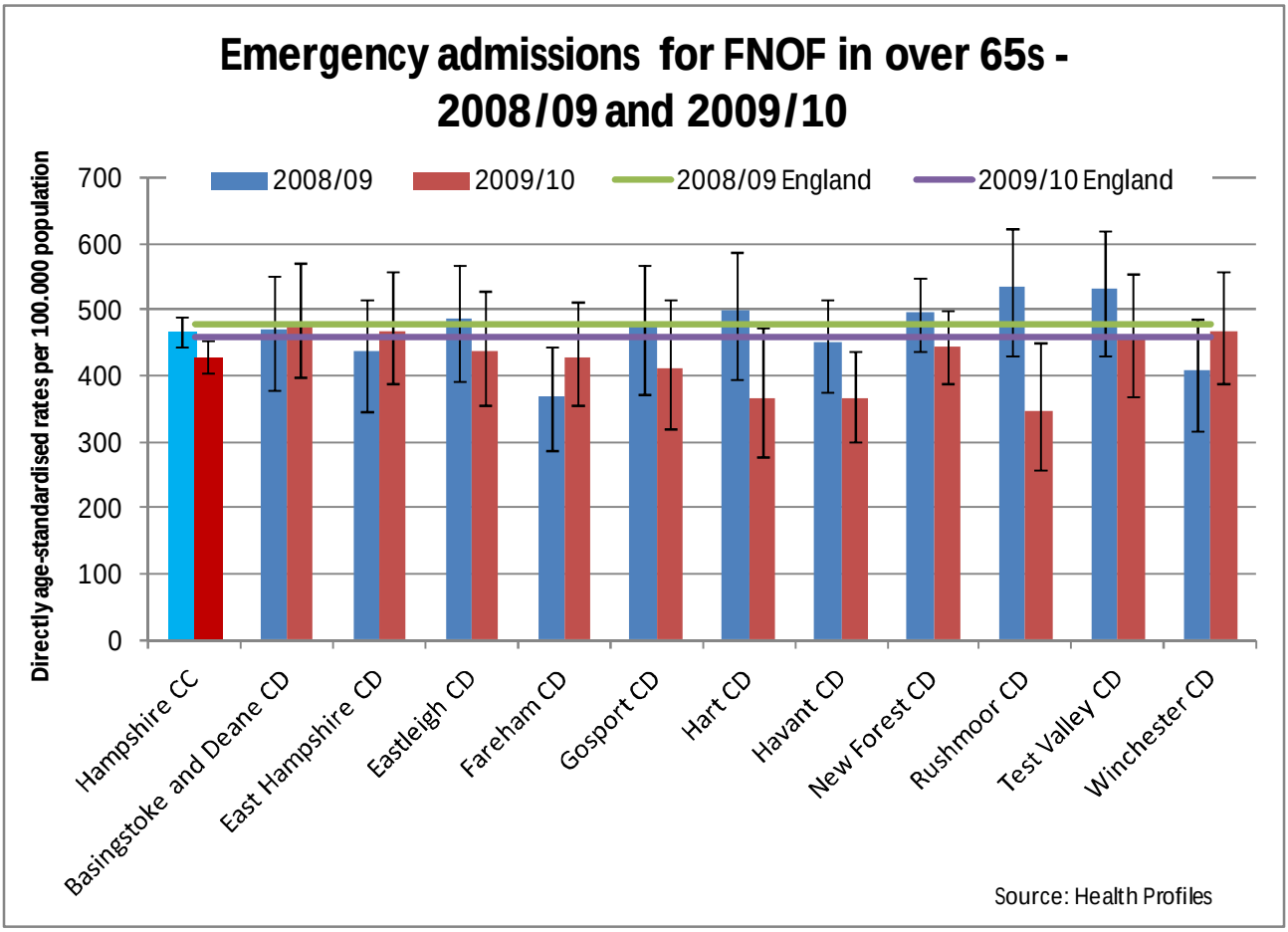
Source: CDS received from provider trusts via secondary uses service (SUS)
(Data only from 2008/09 is shown in table 1 because variation in coding makes comparison with previous years invalid.)

There are no benchmarking data available for this indicator. Hospital admissions for falls reflect not only the rate of falls in an area, but also the type of community services available, such as falls prevention teams and intermediate care beds. Therefore changes in the rate of hospital admissions are as likely to reflect changes in the provision of health services as changes in the numbers of people falling. The trend in the rate of falls varies widely between districts in Hampshire. Some of this variation will be real differences in the number of falls, along with the impact of changes in coding practices in hospitals and variations in the provision of local services .

Gathering comparable and meaningful data will be important to help monitor progress in implementing the strategy. The Public Health Outcomes Framework (DH, 2012) will assist in measuring falls and hip fractures. Under the health improvement domain, falls and injuries in the over 65s will be an indicator. Under healthcare public health and preventing premature mortality, hip fractures in the over 65s will be measured.

Hip fractures
The most common serious consequence of falling is a hip fracture (fractured neck of femur) and over 70,000 hip fractures occur each year in the UK. Half of people suffering a hip fracture never return to their previous level of independence. About 10% die within a month, a third within 12 months and approximately 20% enter a care home.

The rate of hospital admissions for a broken hip in people over the age of 65 in Hampshire during 2009/10 was lower than the national and regional rates. Rushmoor and Havant had rates that were significantly lower than the national rate. All the other districts had rates that were not significantly different from the national rate. However these district comparisons should be treated with caution as they fluctuate between one year and the next and consider relatively few people.



In 2010/11 there were 1665 emergency admissions for fractured neck of femur for people registered with a GP Practice in Hampshire. Between 2005/06 and 2010/11 there was an 8% increase in the number of emergency admissions for fractured neck of femur (FNOF), which reflects the increase in the number of people aged over 65 in Hampshire during this time.

Table 2: Trend in Fractured neck of femur (FNOF) Emergency Admissions – Hampshire residents (all ages) at all hospital providers

Financial Year	Emergency Admissions for FNOF	% change year on year
2005/06	1535	
2006/07	1517	-1%
2007/08	1555	3%
2008/09	1620	4%
2009/10	1593	-2%
2010/11	1665	5%

Source: CDS received from provider trusts via secondary uses service (SUS)

More than 90% of all emergency hospital admissions for FNOF occurred in the over 65's age group. For female admissions only, this rises to 94%.

In the older age groups, women are admitted to hospital as emergencies with FNOF more frequently than men.

Overall, the time people stay in hospital because of a hip fracture (length of stay) has increased slightly over the past six years. There was a marked increase in length of stay between 2005/06 and 2007/08 but this has been reversed in the last three years. The Hampshire average for 2010/11 of 22.18 days is in the mid range of those nationally (12.8 - 39.5). Length of stay may vary according to the range of services provided within hospital, particularly rehabilitation which can be hospital or community based.

Many of the people who have lengthy and often inappropriate stays in hospital have complex health and social care needs; in particular those with mental health problems and dementia stay in acute care settings longer than necessary. Well integrated, holistic services are vital to improve both the quality and cost effectiveness of their treatment and care.

Clinical guidelines recommend that for optimal outcome, patients with fractured neck of femur should receive their operation on the day of, or the day after admission. In Hampshire in 2010/11 79% of patients had their operation on the same day or the day after admission; the number of patients waiting for three nights or more for their operation has reduced over the six years.

A national audit of falls and bone health in older people by the Royal College of Physicians in 2010 showed that across the UK older people with fractures do not routinely receive key aspects of care for falls prevention or bone health, needlessly exposing them to greater risk of further falls or fractures.

Key messages from the 2010 national audit were:

- Many patients do not receive adequate pre-operative assessment and care
- Even if older people attend hospital with serious injuries they are not receiving falls and bone health assessments in order to prevent further injuries. Patients with non-hip fragility fractures are only half as likely to receive assessment or treatment for secondary prevention as patients with hip fractures
- Few local healthcare organisations provide fully integrated falls prevention and bone health services that are attended by a majority of older people who have already sustained a fracture following a fall
- Many providers are failing in their responsibility to provide expertise to reduce falls and fractures in the high risk care home population

Although Hampshire services generally appeared to perform well when reviewing local results against key indicators, the number of cases audited from individual hospital and community trusts was too small to make statistically significant comparisons. However, there are still gaps in local services and the national key messages remain highly relevant to local commissioners and providers.

3 What are the solutions?

Well organised, fully integrated services using interventions based on national standards and evidence based guidelines can prevent future falls and reduce death and disability from fractures.

The Department of Health's Older Person's Prevention Package identifies four key objectives that commissioners working across health and social care should consider when developing local services for falls and fracture prevention, together with the evidence based interventions that are most effective for each risk group (shown in Fig1).

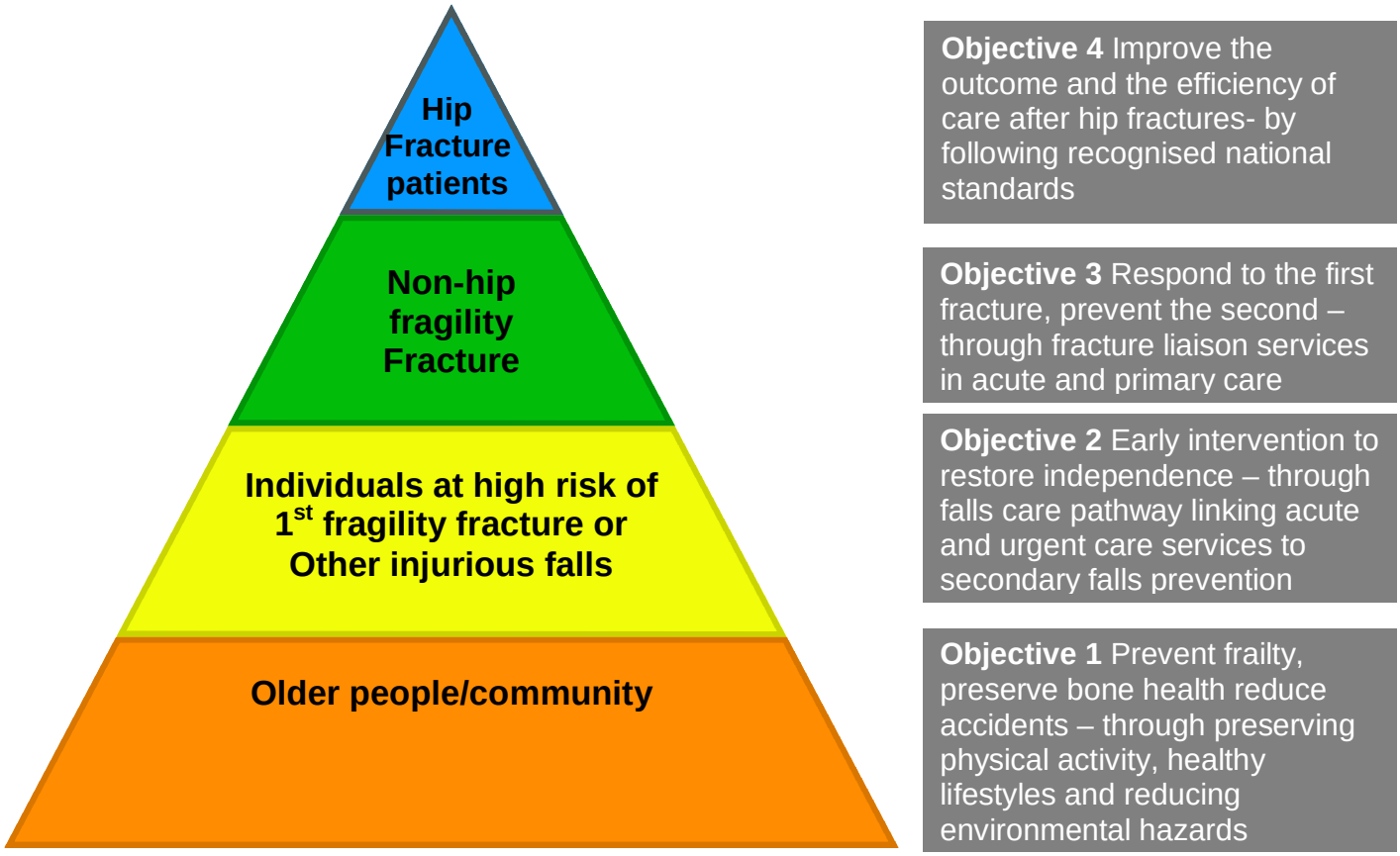
Some evidence-based interventions such as multi-factorial falls risk assessments and postural stability exercise support all four objectives.

Other interventions are more specific, such as guidelines for the treatment of hip fractures (objective 4); and it is estimated that 50% of all potential hip fractures could be prevented by identifying and treating the 16% of post-menopausal women at risk because they have had a new or prior fracture (objective 3).

Many different groups and organisations play a part in providing information, support, prevention programmes and treatment. Given the size of Hampshire and diversity of its communities, there will not be a single service model that fits all; but improved health outcomes will be common to all.

It is important that we harness what is already working, identify what we could do more efficiently and effectively and identify what we need to develop to commission a truly comprehensive and integrated falls prevention and bone health service across Hampshire.

Figure 1: A systematic approach to falls and fracture prevention



Source: Adapted from Falls and fractures: effective interventions in health and social care DH 2009

3.1 Preventing falls

People want to live actively and independently into old age. Falling and the subsequent fear of falling again tend to make people lose confidence in carrying out their normal activities. Although the risk of falls increases as people get older, falling is not an inevitable result of ageing.

The causes of falls are varied with numerous risk factors, many of which are potentially modifiable. Evidence suggests that the risk of falling increases with the number of risk factors. Interventions which address multiple risk factors are most effective in helping to reduce the loss of function and independence many older people face due to falls, as well as reducing the financial implications.

Raising awareness of risk factors will help people to make more informed choices, and providing consistent and comprehensible advice about effective interventions can support people to reduce the risks of falling for themselves.

Multifactorial interventions should look to:

Increase physical activity

Weight bearing exercise throughout life promotes healthy, strong bones. Evidence-based exercise programmes that improve balance and strength help to prevent falls, reduce fear of falling and increase confidence.

Adopting a more physically active lifestyle has proven health benefits, even for people who were previously inactive. Regular activity can relieve some of the pain and disability associated with common diseases that affect older people including cardiovascular disease, arthritis, osteoporosis, and hypertension. Having an active lifestyle also helps to maintain independence and provide opportunities for social interaction, reducing social isolation and reducing the risk of depression. The prevalence of mental illnesses is lower among people who are physically active. Yet only 60% of men and women over 50 are active and amongst the over 80s only 60% of men and 35% of women are active.

Health Promotion, Exercise and Falls Awareness

Better Balance For Life, a community based physical activity falls prevention programme, has been developed to promote falls awareness, to prevent falls and to minimise their harm both physically and mentally when they do occur. This is led by Hampshire County Council's Older People's Well-Being team in partnership with Southern Health NHS Foundation Trust, District and Borough councils and voluntary organisations. It is part of the Ageing Well in Hampshire Older People's Well-Being strategy 2011- 2014. This aims to promote the independence and wellbeing of older people living in the community and to target the 84% of older people (approximately 235,000) over 65 in Hampshire who are not intensively using health and social care. Falling and the fear of falling is one of the major ways their independence can be lost.

The Better Balance For Life project promotes the use of simple and accessible exercises that can form part of the regular activities in community social clubs or at home to maintain and improve an individual's strength, flexibility and balance. A training pack has been developed, and facilitators' workshops run across the county, to promote the use and understanding of the exercises in the prevention of falls. The programme is also being taken up within care homes and sheltered housing.

A co-ordinated prevention and early intervention falls initiative (by Hampshire County Council, Southern Health NHS Foundation Trust and local District and Borough councils) is providing a joined up approach to the provision of evidence based exercise sessions across the county. It is identifying the gaps in postural stability exercise classes and developing the pathways between health and a range of community providers.

There is a need to ensure that the benefit of this approach includes people of younger ages to maximise long term effects as part of a wider prevention agenda and promotion of positive healthy living messages.

Review medication

Some medicines make an older person more likely to fall, such as drugs for treating high blood pressure, heart arrhythmias and those acting on the central nervous system such as antidepressants, tranquillisers and sleeping tablets.

Many older people take several drugs which may interact to increase the risk of falling and they should have regular medication reviews.

Local community pharmacists currently offer to review the use of medicines. These reviews search for overlaps and interactions between medications; identifying problems experienced by patients with their medication; and endeavouring to improve the effectiveness of medication by finding out how and when they are taken.

Local falls co-ordinators are developing a training project for Community Pharmacists and GPs to enhance medication reviews to take account of falls prevention and osteoporosis identification and treatment.

Make homes safer

Older people typically spend between 70 - 90% of their time at home so it is important that homes provide a safe environment. Understanding potential risks and making improvements to home safety can help to reduce the risk of falls.

The Older People's Well-Being Trigger Tool has been developed to assist all those who visit older people in their own homes to identify the possible hazards that could result in a fall, and importantly where to go for assistance. This provides contact details of a range of relevant organisations that can help. Training, based around scenarios in an older person's home is provided to increase people's knowledge and understanding of the possible issues and how to respond.

Handyperson services can provide basic help with repairs and adaptations in the home. This would help in preventing deterioration of an older person's living conditions, as well as enable them to retain their independence in a safe and secure environment.

The need to go to the lavatory at night is a serious issue for many older people and an estimated 6 million adults in the UK have continence difficulties. Urgency and nocturia (waking at night with the need to pass urine), have both been linked with falls. Moving about at night is never easy and there are practical measures that can be taken to tackle this, such as a clear and lit path from the bedroom to the bathroom.

Reduce alcohol consumption

Alcohol acts on the central nervous system and alters perception and our ability to keep our balance. This increases the risk of falling at all ages, but more so as we get older and our bodies become less efficient in metabolising alcohol - which tends to stay in the blood stream longer. Many medicines interact with alcohol and put a person at increased risk of falls.

Alcohol also increases the risk of cardiac arrhythmias, high blood pressure, osteoporosis, digestive disorders, poor circulation, memory loss and incontinence. The extent of alcohol misuse amongst older people is unknown and is often described as a 'hidden' or 'neglected' area of research in the UK.

The Hampshire Alcohol Strategy 2011-2014: "Alcohol Outcomes" has recently been developed across Hampshire Partnerships to be the framework to systematically minimise the risks, harms and costs caused by alcohol to individuals, families, communities, business and public services in Hampshire. It has four key messages:

- Establish sensible drinking as the norm
- Identify and support those who need help
- Reduce alcohol related disorder

- Work in partnership with shared responsibility

Check eyesight
Poor sight can contribute to falls. It is important that older people have their eyesight checked regularly. NHS eye tests are free to all people aged over 60. People over 60 are advised to have an eye test every two years and people over 70 should have their eyesight checked every year. As well as checking the quality of sight, optometrists can also check eye health. They are trained to recognise abnormalities and diseases in the eye such as cataracts, glaucoma and age-related macular degeneration.

Shoes and feet
Poor footwear and foot problems contribute to the risk of falling. Shoes need to fit and ideally be fastened securely. Ill-fitting and loose-fitting shoes lead to loss of balance, as do backless and high-heeled shoes. Corns, bunions and verrucas should be dealt with by a chiropodist or podiatrist.

Assessment and treatment of other medical problems
Many medical conditions can increase the risk of falling, particularly those that can affect walking and balance such as stroke and Parkinson's Disease and those causing giddiness or faintness such as some cardiac conditions. Some people will have more than one condition which could predispose them to fall and will need skilful assessment and individually tailored treatment and falls interventions.

Residential and nursing homes
Residents in care are a vulnerable group at high risk of falling. Around 40% of people who move into care homes can be attributed to a previous fall and it is widely acknowledged that people who have already fallen are at high risk of falling again. Residents are also likely to be physically frail, have an existing medical condition (such as Parkinson's, arthritis or dementia) or have a sensory or physical impairment that can increase the risk of falling. Medication and combinations of medications may also increase the risk of falling, though regular medication review should be standard in these settings. Patients in any health care setting may also be at higher risk of falls and injury.

Although there is good evidence that the type of multi-factorial interventions described can reduce the risk of falls and fractures for people in care homes, for those with dementia the evidence base is less clear.

Workforce
Staff from a range of services and voluntary groups come into contact with older people who are at risk of falling - whether in their own homes, in the community, in health or residential care facilities. It is important to ensure that they have the right skills and tools to identify an individual's potential risk of falling; the information to know what help and support is available locally and that their concerns are acknowledged and acted upon.

It is also important to have a workforce trained to provide effective interventions and that can train others.

3.2 Preventing fractures

Fractures, particularly hip fractures, are one of the most debilitating results of an accidental fall. Hip fractures can result in medical complications, infections, blood clot in the leg and failure to regain mobility. Half of hip fracture patients lose the ability to live independently. Up to 14,000 people a year die in the UK as a result of a hip fracture due to osteoporosis.

Preventing, identifying and treating osteoporosis
Approximately three million people in the UK have osteoporosis. The condition is responsible for 70,000 hip fractures, 50,000 wrist fractures and 40,000 spinal fractures every year in the UK. There are estimated to be over 70,000 women and 19,000 men with osteoporosis in Hampshire.

Ideally we would like to prevent osteoporosis from occurring in the first place by reducing the risk factors that can be changed. For the large numbers of people who are already potentially at risk from osteoporosis, identification, thorough risk assessment and appropriate treatment will reduce the risk of subsequent fractures.

Risk factors for osteoporosis	
Age	The risk of osteoporosis increases with age as bones naturally become weaker and less dense. Evidence suggests a significant increase in prevalence of osteoporosis with each decade after age 60.
Gender	Women are at greater risk of osteoporosis due to smaller bones and therefore lower total bone mass. Additionally, women lose bone more quickly following the menopause and on average live longer. Osteoporosis is less common in men but is still a significant problem (around one in twelve men over 50)
Hormonal effects	Women are at greater risk of osteoporosis than men due to the decrease in the hormone oestrogen after the menopause. Women are at greatest risk of developing osteoporosis if they have had: • **Early menopause** (before the age of 45) • **Hysterectomy** before the age of 45, especially when the ovaries are also removed • **Absence of periods** for a long time (more than 6 months) as a result of over-exercising or over-dieting • **Testosterone** helps to keep bones healthy and men continue to produce this hormone into old age. The risk of osteoporosis is increased in individuals with low levels of testosterone

Family history	A family history of osteoporosis greatly increases the risk of developing the disease
Alcohol	A high alcohol intake reduces the ability of the body's cells to make bone.
Smoking	Although many people are aware of the main dangers of smoking, the harmful effect smoking has on bone health is less recognised. Smoking destroys nutrients that bones need for healthy growth including Vitamin D. Smoking also damages the cells that rebuild and repair bone. Tobacco lowers the levels of hormones in the body which help keep bones strong and a reduction in oestrogen levels in women may cause early menopause.
Use of corticosteroid medication	Long-term use of high dose corticosteroid tablets increases the risk of osteoporosis. The risk of osteoporosis seems mainly to be associated with corticosteroid tablets so doses should be kept as low as possible or delivered in a different way such as inhalers for asthma. People vary in the amount of bone they lose but the loss is usually greatest in the first six months of taking corticosteroid tablets
Medical conditions	• Medical conditions which affect the absorption of foods, such as Crohn's disease and coeliac disease • Endocrine disorders such as an over active thyroid disease or diabetes • Inflammatory disorders such as rheumatoid arthritis
Ethnicity	White women have a 2.5-fold greater risk of getting osteoporosis. Afro-Caribbean women have a higher Bone Mass Density (BMD) than white women at all ages due to a higher peak bone mass and slower rate of loss
Activity levels	Physical activity is highly recommended as the first step of preventing osteoporosis
Diet	Calcium gives bones strength and rigidity and Vitamin D is vital to help the body absorb calcium. There is evidence showing that giving Vitamin D and calcium supplementation to care home residents aged over 75 results in a 27% reduction in hip fracture and may have an effect on improving balance and reducing falls.
Weight	Weight loss or low body mass index is an indicator of lower BMD.

A healthy, well-balanced diet and physical activity are key factors in having strong bones and helping to reduce fractures. Joint strategies already exist to:

- improve nutrition
- reduce obesity
- increase physical activity
- reduce alcohol misuse
- reduce the number of people smoking

amongst the wider Hampshire population. These strategies should all have a longer term impact on people's future bone health and risk of falling.

The Community Nutrition Strategy "Eating well – living well" 2011-2014 being produced as part of the Ageing well in Hampshire Older People's Well-Being strategy recommends key actions for the promotion of a nutritionally complete diet and physical activity.

Identification of people who will benefit from further investigation and treatment is difficult, and focus has shifted from looking at osteoporosis in isolation, towards identifying an individual's absolute risk of future fragility fractures. NICE is developing clinical guidelines on the most effective use of fracture risk assessment tools such as FRAX and QFracture to identify who should be offered further assessment and treatment.

If someone develops osteoporosis there are a range of effective treatments available which can ameliorate the effects and reduce the incidence of fractures. NICE gives guidance on the most cost effective ways to treat people with osteoporosis at risk of fragility fractures and those who have already sustained a fracture (NICE Technology Assessments (TAs)160 and161).

However, osteoporosis is often silent and may not be diagnosed until someone has already had a fracture. When this happens it is crucial that the person with any fragility fracture has a comprehensive assessment of their risk of further fall and fractures, whether they need to start treatment for osteoporosis and what other interventions would most help them to stay safe and independent.

This requires a structured, well co-ordinated approach from a range of professionals and agencies, both within the hospital, in primary care and in the community and may be delivered as **fracture liaison services**.

3.3 Minimising harm when people fall

We acknowledge that we will not be able to prevent all falls and so need to consider how best to minimise the impact when someone does fall.

For a person who lives alone or who spends long periods of time without contact, the fear of falling and being unable to get up again can be overwhelming. The fear of falling can be as disabling as a fall itself. If someone is unable to summon help, they may spend hours on the floor in considerable discomfort. Possible consequences of having a fall and not being able to get up include hypothermia, pressure-related injury and infection.

Although not all falls can be prevented, steps can be undertaken to help minimise harm for those who do fall:

Coping with a fall
If someone has fallen but is not hurt, it is important that they try to get up to avoid any possible complications. Learning how to get up after a fall can be beneficial but clinical experience and research shows that people at risk of falling can become anxious at the thought of being on the floor. This can be addressed during evidence based falls exercise classes by providing falls information.

Some precautionary steps will help to reduce discomfort for people who are unable to get up following a fall as they wait for assistance, such as keeping warm, access to responsive call systems and changing position.

Home risk assessment
Home risk assessment will facilitate safer discharge from hospital and will contribute to falls prevention. Older people who have fallen should receive a home hazard assessment, and be supported to have necessary modifications made.

Hip protectors for older people in care homes.
Some studies have shown that hip protectors can be effective in reducing the incidence of fractures, particularly for confused older residents in care homes who cannot participate in a falls prevention programme. However, they only work when they fit properly and are being worn. Compliance can be an issue if people find them uncomfortable or need to change frequently. There are a large number of people in care homes in Hampshire, and further work is required to establish who would most benefit.

Telecare
Telecare systems provide equipment to monitor people who are at risk of falls in their own homes and can therefore improve their safety and help them to stay independent for longer. It benefits all those involved in delivering care, most importantly clients, by providing non intrusive but highly effective care in the least intensive setting – the person's own home.

4 National and local policy context

There are several policies and guidelines that set out measures to reduce the number and impact of falls, and to support older people's independence and wellbeing.

4.1 National Service Framework for Older People - Standard 6: Falls

Aim: To reduce the number of falls which result in serious injury and ensure effective treatment and rehabilitation for those who have fallen.

Standard: The NHS, working in partnership with councils, should take action to prevent falls and reduce resultant fractures or other injury in their populations of older people. Older people who have fallen should receive effective treatment and, with their carers, receive advice on prevention through a specialised falls service.

Recommended interventions:

- Identification of people most at risk, assessment and putting in place of preventive measures
- Prevention of osteoporosis and treatment of osteoporosis in affected people.

4.2 National Service Framework for Older People - Standard 8: The promotion of health and active life in older age

Aim: To extend the healthy life expectancy of older people by ensuring the health and well being of older people is promoted through a co-ordinated programme of action led by the NHS, with support from Local Authorities.

4.3 Department of Health Prevention Package for Older People 2009

Investing in prevention services at local level can offer a more efficient use of resources and help deliver better outcomes for older people. The Prevention Package for Older People promotes local provision of preventive services in areas including falls prevention, foot care and intermediate care.

4.4 National Institute of Clinical Excellence: Clinical Guideline 21 - The Assessment and Prevention of Falls in Older People

This provides evidence-based guidelines on clinical practice relating to the assessment of older people and prevention of falls in older people, including:

- risk identification
- multi-factorial assessment
- interventions to promote independence, improving physical and psychological function.

4.5 American Geriatrics Society (AGS)/ British Geriatrics Society (BGS) Clinical Practice Guideline: Prevention of Falls in Older Persons

The aim of the guideline is to assist health care professionals in their assessment of fall risk and their management of older adults who have fallen or are at risk of falling. Multi-

factorial assessment coupled with tailored interventions based on the assessment findings can have a dramatic public health impact while improving quality of life in the older population.

4.6 Blue Book

The British Orthopaedic Association and the British Geriatrics Society produced the "Blue Book" which provides guidance on the care of patients with fragility fractures and emphasises the need for co-ordinated services and standards for hip fracture care. It emphasises the importance of monitoring adherence to standards via the National Hip fracture Database (NHFD)

4.7 A vision for adult social care: Capable communities and active citizens

The Vision for a modern system of social care is built on seven principles:

- **Personalisation:** individuals not institutions take control of their care. Personal budgets, preferably as direct payments, are provided to all eligible people. Information about care and support is available for all local people, regardless of whether or not they fund their own care.
- **Partnership:** care and support delivered in a partnership between individuals, communities, the voluntary and private sectors, the NHS and councils - including wider support services, such as housing.
- **Plurality:** the variety of people's needs is matched by diverse service provision, with a broad market of high quality service providers.
- **Protection:** there are sensible safeguards against the risk of abuse or neglect. Risk is no longer an excuse to limit people's freedom.
- **Productivity:** greater local accountability will drive improvements and innovation to deliver higher productivity and high quality care and support services. A focus on publishing information about agreed quality outcomes will support transparency and accountability.
- **People:** we can draw on a workforce who can provide care and support with skill, compassion and imagination, and who are given the freedom and support to do so. We need the whole workforce, including care workers, nurses, occupational therapists, physiotherapists and social workers, alongside carers and the people who use services, to lead the changes set out here.

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_121508

4.8 Equity and Excellence, Liberating the NHS

The coalition government's White Paper Equity and Excellence, liberating the NHS will influence the context within which this strategy will have to be implemented, with Clinical Commissioning Groups (CCGs) taking the lead in commissioning some health care services.

4.9 Healthy Lives, Healthy People

Healthy Lives, Health People is the White Paper outlining the coalition government's strategy for improving the public's health in England. It looks at health and wellbeing throughout life including ageing well.

It proposes a new role for local government in public health that will enable better integration to improve health across service delivery areas such as social care, transport, leisure, planning and housing as well as healthcare services, keeping people connected active and independent in their own homes.

4.10 National outcomes frameworks for NHS, Social Care and Public Health

National outcome frameworks have been produced for the NHS, Social Care and Public Health. Within the high level outcomes shown below are detailed ones which are more specific to falls and will become part of the monitoring measures for this strategy.

	WELLBEING	**PREMATURE DYING**	**RECOVERY**	**SAFETY**	**EXPERIENCE**
NHS	Enhancing quality of life for people with long term conditions	Preventing people from dying prematurely	Helping people to recover from episodes of ill health or following injury	Treating & caring for people in a safe environment & protection from avoidable harm	Ensuring that people have a positive experience of care
SOCIAL CARE	Promoting personalisation and enhancing quality of life for people with care & support needs		Preventing deterioration, delaying dependency and supporting recovery	Protecting from avoidable harm & caring in a safe environment	Ensuring that people have a positive experience of care
PUBLIC HEALTH	Improvements against the wider factors that affect health and wellbeing and health inequalities. People helped to live healthy lifestyles, make healthier choices and reduce health inequalities	……people dying prematurely, while reducing the gap between communities.	Reduced numbers of people living with preventable ill health and people dying prematurely, while reducing the gap between communities.	The population's health is protected from major incidents and other threats, while reducing health inequalities	Ensuring a positive experience of care and support

4.11 Quality and outcomes framework (QoF)

The quality and outcomes framework is part of the contract for general practice which rewards the provision of quality care.

From April 2012 three new indicators, based on NICE guidance on osteoporosis have been agreed. These include:

- producing a register of patients over 50 with previous fragility fractures and a diagnosis of osteoporosis
- recording the percentage receiving appropriate bone sparing treatment
- recording those over 75 with a fragility fracture and percentage on appropriate treatment.

This has the potential to identify those with osteoporosis and hence greatly improve their care, as well as providing better information to monitor outcomes.

4.12 Key Local Strategies

The emerging **Joint Hampshire Health and Wellbeing Strategy will** need to have oversight of the successful joint commissioning of an effective and coherent fall prevention Bone Health pathway across the whole of Hampshire.

Ageing well in Hampshire; Older People's Well-Being Strategy April 2011 – March 2014 is a joint partnership strategy between statutory and voluntary/community organisations to improve older people's independence, health and wellbeing.

Older Persons Partnerships across Hampshire have action plans many of which feature falls as a priority.

District and Borough Councils have joint **Health and Wellbeing action plans**, many of which identify falls prevention as a priority, and provide a route to develop local falls prevention interventions.

The **Clinical Commissioning Groups (CCGs)** will be key partners in implementing the strategy aligned with their own healthcare commissioning strategies.

Falls and Bone Health Locality Groups across the county have been working for some time with local clinicians to prevent falls and improve the treatment of osteoporosis and fragility fractures. Their local experience and expertise will be a great asset and will help to shape the county wide implementation plan.

5 Care Pathway

The following patient referral and care pathway has been taken from the NICE clinical guidelines for the assessment and prevention of falls in older people (CG21) and provides an overview of the evidence-based elements needed.

Patient referral and care pathway

CASE/RISK IDENTIFICATION IN GENERAL SERVICES

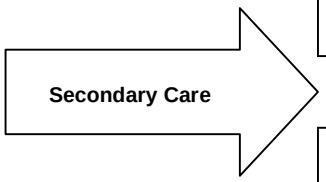
Ask if fallen in the past year and about frequency, context and characteristics of the fall.
Observe for balance and gait deficit and potential to benefit from interventions to improve balance and mobility.

FALLS SERVICE

All healthcare professionals dealing with patients known to be at risk of falling should develop and maintain basic professional competence in falls assessment and prevention.

Case/risk identified at health screen

Case/risk identified opportunistically at presentation with fall/other problem



Case/risk identified opportunistically at presentation with fall/other problem

Presentation at A&E with fall injury

MULTIFACTORIAL FALLS RISK ASSESSMENT

Offer multifactorial falls assessment.
This may include:
- falls history
- gait, balance, mobility, muscle weakness
- osteoporosis risk*
- perceived functional ability
- fear of falling
- visual impairment
- cognitive impairment
- neurological examination
- continence
- home hazard
- cardiovascular examination
- medication review.

*Refer as necessary

The specialist services for falls and for osteoporosis should be operationally linked or dovetailed.

MULTIFACTORIAL INTERVENTIONS

Offer individualised multifactorial intervention to older people at risk including:
- strength and balance training
- home hazard assessment and intervention
- vision assessment and referral
- medication review/withdrawal

After medical treatment for an injurious fall, patients should be offered multidisciplinary assessment and intervention.

STRENGTH AND BALANCE TRAINING

HOME HAZARD INTERVENTION AND FOLLOW-UP

MEDICATION REVIEW/WITHDRAWAL

CARDIAC PACING

EDUCATION AND INFORMATION

To promote participation of older people, falls prevention programmes should:
- discuss changes a person is willing to make to prevent falls
- information should be relevant and available in languages in addition to English
- address potential barriers such as low self-efficacy and fear of falling.

Programmes should be flexible to accommodate different needs. Information on the following should be provided orally and in writing:
- measures to prevent falls
- motivation
- preventable nature of some falls
- physical/psychological benefits of modifying risk
- further advice and assistance
- how to cope with a fall.

It is important that the referral and care pathway for falls dovetails with the care pathway for assessment, prevention and treatment of osteoporosis and includes risk assessment for fragility fractures.

As the new osteoporosis registers in general practice (4.11) are developed, there will need to be local agreement on how the people identified are managed between primary and secondary care services; and CCGs may wish to review and refine the pathway they commission.

6 Current provision in Hampshire

There are currently a range of falls prevention and treatment services across Hampshire, some of which are part of general acute, community and primary care services; others have been set up specifically to address falls.

There are two active falls prevention groups in the south of the county and a developing group in the north. Falls clinics and falls prevention exercise groups are being established to fill some of the gaps identified.

Provision is variable across the county. A map of services identified during the strategy development and consultation process is shown in Appendix X; but this can only be a snapshot of what is a dynamic and changing range of provision.

7 Consultation

A written consultation was undertaken with stakeholders during January and February 2012, supported by workshops in Eastleigh and Basingstoke. Consultees were asked specific questions about health needs and service provision. Those who took part were asked for their top three priorities to reduce falls and the impact of falls, and for any additional comments.

Responses are summarised in appendix X and have been incorporated into the strategy.

The top priorities identified have been put into the following themes

- **Advice and information**

  Health promotion advice on healthy diet and physical activity
  Increasing awareness of what services are available
  Details of evidence-based exercises
  Alerting people that fractures over age 50 may be a warning of osteoporosis
  Advice on Vitamin D to reduce falls and improve bone health
  Education as to how to fall and what to do if you fall if alone

- **Approach to delivery & gaps in service**

  Fracture liaison service with case finding
  Early identification of those at risk

Falls pathway with acute and community/LA oversight and integration of only evidenced based falls interventions
Exercise that is evidence based, affordable
Assessing home environments
Easy access to mobility aids
Reducing medicines

□ **Training and development**

Supporting care homes
Training for wider range of staff on all elements of pathway

Across all these priorities was a strong message for different sectors to work more closely together

8 Next steps

Addressing falls prevention and bone health is complex. It requires a multi- agency, multi-disciplinary approach. In order to ensure all partners share a common understanding of the agreed approach the following principles have been developed:

- **Build partnerships with commissioners, providers, communities and consumers** - Involve patients and users in the design of service responses and ensure strong and balanced stakeholder participation
- **Use approaches likely to succeed** built upon evidence to identify the most appropriate investments in prevention and management.
- **Minimise cost and optimise quality of life** - Leverage existing resources across sectors to build the capacity and infrastructure required to sustain outcomes
- Strong emphasis on the **identification and realisation of measurable benefits** through **strong governance**
- **Co-ordinated Long Term Approach** - Co-ordinate effort through identification of shared interests to drive collaboration to benefit the population not just in the short term, but for future generations.
- **Clear communication and increased information sharing** between commissioners and providers to ensure ownership and real change can be delivered

8.1 Governance Arrangements

In order to ensure that the Strategy is implemented a governance structure and high level implementation plan has been developed. It is intended that this takes account of CCGs commissioning plans; adult services commissioning plans and District and Borough Health and Wellbeing plans.

A Hampshire Falls Prevention and Bone Strategy Board will be accountable ultimately to the Hampshire Health and Wellbeing Board for implementation of the joint strategy and will work closely with established local falls groups to support current good practice and help to further develop effective local services.

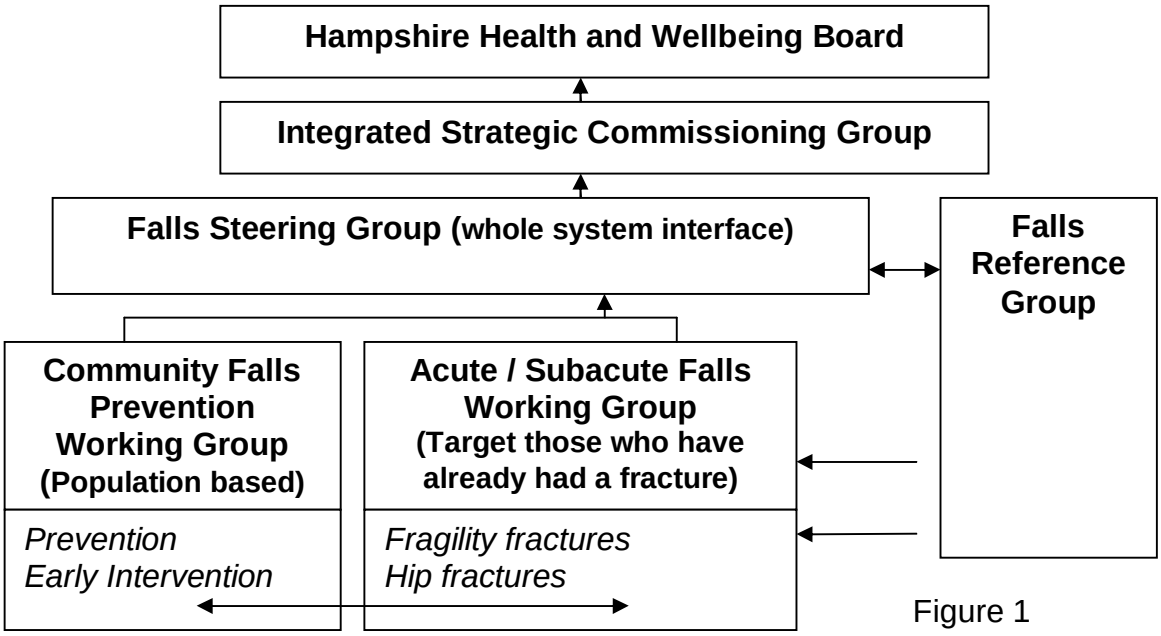


Figure 1

The governance arrangements are described in figure 1. The Falls Steering Group will maintain an overview of the delivery of the Strategy. It will be supported by two working groups. One of which will be population based and the other will focus on targeted service interventions for people who have already fallen and experienced a fracture. The Reference Group will be formed by multi agency interdisciplinary supporters across all sectors who wish to engage in the change process. This Group will be engaged via information sharing and good practice events. All the associated falls groups will build on existing groups that are already focusing on falls. The added value that they will bring will be in terms of convening to focus attention on specific short term tasks.

8.2 Implementation Details

Delivering the Strategy will require commitment from all key agencies including stakeholders, commissioners and providers. Success will depend on each agency and provider making their actions part of their routine business delivery. To further increase the likelihood of success a phased process is being developed. A co-ordinated approach is needed to ensure that the right action takes place across the whole system. The challenge will be to ensure that all parts of the system change appropriately.

The draft phased process is illustrated in figure 2 and shows the three key stages that will be required. The first phase has already started and focuses on building a firm foundation to deliver the required changes. Further development of the Falls Steering Group will be pivotal in ensuring that work continues with all commissioners to develop their commissioning strategies and plans to support the Falls Prevention and Bone Health Strategy. It is recommended that this important cause of avoidable ill health, increased dependence and mortality should be reflected in the Hampshire Joint Health and Wellbeing Strategy to enable partners, as commissioners and providers to prioritise falls.

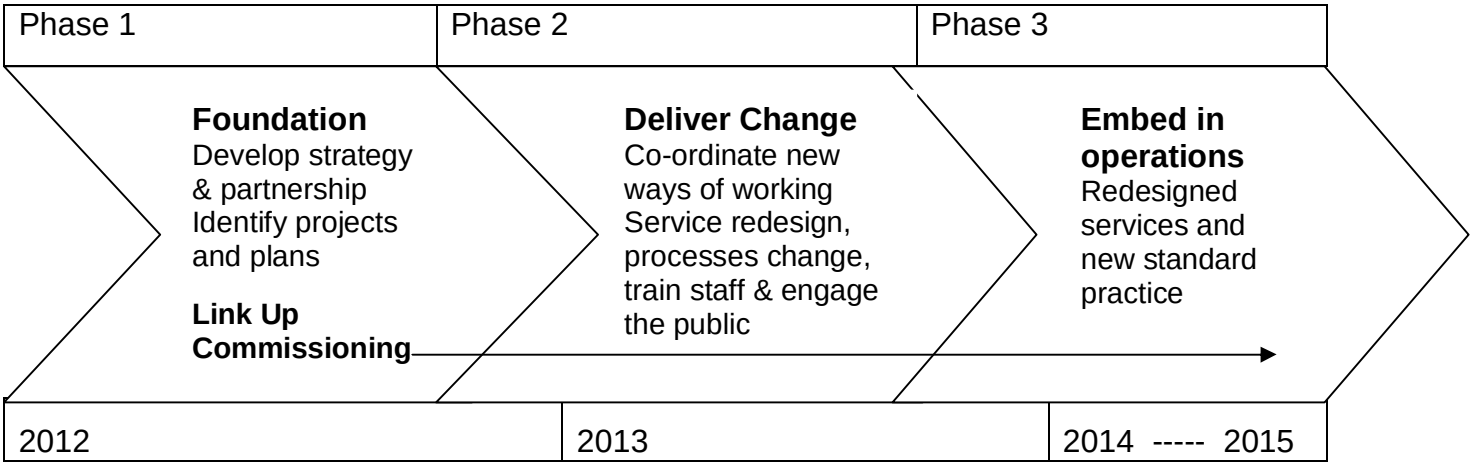


Figure 2

8.3 High Level Actions

A series of draft high level implementation actions have been identified to support delivery of the Strategy and to ensure change happens. More work in relation to project plans will be carried out and overseen by the Falls Steering Group. The actions include the following:

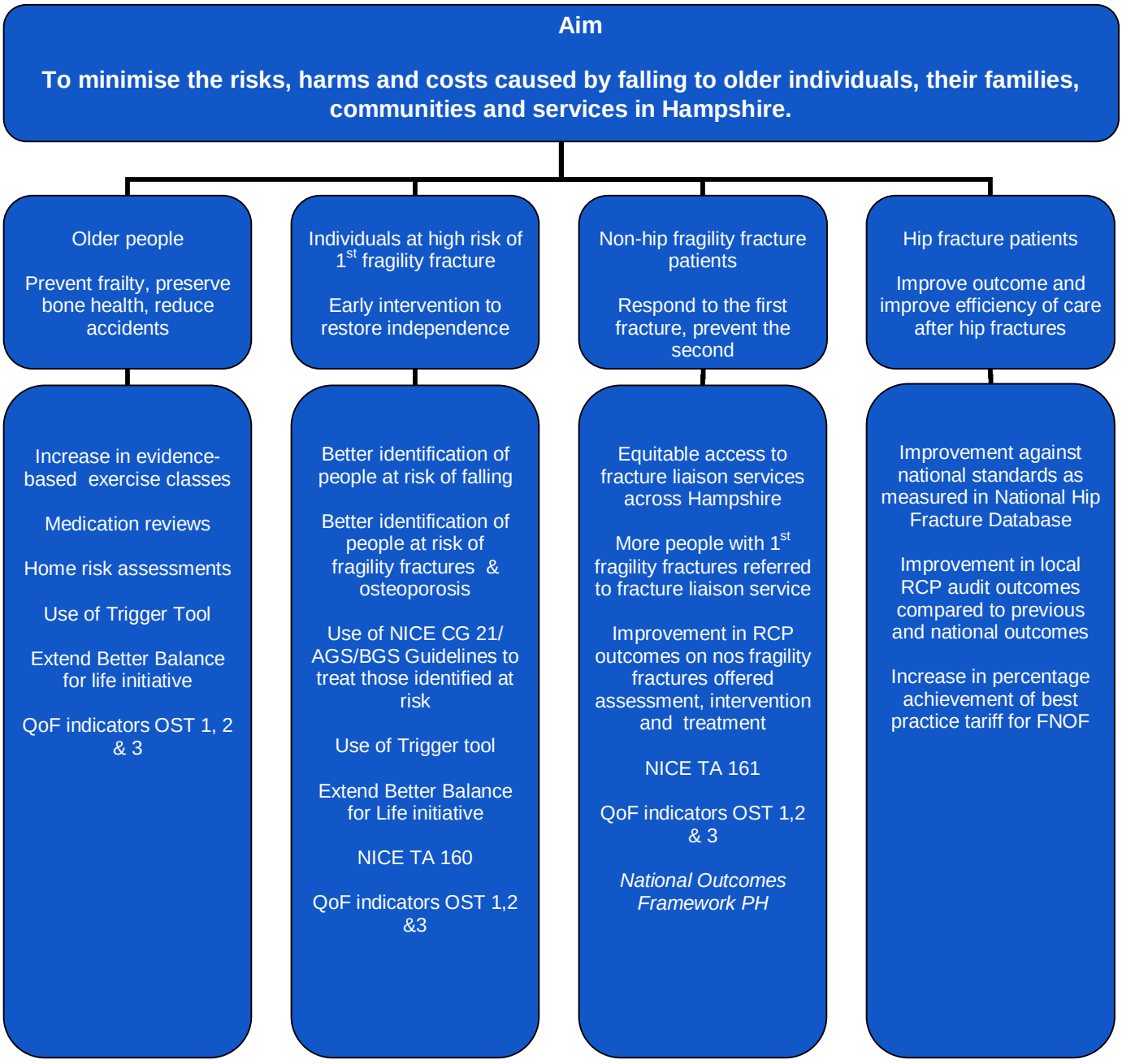
CROSS CUTTING ACTIONS				
Effective leadership & coordination to implement the Strategy	Improve data gathering and dissemination of best practice & resources	Create safer environments to prevent injury from falls	Service redesign & collaboration	Education & Training

ACTIONS							
Objective 1		*Objective 2*		*Objective 3*		*Objective 4*	
1A	Healthy Lifestyles	2A	Better Identification	3A	Define integrated pathway(s)	4A	Improved Service outcome and experience
1B	Better Signposting	2B	Increased use of protocols and guidelines	3B	Better co-ordination of services	4B	Better co-ordination of services
1C	Home Risk Assessments	2C	Better Risk assessments	3C	Service gaps and duplication		
1D	Communication & Information	2D	Reporting & Monitoring	3D	Improving Commissioning		

9 Conclusion

This commissioning strategy provides a framework to reduce the substantial and growing impact of falls on individuals, families, communities and subsequently on services in Hampshire. It builds on the good practice that already exists across Hampshire to provide a clear focus on areas of work that require a more joint and systematic approach to ensure that effective action is taken, both within the community and amongst those at higher risk from falls and their consequences.

The following diagram provides a summary of the aim and key outcomes of the joint commissioning strategy and will be underpinned by accurate, timely data to monitor progress against outcomes.



10 References

1. Source: Synthetic estimates from DH Prevention Package for older people

2. Department of Health Prevention Package for Older People Source: Synthetic estimates from DH Prevention Package for older people

3. Falling standards broken promises. Report of the national audit of falls and bone health in older people 2010.RCP.

4. NICE Clinical Guideline 124
Length of stay for emergency admission from Right Care Atlas

5. http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_12568.pdf

Appendix Nine

HAMPSHIRE COUNTY COUNCIL

Report

Committee:	Health Overview and Scrutiny Committee
Date:	27 March 2012
Title:	'Safe and Sustainable' Review Of Children's Congenital Cardiac Services In England
Report From:	Chief Executive

Contact name: Katie Benton, Scrutiny Officer
Marie Mannveille, Scrutiny Officer

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1. Purpose of Report

1.1. To update the Health Overview and Scrutiny Committee (HOSC) on the outcomes of a referral to the Secretary of State by Yorkshire and Humber Joint Health Overview Scrutiny Committee (JHOSC) on the 'Safe and Sustainable' Review of Children's Congenital Cardiac Service In England.

1.2. To comment on the findings of an independent report on family travel analysis which had been commissioned by the Joint Committee of Primary Care Trust's (JCPCT) to test assumptions regarding patient flows and manageable clinical networks.

2. Background

2.1. On 2 March 2012 the following statement was released from the National Specialised Commissioning Team:

"Following a referral to the Secretary of State for Health by Yorkshire and Humber Joint Health Overview Scrutiny Committee (JHOSC), the advice by the Independent Reconfiguration Panel (IRP) to the Secretary of State for Health was published in February 2012. The Secretary of State accepted the IRP's advice which showed that the JCPCT had consulted appropriately with the JHOSC.

However, the IRP advised that an independent report on family travel analysis which had been commissioned by the JCPCT should have been published before the deadline for submission of responses to consultation. The reason for not so doing was that the report was not available at the time, but it was published by the JCPCT in October 2011 and is available at:
http://www.specialisedservices.nhs.uk/document/testing-assumptions-future-patient-flows-manageable-clinical-networks-safe-sustainable/

The IRP suggested that any comments which stakeholders may wish to make with regard to this report should be considered by the JCPCT alongside the report itself as part of its decision making process. The JCPCT requests that any such comments are received in writing by 16 April 2012."

2.2. The suggested text of a draft response from the HOSC to the JCPCT with regard to this report on family travel analysis is attached at Annexe A. Agreement of this response would enable the JCPCT to receive such comments by their deadline of 16 April 2012.

2.3. The Executive Summary of the Report referred to is attached at Annexe B.

3. Recommendation

3.1. That the HOSC make an additional response to the Joint Committee of Primary Care Trust's in relation to the independent report on family travel analysis.

Hampshire Health Overview and Scrutiny Committee

Response to Safe & Sustainable Team regarding the PWC findings 'Testing Assumptions for Future Patient Flows and Manageable Clinical Networks'

The Hampshire Health Overview and Scrutiny Committee (HOSC) welcomes the opportunity to comment on the findings of the work undertaken to test assumptions regarding patient flows and manageable clinical networks. Detailed below are the points the Committee wishes to reaffirm following the publication of the independent report on family travel analysis, for consideration by the JCPCT.

Isle of Wight

The HOSC is disappointed that this piece of work did not look at travel for patients from the Isle of Wight for those options not including Southampton General Hospital as a surgical centre. This was flagged as a concern by the HOSC and others during the consultation period, due to suggestions locally that travel times to other centres would exceed retrieval time standards.

- Can the JCPCT confirm that issues for patients from the Isle of Wight have been considered as a separate piece of work to inform the decision making on the configuration of surgical centres?

Procedure Levels

The HOSC notes that the report found certain postcode areas may not flow to the centre assumed in the Safe & Sustainable proposals. While it is indicated if this may have an impact on centres reaching the 400 procedures threshold, the report does not appear to give details of the extent of variation, and therefore the impact on assumed procedure levels at each centre.

The HOSC notes that both Option A and Option B, which came out most favourably in the pre consultation options analysis, would potentially involve centres not reaching the 400 procedures threshold according to the findings of the PwC report. However, the HOSC has in previous submissions questioned the evidence base for setting a threshold at 400. The literature review supporting this work found an association between greater volume and outcome, however it was clear that specific thresholds for procedures undertaken on a centre or individual surgeon basis were not considered appropriate. Therefore, given that the options under consideration would increase all centres activity to over 300 procedures per year, which would be an improvement on the figures reported for 2009/10 in the pre-consultation business case (at which time 5 of the 11 centres were undertaking under 300), either of these options (A or B) should be considered acceptable from the perspective of increasing procedure levels at designated surgical centres.

The HOSC recommends that consideration be given to selecting a future configuration of centres that takes account of centres capacity to grow to accommodate the predicted procedure levels. Under the proposed options some centres would need to double the number of procedures undertaken compared to 09/10 levels. The JCPCT will need to be assured that an increase of this magnitude is realistic for those centres, and can be achieved safely and while maintaining a quality service and a high level of personal care for each individual.

Impact of GUCH procedures

The HOSC notes that clinicians surveyed as part of this work expressed concern that 'the projected flows were worked out on children's procedures only, but practically grown up children's (GUCH) services would also be undertaken and these could stretch units beyond their capacity'. This reflects concerns previously expressed by the HOSC regarding the decision to exclude GUCH procedure numbers from this review.

The HOSC notes that a separate review of services for Adults with Congenital Heart Disease has recently been initiated by the National Specialised Commissioning Team.

- Can the JCPCT confirm to the HOSC whether a centre not designated for children's heart surgery will be able to offer GUCH surgery?

If expertise is to be concentrated at designated centres for children's surgery it seems likely that GUCH procedures will follow where the expertise and facilities are located. Therefore the HOSC suggests that the potential numbers involved be taken into account when considering the scope for existing centres to increase their capacity to the levels anticipated under each of the options under consideration as part of this Safe & Sustainable review.

Existing Networking

The HOSC is disappointed to learn that referrers reported 'the most well developed current networks were those related to centres that were more likely not to continue to be cardiac surgical units under S&S options'. The HOSC would recommend that the JCPCT consider existing network features in weighing up the options, as maintaining centres which have already established some of the desirable network features would enable a quicker transition to the proposed model. This would avoid the need to stop existing good practice, and instead build upon existing foundations.

Travel Times Low Priority

The report notes that travel time to a surgical centre was a low priority factor for parents when considering where to take their child for surgery. This reiterates the findings of the work originally behind the options analysis. Therefore the HOSC recommends that when considering the future pattern of provision, the JCPCT considers travel issues a minor consideration when comparing options, and gives priority to maintaining surgery at the centres assessed as providing the highest quality services by the original expert panel led by Sir Ian Kennedy.

Transition

The HOSC welcomes the feedback highlighted in the report regarding the importance of good transition planning, and supports the suggestion that consideration be given to aligning children's heart surgery with other networks, to ensure Children with co-morbidities receive joined up services from a limited number of sites.

Additional Support for Parents

The HOSC supports the suggestions identified in the report which would mitigate issues for patients of having to travel further for surgery; such as financial assistance with travel costs, availability of affordable overnight accommodation, and information on travel to centres to assist parents with decision making.

Concluding Remarks

In conclusion, the HOSC continues to support Option B and does not consider the findings of the PwC report to change this view. However, the JCPCT may wish to consider the findings in relation to the Newcastle Hospital, and consider whether an 'Option E' would be preferable

given the findings of this piece of work and other information identified during the consultation period. If an alternative option were to be considered, the Hampshire HOSC would wish to suggest that the following principles be prioritised:

- Retaining centres identified as having greatest capacity to meet the criteria as identified by the scores awarded by the expert panel
- Retaining centres with established clinical network features that could be built upon
- Retaining centres which meet the retrieval times guidance including for patients from the Isle of Wight