Agenda Item 6

HAMPSHIRE COUNTY COUNCIL

Report

Committee:	Health Overview and Scrutiny Committee
Date of Meeting:	30 March 2009
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 March 2005. This places particular emphasis on the duties imposed on the NHS by the Health and Social Care Act 2001.

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

- *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
- *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.

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 Information

2. **South Central SHA: Consultation on proposals to fluoridate drinking water in Southampton and South West Hampshire**

2.1. No further information has been received about progress with the Judicial Review challenge to the SHA.

Recommendations

2.2. Members are kept briefed on progress with the Judicial Review.

2.3. That, because of the increasing financial pressures on the NHS, the Chairman writes to the SHA asking that the plans to add fluoride to water in Southampton and South West Hampshire are withdrawn and the costs associated with the court proceedings avoided

Items for Action

3. **Hampshire Partnership NHS Foundation Trust: Proposals to modernise adult mental health rehabilitation.**

3.1. Hampshire Partnership will attend the meeting to brief members on the outcome of the Independent Review commissioned by Hampshire Partnership NHS Foundation Trust. The full report, and a summary of the key findings and communications plan are attached at Appendices One and Two respectively.

3.2. Hampshire Partnership Trust and NHS Hampshire have confirmed that they have informally considered the report but this will be formally considered at future meetings. Any feedback from the HOSC will inform the formal consideration of the report.

Recommendations

3.3. That the HOSC welcomes the joint approach adopted by Hampshire Partnership and NHS Hampshire to agreeing next steps to be taken in this process.

3.4. That the HOSC confirms its expectations in relation to:

- The key points to be considered in responding to the findings of the independent review.
- The next steps to be taken in response to this work

4. **NHS Hampshire: Proposals to cease the development of Oak Park Hospital**

4.1. Further to the discussion at the last meeting the Chairman wrote once again to the Chief Executive of NHS Hampshire highlighting the continuing issues of concern to members. This correspondence is attached at Appendix Three. In particular members have stated that:

- Should the plans to cease the development of Oak Park Hospital proceed this **would** constitute a substantial service change
- Members were **not** satisfied that any of the three options proposed will meet the health needs of this highly vulnerable population
- The lack of coherence in the presentation of the options means that the HOSC is **not** convinced that they are in the interests of the community affected.

4.2. The response of the Trust is attached at Appendix Four

4.3. The NHS Board meeting on 28 January agreed to defer the decision about Oak Park until September 2010 in order to allow more robust plans to be developed and to consider ambulatory and in-patient care together.

4.4. Members of the Panel reviewing this decision have now had an opportunity to visit all the health facilities in the area that will be affected should the Oak Park development not proceed. Members were very impressed by the professionalism and dedication of the staff they met, and the high quality of care provided in sometimes difficult environments. In particular members were of the view that plans to locate diagnostics at the Children's Centre means that only outpatients could take full advantage of the services that were planned at the Oak Park Community Hospital. It is not clear what implications this may have for inpatients.

4.5. Additionally whilst opportunities for partnership working in relation to the provision of inpatient services were to be welcomed these did not provide a viable or timely alternative to the inpatient care planned for Oak Park Community Hospital.

4.6. The Panel established to consider this matter on behalf of the HOSC met informally with NHS Hampshire on 12 February. The notes from this meeting are attached at Appendix Five.

4.7. NHS Hampshire have prepared an information pack for members on the Oak Park Community Hospital Review which was electronically circulated on 19 March. Paper copies of this document will be provided at the meeting.

Recommendation

4.8. Members confirm if they are satisfied with:

- The next steps in this process proposed by NHS Hampshire .
- The viability of the alternative service provision envisaged for outpatients, inpatient and minor injuries should Oak Park Community Hospital not proceed.
- That the way forward proposed by NHS is in the interests of the population affected.

5. Children's Cardiac Surgery Services

5.1. At its meeting on 16 March 2010 the Hampshire, Southampton, Portsmouth and Isle of Wight Health Scrutiny Joint Committee gave consideration to proposals by the NHS Nationalist Commissioning Group to provide a safe and sustainable programme for Children's Cardiac Surgery. The report presented to the Joint Committee is shown as Appendix 6 and the extract of the Joint Committee Minutes is shown as Appendix 7.

Recommendation

5.2. That the Hampshire, Southampton, Portsmouth and Isle of Wight Health Scrutiny Joint Committee continues to monitor progress with the Children's Cardiac Service and takes whatever action it deems necessary.

6. Provision of Children's Neurosurgery Services

6.1. At its meeting on 16 March 2010 the Hampshire, Southampton, Portsmouth and Isle of Wight Health Scrutiny Joint Committee gave consideration to proposals by the NHS Nationalist Commissioning Group for the provision of Children's Neurosurgery Services. The report presented to the Joint Committee is shown as Appendix 8 and the extract of the Joint Committee Minutes is shown as Appendix 9.

R*ecommendation*

6.2. That the Hampshire, Southampton, Portsmouth and Isle of Wight Health Scrutiny Joint Committee continues to monitor progress with the Children's Neurosurgery Services and takes whatever action it deems necessary.

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

PSYCHIATRIC INTENSIVE CARE UNIT
INDEPENDENT REVIEW REPORT
HPNHSFT Ref:- MJ/jhg/PICUPanel.001

Introduction

The report authors were commissioned by Chief Executive Nick Yeo and Debbie Fleming, Chief Executive Officers for Hampshire Partnership NHS Foundation Trust (HPNHSFT) and Hampshire Primary Care Trust (HPCT) respectively, to undertake an independent clinical review in respect of psychiatric intensive care services, the pivotal matter being the closure of Ellingham Ward Psychiatric Intensive Care Unit (PICU) on the Woodhaven site, that ward having been closed temporarily in October 2009 to date.

The three panel members did not know each other prior to the review, and were drawn from different parts of the country. The reviewers' Curriculum Vitarum are available as attachments in Appendix 1.The clinical reviewers were "lent" by their employing Trusts. They were not remunerated additionally for the time given to carry out this work. They had no incentive re conclusions they drew - in one direction or another (i.e. they were not "tipped a wink".)

The Panel would like to thank all those who gave their time to supporting the review process. Their willingness to share honestly their perceptions and to let the Panel know their determination to find the best way forward was impressive.

Terms of Reference

The review team received a bundle of documents prior to visiting the Trust for two whole days of interviews, focus groups and discussions. During the visit, the Panel was shown round Ellingham. The role of the independent clinical review panel set out in the Terms of Reference attached as Appendix 2 to this Report required it to-

1. Review the emerging proposals from the Trust with reference to national best practice

2. Take into account the views and opinions of service users, carers and clinicians

3. Commission independent research and/or seek expert opinion as necessary

4. Seek to establish whether there are any alternative proposals that represent "realistic, cost-effective and preferred alternatives" for the configuration of PICU services across Hampshire

5. Publish a report for consideration by the Chief Executive Officers of NHS Hampshire and HPNHSFT

The main body of the report is structured to address, in turn, each.

Report

1) Review the emerging proposals from the Trust with reference to national best practice

The Panel has structured its considerations around this in terms of the optima and inter-play between efficiency, effectiveness and fairness.

i) Efficiency

Finding

Panel concluded that the business and efficiency rationale for the permanent closure of the PICU beds at Ellingham Ward was sound – that is, the numbers added up, although the temporary closure was, in the event, precipitous.

Mitigation

HPNHSFT faced a near £2 million gap between projected income and expenditure 2009/10. (Some discussion about our understanding of the make-up of that funding gap follows). In such an organisation, in the face of such a funding gap, broadly speaking, money could be taken out from:-

a) Back office and management with effectively no impact on direct clinical care activity
b) Changing how things are done and doing them more efficiently (which in mental health usually amounts to reduced staff numbers carrying out the same total amount of clinical work because most clinical cost in mental health is payment to staff).
c) A frank cut i.e. ceasing clinical face to face activity

We were told more than one proposal was discussed and some back office services were merged. The Panel recognises that a sum of the size required could not be met by those measures alone. Of the proposals that HPNHSFT looked at preliminarily, it saw that that which was most likely to achieve the level of saving and, on balance, cause the lowest risk to direct care, appeared to be that around PICU Trustwide - as a type b) measure. The HPNHSFT felt that capacity had been identified. The Panel were told that there were 6 to 8 PICU beds free across HPNHSFT July to September 2009. A proposal scoping the impact of closing Ellingham, the 6 bedded PICU unit at Woodhaven, was "worked up" around demand, by the interim Director of Operations, 4th September 2009. It looked at patient units of care as OBN's and to some extent, flows, and took some

reference from the *Department of Health, Mental Health Policy Implementation Guide, National Minimum Standards for General Adult Services in PICU and Low Secure Environments* (This document is referred to hereafter as the PIG).

Apropos of the efficiency argument, one interviewee told the Panel that the proposal had not properly taken fluctuation into account and, in fact, the result of the Ellingham closure would be insufficient PICU provision across HPNHSFT 76% of the time. This was not the view of other contributors, including those who are actually managing PICU placements across HPNHSFT currently. They told the Panel that for them the closure of Ellingham was not a "heart-sink" event, in terms of organizing/finding PICU beds. We were told to date no private PICU has been required and in fact there are, Trustwide, a few contingency PICU beds which can be tracked daily.

Another contributor put forward that the proposal was flawed in terms of the efficiency on patient flow argument because it did not acknowledge that acute bed pressures had been so great in months leading up to the closure, that at Windsor Ward ill patients were being accommodated in "put up" beds. This was refuted by other clinicians directly involved in care provision at the time. The Panel can only note that all the performance data they saw, showed Windsor occupancy at 80% to 90% and the readmission rate <5% - which are satisfactory.

To the Panel, most representatives of the Trust were clear that the Ellingham closure was driven by essential efficiency. In other words, the HPNHSFT could not continue spending more money than it was allocated to spend, given legal and other duties and the reality of working responsibly within a governed financial envelope and a business year. One senior contributor, however, proposed to Panel that the closure was a step along a planned "direction of travel" towards less reliance on beds and enhanced community services, i.e. that was a direction embracing some core values and principles, strongly supported and desirable. The Panel did not consider that that explanation rang true re: the closure of Ellingham and could see how reiteration of it, around this particular matter, will have amplified the feelings that have arisen between management and clinicians discussed in Section 2, in other words that the Trust was seeking to "dress up" the saving as of clinical benefit or enlightenment. This would seem to the Panel disingenuous. The Panel could see that reduced reliance on beds might be a feature of the 5 year plan and accept that it is widely spoken about and implied by New Horizons. But identification of the Ellingham closure as an intentional harbinger of that had left a sense that anything (inpatient based) could be closed, at any time to "advance" services

on the most according to how an individual at the time defined progress and this made a space for cynicism and anger.

The Panel could see also that over the course of the decision making about, and operationalisation of, the Ellingham closure, some "tipping points" were put forward as if causal and out of the efficiency context. Most notable was the need to address the staffing crisis resultant from the vacancy freeze equivalent. The Panel can see that was not at all helpful either. This they did not, however, see as "the Trust" being deliberately devious, but again it has damaged the confidence in how decisions are planned, made and explained as they should be.

Nevertheless, in practical terms, we note again that the closing of Ellingham Ward has released the savings to allow the HPNHSFT to continue business appropriately.

ii) Effectiveness

Finding

On balance, the emerging proposal, of which the permanent closure of Ellingham Ward as a PICU is part, does not, in its own right, necessarily reduce the effectiveness of treatment of New Forest, or other, service users who might otherwise have been admitted to Ellingham Ward.

The Panel considered that a shared developed dashboard of clinical, with performance, quality indicators should be progressed by HPNHSFT across the PICU and acute localities for accountable monitoring of effectiveness.

Mitigation

There was a background of some of the whole Trust PICU provision being used to manage patients who might otherwise have needed private sector local secure provision away from the area. Those patients *de facto* were liable to a long (>60 day) length of stay and sometimes significant periods of managed leave in the community as part of rehabilitation and recovery.

Historically, that had been, in part, an intentional strategy within HPNHSFT when it had held, for the HPCT, a near £1 million risk-share budget around low secure services. That funding was taken back by the HPCT in March 2009. In a telephone conference with the Panel, the HPCT wished to maintain this was not a disinvestment as such. But it was a significant loss of income to the HPNHSFT and particularly focussed the need to look at PICU in HPNHSFT in line with the PICU component described by the PIG. Moreover, there had been a gap in the capital charge relating to Ellingham from its opening .

The Panel took from the PIG, matters relating to clinical quality and "National Best Practice". To help Trusts separate appropriately between the 2 functions (PICU and low secure), the PIG Group defined a PICU admission as not ordinarily more than 8 weeks. A patient needing PICU could not safely be treated in an open facility. The PIG differentiated the low secure service aim as to provide a more homely secure environment, with occupational and recreational opportunities, and links with the community facilities in which patients would ordinarily stay up to 2 years. The PIG recommends the differences and functions between PICU and low secure environments to be taken into consideration when implementing the standards and speaks to the special skills, particularly team work and inter-professional relationships, that PICU staff must develop. Panel noted, however, that the PIG guidance does not suggest that the physical annexing of a PICU to a locality inpatient unit is the most desirable model. A detailed desirable layout is described, actually specifying that bed numbers should preferably be 12 to 15.

Also included in the PIG, on PICU, is the imperative for mutual agreement between referrer and admitting unit on the positive therapeutic benefits expected to be gained for the time-limited admission. In other words, for the purpose of the PICU stay to be explicit. The Panel could see that maintenance of communication between the home acute unit and the PICU is, on the face of it, easier when the units are just a door apart. Nevertheless, a corollary risk is that the key purpose of the PICU becomes blurred. The Panel also share the view articulated in the PIG that good governance around information sharing and multidisciplinary work using full CPA around the 5 broad categories in the PIG:-

- Social support
- User agencies
- Legal/judicial
- Community and inpatient mental health
- Medical services, primary and secondary,

mitigates against quality risks and that communication is not location dependent.

The Panel was impressed by the effort the nursing team on, and leading, Windsor had made, when the closure of Ellingham was announced, to draft up protocols to facilitate the above. Some contributors to the Panel reflected that one, perhaps unexpected, but beneficial, outcome had in fact been to focus better on what clinical factors actually indicated transfer to PICU. In addition, to greater stringency at assessing clinical need at gatekeeping to Windsor, staff reported to Panel an improved openness in the dialogue; they had, with external agencies for example, approved Mental Health Practitioners. The Panel heard that at the closure, one relative had correctly complained about transfer of information about their relative, to the unit to which transfer was taking place. The Team on Windsor had taken this as a learning opportunity to work on improving those pathways. Particularly we note in the PIG, the observation that where requested, a Carer view on the care and treatment process (including transfer to and from PICU) will be expressed in a face to face meeting. We add this to indicate that the PIG recognises the decision to transfer to PICU as specific and important requiring multidisciplinary patient and carer involvement. But it does recognise that the transfer may, and indeed is quite likely to be, to a different site.

We have discussed the PIG, not because we have had any evidence to suggest that Ellingham or any of the other PICU facilities in the Trust fall short of any of the quality standards on a case *per* case basis. Individuals testimonials state the contrary. The Panel did however pick-up internal contradictions. One posit was that Woodhaven had been “a balanced tripod” with Learning Disability, Mental Health and PICU and that the removing of PICU from the site had unbalanced it. The National Service Framework operative for the past 10 years would not have particularly supported those 3 functions on a site as providing an optimal balance. Moreover, the Panel heard some contributors saw the transition processes to and from Windsor to Ellingham previously as seamless, flexible and able to accommodate “grey” cases. Other contributors said that there was a well accepted, and indeed required, use of Ellingham for low secure type patients, i.e. patients who would not pass to Windsor. The Panel did not see cumulative date to allow evidence based ingress to this. But it seems to be the Panel was also asked to consider that the expertise of the previous Windsor team was so specialist that it could not be transferable and now individuals from the clinical Team had been moved, their skills were lost to the Trust and they were “square pegs in round holes”.

The Panel considered re: effectiveness, that relying more on the PIG in with the business case could have been helpful at the onset to bring together the efficiency and quality imperatives in the drivers for change. This might possibly have better engaged the clinical community at Woodhaven in a wider consideration about the way that services in Mental Health are at the moment, continually changing in response to year on year priorities and new clinical evidence.

The Panel could not but recognise the sense of loss expressed by Ellingham partners. The Panel learnt that the multidisciplinary team at Ellingham had prided itself on working to exceptionally high standards. The relationships with Windsor Ward were described as exemplary and the Team's strength recognised in the 2009 Trust Achievement Awards scheme. Ellingham staff told us that Ellingham had managed its work so that it was often able to "help out" other areas when they ran out of beds and were confident they would treat those patients as well as they would a locality resident. The Panel did ask whether the Ellingham staff did not feel that similar standards could not, with work, be achieved by other units who now would take New Forest PICU cases. To be even-handed, the Panel should note that other contributors thought Ellingham had really worked as back up to low secure, seen by some, from the outside, as parochial and would only "release patients when they were well" i.e. it did not have the PICU focus. The Panel notes, as a matter of fact, that at closure in October 2009, there were 5 patients to locate, 1 was able to go home but 4 had to be admitted elsewhere In this area, and others, the Panel was faced with notably divergent accounts. The Panel can accept that no contributor to the review sought deliberately to mislead it. In some cases, it seemed that strength of feeling had polarised accounts into the very black or very white.

Clinical staff previously at Ellingham told the Panel that the general level of disturbance on Windsor ward had gone up since Ellingham closed and that there were more incidents and more complaints, more episodes of forced medication including Acuphase, a higher proportion of detained patients and the ward was more often locked. The Panel was given a specific example of an incident when Police had had to come to the site, as an additional illustration of how dangerous or overwhelmed the environment in Windsor could be without Ellingham. A second account of the same incident provided by the staff who had worked through it was very different and said that in the relevant case, the service user did not have issues that would have made the use of Ellingham at all appropriate. The Panel was pleased to note that, as a more general point, there is a well

established memorandum of understanding between the HPNHSFT and Hampshire police, ensuring that should police support be required on Windsor ward or elsewhere in the Trust, it is speedily available. Further, one panel member explored in some detail with clinical staff, how this worked in practice and how it was well regarded by nurses on the ward. Another contradiction was heard when one contributor told the Panel that the team on Windsor were now "palpably demoralized". This was a view not subscribed to by the Windsor Ward staff. No indicators could be produced.

iii) Fairness

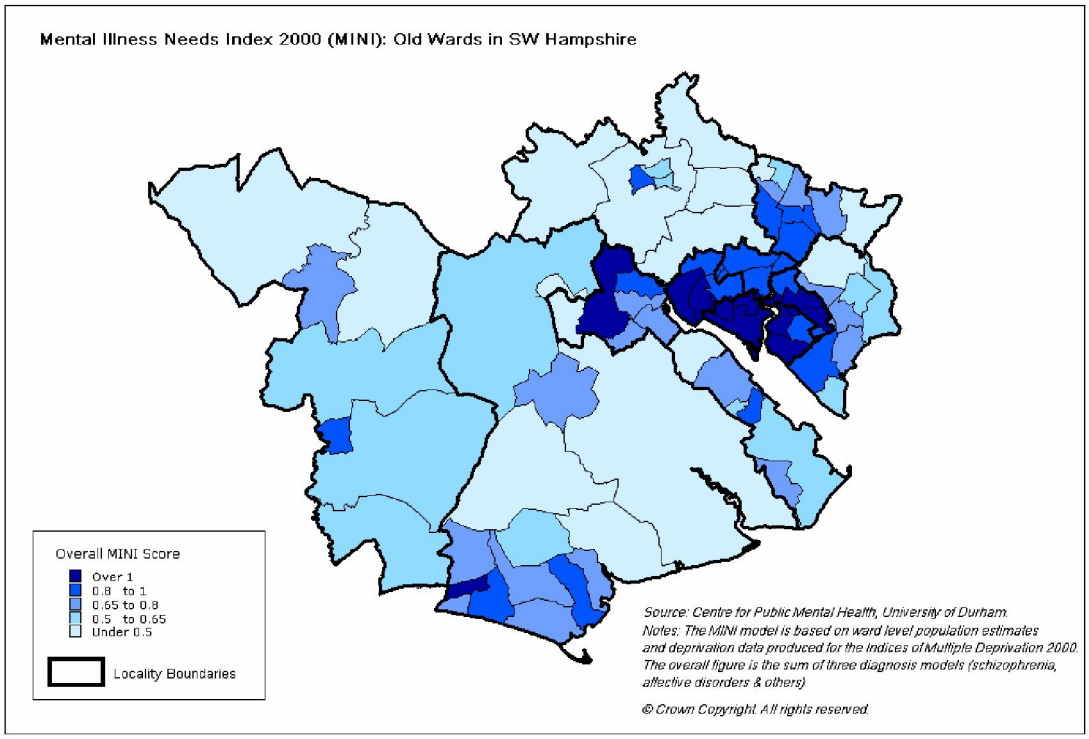
Findings

The Panel also considered the fairness of the emerging proposal of which the permanent closure of Ellingham Ward as a PICU is part. Whilst sensitive to the very strong views of local New Forest residents and staff, the Panel did not form the view that the closure was unfair.

Of real concern, however, is the "fall out" sense of unfairness about the process as well as the actual closure of the ward and the campaigning which the Panel felt frankly, more than anything could disrupt the Trust's business, partnerships and patient care. The Panel was encouraged to hear many contributors say despite it all they felt now with a 5 year forward plan, there was a chance for a different climate to emerge where clinicians, leaders and managers would work together and the Panel thought this could be a vehicle for moving forward.

Mitigation

The Panel has to accept that resource is not infinite and decisions about allocation not rigid. Any responsible body needs to allocate its resources so as to bring the greatest improvement in health opportunity. The Panel did note that New Forest is not actually an area of high psychiatric need, nor of an increasing working age adult population. (See below)



- The number of people resident in the District on Census night 2001 was 169,331. This was an increase of 5.5% over the period 1991 - 2001.
- The proportion of the population aged 60 or over in 2001 was 28.3% an increase of 0.79% on 1991 and the highest proportion in this age group of any district in Hampshire. *(1)*
- The proportion aged 0-15 was 18.1%. This was about the same as in 1991, although those in the 0-4 age group was 0.8% lower than in 1991.
- The proportion of young people (16-24) was the lowest in Hampshire at 8.03%. The average for the County was 11.5%.
- The number of people who described themselves as belonging to one of the "non-white" ethnic groups was 1,935 or 1.1% of the District population.

The Panel can fully understand, however, that any geographical area will engender its own community loyalties and the community cohesion is valuable. The New Forest populists in this debate are supported by the local MP and feel passionately that the area, in this case the New Forest, should have (by inference, including PICU) services positioned locally. The Panel had to note, that the same do not, however, seem to have a significant difficulty with the idea that residents of other areas could access spare capacity in Woodhaven including Ellingham and bring resource with them and yet not suffer by being treated away from their own immediate area. The Panel noted too that currently of the Section 136 suite, is not at Woodhaven but at the local police station. No contributor noticed a core problem with the need *de facto* to transport New Forest

resident patients from there when they are assessed as requiring psychiatric hospitalization after Section 136. Cases may also be access other elements of secondary and tertiary psychiatric care out of the area.

Also of concern was to hear a clinical contributor saying that Units in HPNHSFT beyond Woodhaven, who may send patients to them, select those who they find “less pleasing”. In other words, more than “us and them” dynamic was visible with implied or directly stated lack of confidence in the probity of other partners. Elements of that were explicit when a Panel contributor told us that they should keep Ellingham “because we are not the poor relative like…” (naming another locality).

It was encouraging for the Panel to see, however, more open interrogation in the form of an audit evaluating the Care Programme Approach. Also encouraging was to hear several contributors reflect that they did not think being “too parochial” would always work best for their (New Forest) cases and think what a less focused view in terms of “local”, for example leveraging capacity across at least the boroughs and towns to which HPNHSFT delivers could bring. In practical terms, most accepted that the current arrangement i.e. using PICU beds on 3 of the 6 sites where there are acute units, was sustainable. They touched too on the risk of a very “local services for local people” outlook whereby localities became and felt insular or idiosyncratic and rivalistic which would act against supporting the wider Trust’s development and journey towards excellence.

There is strong language employed by antagonists to closure, giving voice to their dismay which seems to generalize beyond Ellingham, into quite significant anti-HPNHSFT issues - both from some employees and some other partners. Past and other regrets and frustrations, or “hobby horses”, are being collated with this one. Vocabulary included “amateurism”, “rigidity”, “stupidity”, “facelessness”, “short-sightedness”, “pseudo involvement” and “little voice” of clinicians. Some proposed institutional “abuse”, a “climate of fear, spin, reverse engineering, manipulation” and so on. We heard of “cloak and dagger” practices, such as letters being intercepted.

The Panel had to note too that some of the dialogue with them had little to do with the closure of Ellingham than the wider pacey psychiatric and NHS agenda. One clinician described feeling exhausted by “endless changes” and “useless targets” and generalized into beliefs about the functionalised model of mental health and the NSF. Another, in a separate group bemoaned that the New Forest clinicians had difficulty with change.

Others we saw claimed strain in the overall emotional environment and thought all staff were distracted by threats to their career, losing patients, making false economies and shooting themselves in the foot in an existential crisis, but this was not an universal, or even, a majority take on the what it was like in HPNHSFT.

The Panel was passed letters not to be divulged to the Trust, both when they were at the interview days and afterwards. We had no sense that this issue was resolving for the relatively few who came forward to tell us how very strongly they felt. There was a sense from some that the Trust should apologise for what it had done as well as how they did it. The Panel felt that would not be a simple solution given that what the Trust had done (i.e. closed Ellingham temporarily in the first instance) since that particular issue, which is what the Panel had been asked to look at, has not emerged as "a screw-up" as some wish it to be identified, nor the processes behind it "a sham" . The Panel, of course, only saw who they saw, but amongst even those some - and this included current clinical - contributors expressed a sense of relief and achievement that the efficiency saving had been attained.

The Panel heard too some albeit cautious optimism about the development of the forward 5 year plan. We were told there was a specific agenda to try to bring closer together the New Forest Romsey and Mid Hampshire into a West area Working with those issues may help the Trust as a whole move forward.

The Panel felt that the development of a shared dashboard of clinical performance quality indicators should be built up by HPNHSFT across the PICU and acute localities for accountable monitoring of effectiveness. The dashboard should be contributed to and agreed by managers and clinicians and should incorporate known national, regional, PCT and clinical indicators, including for example incidents and complaints, some of which are likely to be targets, others "softer" but equally important to do with patient and staff experience. We felt that the willingness to build up the dashboard would be a signal to both sides of the current "campaign" of the other side to recognise that the previous way of doing things needed to be changed through behaviour and ownership of core principles.

2) Take into account the views and opinions of service users, carers and clinicians

This is the area which, as the Panel think we have touched on above, seems to have caused the most profound difficulties. Effectively all those we spoke to were uncomfortable with the need for the 6 months non-denoument of the plan, once it had really been identified as the one to be taken forward. There was a feeling that the concept of unnecessarily spreading worry, destabilising or infantalising the wider staff groups was not helpful, while respecting the need to let affected staff know early. It was this that the Trust put forward as the explanation for not embarking on an earlier public consultation. Trust management said with hindsight, public and staff consultation should be managed in tandem. Nevertheless the Panel did see some evidence that there was more written and spoken material available than some clinicians saw, or chose to see and technically the Trust change policy had been implemented. Equally, the actual closure happened very quickly as a temporary and urgent measure and much quicker than first proposed – to risk manage Trustwide nurse staffing.

The Panel noted again the stark differences in claims, beliefs, experiences and understanding in this area. The Panel heard from some that the closure had come completely out of the blue with 6 months of contrived secrecy before it. The impression of that voice was that effort had been made to consult nobody but to produce "a done deal". One contributor described the closure as "a betrayal of trust for the families of service users" and it as malicious "hoodwinking" to attribute the need to close to staff shortages. The Panel saw that there had been workshops, specifically one on the 23rd February 2009 for staff and one on 26th February 2009 for service users and carers, and minutes mentioning possible at bed reduction from 2006, particularly around the business opportunities that providing proper low secure facilities could bring. We saw also notes of a meeting with Ellingham Ward staff 18th August 2009 with another booked 25th August 2009.

The Panel could see how, in the weeks before the closure, pressures built up. Although we were told there was never a "freeze" on recruitment by that name, "better vacancy monitoring" was in operation and it was the case therefore that the need to redeploy staff rapidly was the precipitant to the brought forward and rapid closure of Ellingham in October 2009. Given the background, some staff are, by turn, bitter and bemused, cynical and bemused by the message that staff shortages were the actual "cause" of

Ellingham closing and wanted the Panel to know that exactly the same process, i.e. of central recruitment managing is still being translated into “staff shortages” and then those staff shortages are being put forward as the need to close something – as if the problem was of recruitment. Other staff felt that the users and carers from other Woodhaven units had managed to make their voices heard very strongly (described by 1 contributor as ambush) at the Trust AGM. In other words they had the belief that in the squeaky wheel got the oil. Some thought the behaviour of “management” had been very deliberately to go into a huddle and keep a secret. Others thought it was less devious but the result of the coincidence of pressures that had to be managed very promptly. Other staff gave examples of a totally different experience including an email marked “not to be opened” just before the closure was formally announced and a duty placed on lead and managerial staff who knew about the likely change being told in May 2009 that they must absolutely not reveal the closure plans, leaving them feeling complicit with a managerial clinical divide.

It was the case that staff likely to be put at risk were told in advance of any public, or indeed wider clinical, disclosure of changes. It seems also to have been the case that with the additional pressure to review a submission to monitor. Managerial staff accepted with hindsight it would have been preferable to make absolutely, early and repeatedly clear that to remain responsible the HPNHSFT needed to save the amount of money that it did need to save through the program of cost improvement which is expected through the NHS.

The resultant position is saddening and divided. A small number of staff describe their current position as a campaign and expressed an intention to continue to fight and wear down the Trust. The Panel would feel that this would be adverse for individual clinicians and their ability to simultaneously concentrate on their professional duties of care in the areas where they are working. It would also be adverse for the Trust reputation which would adversely affect working relationships with all wider partners and potentially will, of course, suck resources away from direct patient care.

The Panel would be of the view that the building up of the dashboard could be one way of building a bridge. The Panel would also hope that perhaps some of the thinking they have been able to bring forward in this report might be conciliatory. The Panel would feel that the managerial element in HPNHSFT would need to acknowledge that the “noise” of the Ellingham partners has been borne significantly of the passion they feel about the care they want to give to the most ill. Looked at psychologically, PICU staff hold a role in

containing collective anxieties for acute units. Because Ellingham was actually shut with such a short lead time and in away which the staff saw at the time as mindless, some of those Ellingham staff have had not place or way to "work through" the change. Hence some of the "noise" which can be interpreted as a need to convey with absolute clarity how the most vulnerable must be contained and the effects of an organisation does not behave in a containing thinking way. The Ellingham partners would need to recognise that the Trust have heard the noise and understand its cause, and acknowledged that they were clumsy about the closure if was not intending to "pull a fast one". This report may act to help the Trust state it has learnt from the effects the way Ellingham was closed. Particularly there needs to be a more open early debate about, for example, whether delivering the 5 year plan is intended to come with a 20% bed reduction – and where such "ideas" come from.

3) **Commission independent research and/or seek expert opinion as necessary**
All research and sources used stated in this report

4) Seek to establish whether there are any alternative proposals that represent "realist, cost effective and preferred" alternatives for the configuration of PICU services across Hampshire.

Given that our Panel was directed to focus in some detail on the closure of Ellingham Ward, in this matter we are not positioned to comment in detail on alternatives. Nevertheless we did not hear of any compelling "better" alternatives that could have addressed the size of the financial challenge.

Some of the hopes of clinical staff were that all the savings could be found from "non clinical" posts or from "management costs". This did not take into account the reality of running a multi-million pound high risk organisation. We were shown a list of non clinical posts advertised in the HPNHSFT job publication said to add to £1,468,000 per year. We were told by another contributor that actually many of these were not new posts. Amongst them, we noted e.g. Chief Operating Officer, Director of Operations and of Social Care, Interim Deputy Director of Operations and Associate Director of Information and Performance, which to the Panel, appear essential to an FT. The Trust might, however, want to make very public internally its "overhead"/direct care ratio.

Some contributors did try to suggest alternatives intended to allow efficiency. One was to revert to "selling" 2 or more of the 6 Ellingham beds for PICU for areas other than the

New Forest. Another was to put some previous Ellingham staff and function into an high dependency facility in Windsor. Another was that the Ellingham should reopen and the 2 staff teams i.e. that at Ellingham and at Windsor would work flexibly backfilling and opening and closing beds for each other as the need arose. Allied to this was a proposal that each of the PICU's should lose 1 or 2 beds rather than Ellingham being completely closed. The Panel could not see how this would release full savings. An allied proposal was actively to work with the local PCT's to help control the private low secure and rehabilitation spends. The HPNHSFT may wish to reopen this debate with the HPCT but our understanding was that it is because of efficiencies visible in this area that the HPCT took the risk share back and that it would not be desirable to again move to a clinical model with a mixed economy of PICU and low secure. Some put forward preferred closures should be the Assertive Outreach or Early Intervention Service. Given one service has been closed, it was not surprising to hear "why ours?". But taking account of all, even if HPNHSFT were to receive £2 million investment, this Panel would find it difficult to concur that the restoration of the previous Ellingham as such would be the best use of it. Panel know that Ellingham had opened in 2003 – a new Unit not necessarily designated to be a PICU, but a high quality environment and know that HPNHSFT will very much want to safeguard the fabric.

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Dr Alice M Parshall PhD MBBS BSc FRCPsych Clinical Director/ Consultant Psychiatrist West London Mental Health Trust	Helen Greatorex Executive Director of Nursing and Governance Sussex Partnership Trust	Tom Smith Chair Hampshire LINk
Date:……	……	……

Panel Members

Dr Alice Parshall,	Clinical Director, Hounslow Service Delivery Unit, West London Mental Health Trust
Ms Helen Greatorex,	Executive Director of Nursing and Governance, Sussex Partnership Trust
Mr Tom Smith,	Chair, Hampshire LINk.

Sources (in date order)

1. Department of Health Mental Health Policy Implementation Guide January 2002
2. Notes of meeting with Ellingham Ward staff meeting – held on 18th August 2009
3. Local Health Comparisons – SW Hampshire – September 2004
4. List of non clinical posts advertised in Hampshire Partnership Trust from 24 April 2009 to 23 October 2009, handed to Panel by Dr Powell
5. Hampshire Partnership NHS Foundation Trust PICU proposal (04 September 2009)
6. Minutes of confidential Board meeting held on 29/09/2009
7. Audit of inpatient admissions with evaluation of the Care Programme Approach carried out by Dr Palmer, November 2008 to November 2009
8. Quality and Governance Committee Terms of Reference, December 2009
9. West Area Clinical Governance and Management Team Terms of Reference, January 2010
10. Questions/issues arising from briefings held for substantive staff of Rivendale and Ellingham which took place on 14 January 2010
11. Letter from Julian Lewis MP (New Forest East) to Nick Yeo, Chief Executive of 15 January 2010 and notes from Dr Parshall's meeting with Dr Lewis 04/03/2010
12. Letter from Mrs MS to Dr Powell regarding concerns in closure of Ellingham Ward, dated 28 January 2010.
13. Letter from Peter Day RMN to Panel, dated 31 January 2010
14. Email from Mandy Moore regarding Ellingham Closure dated 7 February 2010
15. Hampshire Partnership NHS Foundation Trust Clinical Governance Strategy (draft) February 2010
16. Letters from staff and service users expressing their view, one in the form of a petition to the House of Commons "to save" Eillingham Ward and Crowlin House.
17. Hampshire Partnership NHS Foundation Trust Acute Mental Health Service Directorate structure
18. Complaints/concerns received regarding closure of Ellingham
19. New Forest Council website on population
20. Observations from 6 scientific papers passed from a Consultant psychiatrist contributor to the Consultant Psychiatrist to the Panel.

Interviews

1st February 2010

1. Dr Guy Powell, Consultant Psychiatrist
2. Jane Elderfield, Chief Operating Officer
3. Annabelle Crew, Acute Care Support Manager
4. Diane Wilson, Associate Director Adult Care Hampshire PCT – telephone discussion with Helen Greatorex.

8th February 2010

1. Peter Smith, Area Manager (West)
2. Sarah Leonard, Modern Matron
3. Nick Yeo, Chief Executive
4. Anna Lewis, Director of Operations
5. Dr Charlie Shawcross, Directorate Chair

Appendix Two

Psychiatric Intensive Care Independent Review

Briefing Paper

1.0 Introduction and Context

1.1 After the Hampshire Health Overview and Scrutiny Committee meeting in November 2009, Hampshire Partnership NHS Foundation Trust and NHS Hampshire agreed to arrange for an independent clinical review to determine whether the Trust's proposals for psychiatric intensive care would deliver services that are safe, high-quality, realistic, affordable, cost-effective, viable and address the mental health needs of the local communities.
Terms of reference for the review were developed and agreed by both organisations and then shared with Hampshire's Health Overview and Scrutiny Committee.

1.2 The role of the independent clinical review panel was to:

- Review the emerging proposals from the Trust with reference to national best practice.
- Take into account the views and opinions of service users, carers and clinicians
- Commission independent research and/or seek expert opinion as necessary
- Seek to establish whether there are any alternative proposals that represent "realistic, cost-effective and preferred alternatives" for the configuration of PICU services across Hampshire.

1.3 The panel comprised:

- Independent Consultant Psychiatrist with credibility, authority and personal standing who works outside of South Central SHA.
- Independent Director Of Nursing with credibility, authority and personal standing who works outside of South Central SHA.
- The Chairman of Hampshire LINks (Local Involvement Networks)

1.4 The panel members reviewed over 20 documents, interviewed a number of senior managers, clinicians and external key stakeholders. They also held two open sessions to enable staff who were not being called for an interview to give their views to the panel members. During the review the panel visited Ellingham ward at Woodhaven Hospital.

1.5 This report provides a high level briefing of the key findings.

2.0 Key Findings

2.1 The independent panel have produced a report of their findings and the full report is attached as appendix 1.

2.2 The main body of the report is structured to address each area of the terms of reference as stated in 1.2. This report provides a high level briefing of the key findings.

Efficiency :

Finding

The panel concluded that the business and efficiency rationale for the permanent closure of the PICU beds at Ellingham Ward was sound – that is, the numbers added up, although the temporary closure was, in the event, precipitous.

Effectiveness :

Finding

On balance, the emerging proposal, of which the permanent closure of Ellingham Ward as a PICU is part, does not, in its own right, necessarily reduce the effectiveness of treatment of New Forest, or other, service users who might otherwise have been admitted to Ellingham Ward.

The panel considered that a shared developed dashboard of clinical - with performance - quality indicators should be progressed by Hampshire Partnership NHS Foundation Trust across the PICU and acute localities for accountable monitoring of effectiveness.

Fairness :

Finding

The panel also considered the fairness of the emerging proposal of which the permanent closure of Ellingham Ward as a PICU is part. Whilst sensitive to the very strong views of local New Forest residents and staff, the panel did not form the view that the closure was unfair.

Of real concern, however, is the "fall out" sense of unfairness about the process as well as the actual closure of the ward and the campaigning which the panel felt frankly, more than anything could disrupt the Trust's business, partnerships and patient care. The panel was encouraged to hear many contributors say despite it all they felt now, with a 5 year forward plan, there was a chance for a different climate to emerge where clinicians, leaders and managers would work together and the Panel thought this could be a vehicle for moving forward.

3.0 Recommendations and Further Action

3.1 The Hampshire Partnership NHS Foundation Trust Executive (FTE) will be considering the report and the further action required in relation to the key findings and recommendations outlined within this report at its meeting on 23 March 2010. The associated action plan will be devised and monitored by both the FTE and the Trust Service development and Engagement Programme Board.

3.2 Hampshire Partnership NHS Foundation Trust Board will be considering the report and the further action required at its meeting on 30 March 2010.

3.3 NHS Hampshire will be considering the report at its Governance and Healthcare Assurance Committee in May 2010.

3.4 The Hampshire Health Overview and Scrutiny Committee is requested to note the content of the report and consider what further action Hampshire Partnership NHS Trust can take in relation to the findings contained within the report at its meeting on 30 March 2010.

Mandy Johnstone
Programme Director (Service Development)
Hampshire Partnership NHS Foundation Trust

18 March 2010

Psychiatric Intensive Care Unit (PICU) Independent Review Panel report communications action plan

Background

After the Hampshire Health Overview and Scrutiny Committee meeting in November 2009, Hampshire Partnership NHS Foundation Trust and NHS Hampshire agreed to arrange for an independent clinical review to determine whether the Trust's proposals for PICU would deliver services that are safe, high-quality, realistic, affordable, cost-effective, viable and address the mental health needs of the local communities.
Terms of reference for the review were developed and agreed by both organisations and then shared with Hampshire's Health Overview and Scrutiny Committee.
The role of the independent clinical review panel was to:

- review the emerging proposals from the Trust with reference to national best practice.
- take into account the views and opinions of service users, carers and clinicians
- commission independent research and/or seek expert opinion as necessary
- seek to establish whether there are any alternative proposals that represent "realistic, cost-effective and preferred alternatives" for the configuration of PICU services across Hampshire.

The panel comprised:

- Independent Consultant Psychiatrist with credibility, authority and personal standing who works outside of South Central SHA.
- Independent Director Of Nursing with credibility, authority and personal standing who works outside of South Central SHA.
- The Chairman of Hampshire LINks (Local Involvement Networks)

The panel members reviewed over 20 documents, interviewed a number of senior managers and clinicians and held two open sessions to enable staff who were not being called for an interview to give their views to the panel members.

The panel have produced a report of their findings and conclusions which will be sent with a 'salient points' summary (that will be produced by HPFT) in time for the papers for the Hampshire Health Overview and Scrutiny Committee on 30 March. This will mean that the report will become a public document on their website on Monday 22 March.

The report will be discussed at HPFT's Foundation Trust Executive meeting on 23 March and NHS Hampshire's Governance and Healthcare Assurance Committee in May. A verbal update on the next steps for the report will be provided to the HOSC. This timeline will be included in the communications outlined below.
Actions as a result of the review will be dealt with operationally, outside of this communications plan.

Communicating the review report

Communications surrounding the PICU review report will be jointly owned and managed by NHS Hampshire (NHSH) and Hampshire Partnership NHS Foundation Trust (HPFT) to reinforce the joint commissioning of the review.

Action plan

Actions	Audience	Lead	Deadline / date	Progress / feedback

Actions	Audience	Lead	Deadline / date	Progress / feedback
Produce salient points summary	All	Mandy Johnstone	Wed 17 March	Complete
Draft briefing for staff and stakeholders	Staff and stakeholders	Carol Deans	Thur 18 March	Complete
Draft press release	Media	Carol Deans	Fri 19 March	
Draft covering letters (to include contact for a copy of the full review) for review participants	Review participants	Carol Deans	Fri 19 March	
Full report and summary sent to HOSC	HOSC	Mandy Johnstone	CoP Thur 18 March	Complete
Briefing emailed	NEDs of HPFT	Susan Suliman	Friday 19 March	S Suliman briefed
Telephone call to people who took part in a 1:1 interview with the panel. Use the briefing as a 'script'	Jane Elderfield	Nick Yeo	-	Complete
	Anna Lewis	Jane Elderfield	-	Complete
	Dr Charlie Shawcross	Nick Yeo	-	Complete
	Annabelle Crew	Anna Lewis	Monday 22 March	
	Diane Wilson	Richard Samuel	Friday 19 March	Complete
	Peter Smith	Anna Lewis	Friday 19 March, am	
	Sarah Leonard	Anna Lewis	Friday 19 March, pm	
	Dr Guy Powell	Dr Huw Stone	Monday 22 March, am	Dr Stone aware
	Dr Julian Lewis, MP	Nick Yeo	Monday 22 March, am	
Briefing emailed (where possible, otherwise by post to seconded base) with covering letter to Ellingham staff	Ellingham staff	HR to complete in the name of Peter Smith	Monday 22 March	

Actions	Audience	Lead	Deadline / date	Progress / feedback
Briefing emailed with covering letter to other staff/public who contributed to the review (in writing or as part of an open session)	Review contributors	Jackie Gates	Monday 22 March	
Notify HCC	Gill Duncan /Richard Ellis	Nick Yeo/Jane Elderfield	Friday 19 March, during meeting	
Email briefing	HPFT governors in Southampton and SW constituencies	Susan Suliman	Monday 22 March	
Information made 'public' through NHSH and HPFT staff and public websites	All staff and public	NHSH and HPFT communications teams	Monday 22 March	
Presentation and update re actions taken to Hampshire HOSC meeting	HOSC members	Mandy Johnstone, Dr Huw Stone	Tuesday 30 March	
Joint press release issued	Media	Carol Deans and Sara Tiller	Monday 22 March, first thing	
Article in seconded staff newsletter	Ellingham staff	Sarah Leonard / Carol Deans	Next newsletter	
Article in AMH directorate team brief	AMH directorate staff	Anna Lewis	Next brief	

Appendix Three: Proposals to cease the development of Oak Park Community Hospital – Letter from HOSC Chairman

Thank you for taking the time to meet with members of the HOSC today. We very much appreciated your willingness to discuss issues so openly and would strongly support your views about working in partnership to secure the right outcomes for the population we serve in Hampshire.

I was particularly struck by your comment about making sure we get the right resources to the right part of the patient pathway and I hope you will accept my sincerity about the point I raised about the HOSC looking at issues from the point of view of the service user- not the provision of bricks and mortar.

Services do need to evolve and modernise but in doing so it is vital that the NHS is clear about what is changing and the benefits these changes will bring for local people. It is from this starting point that I would like to share our views about progress with proposals for ceasing the development of Oak Park Community Hospital and re-providing the services in a different way.

We have acknowledged the implications of the economic downturn for our services and the need to forward plan to manage these effectively. Our problem with the current options for re-providing health services in the Havant area is the lack of clarity about the way in which both ambulatory and inpatient services would be delivered, the timeframes for achieving this and the benefits this would bring to the local population.

Plans to provide a community hospital in Havant have an extensive history that I do not intend to rehearse here. Suffice to say this is a long running commitment that was the culmination of a number of plans and programmes for a 'hub and spoke model' to support the redeveloped Queen Alexandra Hospital. The business case for Oak Park Community Hospital underlined the clear health needs in this community and the benefits to be obtained from locally based services that reduce dependence on high cost acute care. At the point of finalising the contract arrangements for this work to commence NHS Hampshire suddenly undertook a financial assessment that stopped this development in its tracks, beginning another round of planning and option appraisal that is likely to extend into a number of years. The Board quite rightly asked for details of the way in which the services planned to be based at Oak Park Community Hospital would be provided should this development not proceed and will consider three options when it meets on 28 January 2010.

Before I share the HOSC's conclusions there were a number of specific comments that Members highlighted in response to the detailed presentation from your team at our meeting:

- The Minor Injuries Unit (MIU) and endoscopy services that were originally included in the original plans and considered clinically/technically feasible up until the decision not to proceed in May 2009 have suddenly been dropped. Whilst there may be a case for the endoscopy service- which we

are happy to discuss further - members are strongly of the view that the case for the MIU has not been made.

The HOSC has already commented about the way in which NHS Hampshire approached the closure of the former MIU at Havant War Memorial Hospital: we accepted this reluctantly at the time because the service had been run down, was not visible to local people and required a different range of skills in the staff manning it. To use this circumstance as the basis for saying this service should be excluded from current plans – without any analysis of how people in Havant could access and use an MIU in this area is a significant concern. We believe the case for this has already been made and there is no evidence in the current options that support the removal of this service from the plans: indeed the original plan was for an Independent Sector Treatment Centre to be provided at Oak Park.

Queen Alexandra A&E is already operating at its limits and the majority of the population in the area have significant transport difficulties in accessing either Queen Alexandra or St Mary's Hospitals. There is no travel time information for accessing the other MIUs suggested, nor is there any attempt to look at how this service could link with GP OOH, which was part of the original consultation. The cost of patients inappropriately attending Queen Alexandra is another factor that seems not to have been considered.

- We strongly disagree with the separation of inpatient and outpatient provision when the Board decides whether or not the Oak Park development should progress. It is clear from the options presented that no viable alternative to the inpatient services proposed exists. Current provision at St James Hospital was assessed in 2006 and judged 'not to meet NHS standards'. Concerns about the ward areas have also been raised by external review bodies such as Mental Health Act Commissioners. Your own PCT premises fact sheets, published in 2009, rate the building condition of both Havant War Memorial Hospital and Havant Health Centre as category 'c' – i.e. failing/unacceptable. This is a major weakness in the options presented.

- The timelines for the preferred option for ambulatory care are very ambitious and high risk. Delays at any point could have a significant impact on the ability of the PCT to deliver the operational services as envisaged. Given the delays that have already been experienced we are not confident that the timelines suggested are deliverable.

- The proposals to co-locate children's services with the mix of adult and older person's care as suggested will bring its own challenges- requiring an appropriate separation of children and adults. This may also have implications for safeguarding.

You will have noted the strength of local feeling about this issue and the need for the public to be confident in the way forward. Inevitably, despite the efforts of your

team, there remains a view that the PCT is reneging on decisions and commitments that were properly made and planned, effectively 'cherry picking' what will and won't be provided because of financial pressures from across the health system, particularly the acute sector. At present the HOSC is firmly of the view that there are no complete alternative options to re-provide the services planned at Oak Park in the Havant area that will not necessitate restarting the business planning cycle, with all the costs and uncertainties that this process brings.

In summary I think it is fair to say that Members felt that considerable further work needs to be done before the HOSC and local people can be confident that there are viable alternatives to the Oak Park Community Hospital and to bring these options to 'life' for the community affected. This was achieved in the original plans but is missing from the current proposals, despite the work that has clearly gone into the options to be presented to the Board on 28 January 2010. The lack of coherence in the documentation gives a sense of fragmentation of local services across this community. Equally whilst I am sure that there has been engagement with local clinicians there is no sense of the clinical leadership necessary to take this work forward.

It is on these grounds that the HOSC came to the conclusion that:

- Should the plans to cease the development of Oak Park Hospital proceed this **would** constitute a substantial service change

- Members were **not** satisfied that any of the three options proposed will meet the health needs of this highly vulnerable population

- The lack of coherence in the presentation of the options means that the HOSC is **not** convinced that they are in the interests of the community affected.

I would be grateful if you could draw this letter to the attention of your Board members prior to their consideration of this issue tomorrow.

I am truly sorry that we begin our working relationship on such a negative note; this is not a matter that we take lightly and we are keen to work with you and NHS Hampshire to move discussions forward. This is however dependent on the HOSC and local people having confidence that a viable alternative to the Oak Park Community Hospital exists. As the options stand at the moment we do not believe this to be the case.

Appendix Four: NHS Hampshire response- PROPOSALS TO CEASE THE DEVELOPMENT OF OAK PARK COMMUNITY HOSPITAL- 12 February 2010.

Thank you for your letter dated 27 January 2010 regarding the proposals for services in the Havant area. I was very pleased to meet the Committee last week and look forward to working with you to ensure that we develop high quality services for local people that make the best use of NHS resources.

I welcome your comments about the work to date on plans for services in the Havant area and would like to assure you that NHS Hampshire is committed to working with you to address concerns raised.

At its meeting on 28 January 2010 NHS Hampshire Board was very mindful of concerns raised about minor injuries services, the separation of inpatient and outpatient planning, the timelines for the preferred option and the proposals to co-locate children's, adults and older people's services.

I thought it would be helpful to address each of these issues in turn:

- We have heard from both the Committee and local people that there is both confusion and anxiety about the provision of minor injuries services locally. We are proposing that we work with yourselves to better understand the type of service that local people feel is needed, any barriers to accessing services and whether there would be sufficient demand to make a minor injuries service viable both clinically and financially.

- We acknowledge the perceived lack of clarity regarding the proposals for ambulatory and inpatient services. The Board has heard from key stakeholders and from local people that the alternative proposals for services were not fully understood and more time needed to be spent working with local people in developing both plans and understanding. In the light of these concerns the Board asked that options for inpatient services be combined with detailed plans for outpatient services and be brought back to the September 2010 meeting of NHS Hampshire's Board.

- The timelines for the delivery of this project are indeed very challenging. We have moved forward at this pace in response to local people who have told us that they do not want to see further delays. The detailed work in designing the community hospital has not been wasted and has been used in designing the preferred option. This combined with the support of our LIFT co. means that the work and procurement are streamlined. To minimise any delays the Board agreed that work should continue to develop a business case for how outpatient services such as podiatry, diagnostics, therapies and a new assessment and treatment day service for older people could all be provided in the Oak Park Children's Services Centre building. This approach allows us to maintain momentum with planning without incurring significant additional costs.

- The preferred option included a new entrance and waiting area for children. This will meet the NSF standards for the separation of adult and children's services.

We are disappointed that local people feel we are reneging on decisions and 'cherry picking' services to be provided. However, I cannot stress enough the severity of the financial situation which has necessitated the change in plans. The NHS Hampshire Board reconsidered future funding challenges at its meeting on 28 January 2010 and reiterated its belief that the construction of a new community hospital on the Oak Park site in Havant is no longer affordable. The Board reaffirmed its commitment, however, to provide an increased range of locally accessible services for the population of Havant and East Hampshire without the need for a new building and agreed to retain the Oak Park site for the future development of health services for the local population.

We would now like to work with Members and local communities to tackle the issues that have been raised. Our aim is to provide greater clarity on the proposals to date, create further opportunities to shape plans for the future particularly regarding inpatient services and minor injuries services.

I understand the Committee has established a panel to work with us and that we already have a meeting set up for 12 February.

I hope that this will be the first step to developing a positive way forward for the development of health services in the Havant area.

Yours sincerely

D.M. Fleming (Mrs)
Chief Executive
NHS Hampshire

Appendix Five: Oak Park Panel: Informal meeting with NHS Hampshire – 12 February 2010

Members of the Panel had an informal meeting with representatives of NHS Hampshire on 12 February. The following were present:

Panel Members
Cllr Anna McNair Scott
Cllr Pat West
Cllr Liz Fairhurst
Cllr Brian Collin
Cllr Jennifer Gray
Denise Holden- in attendance

NHS Hampshire
Jack Climpson
Mike Fulford
Inger Hebden
Sara Tiller
Dr Koyih Tan
Dr Robert Pears

Members confirmed they had visited all the sites providing services to people living in Hampshire and thanked the PCT and Hampshire Partnership for arranging this. Members had been very impressed by the dedication and professionalism of the staff they met and the high quality of care provided in sometimes difficult environments.

It was recognised that Emsworth Cottage Hospital did not provide a suitable environment for in-patient care.

Havant War Memorial Hospital was providing a much needed service in an old-fashioned environment. There was no room for diagnostics limiting the support that could be provided to in-patients. There were constraints in the way in which the configuration of beds could be used, especially in terms of maintaining privacy and dignity. The 'step- up' facility that the Hospital could provide was a particularly valuable service.

Havant Health Centre does currently have x-ray facilities but more could be done to prevent people having to go to Queen Alexandra (QA) for this service.

Petersfield provided an ideal model for community services with flexible use of a range of facilities including an MIU. The occupancy in some areas such as services for people with organic mental illness were already running at 100%.

Services at St James' for people with forensic mental illness were of a very high standard but the environment was less than ideal with difficulties in parking and remoteness from families and community services. The service was also running at 100% occupancy.

There was room for additional services at the Oak Park Children's Centre but members noted that a number of staff expressed their unhappiness about the changes that were planned. This was at odds with the views expressed to the PCT in discussion with the relevant steering groups. Members were concerned that placing diagnostics at the Children's Centre would mean that they were not accessible for inpatients.

Health needs in Havant were significant with a number of significant challenges. A range of programmes was in place to support action to address the inequalities that existed but it was recognised that more needs to be done. People in Havant were already heavy users of acute hospital services (e.g. admissions due to falls) although the inverse care law suggests that they tend to access GPs and community services less than more affluent areas.

QA has a Did not attend (DNA) rate of 10%

It is not known what the DNA rate is for GPs surgeries in the Havant area.

In terms of the economic outlook it wan noted that the impact is likely to be greatest for 2010.11 when there is likely to be flat real growth but a continued increase in demand, partly driven by demographics.

It is essential for the PCT to improve effectiveness. Continuing care and services for people with learning disabilities and special needs were areas of particular challenge. There had been an overall growth of circa 30% in the acute sector in recent years and providers would need to deliver real efficiencies if the financial pressures were to be managed.

Members were very supportive of the 'hub and spoke' model proposed for the south east Hampshire area and noted that 'step up' beds in communities were increasingly important as a means of preventing people having to be admitted to an acute hospital.

There was broad agreement that there was scope for a model of ambulatory care that could meet the needs of this population although this could not be in place until some 30 months after the business plan had been agreed- this would be September at the earliest.

The PCT was taking forward a number of work streams in order to report back to the Board in September including:

1. Inpatient care covering three areas
    - The provision of a 'teaching' nursing home by Hampshire Adult services on the grounds of Oak Park
    - The provision of 'step up/down' beds
    - Older People Mental Health to include services in Fareham

2. Minor injuries including current patterns of activity across the Havant population. Members were surprised to be told that QA had a minor injury service.

More work need to be done with primary care and making better use of GPs.

The was considerable discussion about the need to get local people more involved in planning services for the area and sharing what was already in place. Clear clinical leadership in taking this work forward was also required.

Next Steps

Members remained concerned about the considerable amount of work yet to be done to identify viable alternatives to the services planned for the Oak Park Community Hospital in the Havant area. Planning assumptions were constantly changing and Members did not accept that the suggestion that these would continue to evolve on an almost daily basis. There are very real uncertainties and risks associated with the timelines partly because different messages were being picked up by different audiences. There are particular concerns about inpatient services and the MIU that would not be addressed until some 18 months after the initial decision to cease work on the community hospital- it is not known how long it would be before these services were up and running. Even the current plans for ambulatory care would not come to fruition until 4 years after the decision not to proceed with the community hospital.

Members determined that further work should be undertaken with the PCT to get a sense for the way in which the different work streams planned were being taken forward. A series of Panel meetings would be set up commencing in March to look at the services in greater detail. Specific areas to be covered include

- The further needs assessment being undertaken and current preventative/community based services providing support to people living in the area
- The contribution from primary care/GPs to supporting the emerging models of care
- Inpatient services and current patterns of acute admissions (including avoidable admissions)
- MIU and options associated with unscheduled/OOH services, including current patterns of activity to existing facilities and A&E
- Work with partners including Hampshire Adult Services and Hampshire Partnership
- Action to build public confidence and support for the proposed way forward.

The Independent Reconfiguration Panel (IRP) would be contacted if appropriate.

Appendix 6

Safe and Sustainable Children's Cardiac Surgery Services

Aims: To update the HOSCs on the process for delivering recommendations for the reconfiguration of children's heart surgery services in England.
Author and Date: Jeremy Glyde *Safe and Sustainable Programme Director* National Specialised Commissioning Team 8 March 2010

Introduction

In September 2010 the *Safe and Sustainable* review will make recommendations for a reduced number of children's heart surgery centres in England. There are currently 11 centres in England (see Appendix A). The review is led by the National Specialised Commissioning Team on behalf of the 10 Specialised Commissioning Groups.

Professional and Lay Support

The review has support from the Royal College of Surgeons, the Royal College of Paediatrics and Child Health, the Royal College of Nursing, the Society of Cardiothoracic Surgery of Great Britain, the British Congenital Cardiac Association and the Children's Heart Federation.

The Need for Change

The review is in response to concerns that the current configuration of services is not sustainable and does not provide all children in England with the same opportunity for excellent care:

- Not all centres can provide safe 24/7 cover
- Surgical expertise is spread too thinly across centres
- Risk of occasional practice around some complex procedures
- Risk that smaller centres may lead to less favourable outcomes for patients
- Smaller centres will experience recruitment difficulties; robust succession planning will be difficult, increasing the risk of unplanned and sudden closure of some centres

Likely Changes

The quality framework against which centres will be assessed for designation as specialist providers of children's heart surgery services in the future are likely to state that each centre must:

- Provide a 24/7 service

- Be staffed by a minimum of 4 consultant paediatric cardiac surgeons (current surgeon numbers are set out in Appendix B)
- Perform a minimum of 400 paediatric surgical procedures each year, and ideally a minimum of 500 paediatric surgical procedures each year (current procedure numbers are set out in Appendix C)

The assessment process will not just focus on surgeon numbers and procedure volumes. It will take a holistic assessment of each centre, in particular focusing on the degree to which they meet the standards for designation, and the ability of each centre to expand, grow, and take forward a world class service into the future. Other important issues will be taken into account, including travel times, geography and access for parents.

Implications of Reconfiguration

It is likely that the *Safe and Sustainable* review will recommend a reduction in the number of centres that provide children's heart surgery services. No key decisions have yet been made on the number or location of services in the future pending the outcome of a comprehensive assessment of each centre to be undertaken between May and June 2010, and pending the outcome of formal consultation between September and December 2010.

Although this will mean that some children and their families will have to travel a longer distance for surgery, they will not have to do this for other aspects of care (such as assessment, diagnostic tests, follow-up and ongoing management). The review will recommend a new 'network model' of care that facilitates the delivery of all non-surgical and non-interventional paediatric cardiology care as locally as possible.

Benefits for Children and Families

The *Safe and Sustainable* review aims to develop a new national service that brings the following benefits for children and their families:

- Better clinical outcomes in the surgical centres (reduced mortality and reduced complications)
- Better follow up and other (non-surgical) treatment provided as close as possible to where the family lives

This will be achieved by the implementation of a quality framework that will be consistently applied in all surgical centres and that will achieve the following:

- Improved communication and planning between surgical centres and local services that links care in an effective network model
- A model of care that plans and deliver services around the needs of the child and which takes account of the transition to adult services
- Protocols between surgical centres and local maternity services that provides for early pre-natal screening and arrangements for delivery babies diagnosed with heart abnormalities
- Better access to surgical centres and local services, regardless of where the child lives

- An NHS workforce that is highly trained and expert in the care and treatment of children and young people

Progress to Date

- A Steering Group has been established, chaired by Dr Patricia Hamilton, Immediate Past President of the Royal College of Paediatrics and Child Health (see Appendix D for membership)
- Quality standards have been developed, providing a national quality framework for the future
- Stakeholders have been engaged, the outcome of which has fed into the development of the standards

Future milestones

- Local engagement events – from March 2010
- Centres to self assess against designation standards and submit plans for future expansion – March 2010
- Assessment of centres against designation criteria, including on-site visits – May to July 2010
- Recommendations for reconfiguration and the pre-consultation business case are put out for public consultation – September to December 2010.
- Outcome of consultation is considered – from January 2010
- Decision expected (dependent on outcome of consultation) – March 2011

The pre-consultation business case will set out:

- The objectives to be achieved
- The case for change in line with best clinical evidence
- Recommendations for the future configuration of the national service
- The appraisal of options, including the implications of no change
- The patient group affected by the recommendations and the benefits to service delivery and patient experience
- Other NHS services affected by the recommendations and a plan for addressing the implications of reconfiguration
- The workforce and training implications of the recommendations and how they will be addressed
- That the financial implications are affordable and how they will be addressed
- How stakeholders have been involved in developing the recommendations
- The outcome of Health Impact Assessments, Equality Impact Assessments and Travel Time Assessments
- An analysis of patient flows

- Cross boundary issues facing service provision for the devolved administrations that are affected by commissioning decisions in England
- An implementation plan

Engagement with Stakeholders
In October 2009 a national stakeholder event was held, attended by 200 clinicians, professional association and parent groups. 95% of attendees said that the event was well organised, relevant and provided plenty of opportunity for debate. A large part of the day was spent discussing the draft quality framework that had been circulated for comment in September 2009. Video excerpts of the day are available on the NSC Team website (www.specialisedcommissioning.nhs,uk). Further local engagement events are currently being developed for commencement in March 2010.

The NSC Team has issued two newsletters (summer and winter 2009) and has made available all relevant literature, including minutes of meeting, on its website.

Engagement with Health Overview Scrutiny Committees
The NSC Team has been working with the Centre for Public Scrutiny (CPS) to keep HOSCs informed of progress. The CPS has circulated relevant literature to HOSCs via existing networks.

In March 2010 the NSC Team, via the CPS, will ask HOSCs with an interest in this review to establish a statutory joint HOSC in time for formal consultation activities between September and December 2010.

Appendix A

Current NHS providers of children's heart surgery services in England

Freeman Hospital	Newcastle
Leeds Teaching Hospital	Leeds
Alder Hey Children's Hospital	Liverpool
Glenfield Hospital	Leicester
Birmingham Children's Hospital	Birmingham
Oxford John Radcliffe Hospital	Oxford
Bristol Royal Hospital for Children	Bristol
Great Ormond Street Hospital for Children	London
Royal Brompton Hospital	London
Evelina Children's Hospital	London
Southampton General Hospital	Southampton

Appendix B

Number of consultant paediatric surgeons in England (forecast as at 1 April 2010)

	Paediatric Practice	Paediatric and Adult	**Total**
Freeman Hospital, Newcastle	0	2	**2**
Leeds Teaching Hospital	0	3	**3**
Alder Hey Children's Hospital, Liverpool	2	2	**4**
Glenfield Hospital, Leicester	0	3	**3**
Birmingham Children's Hospital	0	3	**3**
Bristol Royal Infirmary	2	0	**2**
Royal Brompton Hospital, London	1	3	**4**
Great Ormond Street Children's Hospital, London	2	2	**4**
Evelina Hospital, London	1	2	**3**
Oxford John Radcliffe Hospital	0	1	**1**
Southampton General Hospital	0	2	**2**
	8	**23**	**31**

Appendix C

Paediatric cardiac surgical procedures in England (2006/07)

Hospital Trust	Total
Alder Hey Hospital	380
Birmingham Children's Hospital	464
Bristol Children's Hospital	285
Evelina Children's Hospital	358
Freeman Hospital	244
Glenfield Hospital	201
Great Ormond Street Hospital	516
John Radcliffe Hospital	130
Leeds General Infirmary	290
Royal Brompton Hospital	414
Southampton General Hospital	227
Total England	**3509**

Note:

2006/07 is the most recent year for which validated data is available

Data has been validated by the Central Cardiac Audit Database

Appendix D MEMBERSHIP OF THE STEERING GROUP ON SAFE AND SUSTAINABLE PAEDIATRIC CARDIAC SURGERY SERVICES (January 2010)

Name	Constituency	Role
Dr Patricia Hamilton	Chair of the Steering Group	Director of Medical Education for England
Dr Martin Ashton-Key	Specialised Commissioning / Public Health	Public Health Medical Adviser, NSC Team
Mr William Brawn	British Congenital Cardiac Association (President)	Consultant Cardiac Surgeon, Birmingham Children's Hospital NHS Foundation Trust
Dr Geoffrey Carroll	NHS in Wales	Medical Director, Health Commission Wales
Katherine Collins	NHS in Scotland	Programme Director, National Services Division
Steve Collins	National Specialised Commissioning Team	Deputy Director Policy and Coordination, NSC Team
Dr Sarah Crowther	South Eastern SCG Collaborative Zone	Chief Executive, Harrow PCT
Sue Dodd	Department of Health (observer)	Emergency & Acute Care Manager, Vascular Programme, Department of Health
Professor Martin Elliott	British Congenital Cardiac Association	Consultant Paediatric Cardiac Surgeon, Great Ormond Street Hospital for Children NHS Trust
Deborah Evans	South Western SCG Collaborative Zone	Chief Executive, Bristol PCT
Jeremy Glyde	National Specialised Commissioning Team	Programme Manager, NSC Team
Dr Kate Grebenik	Association of Cardiothoracic Anaesthetists	Consultant Anaesthetist, Oxford Radcliffe Hospitals NHS Trust
Catherine Griffiths	Midlands SCG Collaborative Zone	Chief Executive, Leicestershire County and Rutland PCT
Mr Leslie Hamilton	Society for Cardiothoracic Surgery in Great Britain and Ireland (President)	Consultant Cardiac Surgeon, Newcastle upon Tyne Hospitals NHS Foundation Trust
Maria von Hilderbrand	Patients and public	Independent Patient Advocate
Dr Sue Hobbins	Royal College of Paediatrics & Child Health	Consultant Paediatrician, South London Healthcare NHS Trust
Dr Ian Jenkins	Paediatric Intensive Care Society (President)	Consultant Intensivist, University Hospitals Bristol NHS Foundation Trust
Anne Keatley-Clarke	Patients and public	Chief Executive, Children's Heart Federation
Candy Morris	Strategic Health Authorities	Chief Executive, South East Coast SHA
Teresa Moss	National Specialised Commissioning Team	Director of National Specialised Commissioning
Dr Sally Nelson	Public Health	Medical Adviser, South Central SCG
Dr Shakeel Qureshi	British Congenital Cardiac Association (President Elect)	Consultant Paediatric Cardiologist, Guy's and St Thomas' NHS Foundation Trust
Chris Reed	Northern SCG Collaborative Zone	Chief Executive, NHS North of Tyne PCTs
Dr Tony Salmon	British Congenital Cardiac Association (President)	Consultant Paediatric Cardiologist, Southampton University Hospitals NHS Trust
Fiona Smith	Royal College of Nursing	Adviser in Children and Young People's Nursing, RCN
Dr Graham Stuart	British Congenital Cardiac Association	Adult Cardiologist, University Hospitals Bristol NHS Foundation Trust

Appendix 7

CHILDREN'S CARDIAC SURGERY SERVICES

Representatives of the NHS Specialist Commissioning Group gave a presentation on the proposals for Children's Cardiac Surgery Services in England. The principles being that the NHS must provide only the very highest standard of care for children and their families regardless of where they live or which hospital provides their care. Centres should provide care that was based around the needs of the child and the family which took account of the transition to adult services. All relevant treatment, other than surgery, should be provided as locally as possible to the family and clinical standards should be agreed and met by all centres.. Details were given of the current 11 heart surgery centres in England, the nearest being Southampton, and the planned approach for change. Currently some centres could not provide safe 24 hour care. Enough surgeons were needed in each centre to meet day to day needs eg. Operating in theatre, on call for emergencies, ward rounds and outpatient clinics. It was necessary for surgeons to be learning from each other and to be able to work in centres to give them exposure to a large range of procedures. It was proposed that there should be four consultant paediatric surgeons in each centre with enough doctors and nurses to provide 24 hour care and a minimum of 400 paediatric procedures each year. The network model of care would be for tertiary paediatric centres, paediatric cardiology centres and paediatric cardiology periphery services. The benefits for children and families would be:

- Better access to 24 hour care
- Better access to surgical centres with expertise in complex procedures
- Better clinical outcomes (mortality and morbidity)
- An NHS workforce that is highly trained and expert
- Surgeons will mentor and learn from each other
- An effective network that improved planning, delivery and communication
- Strengthened Specialist Children's Liaison Teams
- A national network of surgical centres collaborating in he interests of patients.

The key milestones were that centres would submit initial proposals in March/April 2010; Evaluation of centres against designated criteria would take place in May/June 2010; Recommendations published and formal public consultation September – December 2010 and the post-consultation and designation decision January 2011. Details were given of the Expert Review Panel, the Public Consultation Process and Stakeholders. The Centre for Public Scrutiny would be asking Health Overview and Scrutiny Committees with an interest to establish a National Joint Statutory Health Overview and Scrutiny Committee.

RESOLVED:

That following the formal consultation an update on the proposals for Children's Cardiac Surgery be presented to the Joint Committee.

Appendix 8
Review Update – Children's Neurosurgical Services

Aims: To update the HOSCs on the review of children's neurosurgical services in England.
Author and Date: Jeremy Glyde *Safe and Sustainable Programme Director* National Specialised Commissioning Team 8 March 2010

Introduction
There are currently 15 centres in England that are providers of paediatric neurosurgery (see Appendix A). The review is led by the National Specialised Commissioning Team (NSC Team) on behalf of the 10 Specialised Commissioning Groups. The review aims to identify potential models of care and develop a national strategy for England.

The Need for Change
The review was instigated at the request of members of the British Paediatric Neurosurgeons Group (BPNG) in view of the following concerns:

- The surgical caseload across the 15 centres varies from around 50 to 700 cases each year; this may mean that some centres are not performing the critical mass of surgical procedures necessary to maintain specialist expertise
- Incidence of children being operated on by surgeons who are not paediatric experts, but by adult surgeons who are 'emergency competent' to operate on children
- Only 3 out of 15 centres are able to provide a 24/7 paediatric service

Progress to Date

- A Steering Group has been established, chaired by Mr Paul Chumas, a Past President of the BPNG (see Appendix B for membership)
- Draft quality standards have been developed, providing a national quality framework for the future
- A working group has been established to identify potential models of care
- Stakeholders have been engaged, the outcome of which has fed into the development of the standards

Future milestones
In March 2010 each of the 15 centres will be asked to provide the NSC Team with detailed information on current service provision (including staffing,

infrastructures and support services). The information template was developed in consultation with members of the BPNG and Society for British Neurological Surgeons (SBNS). Between April and May 2010 a former President of the SBNS will visit each of the centres to clarify issues around the information supplied.

A working group set up to identify potential models of care is expected to report by June 2010. The outcome of this work will assist the Steering Group in the development of a national strategy for England.

It is anticipated that the national strategy will be used as the basis for a review of current service provision, with recommendations for reconfiguration made in March 2011. Formal consultation would take place around April to June 2011.

Engagement with Stakeholders
In November 2009 a national stakeholder event was held, attended by 120 clinicians, professional association and parent groups. 90% of attendees said that the event was well organised, relevant and provided plenty of opportunity for debate. Video excerpts of the day are available on the NSC Team website (www.specialisedcommissioning.nhs,uk).

The NSC Team has issued a newsletter (February 2010) and has made available all relevant literature, including minutes of meeting, on its website.

The Steering Group has convened a group comprised of representatives of relevant parent groups to advise the Steering Group on relevant issues from a parent and patient perspective.

Engagement with Health Overview Scrutiny Committees
The NSC Team has been working with the Centre for Public Scrutiny (CPS) to keep HOSCs informed of progress. The CPS has circulated relevant literature to HOSCs via existing networks

In the summer of 2010 the NSC Team will, via the CPS, will ask HOSCs with an interest in this review to establish a statutory joint HOSC.

Appendix A

Current NHS providers of children's neurosurgical services in England

Newcastle General Hospital	Newcastle
Leeds General infirmary	Leeds
Hull Royal Infirmary	Hull
Sheffield Children's Hospital	Sheffield
Royal Manchester Children's Hospital	Manchester
Alder Hey Children's Hospital	Liverpool
Queens Medical Centre	Nottingham
Birmingham Children's Hospital	Birmingham
Addenbrookes Hospital	Cambridge
Oxford John Radcliffe Hospital	Oxford
Frenchay Hospital	Bristol

Great Ormond Street Hospital for Children	London
Kings College Hospital	London
St George's Hospital	London
Southampton General Hospital	Southampton

Appendix B: Steering Group membership

Name	Constituency	Role
Mr Paul Chumas (Chair)	British Paediatric Neurosurgical Group	Consultant Paediatric Neurosurgeon, Leeds Teaching Hospital
Mr Eric Ballantyne	Scottish Health Service (Clinical Director for neurosurgery in Scotland)	Consultant Neurosurgeon, Dundee Teaching Hospitals
Currently Vacant	*Lay representation (1)*	*Lay Chair of the Royal College of Surgeons Patient Liaison Group*
Diana Cargill	Specialised Commissioning	Senior Commissioner for Adult & Paediatric Specialised Services, South West SCG
Dr Geoffrey Carroll	Health Commission Wales	Medical Director, Health Commission Wales
Steve Collins	National Specialised Commissioning	Deputy Director, Policy & Co-ordination
Kim Cox	Specialised Commissioning	Senior Commissioner, Yorkshire and the Humber SCG
Dr Helen Cross	British Paediatric Neurology Association	Paediatric Neurologist, Great Ormond Street Hospital
Jeremy Glyde	National Specialised Commissioning	Programme Manager
Mr William Harkness	British Paediatric Neurosurgical Group	Consultant Paediatric Neurosurgeon, Great Ormond Street Hospital for Children
Julie Hodson	Specialised Commissioning	Senior Specialised Commissioning Manager, South East Coast SCG
Barbara Howe	Specialised Commissioning	Director of Specialised Commissioning, London SCG
Robert Hughes	Lay representation (2)	Chairman, Anna’s Hope

Dr Ian Jenkins	Paediatric Intensive Care Society	Consultant in Paediatric Anaesthesia and Intensive Care, Bristol Royal Hospital for Children
Roz Jones	Specialised Commissioning	Commissioner, North West SCG
Dr Tom Kenny	Public Health	Specialist Registrar in Public Health, Dorset PCT
Ian Langfield	Health Commission Wales	Commissioner, Health Commission Wales
Mr Conor Mallucci	British Paediatric Neurosurgical Group	Consultant Paediatric Neurosurgeon, Alder Hey Children's Hospital
Fiona Maxwell	Scottish Health Service	Network Manager, Scottish Managed Service Network
Lindy May	Nursing	Nurse, Great Ormond Street Hospital
Mr John McMullan	British Paediatric Neurosurgical Group	Consultant Paediatric Neurosurgeon, Sheffield Children's Hospital
Dr Antony Michalski	Children's Cancer and Leukaemia Group (CNS tumours)	Consultant Paediatric Oncologist, Great Ormond Street Hospital
Dr Kevin Morris	Paediatric Intensive Care Society	Consultant Intensivist, Birmingham Children's Hospital
Teresa Moss	National Specialised Commissioning	Director, National Specialised Commissioning Team
Dr Jan Poloniecki	Medical Statistics	Medical Statistician, St George's Hospital / University of London
Mr Ian Pople	British Paediatric Neurosurgical Group and Chair of Standards Writing Group	Consultant Paediatric Neurosurgeon, Frenchay Hospital
Dr Brijender Rana	Public Health	Consultant in Public Health, South East Coast SCG
Mr Peter Richards	British Paediatric Neurosurgical Group	Consultant Paediatric Neurosurgeon, Oxford Radcliffe Hospital

Mr James Steers	British Paediatric Neurosurgical Group	Clinical Lead for Re-provision of Clinical Neurosciences, Royal Hospital for Sick Children Edinburgh
Mr Dominic Thompson	British Paediatric Neurosurgical Group	Consultant Paediatric Neurosurgeon, Great Ormond Street Hospital for Children
Mr Philip Van Hille	Society British Neurological Surgeons	Consultant Paediatric Neurosurgeon, Leeds Teaching Hospital
Dr Edward Wozniak	Department of Health	Paediatric Adviser, Department of Health
Dr Amber Young	Anaesthetists	Consultant Anaesthetist, North Bristol NHS Trust
Vacant (as at June 2009)	Northern Ireland Health Service	

Appendix 9

PROVISION OF CHILDREN'S NEUROSURGERY SERVICES

A review of Children's Neurosurgery Services had been requested by some members of the British Paediatric Neurosurgeon's group which was part of the Society of British Neurological Surgeons. Details were given of the current centres and the need for change. Currently only three centres out of fifteen could provide a separate paediatric neurosurgical on-call rota and some children are seen in an adult setting. A steering group had been established. To date a national stakeholder event had been held in November 2009, a draft quality framework had been developed, a working group had been established to identify potential models of care and a patient/user group had been established. An Information gathering exercise would take place in March – May 2010, the models of care group would report in May 2010, assessment of centres would take place November – December 2010 and recommendations delivered for consultation during 2011.
RESOLVED:

That following the formal consultation an update on the proposals for Children's Neurosurgery be presented to the Joint Committee.