HEALTH OVERVIEW & SCRUTINY PANEL

MINUTES OF THE MEETING of the Health Overview & Scrutiny Panel held in the Guildhall on Thursday 15 December 2011 at 09:30am.

Present

Councillors Peter Eddis (Chair)
Margaret Adair
Margaret Foster
Jacqui Hancock
David Horne

Co-opted Members

Gwen Blackett, Havant Borough Council
Dorothy Denston, East Hampshire District Council
Peter Edgar, Gosport Borough Council (arrived at 10:25).

Also in Attendance

Jane Muir, Portsmouth Local Involvement Network.

Southampton, Hampshire, Isle of Wight and Portsmouth Primary Care Trusts (SHIP PCTs) Cluster.
Sara Tiller, Director of Communications
Richard Samuel, Director South East Hampshire
Jo York, Associate Director Systems Management Urgent Care Lead

Cardio-vascular Network.
Beverley Meeson, Network Manager.

Portsmouth Hospitals NHS Trust.
Graham Sutton, Associate Medical Director and Vascular Surgeon
Cherry West, Chief Operating Officer

Solent NHS Trust.
Kieran Kinsella, Head of Adult Mental Health Acute & Residential Services
Debbie Tarrant, Programme Manager

South Central Specialised Commissioning Group
Mark Satchell, Deputy Director of Specialised Commissioning
Louise Doughty, Head of Commissioning (Mental Health & Learning Disability Services)

Portsmouth City Council.
Councillor Hugh Mason (for item no.9)
Stewart Agland, Local Democracy Manager.
Jane Di Dino, Local Democracy Officer.

98 Welcome, Membership and Apologies for Absence (AI 1).

Councillors Colin Chamberlain, Jean Hammerton and Lee Mason sent their apologies for absence and Councillor Edgar sent his for arriving late.

99 Declarations of Interest (AI 2).

Councillor Edgar declared the following non-prejudicial interests:

1. He is a member of Portsmouth Hospitals NHS Trust's Council of Governors.
2. He was a member of the SHIP PCT Cluster's Developing Safe and Sustainable Acute Services' Expert Panel on vascular surgery.
3. He is Health Spokesperson and Member of the Health & Wellbeing Board at Gosport Borough Council.

100 Minutes from the Previous Meeting Held on 3 November 2011 (AI 3).

RESOLVED that the minutes from the meeting held on 3 November 2011 be agreed as a correct record.

101 Update From the Previous Meeting (AI 4)

The Chair gave the following updates:

Fluoridation.

The NHS was asked if there was a budget for the possible fluoridation of water supplies and if so, whether this could be used on a) dental health education and b) dental screening of school pupils?

Dr Edmondson-Jones, Director of Public Health responded that there is no budget for fluoridation. If it was ever agreed as part of the Operating Framework for the PCT then funds would have to be diverted from elsewhere. However, funding is already provided for dental health education and the 5-year-old dental survey.

The Chair commented that this was a correct and helpful statement. He was concerned to note, however that as it is an intrusive procedure, schools are only able to carry out dental screening of pupils whose parents have given consent. He noted that it might be the children of the parents that do not give consent who would most benefit from this screening. The panel agreed that if an opt-out system were to be introduced, children with poor dental health could be identified and interventions put in place to improve it.

Jane Muir informed the panel that the Portsmouth Local Involvement Network (LINk) was considering commissioning a review into children's dental health. The Chair confirmed that this was at the request from this panel.

RESOLVED that the Chair approach the Members of Parliament for Portsmouth to seek support for the introduction of an opt-out parental consent system for children's dental screening.

Diabetic Retinopathy.
NHS Portsmouth was asked to consider the use of local opticians/ optometrists for the provision of diabetic retinopathy for the next tendering opportunity.

The Senior Development Manager at NHS Portsmouth submitted the following response: an options appraisal will be undertaken when the current contract ends to look at the viability of different models of provision, which will include the potential use of opticians for primary screening.

102 Fairoak, Low Secure Service, St James Hospital, Portsmouth (AI 5).

The Chair reminded the panel that Solent NHS Trust had informed the HOSP of its decision to give notice on Fairoaks on 13 September. He also informed the panel that correspondence had been received from a member of the public who is a relative of a current patient at Fairoak and also from Councillor Mike Hancock MP expressing concerns about the plans for this service. These letters had been circulated to the panel and had been used to inform the questions that had been put to the organisations involved.

Kieran Kinsella, Head of Adult Mental Health Acute & Residential Services, Solent NHS Trust, Mark Satchell, Deputy Director of Specialised Commissioning South Central Specialised Commissioning Group and Louise Doughty, Head of Commissioning (Mental Health and Learning Disability Services), South Central Specialised Commissioning Group were invited to present the report that was circulated with the agenda. The following points were raised:

Fairoak is a low secure unit for people in the criminal justice system who have mental health issues.

Solent NHS Trust and NHS Portsmouth ran Fairoak for a number of years at a loss. Since the commissioner/ provider split last year, Solent NHS Trust is solely responsible for the £400,000 annual shortfall. An efficiency review was carried out but unfortunately the costs could not be sufficiently reduced. As it is a small service with 9 -10 clients, economies of scale cannot be made. Therefore, in May Solent gave notice of its intention to cease providing the service at the end of March 2012.

A list of questions was sent to Solent NHS Trust and South Central Specialised Commissioning Group the day before this meeting. It was agreed that the representatives would try to answer them here and would provide full written responses next week.

In response to questions raised by the panel, the following points were clarified:

Over the last three years, 39 Portsmouth residents have been referred for this type of treatment; approximately 50% of whom were admitted to Fairoak.

There are strict criteria for admissions to a low secure unit. Fairoak managed its own admissions until South Central Specialised Commissioning Group took over the commissioning of this unit in July 2010. Admissions to secure units across the region are managed by the nominated Gate Keeping Providers, Southern Health Foundation.

Fairoak, as far as possible, has been included in these arrangements.

The choice of unit depends on the individual's clinical requirements and any restrictions set by the ministry of justice e.g. away from a victim.

In the South Central area there are the following units:

- Southfield near Southampton.
- Thornford Park, West Berkshire.

The providers and commissioners are looking for the most appropriate alternative placements for the patients who need to be transferred from Fairoak. The travelling distance for visitors is taken into account and there is a low secure unit in Chichester (commissioned by South East Coast Specialised Commissioning Group) which is being reviewed.

The commissioners stopped referring patients to Fairoak on 10 November 2011 as it was felt that it would not be in the patients' best interests to move in and then be transferred shortly afterwards.

There are currently eight patients at Fairoak who have been there on average two years. Five of whom require ongoing low secure care. Three no longer require this service. Some patients have been in the system for a number of years. It is important that staff work closely with local NHS services regarding discharge. Public safety is paramount.

There is a pilot scheme with five individuals from which the learning will be used in the area and nationally.

The building will be transferred to Solent NHS Trust ownership next year. The plans for its future are not known yet. Although the building meets the minimum low secure standards, it was not purpose-built, is very small, is over two floors and is not compliant with the Disability Discrimination Act.

The main benefits of transferring patients to another unit are identified in the Equalities Impact Assessment.

Family and friends can visit every day between 10am and 5pm. However, these hours can be extended if required.

The commissioners are looking into what assistance can be given to assist visitors with travel costs if the patients are transferred to other units. It is thought that assistance is available to people who are in receipt of benefits. The units in Chichester and Newbury are easily accessible by public transport, but the unit near Southampton is not.

Units cannot be too isolated because patients need some access to the community services to assist with their rehabilitation.

There is a shortage of appropriate placements for women nationally. Occasionally some patients from Portsmouth have had to be placed further away than would have been ideal. However, there are female beds in Southfield, near Southampton.

It was agreed that the following facts would be brought to a future meeting:

- A breakdown of running costs.
- The average cost per patient/ per year at Fairoak.
- The average cost per patient/ per year at other units nationally.
- A map of all the units in the South Central area showing the type of unit, number of beds, number of patients and gender.
- Evidence of whether treatment is more successful if people are treated locally to where they live.

When the Southfield unit in Southampton opened 5-6 years ago it was expected that the first cohort would stay for an average of 2 years plus. However, some were discharged after a shorter period; it depends on how the individual responds to treatment. Only those patients who are likely to respond well to the type of environment provided there are admitted. It is not possible to make a meaningful comparison between Southfield and Fairoak because the latter is a smaller unit and admits patients with a larger range of needs.

The aim of this type of service is to enable people to meet their full potential. At the end of their treatment at Fairoak, 30% are able to live fairly independently in the community.

Patients at Fairoak have access to an advocacy service. Some patients work with the commissioners to help plan future services.

There is a range of professionals available including: therapists, psychologists, occupational therapists and nursing staff. Additionally, patients can access medication and a programme of activities which are tailored to the individual.

There are strong links with social services to make rehabilitation as successful as possible.

The commissioners need to work with Solent NHS Trust on the Equalities Impact Assessment to bring in provider issues.

Isle of Wight patients go to Southampton.

Councillor Edgar joined the meeting.

RESOLVED that:

1. **The panel consider the service change to be a substantial variation.**
2. **The consultation in January be broadened to include South East Hampshire residents who have been sent elsewhere.**
3. **A report reviewing the consultation be brought to the panel in February.**

103 Referral to Treatment Times at Queen Alexandra Hospital (AI 6).

The Chair explained that this issue had been brought to the panel's attention because Portsmouth Hospitals NHS Trust was not meeting all of its targets regarding referral to treatment times. It was reported that the plans to clear the backlog by the end of November 2011 had been revised to December 2011.

Cherry West, Chief Operating Officer, Portsmouth Hospitals NHS Trust and Richard Samuel, Director South East Hampshire, Southampton, Hampshire, Isle of Wight and Portsmouth Primary Care Trusts Cluster clarified the following points:

There are many hospital performance indicators and standards; 8 for waiting times alone. The hospital Trust aspires to achieve all the standards and for all patients to receive treatment in a timely way according to their clinical need. There are three broad categories of indicators: those which relate to waiting lists; those that tell us the proportion of patients booked for treatment within 18 weeks and those about length of time patients waited at the start of their treatment

At the start of Summer 2011, there were 1,600 patients waiting longer than 18 weeks. With the support of the Trust Board, PHT made the decision to clear this backlog and as a result a higher proportion of the more than 18 week wait patients have been treated. Priority was given to cancer patients and urgent referrals. At the end of November the number of patients who had been waiting longer than 18 weeks had been reduced to 576. With an optimum level of activity, it is predicted that this will be further reduced to 300 at the end of January.

Some capacity was sourced from other providers to deal with the backlog with the help of the commissioners. The Treatment Centre contacted some patients to offer treatment at an alternative location.

There is currently no skills shortage at the hospital, however, some clinical staff groups are difficult to recruit.

A member of the panel noted that the Havant Health Centre displays the number of people who missed their appointments weekly.

The panel was assured by Ms West that the Trust was moving in the right direction with 1,000 fewer patients waiting no longer than 18 weeks. She also reported that 95% of patients remain on PHT waiting lists for 22 weeks

compared with a standard of 28 weeks.

The Trust recognises that no-one should wait longer than they have to for treatment as this causes unnecessary anxiety.

The waiting list backlog only relates to a few specialist areas.

Mr Samuel said that it is important to note that waiting list times are the responsibility of the whole health system. Referrals from primary care and support in the community are being reviewed in order to ensure that patients are treated in the most appropriate setting.

Queen Alexandra Hospital has some of the shortest waits in the South Central area.

To provide context it was confirmed that 700 patients were admitted to the hospital over the previous week. It was not possible at the meeting to determine how many of these were urgent or cancer patients without further data analysis. 550 of them received treatment within 18 weeks.

The panel expressed concern about the uncertainty patients face because they do not know if the hospital has received the referral letter from the GP. It was agreed that the possibility of acknowledgement letters being sent to patients would be investigated. The Choose and Book system which allows patients to book appointments will also be looked at.

RESOLVED that a progress update on the clearing of the backlog be brought to the next Health Overview & Scrutiny Panel meeting.

104 Centralisation of services at St Mary's Health Campus (AI 5).

In response to questions from the panel, Debbie Tarrant, Programme Manager, Solent NHS Trust clarified the following issues:

St Mary's and St James' Hospital sites have been agreed as the two strategic sites for community health services in Portsmouth. The Estates Rationalisation Plan was presented to the panel at an informal meeting recently by the Director of Estates and Facilities Management who had explained the need to centralise services on to those two sites in order to make best economic use of the two assets and enable them to dispose of leased premises elsewhere in the city. In addition, the refurbishment works undertaken when services move into the health campus ensure a high quality environment for patients.

Currently half of the third floor of St Mary's Healthcare campus and a smaller, deep core area on the ground floor are vacant in block A. Plans are already in place to move a second community mental health team into the third floor and enabling works for that will commence in January. The options for the use of the ground floor space are being explored.

If services were to be moved out of leased and owned premises the lease

would be given up. If services move out of buildings owned by the PCT the buildings would be disposed of, if they have no future use for other health services.

Councillor Edgar informed the panel that he was pleased with the modernisation of Gosport Memorial Hospital.

The first patients were treated at St Mary's Healthcare Campus on 12 December. The maternity centre is achieving its target number of births.

RESOLVED that the report on the centralisation of services at St Mary's Healthcare Campus be noted.

105 Vascular Surgery Review (AI 9).

The Panel agreed to consider this item next.

Beverley Meeson, Cardio Vascular Clinical Network, Sara Tiller, Director of Communications, SHIP PCT, Richard Samuel, Director South East Hampshire, Dr Jim Hogan, Clinical Commissioning Group and Graham Sutton, Associate Medical Director and Vascular Surgeon were invited to answer questions from the panel.

Mr Sutton gave a presentation on vascular services at Queen Alexandra Hospital, during which the following points were clarified:

A sixth vascular surgeon will be appointed next year.

NVD is an acronym for National Vascular Database.

EVAR is an acronym for Endo-Vascular Aneurysm Repair.

The Vascular Society carried out this review in order to bring the UK's outcomes for vascular surgery up to the level with those in Europe by combining services at hospitals that don't do much vascular surgery and have poorer outcomes, to create larger, more successful units. It was never their intention to combine services at hospitals which have good outcomes.

Queen Alexandra Hospital (QAH) has a better survival rate of ruptured Abdominal Aortic Aneurysms (AAA) than Southampton General Hospital (SGH). During the period from January 2010 to September 2011 there were 20 survivors at QAH and 18 at SGH.

Non-invasive techniques are being carried out more often by Interventional Radiologists (IRs) and this poses fewer risks than invasive surgery.

St Richards Hospital (SRH) which is approximately half the size of QAH, has not adopted this new technology and has a higher amputation rate for patients with diabetes. 50% of West Sussex's population are treated at SRH. Patients suffering from heart attacks are sent to QAH. Stroke victims

are also sent to QAH because SRH does not have a 24/7 stroke treatment service.

In response to questions from the panel and the public, the following points were clarified by all parties present for this item:

The network model requires 10 consultants. SGH currently has six. Therefore the staffing model is aspirational. Consultants at QAH have not been approached about a possible move to SGH.

It is important to note that no decision on the proposals has been taken yet.

NHS Sussex supports the outcome of the Sussex PCT vascular review which is that Brighton Hospital will become a vascular centre. West Sussex Health Overview & Scrutiny Panel (HOSP) considers the review to be a major service change which is in the best interests of the population. It has asked that the engagement for this review be aligned with the SHIP PCT review.

It is important to note that the Sussex proposal can meet guidelines with a proportion of the population in West Sussex. This means that if some residents were to go to QAH for treatment, the Sussex model would not be undermined.

The Clinical Commissioning Group is seeking clarification from clinicians about the potential knock-on affect that a transfer of vascular services from QAH would have on other services.

The panel commented that it would be more convenient for most West Sussex residents to go to QAH for vascular services because it was much closer, has good public transport links and has adequate parking. The panel was assured that the views of all those affected by the proposals including West Sussex residents would be sought during the consultation period.

Councillor Edgar informed the panel that he had spoken to a lot of staff at QAH as part of his role on the Council of Governors for Portsmouth Hospitals NHS Trust. All the clinicians are very concerned about their ability to care for patients if vascular services were to be moved. He said that he hoped that the Chief Executive of SHIP PCT would attend a future meeting. He also asked the officers and clinicians present to note that QAH has 2,000 parking spaces, massive facilities including a hyper acute stroke unit with around 1,200 cases per year which is the highest in South Central, and the same as Oxford and Southampton combined. It is a super hospital which serves the most densely populated part of Hampshire and has many pioneering services.

He expressed concern that the SHIP PCT serves people from areas other than Portsmouth at a ratio of 3:1.

SGH has cardiac and neurology services and is a designated trauma centre. Therefore it will automatically become a vascular centre.
Councillor Horne reminded the panel that originally only one option had been presented to the panel i.e. all vascular services transferring to SGH. He was pleased to note that the panel's request for all the options to be explored had been heeded and that there is likely to be a range of options explored in the consultation document.

The consultation will be extended by one week to allow for Easter and will end in April. The panel was assured that the process will be transparent. Members were also told it could see a draft copy of the consultation document, which will also be shown to PHT before the consultation starts.

The aim of the review is to improve the outcomes for patients after vascular surgery without reducing the outcomes of other services.

The expert panel concluded that the stand-alone centres must deliver the same standards as Europe.

Most of the Hampshire area is within 40 minutes drive of SGH. QAH is reachable from well past Chichester within 40 minutes. 30 minutes is time critical but better to travel a bit further to the best place.

SGH and QAH have similar outcomes for Aortic Aneurysm elective repair as those in Europe. This is not the case for the rest of the UK: in 2008, the UK average for planned surgery mortality rates was 7% compared to 2.5% in Europe. In Southampton and Portsmouth in 2010 the rates are below 2.5%

Mr Sutton would be pleased to give his presentation to interested groups rather than simply sending the presentation, as it is important to hear the explanation in order to put it into context.

The SHIP Cluster Board will make the final decision about the future of vascular surgery in this area. It does not normally apply a weighting to the results of the consultation in terms of medics' or the public's views. Its aim is to ensure best outcomes can be delivered. A detailed report on the consultation will be independently verified before it is considered by the Board.

The Admiral of the Ministry of Defence Hospital Unit will write to the SHIP PCT shortly with his views on the proposals. It was agreed that a copy of this letter will be circulated to the panel.

The Chair concluded that QAH appeared to meet the criteria comfortably and it was agreed that the SHIP PCT would bring a table showing how QAH compares with SGH and Brighton to the next panel meeting. He also noted that although QAH and SGH had similar levels of expertise, QAH has superior equipment (a suite opened 2 ½ years ago) and outcomes.

Councillor Edgar commented that there had been some differences in how statistics had been interpreted during the engagement period.

The criteria used to judge PHT's bid to be a stand-alone unit are from the Vascular Society guidelines. The rates of mortality after AAA rupture is not one of these criteria and is not clinically relevant. All the parties involved will agree the data in the consultation document before it is published.

A longer journey time that resulted in a higher risk of mortality en-route would not affect the hospital's survival statistics.

It was agreed that the consultation document will be circulated to the panel informally and confidentially shortly before publication. Members' comments would be very welcome.

The ambulance service has been involved in the consultation process.

It is very hard to diagnose a ruptured AAA. Paramedics would take them to the nearest Emergency Department where the condition would be diagnosed and the patient transferred to a vascular unit at another hospital if necessary.

The consultation document will show the present state of facilities in each of the three hospitals.

The Chair explained that should another HOSP in the area determine that the review constitutes a substantial variation, a joint HOSC would be set up.

He also commented that based on what the panel had heard today, there might be a case for closing Southampton General Hospital but not a case for closing QAH. However, the panel is not considering that option.

The Hampshire HOSP is the last one to make its decision at the meeting on 24 January. Therefore if necessary, an agenda item will be put on the Portsmouth Full Council agenda for the meeting on the same day to determine the composition of joint HOSC representation.

RESOLVED that:

1. **Based on the clinical evidence submitted so far, the panel support the proposed inclusion of the option for Queen Alexandra Hospital to be a stand-alone unit in the vascular surgery review consultation document.**
2. **Should the formation of a Joint Health Overview & Scrutiny Committee (JHOSC) for this issue be triggered, the City Council agree the following representation on this and any future JHOSCs:**

a) If two members of the Health Overview & Scrutiny Panel are required, the Chair and Vice Chair be appointed.

b) If three members of the Health Overview & Scrutiny Panel are required, the Chair, Vice Chair and a member of the group that is

not represented be appointed.

Unscheduled Care (AI 8).

106 Jo York, Associate Director Systems Management Urgent Care Lead, SHIP PCT Cluster clarified the following issues in response to questions from the panel:

Members of staff are being encouraged to have flu jabs. These are targeted at people over 65, pregnant women, people with certain conditions including asthma and Health and Social Care frontline staff.

The Primary Care Nurse will not be on duty 24/7. The GP Out of Hours service has been based at QAH since October 2010 and the nurse will be in post 06:30 to 00:00 Monday – Friday and 08:00- 00:00 on Saturdays and Sundays. The GP out of hours service runs from 18:30 – 07:30/ 7 days a week.

The Primary Care Nurse operates on the same basis in the Emergency Department throughout the year. Its effectiveness will be evaluated routinely.

The aim of the Older People's Assessment Service (OPAS), which went live on 1 November, is to create seamless pathways for older people's care. Portsmouth and South East Hampshire is the front door of the Older People's Partnership and is run by PHT and Southern Healthcare.

Under the OPAS, a consultant is in the Medical Assessment Unit from 8am -8pm every day.

All patients over 65 admitted to the Emergency Department will receive focussed support to enable them to return home as soon as possible. They will be assessed on entry to the ED and be moved either into the community, the Medical Assessment Unit or the Medicine for Older Persons Ward.

Last year there was an unprecedented demand at Christmas and Easter. All partners work together to predict demand over winter, assess capacity and manage discharges and the actual demand is monitored weekly and the resources required assessed.

Councillor Edgar was pleased to note that Hampshire County Council has permanent representation in the Integrated Discharge Bureau at QAH. It also has a strong presence in the Emergency Department to ensure that people attend the appropriate service.

RESOLVED that the report on unscheduled care be noted.

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Dates of Future Meetings.

2 February.

22 March.
31 May.
28 June.
26 July.
27 September.
25 October.
29 November.

The meeting closed at 12:45