

## HEALTH OVERVIEW & SCRUTINY PANEL

MINUTES OF THE MEETING of the Health Overview & Scrutiny Panel held on Thursday, 20 March 2014 at 9.30 am at the Executive Meeting Room - Third Floor, The Guildhall.

### Present

#### Portsmouth Members.

Councillors Peter Eddis (Chair)  
David Horne (Vice Chair)  
Michael Andrewes (deputising for Jacqui Hancock)  
Margaret Adair  
Mike Park

#### Co-opted Members.

Councillors Dorothy Denston, East Hampshire District Council  
Keith Evans, Fareham Borough Council  
Mike Read, Winchester Borough Council

### Also in Attendance

#### NHS England (Wessex)

Simon Jupp, Director of Commissioning  
Stuart Ward, Medical Director and Member of the Wessex Clinical Senate.

#### Portsmouth Hospitals' NHS Trust

Peter Mellor, Director of Corporate Affairs & Business Development  
Graham Sutton, Vascular Consultant  
Perbinder Grewal, Vascular Consultant.

#### University Hospital Southampton NHS Foundation Trust.

Cliff Sherman, Vascular Consultant

#### NHS Portsmouth Clinical Commissioning Group.

Dr Jim Hogan, Clinical Lead.  
Innes Richens, Chief Operating Officer.

#### Portsmouth City Council

Dr Janet Maxwell, Director of Public Health.  
Jackie Charlesworth, Deputy Head of Integrated Commissioning, Integrated Commissioning Unit  
Maggie Vilkas, Operations Manager

### **16. Welcome and Apologies for Absence (AI 1)**

Apologies were received from Councillors Gwen Blackett, Peter Edgar, Margaret Foster, Jacqui Hancock and David Keast.

### **17. Declarations of Members' Interests (AI 2)**

No interests were declared.

### **18. Minutes of the Previous Meeting (AI 3)**

**RESOLVED that the minutes of the previous meeting were agreed as a correct record.**

**19. Proposal to Close the Lowry Unit (AI 4)**

Jackie Charlesworth, Innes Richens and Maggie Vilkas presented the report and then in response to questions from the panel clarified the following points:

- The closure would generate approximately £300,000 savings, which includes staffing, facilities and building costs.
- The proposed closure is driven by an increase in the number of referrals to community services and a steady decrease in attendees.
- It is estimated that 3 or 4 service users would be transferred to the Royal Albert Centre, Lake Road which is run by Portsmouth City Council. This provides the same sort of support as used to be provided at St James' Hospital by the Community Mental Health Team. The Head of Adult Services has reassured them that there is adequate capacity to accommodate new clients from the Lowry Centre and the Patey Centre if required. Staff will accompany service users to the Royal Albert Centre for a handover.
- Nationally, very few day services are still provided in hospital settings.
- Twenty people visit the Lowry Unit; most of them once a week.
- People have generally been referred to the unit to facilitate early discharge from hospitals.
- It is estimated that more than £300,000 has been invested in developing community services over the last 18-24 months.
- The same level of care would be provided for Lowry Centre users but with a community focus.
- The savings would be made in the next financial year and could enable existing services to be maintained. It is not possible to say how much will be invested in community support in the future until the level of need is determined. Telecare plays an important part of this support.
- The two Dementia Cafés are located at The Link, Havant Road and Southsea Community Centre. These are run by the Alzheimer's Society and provide a point of contact for people with dementia and their carers. Support workers and advisors are on hand and speakers regularly attend.
- The Carers Information and Support Programme is a six-week course for carers which helps them learn how to cope with a dementia diagnosis.
- After a diagnosis, the patient and carer are assigned a Dementia Advisor who can signpost them to service when they need them. They are funded by the Clinical Commissioning Group.
- Staff at the Lowry Centre are valued and redeployment to other posts in the organisation will be sought so that their skills are not lost.
- Feedback from service users and family has shown that the service is valued but no particular concerns were raised.

Action.

If the closure goes ahead, details of the impact on service users will be brought to a future meeting.

**RESOLVED that the report on the proposed closure of the Lowry Centre be noted and a further report be brought to a future meeting on the impact of the closure, if it goes ahead.**

## 20. Options for the provision of Vascular Surgery for Southern Hampshire (AI 5)

Councillor Eddis explained reminded the panel that:

- The purpose of the meeting was for the panel to hear the proposals from NHS England (Wessex) for vascular services in South Hampshire.
- Southampton, Hampshire and the Isle of Wight HOSPs would also consider these proposals for vascular services at their meetings in March and April and will each decide if it feels these constitute a substantial variation of services. If one HOSP considers the proposed changes to be substantial, NHS England (Wessex) will launch a public consultation (from the end of May to the end of August). The HOSP would then scrutinise the consultation process and plans. If more than one HOSP considers the proposed changes to be substantial, they must form a joint HOSP to scrutinise the process and plans. We will know by 5 April what the four HOSPs have decided.
- Once all evidence has been heard the panel needs to come to a decision about whether this constitutes a substantial variation. The key feature of a substantial variation or development is that there is a major change to services experienced by patients and future patients. Guidance suggests that in deciding whether a proposal is substantial, the following issues should be considered:
  - In considering whether the proposal is substantial, NHS bodies, committees and stakeholders should consider generally the impact of the change upon patients, carers and the public who use a service, or may use it in the future. An important consideration should be whether the majority of patients using the service would notice a significant material change in how they receive that service, particularly in terms of access or location.
  - More specifically they should take into account:
    - a) Permanent changes in accessibility of services;
    - b) The impact of proposal on the wider community and other services;
    - c) The number of patients affected, changes may affect the whole population (such as changes to accident and emergency), or a small group (patients accessing a specialised service). There should be an informed discussion about whether this is the case and which level of impact is considered substantial;
    - d) Methods of service delivery, for example moving a particular service into community settings rather than being entirely hospital-based.

Maria Cole, a Southsea resident gave a deputation expressing her concerns about the potential impact of longer travel times for friends and relatives to visit patients in Southampton.

Simon Jupp introduced the report outlining the proposals and emphasised that the most important considerations are achieving the best outcomes for patients, minimising patient travel and ensuring that services are sustainable.

Graham Sutton gave a presentation to the panel, which would be published on the website shortly after the meeting.

A discussion involving all parties then ensued and the panel was asked to note the following points.

Graham Sutton explained that:

- PHT meets or exceeds all the standards set out in the national specification.
- Queen Alexandra Hospital is the largest hyper acute heart attack centre in the region and provides an award-winning diabetes service.
- Arterial surgery is a key feature of dialysis. The Specialist Commissioners stated that 24/7 onsite Intervention Radiologists and expert vascular surgeons are required for renal patients.
- The most common serious complications for diabetics are foot disease and limb loss; Interventions to improve blood supply can significantly improve the quality of life for these patients but it is not as easy to measure these outcomes.
- Interventional Radiologists (IRs) are taking over a significant amount of the work of cardiologists, renal surgeons and vascular surgeons and are an integral part of the services provided for vascular and non-vascular patients. Over time, these IRs would be lost if option 4 in NHS England (Wessex)'s proposals were to be adopted.
- PHT wants to work more closely with University Hospital Southampton NHS Foundation Trust by sharing expertise and trainees.
- It also wants to work closely with West Sussex as it does for other services.
- If vascular services were moved to Southampton, the impact on other services caused by uncertainty should not be underestimated. Having vascular consultants on site in case of an emergency is reassuring for other surgeons.
- QA operated in a network with Chichester for four years until this was reviewed.

Cliff Sherman explained that:

- Southampton General Hospital (SGH) is fully compliant with the national service specifications.
- In 2007 poor results were identified in the UK and as result purpose built facilities were installed at SGH.
- It is important that results are improved.
- The cardio vascular strategy document recommends seven days a week access and a maximum wait of 24 hours for carotid surgery. Neither hospital currently achieves this.
- There are not sufficient vascular surgeons at either hospital.
- The pressure on consultants will increase as seven days a week working is introduced across the NHS in all departments. There will be a need to recruit more consultants generally.

- He is the Chair of National Training which has identified that it is a struggle to recruit vascular trainees in this region because of the low number of operations carried out.
- Having one team working on one team is a better use of resources. Not all patients would have to travel across the sites.
- The introduction of phases 1 and 2 of option 4, would create more pressure on SGH but that would be manageable provided that the implementation of the third phase does not stall. Therefore a clear plan of progression is required.
- SGH has a paediatric cardiology unit.
- UHS wants better joint working with PHT.
- A 'Surgeon of the Week' is on duty to deal with referrals.
- QA has a very strong diabetes unit and USH would benefit from closer joint working.
- SGH cannot provide seven day week cover with the current number of staff.
- There are currently 72 units providing vascular services. It is anticipated that this would decrease to 50 in time because they are not carrying out the required number of operations.
- A relatively old study showed that there was no increase in mortality for patients with abdominal aortic aneurysms (AAAs) whose travel to hospital was less than one hour.
- Patients in rural areas are likely to experience longer travel time to hospital by ambulance, so helicopters are used where appropriate.
- Patients with AAAs represent a very small number of vascular patients, who in turn are a very small percentage of the general population.
- Results for aortic surgery are OK at both units at the moment.
- As a trauma centre, SGH requires a vascular unit on site.
- The National Specification Commissioning Reference Group laid down the minimum standards required in order for sites to be vascular units. QA does not meet the standard regarding the size of its catchment area.
- Southampton has a network for other services with the Isle of Wight and Winchester.

Peter Mellor commented that:

- NHS England (Wessex)'s report shows data until December 2012; in PHT's presentation the data is current.
- More detail is required to explain how option 4 would deliver improvements for patients.
- PHT's record of 1 death in 200 occasions would be difficult to improve on.
- The fact that the proposals in option 4 would be phased is irrelevant; the outcome would have a significant financial effect on PHT.
- If services were moved to Southampton, the fixed overheads, the PFI, building, equipment and dedicated theatres would remain. It would be the start of a slippery slope for the hospital.
- Renal services would be affected.
- PHT has six surgeons as required in the national specification.
- He recognises the benefits of a network and proposes the following network as set out in the presentation:

- The present network arrangements for screen detected aneurysms be continued.
- Shared MDT for complex cases
- Shared training in vascular surgery (replicating IR model)
- Shared research
- Two way movement of complex cases
- Complex EVAR to UHS
- Renal compromise cases to PHT
- Create the environment where a regional emergency endovascular service could be developed
- Minimum size of population was set to ensure that a minimum number of operations would be carried out. Portsmouth - meets the number of operations despite having a smaller population.
- Optimistic that will be able to broker a network solution. No need for a consultation.

Janet Maxwell explained that:

- She had been involved in discussions with the Public Health Directors in the North South Central region about vascular services. The group would support the recommendation to have one centre to achieve the best results and having a phased approach to developing the network. The changes would only affect a small number of people.
- It is important to look at the wider health questions; Cardio Vascular Disease is largely preventable. Therefore whilst it is important to treat acute cases, investment in preventing new cases by educating people about smoking, nutrition and lifestyle.

Dr Hogan commented that:

- The debate regarding commissioning vascular services started with Primary Care Trusts; when these were abolished responsibility was transferred to NHS England.
- The Portsmouth, Fareham & Gosport and South Eastern Hampshire Clinical Commissioning Groups (CCGs) were asked to comment on the proposals with the focus on patients' outcomes and concluded that option 4 is their preferred option.

Stuart Ward explained that:

- East Hampshire area is complicated, with different CCGs and residents in the North travelling to Frimley Park for vascular services.
- More investment in helicopter services to transport patients to hospital for specialised services is required as travel by ambulance is taking longer. This is the case for the Isle of Wight.
- Diabetics often have renal problems which are dealt with at QA.
- The expectation is that all significant vascular surgery (open and endovascular surgery) would be undertaken at one centre. As much as possible would be done elsewhere.
- When cardiology was moved to specialist centres, concern was expressed because it was thought that open heart surgeons were required to be on hand for other surgery. This concern has proven to be unfounded.

- SGH and QA hospitals are not sufficiently large to create fully-functional vascular units independently. It would be a challenge to maintain competency of staff.

Simon Jupp added that:

- It is important to have this debate with the Health Overview & Scrutiny Panels in the region.
- The proposals would affect fewer than 1 patient per week
- Consideration has been given to the potential financial impact on PHT of the preferred proposal and on other services.
- The details of the proposals, including funding have yet to be worked through.
- Removal of some services from QA would lead to a loss of income but also a reduction in costs.
- The network would involve PHT and USH in the first instance.
- The Clinical Senate was asked to review the options available and in doing so considered the potential effect on co-dependent services. Although more members were from Southampton, all clinicians were invited to apply.
- The national service specification states that 'the network must cover a population of at least 800,000 people in order that each surgeon is able to perform at least 10 AAA procedures per year.' However, he recognised that QA does perform the required number of procedures despite having a smaller catchment area and therefore, future reports will reflect this.
- HOSPs have a significant influence on the decision-making process.
- He felt for any unit that has felt under threat for the last four years (as mentioned by PHT in its presentation). It is therefore important that this issue be resolved as soon as possible.

Councillor Eddis commented that area boundaries were not always helpful and that residents with AAAs in Chichester are required to travel to Brighton for treatment (with a travel time of at least one hour) rather than to QA which would only take ten minutes.

**RESOVLED that:**

- 1. The proposals for the provision of vascular surgery constitute a substantial variation in services.**
- 2. The Chair and Vice Chair (or if not available other members may substitute) will represent the Portsmouth HOSP on a Joint Health Overview & Scrutiny Committee (HOSC) which will be convened if one or more of the other affected HOSCs (Southampton, Hampshire and the Isle of Wight) consider the proposals to be substantial in nature.**
- 3. NHS England (Wessex) be asked to consider initiating further discussions with NHS England (Surrey and Sussex) to consider if St Richard's Hospital should be part of a network with Portsmouth and Southampton rather than with Brighton.**

The meeting ended at 12.25pm.

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Councillor Peter Eddis  
Chair