B

CABINET – 7 SEPTEMBER 2005 HEALTH AND SOCIAL INCLUSION PORTFOLIO

CONSULTATION ON COMMUNITY SERVICES FOR OLDER PEOPLE

Summary of Purpose and Recommendations:

This report recommends that the Cabinet determines a response to the Consultation.

Cost to Council: £ Neutral **Within existing budget?** Neutral

Contribution to Corporate Plan (Minor/Moderate/Major/Neutral):

	+		-		+		-
		Neutral		**Priorities**			
			Minor	Clean Streets and Public Space		Neutral	
		Neutral		Crime and Disorder		Neutral	
			Moderate	Housing		Neutral	
		Neutral		Managing our Finances		Neutral	

Comments on Impacts on Corporate Objectives and Priorities:

None.

Organisation of excellence | Working with public and partners | Economic well being | Social well being | Environmental well being

PORTFOLIO: HEALTH AND SOCIAL INCLUSION

CABINET – 7 SEPTEMBER 2005

CONSULTATION ON COMMUNITY SERVICES FOR OLDER PEOPLE

1. PURPOSE OF THE REPORT

1.1 To allow the Cabinet the opportunity to respond to the consultation document on Community Services for Older People produced by the South West Hampshire Primary Care Trusts.

2. BACKGROUND

2.1 The South West Hampshire Primary Care Trusts (PCTs) have been reviewing the services provided for older people in local community hospitals and at home. As a result they have produced a document that details two options for changes to these services. (Appendix A)

2.2. The Council has been involved in the review process through its membership of the relevant PCT's Committees and has been involved in the consultation process to date.

2.3 A process of consultation is underway involving a variety of methods including community meetings. As may be expected the proposals have received a lot of interest and debate amongst local people and especially the Leagues of Friends of the hospitals detailed in the document. The deadline for the consultation period is 30th September.

3. THE PROPOSALS

3.1 The consultation document details two options for the Cabinet to consider, both involve reorganisation of services based upon reduction of in-patient beds in New Forest Community Hospitals and redeployment of resources into the community.

3.2 The document contains much complex information the implications of which are not always apparent. Financial information is also not detailed enough to be able to make a proper assessment of the options given. There is also insufficient detail of the community based alternatives to hospital services to allow a clear understanding of the proposals.

3.3 A draft response to the consultation will be circulated at the meeting.

4. OTHER FACTORS

4.1 Hampshire County Council Health Overview & Scrutiny Committee is ultimately responsible for carrying out a detailed investigation of the PCTs proposals. Their decisions will be crucial to the final outcome of the proposals in the consultation document. Ultimately, if they are unhappy with the final proposals they can be referred to the Independent Reconfiguration Panel, a Government body for adjudication in such matters.

4.2 Southampton City PCT is also consulting on changes to its community based services which may have an effect on the local proposals. There is a lack of detail as to how the two consultation proposals will interact. It is not known if there is an overall strategic plan.

5. FINANCIAL CONSIDERATIONS

There are none for the Council. Financial information in the consultation document could be more detailed.

6. ENVIRONMENTAL CONSIDERATIONS

6.1 There are possible implications if any of the hospital sites are redeveloped.

7. CRIME AND DISORDER IMPLICATIONS

9.1 There are no direct crime and disorder implications.

8. PORTFOLIO HOLDER COMMENTS

8.1 (Incorporated into the draft response).

9. RECOMMENDATIONS

That Cabinet consider the consultation document and the draft response to John Richards, Chief Executive of the South West Hampshire PCTs and determine the Council's response.

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Background Papers:

None.

Appendix A

Community Services for Older People
Seeking Local Views on the Way Forward

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Modernising and improving community services for older people

1. Executive Summary

About us

New Forest Primary Care Trust (PCT) and Eastleigh and Test Valley South Primary Care Trust (PCT) are the organisations responsible for making sure the right health services are in place for people in the New Forest, southern Test Valley and Eastleigh Borough. The two PCTs work together as the South West Hampshire PCT Alliance.

Both PCTs are proposing to develop and expand community-based services for older people. This section provides a summary of the proposals and outlines how local people can have their say on the changes put forward.

About our patients

Together New Forest and Eastleigh and Test Valley South PCTs serve a population of 336,000, of which 82,000 are aged over 60. Across the New Forest and Eastleigh and Test Valley South areas 53,000 people are living with a long term illness such as stroke, diabetes, coronary heart disease or chronic obstructive pulmonary (lung) disease: the majority of whom are older persons. These people are more likely to be admitted to hospital as an emergency due to problems arising as a result of their long term illness, or other factors such as the ill health of their partner or the breakdown of equipment.

What community services for older people are included in this consultation?

The services included in this consultation are:

- care for people with long term conditions such as diabetes and heart disease;
- care and rehabilitation for people who are recovering from an illness or injury;
- care of the terminally ill;
- in-patient services commissioned and provided by the South West Hampshire PCT Alliance; and
- outpatient and other clinics currently provided at our community hospitals.

These services are currently provided by a range of health professionals such as:

- district nurses;
- rehabilitation teams made up of physiotherapists, occupational therapists, rehabilitation assistants etc;
- GPs;
- practice nurses;
- nurses who specialise in diabetes, heart disease etc; and
- hospital doctors, nurses and therapists.

Care is provided in a number of places, including:

- patients' own homes (this may include care homes);
- local clinics;
- GP surgeries; and
- in-patient beds in acute and community hospitals.

These services are part of a much wider network of health services including acute hospital care commissioned (purchased) by the PCTs from NHS Trusts in Southampton, Winchester, Bournemouth, Salisbury and sometimes further afield.

How are these services organised now?
The NHS currently provides the following local services:

- district nursing teams caring for people in their own homes and at specialist clinics (e.g. for leg ulcers);
- rehabilitation teams, helping people to recover after an illness or injury in their own homes, in clinics and in community hospitals;
- rapid response teams which provide emergency care for people aged over 65 in their own homes to either prevent these people having to go to hospital or enable them to come home sooner;
- clinics and home visits carried out by specialist nurses for people with long term conditions;
- general care from GPs and practices nurses;
- 106 in-patient beds, outpatient clinics and diagnostic services provided at Romsey, Hythe, Fenwick, Milford-on-Sea and Fordingbridge Hospitals; and
- four in-patient beds purchased at Western Community Hospital (Southampton) and 12 at Moorgreen Hospital (West End).

So what happens to older people now when they are ill?
When an older person is taken ill or suffers an accident or injury they are usually seen by their GP, the Out of Hours service or paramedics in the first instance or go directly to the Accident and Emergency Department. These healthcare professionals must then make sure that the patient is cared for appropriately. Currently, there is not a great deal of support offered to patients at home or in local centres, and our services can be quite difficult to access, so frequently patients are admitted to a large hospital for example: Southampton General, the Royal Bournemouth Hospital or Salisbury Hospital. This sometimes happens even if someone does not need this type of care simply because other appropriate options are not available. If a patient is admitted to one of the acute hospitals, as they begin to recover they do not need the level of care provided there so they may transfer to a community hospital bed for further rehabilitation and stay there for an average of 27 days. There is often a delay in arranging the transfer from acute hospital to community hospital.

Why do these services need to change?
1. To give patients the best care.
Extensive research has revealed that older people would prefer to be treated at home when it is safe and appropriate to do so. Studies have also shown that patients recover quicker and are more likely to return to living independently at home if their stay in hospital is not prolonged and there is the right level of care and support at home.
2. To meet national standards
The Government has set standards for the care of older people and people with long term conditions (called ‘National Service Frameworks’ – NSFs). These NSFs are designed to ensure we learn from best practice and provide the highest standard of care for patients. There are also a number of national reports and

strategies which make recommendations on the best ways to care for older people. The local NHS must make sure that our services meet these national requirements (refer to appendix C for further details).
3. To provide the best possible care within the available resources.
A recent independent study showed that 84% of people in local community hospitals could have been receiving their care in a more appropriate setting eg. at home. Currently this is not happening because there are not enough community services (such as rehabilitation teams, district nurses, community clinics and social care services) to care for patients at home, or close to home. As a result the local NHS is paying for expensive hospital care that is not really needed. In fact this money could be much better spent on improving community services to prevent unnecessary hospital admission, to allow patients to come home from hospital sooner or to be cared for at home.

What changes are being proposed?
We want to strike the right balance between hospital care and care provided in or near patients' own homes. This will involve developing and expanding community services to reduce the need for hospital beds and release the resources currently tied up in the acute hospitals and community hospitals.

The expanded community services will focus on providing services locally when safe and appropriate to do so, preventing emergency hospital admission whenever possible and enabling people to return home from hospital sooner with the right home-based care and support. This means:

1. Preventing illness and injury:
    - More community services focusing on illness and injury prevention, such as falls clinics, obesity prevention, healthy lifestyles and projects such as the Innovations programme (in partnership with Hampshire County Council).
2. Providing more support to help people with long term conditions stay well:
    - More specialist services to provide on-going support for people with long term conditions (e.g. diabetes, Parkinson's disease, heart disease) at local facilities such as GP surgeries.
    - Community health services 24 hours a day, seven days a week, specifically extra hours for community nursing and rapid response.
    - Community matrons, who will be responsible for ensuring especially frail and vulnerable patients receive the right care.
3. More care at home for those who have suffered illness or injury:
    - Expanded community rehabilitation teams to provide more rehabilitation in people's homes or at local facilities.
    - Expanded rapid response teams to provide emergency assessment and support.
    - Specialist night sitting services.
    - Day rehabilitation for patients.
4. Appropriate in-patient care for those that need it
    - These changes will ensure that when in-patient care is required it will be available in a timely way because facilities will be used appropriately.
    - This will be provided at one of the community hospitals or at another suitable facility commissioned (purchased) by the PCTs.

How will this affect patients and local people?
Anyone who needs hospital care will still get it, either at one of the community hospitals or another facility. However under these proposals many more people will receive the right care and treatment either at home, or in a clinic near their home.

With the new services a patient who has been taken ill or suffered an accident or injury might be visited in the first instance by their GP, the Out of Hours service, or a healthcare professional (such as a nurse, or therapist) from a local team. The patient would be assessed and, if it was appropriate and safe to do so, the option of being cared for at home would be discussed with the patient and their relatives or carer. The right level of treatment and support would then be provided at home by the local team – this could be a specialist or community nurse or the rapid response team. Not everyone will be able to be cared for at home but rather than travelling to a big hospital these patients could be cared for at a local facility such as a nursing home, a local unit with beds for rehabilitation or extra-care housing supported by healthcare professionals.

The options
There are a number of ways these changes could be achieved, and these are outlined in detail in the rest of this document.

For ease of reference this Executive Summary includes a breakdown of the options being put forward for consultation:

Option one (this includes four sub-options as this option could be achieved in a number of ways).

To expand and develop community-based services by releasing resources currently tied up in acute hospital beds and community hospitals by closing:

1a.
- 20 inpatient beds at the Fenwick Hospital, Lyndhurst (currently closed temporarily)
- 17 inpatient beds at Hythe Hospital

1b.
- 20 inpatient beds at the Fenwick Hospital, Lyndhurst (currently closed temporarily)
- 19 inpatient beds at Milford-on-Sea Hospital.

1c.
- 20 inpatient beds at the Fenwick Hospital, Lyndhurst (currently closed temporarily)
- 17 inpatient beds at Hythe Hospital
- 19 inpatient beds at Milford-on-Sea Hospital.

1d.

- Reopening 20 inpatient beds at the Fenwick Hospital, Lyndhurst (currently closed temporarily)
- Closing 19 inpatient beds at Milford-on-Sea Hospital
- Closing 17 inpatient beds Hythe Hospital

Option 2
Expand and develop community-based services by releasing resources currently tied up in acute hospital beds and community hospitals. This will mean closing all the community inpatient beds at Hythe, Milford-on-Sea, Fenwick, Romsey and Fordingbridge hospitals.

Subject to the outcome of consultation it is proposed that changes will start to be implemented in November 2005. There will be a phased approach to introducing the changes which could take between one and three years to implement depending on which option is chosen.

How will these changes affect staff?
All of the options will mean the provision of a range of health services which will require recruitment to multi-professional teams. We value the huge contribution of our committed staff and our aspiration would be to re-deploy any staff affected by the proposals.

Currently I have a community hospital near my home, how will I get to a community hospital that is further away?
The principal focus of this strategy is to provide local services as close to people's homes as possible, or even at home. Where patients do need to travel we will work with transport networks and voluntary organisations to overcome any difficulties patients and their carers may have with travelling.

Do these plans take into account the fact that we have an ageing population?
Yes. These proposals focus on building community services which are tailored to meet the needs of this ageing population and will provide efficient and responsive care in the future.

- Around 82,000 people in the New Forest, southern Test Valley and Eastleigh area are over 60 years of age.
- There will be a predicted 24% increase in the over 85 age group by 2011.
- There will be a predicted 17% increase in over 60s in New Forest and 7% increase in over 60s in Eastleigh and Test Valley South by 2011.
- 17.8% of older people are living alone in New Forest and 14.2% in Eastleigh and Test Valley South.

How will you recruit the people to work in these new services?
We already have a committed and experienced workforce who are equipped to meet the challenges of any new services we provide. We have also developed some new and innovative services which have proved very attractive to new recruits as they offer the opportunity to work in modernised services, with personal and professional development opportunities. We are confident that redesigned and modernised services like the ones we are proposing will be attractive to new recruits.

Like many NHS organisations we have had difficulties recruiting to traditional community hospitals as the services delivered do not offer significant personal development or opportunities for promotion and there is uncertainty about the future. As a result the PCT has had to rely heavily on costly bank and agency staff.

How can I have my say on these proposals?
Comments and questions on these proposals are welcomed. We need to know which services you would most like to see provided locally or at home and what concerns you most about these proposed changes. Only by gathering this information from you will we be able to build a service that meets your needs and addresses your concerns.

You can comment in writing to:
The Consultation Office
South West Hampshire PCT Alliance Headquarters
8 Sterne Road,
Tatchbury Mount
Calmore
Southampton
SO40 2RZ

Or by emailing: consultations@swalliance at nhs.uk

Alternatively you can telephone our consultation answer phone on:
023 8087 4352 and someone will return your call if required.

There will also be a series of public meetings, which everyone is welcome to attend, see page 29 for details.

2. Introduction and background

About us

New Forest Primary Care Trust (PCT) and Eastleigh and Test Valley South Primary Care Trust (PCT) came together as the South West Hampshire PCT Alliance in January 2005. Together we serve a population of 336,000 of which 82,000 are aged over 60 (registered population as at January 2004). PCTs are responsible for:

- improving the health of their local population;
- buying health services for their population (we call this commissioning);
- developing Primary Care Services (such as services provided from GP surgeries); and
- providing community-based services.

New Forest PCT has the same geographic boundary as New Forest District Council. Its main centres are Ringwood, Fordingbridge, Hythe, Totton, Lymington, Lyndhurst and New Milton with many other small towns and villages spread throughout the area. The Eastleigh and Test Valley South area comprises Eastleigh Borough and the southern nine wards from Test Valley. Its main centres are Eastleigh, Romsey and Hedge End, with several other small towns and villages spread across the area.

About our patients

The census information from 2001 predicted an increase in the over 60 population of 7% in the New Forest and 17% in Eastleigh and Test Valley South between 2004 and 2011, and an increase in the same time period of 24% in the over 85 age group in both areas.
Recent public health data shows the prevalence of a life long illness (such as stroke, diabetes, coronary heart disease) is 17.8% in the New Forest and 14.2% in Eastleigh and Test Valley South (or 53,000 people). When age standardised this is lower than observed nationally. The majority of people with a long term illness are older persons and are most likely to be admitted to hospital as an emergency. This may be due to problems arising as a result of their long term illness, or other factors such as the ill health of their partner or carer or the breakdown of equipment. Last year across the Alliance 330 patients had between four and 13 admissions to hospital in Southampton. These patients were in hospital for a total of 8080 inpatient bed days. Over the past three years there has also been a 19.5% increase in emergency admissions across the Alliance area.

The Government's vision for adults and older people's services

In their document 'Supporting People with Long Term Conditions' the Department of Health highlighted that providing more co-ordinated and proactive care to people with long term conditions can have a significant impact on helping them to stay healthy, independent and at home. It is also recognised (Ashworth et al 2005) that, whenever safe and feasible, physical rehabilitation should be provided in people's own homes as they are likely to progress better. Research undertaken locally during the public consultation on the Mount hospital in Bishopstoke, and with our recent one-to-one interviews with patients, has told us that being able to

stay independent within their own homes is one of the most important priorities for older people.

In addition the Select Committee on Health, July 9, 2002 reported that:
"Unnecessary stays in hospital of themselves exacerbate the problem of delayed discharges, carry the risk of institutionalisation and of patients losing independence."

Working towards better healthcare
The South West Hampshire PCT Alliance has already begun to employ effective community care which makes a real difference to the quality of life of local older people. The following real case study demonstrates the model of care to which we would like to aspire for all local people with long term conditions.

Dr Peter Hockey, Medical Director, South West Hampshire PCT Alliance writes:

"An 82 year old single retired head gardener, was admitted seven times to Southampton General Hospital during 2000 with exacerbations of Chronic Obstructive Pulmonary Disease (COPD) and heart failure, before being identified by the COPD domiciliary nursing team as a being a frequent visitor to hospital needing support. With regular visits and telephone support he only had two hospital admissions over the next five years – one as the result of a fractured humerus when a vigorous wheelchair driver hit rocky ground at Exbury Gardens, tipping him into the rhododendrons, and the second for an acute exacerbation of COPD requiring a five day in-patient stay. He died in his own home in early 2005 after remaining independent at home, baking more mince pies than his visiting nurses could consume. A successful achievement for a disease which disables, limits and deteriorates year on year. This was good community care in action."

3. What is the purpose of this paper?
Unlike traditional consultations, the South West Hampshire PCT Alliance is not presenting a single firm proposal to replace the current model of service. We have been seeking the views of staff, partner organisations and the public in the development of both the original discussion document, and in the development of the care models described in this paper. This process started in January 2005 building on an already established programme of patient involvement work that has been in place since the PCTs came into existence. Details of the comments received can be found in Appendix B.

This paper aims to:

- outline the context to this consultation;
- outline the project scope and timetable;
- describe the proposed new model of care;
- outline the ways the proposed models could be implemented;
- outline how the proposals link to other service modernisation and redesign projects taking place across Southampton and South West Hampshire;
- explain the consultation process; and
- show people how they can comment on the proposal and help us shape and develop the proposed model of care.

See pages 27 - 29 to find out how you can contribute your views.

4. What is included in this project?
So far, the Community Services Strategy project has involved a thorough review of all community services and community hospitals commissioned (purchased) and provided by the South West Hampshire PCT Alliance to assess what services are needed in the New Forest, Eastleigh and Test Valley South areas.

This has led to the development of a 'model of care', which is a blueprint for how services could be run in the future. This model has been shaped by feedback from patients, the public and stakeholders received during a 'listening phase' which ran between April and June 2005. This feedback has been vital in helping us develop services to meet local needs (see Appendix B).

The agreed requirements of the 'model of care' are:

- a community based service which reduces emergency bed days by at least 10% by 2008 and enables more older people to live at home;
- to reduce the amount of people who are in hospital unnecessarily (we call this 'delayed transfers of care');
- to reduce the average length of stay in hospital;
- to use in-patient beds efficiently and ensure they are accessible to those who need them; and
- to allow approximately £3million of revenue to be released each year which can be used to provide better services for patients and help with our financial recovery;

Some services for older people in Eastleigh and Chandlers Ford are not included in this project. They are:

- rehabilitation services currently provided at the Royal Hampshire County Hospital, Winchester. Proposals to expand community based provision of these services and develop a local inpatient facility were subject to public consultation last year, and will be complete when a new purpose-built rehabilitation unit at Brendoncare Knightwood is opened next year;
- rehabilitation services for people living in Eastleigh Borough, which are provided by Southampton City PCT at the Tom Rudd unit, Moorgreen Hospital, West End. We are currently working with Southampton City PCT as they review their community services and community hospitals and consult local people.
  For general information about the proposals, please see southamptonhealth.nhs.uk where you can also complete an online comment form. Alternatively you can send your comments and questions to:
  Sue Skerry
  Southampton City Primary Care Trust
  Trust Headquarters, Western Community Hospital
  William Macleod Way, Southampton, SO16 4XE

Via email sue.skerry at scpct.nhs.uk or by telephoning 023 8029 6950.

- The same locality model of community services will apply to the Southern Parishes of Eastleigh, but discussion around the purchase of rehabilitation beds for this area will take place within the context of discussions about the re-provision of beds in the Tom Rudd unit
- New Forest PCT also has community hospital bases at Ashurst and the Graham Unit at Lymington. These sites do not provide in-patient beds for older people and are therefore not part of this consultation. However the PCTs are mindful that these sites play an important part in service provision and that they house a number of our community staff.

5. What are the project timescales?

Subject to the outcome of consultation it is proposed that changes will start to be implemented in November 2005. There will be a phased approach to introducing the changes which could take between one and three years to implement depending on which option is chosen. We are also mindful that this consultation is taking place alongside a number of other changes county-wide. The project timetable is shown at Appendix E.

6. What community services do we have now for older people?

Community services for older people in the New Forest, southern Test Valley and Eastleigh provide:

- care for people with long term conditions such as diabetes and heart disease;
- care and rehabilitation for people who are recovering from an illness or injury (this is often called Intermediate Care);
- care of the terminally ill;
- in-patient services in five community hospitals which provide rehabilitation, step up care (this means admitting patients directly to a community hospital) and palliative care (care for the dying);
- outpatient and other clinics; and
- Rapid Response services to provide same day assistance for people who need extra support at home and for short periods of usually up to two weeks.

These services are currently provided by a range of health professionals such as:

- community nurses;
- rehabilitation teams made up of physiotherapists, occupational therapists, rehabilitation assistants etc;
- GPs;
- practice nurses;
- nurses who specialise in treating conditions such as diabetes, heart disease etc;
- hospital doctors and nurses; and
- community mental health nurses.

The care is provided in a number of places, including:

- patients' own homes;
- local clinics;

- GP surgeries; and
- in-patient beds in community hospitals.

We currently provide in-patient rehabilitation services from five community hospitals that we manage directly: Fordingbridge, Hythe, Milford-on-Sea, Fenwick and Romsey.

The South West Hampshire PCT Alliance also commissions (purchases) rehabilitation beds from the Royal Hampshire County Hospital in Winchester, the Western Community Hospital in Southampton and the Tom Rudd unit in West End. New Forest PCT also has community hospital bases at Ashurst and the Graham Unit at Lymington, which do not provide in-patient beds.

Some community based services are provided by Social Services and these include social care, day care, personal care (e.g. help with washing and dressing) and meals on wheels. Services provided by Social Services are subject to means testing. Some services are provided by both health and social services, depending on the assessed patients needs, and these include community equipment and respite care.

The table below shows the current key data relating to community hospitals across the South West Hampshire PCT Alliance:

	Fenwick	**Fordingbridge**	**Hythe**	**Milford-on-Sea**	**Romsey**
In-patient beds	20 GP beds (NB in-patient beds are currently closed)	16 GP 15 Consultant	11 GP 6 orthopaedic	9 GP 10 Stroke	20 GP beds
Occupancy (2004/2005)	76% up until temporary closure of beds	75%	84%	93%	86%
Average length of stay in days	32.22	22	24.38	26.42	22.09
Local health needs (Key highlights from Health Needs Assessment)	Second highest proportion of older people in the Alliance area	Highest percentage of middle-aged people in the Alliance area. Ringwood and Fordingbrige locality have highest hospitalisation rate following accidents and falls	Smallest rate of admission for stroke where patient is subsequently discharged to a nursing home	Oldest population in Alliance. Highest incidence of stroke and fractured neck of femur	Lowest rate of long term conditions

Location	Central to the New Forest, relatively easy access to Southampton University Hospitals Trust (SUHT) and Lymington Hospital	Relatively isolated from other services. Very poor public transport in area. Nearest acute hospital is Salisbury	Relatively easy access to SUHT and Lymington	South West Forest, poor access to SUHT, closer to Royal Bournemouth Hospital, relatively easy access to Lymington	Southern Test Valley, relatively easy access to SUHT, links to Winchester.
Potential of service	Potential to absorb rehabilitation patients from wider geographical area	Potential to absorb rehabilitation patients from wider geographical area	Potential to maximise outpatients services for the management of long term conditions	Potential to host orthopaedic rehabilitation	Potential to host more orthopaedic and stroke rehabilitation
Range of services available	Has small outpatients department which is under utilised. Base for community pharmacists	Has X-ray service on site. Out of Hours based there.	Has X-ray, phlebotomy. district nurses, physio and podiatry on site. Hosts orthopaedic choice and ortho rehab beds (which are poorly occupied.	Post acute stroke unit based here	Has X-ray, day surgery and endoscopy
Backlog maintenance	£376,000	£379,000	£522,000	£376,000	£330,000

7. Is the current model of care effective?

Based on the data we have collected the South West Hampshire PCT Alliance believes we have the potential to offer a far more effective model of care. Although we have the benefit of a large number of community hospital beds we are not necessarily using them to provide the most appropriate care for our patients.

Two recent clinically accredited audits undertaken by the specialist consultancy 'Teamwork' (see appendix F) showed that a high number of patients are being cared for in the wrong care setting for their health needs. The audit demonstrated that 84% of our community hospital beds were being used by people who did not need that level of care. Of these 84%, many could be cared for at home, and some required care in care home settings. This means too many people are staying in hospital beds across South West Hampshire, when they do not need that level of care. Not only is this expensive and unnecessary, but it does not provide people with the best rehabilitation outcomes nor give them the best chance of staying independent at home.

There are, of course, times where care at home is not safe and appropriate and whilst we would always wish to support people's desire to remain at home, there will obviously be times when this is not safe or practical. There will always be times when people need a bed-based care setting and the Alliance is committed to providing this.

The majority of our budget (£187million) is spent on buying (commissioning) acute emergency care for patients - in other words urgent care services that are provided at large district general hospitals. Over the past three years emergency admissions have increased by nearly 20% across the South West Hampshire PCT Alliance area. We do not believe this is because the health needs of our population have deteriorated significantly during this time. Initial findings indicate that:

- we have not been as effective as we should in managing long term conditions;
- we have not monitored the health needs of our older, most vulnerable population across the whole area. Where this has been done we have evidence to show that we have been able to support these people in their homes so they can remain independent; and
- when the Out of Hours Service was first introduced there were some problems in co-ordination and subsequently more people attended Accident and Emergency facilities.

Our Community Hospitals are at present not running as efficiently and effectively as they should, there are empty beds, and not all patients across the South West Hampshire PCT Alliance have access to them. The majority of our resources are used to buy acute hospital care or provide community hospital care and this means we have not been able to concentrate our resources on providing more community services that will both prevent unnecessary hospital admissions, and provide the most effective type of rehabilitation.

8. What needs to change?

We recognise that the majority of our individual services are excellent, and provided by a hard-working and highly skilled workforce. However some of the models of care we have in place are outdated, do not offer good value for money, or the best possible outcomes for patients.

Across the South West Hampshire PCT Alliance evidence has shown us that we are using hospital beds inappropriately (see appendix F for further details), because we do not have the right services in place in the community. Across the whole South West Hampshire PCT Alliance area, we are admitting too many people to acute hospitals who would be able to live healthy and independent lives at home with the right level of support and care.

We have had helpful feedback from our stakeholders who have told us that it is currently very difficult to access our community-based services as they are disparate and are not available every day (see appendix B). Some of our GPs have told us that they often have to admit patients to hospital because they

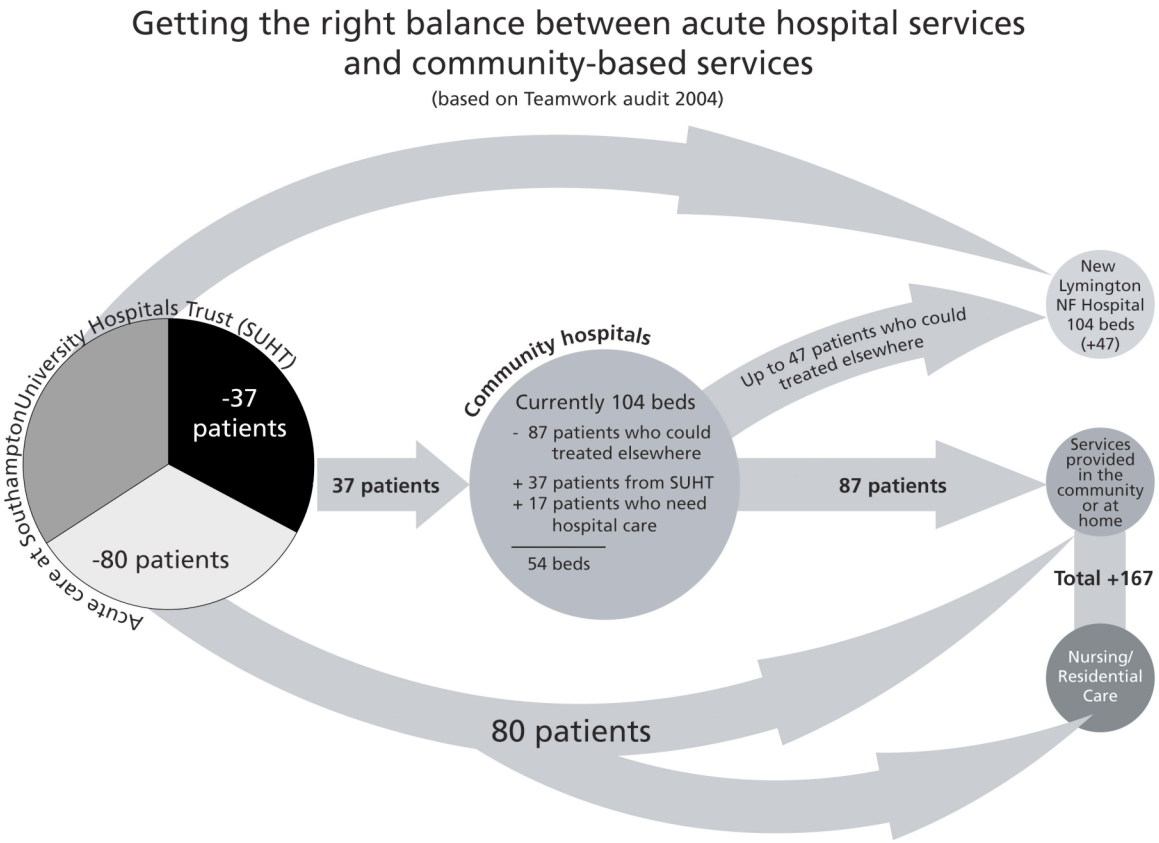
cannot access community services, even if the patient is not sick enough to need a hospital bed. The Accident and Emergency Department at Southampton General Hospital have reported that many patients go to the department because of social or other reasons (e.g. a piece of equipment breaking down). Without easy, 24 hour access to appropriate support or solutions from community services there is no alternative but to admit these patients to hospital.

Therefore, the current type of service we are providing does not offer the right care, in the right place, at the right time. Most of our resources are spent on hospital-based services and this is preventing us from developing and expanding appropriate and effective community-based services.

It is also important to recognise the impact of the new Lymington Hospital on the total number of beds that will be available across the Alliance. There will be an additional 44 beds available in a state-of-the-art health care setting. The development of this hospital will play a crucial part in how any changes are phased in. When the facilities are complete we will be able to care for more people in the new hospital and will need fewer facilities elsewhere.

It should be noted that our existing community hospitals provide more than in-patient beds. If inpatient beds do close it may be decided to reprovide outpatient clinics and other community hospital services in an alternative, appropriate local setting such as GP surgeries.

The following diagram illustrates the concentration of resources in hospital-based services and shows the potential to release these resources to expand community services.



9. How we developed our proposals

The first step to improving and developing local health services involved discussing possible options for the future with the Hampshire and Isle of Wight Strategic Health Authority and our partner organisations such as Patient and Public Involvement Forums, acute hospital Trusts, Hampshire County Council Social Services, Hampshire Partnership NHS Trust, New Forest District Council, Eastleigh Borough Council, Test Valley Borough Council and Hampshire Ambulance Service NHS Trust.

These discussions led to the production of a Community Services Strategy discussion document in April 2005 - a paper outlining high-level strategic options for the future of services for older people.

Subsequently, agreement was reached that the South West Hampshire PCT Alliance should put forward a proposal for consultation that:

- outlines evidence-based alternative services for older people to help them stay at home whenever safe to do so;
- is community based with less reliance on bed-based services;
- will reduce the need for emergency acute hospital care;
- is equitable for patients no matter where they live in the Alliance; and
- is joined up with other current initiatives, for example the new Lymington Hospital and the South West Hampshire PCT Alliance review of maternity services.

10. How have local stakeholders been involved?

Both PCTs are committed to:-

- listening and learning;
- being responsive to the needs of service users and carers; and
- maintaining strong, effective partnerships.

We recognise that the NHS is constantly changing and developing the services that it provides. In order to provide services that are appropriate for the needs of patients and carers, we must seek out and listen carefully to the views of a range of stakeholders. We have therefore done the following:

- involved a wide range of stakeholders, including representatives from the Patient and Public Involvement Forums (PPIF) who are full members of the Project Board and Steering Group;
- conducted a 'listening exercise' which took place between April and June 2005 with the purpose of listening to and learning from stakeholders. This has been achieved by:
  - setting up a reference group of 40 local people to discuss the options (four meetings held);
  - issuing over 1000 questionnaires to the public (so far over half have been returned);
  - letters about the Strategy sent to 64 local stakeholders;
  - holding six annual public meetings (Hamble, Eastleigh, Romsey, Fordingbridge, Hythe, Lymington), where details about the strategy were available;
  - conducting one-to-one interviews with patient, staff and GPs;
  - meetings with both PCTs' Patient and Public Involvement Forums, community groups such as the New Forest Older Persons Focus group, staff, local councils, MPs and Leagues of Friends;
  - attending the New Forest District Council Public Meeting;
  - a dedicated address for letters and comments with over 100 comments received (to date);
  - discussion at Public Board Meetings; and
  - receiving a petition from the Friends of Lyndhurst Surgery and the Fenwick Hospital League of Friends.

Further information can be found at appendix B

11. What are we proposing?
Having undertaken a thorough review of community services and community hospitals across the South West Hampshire PCT Alliance we know we are not providing services that provide the best outcomes for patients or are cost effective. We think that we can make better use of our resources by improving and modernising patient services in line with local needs and national requirements. In order to bring services up to 21st Century standards and to ensure they are value for money any changes we make will need to be wide-scale – we are not going to make a significant difference to the quality and delivery of services by tinkering at the margins!

A new model of care
We plan to build on some of the work already undertaken in the South West Hampshire PCT Alliance by enhancing locally based teams of health care professionals. These locality teams will be made up of a range of health professionals and care staff working together in a local area. The teams will be managed centrally and have a single point of access that is staffed 24 hours a day. Other more specialist services, such as Rapid Response and specialist nursing will be provided centrally.

The diagram overleaf shows how these services might be constructed:

Locality-based older persons community services

Community nursing rehabilitation

Long term condition management

Centralised Alliance services for older people

24/7 single response bed management

Acute Admissions alternatives

Rapid Response

Condition specific support services

Acute care

What will the new service consist of?
We plan that this model will enhance services by ensuring that care is delivered in a systematic and coordinated way, in locality teams where appropriate or by Alliance-wide specialist services. This will focus on:

1. Preventing illness and injury:
    - More community services focusing on illness and injury prevention, such as expert patient programmes and a falls prevention service. This work will be delivered by a range of health professionals working at a local level including practice nurses, community nurses, community matrons, rehabilitation assistants, therapists, specialist nurses and partner organisation staff. There may also be centralised clinics to provide advice, support and proactive management such as falls clinics.

2. Providing planned and systematic care to help people with long term conditions stay well, including:
    - more Alliance-wide and locality specialist services to provide on-going support for people with long term conditions (e.g. diabetes, heart disease etc) delivered by specialist health professionals such as specialist nurses or GPs with Special Interests at local facilities such as GP surgeries;
    - health services 24 hours a day, seven days a week at a local level including extra hours for community nursing and Rapid Response teams;
    - community matrons, who will be responsible for ensuring especially frail and vulnerable patients in a particular locality receive the right care and treatment; and
    - locality teams working actively to help those older and frailer patients who have one or more long term conditions which puts them at risk of becoming acutely ill or their care breaking down. We will identify these patients in each locality and set up mechanisms to ensure their health needs are monitored. We will work closely with Social Services to ensure that social and personal care needs are met. We have already piloted this model of care on a small scale in Milford-on-Sea, where it has been shown to prevent hospital admission.

3. More care for those who have suffered illness or injury to prevent hospital admission or help people get home from hospital sooner with appropriate home support, including:
    - expanded community rehabilitation teams in each locality. These teams, made up of rehabilitation assistants, therapists, and nurses will provide more rehabilitation in people's homes or at local facilities;
    - expanded rapid response teams to provide emergency assessment and support available 24 hours a day;
    - additional consultant medical cover which will provide some medical sessions in the community;
    - specialist night sitting services;
    - day rehabilitation for patients at local centres;
    - clear protocols with Social Services, Hampshire Ambulance Trust and acute hospitals to ensure that patients are only admitted to hospital when clinically necessary; and

- expanded teams to visit patients in A&E or in acute hospitals and smoothly and promptly arrange transfers to care settings which most appropriate for patients needs.

4. In-patient care for those that need it:
   - this will be provided at one of the remaining community hospitals, subject to the outcome of the consultation process, or at another suitable facility commissioned by the PCTs (such as nursing homes, specialist rehabilitation units like the new Brendoncare Knightwood facility due to open next year, or 'extra care' housing like Rowan Court in Eastleigh).

12. How will these changes affect staff?

All of the options will mean the provision of a range of health services which will require recruitment to multi-professional teams. We value the huge contribution of our committed staff and our aspiration would be to re-deploy any staff affected by the proposals.

13. Would the proposed changes work?

The following case study demonstrates how this service model might change care for our older population.

<table>
<tr><th colspan="2">Case study</th></tr>
<tr><td colspan="2">Mr X is 85 and has tablet controlled diabetes. He lives with his wife who has recently become forgetful. He had three hospital admissions last year. Two of these were for urinary tract infections and the third was when he became unwell as a result of poor blood sugar control.
Mr X becomes unwell one Friday night in July, with a raised temperature and a pain in his side. His wife calls the out of hours service, who visit him and think he may have a urinary tract infection.</td></tr>
<tr><td>NOW
He is taken by ambulance to A&E and is admitted to a ward.

Without proper care at home Mrs X slips over while feeding the cat the next morning. A neighbour sees her and calls the doctor who thinks she may have fractured her wrist. She is taken by ambulance to A&E. She has an X-ray, and her wrist is not fractured but she has a nasty sprain. She is upset and worried about her husband, and doesn't think she will be able to cope at home with her sore wrist, and it is noted that she is a little confused. The staff at the hospital think she could be helped by some rehabilitation to improve her confidence. She is admitted to a</td><td>FUTURE
The out of hours doctor starts Mr X on broad spectrum anti-biotics and calls the Alliance Community Services.

A rapid response carer comes to see Mr and Mrs X to ensure Mr X drinks plenty of water to help with his infection. She leaves them with a phone number to call in case they have any concerns during the rest of the night. The next morning another carer from Rapid Response visits and helps Mrs X get breakfast the next morning and feeds the cat for her.

The same morning, a community nurse comes out to review Mr X. His temperature has come down and he is feeling better although still not quite well enough to get up. The nurse</td></tr>
</table>

community hospital. Mr X has his urinary tract infection treated with anti-biotics. After one week in hospital it is agreed he no longer needs to be there, although he is quite frail. As his wife is in the Community Hospital, staff agree to wait for a bed in the same hospital. This will take about a week. Unfortunately, Mr X gets an infection which makes him unwell and he remains in the acute hospital for a total of 21 nights before being transferred to the community hospital. After a further week in the community hospital for Rehabilitation, Mr and Mrs X return home with a package of care.	also notes that Mrs X is a little confused and advises her GP. The nurse feels that Mr and Mrs X would benefit from support at this time and arranges for two visits a day from the Rapid Response team for the next five days, whilst Mr X is recovering. She visits Mr and Mrs X for the next three days to assess and monitor their health needs. The nurse undertakes a detailed assessment with Mr X and ascertains that he often gets urinary tract infections in the summer, because he doesn't always drink enough water, and likes to indulge in sugary ice lollies. She advises him to drink at least two litres of water a day and recommends sugar free ice lollies. She keeps a note reminding her to call or visit Mr X each spring to remind him about the ice lollies. After five days Mr X is better. The Rapid Response service is stopped; however, he has telephone contact from the community team to make sure he is keeping well.

The left hand side of the case study above illustrates how patients are currently admitted to hospital because there are limited alternative services to care for them in the community. We believe that by improving our community services and making them more accessible as described above, we will significantly be able to both prevent people from becoming unwell as a result of their long term conditions, and for those people who do become unwell, we can put in place safe and appropriate services to prevent unnecessary hospital admission.

14. How will this new model of care be achieved?
Two principal options are being proposed within this paper:

> **Option one –** proposes the expansion and development of a community-based service for older people by releasing resources currently tied up in acute hospital beds and community hospitals. This option proposes a reduction of between 27 and 55 community hospital beds and will therefore lead to the closure of two or more of our community hospitals. Therefore option one contains four sub-options each of which sets out different possibilities for which sites could be used and which would need to close.

Option Two - proposes the expansion and development of a community-based service for older people by releasing resources currently tied up in acute hospital beds and all community hospitals. Under this option in-patient beds would be purchased from other settings, such as nursing homes or provided settings in 'extra care' sheltered housing.

What are the options aiming to achieve?
The two options within this proposal are both intended to:

- modernise and improve the care that older people receive by developing and expanding community based services thereby reducing the need for hospital admission, or helping people to come home sooner following an illness or injury
- put the quality and safety of patient services first. They aim to ensure that patient care is neither compromised by inefficient or outdated models of care or by providing services in accommodation which is no longer appropriate for the delivery of modern health care.
- allow both financial resources and existing staff to be re-deployed in new, high quality, flexible services that will support older people in a variety of settings.
- save the NHS millions of pounds on backlog maintenance and converting out-of-date buildings. This money can then be spent on making improvements to health care services.
- help us run services more efficiently and improve our financial position. We anticipate that our plans will generate revenue savings of up to £3million per year to contribute to the shortfall in funding existing services.
- ensure equality of access to all our services.

How will these options benefit local people?
The benefits of this approach include:

- preventing some of the problems which cause admission to hospital
- helping patients to recover more quickly from illness and injury and supporting people to be independent within their own homes whenever possible
- more choice for patients and their carers available through the development of a wider range of community based services; and
- if people are cared for at home, there is less risk of infection being passed from patient to patient and less risk of patients becoming disorientated and institutionalised just by being in hospital (however good the care).

Any proposal to re-provide services will be required to:
- enhance community based services across the Alliance;
- fulfil the requirements of national strategies and the work plans of our of partner organisations, specifically:
    - **National Service Frameworks**
    - **Public Service Agreement for Hampshire County Council Social Services** which sets out a target to achieve a 10% reduction in emergency admissions.

- **Single Surgical Services proposals** for hospitals in Southampton and Winchester
- Public consultation proposals for the **rehabilitation services at Tom Rudd unit, West End**
- Public consultation proposals for the **maternity services,** due in August 2005
- Public consultation proposals for **Out of Hours Services**
- The clinical strategy for the **Lymington New Forest Hospital**

- note that all community hospitals have active Leagues of Friends who have raised significant sums of money to improve the facilities in their local hospitals. It is also recognised that local communities are very attached to their community hospitals and any plans around service changes have the potential to be very emotive.
- ensure that all patients should have equal access to all services which includes community beds, wherever these are provided. There must be clear and transparent admission criteria and all those wishing to access this type of care should have the same rights of access based on patient need.
- share medical care between General Practitioner and consultant.
- make the most efficient use of resources available to the local NHS to help us achieve financial balance and to create a strong foundation for the future development of services;
- take account of local concerns regarding transport for residents in the Alliance area. Our aim, by helping more people to remain within their own homes, where safe to do so, goes some way towards alleviating this concern. However, public feedback has highlighted that our population find it difficult to access acute hospitals for diagnostics, outpatient services and visiting. Further work needs to be undertaken with our partner organisations and providers of community transport to better understand exactly where the constraints are;
- focus on ensuring patients only have the required length of in-patient stay and are not subject to unnecessary delays in transfer between care settings, or between hospital and home, and a key factor within our strategy is to focus part of our community services on in-reaching to acute and community hospital settings to ensure patients can come home as soon as possible; and.
- be consistent with other local priorities

15. Analysis of the options

In analysing the options we needed to assess which community hospital beds 'fit' with the new service models to provide the greatest benefit for patients. To this end, we have taken a number of factors into consideration. These are detailed in the table overleaf.

NB: It should be noted that maternity services are not part of this consultation and the options below do not include maternity beds. A separate consultation on the future of local maternity services will be launched later in the summer and the outcome of this will be considered alongside that of this consultation.

Option 1
There are a number of ways in which option one could be achieved. Having analysed data from all of our community hospitals we have concluded that there are four main ways in which the closure of some inpatient beds could be taken forward. It should be noted that the purpose of this consultation is to find out what you think about our proposals and we will use your feedback to inform the final decision.

Option 1a:
This option involves expanding and developing community-based services by releasing resources currently tied up in acute hospital beds and community hospitals. This would mean keeping the beds at the Fenwick Hospital closed, closing the in-patient rehabilitation beds at Hythe Hospital and transferring Hythe's orthopaedic step-down beds to Milford-on-Sea Hospital.

The rationale for this option is as follows:

- the population in the Milford area is the oldest across the Alliance (50% are aged over 50) and the area has the highest incidence of stroke and fractured neck of femur; and
- this area of the Alliance has the greatest number of people who do not own their own transport (9.3%).

How could we achieve this option?

- By maximising the outpatient services at Hythe Hospital and expanding day services for long term conditions such as diabetes and coronary heart disease.
- By specialising in orthopaedic rehabilitation which would enable us to transfer some of our patients who currently use Christchurch hospital to Milford-on-Sea Hospital. This would reduce our commissioning budget with Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust.

Option 1b:
This option involves expanding and developing community-based services by releasing resources currently tied up in acute hospital beds and community hospitals. This would mean keeping the inpatient beds at Fenwick Hospital closed and closing the inpatient beds at Milford-on-Sea Hospital.

The rationale for this option is as follows: -

- Milford-on-Sea is very close to Lymington (only 4 miles) where the new hospital with its rehabilitation in-patient services will be available (from 2007; and
- this option would allow us to retain the orthopaedic step-down beds at Hythe Hospital, linked to the Orthopaedic Choice service.

How could we achieve this option?

- By transferring Milford-on-Sea Hospital's rehabilitation and stroke beds to the new Lymington Hospital in 2007; and
- By using rehabilitation beds at another New Forest Community Hospital or at Christchurch Hospital until the new Lymington hospital opens.

Option 1c:
This option involves expanding and developing community-based services by releasing resources currently tied up in acute hospital beds and community hospitals. It would mean closing the inpatient rehabilitation beds at Hythe Hospital, Milford-on-Sea Hospital and keeping the inpatient beds at Fenwick Hospital closed.

The rationale for this option is as follows:

- it fits into the modelling of total beds needed once Lymington Hospital has opened (see Teamwork Audit summary Appendix F) and matches most closely the amount of beds we actually need; and
- this would enable a greater amount of investment to be made in community based services.

How could we achieve this option?

- By transferring Orthopaedic Rehabilitation to Romsey Hospital
- By developing community services to provide 24 hour/7 day a week support
- By phasing the closure of inpatient beds to link with the opening of the new Lymington Hospital

Option 1d:
This option involves expanding and developing community-based services by releasing resources currently tied up in acute hospital beds and community hospitals. This would mean re-opening the Fenwick Hospital and closing the inpatient rehabilitation beds at Milford-on-Sea and Hythe Hospitals

The rationale for this option is as follows:

- Milford on Sea is very close to Lymington (only 4 miles) where the new hospital with its rehabilitation in-patient services will be available (from 2007); and
- the Fenwick Hospital is in a central location and allows easy access to both Southampton General and the Royal Bournemouth and Christchurch Hospitals.

How could this be achieved?

- By maximising the outpatient setting at Hythe Hospital and expanding day services for long term conditions such as diabetes and coronary heart disease.
- By transferring Milford-on-Sea Hospital's rehabilitation and stroke beds to the new Lymington Hospital in 2007.

Fordingbridge Hospital and Romsey Hospital have been excluded from option one because:

Romsey Hospital has under recent years diversified to provide a wide range of services including a state-of-the-art X-ray service, endoscopy and day case surgery. It also has an out patients service which has the potential to expand.

There is also the potential to further develop the day case and endoscopy services. More rehabilitation services could be provided from Romsey with the transfer of activity from the Western Community Hospital.

Fordingbridge Hospital serves a population that is comparatively isolated from other areas within the New Forest and has poor public transport links. The hospital has an out patients department and X-ray service which are under utilised and have the potential for expansion. It has a key link to Salisbury Hospital.

However the Alliance will need to ensure that reasonable occupancy levels are achieved and sustained at these sites to ensure they meet the needs of our population and remain viable.

Option 2
This option involves expanding and developing community-based services by releasing resources currently tied up in acute hospital beds and community hospitals .This would mean a phased approach to closing all of the community hospital based in-patient beds across the South West Hampshire PCT Alliance area. These services would be replaced by community teams and improved community services along with the purchase of beds from nursing homes and extra care housing for patients.

The rationale for this option is as follows:

- The modelling undertaken as part of the Teamwork audit demonstrated that 84% of our current community hospital beds were used inappropriately and on this basis, there is a strong case for closing all in-patient beds and using other care settings.
- There is a considerable body of evidence to show that care provided in people's homes promotes recovery.
- This model offers greater flexibility, allowing us to purchase rehabilitation beds as and when we need them close to patients' homes.

How could this be achieved?

- This model operates successfully in other parts of the country where traditionally there have never been community hospitals, or community hospital beds have been closed. In Ashford, Kent, this has been successfully achieved by providing intermediate care and rehabilitation in either nursing home beds, or extra care sheltered housing. There is a strong ethos of returning people to their own homes. More locally, a similar service is being implemented in Eastleigh to replace beds previously provided at the Mount Hospital in Bishopstoke.
- Modelling undertaken in the Community Services Strategy has demonstrated that the Alliance needs between 27 and 55 beds. These could be purchased from local nursing homes at an average rate of £650 per week. This would incur a cost to the PCT ranging from £912,600 per annum (for 27 beds) to £1,859,000 (for 55 beds).

Risks and benefits of options 1 and 2

Option 1 Benefits	Option 1 Risks	Option 2 Benefits	Option 2 Risks
Offers choice of care setting	Does not enable sufficient savings across the South West Hampshire PCT Alliance to establish full service re-design and meet some of our financial saving targets	Enables some community hospital settings to be re-focussed to provide centres of excellence for long term conditions as part of extended day services	Heavy reliance on our ability to successfully manage patients in home settings. Does not maximise opportunities for day and diagnostic services in local settings
Retains some of our community hospitals	There will be difficult decisions about which hospital beds should be retained	Links into the additional nursing homes being provided in the County	Lack of extra care sheltered housing in the New Forest
Will provide an equitable service across the Alliance area			It may be difficult to purchase sufficient nursing home beds within the Alliance area
Allows specialisation for stroke and orthopaedic rehabilitation			May not enable the Alliance to meet future needs of ageing population

Milford-on-Sea, Hythe and Fenwick hospital sites are owned by New Forest PCT. If any site is no longer required for the provision of NHS services then the Trust will dispose of the land.
It is a requirement of the Department of Health that NHS land be sold for the most advantageous price in order to ensure that the maximum funds available are returned to the local NHS. For this reason it is not possible to stipulate who might purchase the land or what any prospective owner may develop on the site. Should the site be developed by a new owner then their plans will be subject to the usual planning consent from the Local Authority. Any funds gained from the sale of the land would help fund other NHS services.

16. Conclusion
The South West Hampshire PCT Alliance has established that it does need to refocus services for older persons to ensure that we provide the most effective health services in terms of clinical evidence, value for money and

appropriateness of care setting. Whilst this is a laudable aim, it does require us to refocus our resources away from community hospital beds in order that we can focus on a more community based service. This paper has attempted to demonstrate the evidence and rationale (using national best practice guidelines) for treating more people within their own homes, both in preventing emergencies and enabling prompt and safe discharge from hospital.
The consultation process will help us to engage with our population to move forward on a mutually agreeable option.

17. How can local people make their views known?
Both PCTs in the Alliance are committed to providing a continuous consultation process with all stakeholders and this extends beyond health care professionals to patients, carers and the local community.

In February 2003, the Department of Health issued Strengthening Accountability. This document provides policy and practice guidance to the NHS based on Section 11 of the Health and Social Care Act 2001. It sets out the requirements upon all NHS organisations to involve patients and the public in the decisions about their local health services.

The aim of Section 11 is to make sure that patients and the public are involved and consulted from the very beginning of any process to develop or change health services and that this continues throughout the process. The Department of Health describe this as "discussing with patients and the public their ideas, your plans, their experiences, why services need to change, what they want from services and how to make the best use of resources."

The NHS is now also required to consult the Overview and Scrutiny Committee of the Local Authority on proposals that are deemed to involve substantial development or variation to local health services. This is detailed in section 7 of the Health and Social Care Act 2001. Patients and the public are encouraged to send their comments directly to the South West Hampshire PCT Alliance, but may also send their comments on the proposal direct to the Overview and Scrutiny Committee. Their details are:

Hampshire County Council Health Review Committee
The Castle
Winchester
Hampshire
SO23 8UD

Some stakeholders will be aware of the work undertaken over the last five months. However to ensure that all stakeholder groups have the opportunity to shape the service model, we are now seeking to expand our discussions to include other stakeholder groups and invite feedback.

All comments received up to and including 30 September 2005 will be considered in the development of the proposed service model. Throughout this time the Alliance will receive and consider the views of stakeholder groups and Hampshire Health Review Committee.

You can make your views known regarding the outline proposal and, or comment on the service model on or before 30 September 2005.

In writing to:

The Consultation Office
South West Hampshire PCT Alliance,
8 Sterne Road
Tatchbury Mount
Calmore
Southampton
SO40 2RZ

A response form is included on page 31 of this document for your convenience.

Alternatively you can comment to us by:

- emailing **consultations@swalliance at nhs.uk (please mark your email Community Services)**
- telephoning the Alliance office on 023 8087 4352
- at a public meeting, details of which are:

Area and venue	Date	Time
Hythe Hythe Community Centre Brinton Lane Hythe. SO45 6DU	Wednesday 20th July	6pm
Milford All Saints Church Hall Greenbanks Close Milford on Sea. SO41 0SQ	Thursday 21st July	2pm
Fordingbridge Avonway Community Centre 36 Shaftesbury Street Fordingbridge. SP6 1JF	Wednesday 27th July	2pm
Lyndhurst Community Centre (off The Car Park) High St Lyndhurst. SO43 7NY	Thursday 28th July	6pm
Romsey Town Hall Market Place Romsey. SO51 8YZ	Friday 29th July	10.30am
Eastleigh Wells Place Centre Eastleigh Baptist Church Wells Place Eastleigh. SO50 5LJ	Tuesday 13th September	6pm

Ringwood Salvation Army Hall Christchurch Rd Ringwood. BH24 1DL	Wednesday 14th September	2pm
Hamble St Andrews Priory Centre High Street Hamble. SO31 4JF	Tuesday 20th September	2pm
Lymington (NEW VENUE) Masonic Hall 10 High Street Lymington. SO41 9AA	Thursday 22nd September	6pm
Totton Hanger Farm Arts Centre Aikman Lane West Totton. SO40 8FT	Thursday 29th September	6pm

What happens next?
Anyone wishing to make their views known should contact the Consultation office as outlined above. Comments received will, where feasible, inform the service model.

Following the consultation period, a report will be prepared for consideration by the PCT Boards in October 2005 who will then make a decision on the best way forward. This will include:

- implementing the agreed model without detriment to the quality of care provided;
- decommissioning some or all of the current in-patient beds, based on the result of the consultation process; and.
- undertaking a post implementation review to identify whether the requirements of the project have been achieved.

Making your views known
You can use this form to let us know your views on the Community Services for Older People. Please continue overleaf or on a separate sheet if you wish.

Your comments should be sent by post or fax to the address below so that we receive them on or before 30 September 2005. You can also email us your comments on consultations@swalliance at nhs.uk

Your name (optional)……

Your address (optional)……

……....

……..

……..

What would you like to tell us about the proposals? (for example, new and different factors that should be considered in the PCTs analysis, issues that strengthen the case for either option)

Please return by 30 September 2005 to:
The Consultation Office, South West Hampshire PCT Alliance, 8 Sterne Road, Tatchbury Mount, Calmore, Southampton, SO40 2RZ

Fax ……

Please tick this box if you would like to receive an acknowledgement. ☐

Appendix A

Glossary

Primary Care Trust (PCT)	Organisations that bring together all primary care practices in an area. They are independent NHS bodies with greater responsibilities and powers. They were set up in response to the Department of Health's Shifting the Balance of power and took over many health authority functions. PCTs are responsible for: • Improving the health of their population • Integrating and developing primary care services • Directly providing community health services • Commissioning (buying) secondary care services PCTs are increasingly working with other PCTs, local government partners, the voluntary sector, within clinical networks and with 'shared service organisations' in order to fulfil their roles.
Intermediate Care	Services that are designed to prevent unnecessary hospital admissions and which enable people to live independently at home through the provision of additional home care and other support.
Audit Commission	A public body responsible for ensuring that public money is used economically, efficiently and effectively. The Audit Commission carries out national research on the public sector to monitor performance and ensure that local authorities and NHS organisations are providing cost effective services.
National Service Framework (NSF)	Guidelines for the health service from the Department of Health on how to manage and treat specific conditions, or specific groups of patients e.g. Coronary heart Disease NSF, Mental Health NSF. Their implementation across the NHS is monitored by the Healthcare Commission.
Stakeholder	The range of people and organisations that are affected by, or have an interest in, the services offered by an organisation. In the case of PCTs it includes patients, carers, staff, unions, voluntary organisations, local authorities, social services, health authority, GPs, neighbouring PCTs, Patient and Public Involvement Forums and NHS trusts.

Community matron	A senior nurse working in the community, specifically look after the needs of the most frail and vulnerable patients and ensure they receive the right services.
Geriatrician	A doctor who specialises in diagnosis and treatment of diseases affecting older people.
Outreach clinic	A clinic for outpatients held near to where they live rather than in the hospital where they may have received treatment.
ETVSPCT	Eastleigh & Test Valley South Primary Care Trust.
Step Up Care	Step up care – when a patient is transferred from the community to a bed based unit.
Step Down Care	Step Down Care – When a patient is transferred from secondary care (hospital based) to a short term facility with specific focus on rehabilitation to allow the patient to return home.
Strategic Health Authority	There are 28 Strategic Health Authorities, responsible for developing strategies for local health services and ensuring high-quality performance. They work with NHS trusts and PCTs that are not meeting targets to find ways of improving their performance.
Overview & Scrutiny Committee	Since January 2003 local authority overview and scrutiny committees have had the power to scrutinise the NHS. The Health and Social Care Act, 2001 (HSCA) provided new powers to overview and scrutiny committees to those local authorities with social service responsibilities Overview & Scrutiny Committee can review and scrutinise all matters relating to the planning, provision and operation of health services in the area of local authority.
Hampshire County Council Health Review Committee	Hampshire County Council Health Review committee is the local name for 'Overview and Scrutiny Committee'. Please refer to the Overview and Scrutiny Committee above for the definition.
Re-provide	Transferring services from one (unsuitable) setting to an alternative care setting.
Out of Hours (OOH)	The primary care on call service which operates during evenings, nights and weekends.

Appendix B

How we have listened so far

How have we engaged with staff and stakeholders to date?

Since the South West Hampshire PCT Alliance started the community services strategy in January 2005, we have been committed to listening to our patients, staff and the local population.

Community Services Questionnaire

Since February 2005, we distributed over 1000 questionnaires to patients using our services (such as District Nursing, Community Rehabilitation, GPs and Community Hospitals) and members of the public. We also made the questionnaire available on our website and have distributed this widely at public meetings. So far we have received over 500 completed questionnaires.

Stakeholders

We have written to 64 stakeholders sending copies of the strategy and inviting their feedback.

Public Meetings

During April the South West Hampshire PCT Alliance held its annual round of public meetings. At each of these there was a stall for the Community Services Strategy, and where requested, the Alliance management team were able to give informal presentations of the strategy and the public had the opportunity to ask questions.

In addition, the South West Hampshire PCT Alliance has been invited to a number of other public meetings organised by other stakeholders. This includes a New Forest District Council public meeting and a meeting organised by the Fenwick Hospital League of Friends and Friends of Lyndhurst Surgery.

Patient and Public Involvement Groups

We have worked with a number of patient and public involvement and other local groups in the development of our proposals for community services. This includes the New Forest and Eastleigh and Test Valley South Patient and Public Involvement Forums, Eastleigh and Test Valley South Local Implementation Team and the New Forest Older Persons Focus Group.

Community Services Strategy Project Board and Steering Group

We have Patient and Public Involvement Forum representatives as full members of both these groups.

One-to-one interview with patients

We have commenced a series of one-to-one interview with patients to ascertain their views about services for older people.

Staff involvement
We have employed a variety of mechanisms to engage with staff across the South West Hampshire PCT Alliance. This includes our monthly team brief which goes out to all staff, and director visits to sites.

We have also produced regular updates on the strategy which have been widely distributed across the Alliance.

Staff have also been offered one-to-one interviews with a member of the project team to discuss the project and to give the opportunity for input to the service model and these have been taken up by a variety of staff working with older people.

Members of the project team have also attended a variety of staff meetings, such as the Senior Managers Forum, the Practice Managers Forum and GP practice meetings with the same purpose.

A workshop was held with staff on July 11, with facilitation from the Department of Health's Health and Social Care Change Agent Team.

What have we heard?
We have heard a wide range of views from our patients, public and staff during the past five months. This has included the completed questionnaires. These have all been fed into this consultation document and views heard throughout the consultation process will help us to ascertain which model we will pursue.

The views we have heard include the following key highlights:

- our community services can be difficult to access, especially by other organisations;
- we should have a single point of access;
- whilst many respondents are in favour of helping people to be able to stay at home, some raised queries about the feasibility of this;
- local access to diagnostics was seen as important;
- it was noted that patients experience difficulty in parking at local acute hospitals and raised concerns about cleanliness in large hospitals;
- our community nursing services were highly praised;
- members of the public felt that where large sums of money had been raised for local hospitals, it would be a shame if these were lost if sites were to close; and
- if community hospital beds were to close, could the community hospitals be put to another use for the community – for example a complementary therapy centre, or centre of excellence for long term conditions.

Appendix C

SUPPORTING POLICY DOCUMENTS GUIDE

Title: Published: Website:	National Service Framework for Older People September 2002 by the Department of Health dh.gov.uk
Title: Published: Website:	National Service Framework for Long Term Conditions March 2005 by the Department of Health dh.gov.uk
Title: Published: Website:	National Beds Enquiry February 2002 by the Department of Health dh.gov.uk
Title: Published: Website:	Health and Social Care Act 2001 2001 by Queen's Printer of Acts of Parliament hmso.gov.uk/acts/acts2001/2001 0015
Title: Published:	Communications and Patient and Public Involvement Guidance Resource Pack 2005 by Hampshire & Isle of Wight SHA
Title: Published: Website:	National Standards, Local Action July 2004 by The Department of Health dn.gov.uk
Title: Published: Website:	Involving Patients and the Public in Healthcare September 2001 by the Department of Health dh.gov.uk
Title: Published:	Health Fit – Configuring Health Services in Hampshire and the Isle of Wight January 2004 by HIOW SHA
Title: Published	Intermediate Care Strategy 2003-2006 December 2003 by Jane Barnacle, head of Intermediate Care, ETVS PCT
Title: Published: Website:	NHS Plan July 2002 by the Secretary of State nhs.uk/national plan/nhs/plan
Title: Published: Website:	Forget-me-not Report January 2002 by the Audit Commission audit-commission.gov.uk
Title: Published: Website:	The NHS Improvement Plan June 2004 by the Department of Health dh.gov.uk
Title: Published: Website:	Independence, well-being and choice: Our Vision for the future of Social Care for Adults in England. Social Care Green Paper March 2005 by the Department of Health dh.gov.uk
Title: Published:	Live Long and Better May 2005 by Eastleigh Borough Council.

Title: Website:	Select committee on Health third report July 2002 parliament the stationery office co.uk/ pa/cm200102/cmselect/cmhealth/617/61702.htm
Title: Website:	Ten High Impact Changes dh.gov.uk
Title: Source:	Home versus centre based physical activity programs in older adults (Ashworth et al 2004) The Cochrane Database of Systematic Reviews 2005 Issue 2
Other Websites	ageconcern.org.uk: helptheaged.org.uk: Changeagentteam.org.uk

Appendix D

Financial Information to support this consultation

The basis behind this proposal is as follows.

1. The current health services we are offering to older people are neither based on best practice, nor offer value for money. The reasons for this are outlined within the consultation document.
2. We wish therefore to transform our service model to improve the care we provide, make better use of our budget and in addition we anticipate we will make some savings.
3. At this stage, prior to knowing the results of the consultation process we can only estimate how the financial flows will be affected, and this is right and proper as we cannot pre-determine the outcome of consultation.
4. We can however offer some clear facts about the current situation.
5. The current costs of running our community hospitals (excluding staff costs) is £2.23M per year.
6. The backlog maintenance for our community hospitals is £7.7m (this includes the Graham Unit at Lymington Infirmary).
7. We have seen an increase in emergency admissions of almost 20 per cent during the past three years at a cost of £11.9m.
8. We are aiming in partnership with Hampshire County Council Social Services to reduce our emergency admissions by 10% by 2008 which will generate recurrent savings of £2.1m per year. With our current configuration of services, we do not have the ability to meet this saving target. The results of this consultation will help us plan for the extent to which we can reach this target.
9. By removing our resources from some or all of community hospitals and re-deploying staff to support a community based model of care we anticipate we will be able to:
   - Establish the right kind of service for older people with will reduce emergency admissions thus help us achieve the saving of £2.1m
   - Use monies from community bed closures both to support the model of care, and contribute towards our current deficit.

   The following are the running costs for the community hospitals across the Alliance:

   The Fenwick - £0.3m
   Fordingbridge -£0.4m
   Hythe - £0.9m
   Milford-on-Sea - £0.3m
   Romsey - £0.3m

   All of our hospitals - £2.23m (approx)

10. Our available budget for community services is approx £11.9m following achievement of a savings plan of £3.5m. As outlined in this

paper, our redesign of services will help us provide the most effective model of care within this budget.

11. Depending on the outcome of this consultation we could redeploy a staffing budget of between £800,000 to £1,300,000 into community services. We anticipate this being split between rapid response style services and other community nursing and rehabilitation services. We are currently working up a more detailed service model for our locality teams taking into account local demographics, the prevalence of long term conditions and the rate of admissions in each area.

Appendix E

CONSULTATION TIMETABLE

ACTIVITY		DATE
1	Draft 1 of Consultation document	17 June 05
2	Workshop with Overview and Scrutiny Committee	7 July 05
3	Service Model & Consultation Document to be agreed by CEO & Chairs	8 July 05
5	Formal Consultation Commences	11 July 05
6	Staff Workshop, facilitated by the Change Agent Team	11 July 05
6	Public Meetings	Throughout July and September 2005
7	End of Consultation Presented to Boards	30 September 05
8	Results of Consultation Presented to Boards.	October 05
9	Commence Implementation	November 05

Appendix F

Summary of the Teamwork Audit

The needs of **1,375 patients** were assessed during the patient dependency census[1]. This was split:

- **1,284 patients in acute and community beds; and**
- **91 patients in elderly mental health beds.**

Acute and Community

Of the 1,284 patients occupying a bed in an acute and community facility**,** this was split:

- 973 patients at Southampton General Hospital;
- 78 patients at Moorgreen Hospital;
- 49 patients at Lymington Hospital;
- 48 patients at Western Community Hospital;
- 35 patients at Royal South Hants Hospital; and
- 101 patients across a number of community sites at Countess Mountbatten House, Fenwick, Fordingbridge; Hythe; Milford; Romsey and Snowdon.

Under the Appropriateness Evaluation Protocols (AEP), approximately, **54 per cent of patients were identified as AEP positive** i.e. 691 patients who could be defined as requiring acute care. As expected, higher proportion of AEP positive patients were observed within the surgical wards and assessment units with a low proportion identified within elderly care and rehabilitation.

Current Care

Examining the profile of current care provision for all patients showed:

- Approximately **11 per cent of patients** were identified as being **on wards that did not specialise in the condition** they had been admitted for, including some rehabilitation wards, vascular surgery, respiratory, gastroenterology and elderly care;
- 38 per cent of patients were waiting for an inpatient procedure or treatment;
- **32 per cent were waiting for an inpatient investigation, typically clinical laboratory tests, CT/MRI scans, and plain film X-ray;**
- **29 per cent were waiting for an inpatient specialist opinion, predominantly consultant and therapist. Within the community hospital sites, 20 per cent of patients were waiting;** and

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- **19 per cent of patients have an identified discharge date**. At Southampton General Hospital, only ophthalmology and the assessment ward areas achieved in excess of 70 per cent. No other ward areas have more than 50 per cent of patients with an identified discharge date. Within the community hospital sites, 21 per cent of patients had an identified discharge date. However, d**ischarge planning had been initiated for 73 per cent of patients**. The predominant reasons given for not initiating this were that the patient was too sick or still awaiting the doctor's decision. **A delay in the discharge process was identified for 30 per cent of patients** mainly due to awaiting a bed another facility social care package being finalised and patient/family delay.

Alternative Care Settings

In total, 520 (40 per cent) patients were identified for more appropriate, alternative care settings. By site, this was broken down into:

- Southampton General Hospital – 323 patients;
- Moorgreen Hospital – 52 patients;
- Lymington Hospital – 20 patients;
- Western Community Hospital – 33 patients;
- Royal South Hants Hospital – 26 patients; and
- Other community hospital sites – 66 patients.

However, of these patients, 116 patients were assessed as AEP positive i.e. clinically assessed as being acutely ill).

Focussing on those who were AEP negative only (i.e. those clinically assessed as not requiring acute care), there were **404 patients (31 per cent) identified for an alternative care setting**. High proportions were identified within the rehabilitation wards within the community hospital sites and the medicine, elderly care and rehabilitation ward areas of Southampton General Hospital.

Of these 404 patients:

- **76 (19 per cent) required only the normal service of a GP / GP on-call and no nursing support**. Home was the care setting identified for the majority of this cohort of patients;
- **108 (27 per cent) required the normal service of a GP / GP on-call with specialist community nursing and/or district nursing support**. Again, home was the care setting most frequently identified;
- **142 (35 per cent) required the normal service of a GP / GP on-call and either 24 hour registered or non-registered nursing support** provided within a nursing or residential home, community hospital or residential rehabilitation centre; and
- **The remaining 78 patients tended to require a higher level of medical support with a full range of nursing support**. Half of this cohort of patients require consultant / other medical staff support with 24 hour registered nursing mainly provided within a community hospital setting.

A range of therapy support was identified within each of these patient cohorts, the main requirement being for combinations of physiotherapy, occupational therapy and rehabilitation assistant support. No requirement for therapy resources was identified for 109 patients (27 per cent).
Input from social services was identified for 227 patients (56 per cent). Of this, the main requirement was for social worker and home care support worker.

Elderly Mental Health

Three sites were included for review:

- Becton;
- Moorgreen Hospital; and
- Western Community Hospital.

In total 91 patients were reviewed.

Current Care

Examining the profile of current care provision for all patients showed:

- **35 per cent of patients were awaiting the scheduling or outcome of their inpatient procedure or treatment** as part of their therapy / rehabilitation;
- **25 patients (28 per cent) were identified as waiting for an inpatient specialist mental health opinion**; predominantly consultant psychiatrist;
- **14 per cent of patients have an identified discharge date**. However, d**ischarge planning had been initiated for 63 per cent of patients**. For a third of patients for whom discharge planning had been initiated, a **delay in the discharge process was identified** mainly due to awaiting a bed another facility and the social care package being finalised.

Alternative Care Settings

In total, 39 (43 per cent) patients were identified for more appropriate, alternative care settings. **Of these patients:**

- **1 patient required only the normal service of a GP / GP on-call and no nursing support**. Residential rehabilitation centre was the care setting identified for this patient;
- **9 (23 per cent) required the normal service of a GP / GP on-call with community psychiatric nursing support**. Home, nursing home and residential rehabilitation centre were the care settings identified;
- **19 (49 per cent) required the normal service of a GP / GP on-call and either 24 hour registered or non-registered nursing support** provided within a nursing or residential home, or respite care facility; and

- **The remaining 10 patients tended to require a higher level of medical support with a full range of nursing support**. The majority of this cohort of patients require consultant / other medical staff support with 24 hour registered nursing provided within a nursing home and residential rehabilitation centre.

A range of therapy support was identified within each of these patient cohorts, the main requirement being for occupational therapy and rehabilitation assistant support. No requirement for therapy resources was identified for 17 patients (44 per cent).

Input from social services was identified for 67 per cent of patients. Of this, the main requirement was for social worker and home care support worker.

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