Public Document Pack

HEALTH OVERVIEW AND SCRUTINY PANEL

Wednesday, 2nd April, 2014 at 5.30 pm

PLEASE NOTE TIME OF MEETING

Conference Room 3 - Civic Centre

This meeting is open to the public

Members

Councillor Stevens (Chair)
Councillor Claisse (Vice-Chair)
Councillor Bogle
Councillor Cunio
Councillor Laming
Councillor Parnell
Councillor Spicer

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PUBLIC INFORMATION

Role of Health Overview Scrutiny Panel (Terms of Reference)

The Health Overview and Scrutiny Panel will have 6 scheduled meetings per year with additional meetings organised as required.

- To discharge all responsibilities of the Council for health overview and scrutiny, whether as a statutory duty or through the exercise of a power, including subject to formal guidance being issued from the Department of health, the referral of issues to the Secretary of State.
- To undertake the scrutiny of Social Care issues in the City unless they are forward plan items. In such circumstances members of the halth Overview and Scrutiny Panel will be invited to the relevant Overview and Scrutiny Management Committee meeting where they are discussed.
- To develop and agree the annual health and social care scrutiny work programme.
- To scrutinise the development and implementation of the Joint Strategic Needs Assessment and Health and Wellbeing Strategy developed by the Health and Wellbeing Board.
- To respond to proposals and consultations from NHS bodies in respect of substantial variations in service provision and any other major health consultation exercises.
- Liaise with the Southampton LINk and its successor body "Healthwatch" and to respond to any matters brought to the attention of overview and scrutiny by the Southampton LINk and its successor body "Healthwatch"
- Provide a vehicle for the City Council's Overview & Scrutiny Management Committee to refer recommendations arising from panel enquiries relating to the City's health, care and well-being to Southampton's LINk and its successor body "Healthwatch" for further monitoring.
- To consider Councillor Calls for Action for health and social care matters.
- To provide the membership of any joint committee established to respond to formal consultations by an NHS body on an issue which impacts the residents of more than one overview and scrutiny committee area.

Public Representations

At the discretion of the Chair, members of the public may address the meeting about any report on the agenda for the meeting in which they have a relevant interest

Smoking policy – the Council operates a no-smoking policy in all civic buildings.

Mobile Telephones – please turn off your mobile telephone whilst in the meeting.

Dates of Meetings: Municipal Year 2013/14

2013	2014
23 May 2013	31 January 2014
18 July	20 March
19 September	2 April
21 November	29 April
	15 May

Council's Priorities:

- **Economic**: Promoting Southampton and attracting investment; raising ambitions and improving outcomes for children and young people.
- **Social**: Improving health and keeping people safe; helping individuals and communities to work together and help themselves.
- **Environmental**: Encouraging new house building and improving existing homes; making the city more attractive and sustainable
- **One Council:** Developing an engaged, skilled and motivated workforce; implementing better ways of working to manage reduced budgets and increased demand.

CONDUCT OF MEETING

Terms of Reference

Details above
The general role and terms of reference for the Overview and Scrutiny Management Committee, together with those for all Scrutiny Panels, are set out in Part 2 (Article 6) of the Council's Constitution, and their particular roles are set out in Part 4 (Overview and Scrutiny Procedure Rules of the Constitution.

Business to be discussed

Only those items listed on the attached agenda may be considered at this meeting.

Rules of Procedure

The meeting is governed by the Council Procedure Rules as set out in Part 4 of the Constitution.

Quorum

The minimum number of appointed Members required to be in attendance to hold the meeting is 3.

DISCLOSURE OF INTERESTS

Members are required to disclose, in accordance with the Members' Code of Conduct, ***both*** the existence ***and*** nature of any "Disclosable Pecuniary Interest" or "Other Interest" they may have in relation to matters for consideration on this Agenda.

DISCLOSABLE PECUNIARY INTERESTS

A Member must regard himself or herself as having a Disclosable Pecuniary Interest in any matter that they or their spouse, partner, a person they are living with as husband or wife, or a person with whom they are living as if they were a civil partner in relation to:

(i) Any employment, office, trade, profession or vocation carried on for profit or gain.
(ii) Sponsorship:
Any payment or provision of any other financial benefit (other than from Southampton City Council) made or provided within the relevant period in respect of any expense incurred by you in carrying out duties as a member, or towards your election expenses. This includes any payment or financial benefit from a trade union within the meaning of the Trade Union and Labour Relations (Consolidation) Act 1992.
(iii) Any contract which is made between you / your spouse etc (or a body in which the you / your spouse etc has a beneficial interest) and Southampton City Council under which goods or services are to be provided or works are to be executed, and which has not been fully discharged.
(iv) Any beneficial interest in land which is within the area of Southampton.
(v) Any license (held alone or jointly with others) to occupy land in the area of Southampton for a month or longer.
(vi) Any tenancy where (to your knowledge) the landlord is Southampton City Council and the tenant is a body in which you / your spouse etc has a beneficial interests.

(vii) Any beneficial interest in securities of a body where that body (to your knowledge) has a place of business or land in the area of Southampton, and either:

a) the total nominal value for the securities exceeds £25,000 or one hundredth of the total issued share capital of that body, or
b) if the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which you / your spouse etc has a beneficial interest that exceeds one hundredth of the total issued share capital of that class.

Other Interests

A Member must regard himself or herself as having an, 'Other Interest' in any membership of, or occupation of a position of general control or management in:

Any body to which they have been appointed or nominated by Southampton City Council

Any public authority or body exercising functions of a public nature

Any body directed to charitable purposes

Any body whose principal purpose includes the influence of public opinion or policy

Principles of Decision Making

All decisions of the Council will be made in accordance with the following principles:-

- proportionality (i.e. the action must be proportionate to the desired outcome);
- due consultation and the taking of professional advice from officers;
- respect for human rights;
- a presumption in favour of openness, accountability and transparency;
- setting out what options have been considered;
- setting out reasons for the decision; and
- clarity of aims and desired outcomes.

In exercising discretion, the decision maker must:

- understand the law that regulates the decision making power and gives effect to it. The decision-maker must direct itself properly in law;
- take into account all relevant matters (those matters which the law requires the authority as a matter of legal obligation to take into account);
- leave out of account irrelevant considerations;
- act for a proper purpose, exercising its powers for the public good;
- not reach a decision which no authority acting reasonably could reach, (also known as the "rationality" or "taking leave of your senses" principle);
- comply with the rule that local government finance is to be conducted on an annual basis. Save to the extent authorised by Parliament, 'live now, pay later' and forward funding are unlawful; and
- act with procedural propriety in accordance with the rules of fairness.

AGENDA

Agendas and papers are now available via the City Council's website

1 APOLOGIES AND CHANGES IN MEMBERSHIP (IF ANY)

To note any changes in membership of the Panel made in accordance with Council Procedure Rule 4.3.

2 DISCLOSURE OF PERSONAL AND PECUNIARY INTERESTS

In accordance with the Localism Act 2011, and the Council's Code of Conduct, Members to disclose any personal or pecuniary interests in any matter included on the agenda for this meeting.

NOTE: Members are reminded that, where applicable, they must complete the appropriate form recording details of any such interests and hand it to the Democratic Support Officer.

3 DECLARATIONS OF SCRUTINY INTEREST

Members are invited to declare any prior participation in any decision taken by a Committee, Sub-Committee, or Panel of the Council on the agenda and being scrutinised at this meeting.

4 DECLARATION OF PARTY POLITICAL WHIP

Members are invited to declare the application of any party political whip on any matter on the agenda and being scrutinised at this meeting.

5 STATEMENT FROM THE CHAIR

6 OPTIONS FOR THE PROVISION OF VASCULAR SURGERY FOR SOUTHERN HAMPSHIRE

Report of the Commissioning Director (Wessex Area Team), detailing options for the provision of vascular surgery for Southern Hampshire, attached.

7 INQUIRY MEETING 3 - ACCESS TO AND SUSTAINING LONG TERM ACCOMMODATION

Report of the Assistant Chief Executive, introducing the speakers that will address the inquiry in relation to access to and sustaining long term accommodation, attached.

TUESDAY, 25 MARCH 2014 HEAD OF LEGAL AND DEMOCRATIC SERVICES

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DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:		OPTIONS FOR THE PROVISION OF VASCULAR SURGERY FOR SOUTHERN HAMPSHIRE		
DATE OF DECISION:		20 FEBRUARY 2014		
REPORT OF:		COMMISSIONING DIRECTOR (WESSEX AREA TEAM)		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Simon Jupp**	**Tel:**	023 8072 5593
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Director	**Name:**	**Debbie Fleming**	**Tel:**	0230 8072 5601
	E-mail:	**debbie.fleming@nhs.net**		
STATEMENT OF CONFIDENTIALITY				
None				

BRIEF SUMMARY

The purpose of this report is to provide members with information on proposals to develop a Vascular Services Network for Southern Hampshire. This proposal is in response to the publication of a national service specification for Specialised Vascular Services in February 2013, for adoption from October 2013. The proposal ensures that vascular services in Southern Hampshire are compliant with the service standards identified in the specification and are sustainable in the future.

RECOMMENDATIONS:

(i) Members are asked to consider the proposals identified in this paper and establish whether the proposals and preferred option, option 4, constitutes a substantial change in service.

REASONS FOR REPORT RECOMMENDATIONS

1. As part of the Health Overview Scrutiny Panel's terms of reference the Panel has a role to respond to proposals and consultations from NHS bodies in respect of substantial variations in service provision. If this proposal constitutes a substantial change in service by more than one Health Overview Scrutiny Committee (HOSC), it will need to be considered by a joint HOSC.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. This paper shows that 4 options have been considered by NHS England. These considerations are detailed in Appendix 1, including a full analysis of the options, and include the following options:
   a. Do nothing;
   b. Establish two vascular networks;
   c. Establish a Southern Hampshire Vascular Network and move all major complex arterial vascular surgical procedures to Southampton;

d. Establish a Southern Hampshire Vascular Network and move, on a phased basis, all major complex arterial vascular surgical procedures to Southampton, with further phases considered following successful implementation of phase 1.

DETAIL (Including consultation carried out)

3. The Health and Social Care Act 2011 transferred the direct commissioning of specialised services from NHS Specialised Commissioning to NHS England. NHS England Wessex Area Team is responsible for commissioning and monitoring specialised services provided to the residents of Southampton, Hampshire, Isle of Wight and Portsmouth, as well as those in Thames Valley. All specialised services across England have been subject to national review, vascular surgery is one of these specialised services. In February 2013 the national service specification for Specialised Vascular Services was published, for adoption from October 2013.

4. The national service specification identifies key requirements that all Trusts that provide a vascular service must meet. In order for vascular services in Southern Hampshire meet the key requirements identified in the specification a number of options have been considered.

5. This paper provides an update to the HOSC on the development of these options as part of the statutory duty set out in section 244 of the NHS Act 2006, superseded by regulation 13 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 to consult with the Local Authority on proposals that may be a significant development and variation in health services.

6. Since December 2008 we have carried out a thorough process to determine what we believe is the best solution for providing vascular services across Southern Hampshire.

7. Throughout this process we have been mindful of the Secretary of States four tests for service reconfiguration:

   - support from GP commissioners;
   - strengthened public and patient engagement;
   - clarity on the clinical evidence base; and
   - consistency with current and prospective patient choice

   It is the view of commissioners that the proposal outlined in this document has been developed taking proper account of these four tests.

8. Appendix 1 outlines the background and details of the case for change to vascular services, the full options considered and outcomes of the option appraisal. It highlights the progress to date since December 2008, comparative performance across local providers alongside outcomes from stakeholder engagement and the impact assessment of the proposed changes.

9. The Panel are asked to note the issues, evidence and options for vascular services and consider if the proposed option 4 is the preferred option, and if so, whether this constitutes a substantial change in service for the residents of Southampton. In considering the evidence the Panel should consider what the best and sustainable option for the future is.

RESOURCE IMPLICATIONS

Capital/Revenue

10. None

Property/Other

11. None.

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

12. The duty to undertake overview and scrutiny is set out in Section 21 of the Local Government Act 2000 and the Local Government and Public Involvement in Health Act 2007.

Other Legal Implications:

13. None

POLICY FRAMEWORK IMPLICATIONS

14. None

KEY DECISION? No

WARDS/COMMUNITIES AFFECTED:	ALL

SUPPORTING DOCUMENTATION

Appendices

1.	Outline of options for the provision of vascular surgery for Southern Hampshire

Documents In Members' Rooms

1.	None

Equality Impact Assessment

Do the implications/subject of the report require an Equality Impact Assessment (EIA) to be carried out.	Yes/No

Other Background Documents

Equality Impact Assessment and Other Background documents available for inspection at:

Title of Background Paper(s)	Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)
1. None	

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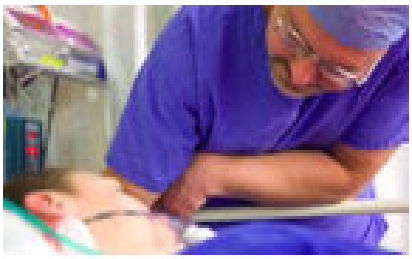
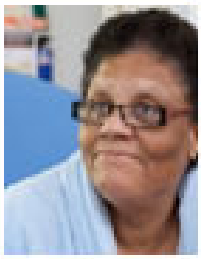
NHS England

Options for the Provision of Vascular Surgery for Southern Hampshire

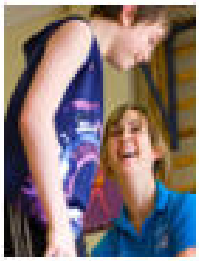
Update for Health and Scrutiny Committee





Wessex

March 2014



THE NHS CONSTITUTION

the NHS belongs to us all

Options for the provision of Vascular Surgery for Southern Hampshire

Update for Health and Scrutiny Committee

BACKGROUND

1. Vascular services are for people with disorders of the arteries and veins. These include narrowing or widening of arteries, blocked vessels and veins, but not diseases of the heart and vessels in the chest.

2. These disorders can reduce the amount of blood reaching the limbs or brain, or cause sudden blood loss if an over-stretched artery bursts. Vascular specialists also support other medical treatments, such as major trauma, kidney dialysis and chemotherapy.

3. Complex vascular surgery covers:

    - **People with abdominal aortic aneurysms (AAA):** This is a condition in which the main artery in the abdomen becomes stretched and prone to bursting. Timely detection and treatment of abdominal aortic aneurysms prevents later problems with rupture and bleeding, and can be life-saving. Treatment for AAA can be either by open surgery or by a much less invasive approach through the major blood vessels which is called endovascular surgery (EVAR).

    - **Screening people for abdominal aortic aneurysms (AAA):** People with aneurysms are unlikely to notice any symptoms prior to a rupture so a national population-based screening programme is being rolled out, offering screening via an ultrasound to men in their 65th year. Men aged over 65 are not invited but can self-refer.

    - **People with strokes or transient ischaemic attacks (TIAs or mini-strokes):** Sometimes, these problems with the blood supply to the brain occur because of a narrowing in a blood vessel in the neck called the carotid artery. This can be treated with an operation to improve the flow of blood and reduce the risk of future strokes.

    - **People with poor blood supply to the feet and legs:** Some people, particularly those who smoke or have diabetes, can develop narrowing in the blood supply to the legs and feet. This can cause pain on walking, ulceration and infection. Surgical or interventional radiological treatment can improve the blood supply, make walking easier and prevent the serious complications of inadequate blood supply. When limbs cannot be saved vascular surgeons are also needed to undertake major amputations.

4. There are also roles for vascular surgery supporting other major specialities such as:

    - **People with other conditions needing vascular services:** Vascular surgeons and interventional radiologists support a number of other services including as trauma, neurosurgery, cardiac surgery, dermatology, clinical laboratory services, nephrology, plastic surgery, and other surgical disciplines.

5. There is a great deal of change underway within the vascular specialty, at both a national and international level, and this is having a big impact on services locally. Advances in medical treatments, a greater focus on prevention of vascular disease and the screening programme for abdominal aortic aneurysms (AAA) mean that treatments for vascular conditions are improving. The number of 'open' surgical procedures performed is already decreasing, and this trend is expected to continue as more people are screened and the number of 'key hole' style procedures increase. This means that the future arrangements for vascular services must be both robust enough and dynamic enough to keep up with these advances.

6. In Southern Hampshire and the Isle of Wight, about 640 people require complex vascular surgery each year from a population of 1, 497,000. This represents about 0.04% of the population.

7. Vascular specialists in the UK and Ireland have set out how vascular services should be organised. The Vascular Society of Great Britain and Ireland (VSGBI) and The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) have both published recommendations around vascular provision. The recommendations state that the best outcomes are achieved in specialist vascular units with dedicated vascular teams available 24 hours a day, seven days a week, and using new technologies that improve clinical outcomes.

8. Following national reorganisation of NHS Services introduced in April 2013, all specialised services across England have been subject to national review, vascular surgery being one of these specialised services. Each service has been reviewed by a Clinical Reference Group (CRG) and national service specifications have been developed for each programme based on delivering safe, consistent and sustainable networked services. In February 2013 the national service specification for specialised vascular services was published, for adoption from October 2013. This specification identifies the key requirements for hospitals delivering vascular services so that patients get the best possible results.

9. The national service specification for specialised vascular surgery identifies key requirements that all Trusts that provide a vascular service must meet. These are:

    - **Vascular services must be organised into a network model** of care following the principles and governance set out in the national guidance on Operational Delivery Networks with all elective and emergency arterial care carried out in an arterial centre.

    - **There are at least 6 vascular surgeons** employed in each arterial centre. (N.B. The Royal College of Surgeons has designated vascular surgery as a speciality which means that general surgeons can no longer treat vascular patients)

    - All vascular consultants working in vascular networks must routinely **enter data** regarding index procedures should be entered **into the National Vascular Registry** (NVR.)

10. The national service specification also describes how the vascular network needs to be organised to allow for sufficient procedures to be undertaken. It states that **the network must**:

    - **Cover a population of at least 800,000 people in order that each surgeon is able to perform at least 10 AAA procedures per year.** This will mean that each centre will be undertaking

the recommended minimum of 60 AAA operations a year. Medical evidence shows that patients have a better chance of a successful recovery if they have their operations at centres which perform higher numbers of specialised vascular operations. Currently the catchment area for University Hospital Southampton is 900,000 and for Portsmouth Hospitals NHS Trust 650,000.

- **Have at least six vascular surgeons and vascular interventional radiologists to make sure that there is sufficient out -of- hours emergency cover.** Up to 40% of vascular patients are emergencies or urgent referrals. Consultants are directly involved in the care of most of these patients and the out-of-hours workload is more onerous than many other surgical specialties. Having surgeons on call 24/7 means no delays in treatment and a 1 in 6 rota ensures that these surgeons are properly rested. The National Vascular Registry currently reports that Southampton has 6 vascular surgeons and Portsmouth has 3 undertaking more than five cases annually.

- **Invest in specialist interventional radiology to carry more key hole than open surgery.** These new treatments are less invasive than open surgery and increasingly favoured by patients. Some highly-specialist thoracic EVAR currently goes to London. Costs, and patient inconvenience, are reduced with a local service. Both Southampton and Portsmouth currently undertake surgery using EVAR.

- **Delivers the advances in screening for aortic aneurysm**. Planned operations have better outcomes than emergency operations. Screening identifies aortic aneurysms so more operations can be planned. Networks enable better co-ordination and monitoring of the screening programme and quality is scrutinised at network meetings. The Hampshire AAA screening programme covers Southampton and surrounding areas, Portsmouth and the Isle of Wight and the south of the county.

11. In order to provide sustainable vascular services for Southern Hampshire the key requirements for vascular services have been reviewed and a number of proposals have been considered. The purpose of this document is to present these proposals and to clarify the reasoning behind the preferred option.

THE CASE FOR CHANGE

12. Medical evidence shows that the UK could do so much better for patients in comparison to other European countries for some vascular procedures. The UK has the highest death rates in Western Europe following elective abdominal aortic aneurysm surgery and is among the slowest nations for uptake of new endovascular technology, which allows some procedures to be undertaken by 'keyhole' style inventions which avoid the need for open surgery. Patients in the UK are not always treated by a vascular specialist and stay longer in hospital following their surgery than the rest of Europe.

13. Vascular specialists in the UK and Ireland have set out how vascular services should be organised. The Vascular Society of Great Britain and Ireland (VSGBI) and The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) have both published recommendations around emergency vascular provision. The NCEPOD Report 2005 into patient

outcome and death following abdominal aortic aneurysm (AAA) found the overall mortality rate for elective surgery was 6.2%.

14. The national service specification for specialised vascular services is written in the light of these recommendations and published evidence of the Department of Health (DH), the Royal College of Radiologists (RCR), and all relevant NICE Guidance. The VSGBI and NCEPOD guidance on the provision of emergency and elective vascular surgery services states that the best outcomes are achieved in specialist vascular units with dedicated vascular teams available 24 hours a day, seven days a week. The VSGBI recommends fewer and higher volume units. The evidence supports minimum numbers of elective procedures that vascular units should undertake and links surgeon elective volume with outcome.

15. In addition the vascular specialty is changing with more operations being performed by Interventional Radiologists using a less invasive approach through the major blood vessels which is called endovascular surgery (EVAR). There is also a new screening programme for AAA. This means that less and less 'open' vascular operations are being performed; this will have a big impact on services locally.

16. Locally vascular services are good, with outcomes for patients in Queen Alexandra Hospital Portsmouth and University Hospital Southampton comparable with European levels. In some hospitals though there are not enough consultants to provide high quality 24 hour care for patients with vascular diseases. This means that not all patients are treated by a specialist consultant, particularly those needing treatment out of hours.

17. Another issue is the availability of interventional radiologists. Skilled interventional radiology consultants can use specialist techniques to save limbs and organs that might otherwise have to be removed. Changing the service so that round-the-clock interventional radiology rotas become possible will ensure that no-one misses out on these benefits because of where and when they become ill.

18. At the moment, not all patients in Southern Hampshire are able to access the latest treatments and techniques. For example, a type of treatment for blood clots which are blocking important arteries is not at present available at all times in every hospital in our region.

19. In order that local centres perform enough operations in the future to maintain the skills of surgeons, and therefore maintain good outcomes for our patients, the current arrangements need to change. Our proposal is to change the current arrangement so that services are provided through a Vascular Network where major complex surgical procedures are undertaken in a major arterial centre, rather than provided in a lot of stand-alone centres only carrying out a few procedures each year. Concentrating major complex surgical procedures into a major arterial centre will ensure that patients are taken to the hospital promptly, ensuring everyone gets the treatment they need, when they need it. This may mean that some patients have to travel further for their surgery but the Vascular Society of Great Britain and Ireland states that the longer travel time will be more than outweighed by the better outcomes for all local patients.

20. As previously described the national service specification for specialised vascular services was published in October 2013. This specification identifies the key requirements for hospitals delivering vascular services so that patients get the best possible results. We are determined to improve our local NHS so that these standards are met in full and this can only achieve this by changing the way that vascular services are provided.

21. Any new plans for vascular services must be sustainable.

PROGRESS TO DATE

22. Since December 2008 we have carried out a thorough process to determine what we believe is the best solution for providing vascular services across Southern Hampshire.

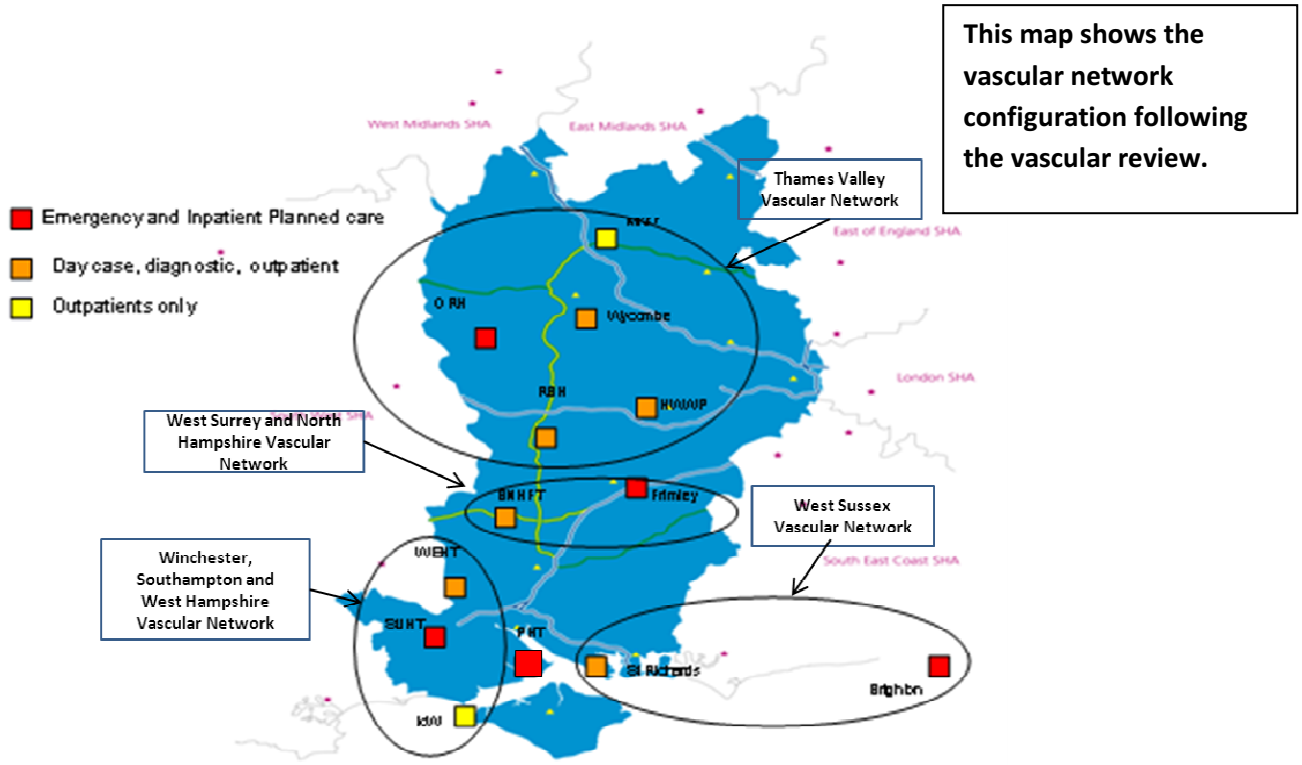
23. Throughout this process we have been mindful of the Secretary of States four tests for service reconfiguration:

- support from GP commissioners;
- strengthened public and patient engagement;
- clarity on the clinical evidence base; and
- consistency with current and prospective patient choice

Time line of how the proposals for vascular services have been identified.	
December 2008	The South Central Cardiovascular Network produced a report into the provision of emergency vascular surgery for people living within the NHS South Central area.
October 2009	An external report was commissioned on the future development of vascular surgery provision across the South Central region of England. The report concluded that the current arrangements for service provision were not sustainable and therefore units covering larger areas were needed.
April 2010	Prompted by the 2009 report, NHS South Central asked the South Central Cardiovascular Network to develop a detailed service specification for vascular services. The aim of this specification was to improve outcomes for local patients by ensuring that local services complied with national standards and Vascular Society guidelines. A local Vascular Surgery Service Specification was developed with local vascular surgeons and interventional radiologists and agreed, and an Options Appraisal document, which included a 'Case for Change', was produced.
Oct 2010	Local hospital Trusts were asked to submit proposals for achieving the quality standards set out in the service specification.
Dec 2010	Proposals were received from University Hospital Southampton NHS Foundation Trust, Portsmouth Hospitals NHS Trust and Frimley Park NHS Foundation Trust. In December 2010 an assessing panel received presentations from interested trusts. Following these presentations the panel recommendations were that: 52. A network was established between Southampton and Portsmouth vascular services, with all emergency and planned complex vascular surgery being carried out at Southampton. 53. The longstanding relationship between Basingstoke and North Hampshire NHS Trust and Frimley Park Hospitals

	NHS Trust vascular services should continue, with all emergency and planned complex vascular surgery being carried out at Frimley Park Hospital. 54. Day case, diagnostic and outpatient vascular services should be supported in local hospitals.
April 2011	To ensure that lay representatives, clinical experts and GP commissioners were in agreement with the service specification the Cardiovascular Network involved GP commissioners, LINk representatives, the Vascular Surgery Strategic Group, South Central PCTs, South Central Strategic Health Authority, South Central acute Trusts and clinical advisors in a review of the service specification.
June 2011	Portsmouth Health Overview and Scrutiny Panel members expressed concern about a model which involved moving complex vascular surgery from Queen Alexandra Hospital.
August to Sept 2011	NHS South Central undertook a six week engagement exercise with the public and key stakeholders on proposals for three clinical areas; major trauma, stroke and vascular surgery. Details of the engagement exercise were also shared with key stakeholders in the South East Coast SHA area. During September 2011 Portsmouth submitted a further proposal suggesting that vascular surgery should be retained at Queen Alexandra Hospital in Portsmouth and that this provided emergency and planned care for the Portsmouth population and the population of Chichester, utilising clinicians from Chichester. However, the bid was not supported by the Lead Clinicians at St Richard's Hospital, Chichester, who identified that they would be developing a network with Brighton. Following this NHS Sussex engaged with residents in Sussex about vascular services in the area. They have now established a hub and spoke arrangement with Chichester and more services have been centralised in Brighton.
Oct 2011	Feedback from the engagement exercise revealed: • Concern about the implications for other services at Queen Alexandra Hospital, Portsmouth if the option to provide emergency and elective complex inpatient vascular surgery from Southampton General Hospital were to go ahead • Interest in exploring the option for surgeons at Queen Alexandra Hospital to work with surgeons at St Richards Hospital, Chichester to provide a service to people living in the Portsmouth, south east Hampshire and Chichester areas.
	A second expert panel was held on 20 October, 2011 to consider a new proposal from Portsmouth Hospital Trust and the output of discussions between clinicians at Southampton General Hospital and Queen Alexandra Hospital to work as part of a network across the two hospital sites. It concluded that: • The proposal of a vascular service across the St Richards and Queen Alexandra Hospital sites would be clinically viable for the present time but was not the ideal solution for patients in the long term. The panel's main concerns were the lack of involvement from St Richard's clinicians and management which meant that the proposal could not be delivered. • The option of a single vascular service offered from the two hospital sites would provide the best chance for long term sustainable vascular services for local people.
	The National Clinical Assessment Team, led by Professor Matt Thompson, Professor of Vascular Surgery, St George's Vascular Institute concluded that

	there should be one vascular centre for the Southampton, Hampshire, Portsmouth and Isle of Wight area based at Southampton.
Nov 2011	An engagement report was considered at a meeting of the SHIP PCT Cluster Board on November 1
	Portsmouth Hospitals NHS Trust said that it believed it could make the necessary changes to meet the standards laid down within the Service Specification in its own right, rather than in a network model with University Hospitals Southampton NHS Foundation Trust or with St Richards Hospital, Chichester. The SHIP PCT Cluster asked Portsmouth Hospitals NHS Trust to provide a detailed case for how it will meet the service specification as a standalone centre. On November 23, the SHIP PCT Cluster received a proposal from Portsmouth Hospital NHS Trust for a standalone centre at Queen Alexandra Hospital. Local commissioners and GPs reviewed the proposal and asked for further detail from the Trust which resulted in a revised proposal submitted on December 14, 2011.
January 2012	This proposal was reviewed by the panel of clinical experts on January 5, 2012 and they concluded that it was clinically viable in the short term. However the panel felt that the proposal posed a number of challenges in the longer term particularly around recruiting sufficient staffing, ensuring that a rota of surgeons was fully occupied and offering the right level of development and training to ensure that clinical best practice was maintained.



This map shows the vascular network configuration following the vascular review.

February 2012	The former SHIP PCT Cluster advised stakeholders that it was not possible to publically consult on a network model as providers could not agree on this collaboration.
June 2012	Hampshire Health Overview and Scrutiny Committee hosted a meeting involving Portsmouth Hospitals NHS Trust, University Southampton NHS Foundation Trust, commissioners and a national independent clinical expert Professor Jonathan Earnshaw. The meeting encouraged both Trusts to work collaboratively and for Professor Earnshaw to facilitate further discussions between clinicians.
February 2013	National specification for vascular services published and the former SHIP PCT Cluster and shadow CCGs restated their intention to commission in line with the specification.
September 2013	The Wessex Clinical Senate, an independent group of experts who assist commissioners to put patient outcomes and quality at the heart of the commissioning system, considered proposals on how vascular services should be set up in Southern Hampshire. The Senate made a number of recommendations on Vascular Surgery in South East Hampshire. Details of this can be found at: South of England » Publications and reports

OPTIONS FOR CHANGE

24. As a result of the earlier engagement about the future organisational arrangements for vascular services in Southern Hampshire, we developed a long list of options.

Option 1: do nothing

25. Option 1 would maintain services as they are with Southampton continuing as the arterial centre for the Southampton, Winchester and West Hampshire Vascular Network, and Portsmouth remaining as a stand-alone vascular centre for Portsmouth.

Option 2: establish two vascular networks

26. Option 2 would create two vascular networks with Southampton continuing as the arterial centre for the Southampton, Winchester and West Hampshire Network, and creating another Network in Portsmouth, utilising surgeons from St Richard's Hospital Chichester, and the Queen Alexandra Portsmouth, to serve Portsmouth, south east Hampshire and the Chichester area.

Option 3: establish a Southern Hampshire Vascular Network and move ALL major complex arterial vascular surgical procedures to Southampton

27. Option3 would mean that a network would be established between Southampton and Portsmouth vascular services. The network would have one major arterial centre which would be located in Southampton. The arterial centre would undertake all emergency and planned major complex arterial procedures with minor procedures being undertaken as close to the patients home as possible. Following surgery in Southampton all patients would be able to transfer home or back to their local hospital for their post-operative stay if this was needed.

Option 3 would include:

- Establishing a single rota for emergency seven day vascular assessment and interventions and support for the major trauma and renal centres.
- All Emergency and non-emergency AAA patients being operated on in Southampton.

- All Infra-inguinal by-pass surgery being undertaken in Southampton
- All Surgery following a transient ischaemic attack (TIA) or stroke (such as carotid endarterectomy) taking place in Southampton.
- All Major amputations being undertaken in Southampton.
- Patients requiring minor procedures would continue to be cared for in hospitals as close to their home as possible.

Option 4: establish a Southern Hampshire Vascular Network and move, on a phased basis, all major complex arterial vascular surgical procedures to Southampton. (Options for surgery following a transient ischaemic attack (TIA) or stroke (such as carotid endarterectomy CEA) and major amputations will be considered at a later date following successful implementation of the initial phases.)

27. Our fourth, and preferred option, is that all of the hospitals in Southern Hampshire work in partnership to deliver vascular services as part of a Vascular Network achieved on a phased basis, the initial phases concentrating on surgery for AAA .

28. Major amputations and infra-inguinal by-pass surgery have not been included in the initial phase as there are a larger numbers of patient numbers who undergo these procedures, some of whom will require long episodes of post- operative recovery and rehabilitation. Our aim is that any ongoing treatment takes place as close to the patients' home as possible. We therefore need to make sure that any proposed changes in services mean that patients can return to their local hospital at the earliest opportunity.

29. The national service specification for vascular services allows for a period of evaluation stating that "Provider networks will work towards the aim of all leg amputations being undertaken in arterial centres by 2015 and develop a robust implementation plan to achieve this"

30. Larger numbers of patients undergo a CEA each year which means that centralising this service would impact on a larger number of people. It will be beneficial to allow some time for evaluation before taking any further steps to centralise services, when this will involve more significant numbers. It is also noted that further work is underway nationally to assess the provision of CEAs surgery across the country, so allowing some time to elapse will enable more evidence to be obtained that will support future decisions as to where this procedure is best undertaken.

31. The network would have one major arterial centre which would be located in Southampton the major trauma centre for the area, but provided by a single clinical service across both Southampton and Portsmouth. The arterial centre would undertake the small number of major complex arterial procedures with minor procedures being undertaken as close to the patients home as possible. The single clinical service would bring together clinicians from across the network into joint surgical and interventional radiological rotas. This will ensure adequate clinical expertise is available across the network. Joint multidisciplinary teams (MDT) would meet on a regular basis to discuss the care of patients and how they should most appropriately be managed. The network will focus on the needs of the local population and will ensure that where possible, diagnosis, day surgery, reablement and rehabilitation takes place as close to the patients home as possible.

32. It is proposed that there would be a phased approach to the implementation of this option, which is based on and takes account of the recommendations made by the Wessex Clinical Senate in September 2013:

33. **Phase 1** would include:

- Establishing a single rota for emergency seven day vascular assessment and interventions and support for the major trauma and renal centres.
- All emergency AAA patients (open and EVAR) being operated on in Southampton. This work will take place in collaboration with the South Central Ambulance Service and local A&E departments to ensure that there are no delays in patients receiving the care they need.
- Ensuring that out-patient clinics, initial investigations, surgery for venous disease, re-ablement and rehabilitation would also be carried out as close to the patients home as possible. All of these services would continue to be provided in the local hospitals providing that they meet with defined quality standards.
- Establishing regular MDTs and joint training opportunities.
- Considering the options and timescales for redirecting all non-emergency AAA patients, including those who have been picked up as part of the AAA screening programme, so that they are operated on in Southampton.

34. Phase 1 would be implemented before the end of December 2014. This date could potentially be brought forward but this is dependent on the providers reaching agreement sooner.

35. **Phase 2** would include:

- All non-emergency AAA patients (open and EVAR), including those who have been picked up as part of the AAA screening programme, being operated on in Southampton, if not already implemented as part of phase 1.
- Considering the options for phase 3.

36. Phase 2 would be carried out immediately after Phase 1, and therefore be implemented from January 2015.

Phase 3

37. As part of this phased approach, it is proposed that there is a formal review before the end of 2015/16, once phases 1 and 2 have been completed and the new arrangements have had time to become properly established. Under phase 3, commissioners and providers should review the options relating to surgery following a transient ischaemic attack (TIA) or stroke (such as carotid endarterectomy CEA) and major amputations, and agree the way forwards by the end of March 2016.
38. The options and timescales for patients who need a infra-inguinal by-pass may also need to be considered as part of phase 3, if no formal decision about this surgery has been made under phase 2 of the proposal. It is important to note that the management of patients needing an infra-inguinal by-pass is key to reducing the number of major amputations, which means that this will need careful consideration.
39. As previously highlighted, no decisions have been made as to the outcome for the procedures that need to be considered under phase 3, and further discussion will need to take place between all key stakeholders before any further recommendations are made.
40. The work being undertaken nationally in regard to major amputations and CEAs will influence any future recommendations. The exact details of any future proposals will need to be planned in collaboration with vascular surgeons and other key clinicians from both Portsmouth and Southampton.

OPTIONS APPRAISAL

Option 1: do nothing

40. It is not possible to leave services as they are now because the existing service at the Queen Alexandra Hospital Portsmouth does not meet the minimum standard identified in the NHS National Service Specification for Specialised Vascular Services.

Option 2: establish two vascular networks

41. This option has not been considered as St. Richards Hospital in Chichester has now formed a Vascular Network with Brighton.

Option 3: establish a Southern Hampshire Vascular Network and move all major complex arterial vascular surgery to Southampton

42. This option would provide long term sustainable vascular services for local people and it meets all of the service specification requirements. However, this option has been discounted on the basis that as a consensus could not be reached between Southampton and Portsmouth as to how this should be implemented. It has been concluded that this model would not be the preferred option, as without agreement from the trusts, commissioning such a large scale change could create risks to the safe transition of services for patients.

Option 4: establish a Southern Hampshire Vascular Network and move a specified group of major complex arterial vascular surgical procedures to Southampton

43. The proposal to establish a Southern Hampshire Vascular Network and move all major complex arterial vascular surgery to Southampton has been assessed by all key stakeholders including an expert clinical panel, the National Clinical Assessment Team and the Wessex Clinical Senate, and it is broadly recognised that this provides the best chance for long term sustainable vascular services for local people. It meets all of the service specification requirements and therefore provides the best option for improving outcomes for local people. However, delivering this on a phased basis reduces the impact of the change on Portsmouth Hospitals NHS Trust in terms of loss of income, and allows both Trusts more time to plan for the changes and work together in implementing them. This will ensure that this change can be implemented successfully, in a safe and sustainable way.

44. The option enables as many vascular procedures as possible to be undertaken close to the patients' home whilst concentrating highly specialist skills for the most complex surgery. Our preferred option will establish a Southern Hampshire Vascular Network with major complex vascular surgery carried out in the future in Southampton with local services remaining as they are currently. This option would bring all of the vascular expertise, vascular surgeons, interventional radiologists and other key staff, into a single service.

45. Option 4 ensures that patients will receive the best level of care, at the right time and in the right place, with services consistently provided by a consultant-led team 24/7. Developments in technology mean that for emergency patients, open surgical procedures will be minimised, leading to improved outcomes, reduction in risk, reduction in post-operative complications, and a reduction in the length of time spent in hospital as an in-patient, services will be more planned and robust, and will always be provided by a consultant led team 24/7. Non-emergency patients will benefit by having services tailored to their needs. This level of service will be more structured, and patients will not be affected by the need to cancel planned interventions due to emergency admissions. This represents a more efficient use of resources, and the consequence will lead to more patients being treated at the right time and in the right place. This will result in greater efficiencies and effectiveness.

46. The risks and benefits of all of the options have been assessed and take account of the changes in technology and best practice.

47. The impact of the proposal on other service providers, including the NHS, local authorities and the voluntary sector and also the wider community has been considered in the development of this proposal.

48. The workforce implications have been considered and the option proposed provides a long term sustainable workforce for the provision of vascular services for local people.

49. Once the preferred option has been agreed the Wessex Area Team will work in collaboration with the trusts to ensure that the appropriate project support and mechanisms are in place to safeguard implementation within the agreed timescales.

50. If the HOSC agree that this proposal constitutes major service reconfiguration we will be going out for public consultation on 26 May 2014. The public consultation will close at the end of August 2014. The agreed proposal will be implemented commencing 1 November 2014. If agreement from the Trusts is reached sooner, the implementation date will be brought forward in line with their plans.

It should be noted that the Wessex Clinical Senate recommended that:

55. As a matter of urgency, all emergency and elective major inpatient interventions (such as AAA repair, symptomatic and ruptured aneurysm treatment) should be delivered at University Hospitals Southampton

STAKEHOLDER ENGAGEMENT

51. There has been ongoing dialogue with stakeholders from across Southern Hampshire in the development of these options. This includes:

- Heath and Scrutiny Committees
- NHS England, Medical Directorate
- Specialised Commissioning
- Wessex Clinical Senate (Chair: Prof William Roche - The Senate's role is to provide high quality, independent, non-biased clinical advice). The senate reviewed all options in September 2013 and the proposal was supported.
- NHS England Wessex Area Team
- NHS Fareham and Gosport CCG, NHS South Eastern Hampshire CCG, NHS Portsmouth CCG, NHS Southampton CCG, NHS Isle of Wight CCG, NHS West Hampshire CCGs
- Trusts vascular surgeons.
- There are several Healthwatch groups who will have an interest in the development including:
    - Hampshire
    - Isle of Wight
    - Portsmouth
    - Southampton

56. Between August and September 2011 an engagement exercise took place to as part of the Safe and Sustainable Acute Services: Stroke, Major Trauma and Vascular Surgery review. The engagement exercise identified a number of concerns about the proposals put forward at that time. Local people told us that they wished to see a collaborative vascular network model developed, with surgeons and interventional radiologists working across both sites. The current proposal takes account of the wishes of local people. In addition a Vascular Patient Reference Group was formed in 2012 to discuss the implications of the proposal.

57. During the autumn of 2010 a review of vascular services in South Central (which included South Hampshire) was undertaken. As a result of this review a local Vascular Surgery Service Specification was drafted and agreed, and an Options Appraisal document, which included a 'Case for Change', was produced. Across the region service provider were invited to submit proposals for the provision of vascular services in line with the service specification and national guidance. In December 2010 an assessing panel received presentations from interested trusts.

58. Following these presentations the panel recommendations were that:
    - A network was established between Southampton and Portsmouth vascular services, with all emergency and planned complex vascular surgery being carried out at Southampton.
    - The longstanding relationship between Basingstoke and North Hampshire NHS Trust and Frimley Park Hospitals NHS Trust vascular services should continue, with all emergency and planned complex vascular surgery being carried out at Frimley Park Hospital.
    - Day case, diagnostic and outpatient vascular services should be supported in local hospitals.

59. There are four patients/carers on the national Clinical Reference Group for vascular services which developed the national specification which informed the local proposal.

60. In addition a local Patient Reference Group was formed in 2012 which provided an opportunity to discuss the improved quality being sought for patients and the practical considerations such as travel and patient information for patients accessing vascular interventions.

61. There is a group of people including members of the public, hospital staff and politicians that do not wish to see any change to vascular services in Portsmouth. Every effort has been made to share the evidence base and the benefits for patients as a consequence of this change, and this work will be on-going.
62. Individual vascular surgeons have different views as to how services should be delivered, with some having more regard to the new national standards than others, and some being more open to collaborative working than others. Discussions are on-going.

IMPACT ASSESSMENT

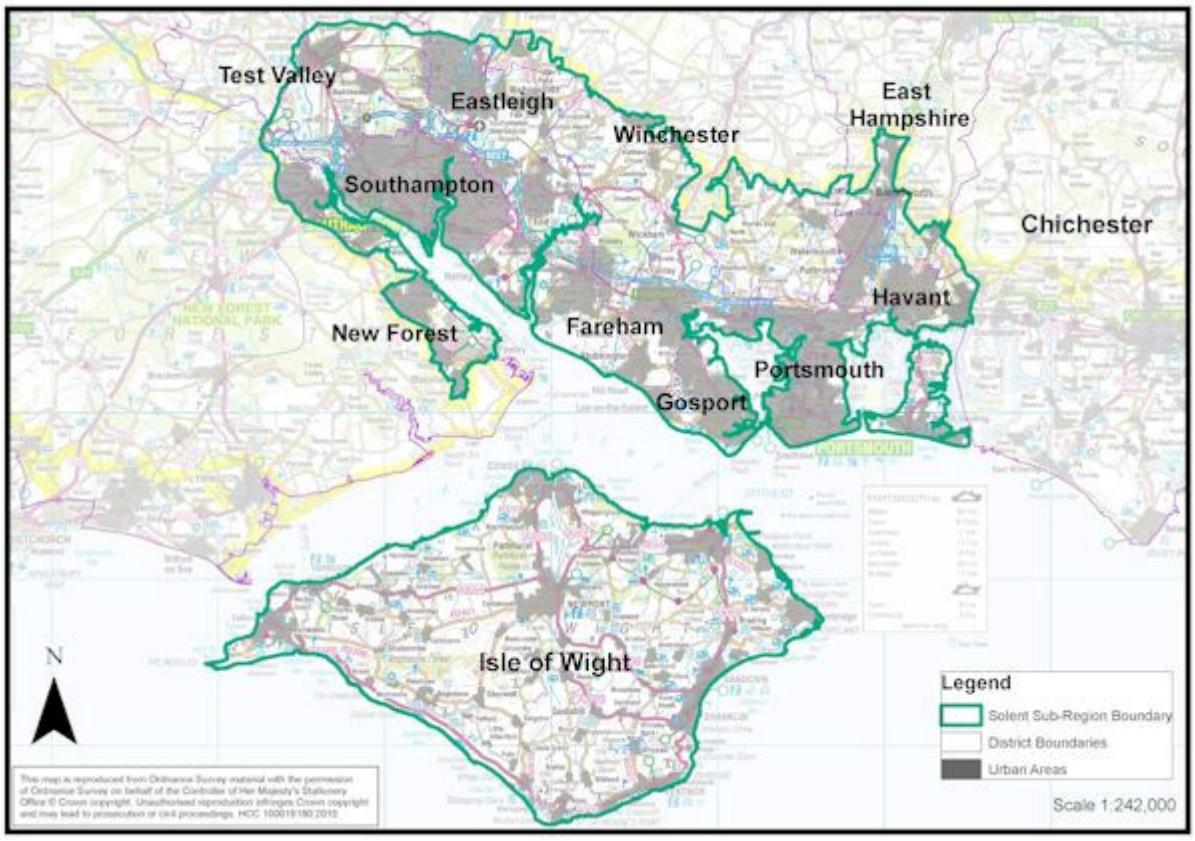
63. In July 2011 a South Central Vascular Surgery Review, Strategic Equality Impact assessment was undertaken. The impact assessment takes consideration of the demographic profile of the area and the impact on vulnerable people and health equality.

64. The impact assessment is currently in the process of being refreshed.

65. It is important to note that Specialised Services by their nature, deal with low volumes of patient numbers, therefore the number of patients that will be affected by this change are relatively small.

66. Under the terms of this proposal, patients requiring complex vascular surgery will be required to travel to Southampton for their operation. Those being admitted as an emergency will be taken directly to Southampton by ambulance, rather than to Portsmouth. Most patients will be discharged directly home once medically fit following surgery, which means that it should not be necessary for patients to be repatriated to Portsmouth. All outpatient appointments will remain in the hospital nearest to their own home.

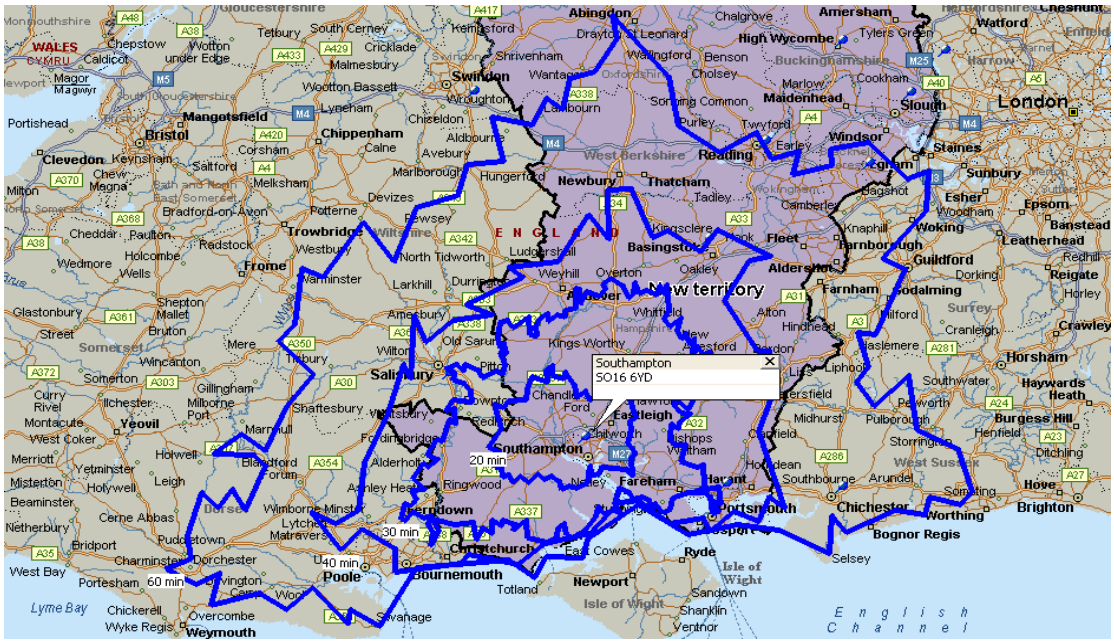
67. This proposal will affect the population of Southern Hampshire. The map below shows the area covered by Southern Hampshire.



68. This proposal will change access to services for patients from across Southern Hampshire as they will be taken to Southampton in an emergency situation and over time, will need to travel to Southampton for complex elective surgery.

69. The impact on service users has been assessed in terms of:

- **Waiting Times –**waiting times are defined by the NHS Constitution and when the agreed proposal is implemented, providers will be monitored against these definitions through the NHS Standard Contractual Arrangements.
- **Transport (public and private)** – Phase 1 of the proposal is in relation to emergency situations and therefore transportation would be via ambulance. Phase 2 will mean that a small number of patients, family/carers may be required to travel a slightly longer distance, as a result of these changes. However, the service they are travelling for will be an improved service.
- **Travel Time** – Isochrone data provided by South Central Ambulance Service has identified that all hospitals are within the 60 minute travel distance for safe transfer of vascular patients across Southern Hampshire in an emergency. Some patients have to travel further for their surgery but the Vascular Society of Great Britain and Ireland states that the longer travel time will be more than outweighed by the better outcomes for all local patients. In an emergency situation, such as in the case of a ruptured AAA, the maximum expected travel time under blue light conditions is 40 minutes.



70. This map above shows 20, 30, 40 and 60 minute Isochrones (Ambulance travel times under blue light conditions).

71. In 2009 the NHS AAA screening programme for men aged 65 was introduced with full implementation in 2013. The aim of this programme is to identifying apparently healthy people who may have an AAA. This programme will therefore mean an increased number of patients requiring vascular surgery for AAA. This surgery will however be undertaken as a planned procedure rather than undertaken in an emergency situation.

72. The impact on staff has been assessed. The affected staff includes a small number of doctors, nurses and therapists at Portsmouth Hospitals NHS Trust and University Southampton Hospital NHS Foundation Trust. The change will involve closer multi-disciplinary working across the two organisations and some potential additional travel for doctors in line with the proposed joint rota**.**

COMPARATIVE PERFORMANCE ACROSS LOCAL PROVIDERS

Volume of Elective AAA repairs and in-hospital mortality by Trust, Jan 2008 to Dec 2012					
	Trust	**Number of AAA performed**	**Number of Open procedures**	**Number of EVAR procedures**	**In-hospital Mortality (unadjusted)**
PHT	Portsmouth Hospitals NHS Trust	216	105	111	4.20%
UHS	University Hospital Southampton NHS Foundation Trust	377	201	176	0.80%
BHT	Buckinghamshire Healthcare NHS Trust	166	90	76	1.80%
HWPT	Heatherwood and Wexham Park Hospitals NHS Foundation Trust	72	18	54	1.40%
OUH	Oxford University Hospitals NHS Trust	271	125	146	1.10%
BST	Brighton and Sussex University Hospitals NHS Trust	250	75	175	1.20%
FPH	Frimley Park Hospital NHS Foundation Trust	309	125	184	1.00%
WSH	Western Sussex Hospitals NHS Trust	130	130	0	1.50%
DCH	Dorset County Hospital NHS Foundation Trust	73	73	0	6.90%
RBCH	Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust	333	109	224	1.80%
SFT	Salisbury NHS Foundation Trust	82	68	14	1.20%
	Data Source: National Vascular Registry - 2013 Report on Surgical Outcomes, Consultant Level Statistics				

Volume and outcomes of carotid endarterectomies, October 2009 to September 2012					
	Trust	**Number of CEAs performed**	**Number of CEAs with outcome data**	**% stroke and/or death within 30 days (unadjusted)**	**Median (IQR) delay between sympton and surgery**
PHT	Portsmouth Hospitals NHS Trust	215	215	1.90%	22(12,65)
UHS	University Hospital Southampton NHS Foundation Trust	299	299	1.70%	16(11,26)
BHT	Buckinghamshire Healthcare NHS Trust	244	239	2.10%	11(8,16)
OUH	Oxford University Hospitals NHS Trust	244	234	3.00%	19(8,41)
BST	Brighton and Sussex University Hospitals NHS Trust	120	120	1.70%	9(7,14)
FPH	Frimley Park Hospital NHS Foundation Trust	200	199	2.50%	9(5,20)
WSH	Western Sussex Hospitals NHS	83	81	3.70%	16(12,24)

Volume and outcomes of carotid endarterectomies, October 2009 to September 2012					
	Trust	**Number of CEAs performed**	**Number of CEAs with outcome data**	**% stroke and/or death within 30 days (unadjusted)**	**Median (IQR) delay between sympton and surgery**
	Trust				
DCH	Dorset County Hospital NHS Foundation Trust	88	88	5.70%	10(5,29)
RBCH	Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust	160	111	9.00%	18(8,40)
SFT	Salisbury NHS Foundation Trust	71	71	0.00%	10(5,33)
Data Source: National Vascular Registry - 2013 Report on Surgical Outcomes, Consultant Level Statistics					
Please note that the outcome information was derived from three years of data, on patients who underwent surgery between 1 October 2009 and 30 September 2012. The median delay was based on one year of data, and relates to patients treated between 1 October 2011 and 30 September 2012.					

Appendix A. Evidence base

The evidence base concerning the relationship between patient outcome and the organisation of vascular services has become more extensive over the past few years. There is a strong evidence base that suggests that mortality from elective aneurysm surgery is significantly less in centres with a high caseload than in units that perform a lower number of procedures. A meta-analysis of the existing literature (Holt, Poloniecki et al. 2007) reviewed studies containing 421,299 elective aneurysm repairs and reported a weighted odds ratio of 0.66 in favour of higher volume centres dichotomised at 43 cases per year. However, although robust, meta-analyses can be criticised due to publication bias, heterogeneity and the predominance of data from certain countries, additional information may be gathered by analysing national administrative data. HES data for elective aneurysm repair in the UK between 2000-2005 (Holt, Poloniecki et al. 2007) demonstrated that the mean mortality for an elective repair was 7.4%, and that 80% of all aneurysm repairs were carried out in units performing less than 33 cases annually.

Importantly, the mortality rate in the units with lowest caseload was 8.5% as compared to the 5.9% reported by units with a higher workload. Even more worrying were the many small volume centres where the elective mortality may often exceed 20%. A similar pattern was seen in a recent report from the Vascular Society – Outcomes after Elective Repair of Infra-Renal AAA 2012, and it remains noticeable that some low volume units have mortality rates vastly in excess of the national average

Recent data have demonstrated that the early mortality difference observed between low and high volume units is maintained in the long term (Holt, Karthikesalingam et al. 2012).

With regard to ruptured AAA, the absolute mortality differences between hospitals in the lowest and highest volume quintiles reached 24% (Holt, Karthikesalingam et al.). Data on operative mortality in isolation, only tells part of the story, as case mix and patients considered “unfit” for surgery must also be considered. In these areas there is evidence to suggest disparate practices, with no surgical intervention being offered to over 50% of emergency patients with ruptured AAA in low volume units as compared to approximately 20% in the highest volume centres (Holt, Karthikesalingam et al.).

Two recent studies have investigated the effect of endovascular repair on the volume-outcome relationship for elective aneurysm surgery. The studies demonstrated that:

• Hospital volume was significantly related to elective aneurysm mortality for open repair, endovascular repair and the combined (open + endovascular) group (Holt, Poloniecki et al. 2009). There was a significant difference between endovascular mortality between the lowest and highest quintile providers (6.88 vs. 2.88%), and a 77% reduction in mortality was observed for every 100 endovascular repairs performed. Higher volume hospitals were more likely to adopt endovascular therapy (44% in high volume hospitals vs. 18% in low volume hospitals) (Dimick and Upchurch 2008).

• Hospital volume was an independent predictor of mortality.

• Results were defined by the total aneurysm caseload rather than either endovascular or open cohorts alone i.e. hospitals with a large, predominantly endovascular, caseload also reported better

than average results from open aneurysm repair. The use of endovascular and minimally invasive techniques is a rapidly developing area within vascular services and there is likely to be a further shift towards endovascular repair of aneurysm over coming years.

The evidence for volume-outcome relationships has been described for abdominal aortic aneurysms. However, there is evidence that similar relationships affect the performance of other vascular procedures including lower limb arterial reconstruction and carotid endarterectomy (Karthikesalingam et al 2010;Moxey et al 2012)

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DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:		INQUIRY MEETING 3 – ACCESS TO AND SUSTAINING LONG TERM ACCOMMODATION		
DATE OF DECISION:		2 APRIL 2014		
REPORT OF:		ASSISTANT CHIEF EXECUTIVE		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Dorota Goble**	**Tel:**	**023 8083 3317**
	E-mail:	**dorota.goble@southampton.gov.uk**		
Director	**Name:**	**Suki Sitaram**	**Tel:**	**023 8083 2060**
	E-mail:	**suki.sitaram@southampton.gov.uk**		
STATEMENT OF CONFIDENTIALITY				
None				

BRIEF SUMMARY

This report provides details for the third meeting of the Health Overview and Scrutiny Panel (HOSP) Inquiry examining the impact of housing and homelessness on the health of single people. At this meeting the inquiry will examine the barriers to remaining in long term accommodation, potential health risks of poor quality accommodation and availability of suitable accommodation.

The issues will be separated into two sections:

PART A will focus on access to suitable long term accommodation for single homeless people. Presentations will include:

- An overview of single housing provision - Sherree Stanley, Manager- Housing Delivery & Renewal
- HMO Licensing and quality of private sector provision - Mitch Sanders, Head of Regulatory Services and Janet Hawkins, Team Leader.
- The landlord's perspective - Colin Bagust, Southern Landlords Association South Hampshire Branch
- Probation Services – Rob Turkington, Operations Manager

PART B will focus on supporting people into sustaining long term accommodation:

- Developing life skills - Booth Centre, Peter Walton, Operations Manager
- Floating support Service, Family Mosaic - Steve Curtis, Regional Manager

RECOMMENDATIONS:

(i) The Panel is recommended to consider the information provided by presentations and use this, alongside the appendices, as evidence in the inquiry.

REASONS FOR REPORT RECOMMENDATIONS

1. To enable the Panel to consider the evidence in order to agree findings and recommendations at the end of the inquiry process.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. Not to proceed with inquiry. This option was rejected as the Panel have agreed to undertake the inquiry given the current high demand for single accommodation alongside the fact that single homeless people are less likely to be in priority need. It is widely known that homelessness, especially rough sleeping, has significant and negative consequences for an individual's health. Many studies have found strong correlations between homelessness and a multiplicity, and increased severity, of both physical and mental health conditions.

3. However, despite this increased morbidity, homeless people consistently miss out on the healthcare they need. As a result, health problems are left untreated and health deteriorates. When homeless people do access health services, they are likely to do so in an unplanned way (for example through accident and emergency) and to be in a state of chronic ill health. This results in longer stays in hospital and multiple readmissions, and has clear cost implications. The Inquiry aims to consider the impact and barriers to single homelessness people accessing healthcare and other services and make recommendations that aim to reduce blockages in the system and prevent future increasing demand on services, within existing cost constraints.

DETAIL (Including consultation carried out)

4. The purpose of the Inquiry is to consider the impact of housing and homelessness on the health of single people, a significant number of whom have complex needs, and live unsettled and transient lifestyles, and to examine the difficulties that their everyday life presents to deliver a preventative and planned approach to improve their health and well being and access to a settled and decent home.

5. The third meeting will be split into two sections.

   Part A of the Inquiry aims to consider access to suitable long term accommodation.

   Part B will consider support services to sustain long term accommodation.

PART A: ACCESS TO SUITABLE LONG TERM ACCOMMODATION

6. The panel have heard about the reliance on the private sector for sustainable accommodation for homeless people. Sherree Stanley-Conroy, Manager-Housing Delivery & Renewal, will highlight the actions the council is taking to address the supply of homes for single people, and some of the factors driving demand to the panel. Appendix 1 outlines the actions in the housing strategy relevant to single homeless people. A copy of the full housing strategy can found at http://www.southampton.gov.uk/Images/Housing%20Strategy%202011-2015_tcm46-199356.pdf

7. The cost and availability of accommodation will have a knock on effect on the housing options available to homeless people in the private sector. Janet Hawkins and Mitch Sanders from Regulatory Services will highlight the issues around Housing in Multiple Occupation (HMO) Licensing and the quality of the private sector provision in the city. Appendix 2 gives the panel key background information on HMO licensing in the city.

8. Colin Bagust, Southern Landlords Association South Hampshire Branch will also attend the meeting to highlight the landlord's perspective on HMO licensing and providing accommodation for single homeless people.

9. Real Lettings operate a social landlord service from the Two Saints Cranbury Homeless Day Centre. Appendix 3 highlights the services and benefits they provide to homeless clients. Dominic Thompson, Manager Real Lettings South, will highlight the key issues for their clients to the panel.

10. In addition, Alison Ward, Project Manager No Limits will provide a verbal update to the panel about assessing the need for a social landlord service to cover the whole city.

11. Probation Services recognise that getting offenders into suitable accommodation is a crucial step in avoiding reoffending. Robbie Turkington, Operations Manager, will speak to the panel about the barriers their clients experience in accessing accommodation following a custodial sentence.

TO BE CONFIRMED

PART B: SUPPORT SERVICES TO SUSTAIN LONG TERM ACCOMMODATION

12. The Salvation Army offer accommodation and support to single homeless people. Peter Walton, Operations Manager, will outline the services and issues their clients face the Housing First model used successfully in America. Appendix 4 highlights the issues and potential solutions for single homeless people in the city. For further information on the Housing First model view the Shelter good practice briefing

13. Floating support is essential to homeless people to develop their independence and life skills when they move on to suitable accommodation. Family Mosaic is commissioned through Supporting People to provide key services to homeless people in their homes.

    Appendix 5 outlines the services provided by Family Mosaic. Steve Curtis, Regional Manager, will highlight the key challenges their service and clients experience and potential solutions.

14. The Panel is invited to have a discussion on the availability of suitable accommodation for single homeless people and support services to keep them in their own homes, alongside the back ground information provided in this report, and use this as evidence for the inquiry.

RESOURCE IMPLICATIONS

Capital/Revenue

15. None

Property/Other

16. None.

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

17. The duty to undertake overview and scrutiny is set out in Section 21 of the Local Government Act 2000 and the Local Government and Public Involvement in Health Act 2007.

Other Legal Implications:

18. None

POLICY FRAMEWORK IMPLICATIONS

19. None

KEY DECISION? No

WARDS/COMMUNITIES AFFECTED:	ALL

SUPPORTING DOCUMENTATION

Appendices

1.	Housing Strategy Actions relating to single homeless people
2.	HMO licensing issues in the city
3.	Two Saints Real Lettings services and benefits
4.	Salvation Army clients - issues and solutions
5.	Outline of floating support services, Family Mosaic

Documents In Members' Rooms

1.	None

Equality Impact Assessment

Do the implications/subject of the report require an Equality Impact Assessment (EIA) to be carried out.	Yes/No

Other Background Documents

Equality Impact Assessment and Other Background documents available for inspection at:

	Title of Background Paper(s)	Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)
1.	None	

Housing Strategy Action Plan 2011- 2015 – Actions relevant to Single Homelessness
2013 Progress report

1. MAXIMISING HOMES FOR THE CITY

Actions *Measure of success*	**Timescales and milestones**	**Financial and other resource requirements**	**Responsible Officer**	**Progress to end July 2013**	**RAG**
Assist Housing Associations to bid for the maximum resources for affordable homes through the 2011-15 HCA bidding round *Deliver 850 new affordable homes during 2011-2015 that meet HCA design guide and minimum Level 4 Code for Sustainable Homes*	March 2015	RSL partners, developers, Planning, HCA £18.8m funding from HCA already in place for schemes completing in 2011/12. Attract maximum future funding for period 2011-15.	Housing Delivery & Renewal Manager	196 affordable homes provided in 2012/13. On target to provide 330 in 2013/14. All 7 partner Registered Providers have funding available to work in the city and the council continues to support any new bids for funding from partners, including successful bids under the 2013-15 mini bidding round.	G
Manage the Housing Register with a focus on households who will realistically be housed *Removal of applicants no longer in need of social housing and more reliable information about those in need to enable focus on assisting and prioritising applications. Improved offer process and reduced numbers of refusals*	March 2012	Within existing budgets. SCC in partnership with RSL partners, housing management and other support providers	Housing Needs Manager	Now subject to Lettings Policy review. Current Administration show clear wish to retain housing needs as the priority for social housing.	G
Promote Shared Ownership, low cost home ownership and Right to Buy *Shared Ownership and other low cost home*	Ongoing	Shared Ownership – resources from HCA, Partners -RSL partners, planning,	Head of Housing Management and Housing	SCC continue to take part in the bi-annual HomeBuy shows to help promote all new build low cost home ownership opportunities to residents- c 500 visitors per event.	G

Actions *Measure of success*	**Timescales and milestones**	**Financial and other resource requirements**	**Responsible Officer**	**Progress to end July 2013**	**RAG**
ownership opportunities promoted to residents via partnership between council and HomeBuy agent		developers	Delivery & Renewal Manager	RTB number have increased significantly since Government changed level of discount 63 homes sold in 2012/13, and 20 so far in 2013/14.	
Develop a new letting policy and Strategic Tenancy Policy to accommodate legislative changes and new affordable housing products *New policy agreed which is a simplified policy which will make it easier and less time consuming to explain and administer*	April 2012	Within existing budgets - Partners - tenants/ wider community. Housing Association Partners and neighbouring authorities	Housing Needs Manager	Completed. Tenancy strategy and requirement to have Landlord policy for use of Fixed term (flexible) tenure in place.	G

2. IMPROVING HOMES TRANSFORMING NEIGHBOURHOODS

Actions *Measure of success*	**Timescales and milestones**	**Financial and other resource requirements**	**Responsible Officer**	**Progress to end July 2013**	**RAG**
Attract investment to improve Southampton's private homes *Secure external funding to improve a minimum of 100 private homes in 2012/13*	31 March 2012	Work within existing budgets to attract funds Partners – SCC Contractors, PUSH, LEP, HCA	Regulatory Services Manager (Neighbour-hoods)	Grant funding of £114,000 was obtained from the Department of Health to fund a winter fuel poverty project in 2012/13. The project levered in additional funding from energy companies and combined with some council funding this was used to improve 1,643 private homes in 2012/13, which exceeded the target.	G

Actions *Measure of success*	**Timescales and milestones**	**Financial and other resource requirements**	**Responsible Officer**	**Progress to end July 2013**	**RAG**
Work with other partners and social landlords develop ongoing and sustainable projects that help tenants and residents into training and employment and reduce worklessness and financial exclusion *Reduced demand on state benefits from Council tenants* *More tenants and family members in work and contributing to the local economy* *Reduction in arrears and evictions due to financial issues*	March 2015	Project funding currently available of £30k pa in Housing management – wider resources drawn in from third party funding and other partners	Head of Housing Management	Housing Skills & Employment Group now meeting- brings together council & RP partners. Intention is that longer term, £30k from HRA will be pooled into a wider Strategic Investment Budget, but in short term £30k being used to reopen job clubs from Sep '13. Further £75k of HRA money given to City Limits to fund Employment Officers- 157 have been supported by these posts to move closer towards the job's market.	G

3. EXTRA SUPPORT FOR THOSE WHO NEED IT

Actions *Measures of success*	**Timescales and milestones**	**Financial and other resource requirements**	**Responsible Officer**	**Progress to end July 2013**	**RAG**
Manage the tender process for new support services for homeless people in the city *Tenders completed and awarded*	Up to March 2012	Within existing staff and Supporting People resources. £2.5million available in 2011/12, £1.9 million available from 2012/13	Commissioner for Adult Care Services	Tender process undertaken and successfully concluded. New services commenced between February and April 2012. All services operating effectively	G
Plan to increase housing options, with support for those who need it, including people with mental health problems, drug and alcohol users (to promote recovery), people fleeing domestic violence, and other need	March 2013	Within staff resources	Commissioner for Adult Care Services, Head of Housing	Individual strategic reviews undertaken, and leading to changes: - reconfiguration of services to people with mental health problems – and second review commencing in 2013	G

Actions *Measures of success*	**Timescales and milestones**	**Financial and other resource requirements**	**Responsible Officer**	**Progress to end July 2013**	**RAG**
groups. *Plan developed to manage increased and changed accommodation options for a range of groups in place. Action plan for delivery agreed.*			Management, Head of Housing Needs	- New accommodation being developed for teenage parents, close to the city centre - Changes made to some domestic violence services – increasing self-contained flats New units added to future contracts for people with alcohol problems, including short-term/respite flat.	
Continue to focus on homeless prevention *No increase in homeless acceptances – sustain current level of homeless prevention casework (700)*	According to legislative change implementation - ongoing	Within existing staff resources CLG funding £486K 2012/13– future years expected at the same level Partners SCC and voluntary sector	Housing Needs Manager	Homelessness prevention remains clear priority for the Homelessness team. 2012 saw increased numbers of cases where homelessness was prevented.	G

APPENDIX 2

HMOS IN SOUTHAMPTON

- City has just over 100,000 homes of which a little under 25% are rented from private landlords. Within the private rented sector 7,000 homes are estimated to be in multiple occupation. Therefore one in ten private homes is an HMO which is five times the national average.

- Stock condition survey (2008) shows that 38% of all private homes do not meet the Decent Homes Standard. Most commonly due to serious housing hazards (falls and fire) and poor thermal efficiency. Total cost to remedy estimated at £111M.

- Private rented homes generally in the poorest condition with a quarter having a hazard likely to result in harm needing medical treatment. Private tenants also experience higher levels of fuel poverty; 95% homes have potential to improve energy efficiency.

- Vast majority of HMOs in the city are either shared houses or bedsits occupied with 4 or more tenants. Most tenants (84%) are aged between 16 and 34 years.

- Many other issues are faced by tenants of HMOs including overcrowding and/or inadequate facilities, ineffective management and anti social behaviour.

- Poorly managed and maintained HMO properties can have an adverse impact on the local area and community. Most landlords manage their properties well and want to comply with the law.

Regulatory Services

Regulatory Services works with tenants, landlords and other partners to improve the private rented sector in the city; the aim is to keep homes warm, safe and secure.

Environmental Health Practitioners receive and investigate complaints about disrepair and management of private rented properties as well as completing a risk based reactive inspection programme.

Year	Number of service requests (total)
2009/10	602
2010/11	572
2011/12	555

The service works with responsible owners but will take enforcement action where appropriate to require landlords to improve their properties; a range of legislative powers is available including the Housing Act 2004.

HMO Licensing

Licensing is aiming to:

- Improve property conditions in HMOs; ensure that basic health and safety requirements are met; the property meets the basic standards i.e. number of bathrooms and kitchens

are appropriate for the number of tenants, the property meets fire safety requirements and has suitable and adequate management.

- Protect the health and safety of occupiers and minimise the impact on neighbourhoods through poorly managed and maintained properties.

Mandatory and Additional HMO Licensing:

- A Mandatory Licensing scheme has been in operation since 2006, it is citywide and includes the larger HMO properties where there are 3 or more storeys and 5 or more occupiers. There are estimated to be around 500 properties in the city most of which have been licensed.

- Since July 2013 the City Council has had a designation for Additional HMO Licensing in 4 wards (Bevois, Bargate, portswood and Swaythling). This means that all HMOs in these 4 wards need to be licensed.

- There are an estimated 4500 properties in the designated area and applications have been received for just over 1600. The applications are currently being processed; there is a team of officers receiving, completing inspections and assessing applications to issue licences. Licence conditions are attached to each licence and include the council's expectations for effective management. These will be monitored where needed.

- To date we have been accepting applications from responsible owners who have wanted to comply with the requirements. From March 2014 we will be moving to our enforcement phase where we intend to deal robustly with landlords who let properties in a poor or dangerous condition or who have poor management arrangements or who fail to make a licence application in a timely manner. This will include prosecuting where appropriate. We will use the intelligence we have to plan programmes of work to find unlicensed HMOs. We will work with partners where we are able to achieve this.

- To enable the scheme to be effective we have additional staff resource paid for by the licence fees including dedicated legal support and have just recruited an HMO warden who will work closely with residents, tenants and landlords to enable existing legislative provisions to be enforced with regard to issues such as letting boards (where needed).

- As far as other areas of the city, the legislation does not allow is to extend the existing scheme however the Cabinet report approved in February 2013 for the Additional HMO Licensing scheme set out 2016 as the date where we would consider a designation for other areas of the city. It would take a year to implement a further designation; this process is likely to start earlier than expected in July 2014.

- We work very closely with other council service i.e. planning and legal services and have a good working relationship. We have also been working with landlord groups in the city through our newly created consultative forum and are in the process of arranging our first stakeholders forum which we hope interested organisations, local residents groups and tenants will attend

- The service has always found it difficult to develop a maintained dialogue on a collective basis with tenants other than students. There are regularly low numbers of responses with customer satisfaction questionnaires and we received very little feedback to the consultation for HMO Additional Licensing.

Southampton City Council Homelessness Health Inquiry
Real Lettings South

Introduction
Real Lettings South was set up in 2011 by Two Saints (a Registered Provider - housing association) to provide a professional residential management service for private sector landlords. RLS provides both a good rate of financial return for owners as well as managing homes for vulnerable homeless people. Real Lettings South is a "not for profit company" which will eventually manage a property portfolio of a sufficient size not to require public subsidy.

In the first two years of operation over 70 homes have been provided in Southampton for vulnerable homeless people along with an additional 100 homes across Hampshire, West Berkshire and Poole.

Benefits of RLS
RLS is one way of overcoming the barriers which people face when accessing the private rented sector:-
-no deposits or rent in advance or fees are charged to tenants
-rents covered by Housing Benefit
-additional housing management is provided throughout the tenancy
-professional housing management service
-some security of tenure

In the City RLS has helped meet the following accommodation needs
-move on accommodation for people ready to leave Patrick House, the Booth Centre and other Supported Housing
-accommodation for people assessed by the Street Homelessness Prevention Team
-accommodation for ex-offenders

All RLS tenants are vulnerable on the basis of one or more of the following grounds
-substance misuse
-alcohol misuse
-Ex-offenders
-ill health
-learning difficulties
-mental health
-homelessness

Funding
RLS was set up with funding from Southampton City Council as part of the South Hampshire Cross Authority Group (£30,000 in 2012/13)and additional work in the City has been funded through the national charity Crisis and Southampton Probation Service (2013/14 £47,000).

RLS is also involved in a number of other initiatives to help increase the provision of accommodation in Southampton. RLS was responsible for leasing the property in Southampton used for the Breathing Space project. RLS has secured HCA Empty Homes Grant to help convert an empty property in Northam Road into 6 studio flats.

Dominic Thompson
Manager Real Lettings South 25/03/2014 RLS SCC Health Inquiry v2

APPENDIX 3

ISSUES AFFECTING ACCESS TO SERVICES FOR THE SINGLE HOMELESS

Although there are many areas in which there is a lack of fair access to services across social, housing and health provision I intend to focus on three in particular. These are the sanctions process, individuals who are entrenched in homelessness and failures in joined up service delivery.

Sanctions
It is well documented that there is a significant correlation between anxiety and irrational beliefs and behaviour (see Bridges and Harnish 2010 for a review of papers in this field). Equally well established is the preponderance of mental health problems amongst the homeless population (reviewed by Fazel et al 2008) and homelessness is itself anxiogenic.

Given these factors it is reasonable to conclude that there will be a larger proportion of irrational decisions made by the homeless group than for a similar number of people in housing after controlling for other factors. This means that individuals struggling with significant life challenges who are often highly anxious are exposed to the same sanction regime as those in conditions that are more conducive to rational responses.

Sanctions are clearly devised in harmony with an economic theory that relies on people as rational actors who seek to maximise their economic good. Although this has been challenged in general it is clearly suspect for a group that can be shown to have a greater predisposition towards irrationality. I submit, therefore that the application of sanctions to the homeless in the same way as to the general population is inherently unfair and presents a further bar to their progress through homelessness readiness programmes.

The solution to this problem would be for all local DWP staff to consult with Homelessness providers *before* issuing sanctions. There are more creative and positive methods to meaningfully engage our clients with seeking work, which can be utilised in a multiagency approach. It would be ideal if there was an agreed protocol between all local providers and local DWP staff

Entrenched Homelessness
There are amongst the Homeless group in Southampton a number of clients who move from one provider to another multiple times and have had no success in moving towards independent accommodation in the current model.

The Southampton model is one of ‘Housing Readiness’ which means that clients are prepared for housing by receiving help with addictions and mental health issues and are given input to build the skills of daily living. This approach has marked success with a large section of the people we support. However this is evidently not true of the Entrenched group.

Another approach that has been pioneered over the past decade, originally in North America, is that of ‘Housing First’. This model is targeted specifically at the most vulnerable and seeks to initially provide stable accommodation and once this is in place support is then provided, often primarily at the place of residence. This method has been demonstrated in terms of viability and success rate (see Rynearson, Barrett and Clark 2010 for a review)

I propose that the Entrenched group in Southampton is among our most vulnerable clients and the most excluded, but also the group most likely to respond positively to a ‘Housing First’ approach. To this end, I believe there would be significant value in a pilot programme in Southampton to test the efficacy and cost benefit that this approach could provide.

Failures in Joined up Service Delivery

However systems are structured for the provision of services there are always criteria for access. Furthermore there is always a ‘gap’ somewhere in the overarching structure where a clearly vulnerable person does not hit the criteria of any particular service. For example an individual may have addiction issues, mental health problems and learning disabilities and clearly in need of support but may not be severe enough on any individual axis to access services that would help them.

This problem is exacerbated by cuts in public spending and the greater need for managers to protect their budgets. This can lead to interagency wrangling which can take significant time to resolve. Meanwhile the client may be experiencing increasing difficulties with no assistance.

My proposal for this problem is to appoint a ‘Gaps Officer’ for Southampton who’s role would be to adjudicate on these fringe situations and decide which agency would take lead responsibility for each individual in a ‘gap’. This could be added to a role that already exists or jointly funded by Social Services and Health.

References

Bridges, K. and Harnish, R. (2010) Role of irrational beliefs in depression and anxiety: a review. *Health*, **2**, 862-877. doi: 10.4236/health.2010.28130.

Fazel S, Khosla V, Doll H, Geddes J (2008) The Prevalence of Mental Disorders among the Homeless in Western Countries: Systematic Review and Meta-Regression Analysis. PLoS Med 5(12): e225. doi:10.1371/journal.pmed.0050225

Rynearson, S., Barrett, B., Clark, C.(2010). *Housing First: A review of the literature.* Prepared for the National Center on Homelessness among Veterans. Tampa, Florida: Louis de la Parte Florida Mental Health Institute.

APPENDIX 4

FLOATING SUPPORT SERVICES – FAMILY MOSAIC

The people we support

The Homeless Floating Support Service offers support to people living within Southampton. Our service supports up to 220 people for approximately six months to a year.

The service supports adults between the ages of 16 and 60 and is aimed at individuals and families who are either homeless or are at the risk of being made homeless and who could be experiencing a range of problems accessing or maintaining accommodation.

We also offer a resettlement service to people who have a history of homelessness and/or are moving out of an institutionalized setting such as a hostel, hospital or prison. This is to support them to maintain their tenancy and re-integrate into their local community. Although the service is short term, the focus is on long term solutions in ensuring sustainability of accommodation, financial stability, social inclusion, reducing risk of relapse, re-offending and, of course, homelessness.

In addition, Southampton HFS provide the resettlement support for ex-offenders who are still considered to be a risk to the public within a Multi Agency Public Protection Framework; working alongside statutory agencies to achieve the above-mentioned outcomes for the clients and to reduce risk to the public.

The service is available to all irrespective of tenure. We have worked with home owners facing repossession, private tenants, social housing tenants and street homeless.

Our referral sources include (but are not restricted to) Social Services, Probation Services, Registered Social Landlords, Health professionals, Solicitors, Advice agencies (such as CAB, CLEAR, Debt Advice Services), Two Saints, Salvation Army, Society of St. James, Drugs and Alcohol Services, Street Homeless Prevention Team, Domestic Violence refuges and safe houses for trafficked individuals.

The service we offer

The support is short term and aims to empower the service user, facilitate independence and give the service user the resources to address their own issues appropriately in the future. Meeting these needs often involve sign posting and referring to other agencies and other collaborative approaches; to this end we have strong working relationships with both statutory and voluntary agencies.

People receiving support from us will meet with their support worker on a regular basis to address identified issues and work towards agreed goals. This is worked out and agreed at the beginning of the service and regularly reviewed. The support can focus on things like housing, health, money, employment/education and community activities. This is agreed in an Action Plan which is drawn up and regularly reviewed with the service user.

It is recognized that homelessness is just symptom of many other issues as a result we have specialisms within the team, such as the Health Trainer and Social Inclusion.

Additionally we run regular Drop In advice surgeries across the city providing free housing related advice. These are held in Local Housing Offices and Daycentre and are available to all members of the public.

Effectiveness of support

In the last calendar year the service responded to 1027 cases. These comprised of 479 people provided with a package of support (ie receiving regular support from an allocated support worker), and 548 people helped through the Drop Ins to either access or maintain their accommodation.

Following a programme of support our service users are contacted regarding the quality of the service that they received. Below is a snapshot of the results from Customer Satisfaction Surveys of the last quarter:

Key Indicators

- Satisfaction with Support - 100%
- Support Staff - 99%
- Involvement - 92%
- Consultation - 97%
- Know how to complain - 94%

Your Views - How could we improve?

Comments from client feedback forms

Don't think you could, I was impressed
Not. Based on my experience it could not have gone any better for me
Could go on longer
I was perfectly happy with the service I received.
I don't think you can
More of In Touch, should take over
Not sure, I had no complaints and its effective
[Name] was very good, so I don't know how you could improve
Does not need to improve
Did an excellent job, no improvement required
Don't know
Don't think it can be improved
Gave me access to funding to develop myself and open doors for myself, Support was excellent
Could not improve
Service could continue for longer
Don't know
I think a good job was done with my support
You can't, service is excellent
No, can't think of anything
More frequent visits, once a week would have been good
I don't think it can be improved
Don't know
Don't think you can. The service I received was excellent
I don't, (name) was excellent
If client could select gender of their worker
On my personal experience you can't improve, service is very good
Place of first meeting could be improved
I can't think of anything, everything was very good
Haven't thought about it was good
Could go on for longer

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